Bundle Health and Safety Committee 9 July 2019

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12 Date and time of the next meeting: Tuesday 8th October at 9.30am Woodlands House, Ground Floor

HEALTH AND SAFETY COMMITTEE
To be held on 9 July 2019 at 9.00am

WOODLANDS HOUSE, GROUND FLOOR, NANT FAWR 2

AGENDA

	PRESENTATION – Structure and Process for Staff Health and Safety Training	
1	Welcome & Introductions	Michael Imperato
2	Apologies for Absence	Michael Imperato
3	Declarations of Interest	Michael Imperato
4	Minutes of the Committee Meeting held on 9 April 2019	Michael Imperato
5	Action Log	Michael Imperato
6	Chairs Action taken since last meeting	Michael Imperato
7	**Items for Review and Assurance**	
7.1	Health and Safety Annual Report	Charles Dalton
7.2	Pedestrian Access Strategy – Update and Assurance	Geoff Walsh
7.3	ProACT Audit Survey Progress	Charles Dalton
7.4	HSE Inspection of Violence and Aggression and Musculoskeletal Disorders in Healthcare 2018-19	Charles Dalton
7.5	Enforcement Agencies Report	Charles Dalton
7.6	Fire Enforcement and Management Compliance Report	Geoff Walsh
7.7	Health and Safety Assurance Schedule and Priority Improvement Plan 2019/20	Charles Dalton
7.8	Environmental Health Inspection of All Aroma Coffee Outlets, University Hospital of Wales (UHW) on 25th April 2019	Geoff Walsh
7.9	Updated Health and Safety Related Policies Schedule	Rachael Daniel
8	**Items for Approval/Ratification**	
8.1	Contractor Control Policy	Geoff Walsh / Charles Dalton
8.2	Work Programme 2019/20	Martin Driscoll
8.3	**Sub Committee Minutes:** i. Operational Health and Safety Group – February 2019 ii. Fire Safety Group – March 2019	 Martin Driscoll Geoff Walsh
9	**Items for Noting and Information**	
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12	**Date and time of next Meeting**	
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UNCONFIRMED MINUTES OF THE HEALTH AND SAFETY COMMITTEE HELD AT 9.30am on 9 APRIL 2019 IN THE CORPORATE MEETING ROOM, HEADQUARTERS, UNIVERSITY HOSPITAL OF WALES (UHW)

Present:

Michael Imperato	**Independent Member – Legal (Chair)**
Charles Janczewski	Vice Chair
Akmal Hanuk	Independent Member - Local Community

In attendance:

Janice Aspinall	Staff Safety Representative
Charles Dalton	Head of Health and Safety
Martin Driscoll	Director of Workforce and OD
Carol Evans	Assistant Director of Patient Safety and Quality
Nicola Foreman	Director of Corporate Governance
Stuart Egan	Staff Lead for Health and Safety
Fiona Jenkins	Director of Therapies and Health Sciences
Fiona Kinghorn	Director of Public Health
Geoff Walsh	Director of Capital, Estates and Facilities
Mark Pinder	Arjo UK Representative (for agenda item HCS: 19/035)
Samantha Skelton	Manual Handling Adviser (for agenda item HCS: 19/035)

Apologies:

Secretariat:

Rachael Daniel	Health and Safety Adviser

PART 1

HSC: 19/029 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

HSC: 19/030 DECLARATIONS OF INTEREST

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

HSC: 19/031 MINUTES OF PREVIOUS MEETING

The minutes of the Health and Safety Committee held on the 22nd January 2019 were **APPROVED** and **ACCEPTED** as a true record with the exception of the following minor amendment:

(i) Charles Janczewski - Vice Chair's apologies to be recorded.

HSC: 19/032 UPDATED ACTION LOG

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

- HSC: 19/006 – the Director of Corporate Governance advised the Terms of Reference will need to be presented to the May Board meeting for sign off along with the Committee's Workplan.

  ACTION – Mrs N Foreman

- HSC: 19/015 – the Head of Health and Safety informed the Committee a Managers Safety Course with an accompanying handbook had been developed to support Managers in their role in relation to health and safety and also references their responsibilities for implementing policies and procedures.

  A pilot course was delivered for safety representatives the previous week and was very well received, the course will now be offered to Managers with the first course running in June 2019.

HSC: 19/033 PRESENTATION ON THE ARJO PROACT AUDIT SURVEY FINDINGS

Mr Imperato welcomed Mr Mark Pinder, National ProACT Manager for Arjo UK to the meeting.

Mr Pinder provided the Committee with details of the audit undertaken in November 2018. He added the data was being compared to the two previous audits undertaken in 2016 and 2017 with the trend graphs looking very similar.

The Vice Chair queried whether the community was part of the audit, it was confirmed it was not.

The Independent Member – Local Community queried whether there were any costings associated to the audit, he was advised these were currently being worked up. Mr Hanuk then queried whether this was considered as core or non-core business, this was confirmed as being core business.

The Chair requested assurances at the next meeting on how the results of the audit were to be taken forward. The Director of Therapies and Health Sciences added that a paper will also need to be presented to Management Executive.

ACTION – Mr C Dalton

The Committee **NOTED** the findings of the Arjo Proact Survey and **REQUESTED** assurances on the findings at the next meeting.

