HEALTH AND SAFETY COMMITTEE

9.30am on Tuesday 24 October 2017
Corporate Meeting Room, Headquarters, UHW

CARING FOR PEOPLE
KEEPING PEOPLE WELL

Health and Safety Committee
9.30am on 24th October 2017
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 18 July 2017	*Chair*
5	Action Log Review	*Chair*
Deliver Outcomes that Matter to People		
Our Service Priorities		
Sustainability		
6	Corporate Risk Assurance Framework	*Director of Corporate Governance*
7	Fire Safety – Assessment of External Cladding Panels on UHB Buildings	*Director of Capital, Estates and Facilities*
8	Updated Fire Safety Annual Report	*Director of Capital, Estates and Facilities*
9	Fire Enforcement and Management Compliance Report	*Director of Capital, Estates and Facilities/Head of Health and Safety*
10	Shared Services Fire Safety Audit of University Hospital Llandough	*Director of Capital, Estates and Facilities*
11	Enforcement Agencies Correspondence Report	*Head of Health and Safety*
12	Health and Safety Priority Action 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		
13	Work Programme 2017/18	*Director of Corporate Governance*
14	Health and Safety Priority Action Plan (in detail)	*Head of Health and Safety*
15	EHO Report of Catering, Rookwood on 13th July 2017	*Director of Capital, Estates and Facilities*
16	EHO Report of Ward Based Catering, UHW on 14th September 2017	*Director of Capital, Estates and Facilities*
17	EHO Report of Aroma Units, UHW on 14th September 2017	*Director of Capital, Estates and Facilities*
18	EHO Report of Central Food Production Unit (CPU), UHW on 12th September 2017	*Director of Capital, Estates and Facilities*
19	**Minutes from other Committees/sub-Committees/Groups** Operational Health and Safety Group – June 2017 Fire Safety Group – May 2017 Security and Personal Safety Strategy Group – May 2017	*P Welsh* *G Walsh* *C Dalton*
20	Updated Health and Safety Related Policies Schedule	*Director of Corporate Governance*
21	Review of the Meeting	Oral *Chair*
22	To note the date, time and venue of the next meeting:- • 9.30am on Tuesday 23rd January 2018 in the Corporate Meeting Room, Headquarters, University Hospital of Wales.	

UNCONFIRMED MINUTES OF THE HEALTH AND SAFETY COMMITTEE HELD AT 9.30am ON 18 JULY 2017 IN SEMINAR ROOM 1, COCHRANE BUILDING, UNIVERSITY HOSPITAL OF WALES (UHW)

Present:

Martyn Waygood	**Independent Member – Legal (Chair)**
Stuart Egan	Independent Member – Trade Union/Health and Safety Staff Lead (1st part of meeting)

In attendance:

Charles Dalton	Head of Health and Safety
Fiona Jenkins	Director of Therapies and Health Sciences (2nd part of meeting)
Fiona Kinghorn	Deputy Director of Public Health
Catherine Salter	Staff Representative (RCN)
Peter Welsh	Director of Corporate Governance
Lee Wyatt	Head of Facilities

Apologies:

Carol Evans	Assistant Director of Patient Safety and Quality
Geoff Walsh	Director of Capital, Estates and Facilities

Secretariat:

Rachael Daniel	Health and Safety Adviser

PART 1

HSC: 17/054 WELCOME AND INTRODUCTIONS

The Chair welcomed all present to the meeting. Mr Waygood informed the Committee as Mr Egan would not be able to stay for the full meeting those items on the agenda requiring action would be taken first.

HSC: 17/055 DECLARATIONS OF INTEREST

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

HSC: 17/056 MINUTES OF PREVIOUS MEETING

The minutes of the Health and Safety Committee held on the 25 April 2017 were **APPROVED** and **ACCEPTED** as a true record.

HSC: 17/057 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 no formal meeting had taken place to progress the overall strategy for pedestrian safety, the Director of Capital, Estates and Facilities had been progressing pedestrian safety within the tunnels.

  The Deputy Director of Public Health stressed the need for pedestrian safety to be a key design component when planning future projects.

  An update on progress was requested for the next meeting.

  ACTION – Mr G Walsh/Mr C Dalton

  The Independent Member – Trade Union advised of concerns relating to the mini roundabout outside the Emergency Unit whereby there was not enough turning room so vehicles had to mount the pavement. The Head of Facilities stated he would investigate this further.

  ACTION – Mr L Wyatt

  The Director of Corporate Governance thanked the Capital and Estates Teams for significant improvements made at University Hospital Llandough (UHL) in respect of road safety.

- 17/036 – the Head of Health and Safety advised the one page guidance in respect of wedging fire doors open had been discussed at the Fire Safety Group and would be produced by the Senior Fire Safety Adviser.

  ACTION – Mr L Wyatt/Mr G Walsh

HSC: 17/058 CORPORATE RISK ASSURANCE FRAMEWORK DOCUMENT (CRAF)

The Director of Corporate Governance informed the Committee there continued to be 9 significant risks on the CRAF and their scoring remained static whilst minor changes had been made to 2 of the risks.

Mr Welsh advised following the Development Day on the 27th April 2017, there was now a review of the way the Health Board addressed and prevented risks and more emphasis would be placed on the impact of risks. Mr Welsh advised that Committee Members had a role to play in addressing their risks and requested any comments on how risks should be managed were to be forwarded to himself and Sian Rowlands, Head of Corporate Governance by the end of August 2017. An update would then be provided to the October meeting of the Audit Committee.

The Head of Health and Safety informed the Committee there was documentation behind the risks on the CRAF which demonstrated key milestones taken to reduce the risks. The Head of Facilities supported this by adding the risk register was being reviewed by the Capital and Estates Team.

The Staff Representative (RCN) queried the status of the e-datix risk management module, it was **AGREED** that a timeline would be obtained from the Assistant Director of Patient Safety and Quality.

ACTION – Miss R Daniel/Mrs C Evans

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: 17/057 LETTER TO CEO's FROM WELSH GOVERNMENT (WG) RE HEALTH AND SAFETY ASSURANCE

The Director of Corporate Governance informed the Committee the letter from Welsh Government had been sent to all Health Boards and was to be received by this Committee so that assurances could be given to the Board that health and safety was being sufficiently managed and given appropriate priority. Mr Welsh added he was comfortable that the Health Board had the necessary arrangements in place to manage health and safety risks. The Chair concurred with this stating the Health Board had a designated Lead Director for health and safety and this Committee was a formal Committee of the Board. Mr Waygood added it was justified that the Health Board should have a Health and Safety Committee in its own right and not form part of a Quality and Safety Committee where health and safety risks may not be given the attention that was merited.

The Independent Member – Trade Union stated there were good processes in place and the Health Board was very good at addressing those issues it has the knowledge of, however the unknown was a concern. The Deputy Director of Public Health added there was a clear system in place and progress was being made, however it was essential that any risks were owned by the organisation.

The Head of Health and Safety stated the Priority Action Plan was a useful mechanism for providing assurance to the Board.

The Staff Representative (RCN) said there was monetary implications for some risks which required investment if they were to be resolved.

The letter from Welsh Government was **RECEIVED** and **NOTED** by the Committee.

HSC: 17/058 HEALTH AND SAFETY ANNUAL REPORT

The Head of Health and Safety presented the key issues in the annual report:

- Incident data collated from the Datix system showed a high level of close out and management involvement.
- RIDDOR events have remained constant but there had been a continued increase in the number of patient behavioural incidents which had doubled over the last 2 years and up 28% on the previous year.
- The Health Board received its second Health and Safety Executive (HSE) enforcement action since 2001 relating to Legionella requirements.
- The HSE were also active in visiting the Health Board and applying "Fees for Intervention"
- A change in the way fines were applied highlighted the significant potential risk of a fine being in the order of £1-2 million.
- The number of Prosecutions and other Police interventions were significantly lower than previous years, however the Health Board was working closely with the Police, Crown Prosecution Service and Shared Services Legal to improve the Memorandum of Understanding between all parties.
- Training compliance for both manual handling and violence and aggression had improved, although this mostly related to e-learning Module A and not tutor led training.
- Training improved although it was still not at the target level of compliance and some Clinical Boards were demonstrating low compliance or poor progress in improving the percentage of their staff trained. This is being pursued by the Mandatory Training Steering Group.
- Tutor led training continued to show a very high level of failure to attend on the day and this was being considered by the Health and Safety Operational Group.
- With the appointment of a new Staff Safety Representative Chair and Deputy the workplace inspection regime had been reviewed and enhanced local representative's involvement.
- Notably consistently high Environmental Health Star ratings of food preparation areas and restaurants was achieved during the period.
- Dirty medical sharps injuries were 37% lower since the introduction of safer sharps in 2012/13.
- Dirty needle stick injuries were 17% lower than the previous year.

The annual report also demonstrated the improvement in the management of health and safety aspects through the priority action plan and the control of policy schedule, keys areas of progress included:

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

The Chair thanked Mr Dalton for his presentation. Mr Waygood stated compliance to training and particularly the failure to attend rate needed to be reported to the Board. The Deputy Director of Public Health agreed and added it also needed to be reported to the Clinical Board's Performance Meetings.

Mr Dalton referred to Table 39 - benchmarking data and suggested this be used as the format in which Clinical Boards reported to the Committee in order for assurances to be obtained. The Director of Corporate Governance also suggested this be shared with Management Executive.

ACTION – Mr P Welsh

Mr Waygood stated the Medicine Clinical Board should be first to attend the Committee to explain their position and provide assurance as they were clearly experiencing some difficulties. The Director of Therapies and Health Sciences advised she would raise the matter at their Performance Review. Mrs Jenkins also added this data needed to be shared with the Clinical Boards as a priority.

ACTION – Mrs F Jenkins

The Staff Representative (RCN) referred to Table 15 and the number of 'workplace stressor demands' incidents and queried where the Health and Wellbeing Group reported to, Mr Welsh advised he would raise with the Assistant Director of Organisational Development.

Action – Mr P Welsh

Mrs Salter referred to page 51 and queried whether any additional funding would be made available to purchase additional glide sheets. Mrs Jenkins stated there was no corporate budget and the resourcing should come from the Clinical Boards. Mrs Kinghorn advised the positive aspects of the glide sheets needed to be shared with the Clinical Boards.

ACTION – Mr C Dalton

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

ASSURANCE was provided by:

- Health and Safety aspects being monitored and progressed as appropriate.

HSC: 17/059 LETTER TO CEO's FROM WELSH GOVERNMENT (WG) RE FIRE SAFETY GRENFELL TOWER

The Director of Corporate Governance informed the Committee the letter had been sent to all Health Boards and the Director of Planning was taking the lead in providing a response to Welsh Government (WG). Mr Welsh added a report had also been presented to Management Executive the previous day.

The Staff Representative (RCN) informed the Committee staff had raised concerns with herself in respect of whether any of the Health Board buildings had cladding which posed a fire risk and requested that a brief message of assurance be issued through 'CAV Have You Heard', this was **AGREED.**

Action – Mr L Wyatt

Mr Welsh requested the formal report be brought to the next Committee meeting.

ACTION – Mr L Wyatt/Mr G Walsh

HSC: 17/060 FIRE SAFETY ANNUAL REPORT

The Head of Facilities highlighted the key issues in the annual report:

- Enforcement notice for Whitchurch Hospital would remain until the hospital was unoccupied.
- 28 fires reported during the period.
- 510 unwanted fire signals reported during the period.
- Compliance to fire safety training required vast improvement.

The Staff Representative (RCN) expressed her disappointment at the quality of the Fire Safety Annual Report. Mr Wyatt advised there was a lot of ongoing work behind the report and the Director of Corporate Governance added the Fire Safety Group provided continual assurance to this Committee.

The Chair queried whether the report gave sufficient understanding on the position of compliance to fire training and evacuation. Mr Waygood added he did not consider section 9.0 to be an action plan but comments and would like to see more detail in relation to the effectiveness of training, compliance to evacuation procedures and compliance with fire risk assessments.

The Director of Therapies and Health Sciences concurred that the report was not robust enough and did not provide assurance to the Committee, it also needed to cover the correct financial year and required a detailed and specific action plan with targets.

The Fire Safety Annual Report was **RECEIVED** by the Committee but did not provide the necessary assurances and a more detailed report was **REQUIRED** for the next meeting.

ACTION – Mr L Wyatt/Mr G Walsh

HSC: 17/061 FIRE ENFORCEMENT AND MANAGEMENT COMPLIANCE REPORT

The Head of Facilities advised the Committee Whitchurch Hospital was vacated by the 7th July 2017 and the enforcement notice would now be reviewed by South Wales Fire Service. Mr Wyatt also advised the second enforcement notice was in relation to a patient smoking in their bedroom at Hafan y Coed, University Hospital Llandough (UHL) and the Fire Service considered the Health Board had failed to control smoking.

In relation to Whitchurch Hospital the Director of Corporate Governance informed the Committee whilst there were no staff in the hospital there was still a significant amount of medical records and equipment stored there which had been reported to Management Executive as the Health Board had a period of time to remove the records.

In respect of the enforcement notice at Hafan y Coed the Chair queried whether the Health Board was content that assurances made to South Wales Fire Service were sufficient for the enforcement notice to be lifted. The Head of Health and Safety confirmed a 12 point action had been developed which was being led by the Mental Health Clinical Board and had been shared with South Wales Fire Service. The Deputy Director of Public Health added a trial was being undertaken in relation to the purchase and use of e-cigarettes to see if smoking could be reduced with this client group but added it was a very challenging area. Mr Waygood requested an update for the next meeting.

ACTION – Mrs F Kinghorn

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

ASSURANCE was provided:

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

HSC: 17/062 SHARED SERVICES FIRE SAFETY AUDIT OF UNVERSITY HOSPITAL LLANDOUGH

The Head of Facilities informed the Committee NHS Wales Shared Services Partnership – Specialist Estates Services carried out an in-depth fire safety audit at University Hospital Llandough (UHL) during November 2016 and an action plan had been developed to address those issues raised in the audit. Mr Wyatt informed the Committee some of actions required updating but the action plan was being monitored by the Fire Safety Group.