HSC: 19/034 BOARD ASSURANCE FRAMEWORK (BAF) – HEALTH AND SAFETY RISKS UPDATE

The Director of Corporate Governance informed the Committee the Corporate Risk Assurance Framework (CRAF) no longer exists and has been replaced by the Board Assurance Framework (BAF) which highlights the big risks for the Health Board.

Each Corporate Department and Clinical/Service Board will have their own risk register and high level health and safety risks should be reported through this Committee. Mrs Foreman added Mandy Collins, Interim Head Corporate Governance would be supporting departments with this process.

The Head of Health and Safety stressed the risk assessment process must underpin the BAF. Mrs Foreman advised the Risk Management Policy was currently being reviewed.

The verbal update in respect of the BAF was **RECEIVED** and **NOTED** by the Committee.

HSC: 19/035 PEDESTRAIN ACCESS SAFETY STRATEGY AND INDEPENDENT SURVEY REPORT

The Director of Capital, Estates and Facilities informed the Committee the key risks had been extracted from the Independent Report which identified three high risk areas:

- Allensbank Road entrance to the roundabout adjacent to the multi-storey car park. Mr Walsh advised this entrance was not under health board control and requires discussion with the Local Authority.

- Residential Road/Heath Park Way delivery/logistics areas. Mr Walsh advised delivery vehicles were queuing on the zig zag lines and to resolve this consideration was being given to removing some of the zebra crossings in the area. He added Shared Services had changed some of their deliveries to avoid a build-up of delivery vehicles. It had also been agreed that Shared Services would arrange for banksmen to be present however there had been no evidence of this and he would continue to work closely with Shared Services.

- Access from footbridge over A48/Dental car park 6 to Gateway Road, there is currently no footpath through the car park to the Dental Hospital.

The Staff Lead for Health and Safety welcomed the report and highlighted a few recent concerns in respect of contractor control and pedestrian safety at University Hospital Llandough. Mr Walsh stated he would discuss these outside of the meeting as they were operational issues that he is not aware of and therefore cannot respond to at this time.

The Head of Health and Safety stated pedestrian safety must be routinely considered as part of the work programme for any contract.

The Director of Workforce and OD noted the three high risk areas and queried whether any timescales had been identified. Mr Walsh advised the report would be considered as part of the Sustainable Travel Plan but there was no programme plan at this time.

The Independent Member – Local Community acknowledged this would not be immediately resolved but queried whether there was any interim strategy. Mr Walsh stated the highest risk related to the stores area and further conversations were required with Shared Services in relation to having banksmen. Mr Dalton added they must take responsibility for banksmen and for ensuring vehicles were not delivering until it was safe for them to do so.

The Vice Chair requested the Committee was kept up to date with progress against the programme of works.

ACTION – Mr G Walsh

Mr Driscoll informed the Committee he was now the Executive Lead for Health and Safety and he would raise at Executive Team.

ACTION – Mr M Driscoll

The contents of the Independent Report was **NOTED** by the Committee.

HSC: 19/036 ENFORCEMENT AGENCIES CORRESPONDENCE REPORT

The Head of Health and Safety informed the Committee the final submission in relation to the contractor fall was being submitted the following day with the preliminary hearing being held on the 2nd May. The outcome would be brought to the July Committee Meeting.

ACTION: Mr C Dalton

Mr Dalton also informed the Committee that the Health and Safety Executive (HSE) was currently undertaking a programme of Well Working Audits of Healthcare. Two Health Boards in Wales had already been audited and it has

been intimated that Cardiff and Vale would be audited in the 3rd quarter although this had not yet been confirmed by the HSE. The audits were focusing on violence and aggression and musculoskeletal disorders and preparations will need to be put in place.

The Chair requested an update be provided to the July meeting.

ACTION – Mr C Dalton

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: 19/037 CONTROL OF CONTRACTORS IN NON-ESTATE ACTIVITIES

The Head of Health and Safety advised this was a progress report following previous submissions to the Committee.

The Chair advised the culture of the organisation would be looked at in any legal proceedings and this was an important paper in respect of the continued progress made by the Health Board in contractor control management in both estates and non-estate activities.

The Independent Member – Local Community requested clarification in respect of the red and amber cards issued to contractors. The Director of Capital, Estates and Facilities advised a red card resulted in the contractor immediately leaving site and the amber card related to a procedural breach, also two amber cards equated to a red card. Mr Walsh added all contractors have to attend the Health Board induction and are then registered on the system. All contractors also have to submit health and safety information to the health board.

The Committee **NOTED** the progress made in relation to both estates and non-estates contractor control activities.

ASSURANCE was provided by:

- The actions and details identified within the report.

HSC: 19/038 FIRE SAFETY MANAGEMENT AND COMPLIANCE REPORT

The Director of Capital, Estates and Facilities informed the Committee there were currently no enforcement notices in place and no significant audits had taken place.

Mr Walsh advised the Fire Service had changed their policy when responding to fires and would now not be sending two appliances and would be driving at normal road speed until an actual fire had been confirmed. Concerns have been raised with the fire service in relation to the high rise buildings on site.

The Staff Lead for Health and Safety informed the Committee as part of workplace inspections he repeatedly sees the tunnels full of items that should not be stored there which impacts on fire safety. Mr Walsh stated the Fire Safety Officers constantly raise the same issue and the estates/waste teams clear on a regular basis but it is a constant challenge to keep the tunnels clear.

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

ASSURANCE was provided by:

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

HSC: 19/039 HEALTH AND SAFETY IMPROVEMENT PLAN – EXCEPTION REPORT

The Head of Health and Safety updated the Committee on the current status of the improvement plan.

The Vice Chair requested for abbreviations not to be used and noted 52 milestones must be a challenge to manage. The Head of Health and Safety stated this was a live document and the milestones would be updated accordingly.

The improvement plan was **RECEIVED** and **CONSIDERED** by the Committee.

REASONABLE ASSURANCE was provided by:

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

HSC: 19/040 HEALTH AND SAFETY RELATED POLICIES SCHEDULE

The Health and Safety Adviser informed the Committee an extra column had now been added to the schedule following a request at the last meeting. This column provided details of the status of those policies which were currently out of date.

The schedule was **NOTED** by the Committee.

HSC: 19/041 SECURITY SERVICES POLICY

The Director of Capital, Estates and Facilities informed the Committee informed the Committee amendments made to the Policy were in relation to managerial changes and policy format.

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

PART 2

HSC: 19/042 COMMITTEE WORK PROGRAMME FOR 2019/20

The Work Programme for 2019/20 was **RECEIVED** and **NOTED** for information by the Committee.

The Director of Corporate Governance advised the work programme required some amendments which she would take forward.

ACTION – Mrs N Foreman

HSC: 19/043 REGULATORY REVIEW AND TRACKING REPORT 1ST APRIL 2018 – 31ST MARCH 2019

The Regulatory Review and Tracking Report was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 19/044 HEALTH AND SAFETY IMPROVEMENT PLAN (IN DETAIL)

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

HSC: 19/045 LONE WORKER DEVICES REPORT

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

HSC: 19/046 ENVIRONMENTAL HEALTH INSPECTION REPORT OF BARRY HOSPITAL ON 13TH MARCH 2019

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

HSC: 19/047 OPERATIONAL HEALTH AND SAFETY GROUP MEETING OF DECEMBER 2018

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

HSC: 19/048 FIRE SAFETY GROUP MINUTES OF DECEMBER 2018

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

HSC: 19/049 **WATER SAFETY GROUP MINUTES OF DECEMBER 2018**

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

HSC: 19/050 **REVIEW OF THE MEETING AND ITEMS TO BRING TO THE ATTENTION OF THE BOARD OR OTHER COMMITTEES**

The Director of Workforce and OD stated operational issues should be taken to the Operational Health and Safety Group with the appropriate individuals present and not discussed at the Committee meeting.

HSC: 19/051 **DATE AND TIME OF NEXT MEETING**

The next meeting will be held at 9.30am on Tuesday 9th July 2019 in the Corporate Meeting Room, HQ, University Hospital of Wales.

Signed ……

Date ……

ACTION LOG
FOLLOWING HEALTH AND SAFETY COMMITTEE MEETING
9 APRIL 2019

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Actions Completed					
HSC 19/006	Terms of Reference	To be presented to the May Board meeting.	N Foreman	30/05/19	**COMPLETED.** Board meeting 30th May 2019
HSC 19/035	Pedestrian Access Safety Strategy	Committee to be kept up to date with progress against programme of works.	G Walsh	09/07/19	**COMPLETED.** This is on the agenda
HSC 19/035	Pedestrian Access Safety Strategy	To be raised at Management Executive	M Driscoll	09/07/19	**COMPLETED.** This has been raised at Management Executive
HSC 19/036	Enforcement Agencies Correspondence Report	Update to be provided at July meeting in respect of HSE Well at Work Audit	C Dalton	09/07/19	**COMPLETED.** This is on the agenda
Actions in Progress					
HSC 19/036	Enforcement Agencies Correspondence Report	Committee to be informed of outcome from legal proceedings in respect of contractor fall case.	C Dalton	09/07/19	The Head of Health and Safety would advise the Committee after the Court Hearing w/c 15the July 2019
Actions referred to other Committees/Board					

Report Title:	**Health and Safety Annual Report 2018/19**								
Meeting:	Health and Safety Committee						**Meeting Date:**	09/07/2019	
Status:	**For Discussion**		**For Assurance**	✓	**For Approval**		**For Information**		
Lead Executive:	Executive Director Of Workforce and Organisational Development								
Report Author (Title):	Head of Health and Safety								

SITUATION

This report has been prepared to provide assurance to the Committee that the Health Board's health and safety risks have been appropriately managed during 2018/19.

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

The report covers the period the 1st April 2018 to the 31st March 2019; however it also refers to progress made since this date.

BACKGROUND

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

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

The previous 2017/18 report was considered at the July 2018 Health and Safety Committee.

ASSESSMENT

The full report can be found via the internet access link.