The Director of Corporate Governance advised he would share the action plan with the membership of the Managers' Forum at UHL.

ACTION – Mr P Welsh

The Health and Safety Adviser suggested the Leads identified on the action plan should be job title and not initials and also an extra column be added for progress made, this was **AGREED**.

Action - Mr L Wyatt/Mr G Walsh

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

ACTION – Mr L Wyatt/Mr G Walsh

HSC: 17/063 ENFORCEMENT AGENCIES CORRESPONDENCE REPORT

The Head of Health and Safety informed the Committee in respect of the Contractor fall incident the Health and Safety Executive were still interviewing staff and therefore no outcome at present was known.

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: 17/064 TREND ANALYSIS OF CONTRACTOR CONTROL SAFETY BREACHES

The Head of Facilities informed the Committee a lot work had been undertaken to reduce the number of contractor control safety breaches and this was predominately achieved through Contractor Monitoring across all Health Board sites. Mr Wyatt advised the Contractor Monitoring consisted of challenging contractors present on site and auditing them on their paperwork, risk assessments, working procedures and induction status.

Mr Wyatt explained the process was maturing and they were still finding issues but there were fewer breaches and these were improving on a monthly basis.

The Chair stated the report provided significant assurance to the Committee.

The report was **RECEIVED** and the Committee **AGREED** the on-going contractor control measures.

ASSURANCE was provided by:

- The on-going monitoring and challenging of contractors on site.
- Monthly analysis of contractor control.

HSC: 17/065 HEALTH AND SAFETY EXECUTIVE PRIORITY ACTION PLAN EXCEPTION REPORT

The Head of Health and Safety informed the Committee there were six red areas on the plan, these were in relation to:

- Risk Assessments
- Health and Safety Management Training
- Bariatric Patient Care
- Firecode/Fire Training
- Backlog Maintenance
- Legionella Survey and Risk Assessments

The Staff Representative (RCN) queried given the number of incidents reported in the annual report for workplace stressor demands whether this should be included on the action plan. The Head of Health and Safety confirmed following the publication of the annual report the action plan would undergo a full review.

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

REASONABLE ASSURANCE was provided by:

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

HSC: 17/066 INCIDENT REPORTING POLICY

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

Mr Dalton also informed the Committee the Procedure under pinning the Policy required amendment but did not affect the Policy content.

The Staff Representative (RCN) queried whether staff could still complete paper copies and whether e-datix was available in Welsh. The Health and Safety Adviser stated paper copies were no longer available and only e-datix was to be used to report incidents, if staff had difficulties in completing e-datix they should report this to their line manager who could then complete on their behalf. In respect of e-datix being available in Welsh Miss Daniel did not think it was as it was a national system but would verify with the Clinical Governance Department.

ACTION – Miss R Daniel

The Policy was **APPROVED** by the Committee

HSC: 17/067 SHARPS MANAGEMENT POLICY

The Health and Safety Adviser informed the Committee this was a review of a current Policy to which minor changes had been made. Miss Daniel advised the Policy originally had a two review period due to it being a new Policy but was now embedded within the Health Board so would revert to a three year review period. Miss Daniel added the Policy had been consulted upon via the intranet consultation pages and the Operational Health and Safety Group.

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

HSC: 17/068 1ST AID POLICY

The Head of Health and Safety informed the Committee this was the 3rd review of the Policy which followed Health and Safety Executive (HSE) Guidance and minor changes had been made. Mr Dalton added the Policy had been consulted upon via the intranet consultation pages and the Operational Health and Safety Group.

The Staff Representative (RCN) referred to section 4.5 and queried whether these should actually be responsibilities of the Health and Safety Department as opposed to LED. Mr Dalton concurred 4.5.1 should remain with LED but 4.5.2 and 4.5.3 transfer to Health and Safety.

Mrs Salter referred to section 5.2.2 and queried whether this now included Mental Health Nurses, Mr Dalton confirmed that it did. Mrs Salter requested communication be sent out to outline this change, prior to this the Director of Therapies and Health Sciences requested that this be re-checked.

ACTION – Mr C Dalton

The Chair referred to section 4.9 and queried whether it was a Health Board requirement or a regulatory requirement, Mr Dalton confirmed regulatory. Mr Waygood stated therefore it should read in compliance with regulations.
ACTION – Mr C Dalton

The Policy was **APPROVED** by the Committee

PART 2

HSC: 17/069 COMMITTEE WORK PROGRAMME FOR 2017/18

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

HSC: 17/070 REGULATORY REVIEW AND TRACKING REPORT

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

HSC: 17/071 HEALTH AND SAFETY EXECUTIVE PRIORITY ACTION PLAN (DETAILED)

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

HSC: 17/072 WASTE MANAGEMENT COMPLIANCE REPORT

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

HSC: 17/073 LONE WORKER DEVICES REPORT

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

HSC: 17/074 ENVIRONMENTAL HEALTH REPORT OF BARRY HOSPITAL OF WALES ON 21ST FEBRUARY 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: 17/075 ENVIRONMENTAL HEALTH REPORT OF AROMA COFFEE OUTLET, UNIVERSITY HOSPITAL LLANDOUGH ON 20TH JUNE 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: 17/076 OPERATIONAL HEALTH AND SAFETY GROUP MEETING OF MARCH 2017

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

HSC: 17/077 FIRE SAFETY GROUP MINUTES OF FEBRUARY 2017

The Director of Therapies and Health Sciences noted the poor attendance from Clinical Boards and stressed attendance at this meeting must be prioritised by Clinical Boards due to the increased emphasis being placed on fire safety.

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

HSC: 17/078 SECURITY AND PERSONAL SAFETY STRATEGY GROUP MINUTES OF FEBRUARY 20167

The Staff Representative (RCN) requested minute 2.2 be reworded to reflect whilst violence and aggression training was not part of the mandatory training core modules, the training is based off risk assessment and is over and above the requirements of mandatory training.

ACTION – Mr C Dalton

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

HSC: 17/079 HEALTH AND SAFETY RELATED POLICIES SCHEDULE

The Heath and Safety Adviser informed the Committee communication had been received from the Assistant Director of Organisational Development who advised there were a number of Health and Wellbeing policies due for review and was proposing a slightly different arrangement for them. The Health and Wellbeing at Work Strategy was the key document and instead of having a number of other related policies, there would be a series of 'statements' that fall under this overarching document, one of which would be Stress and Mental Health Wellbeing.

Miss Daniel also noted the Asbestos Policy was due for review but had not come forward to the Committee, the Head of Facilities stated he would take this back to the Department.

ACTION – Mr L Wyatt

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

HSC: 17/080 REVIEW OF THE MEETING AND ITEMS TO BRING TO THE ATTENTION OF THE BOARD OR OTHER COMMITTEES

It was **AGREED** the following should be brought to the attending of the Board:

- Compliance to training and the failure to attend rate.

Mr Welsh highlighted to the Committee this was Mr Waygood's last meeting and wanted to formally record his thanks and appreciation for the way in

which he had led the Committee for the last 8 years, this was fully endorsed and supported by all members.

Mr Waygood thanked Mr Welsh for his kind words. Mr Waygood thanked everyone for bringing their vibrancy and commitment to the meeting and stressed how pleased he was that this Committee retained its status as being a formal Committee of the Board.

Mr Waygood thanked Miss Daniel and Mr Dalton for their support during his Chairmanship of the Committee and thanked Mr Welsh for his leadership since taking over as Executive Lead for Health and Safety.

HSC: 17/081 DATE AND TIME OF NEXT MEETING

The next meeting will be held at 9.30am on Tuesday 24th October 2017 in the Corporate Meeting Room, HQ, University Hospital of Wales.

Signed ……

Date ……

UP DATED ACTION LOG

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

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
HSC: 17/032	25/04/17 & 18/07/17	Pedestrian Safety	Pedestrian Safety Strategy to be developed	Mr Charles Dalton/Mr Geoff Walsh	**ACTION STILL UNDERWAY**
HSC: 17/032	18/07/17	Pedestrian Safety	Concerns raised in relation to lack of space for turning by the mini roundabout outside the Emergency Unit.	Mr Lee Wyatt	**COMPLETED** Lee Wyatt has attended site with Ian Fitsall and reviewed all turning and pull in points. No sign of marks and observed no issues. Contacted Peter Welsh for further info and site meeting to observe. No reply as yet.

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
HSC: 17/034	25/04/17 & 18/07/17	Fire Safety	One page guidance to be developed in respect of wedging fire doors open.	Mr Geoff Walsh	**ACTION STILL UNDERWAY**
HSC: 17/058	18/07/17	CRAF - E-Datix Risk Module	To clarify the status of the e-datix risk module	Miss Rachael Daniel	**COMPLETED** No agreed implementation date as yet but will be considered as part of the e-datix workplan.
HSC: 17/058	18/07/17	Health and Safety Annual Report	Benchmarking data to be shared with Management Executive	Mr Peter Welsh	**COM PLETED**
HSC: 17/058	18/07/17	Health and Safety Annual Report	Benchmarking data to be raised at Medicine Clinical Board's Performance Review	Mrs Fiona Jenkins	**COMPLETED**
HSC: 17/058	18/07/17	Health and Safety Annual Report	Benchmarking data to be shared with Clinical Boards	Mr Charles Dalton	**COMPLETED**
HSC: 17/058	18/07/17	Health and Safety Annual Report	Positive aspects of the fabric glide sheets to be shared with the Clinical Boards	Mr Charles Dalton	**COMPLETED**
HSC: 17/059	18/07/17	WG Letter Re Grenfell Tower	A brief message of assurance to be issued via 'CAV Have You Heard' re fire cladding risk.	Mr Lee Wyatt	**ACTION STILL UNDERWAY**
HSC: 17/059	18/07/17	WG Letter Re Grenfell Tower	Formal report to be brought to next meetings.	Mr Lee Wyatt/Mr Geoff Walsh	**COMPLETED** Agenda Item

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
HSC: 17/060	18/07/17	Fire Safety Annual Report	A more detailed Annual Report to be brought to the next meeting.	Mr Lee Wyatt/Mr Geoff Walsh	**COMPLETED** Agenda Item
HSC; 17/061	18/07/17	Fire Enforcement and Management	Feedback on trial of e-cigarettes in the Mental Health Clinical Board.	Mrs Fiona Kinghorn	**ACTION STILL UNDERWAY**
HSC: 17/062	18/07/17	Shared Services Fire Safety Audit of UHL	Findings of audit to be shared with UHL Manager's Forum.	Mr Peter Welsh	**COMPLETED**
HSC: 17/062	18/07/17	Shared Services Fire Safety Audit of UHL	Action Plan to be amended to reflect job titles and extra column added for progress made.	Mr Lee Wyatt/Mr Geoff Walsh	**COMPLETED** Agenda Item
HSC: 17/066	18/07/17	Incident Reporting Policy	To determine whether e-datix was available in Welsh.	Miss Rachael Daniel	**COMPLETED** E-datix is a national system and there is not a welsh version.
HSC: 17/068	18/07/17	1st Aid Policy	To clarify whether section 5.2.2 now included Mental Health Nurses.	Mr Charles Dalton	**COMPLETED** Mental Health Nurses are included.
HSC: 17/068	18/07/18	1st Aid Policy	Section 4.9 to be amended.	Mr Charles Dalton	**COMPLETED**

3

CORPORATE RISK AND ASSURANCE FRAMEWORK UPDATE REPORT
Name of Meeting: Health and Safety Committee **Date of Meeting:** 24 October 2017

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

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

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

The Health and Safety Committee is asked to:

- **CONSIDER** the CRAF Update Report.

SITUATION

Following the Board meeting on 25 May 2017, and agreement to review and renew the Risk Management Process, we are continuing to engage with Clinical Boards and Corporate areas to support review / amendment of their risk registers.

This analysis is resulting in areas having to revisit their registers and make significant changes to more accurately capture their risks and controls, and

identify appropriate target scores and key actions required to achieve these within a set timescale.

A short, simple procedural guide to assist staff in reviewing their risk management processes is now being finalized following feedback, and will be disseminated later this month.

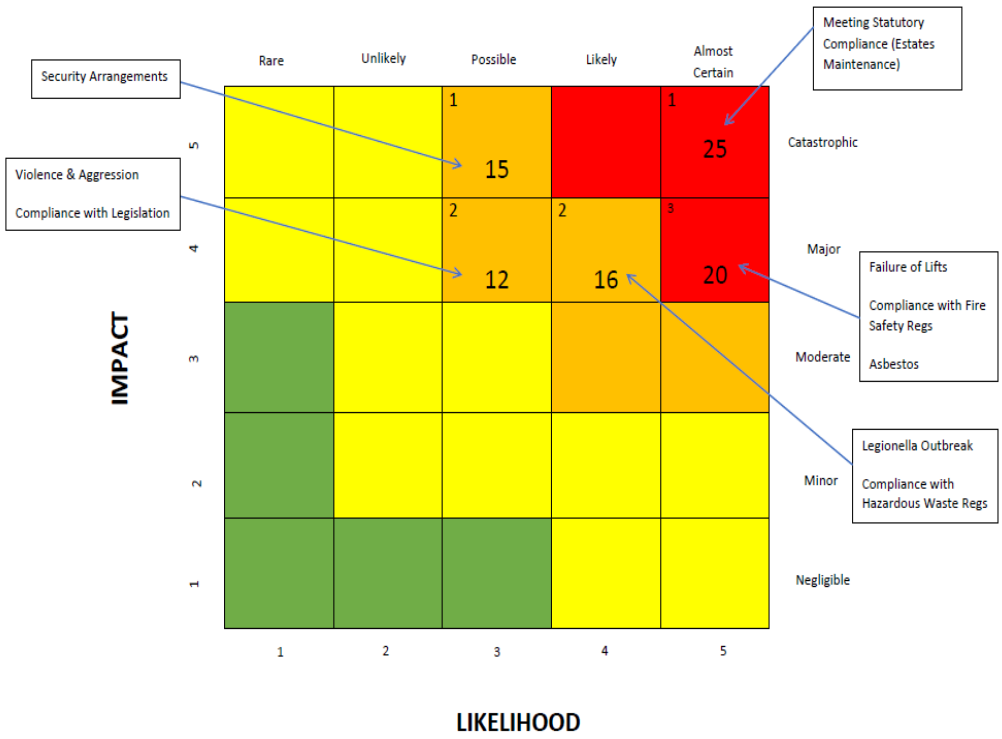
BACKGROUND

Each risk contained within the CRAF is assigned to Board or a Lead Committee for oversight.