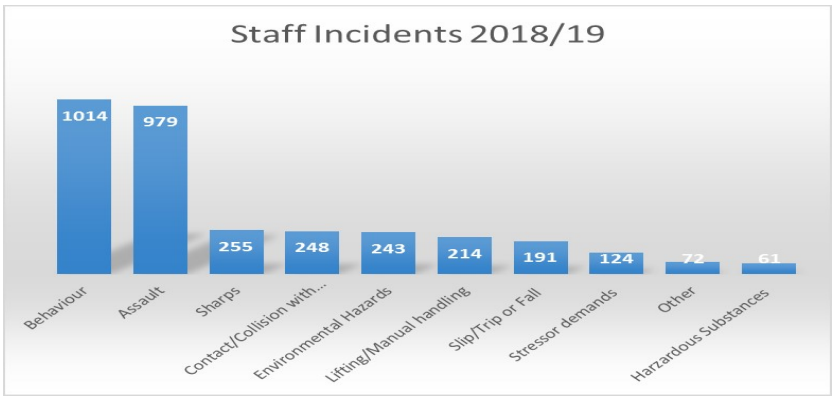
The Annual Report considers trends in incidents, personal injury claims, training and management processes and progress in the 8 strategic areas. It concluded that the trends of incidents and management processes continue to show progress in improving staff and health and safety risks.

Key issues highlighted include:

1. Health & Safety Management

- The HSE has been very active during the period in visiting the Health Board, including correspondence, queries and visits relating to 9 aspects, all of which were successfully resolved and closed out with no enforcement actions. They have however continued to pursue action in relation to the Contractor Fall, conclusion of which is expected in July 2019.

- The development of the Manager Safety Training program has been progressed with a successful pilot course being run in March and the formal course commencing early in the New Year financial year.
- There has been a notable reduction in the number of lost time (RIDDOR) injuries, reported through the Datix system, down from 118 to 99 incidents. Manual handling and violence and aggression incidents have remained reasonably consistent, however there is a marked reduction in the number of slip, trips and falls, resulting in lost time.
- With regards to all staff reported incidents there was a reduction of 8% in the number of events from 3682 to 3401.



- Staff reported incidents show that violence and aggression accounts for 59% of all events and show a small rise of 3% over 2018/19, with the exception of behavioural events all other categories reflect a reduction.
- Mandatory training of health and safety has significantly improved, with 4 clinical boards achieving the 85% target a further 3 being above 80%, only Surgery falling below 70%.
- Conversely tutor led training compliance for both manual handling and violence and aggression is well below requirement and a review is being progressed with an aim to enhance competence.

2. Personal Safety/Violence and Aggression

- Although incident statistics show a small increase in the number of behavioural incidents reported, the average number of incidents reported over the last 4 years 2015 - 2019 is some 24% lower than the previous 5 years 2010 - 2015. Some of this reduction however may be associated with the changing of description fields within the incident reporting system but it represents a significant improvement.
- The number of prosecutions for assaults on staff significantly increased during the year from 52 to 81. This effectively equates to a successful conviction every four and a half days of the year and the ten year average is still significantly greater than one successful conviction per week. There were some notable convictions and a number of custodial sentences during the period, these were enhanced by the introduction of a new Assault on Emergency Workers Act (2018) which effectively doubles the sentence for assaults on our NHS staff.
- The Welsh Government reviewed and issued the Obligatory Responses to Violence in Healthcare, the Health Board undertook a programme of road shows and poster campaign to enhance awareness.
- The lone worker devices continue to be highly valued by staff with average usage being at 70% and devices in great demand. The contract will be renewed in the coming year.

3. Manual Handling

- There is a positive trend in the reduction of manual handling incidents with the overall number of manual handling incidents for 2018/19 16% lower than the previous year. Equally data shows that the 5 year average from 2014/15 for all manual handling incidents represent a significant improvement of being 38% lower than the previous 5 years and lost time events being 26% lower.
- Manual handling training shows that whilst the Health Board has offered foundation training at the staff turnover rate of 10.01% for both patient handling and inanimate handling, compliance is at 68% and 60% respectively. However a number of the recruited staff would have come from other NHS Organisations and already have the passport compliance.
- Refresher training has a lower level of compliance at just 34% and 22%, however it is noted that the compliance to e-learning module A (relevant only to those staff who have been identified as having no significant manual handling risk) stands at over 20 times its training needs analysis estimate; with some 5491 staff having undertaking this course when the estimate was that only some 261 staff required this. This clearly highlighted that the e-learning course was being selected to show compliance on the ESR system, when in reality a practical course was needed.
- To resolve this, the training department has worked with the Learning and Education Department and this course is no longer considered as compliance. It is equally disappointing that only 49 staff chose to undertake the positive evaluation assessment which could have been undertaken at their workplace or by a visit to one of the training units.

4. Health

- There were a significant number of informal environmental monitoring assessments undertaken and a total of 45 formal reports completed, these included 19 hazardous substances, 9 temperature/humidity, 4 vibration/noise.
- Control of Substances Hazardous to Health (COSHH) compliance increased from 62% in 2017/18 to 82% in 2018/19. The health and safety department also initiated further monitoring on compliance to hand arm vibration.
- A hand arm vibration project group has also been established following a gap analysis of health procedures and an indicative risk assessment was completed by each Clinical Board to identify priority areas, monitoring was carried out and reports completed identifying any further actions required.

5 Fire

- Fire Safety will be subject to a separate annual report, however a key achievement during the year is a 22% reduction in the number of false alarms and a 32% reduction in fire engine attendance.

6 Patient Environment

- Following the completion of a Manual Handling Proact Audit in November the results recognised an improvement in the age and quality of patient hoists with a reduction in the amount of discontinued and well beyond hoist from 14% to 5% due to previous purchase. However, it did highlight that some equipment was of poor standard. The audit also identified benefits in the review of hygiene equipment that is used on the wards and the need for greater use of single patient slings. These aspects are being progressed through an action plan.

7. Estates

- Corporate recruitment of Adviser to enhance contractor control for non-estate activities.
- High degree of contractor control maintained throughout 2018/19, reduction in the number of non-compliance issues identified with the new advisory category introduced.
- Average number of contractor site visits maintained throughout the year at 66 visits per month.
- High level of scrutiny of contract control documentation has been maintained by the health and safety team ensuring RAMs are suitable and sufficient.
- Notably consistently high Environmental Health star ratings of food preparation areas and restaurants was achieved during the period.
- Estates continue to enhance contractor control and implementing the same standards for contractors working in other areas is being pursued.

Future plans 2019/20

- Further development of permit to work systems and Job Registration Form system to an access format to enable the system to be audited better.
- Update the Asbestos Management Plan to better reflect the management of asbestos within the UHB and continue to prioritise Regulation 18 areas to reduce the risk of asbestos exposure to maintenance and contractor staff.

8. Sharps Safety

- The reporting of sharps injuries is the lowest recorded to date at 255 being 8% lower than 2017/18. Furthermore since the introduction of safer sharps initiative 5 years ago, data demonstrates an average reduction of 29% over the pre safer sharps periods.
- A third (84) of the reported sharps incidents relate to non-dirty needle events.
- The numbers of needle stick personal injury claims remain low at only 3% of the All Wales NHS number of events whilst employing 16% of the workforce.

ASSURANCE is provided by: Health and Safety aspects being appropriately monitored and progressed as detailed within the report.

RECOMMENDATION

The Health and Safety Committee is asked to:

- Note the contents of this report.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	/	7. Be a great place to work and learn	/
3. All take responsibility for improving our health and wellbeing	/	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**PEDESTRIAN ACCESS STRATEGY – Progress Update**								
Meeting:	**Health and Safety Committee**						**Meeting Date:**	**09/07/2019**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**√**
Lead Executive:	**Director of Planning**								
Report Author (Title):	**Director of Capital Estates and Facilities (02920 743761)**								

SITUATION

The Health Board has undertaken a Pedestrian Access study at University Hospital of Wales. The study is now complete and this report highlights the recommendations and details the next steps and actions.

REPORT

BACKGROUND

Introduction

Cardiff and Vale University Health Board recognises its responsibility for the management of Pedestrian safety throughout its portfolio of properties.

University Hospital of Wales (UHW) has seen significant increases in Clinical activity during the last 10 years which has resulted in dramatic increases in traffic and pedestrian volumes at this site. The UHB has undertaken a number of traffic management studies at UHW to identify traffic movements and profiles and has implemented infrastructure changes to reduce traffic congestion, improve health and safety and reduce vehicle emissions.

The UHB is also promoting and encouraging patients, visitors and staff to adopt where appropriate sustainable and active travel methods to attend UHB premises e.g. cycling and walking etc. As UHW has significant volumes of pedestrians who need to traverse the site there is a need to develop a Pedestrian Access strategy. This need is also reinforced as there has been a pedestrian incident at UHW. Whilst the strategy will initially focus on UHW, the program will be expanded to address the requirements of other Health Board sites.

Traffic and Transport Management

UHW has observed significant increases in activity due to historic and current rationalization programmes where services have transferred to this site but also associated with natural growth and changing models of healthcare. UHW has four vehicle entrances/exits and a range of pedestrian access points and is flanked by a range of busy road networks serving Cardiff city and surrounding districts.

The UHB's Transport and Travel Team have been developing a range of promotional and infrastructure measures to encourage patients, visitors and staff to consider alternative methods to travel to the UHB, to reduce traffic congestion, improve health and safety and curb vehicle emissions.

Pedestrian Incident

There has been an incident at UHW whereby a pedestrian was involved in a collision with a vehicle and the pedestrian suffered a broken leg. This resulted in an HSE investigation and the UHB prepared an action plan which was accepted by the HSE. This highlighted and prioritized the need for a formalised Pedestrian Access strategy for UHW to be developed and implemented.

Pedestrian Access Strategy

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

The study focused on UHW, as this site has a complex range of pedestrian requirements/issues and how these interrelate with other transport and traffic matters. The findings and recommendations can also be applied and replicated at other UHB sites as there are many findings which will apply to all premises.

Recommendations

The final report has now been received and the following is a summary of the recommendations to be implemented at UHW:

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

Areas of Highest Risk

The areas of highest risk are:

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

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

ASSESSMENT

Traffic Management and Transport Strategy

A Sustainable Transport Strategy is being developed for the UHB which will include:

- Policy Development
- Travel Planning
- Traffic Management
- Car Parking
- Pedestrian Access Strategy

The strategy is scheduled to be finalised, December 2019 in line with the task and finish group programme of works

It is proposed to review and blend the Pedestrian Access recommendations into the strategy. An external Highways and Engineering Consultant ADL has been appointed and has commenced this work. The pedestrian access elements and requirements will be developed for all main UHB sites and the strategy is being managed by the Sustainable Transport and Travel Steering Group.

Action Plan for Areas of Highest Risk

In order to prioritise the three areas of highest pedestrian risk a Task and Finish group is being established. The key aims of the group will be to identify the cause of the risk and develop tangible cost effective solutions to mitigate the risk to an agreed practical level.

Membership of the group will include representatives from Transport and Sustainable Travel, Estates, Health and Safety, Public Health Wales and support from ADL and other stakeholders as required.