The Board agreed the production of more visual, less text based standardized reports and this report is prepared with that aim in mind albeit the detail is extracted from the CRAF in its current format (updated 11 September 2017). As work progresses, the Board, its Committees and our stakeholders should more easily be able to gain assurance from the CRAF.

ASSESSMENT AND ASSURANCE

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



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

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There have been no changes since the report presented to the Committee in July 2017.

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

http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/248865

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

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

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

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

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

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Fire Safety - Assessment of External Cladding Panels on UHB Buildings
Name of Meeting: Management Executive **Date of Meeting:** 10th July 2017

Executive Lead : Director Strategy & Planning
Author: Director of Capital, Estates & Facilities. Tel 029 2074 4335
Caring for People, Keeping People Well: This report underpins the Health Board's "Our Service Priorities" and "Sustainability" elements of the Health Board's Strategy.
Financial impact : Capital costs associated with initial survey work and remedial work as identified
Quality, Safety, Patient Experience impact: The safety of patients staff and visitors is of paramount importance and has been considered as part of the survey work undertaken and in assessing the risk associated with each building.
Health and Care Standard Number: 2.4, 12
CRAF Reference Number: 5.2 & 6.4.8
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

REASONABLE ASSURANCE is provided by:

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

RECOMMENDATION

- **Note** the details of the report and the investigation work undertaken to date
- **Support** the recommendation to undertake testing of the Link Block 4 cladding
- **Support** an evacuation exercise utilizing ward B6 following refurbishment
- **Note** the intention to seek approval from South Wales Fire Authority in respect of our investigations and findings

SITUATION

The purpose of this report is to provide the Management Executives with:

- Details of buildings across the UHB that have external cladding panels installed
- Initial information relating to the type of panel that has been installed
- Recommendations of further investigations that should be considered to provide further assurance on the safety of panels
- The level of risk associated with the respective buildings

- The numbers of staff across the UHB that have undertaken their mandatory fire safety training

BACKGROUND

The recent tragic event in London where the Grenfell Tower was destroyed by fire resulting in significant deaths, has raised a number of significant questions in relation to the fire safety standards of the building and in particular the fire integrity of External Composite Panels.

In addition to the external panels, questions have been raised in relation to fire compartmentation within the building and the means of escape.

The external cladding panels installed on Grenfell Tower were of Aluminium Composite Material (ACM). The panels consist of two thin coil coated aluminium sheets bonded to a non alluminium core which is generally an insulating material.

Initially, Welsh Government (WG) together with National Wales Shared Services Partnership – Specialist Estate Services (SES) have requested details of all buildings which have external cladding panels fitted, details of the panels, information on the suitability of fire compartmentation, standard of Fire alarm system and whether sprinkler systems are installed.

Both WG and SES are also requesting information regarding the UHB's fire evacuation plans and staff training.

The UHB received email correspondence on Monday 3rd July from SES confirming that the Cabinet Office now places greater emphasis on the ACM . An extract or the Cabinet Office communication follows:

"There has been much concern about the potential flaws in the Aluminium Composite Material (ACM) cladding used on Grenfell Tower. It is important to stress that ACM cladding it is not of itself dangerous, but it is important that the right type is used. If you identify that a cladding on any of your buildings over 18 metres, including your ALBs and wider sector, is made of ACM then a sample will need to be tested. "

"How to identify which buildings need samples of Aluminium Composite Material Cladding sent for testing

If a building has ACM you should consult the table below which is based on relevant approved document B and departmental guidance:

Trigger heights for investigation of ACM Cladding Systems			
Building Use	**Overnight accommodation**	**Trigger Height/storey***	**Test?**
Schools	Yes	Any height	Yes

	No	18 metres or more	Yes
Health care facilities (including Hospitals)	Yes	2 storeys or more	Yes
	No	18 metres or more	Yes
All other buildings	Yes	18 metres or more	Yes

** Height is measured from ground level at its lowest point to the upper surface of the top storey (excluding plant rooms)"*

ASSESSMENT AND ASSURANCE

In accordance with the guidance as set out above a survey has been conducted to identify any building with Aluminium Composite Material (AMC) cladding.

There are four buildings all on the UHW site that have been identified which hit the trigger point in terms of overnight accommodation and height/storey, these being:

- Womens Unit
- Childrens Hospital
- Link Block 4
- Tertiary Tower

Both the Womens Unit and the Childrens Hospital have partial cladding which has through the O&M Manuals confirmed that it is appropriately fire rated.

The cladding identified on Link Block 4 is limited to the top floor only. No information can be located to confirm the specification of this panel and it is recommended that the UHB undertake the required testing to identify the material.

There is no information readily available in respect of the cladding on the Tertiary Tower and the UHB are in contact with the designers to assist with its specification. It should be noted that the Tertiary Tower has a sprinkler system throughout the building which will mitigate any risk. The System being subject of a service contract with Tyco International.

The surveys undertaken however, have confirmed that none of the panels are ACM as the outer sheet is steel coated.

Unlike the tower block in London all our buildings are fitted with an L1 alarm system with automatic detection in every room to give the earliest warning of fire possible. The system is maintained by the manufactures Protec, with two full time engineers on site, undertaking maintenance and testing in accordance with the relevant British Standard. Protec also provide an on call service for any emergency out of hours.

All buildings have extensive fire compartmentation to restrict the spread of fire and staff will lead an evacuation if necessary. We are aware of defects in the

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compartmentation some areas and we have a priortised action plan to carryout remedial action where defects have been identified.
The UHB are in the process of arranging a meeting with the the South Fire Authority to share the information relating to the cladding with them to determine whether they are satisfied with our approach and subsequent findings.

Annual fire training is a mandatory requirement within the Health Service and to achieve the Boards target of achieving a minimum of 85% compliance has proofed difficult to achieve. The figures to the end of June 2017 record a 48% compliance rate and this is the level achieved over a number of years.

Several initiatives have been trialed to raise the training figures and include mandatory months in May and November where a training session is provide every day and cascade training on wards where it is difficult to release staff.

We have carried out a number of evacuation exercises in the past to demonstrate the effectiveness of our procedures. We have now purchased a number of manikins in order to assist with any proposed exercise. However, the inability of the Clinical Boards in releasing staff together with the availability of an empty ward are barriers to undertaking more frequent exercises.

However, there is an opportunity with the immediate support of the Clincal Boards and ME to plan an exercise following the refurbishment of B6 North' prior to its re-occupation. This would require the commitment of nursing staff, portering staff etc along with the UHB fire officers and South Wales Fire & Rescue Service.

The table below identifies all buildings with external cladding including those that do not hit the overnight accommodation & Height/storey trigger criteria.

Detailed list of buildings within the UHB that have cladding.

Overnight accommodation two story or more.

- Children's Hospital (UHW)

  Four story building
  L1 Fire Alarm
  Sprinklers throughout
  Extensive fire compartmentation
  Cladding details confirmed as fully fire rated

  Risk:- Very Low
  Recommendation:- None

- Tertiary Tower (UHW)

  Seven story building
  L1 Fire Alarm
  Sprinklers throughout
  Extensive fire compartmentation.

  Cladding details currently being investigated

  Risk:- Very Low
  Recommendation:- Confirm cladding details

- Women Unit (UHW)

  Four story building, cladding on one elevation.
  L1 Fire Alarm
  Extensive fire compartmentation currently being upgraded.
  Cladding Details:
  Rockwool Fire Pro cladding providing 120 minutes fire resistance with steel sheet cover panels.

  Risk:- Very Low
  Recommendation:- None

- Link Block 4 (UHW)

  Five story, cladding to top floor only.
  L1 Fire Alarm System
  Fire compartmentation has not been fully surveyed: however is on fire stopping action plan.
  Cladding details currently being investigated

  Risk:- Moderate property risk
  Recommendation:- Confirm cladding details and complete compartmentation upgrade.

- East 4 & East 6 (UHL)

  Two story with full/partial cladding
  L1 Fire Alarm system
  Extensive fire compartmentation
  No sleeping in the area fitted with insulation cladding
  Cladding details currently being investigated

  Risk:- Low risk
  Recommendation:- Confirm cladding details

- MHSOP (UHL)

  Two story with partial cladding to first floor only.
  L1 Fire Alarm system
  Extensive fire compartmentation
  Cladding details currently being investigated

  Risk:- Low risk
  Recommendation:- Confirm cladding details

Our initial investigations indicate that ALL the buildings listed above have external composite material made of STEEL construction NOT aluminium.

These finding shall be clarified with the assistance of the South Wales Fire Brigade.

No overnight accommodation.

The following buildings have cladding however are not considered a risk as they do not have sleeping accommodation and are not over 18m high.

Services Accommodation Building (UHW)

Three story building
L1 Fire Alarm System
No sleeping risk
A compartmentation survey has been carried out and is within a priority action plan to carry out the remedial actions.
Cladding details unreliable

Risk:- Low
Recommendation:- Confirm cladding details and complete compartmentation repairs.

- Helen Durum Building (UHW)

  Four story, cladding to upper floors only.
  L1 Fire Alarm System
  No sleeping risk
  Cladding details unreliable

  Risk:- Low
  Recommendation:- Confirm cladding details.

- CAVOC, Outpatients, Women's Centre (UHL)

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Two story, partial cladding mainly top floor.
L1 Fire Alarm system
Extensive fire compartmentation
No overnight accommodation
Cladding details unreliable

Risk:- Low
Recommendation:- Confirm cladding details

All the buildings in question are fitted with an L 1 alarm system with automatic fire detection in every room to give the earliest warning of fire.

With the exception of Link Block 4 which only has cladding on the top storey and phase 1 of the Children's Hospital, all medium rise buildings with sleeping accommodation are fitted with sprinklers.

Residential Blocks

. The high rise residential blocks at the Heath do not have any cladding they have and L1 fire alarm system.

Risk:- Low
Recommendation:- None

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ANNUAL FIRE SAFETY REPORT

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

ASSURANCE AND RECOMMENDATIONS

ASSURANCE is provided by:

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

The Health and Safety Committee is asked:

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

SITUATION

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

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

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

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

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

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BACKGROUND

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

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

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

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

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

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

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

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

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

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

ASSESSMENT

1.0 FIRE RISK ASSESSMENTS

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

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

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

During the period a total of 934 managerial actions were identified, 345 of which were risk rated at 6 or below, 589 therefore were of higher risk .The DFSMs have confirmed that 187 of these have been resolved. The 4 most common failings relate to training compliance, doors wedged open, obstuctions in fire routes and electrical appliance fire risks including portable equipment.

2.0 ENFORCEMENT NOTICES

During the period of April to April 2016/17 there were no new Enforcement Notices issued by South Wales Fire Service There remained in force however the historical Notice in relation to the Whitchurch site This Notice should be withdrawn as soon as the premises are vacated which is scheduled to be completed in July 2017.

3.0 AUDITS

3.1 NHS Wales Shared Services Partnership

Specialist Estates Services undertook an in-depth fire audit of the Llandough site in November 2016. The report was submitted to the Health Board in March 2017. An action plan has been compiled with all the necessary remedial actions with relevant completion dates and responsibilities. The action plan has been presented to the Fire Safety Group Meeting for consideration and will be monitored by the group.

3.2 South Wales Fire Service Audits

Regular fire audits are carried out by SWFS, during the period the Fire Service has issued a total of 17 Notices, 3 of which were rated by the service as INO2 (minor non-conformance). The reports are sent to the local management and their Deputy Fire Safety Managers, Estates and Capital Planning to address the issues they are responsible for and monitored at the Fire Safety meetings.

4.0 UNWANTED FIRE SIGNALS

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

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

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

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

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

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

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

5.0 FIRE TRAINING

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

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

6.0 COMPARTMENTATION

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

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

7.0 APPOINTMENT OF DEPUTY FIRE MANAGERS

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

8.0 RECENT FIRE AT GRENFELL TOWERS

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

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

FIRE ENFORCEMENT AND MANAGEMENT COMPLIANCE REPORT
Name of Meeting : Health and Safety Committee **Date of Meeting** 24/10/2017

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

ASSURANCE AND RECOMMENDATIONS

ASSURANCE is provided by:

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

The Health and Safety Committee is asked:

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

SITUATION

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

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

BACKGROUND

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

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

ASSESSMENT

There were two Enforcement Notices in force.

The Enforcement Notice at Whitchurch Hospital was issued due to fire incidents relating to patients and smoking materials. South Wales Fire Service (SWFS) have visited site on the 4th October 2017 and have confirmed verbally they will lift the notice and written confirmation will be sent by week ending the 13th October.

The Enforcement Notice at Hafan y Coe, has now been rescinded following implementation of the controls and procedures agreed with SWFS.

There have been two further audits carried out by SWFS since the last report. Both audits were carried out at Llanishen Clinic, one for the upper building and the second for the lower building. All deficiencies have now been rectified.

SHARED SERVICES FIRE AUDIT UHL REPORT
Name of Meeting : Health and Safety Committee **Date of Meeting** 24/10/2017

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

ASSURANCE AND RECOMMENDATIONS

ASSURANCE is provided by:

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

The Health and Safety Committee is asked:

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

SITUATION

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

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

BACKGROUND

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

ASSESSMENT

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

The action plan is attached as an appendix.