As the Allensbank Road entrance to the UHW site is managed by the Council, the solution will require discussion and coordination with the Council.

Task and Finish Group Programme of Works

- June/July 2019: Establish Task and Finish group.
- July 2019: Agree Terms of Reference and objectives and engage necessary resources.
- August 2019: Develop options for areas of highest risk.
- September/October 2019: Options developed into costed solutions and presented for approval.
- October/November 2019: Stakeholder engagement for agreed solutions.
- December 2019: Approval of final solutions.
- January 2020 onwards: Implementation phase.

ASSURANCE is provided by:

RECOMMENDATION

The Health and Safety Committee is asked to: **NOTE the content of the report.**

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

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

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

Report Title:	**ProACT Audit Survey Progress**								
Meeting:	Health and Safety Committee						**Meeting Date:**	9/7/2019	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	√	
Lead Executive:	Director of Workforce & Organisational Development								
Report Author (Title):	Head of Health & Safety (02920 743751)								

SITUATION

The Health and Safety Committee received a presentation on the independent findings of the "ProACT" Audit on manual handling equipment status according to patient functional levels at the April meeting.

The Committee requested that a progress report and action plan be brought to the July meeting.

BACKGROUND

ProACT is an assessment tool used to provide an insight into patient handling (and hygiene) equipment. It reviewed the mobility levels of patients,type, age and condition of equipment available (2017 included washable hoist slings and hoist batteries) and service and routine maintenance information.

The results provided the Health Board with recommendations related to patient handling equipment. It identifed aged/obsolete equipment with limited/no service support and the need for new equipment to meet patient functional levels and care processes.

ISO/TR 12296 Guidelines 2012 and 2010 Healthcare Guidelines provide recommendations for equipment type and number to enable meeting patient and care giver needs within healthcare facilities.

ASSESSMENT

Age and condition of hoists

The survey identified that significant progress had been made in improving the age and condition of our hoists, however it did identify that 5% of our stock of lifting aids were either obsolete or well beyond the manufacturer's recommended working life.

This equated to some 21 lifting aids, some of which were hoists which would require capital investment and some were other lifting aids which would require local funding.

A bid was submitted for the capital component of hoisting equipment in late 2018 which was unsuccessful, however a further submission will be drafted for consideration in the current fiscal year.

Each clinical area has been given details of their equipment which require resourcing for local action.

Hoist Servicing
The service contract for maintenance is for service only and does not include any parts that need to be replaced at specified intervals to maintain the safety and lifespan of the product, this may result in hoists breaking down more regularly. Hoists need to be LOLER inspected every 6 months and serviced annually.

Arrangements for when hoists break down was an elongated process, from the ward reporting the issue to estates to it potentially being fixed by the contractor. The ward pay for the repairs and the process is very complicated, this was causing huge delays in repairs, and having an impact on patients care, staff safety and the potential for loss of rehabilitation goals for some patients due to the lack of appropriate equipment. The Estates Department has reviewed this approach by introducing a simple approach whereby repairs up to a reasonable fee are directly funded. However further progress is being planned, with Procurement and Estates implementing a gold contract and the Manual Handling Adviser is actively involved.

Slings
The audit highlighted that there were nearly 200 re-usable slings which were beyond the manufacturer's life expectancy.

Poor condition and damaged slings were removed at the time of the assessment and all remaining slings marked with a unique identification number facilitating the Health Board to initiate an active asset management programme.

There is a legal requirement to inspect and record data on a 6 monthly basis to ensure safe product use (schedule 1 Reg 10(1) The Lifting Operations and Lifting Equipment Regulations 1998).

Current procedure requires the local management to follow the LOLER Inspection Procedure, the Audit identified that the current procedure had not been fully complied with and that some slings could not be identified as being examined.

As part of the audit each sling was fitted with a unique tag to facilitate identification. However, a review of the practice was identified as necessary. It was considered that the first process would be to minimise the number of re-usable slings, this would immediately improve compliance and diminish infection control risks.

A pilot has been initiated within the Stroke Unit to trial an alternative single patient sling, this is being monitored by the Manual Handling Adviser and findings will be reported at the Local and Operational Health and Safety Group Meetings.

Clinical Boards have been alerted to the concerns at each at their Health and Safety Groups and a local plan will be progressed for discussion at the Operational Health and Safety Group to either continue with the existing procedure or to introduce independent LOLER inspections which will incur an additional cost within the areas.

The Operational Health and Safety Group will review the status and actions and an action plan will be brought to this Committee for assurance.

RECOMMENDATION

The Health and Safety Committee is asked to: **NOTE the content of the report.**

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	√	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing	√	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
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5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant, click here for more information

Prevention	√	Long term	√	Integration		Collaboration		Involvement	√

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

Report Title:	**HSE Audit of Violence and Aggression and Musculoskeletal Disorders in Healthcare 2018/19 – Progress Update**								
Meeting:	Health and Safety Committee						**Meeting Date:**	9/7/2019	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		√
Lead Executive:	Director of Workforce & Organisational Development								
Report Author (Title):	Head of Health & Safety (02920 743751)								

SITUATION

The Health and Safety Committee was informed at the April meeting that the Health and Safety Executive (HSE) has initiated a program of auditing Health Boards on their compliance to Violence and Aggression and Musculoskeletal Disorders controls.

It is understood that the HSE has indicated that it intends to progress these audits with Cardiff and Vale being inspected during the current year, most likely in the 3rd quarter of the fiscal period. The committee requested that it be kept updated on developments and knowledge of the process.

BACKGROUND

Introduction

Inspections are planned nationally to examine the management arrangements for violence and aggression and musculoskeletal disorders (MSDs) at care providers in the public sector. The available evidence indicates that assaults on staff and musculoskeletal disorders continue to be prevalent within this sector.

Cardiff and Vale University Health Board recognises its responsibility for the management of violence and aggression and musculoskeletal disorders risks to its staff. Violence and aggression and manual handling are 2 of the 8 health and safety priority improvement plan areas.

The HSE have undertaken one of these inspections at ABMU (now Swansea Bay Health Board) in late 2018 and had subsequently issued 9 improvement notices.

What will be covered at the inspection

The Health Board has reviewed the HSE Inspector guidance this identifies:

- Inspectors leading on these visits should have good experience in carrying out management inspections of large organisations.
- Each visit will be a joint visit with an occupational health inspector.
- They may visit clinical areas where numbers of people may not be appropriate.
- Inspectors should obtain the care provider's local statistics initially to identify target areas.
- They should also contact local trade union representatives.
- They should choose to focus on two or three clinical areas where violence and aggression is a significant issue. Separately, choose two or three clinical areas with the highest MSD rates.

- Accident and Emergency should be included automatically as our intelligence indicates that it is a problem area for both topics.
- A management inspection approach is envisaged following the Plan, Do, Check, Act principles.
- They will obtain the relevant policies, risk assessments, training records etc in advance of the site visit.
- They should identify the relevant people to see and the areas to go to, aim for a hierarchical approach starting at a senior level.
- The Health Board should be asked to draw up a timetable in advance so that everyone who they wish to speak to is available and the site visit runs efficiently.
- The site visit should take approximately one day per topic (two days total), allowing time to speak to relevant members of staff and to view clinical areas where appropriate.
- Once your site visit is completed, they may discuss with the sector on action proposed.
- They should be prepared to give face to face feedback as well as written correspondence.
- The "Fees for intervention" any Notification of Contraventions (NoCs) and Notices will be applied

The HSE recognises that during the site visits, Inspectors should be accompanied by an employee of the care provider at all times in clinical areas and follow their visitor health and safety policy as advised. Similarly, there may be ongoing clinical situations which may mean that you are unable to visit an area at short notice.

ASSESSMENT

Progress Update

The Head of Health and Safety has met with his counterpart from Swansea Bay UHB. Whilst the internal report is not available it has been established that 4 of the Improvement Notices related to the management of manual handling risks to staff within the theatre department, emergency department and porters and 4 related to violence and aggression management in the emergency department and porters. The final improvement notice related to inadequate arrangements to report and investigate incidents to ensure lessons are learnt.

It was also established that the HSE didn't completely follow the above Inspector guidance.

The Head of Health and Safety has allocated an Adviser to coordinate a review of our status and develop an action plan for any identified shortfalls against both the above guidance and experience of other Health Boards.

The impending inspection has been communicated at the Operational Health and Safety Group and each of the Clinical/Service Board's health and safety meetings.

The Adviser has initiated a number of meetings and actions to give greater assurance of our risk with knowledge status with particular emphasis on status of risk assessments, management controls and training compliance.

Initial assessment considers that violence and aggression and manual handling managerial arrangements and controls at Cardiff and Vale differ significantly from ABMU, for example:

- We have much more developed security and lock down arrangements.
- Although both work to the All Wales Passport Schemes, the manual handling and violence and aggression training models are different.
- The level of compliance to manual handling and violence and aggression training identified within the annual report is concerning and will need urgent progress.

ASSURANCE is provided by: Health and Safety aspects being appropriately monitored and progressed as detailed within the report.

RECOMMENDATION

The Health and Safety Committee is asked to: **NOTE the content of the report.**

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
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Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant, click here for more information

Prevention	√	Long term	√	Integration		Collaboration		Involvement	√

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

Report Title:	Enforcement Agencies Report								
Meeting:	Health and Safety Committee						**Meeting Date:**	09/07/2019	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**		
Lead Executive:	Director of Workforce and Organisational Development								
Report Author (Title):	Head of Health and Safety								

SITUATION

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

During the period there was one additional issue raised by the Health and Safety Executive (HSE) relating to:-

a) Needlestick injury in Medicine Clinical Board whilst administering insulin to patient.

This report updates the Committee on progress for each event.

BACKGROUND

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

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

ASSESSMENT

Road Traffic Accident at UHW

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

The remedial actions and the pedestrian safety strategy have progressed as reported by the Director of Capital, Estates and Facilities and continues to be an agenda item on the Health and Safety Committee

Contractor Fall

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

Legal Action is being pursued by the HSE against both the Health Board and the Contractor. The case will be heard in court on the 15th July 2019. Legal advice was sought and submission made with regards to the Health Board's level of culpability.

Training Needs for phlebotomy staff working with patients at Hafan y Coed

The HSE had received a concern from a member of phlebotomy staff about training for working in Hafan y Coed, UHL to take blood from patients. The HSE enquired as to what the minimum training requirements are for this group of staff.