Ref. No.	Recommendation	Risk Rating	Lead	Date	Progress
4.3.1	The Board should continue to ensure risk assessments are periodically reviewed and maintained up-to-date, in accordance with the review frequency stipulated in the fire risk assessments.	L	Senior Fire Safety Adviser	Oct-16	Completed
4.3.2	The Board should review the existing fire risk assessments to reflect the aspects identified in this report.	L	Senior Fire Safety Adviser	Dec-18	75%
4.3.3	The Board should consider enhancing the 'Project Design Protocol' with the inclusion of an action to review fire risk assessments following completion of any schemes.	L	Senior Fire Safety Adviser	Nov-16	Completed
5.3.1	The Board should consider the guidance in WHEN 09/16 and the recommendations of this report, when developing/refining the site specific documentation.	L	Senior Fire Safety Adviser	Nov-16	Completed
5.3.2	The Board should ensure the drawings reflect the 'as installed' standards for all fire related provisions and that they are maintained up-to-date.	L	Head of Discretionary Capital & Compliance	9/1/2017	70%
5.3.3	The Board should retain relevant fire documentation preferably in a fire information box located at the main entrance or in the existing security lodge.	L	Senior Fire Safety Adviser	11/1/2016	Completed
5.3.4	The Board should ensure any future building alterations / proposals are considered in the light of the fire documentation as detailed in the existing policy.	L	Head of Capital Planning	Nov-16	Completed
5.3.5	The Board should introduce a procedure to periodically review the documentation to ensure it remains up-to-date.	L	Senior Fire Safety Adviser	As required	Dec-16

6.3.1	The Board should ensure fire wardens are appointed in all wards and departments as stipulated in the Fire Policy and promote a consistent approach to routine fire safety checks.	M	Department Heads	3/1/2018	75%
6.3.2	The Board should review the functionality and content of the dedicated fire safety section on their intranet site to improve the dissemination of fire related information.	L	Senior Fire Safety Adviser	9/1/2017	No progress to date
6.3.3	The Board should continue to ensure the current high standard of general house-keeping within the patient areas is maintained and improve the aspects identified through this report and the fire risk assessments including management cooking facilities.	M	Head of Estates & Facilities	Dec-16	Completed
6.3.4	The Board should continue with its endeavours to improve cylinder management, ensure schematics of medical gas pipe routing are available and the ASVUs labelled, protected/maintained.	L	Pharmacy	3/1/2018	Completed
6.3.5	The Board should ensure uncontrolled smoking practices are managed accordingly.	M	Fire Safety Manager	12/1/2017	Completed
6.3.6	The Board should ensure the measures to mitigate the potential arson and security risk are maintained.	L	Fire Safety Manager	Oct-16	Completed
6.3.7	The Board should ensure portable appliance testing is conducted for all equipment as necessary, and ensure electrical risks are detailed in the fire risk assessments and prioritised for action accordingly.	M	Head of Discretionary Capital & Compliance		Completed
6.3.8	The Board should continue to improve training performance.	M	Department Heads	12/1/2017	51%
7.3.1	The Board should undertake a full review of the fire alarm installation and system infrastructure to reconfigure and establish zoning arrangements that reflect the compartmentation and departmental boundaries.	H	Electrical Project Engineer	3/1/2018	50%

7.3.2	The Board should review the device address descriptions to remove any ambiguity as to the location of the individual devices and reflect the zoning arrangements.	**M**	Electrical Project Engineer	3/1/2018	50%
7.3.3	The Board should ensure accurate zone plans are displayed adjacent to all fire alarm panels.	**L**	Head of Discretionary Capital & Compliance	3/1/2018	25%
7.3.4	The Board should develop a C&E schedule detailing all ancillary devices interfaced with the fire alarm and ensure the C&E is fully validated on an annual basis.	**M**	Electrical Project Engineer	3/1/2018	50%
7.3.5	The Board should ensure a full set of accurate as installed drawings is available which also details the interfaces to any ancillary equipment linked to the fire alarm system.	**L**	Electrical Project Engineer	3/1/2018	50%
7.3.6	The Board should continue with a phased programme to replace the obsolete detectors and upgrade to an L1 standard where necessary.	**M**	Electrical Project Engineer	3/1/2018	95%
7.3.7	The Board should ensure the fire risk assessments address the omission of the magnetic lock over-ride facilities as required by BS 7273:4.	**L**	Electrical Project Engineer	3/1/2018	Completed
7.3.8	The Board should ensure non-conformities identified through maintenance inspections are prioritised for action including rectification of repeater panel displays.	**M**	Electrical Project Engineer	3/1/2018	75%
7.3.9	The Board should ensure the complete fire alarm system is maintained in accordance with BS 5839:1; reference should also be made to the 'Users responsibilities' as defined in the above standard.	**M**	Electrical Project Engineer	10/1/2016	Completed
7.3.10	The Board should review the incident reporting arrangements to improve performance management and further reduce the incidence of false alarms.	**L**	Senior Fire Safety Adviser	Oct-16	Completed

8.3.1	The Board should review the site fire drawings to accurately illustrate all compartment and sub-compartment walls, hazard room enclosures and any other passive protection such as enclosures to protected shafts and protected routes.	**M**	Head of Discretionary Capital & Compliance	3/1/2018	70%
8.3.2	The Board should instigate a procedure that ensures designated elements of fire construction achieve the requisite period of fire resistance and are adequately fire stopped with suitable materials.	**M**	Head of Discretionary Capital & Compliance	12/31/2018	Phased programme across all sites with UHW prioritised
8.3.3	The Board should ensure the potential for external fire spread and space separation requirements are reflected in the response procedures and addressed in the fire risk assessment with action prioritised as necessary.	**L**	Senior Fire Safety Adviser	Oct-16	Completed
8.3.4	The Board should conduct a survey of the ventilation system and prepare an up-to-date set of 'as installed' drawings illustrating the whole ventilation system, following which fire damper provisions should be assessed accordingly.	**M**	Head of Discretionary Capital & Compliance	3/1/2018	75%
8.3.5	The Board should review the maintenance regime for the mechanical ventilation to ensure maintenance/testing of fire dampers is conducted at least annually in accordance with BS9999.	**M**	Head of Discretionary Capital & Comp	A maintenance regime has started	75%
8.3.6	The Board should ensure all other specialist ventilation and smoke extract systems are suitably tested and maintained.	**M**	Head of Discretionary Capital & Compliance	3/1/2018	75%
8.3.7	The Board should consider the necessity for the remaining smoke extract hoods with a view to decommissioning these if they are deemed to be unnecessary through a risk assessed approach.	**L**	Head of Capital Planning	3/1/2018	To be considered during Rookwood relocation project

8.3.8	The Board should ensure all fire doors are subject to a six-monthly maintenance regime and continue to address the fire doors deficiencies as identified through the fire risk assessment process and this report.	**M**	Head of Estates & Facilities	Oct-16	Completed
8.3.9	The Board should ensure that all designated escape routes are appropriately signed, illuminated, safely usable and clear of obstructions at all times. Details of which should be recorded in the fire risk assessments.	**M**	Head of Estates & Facilities	3/1/2018	Completed
8.3.10	The Board should prepare drawings detailing the extent of, and assess the existing emergency escape lighting provisions. Any areas identified as not having sufficient escape lighting should be upgraded as necessary.	**M**	Head of Discretionary Capital & Compliance	3/1/2018	Phased programme across all sites with UHW prioritised
8.3.11	The Board should review the escape lighting testing regime to ensure compliance with BS5266 including the annual 3 hour duration testing and continue to ensure any future upgrades include self-testing facilities to support future maintenance.	**L**	Head of Discretionary Capital & Compliance	3/1/2018	Phased programme across all sites with UHW prioritised
8.3.12	The Board should ensure that all facilities for fire fighting purposes are referenced in the fire manual as well as the fire risk assessments which should also consider the benefit of extending the internal fire main along the street.	**L**	Senior Fire Safety Adviser	3/1/2018	Fire main to be considered during Rookwood relocation project
9.3.1	The Board should undertake a complete review of the Llandough response procedures which should then be reflected in site specific documentation.	**H**	Senior Fire Safety Adviser	2/1/2017	New procedures have to be prepared, agreed and implemented following the change to the Fire Service 's response.
9.3.2	The Board should develop department specific procedures, particularly for areas accommodating very high dependency patients and areas where a higher level of control may be required.	**L**	Senior Fire Safety Adviser	9/1/2017	Completed

9.3.3	The Board should develop and display fire evacuation plans complying with the principles of BS ISO 23601.	L	Head of Discretionary Capital & Comp	3/1/2018	Not started to date
9.3.4	The Board should review the arrangements for vertical evacuation ensuring availability of suitable evacuation aids recognising the patient's condition (including bariatric) and the location and likely number of aids required for effective evacuation of mobility impaired persons.	H	Fire Safety Manager	3/1/2018	New procedures have to be prepared, agreed and implemented following the change to the Fire Service 's response.
9.3.5	The Board should ensure that revised any procedures are disseminated to staff and reflected in the training syllabus, including the use of evacuation aids and lift operations.	M	Senior Fire Safety Adviser	8/1/2017	Completed
9.3.6	The Board should conduct scenario based evacuation exercises including interaction with the Fire and Rescue Service.	M	Senior Fire Safety Adviser	2/1/2018	New procedures have to be prepared, agreed and implemented following the change to the Fire Service 's response.
9.3.7	The Board should continually review and update its procedures to reflect the outcomes of future exercises.	L	Senior Fire Safety Adviser	Oct-16	Completed

ENFORCEMENT AGENCIES REPORT
Name of Meeting: Health and Safety Committee **Date of Meeting:** 24/10/2017

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

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ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

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

The Health and Safety Committee is asked to:

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

SITUATION

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

During the period there were no further new events raised by the Health and Safety Executive (HSE). However 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

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.

Legionella

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

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

Hydrotherapy Pool

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

Contractor Fall

The HSE has initiated an investigation following a fall from height of a contractor engaged to clean the windows on the Women's Unit on the 22nd September 2016.

Assessment

Road Traffic Accident at UHW

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

The investigation report was submitted to the HSE. The HSE confirmed that the remedial actions were suitable and have closed their investigation. However they did consider the Health Board should review our pedestrian strategy for similar public/vehicle risks in other areas. This has yet to be completed and therefore the item remains active

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Legionella

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

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

The Water Safety 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

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 wrote to the Health Board during the period stating they would be applying “Fees for Intervention” in relation to our control of contractors during this event. They have yet however, to indicate any decisions with regards to any subsequent enforcement action. Although it is known they have equally been in contact with the contracting company.

HEALTH AND SAFETY PRIORITY ACTION PLAN 2017/18
Name of Meeting: Health and Safety Committee **Date of Meeting:** 24/10/2017

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

ASSURANCE AND RECOMMENDATION

REASONABLE ASSURANCE is provided by:

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

RECOMMENDATION

The Health and Safety Committee is asked to:

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

SITUATION

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

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

BACKGROUND

The Priority Action Plan is monitored at each of the Operational Health and Safety Group meetings and progress reported at each Health and Safety Committee meeting. It is also considered that each Clinical Board has in turn produced its own Priority Action Plan based on the eight strategic areas.

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

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

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

ASSESSMENT

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Below summarises the status of the plan by the strategic area

Table 1

	Total no of requirements	Green	Amber	Red
Health and Safety Policy Management and Organisational Arrangement	4	0	2	2
Violence and Aggression (inc Lone worker)	7	1	6	0
Manual Handling	4	1	3	0
Health Issues	6	1	3	2
Patient and Environment Health and Safety	8	3	4	1
Fire Safety Management	3	1	1	1
Estate Health and Safety Management	6	1	2	3
Sharp Safety	1	1	0	0
Total	39	9	21	9

The Priority Action Plan has been reviewed and updated; this includes removing all progressed areas during the year. The above demonstrates of the revised total of 39 requirements 9 have been resolved and 9 are a high priority and non compliant. A further 21 are identified as amber, thus meaning that the risk has been reduced as a result of action taken but further control measures are required.

Areas Added or significantly advanced during the Period

	Requirement	Progress	Action Required	Accountable Lead
2.5	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.	A working group is set up nationally to revise the MOU to include these events.	Local plans to be delegated through the Personal Safety and Security Strategy Group and communicated.	Personal Safety Manager
3.3	Suitable and sufficient patient handling equipment is available	60 replacement hoists and 10 new shower chairs have been purchased and delivered to each area	Verify that the additional hoists have significantly improved status of the Pro-act audit findings.	Head of Health and Safety
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 Workforce, 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 clinical board identified that staff rotas were not including any breaks. Audit Committee recommended this be progressed to appropriate committee	Mental health clinical board 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	Identified manual handling risks in the delivery of care to bariatric patient care. Pilot being developed by manual handling and Medicine clinical board staff to design and develop an improved care model	Internal Medicine and Manual Handling to work closely in actioning a ward area better designed to care for bariatric patients	Senior Nurse Medicine/Head of Health and Safety
7.6	Development of a pedestrian strategy	Pedestrian safety in tunnels being pursued	An overall strategic approach to be developed.	Director of Capital,

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	for the 2 major Health Board sites in relation to their traffic risks.	by Estates Department.		Estates and Facilities

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 module 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 November/December.	Complete course and place on ESR	Head of Health and Safety
4.5	As above			
5.6	Bariatric Patient Care	Meeting with Assistant Director of Nursing – progressing issues on care basis with Nursing Director.	Progress as stated above	Assistant Director of Nursing
6.1	Firecode	Fire Policy submitted for approval. Training improvements being pursued through PPP.	Planned "toolbox" talks to wards by Fire Advisers to enhance local knowledge. Each Clinical Board to monitor local compliance. Fire Policy approved at July 2015 meeting	Director of Planning
7.3	Back log maintenance of the UHB Estate Impact: Resources available to estates in line with an increasing burden of ageing physical infrastructure, bringing increased maintenance costs and increased refurbishment costs.	Regular reviews of estate condition via Estate Property Appraisals. Health and Safety Committee informed at October 2013 meeting that backlog maintenance items include equipment that has passed it replacement date but was still functional	Report to be prepared to identify that there is an appropriate system for prioritising and monitoring failed equipment with Health and Safety implications. Results of the property appraisal presented to October 2014 Health and Safety Committee. Committee updated on scale of problem, priorities reflected in the IMTP. A complete "risk based"	Director of Capital, Estates and Facilities/ Director of Therapies and Health Sciences (for medical equipment) Director of

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			Service Board – "Building Services Review" currently taking place for submission of a Business Case to Health Board and Welsh Government.	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	As above			

HEALTH AND SAFETY COMMITTEE WORK PROGRAMME 2017 - 2018

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

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

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

HEALTH AND SAFETY PRIORITY ACTION PLAN 2017/18

1. Health and Safety Management

CRAF Ref	Ref	Requirement	Status Oct 2017	Progress	Action required	Accountable Lead	Status	Priority	Time Scale
8.1.4	**1.1**	A comprehensive programme of risk assessments to be completed with identified control measures implemented	Risk Assessment Procedure expanding the requirement so that assessments greater than 10 are validated and monitored	E-Datix risk has been purchased but it is understood there is no agreed implementation date.	Review of Risk Register and E-datix implementation.	Director of Corporate Governance	Red	High	Dec 2017
	1.2	Monitoring of Mandatory Training	Steering Group formed to enhance staff training compliance to target 85%+	Enhanced ESR has been implemented by lED/IMT – this has led to a lack of availability of data.	Progress mechanism for enhanced monitoring and accountability for increasing compliance at Clinical Board	Director of Workforce and OD	Amber	High	Dec 2017
	1.3	Health and Safety Compliance	Health and safety audit undertaken in hospital setting in 2016. Audit to be expanded to cover community and Estates areas.	Health and Safety and Estates are progressing a GAP analysis of statutory compliance.	Complete analysis	Head of Health and Safety	Amber	Mod	Dec 2017
	1.4	Health and Safety Management Training	The only formal management training offered by the Health and Safety Department is the Risk Assessment/Working Safely Course. The Estates Department Managers all undertake the IOSH Managing Safely Course	Training course under development with an aim of offering the course during November/December.	Complete course and place on ESR	Head of Health and Safety	Red	Mod	Dec 2017

2. Violence and Aggression

CRAF Ref	Ref	Requirement	Status Oct 2017	Progress	Further Action required	Accountable Lead	Status	Priority	Time Scale
9.2	**2.1**	Have in place an action plan to ensure full and ongoing compliance with requirements of the All Wales Violence and	Lack of ability to release staff for training has also reduced compliance. A number of specialist programmes for training have been initiated. It has	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	Amber	High	Dec 2017

		Aggression Passport Scheme.	subsequently reviewed its prioritisation of training.			Safety Group			
6.4.6	**2.2**	Sufficient Trained Staff to respond to personal attacks and safely restrain	Security Team not trained to required standard. Security team required to be of suitable size and deployed to respond to events.	Meeting between EU and Security and trainers has agreed a programme of developing a combined response team, with a two day training course on module D. Validation of suitability of Mental Health training completed. Training dates have been set up for January 2017. Further dates will be rolled out over the following months.	Issues around releasing staff to attend training. Commitment to undertake training required from EU and Security Services.	Head of Security Services	Amber	High	Dec 2017
	2.3	Ensure suitable protocol/procedure for restraint of patients with capacity.	The HB has protocols for the restraint of mental health patients, similar procedures are required for patients with capacity	Training course for paediatrics established. Preparation of procedure based off MH document being initiated. National project in calming the storm covering this feature.	Ongoing, awaiting the outcome of Calming the Storm process.	Head of Health and Safety/ Personal Safety Adviser	Amber	High	Dec 2017
6.4.6	**2.4**	Safe Haven facility	Safe Haven facilities available however there is a lack of facilities to treat high risk patients outside of Safe Haven 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	Dec 2017
	2.5	Develop enhanced guidance on non gratuitous violent	The Case Management Team is actively supporting staff in a significant number of these	A working Group is set up nationally to revise the MOU to include	Local Plans to be delegated through the Personal Safety Strategy Group and	Personal Safety Adviser	Amber	High	Dec 2017

		incidents to demonstrate enhanced support to Staff on violent events, relating to patient medical conditions, where legal intervention is inappropriate.	events.	these events.	communicated.				
		Lone Worker							
6.4.6	**2.6**	Ensure effective implementation of Lone Worker system.	Each Clinical Board is given data of individual usage to pursue improvement. Target of 75%	Current compliance showing 74% compliance. Request sent to all CB's requesting confirmation that all lone workers at risk have suitable arrangements in place.	Response required from Clinical Boards regarding their arrangements.	V&A Group/ Chairs of Clinical Boards Health and Safety Group	Amber	Mod	Dec 2017
	2.7	Staff at risk has access to suitable lone worker system	Success of new system in demand outstripping budget.	Monitoring each Clinical Board and effective distribution of current budgeted devices.	If target of 80% usage is exceeded, make business case for management team to expand budget.	Head of Health and Safety/ Director of Corporate Governance	Green	Mod	July 2017

3. Manual Handling

CRAF Ref	Ref	Requirement	Status Oct 2017	Progress	Further Action required	Accountable Lead	Status	Priority	Time Scale
8.1.4	**3.1**	All staff involved in manual handling tasks require training to required standard and refreshed at the agreed intervals	Training Working Group formed led by Assistant Director of OD. Training frequency assessment (TFA) commenced	Working with LED and direct visits to hotspot areas.	Further development of ward based training.	Assistant Director of OD Head of Health and Safety	Amber	High	Dec 2017
6.4.1	**3.2**	LOLER compliance (Lifting operations, Lifting equipment regulations)	LOLER regulations require the inspection and maintenance of all lifting equipment including hoists and slings. Slings have previously been internally inspected; however HSE has indicated recently that this must be an independent assessment.	Procurement is reviewing contracts for servicing. This has resulted in a shortfall in service cover.	Issue new service agreement	Procurement	Amber	Mod	Dec 2017

8.4.1	**3.3**	LOLER – suitable and sufficient patient handling equipment is available.	Restricted finance has resulted in aged hoisting stock.	Delivery dates for new equipment established.	Verify that the additional hoist has significantly improved has significantly improved status Pro-act audit finding	Head of Health and Safety	Green	High	April 2017
6.4.1	**3.4**	The Health Board has a contract to maintain hoists.	A procurement review of maintenance contract has resulted in delays in repairs to key items which compromises patient care.	Meeting held with procurement to discuss a change to the servicing contract to a gold contract, this would speed up repairs this was decided against for cost reasons, existing level of service maintained , servicing only, However with the replacement of 60 old hoists within the UHB it is anticipated the breakdowns will be less, but not diminished.	Complete management programme and mechanisms for speedy repairs.	Director of Capital, Estates and Facilities	Amber	High	Dec 2017

4. Health Issues

CRAF Ref	Ref	Requirement	Status Oct 2017	Progress	Further Action required	Accountable Lead	Status	Priority	Time Scale
8.1.4	**4.1**	Safe use of peracetic acid in sterilisation of medical instruments.	The use of peracetic acid is being introduced into four areas to sterilise instruments, this chemical is subject to COSHH being of higher hazard.	Specialist Adviser working with Clinical Boards to undertake monitoring and ensure controls are in place.	Based findings of monitoring, implement appropriate controls including spill response.	Chair of Surgery Health and Safety Group	Amber	High	Dec 2017
	4.2	Adherence to the No Smoking Policy.	Smoking policy in place and Enforcement Officer appointed. Smoking breaches being reported through fire and smoking meetings.	Position on E-ciggs clarified, supporting its controlled use.	Develop guidance on usage to include fire risk.	Head of Health and Safety/ Director of Public Health	Amber	High	Dec 2017
	4.3	DSEAR compliance to regulations requires area of potential explosives to be	Reports have identified that some areas within Laboratories require assessment.	Environmental form developed	Implement form.	Head of Health and Safety/ Health and Safety and	Amber	High	Dec 2017

		assessed and control measures in place.				Environmental Adviser			
	4.4	Hydrotherapy Pool	Evidence shows variance of agreed standards – lack of monitoring at the required frequency and outstanding maintenance issues.	Work has been initiated.		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 Workforce, 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 Clinical Board to review rotas to include sufficient time to allow staff to take breaks.	Director of Operations - Mental Health Clinical Board	Red	High	Jan 2018

5. Health & Safety Patient and Environment Safety

CRAF Ref	Ref	Requirement	Status Oct 2017	Progress	Further Action required	Accountable Lead	Status	Priority	Time Scale
6.4.1	**5.1**	Window Closures A programme of work is required to fit anti tamper devices to the in place ligature closures.	Not all windows above the ground floor are fitted with 100mm restrictors. A programme of work has been undertaken to replace all high risk areas. Medium and lower risk areas are still required for action	Survey and risk assessment of all windows above the ground floor has been completed. Action has been taken to rectify those windows which failed to meet the required standard.	Further work on anti tamper screws to be initiated to meet hazard alert guidance.	Director of Capital, Estates and Facilities	Amber	Mod	Dec 2017

6.4.4	**5.2**	Legionella – Legionella Policy and Water Safety Group	Legionella Policy approved and Water Safety Group established	Policy approved at Health & Safety Committee, making Water Safety Group a subcommittee of said Committee. The HSE has lifted the enforcement notice.	Review of flushing and auditing of compliance. Water Safety Group to monitor compliance.	Director of Capital, Estates and Facilities/ Head of Health and Safety	Amber	High	Dec 2017
	5.3	Low use water outlets are flushed at agreed intervals.	HSE inspection and audit show poor compliance to flushing regime	Estates are developing a revised log sheet and have implemented a monthly regime of compliance monitoring.	Implement Action Plan	Clinical Boards	Amber	High	Dec 2017
	5.4	Record Storage - The organisation has the requirement to safely store its mandated records for the agreed periods.	There is insufficient suitable storage for all records particularly in relation to archived records in the community.	Further storage procured at Nant Garw and project to enhance greater usage of scanning.		Head of Operations and Delivery - CD&T	Green	Mod	July 2017
	5.5	Patient showering equipment	An audit of the Manual Handling Equipment identified that some of the showers in inpatient care did not have suitable shower trolleys and chair for the patient type in that area amounting to 92 shower chairs and 17 shower trolleys	Shower chairs due for delivery in June to enhance patient experience.		HOD's – Clinical Boards	Green	Mod	July 2017
	5.6	Bariatric Patient Care	Risks have been identified of emergency evacuation of bariatric patients in care above the 1st floor. Limited availability for weighing patients	Meeting with Assistant Director of Nursing – progressing issues on care basis with Nursing Director.	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	Dec 2017
	5.7	Moving fallen patients	Hover Jacks have been procured for UHW & UHL to safely move fallen patients with risk of spinal injuries	2 devices purchased from CB budget.		Head of Health and Safety	Green		Mar 2017
	5.8	Monitoring Schedule	A programme schedule of environmental monitoring to	A priority monitoring programme has been	Implement Priority Programme	Head of Health and Safety	Amber	Mod	Dec 2017

			confirm health and safety compliance.	introduced to ensure that these areas of risk are completed.					

6 Fire Safety Management

CRAF Ref	Ref	Requirement	Status Oct 2017	Progress	Further Action required	Accountable Lead	Status	Priority	Time Scale
6.4.5	**6.1**	Firecode	All staff within the organisation are required to be provided with Fire Safety Training. The organisation is at approximately 50% compliance.	Fire Policy submitted for approval. Training improvements being pursued through PPP.	Planned "toolbox" talks to wards by Fire Advisers to enhance local knowledge. Each Clinical Board to monitor local compliance. Fire Policy approved at July 2015 meeting	Director of Planning	Red	High	Dec 2017
6.4.5	**6.2**	Fire Compartmentation	Programme of improved fire compartmentation initiated	Fire Annual Report presented to January 2014 Health and Safety Committee. Follow up report for April 2014 meeting	Health and Safety Committee to review and consider risks associated with fire dampers/compartmentation . 2015 Fire Annual Report presented to January 2015 meeting.	Director of Capital, Estates and Facilities	Amber	High	April 2018
6.4.5	**6.3**	Fire Risk Assessments are required to be completed for all areas.	Fire Risk Assessments shows no direct progress. Revision of Deputy Fire Safety Manager responsibility and local area ownership.	Deputy Fire Safety Managers meetings and agreement via HOD's of DFSM areas. Progress reports on actions to be submitted to the Health and Safety Committee.	Revised protocol for action	Head of Health and Safety	Green	High	Mar 2017

7. Estates H&S Management

CRAF Ref	Ref	Requirement	Status Oct 2017	Progress	Further Action required	Accountable Lead	Status	Priority	Time Scale
6.4.7	**7.1**	Asbestos	Implement Asbestos Management Plan	The Asbestos Management Plan has been implemented. The Asbestos Management Group meets quarterly. Permanent resources now recruited and AMP and Policy updated.	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	Director of Capital, Estates and Facilities	Amber	High	Dec 2017

				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.	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.				
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	Dec 2017
6.4.1	**7.3**	Back log maintenance of the UHB Estate Impact: Resources available to estates in line with an increasing burden of ageing physical infrastructure, bringing increased maintenance costs and increased refurbishment costs.	A programme of estate 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	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	Director of Capital, Estates and Facilities/ Director of Therapies and Health Sciences (for medical equipment)	Red	High	Dec 2017

			to a rigorous risk assessment procedure to establish prioritisation of resources.		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 Planning			
6.4.2	**7.4**	Passenger lift safety	The Health Board operates a system of maintaining its responsibilities to inspect and maintain lifts through a planned inspection and maintenance programme. Recent inspections identified defects that require these to be taken out of service.	Current regime showing improved HSE Compliance.	Continued monitoring of lift failures and HSE concern.	Director of Capital, Estates and Facilities	Green	High	July 2017
6.4.4	**7.5**	Legionella Survey and Risk Assessment		Survey initiated has identified a number of remedial actions are required. 10 new risk assessments for UHW carried out this year in high risk areas. Risks currently being prioritised 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	Red	High	April 2018
	7.6	Development of a pedestrian strategy for the 2 major health board 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

8. Sharps Safety

CRAF Ref	Ref	Requirement	Status Oct 2017	Progress	Further Action required	Accountable Lead	Status	Priority	Time Scale
8.1.4	**8.1**	Enhanced protection for staff against needlestick injuries and implement	Improvements in protocols and safer sharp boxes noted in annual report. Progress reports submitted to Health	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	Head of Health and Safety/Health and Safety	Green	Mod	July 2017

		requirements of the EU Directive	and Safety Committee		use of safety sharps devices.	Adviser – Sharps Lead			

Catering Department, Rookwood Hospital

Food Hygiene Inspection

Executive Lead : Director of Capital, Estates & Facilities
Author : Operational Services Manager (North) Ext 45140
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 : NA
Quality, Safety, Patient Experience impact: Consistent implementation of the documented Food Safety Management System will ensure compliance with the Food Safety Regulations and provide a safer patient, staff and visitor experience. A UHB food safety document template has been finalised and is being used throughout catering services.
Health and Care Standard Number 2.1 CRAF Reference Number N/A
Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Committee is asked to:

- **NOTE** the food hygiene rating and the remedial actions taken following the receipt of the Environmental Health Officer Inspection Report.

SITUATION

An inspection of the Catering Department, Rookwood Hospital, took place on 13th July 2017, the outcome of which was confirmed in writing in a letter report dated 14th July 2017, from the Commercial Services Officer – Food Safety & Port Health (Cardiff).

In this report it was noted that the Catering Department, Rookwood Hospital was given a score of **5 (Very Good)** in the National Food Hygiene Rating Scheme.

BACKGROUND

It is a legal requirement that each Hospital is registered as a food premises with the Local Council and is therefore subject to an annual inspection by the Environmental Health department.

ASSESSMENT

On receipt of the letter report from the Commercial Services Officer, an action plan was developed by the Operational Services Manager (North) to address the issues raised and is attached as an appendix to this report. This will be monitored within Operational Services by the PFI/Compliance Manager on behalf of the Head of Estates & Facilities

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SCHEDULE A			
Food Hygiene & Safety Procedures	**Management Response / Action**	**Time Scale / Update**	**Lead**
The air temperature of the fridge in Ward 7 kitchen was 6.3˚C. If sandwiches from the Good Food Chain are to be stored in this fridge, you must ensure it is capable of storing these at 5˚C or colder. There were no sandwiches being stored at the time of my visit. *Food Safety and Hygiene (Wales) Regulations 2013 Schedule 4 para 2 (1)*	• Sandwiches are not kept in the ward kitchen fridges, they are taken to the ward at the start of the meal service in a cooler bag and any unused sandwiches are returned to the main kitchen at the end of each meal service. Fridge temperature is being checked daily by supervisors and reading between 3˚C & 4˚C	Immediate / Completed	OSM
The blade of the heavy-duty can opener was encrusted with food, which would cause contamination of the food in the next tin opened. This part of the can opener must be cleaned and sanitised regularly *Regulation (EC) No 852/2004 Annex II Chapter V Para 1(a)*	• The blade has now been cleaned and sanitised; staff have been instructed to ensure the blade is cleaned after use and is now on the daily cleaning schedule.	Immediate / Completed	OSM
Structural / Cleaning Issues	**Management Response / Action**	**Time Scale / Update**	**Lead**
There was lime scale beginning to develop around the taps to the hand wash basin in Ward 5 kitchen. Clean the taps and maintain in a clean condition. *Regulation 852/2004, Annex II, Chapter I, paragraph 1* *Regulation (EC) No 852/2004 Annex II Chapter I Para.4*	• Taps have been de-scaled, cleaned and are maintained in accordance with the cleaning scheduled.	Immediate / Completed	OSM

There were dead inspects and cobwebs noted on the floor covering in the kitchen. Thoroughly clean the floor and maintain in a clean condition. *Regulation (EC) No 852/2004 Annex II Chapter I Para 1*	• Floor has been vacuumed and deep cleaned and all corners and edges mopped. Staff have been informed to ensure all areas are thoroughly checked following cleaning schedule.	Immediate / Completed	OSM
There was a hole in the ceiling around pipe work (near freezer 3). Repair or renew the ceiling to leave a surface that will prevent the accumulation of dirt. *Regulation (EC) No 852/2004 Annex II Chapter II Para. 1(c)*	• Ceiling was repaired by the estates dept on the 17.7.17	Immediate / Completed	OSM
There was no soap at the wash hand basin in Ward 7 kitchen. Wash hand basins must be provided with soap. This was rectified at the time of inspection. *Regulation (EC) No 852/2004 Annex II Chapter I Para 4*	• Dispenser was faulty, an estates request was logged and dispenser was replaced on the 14.7.17	Immediate / Completed	OSM
Confidence in management /control procedures	**Management Response / Action**	**Time Scale / Update**	**Lead**
I was pleased to see that independent probe checks of fridges and freezers were being carried out on a weekly basis. However, as discussed you must ensure staff record the actual temperature and don't round the temperature up or down.	• Supervisors now use the infra red thermometer to monitor fridges and freezers daily for a more accurate reading	Immediate / Completed	OSM

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It was noted that there was no hot water to the wash hand basin and sink in the pot wash area as works were being carried out on the water supply. Could you please advise when this work is complete and the water supply is restored. The water supply to all other wash hand basins and sinks in the main kitchen and wards was not affected. *Regulation (EC) 852/2004 Article 5*	• Pot wash area hot water is now back in use and water supply was reconnected on the 14.7.17.	Immediate / Completed	OSM
Recommendations and Advice	**Management Response / Action**	**Time Scale/ Update**	**Lead**
The door to Ward 5 kitchen was jammed open, making it difficult to access the hand wash basin. The door must be kept closed to ensure staff have easy access to the hand wash basin at all times. The dishwasher in the John Pathy Day Hospital kitchen was sat on top of a metal box. This box was damaged and beginning to rust. I recommend it is either removed or cleaned and repainted. Guidance in relation to how to comply with the allergen labeling requirements can be found at www.food.gov.uk/business-industry/allergy-guide . An interactive food allergy training tool can be found at food.gov.uk/allergy-training	• Catering staff and ward staff have been informed that the kitchen door is to remain closed at all times, poster is fully visual and ward manager is to raise at ward meetings. • Metal box has been cleaned and repaired. Box to be replaced on 04/10/17	Immediate / Completed July/October 2017	OSM OSM

Ward Based Catering Department, University Hospital of Wales.

Food Hygiene Inspection

Executive Lead : Director of Capital, Estates & Facilities
Author : Operational Services Manager (North) Ext 45140
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 : NA
Quality, Safety, Patient Experience impact : Consistent implementation of the documented Food Safety Management System will ensure compliance with the Food Safety Regulations and provide a safer patient, staff and visitor experience. A UHB food safety document template has been finalised and is being used throughout catering services.
Health and Care Standard Number 2.1 CRAF Reference Number N/A
Equality Impact Assessment Completed: Not Applicable.

RECOMMENDATION

The Committee is asked to:

- **NOTE** the food hygiene rating and the remedial actions taken following the receipt of the Commercial Services Officer Inspection Report.

SITUATION

An inspection of the Ward Based Catering Department, University Hospital of Wales, heath Park, Cardiff, took place on Thursday 14th September, 2017, the outcome of which was confirmed in writing in a letter report dated 19th September, 2017, from the Commercial Services Officer – Food, Safety & Port Health (Cardiff).

In this report it was noted that the Ward Based Catering Department, University Hospital of Wales, was given a score of **5 (Very Good)** in the National Food Hygiene Rating Scheme.

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BACKGROUND

It is a legal requirement that each Hospital is registered as a food premises with the Local Council and is therefore subject to an annual inspection by the Environmental Health department.

ASSESSMENT

On receipt of the letter report from the Commercial Services Officer, an action plan was developed by the Operational Services Manager (North) to address the issues raised and is attached as an appendix to this report. This will be monitored within Operational Services by the PFI/Compliance Manager on behalf of the Head of Estates & Facilities.

SCHEDULE A			
Food Hygiene & Safety Procedures	**Management Response / Action**	**Time Scale / Update**	**Lead**
The pre packed sandwiches you receive are required to be stored below 5°C. Between pack testing of sandwiches in the insulated box for delivery to the children's ward was between 7-11˚C. You must ensure that these products are stored below 5°C. *Food Hygiene (Wales) Regulations 2006 Schedule 4 para 2 (1)*	• Smaller insulated containers have been purchased and are now currently being used	Immediate / Completed	OSM
Structural / Cleaning Issues	**Management Response / Action**	**Time Scale / Update**	**Lead**
Whilst patch up works had been carried out to the floor in C7 kitchen since my last inspection, the seals around the repairs were beginning to split. Renew or repair any affected seals and leave in a sound easy to clean condition. I understand a re-flooring program and refurbishment of ward kitchens is currently on going, which is very positive going forward, ensuring that standards are continuing to be improved year on year. *Regulation (EC) No 852/2004 Annex II Chapter II Para. 1(a)*	• A programme is currently in place to refurbish all kitchens which includes replacement of floors.	Refurbishment programme ongoing	OSM
The floor covering in ward A7 kitchen was dirty especially at floor/wall junctions and behind or below equipment. Thoroughly clean the floor and maintain in a clean condition. *Regulation (EC) No 852/2004 Annex II Chapter I Para 1*	• Floor and walls have been cleaned and will be maintained	Immediate / Completed	OSM

Confidence in Management / Control Procedures	Management Response / Action	Time Scale / Update	Lead
You have put in place a documented Food Safety Management Procedure based on HACCP principles. However, I would make the following observations; The temperature inside the insulated container with ice pack used for delivering sandwiches to the children's wards was between 7˚C and 11˚C with the infra-red thermometer. As discussed the sandwiches must be stored below 5˚C. Many of the items stored within the box did not require refrigeration but were kept cold for better palatability. I suggest a separate insulated container is used for the sandwiches. This practice must also be reflected in your HACCP document. No calibration checks had been recorded for the fridges on C7 ward kitchen. *Regulation ((EC) 852/2004 Article 5*	• Smaller insulated containers have been purchased and are now currently being used. • HACCP document updated • Checks have been completed and staff reminded of importance of checks.	Immediate / Completed Immediate / Completed Immediate / Completed	OSM OSM OSM
SCHEDULE B - RECOMMENDATIONS			
These recommendations provide advice on good practice. There was a gap around the pipe running through the wall to the left of the hand wash basin in ward A7 kitchen, I recommend this is suitably sealed to assist cleaning and prevent pest access points. It was noted this was an internal wall and the gap wasn't to an external wall.	• Gap around pipe has been sealed by Estates staff	Immediate / Completed	OSM

Key - OSM Operational Services Manager (North)

AROMA UNITS, UNIVERSITY HOSPITAL OF WALES (UHW) FOOD HYGIENE INSPECTION – 14th September 2017
Name of Meeting: Health & Safety Committee. **Date of Meeting:** 24th October 2017

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 14th September 2017 the outcome of which was confirmed in writing in a letter report dated 20th September 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.

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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 14th September 2017 (Report dated 20th September 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
• The probe wipes on the Children's unit were out of date (expired 3/11/2016) Probe wipes used after the expiry date may not have the same disinfection qualities and present a risk of cross contamination if the needle probe isn't suitably cleaned and disinfected. *Regulation (EC) No 852/2004 Annex II Chapter V para 1(a)*	• Probe wipes were removed and replaced immediately, this check is now added to the supervisors weekly monitoring checks	Immediate	Completed

Aroma Units UHW September 2017

Structural / Cleaning Issues	Response / Action	Time Scale	Update
• The floor covering in the Children's Hospital Aroma was dirty at floor/wall junctions. Thoroughly clean the floor and maintain in a clean condition. *Regulation (EC) No 852/2004 Annex II Chapter I Para 1*	• Flooring thoroughly cleaned, staff addressed and Supervisor weekly checks will be monitored by Duty Manager	Immediate	Completed
The following were dirty and required thorough cleaning: • the door seals to some of the under counter fridges in Aroma Express; • The needle of the probe thermometer in Aroma Express; *Regulation (EC) No 852/2004 Annex II Chapter I para 1*	• Door seals and probe cleaned thoroughly, staff addressed and items added to weekly check list.	Immediate	Completed

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;			
• Your HACCP states that all fruit and salad is washed prior to use. You currently buy in washed ready to use salad leaves which are not washed prior to use. Your document needs to be amended to reflect this;	• HACCP Document amended by the Catering Services Manager and reissued	Immediate	Completed
• A number of monitoring forms on the units weren't dated and didn't indicate which unit they were for;	• All monitoring forms have been updated with location and date added	Immediate	Completed
• Whilst in practice staff were applying the 5°C critical limit for fridges, your HACCP document needs to be updated to reflect this;	• HACCP updated to indicate 5°C critical limit	Immediate	Completed
• 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. I don't feel the current monitoring records are robust enough to demonstrate this;	• 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

• 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; *Regulation (EC) 852/2004 Article 5*	• Listeria guidance document added to the HACCP file to reflect understanding, although as directed in point 1above the 4-hour rule is observed and sandwiches disposed of afterwards.	Immediate	Completed

Schedule B – Recommendations, Advice & Information

Recommendations	Response / Action	Time Scale	Update
• I recommend dispensers are installed for the blue roll that is used on the units for cleaning surfaces. This will prevent direct handling of the clean roll and possible contamination.	• Dispensers installed and new size blue roll ordered	Immediate	Completed
• I recommend a dispenser is provided for the cling film used on the X-ray unit.	• New dispenser purchased and in place	Immediate	Completed
• I recommend that the soap and paper towel dispensers in the Children's unit are moved closer to the newly moved wash hand basin.	• Soap and paper towel dispenser relocated	Immediate	Completed
• I understand works are due to start on a new ready to eat kitchen. I strongly suggest a double sink unit and a dedicated wash hand basin with non-hand operable taps are incorporated into the plans.	• Double sink, wash hand basin with non-hand operated taps installed and room completed.	Immediate	Completed

CENTRALFOOD PRODUCTION UNIT, UNIVERSITY HOSPITAL OF WALES (UHW) **FOOD HYGIENE INSPECTION – 12th September 2017**
Name of Meeting : Health & Safety Committee **Date of Meeting :** 24th October 2017

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 : 2.1 and 2.5 **CRAF Reference Number**
CRAF Reference Number: N/A
Equality and Health Impact Assessment Completed: N/A

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The maintenance of the Food Hygiene Rating score of **5 (Very Good).**

RECOMMENDATION

The Committee is asked to:

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

SITUATION

An inspection of The Central Food Production Unit at the University Hospital of Wales took place on the 12th September 2017 the outcome of which was confirmed in writing in a letter report dated 21st September 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 Central Food Production Unit at The University Hospital of Wales were given a score of **5 (Very Good)** in the National Food Hygiene Rating Scheme.

BACKGROUND

It is a legal requirement that each hospital / food unit is registered as a food premises with the Local Authority and is therefore subject to a 6 monthly 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 12th September 2017 (Report dated 21st September 2017)

Schedule A – Legal Requirements

Food Hygiene and Safety Procedures	Response / Action	Time Scale	Update
• At the time of inspection, chicken and mushroom portioned pies were in the main freezer on a rack minus their protective lids. It became clear on discussing with staff that this is common practice with meals requiring toppings such as pastry lids and potato piping as these cannot be placed until the fillings are cold. There is a risk of potential contamination of such products with this practice and as discussed this must cease or a suitable method of covering the products/ rack be provided. We discussed the use of a shroud to encompass the rack and this would be suitable on the basis that it is made of a suitable material that is able to be effectively cleaned. Such cleaning would be required to be added to the cleaning schedule. **Regulation (EC) No 852/2004 Annex II Chapter IX para 3**	• Shrouds to cover the items have been purchased with the cleaning of these added to the cleaning schedule.	Immediate	Completed

Central Food Production Unit UHW September 2017

• Raw frozen fish fingers were being stored on the same shelf as ready to eat bread rolls in the decanting area (Sue's freezer). These must be separated due to the potential risk of contamination. **Regulation (EC) No 852/2004 Annex II Chapter IX para 3**	• These items have been removed and stored underneath any cooked items to prevent cross contamination	Immediate	Completed

Structural / Cleaning Issues	Response / Action	Time Scale	Update
• The brush strip to the delivery doors in the goods in area is too high allowing a gap beneath. Re-secure the strip lower on the door to provide an effective seal when the doors are closed. **Regulation (EC)No 852/2004 Annex II Chapter I Para 1**	• Contractor called to adjust the brushes	Immediate	Completed
• The doorframe protector to the internal chamber in the low risk area walk in chiller was damaged. Make good and leave in a sound, easily cleansable condition. **Regulation (EC) No 852/2004 Annex II Chapter I Para 1**	• Reported to estates and made good.	Immediate	Completed

• The internal surfaces of the dishwasher in particular the upper surface and the door hinges were in need of further cleaning. Clean the dishwasher and maintain in a clean condition. Ensure that this is covered on the cleaning schedule. **Regulation (EC) No 852/2004 Annex II Chapter V para 1**	• Dishwasher cleaned thoroughly, staff addressed and Supervisors monitoring closely and checking cleaning schedule	Immediate	Completed
• A small amount of mould growth was noted to the lid seals of freezers 5 & 8. Remove the mould and maintain in a clean condition. **Regulation (EC) No 852/2004 Annex II Chapter V para 1**	• Cleaned thoroughly, staff addressed and closer monitoring implemented	Immediate	Completed

Confidence in Management / Control Procedures	Response / Action	Time Scale	Update
Discrepancies were noted in the HACCP as follows: • The HACCP states that sampling failures will be notified to EH department. Your records show that there was a failure in July 2017 with the identification of listeria in a kitchen drain, this Department wasn't notified as per HACCP.	• Department now informed and the process followed in the future.	Immediate	Completed

Sections 2 & 4 – legislation requirements. As an approved premises you must include a reference to Regulation (EC) No 853/2004 • The storage of the portioned but unlidded meals in the freezer has not been covered by the existing HACCP. You will need to ensure that hazards are identified and controls in place for this element of storage which differs to existing storage as it is open high risk food. **Regulation (EC) No 852/2004 Article 5**	• HACCP updated to include this type of storage	Immediate	Completed

Schedule B – Recommendations, Advice & Information

Recommendations	Response / Action	Time Scale	Update
• The coloured corner tabs on the new plastic tubs present a possible contamination risk as they are loose fitting and their use should be reconsidered.	• Coloured corner tabs disposed of and not used	Immediate	Completed
• The main freezer floor is deteriorating and as discussed, any loose paint should be removed and the concrete left smooth.	• Checked and swept out Daily to ensure no loose paint is present	Immediate	Completed
• In view of the practice of the unlidded portioned meals I would advise that you review all practices with staff to ensure that all are covered within your HACCP and make amendments should they be required.	• HACCP amended and shared with the team to ensure understanding	Immediate	Completed

MINUTES OF THE OPERATIONAL HEALTH AND SAFETY GROUP HELD AT 9.30AM on MONDAY 5th JUNE 2017 – CORPORATE MEETING ROOM - UHW

Present:

Charles Dalton	Head of Health and Safety
Caroline Murch	Environmental Health and Safety Adviser
Rachael Daniel	Health and Safety Adviser
Rachael Sykes	Health and Safety Adviser
Frank Barrett	Senior Fire Adviser
Stuart Egan	Staff Representative
Yvonne Hyde	Senior Nurse IP&C
Sian Kingston	Claims Team
Linda Jones	Claims Team

Clinical/Service Board Representatives

Jon McGarrigle	Estates Services
Heather Gater	Women and Children
Rowena Griffiths	Dental Services
Rhys Davies	Primary, Community and Intermediate Care
Tina Bayliss	Surgery Services

Apologies:

Peter Welsh	Director of Corporate Governance
Sue Morgan	Primary, Community and Intermediate Care
Clive Morgan	Assistant Director of Therapies
Nicola Bevan	Occupational Health
Mathew Price	Specialist Services
Sarah Dix	Medicine Services

This meeting was chaired by Mr Charles Dalton – Head of Health and Safety, in the absence of Mr Peter Welsh – Director of Corporate Governance.

OHSG: 15/17 Minutes of the Meeting held March 2017

The minutes of the meeting held on the 15th March 2017 were accepted as a true record with a slight amendment to page 3 - OHSG: 06/17 Revised Changes to Fines and Sentences; to read 'The Head of Health and Safety updated the Group on the changes to fines and sentences being **imposed** by the HSE as a result of non compliance and negligence claims'

OHSG: 16/17 Action Log

The Chair reviewed items on the Action Log and the following was reported:-

45/16 PI Claims
The Chair highlighted that he had recently received a fuller report from the Claims Manager looking at where they are making changes, however the report required slight amendments and as a result it was noted that this would be circulated to the Group and discussed at the next meeting once amendments had been made.

It was noted that this item was on the agenda and would be discussed further on in the meeting.

05/17- Contractor Control
It was reported that this item had been completed. It was confirmed that a copy of the Contractor Control Policy had been circulated to the Group, following the previous meeting.

08/17 – Fire Safety – Wedged open doors.
The Chair confirmed that he had raised the concern in relation to guidance on wedged open doors, at the Fire Safety Group where it was agreed that the Senior Fire Officer would take this forward. This item had been closed out.

10/17 – Health and Safety Tutor Led Training

It was noted that this item was on the agenda and would be discussed further on in the meeting.

OHSG: 17/17 Feedback from Health and Safety Committee

The report was received and noted by the Group.

The Health and Safety Adviser – RD highlighted that the Health and Safety Committee was held on the 25th April 2017, were a number of policies had been approved. It was noted that some required slight amendments prior to being uploaded on to the Intranet.

OHSG: 18/17 Enforcement Agencies Correspondence Report

The report was presented and considered by the Group.

The Chair informed the Group that there were five areas of concern, these being:-

- Road traffic Accident – The Group were informed that a contractor van was reversing down the Emergency Admissions Access 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. Remedial actions had been agreed to improve pedestrian safety. Geoff Walsh and Charles Dalton are developing a strategic site safety plan.

- Legionella – It was reported that this item had been closed by the HSE, however there is still an ongoing mandate to continue to carry out vigorous audits.

- Lift Compliance – The Chair highlighted sustained improvement in relation to Lift Compliance and although this had been removed from the Agenda it continues to be monitored and remains on the Priority Action Plan.

  The Estates Representative reported that an application for funding had been raised and if approved this would allow the Health Board to upgrade around three to four of the lifts.

- Hydropherapy Pool – It was noted that a Work Group was formed between Therapies, Estates and the Health and Safety Department. The Action Plan has continued to be actively perused, and this had resulted in significant improvement and investment in the Hydrotherapy Pool.

  Further Estates employees had undertaken formal water treatment and competency training and the Group is continuing to meet on a regular basis to ensure cooperation and completion of the action remits.

- Contractor Fall – It was reported that there had been no correspondence on this matter during the period.

The Chair highlighted that the HSE agreed for the Local Inspector to meet with the UHB Staff Safety Representatives on a non specific topic area to improve the joint understanding of their role. The Staff Representative - Mr S Egan confirmed that this meeting has been arranged for the 12th July.

OHSG: 19/17 Fire Safety Management and Enforcement Report

The Senior Fire Adviser updated the Group on the position of the Fire Service in relation to responding to an alarm. He advised the Group that the Fire Service will no longer send three appliances unless a fire is confirmed. It was noted that they would send one to investigate.

He re-iterated the importance for staff to dial 3333 to confirm a fire and asked that the Group take this back to their areas.

It was noted that The Fire Service are aiming to reduce the number of False alarms and as a result are looking to impose improvement notices for Health Boards and other Organisation that are repeat offenders.

The Senior Fire Adviser reported that there is one Enforcement Notice at Whitchurch Hospital which was issued due to fire incidents relating to patients and smoking materials, this is due to expire on 27th July 2017. He advised that services are being relocated and Whitchurch Hospital as of this month will be vacant and as a result the enforcement would be lifted.

He also reported that no evacuation training has been completed, however it was noted that the supplier of the evacuation equipment had offered to provide further training free of charge, this would commence once they had completed servicing the equipment.

It was highlighted that in addition to the above the Health Board had placed an order for rescue manikins to aid with carrying out evacuation drills.

OHSG: 20/17 Health and Safety Priority Action Plan

The Chair reminded the Group that at the last meeting it was requested that all red areas be discussed in full.

It was noted that of the 35 total numbers of requirements 6 had been rated as Red. The Chair gave an overview of these items and informed the Group that the full report was attached for information.

The following items were discussed:-

Item 1.1 - A comprehensive programme of risk assessments to be completed with identified control measures implemented
It was reported that although meetings have taken place to progress this, no plan in place as yet to implement.

Item 1.4 & 6.1 - Health and Safety Management Training and Fire Safety Training
The Chair reported that concerns were raised at the Health and Safety Committee in relation to poor level of training compliance. It was noted that Fire Safety Training is running at around 52% with other training compliance around the same mark.

He added that the Committee has asked the Fire Safety Group to look at ways to improve compliance and report back to its July meeting.

Item 5.6 - Bariatric Patient Care
The Chair raised concerns in relation to patient care and also fire safety around bariatric patients. It was reported that this concern had been raised with the Director of Nursing and the Manual Handling team are also looking to progress this.

The Dental Service Representative reported that this had also been raised in the LIPS meeting and discussions on how to improve bariatric patient care within dental has been on the agenda.

It was agreed that Ms R Griffiths would report any progress at the next meeting in September.

Item 7.3 - Back log maintenance
The Environmental H&S Adviser reported that the estates department are at early stages of evaluating some approach tools to look at backlog maintenance and would report any progress at future meetings.

OHSG: 21/17 Tutor Led Training - Future Attendance

The Chair confirmed that the report presented at the last meeting had been updated although further work is needed before the amended document is circulated to the Group.

He informed the Group that further discussions were also needed around realistic costing in relation to failure to attends, but also felt that areas should be reimbursed for any courses cancelled short notice.

It was agreed that this would be an agenda item at September's meeting.

OHSG: 22/17 PI Claims Report

The Group received and noted the report which highlighted New Personal Injury claims for period – 15/03/17 to the 26/05/17.

The Health and Safety Adviser highlighted page 3, where it details a recent case which was in relation to a patient fall. It was noted that the Health Board had been successful on this occasion due to a witness statement.

The Claims Representatives gave an overview of this report highlighting some recent cases.

OHSG: 23/17 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: 24/17 Clinical/ Service Board Feedback

24/17.1 - Surgery
It was reported that Surgery Services have been asked to look at their mandatory training and PADR's. It was noted that meetings are taking place and any progress will be brought to the next meeting.

The Group were informed that Ward B6 is undergoing a refurbishment. The Ward will be closed at the end of the month for about 3 weeks.

24/17.2 – PCIC
The Representative - Mr R Davies raised concerns in relation to parking across Health Board sites, it was noted that this is impacting on clinic times and staff have been asked to report back on what are causing the delays. It was agreed that any findings be brought to this meeting.

He also highlighted that the actions on the Action Plan in relation to the incident at CHAPS had almost been completed and any findings would be reported back to this meeting.

Concerns were raised around temperature levels in Department of Sexual Health (DOSH). It was reported that it was too hot and as a result the area had added this to the Risk Register. It was noted that this issue has been raised with Estates. It was also noted that exposed pipes remain a concern at Roath Clinic; The Health and Safety Adviser – Ms R Daniel agreed to chase this up.

OHSG: 25/17 Policies and Procedures

The Chair informed the Group that a number of Policies and Procedures are out for comment in readiness for approval at the Health and Safety Committee in July.

It was noted that any comments are to be made to the author, by the 30th June 2017.

The Health and Safety Adviser queried the position on the Asbestos Policy and the Health and Wellbeing. The Group Secretary informed the Group that the Health and Wellbeing policy was not ready for submission to this meeting and had not received any documentation in relation to Asbestos.

The Health and Safety related procedure schedule was received by the Group for information.

OHSG: 26/17 DATE AND TIME OF NEXT MEETING
September – Corporate Meeting Room – HQ - UHW

MINUTES OF THE FIRE SAFETY GROUP HELD AT 9:30AM ON 19 MAY 2017 IN THE CORPORATE MEETING ROOM, UHW

Present:	Geoff Walsh	Dir of Capital, Estates and Facilities **(Chair)**
	Charles Dalton	Head of H&S/Fire Safety Manager
	David Hanks	DFSM Child & Women
	Frank Barrett	Senior Fire Safety Adviser
	Richard Steed	Cardiff University – Fire Adviser OSHEU
	Rowena Griffiths	DFSM Dental /Nurse Manager
	Nick Gidman	DFSM Cardiac
	Sarah Congreve	DSFM PCIC Vale Locality Manager
	Sarah Maggs	DFSM Facilities
Apologies:	Abigail Harris	Executive Director of Planning
	Cheryl Evans	DFSM C&W– O&G Directorate
	Catherine Salter	Staff Representative Service
	Dale-Charlotte Moore	DFSM - Critical Care
	Ian Fitsall	DFSM Facilities
	Ian Wile	DFSM Mental Health
	Peter Welsh	DFSM Executives - Director of Governance
	Rhys Davies	DFSM PCIC Locality Manager
	Scott Gable	DFSM – CD&T

In Attendance:

Zoe Brooks	Health and Safety

17/10 Minutes of the Meeting

The minutes of the meeting held on the 6th February 2017, were accepted as a true record.

17/11 Action Log

16.10.2 Vertical Evacuation

The Senior Fire Safety Adviser informed the Group that the suppliers of the Evacuation equipment would be visiting the Health Board on the 10th June to service equipment. It was noted that as part of the servicing agreement, they would return shortly after to train staff. Item Closed

16/23 Fire Warden Training and 16/29 Fire Training Stats

It was reported that the Mandatory Steering Group had not yet met since the last Fire Safety Group and as such there were no new updates.

16/26 Planned Evacuation

At the December meeting, the Senior Fire Adviser was asked to look into the purchase of dummies to use as casualties in order to carry out planned evacuations.

The Senior Fire Adviser reported that a purchase of these dummies had been raised and was awaiting authorisation to complete the order.

16/30 Smoking on Site

The Fire Safety Manager highlighted that concerns were raised in relation to residential smoking and suggested that a ban on smoking in the residential building be prohibited as part of their lease.

The Chair agreed to discuss this issue with the Executive Director of Governance.

17/04 DFSM Surgery

The Chair reported that he had written out to the Clinical Board, however had not received a reply.

It was agreed that this would be taken back to the Health and Safety Committee for resolution.

17/12 Shared Service Fire Audit – UHL

The Group received and noted the Independent Review Report for Llandough Hospital.

The Senior Fire Adviser informed the Group that an Independent review of Fire precautions at Llandough Hospital had taken place in November and the Health Board has now received the report.

He highlighted that there were three high risk areas relating to the fire alarm system and zoning arrangements, Fire Procedure and vertical evacuation.

It was noted that fire drawings were being looked at and updated in order to review fire alarm systems and zoning. An update would be given at the next meeting.

The Senior Fire Adviser also reported that he was in the process of reviewing the Fire Procedures and once completed will be brought to the Group for comment and approval.

The Group were advised that the full report was available and would be circulated for information. It will also noted that this report would be taken to the next Health and Safety Committee in July.

17/13 Fire Training Compliance

The Fire Safety Manager highlighted that at the Health and Safety Committee in April 2017, concerns were raised in relation to fire training compliance and requested assurance that every effort is being made to improve figure.

It was noted that the compliance percentage as of February was running at around 50%.

The Chair raised concerns around areas not being aware of their statutory obligation and managerial requirements to ensure staff are trained.

A long discussion took place and it was agreed to take this back to the Health and Safety Committee with the suggestion that Heads of Delivery attend the Committee to give assurance that training is being prioritised.

17/14 Enforcement Notice Status

The Senior Fire Adviser reported no new Enforcement Notices had been issued during the period. It was noted that Whitchurch would be vacant from June and as such the Health Board can apply for the enforcement notice to be lifted.

17/15 Fire Risk Assessment Status

The Fire Safety Manager highlighted that a DFSM meeting had taken place on the 2nd May 2017 and gave an overview of items that were discussed.

He reported that there were no managerial actions above 15 issued during the period; however the one for the PSA Building still remains as ongoing as there are issues around fire compliance of the building.

It was noted that there were a total of 33 areas assessed during the period (January 2017 – March 2017) of which 136 Managerial actions were identified. The Group were informed that there was one rated above 12 that related to Riverside Health Centre; it was confirmed that this issue had been resolved.

The Fire Safety Manager also reported that at the DFSM Meeting discussions took place around the IN01/02 the Health Board has received

during the period by the South Wales Fire Service and also discussed the issues around E-Cigarettes.

The Senior Fire Adviser added that a safety notice on the use of E-Cigarettes had been issued on the use of these devices.

The Chair asked that this notice be circulated and put on to the Intranet for information.

17/16 Fire Annual Report

The Fire Safety Manager reported that the Fire Annual Report was being prepared and would be going to the next Health and Safety Committee in July.

17/17 Planned Evacuations

The Senior Fire Adviser informed the Group that there are no planned evacuations; however The Special Care Baby Unit (SCUB) had agreed to carry one out using dummy like baby dolls.

17/18 NWSSP-FS Audit 17/18

It was noted that the NWSSP-FS Audit for 2017/18 is due at the end of May. The Senior Fire Adviser reported that most areas had been signed off with one or two outstanding areas reporting back shortly in readiness for submission before the deadline.

17/19 Any Other Business

Dental
DFSM for Dental Services raised concern in relation to Fire appliances unable to get to the Dental Hospital due to onsite traffic.

The Chair reported that on site traffic is being managed although on some occasions outside of the Health Boards Control the traffic along Dental can back up.

The DFSM – Dental queried whether these false alarms should be reported through Datix.

The senior Fire Adviser raised concerns regarding the large quantity of combustible materials being stored in main corridors at UHW; in particular the plastic wheelie refuses bins. He highlighted that if not possible to re-locate elsewhere should at least be changed to metal lockable bins.

17/20 Date of Next Meeting
7th August 2017 – Corporate Meeting Room, HQ UHW – 9.30AM

MINUTES OF THE SECURITY & PERSONAL SAFETY STRATEGY GROUP HELD AT MAY 2017 IN THE MANUAL HANDLING UNIT, DENBIGH HOUSE, UHW

Present:	Charles Dalton	Head of Health and Safety **(Chair)**
	Carl Ball	Personal Safety Manager
	Damien Winston	Security Manager
	Emma Foley	Case Manager Officer
	Emma Thomas	Representative - PCIC
	Kevin Fox	On Site Police
	Heather Hancock	Representative - Mental Health
	PC Tom Haigh	South Wales Police
	Raymond Cockayne	Assistant Security Manager
	Catherine Salter	RCN Representative
	Amanda Watkins	Primary Care – Operations Manager
Apologies:	Peter Welsh	Director of Corporate Governance
	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

The Chair introduced and welcomed the New Security Manager – Mr Damien Winston.

17/13 Minutes of the last meeting

The notes of the Security and Personal Safety Strategy Group held on in February 2017 were **APPROVED** and **ACCEPTED** as a true record with the following amendment:-

The Staff Side representative highlighted that item 2.2 minute number 17/03 refers to Violence and Aggression training for Security as not being a mandatory course and felt that this was misleading as this training is essential to their role

The Chair highlighted for accuracy this training was not one of the ten Mandatory training, however Violence and Aggression is based off risk assessment and over and above the requirements of Mandatory Training.

The Assistant Security Manager highlighted that there was a poor uptake for this course and a commitment is needed from both A&E and Security.

It was re-iterated that based off Risk Assessment this course is mandatory and efforts should be made for Staff to attend. It was agreed that Personal Safety, A&E and Security to meet to progress further. **Action CB**

17/14 Action Log

Security feedback/Spit Protectors
It was noted that concerns had been raised by Security, in relation to dealing with Patients or visitors who spit and not having masks to hand.

The Personal Safety Manager confirmed that the department had looked in to these spit protectors full face masks and found that whilst British transport Police use these, they are not used in any other Health Board in Wales; visors are used.

He added that he could not find much information on the full face spit protectors other that the manufacturer advice.

He highlighted that there are many visors on the market, one being a flexible visor that can be carried around in a pouch.

The Chair re-iterated the need to look at ways to protect staff against Patients or Visitors spitting and suggested that a planned kit is available for security to carry around. **Action DW**

Developing a Protocol for Security Specialling for long Periods
The Chair informed the Group that at the last meeting it was highlighted that Security are specialling patients on some occasions, for over two hours, which is having an impact on responding to other incidents.

The Personal Safety Manager advised that due to cost implications on this matter, this should be progressed by the new Head of Security. **Action DW**

Communicating Potential Lone worker Risk in Community Settings
The Chair reported that he had met with the New Case Manager for the Ambulance Service, who has agreed to meet with himself and the Personal Safety Manager on other matters, however confirmed that this item will be on the agenda for discussion.

CCTV at Children's Hospital
The Assistant Security Manager reported that this is still an ongoing issue and IT is looking into this matter for resolution. **Action: RC** Feedback at next meeting.

17/15 Priority Action Plan/ Risk Register

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

The Chair Informed the Group that the Health Board is currently going through a revision on how the Risk Register is being delivered and reported that a development day had taken place.

He raised concerns in relation to training compliance and highlighted that this had also been raised at the Health and Safety Committee as an issue. It was noted that the Health Board was looking at the training needs analysis to ensure accuracy.

The Group was informed that according to All Wales Statistic, Cardiff and Vale deliver more tutor led Violence and Aggression training Module B and C than any other Health Board in Wales.

17/16 V&A Risk Assessments - Home Visiting

The Personal Safety Manger highlighted that during a recent home visit by the Community Team, concerns were raised in relation to a patient having replica fire arms on display (which staff were not aware it was a replica at the time). He reported that the Team had asked if a specific Risk Assessment could be provided for this type of incident; however it was felt that the general Violence and Aggression Risk Assessment would be appropriate. It was noted that on this occasion Police attended and reassurance was given.

It was suggested that a Guidance or Protocol be established to deal with this or similar situation; the Chair asked that this general guidance, once put together is circulated and put onto the Violence and Aggression Web page. **Action CB/EF**

17/17 Security feedback

<u>PPE</u>
The Assistant Security Manager raised concerns in relation to stab vests conditions, reporting that there are no funding available to replace them; this would have to be procured from the Security budget.

He informed the Group that new encrypted body cams had been purchased, although they have not been used as yet.

<u>Security Office Relocation</u>
He also reported that Security would be out of the Control Room for around four weeks due to the area being refurbished; Security had been relocating to Pembroke House. It was noted that the ID badge service will also be carried out form this interim location. A notice had been put on the Intranet, informing staff of these arrangements.

Use Of Body Cams at UHL
The Case Management Officer informed the Group that staff on Gwenwyn Ward had raised concerns following an incident on the Ward, where Security had attended without body cams.

The Assistant Security Manager reported that as part of the introduction of Body Cams as well as stab vests, these would be enforced as PPE; therefore a sign out form will be present at the beginning of each shift to ensure that these items are in situ.

Whitchurch Hospital Security
The Chair queried the position in regards to Security at Whitchurch, once the Hospital becomes vacant. The Assistant Security Manager reported that discussions are still ongoing, especially in relation to the Locality Offices.

E-DATIX
The Chair also queried whether the Security Officers were using EDATIX to report security incidents (not just violent incidents). He reported that loss property was noted as 10 last year, theft 19 and vandalism only effecting 7 people; he felt that these figures were low.

The Security Manager highlighted that discussions had taken place between himself and The Assistant Manager around the EDATIX system, and what the Security Officers are requested to report. He reported that meetings would take place with the Team Leaders to re-iterate the importance of reporting incidents.

Data Protection
The Staff Side Representative raised concern around data protection breach, involving the Radiation Badges. She informed the Group that a number of Organisations sign up to wear a badge to monitor radiation levels that they are subjected too.

It was noted that the provider of these badges data protection had been breached and individual's details have been compromised. It was reported that a notice went out in March to all staff that were at risk and advice on how to look out for signs that their details had been used.

17/18 V&A Training – Compliance

A report was circulated to the Group.

The Staff Side Representative gave an over view of the report and reasoning around some of the figures.

It was highlighted that the 2016/17 statistics identified a reduction in Mental Health Training, it was suggested that this was relating to the move from Whitchurch to Hafan Y Coed.

The Chair asked that this report be circulated to each a Clinical Board for information.

17/19 Lone worker

A report was circulated and noted by the Group.

The Case Management Officer reported that there were 616 live devices in the Health Board running at a 70% usage in most areas. She brought the Groups attention to a table that breaks this down by sub group and highlighted that if the area is running below 70-75% and are requesting additional devices, then they will be asked to look at the current allocation, before any more devices are issued.

It was noted that the new Skyguard devices have had a positive response.

17/20 Police Partnership

There was no reported feedback from the South Wales Police.

17/21 Date and Time of Next Meeting

12th September 2017 – 14:00PM – Manual Handling Unit, Denbigh House UHW

UPDATED HEALTH AND SAFETY RELATED POLICIES SCHEDULE

POLICY	UHB REFERENCE NO	AUTHOR/LEAD RESPONSIBLE OFFICER	SUBMISSION TO HEALTH & SAFETY COMMITTEE	APPROVAL DATE	REVIEW DATE
Management of Stress & Mental Health Wellbeing in the Workplace	UHB 071	Employee Wellbeing	July 2014 (2nd review)	July 2014	July 2017
Management of Asbestos	UHB 072	Director of Planning	July 2014 (2nd review)	July 2014	July 2017
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

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

POLICY	UHB REFERENCE NO	AUTHOR/LEAD RESPONSIBLE OFFICER	APPROVING COMMITTEE	APPROVAL DATE	REVIEW DATE
Safe Use of Ionising Radiation	UHB 031	Superintendent Radiographer	Quality & Safety	December 2016	December 2019
Safety Notices & Important Documents	UHB 069	Head of Corporate Risk & Governance	Quality & Safety	August 2011	August 2014
No Smoking and Smoke Free Environment	UHB 073	Head of Health Promotion	UHB Board	July 2016	July 2019
Occupational Health	UHB 103	Business Manager, Workforce & OD	Workforce & OD	March 2012	March 2015
Mandatory Training	UHB 080	Learning Education & Development Manager	Workforce & OD	June 2013	June 2016
Risk Management	UHB 023	Head of Corporate Risk & Governance	Audit	July 2013	July 2016
Working Time	UHB 168	Business Manager, Workforce & OD/Unison	People, Performance & Delivery	July 2014	July 2017
Domestic Abuse, Violence against Women & Sexual Violence	UHB 167	Senior HR Policy & Compliance Officer	People, Performance & Delivery	March 2015	March 2018