It was explained that it is a mandatory requirement for them to attend violence and aggression level B&C classroom based training which covers theory, de-escalation and break away techniques. We would not train them to level D as we would not expect them to be involved in restraining patients and that if a situation arose they should breakaway and remove themselves from the situation.

A formal response was prepared based on the practice that upon arrival phlebotomy staff would report to the ward and would then be escorted to the treatment room where upon the escort would remain with the phlebotomy staff and patient until bloods had been taken. This was accepted by the HSE inspector. **Item closed**

Lift inspection failure report

The estates department has being contacted by the HSE following their receipt of a report of a hydraulic lift inspection failure report.

A response is being prepared by the estates department to assure that the lift in question was taken out of service and that there is an appropriate planned maintenance programme.

New Item - Needlestick Injury in Medicine Clinical Board

Following a reported needle stick injury to a nurse on A7, the HSE required information as to the use of non safety needles.

The adviser had initiated an internal investigation which highlighted that the injury occurred whilst administering insulin to a confused patient using their own insulin pen. The stock of safety insulin pens had run out on the ward and staff were advised to use safety needles and vials of insulin in the absence of safety insulin pens, unfortunately the nurse did not follow this advice.

Patients would normally administer their own insulin unless they were unable to do so which was the case with this patient as they were very confused and agitated. The Ward Manager is now ordering an extra supply of safety insulin pens as a back up to their regular stock. Staff are advised to use safety insulin needles and vials of insulin if there are no safety insulin pens on the ward. HSE has accepted the Adviser's report - **Item closed**

New Item – HSE Audit of Violence and Aggression and Musculoskeletal Disorders

Information has been received that the HSE intend to undertake an audit of violence and aggression and Musculoskeletal Disorders risk controls within all Health Boards in Wales. They have recently completed a similar audit at ABMU and issued 9 Improvement Notices relating to muscular skeletal disorders, manual handling, violence and aggression training, wellbeing management and incident investigation.

No confirmation of the date of visit has yet being received, it is understood the HSE will aim to visit in the third quarter of 2019/20.

Details of the ABMU findings are being reviewed for comparison against our practice.

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

RECOMMENDATIONS
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

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
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Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	√	Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**FIRE ENFORCEMENT AND MANAGEMENT COMPLIANCE REPORT**								
Meeting:	**Health and Safety Committee**						**Meeting Date:**	**09/07/2019**	
Status:	**For Discussion**		**For Assurance**		**x**	**For Approval**		**For Information**	
Lead Executive:	**Director of Planning**								
Report Author (Title):	**Senior Fire Safety Adviser**								

SITUATION

This paper provides an update on relevant fire safety issues.

Key issues:

1. **Fire Risk Assessments**
2. **Fire Service Audits and Familiarisation visits**
3. **Fire Service Response to Fire Alarm Activations**
4. **False Alarms and Unwanted Fire Signals (UwFS)**
5. **Fire Incidents**
6. **Training**
7. **Fire Compartmentation**

BACKGROUND

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

ASSESSMENT

1.0 Fire Risk Assessments

We currently have fire risk assessments in place for 397 areas all of which are up to date. The action plans from the assessments are monitored for compliance by the Estate Department and the Compliance Manager and the Management issues are monitored through the Deputy Fire Safety Manager Group.

2.0 South Wales Fire Service Audits and Familiarisation Visits

South Wales Fire Service (SWFS) continue to visit our premises to carry out fire safety audits of pre-arranged areas under the Regulatory Reform (Fire Safety) Order 2006 including auditing and requesting copies of the appropriate fire risk assessments. In addition they also carry out regular 7.2(d) familiarisation visits under the Fire Services Act 2004.

Completed Fire Safety Audit - 20th June 2019

Planned Fire Safety Audits - 27th June and 9th July 2019

Completed 7.2(d) visits - 10th June 2019
Planned 7.2(d) visits - 25th July and 12th and 13th August 2019

3.0 Fire Service Response to Fire Alarm Activations

C&V UHB has been informed by South Wales Fire Service (SWFS) that they have changed their response originating from Automatic Fire Alarm Systems.

From the 4th February if a call is received at Fire Service Control between the hours of 8 a.m. and 6 p.m. following an alarm activation, unless it is confirmed there is a fire they will only send a single appliance at **NORMAL ROAD SPEED TO INVESTIGATE.**
It is essential on discovering a fire, a call is made to our switch room on 3333 if you discover a fire or have good reason to believe there is one. Our switch room staff on receiving confirmation will them contact SWFS who will then dispatch the full pre-determined attendance (PDA) on blues and twos.

4.0 False Alarms and Unwanted Fire Signals

Unwanted fire signals (UwFS) lead to disruption of service/patient care, increased costs and unnecessary risk to those required to respond to the alarm.

In the last twelve month period 359 UwFS recorded, although this number is high it is a reflection on the size and age of our alarm system. We have however seen a decline in this number with a significant reduction this year on the back of a similar reduction the previous year.

Performance Indicators	
for Cardiff & Vale University HB	
for UwFS between 03/07/2018 and 30/06/2019	
False Alarms and Unwanted Fire Signals	
Hospital	**False alarms including UwFS**
Barry Hospital	3
Cardiff Royal Infirmary	9
Hafan Y Coed	18
Llandough Hospital	73
Rookwood Hospital	3
St David's Hospital (Cardiff)	6
University Hospital of Wales	236
Whitchurch Hospital	2
Total	**359**

NB. - South Wales Fire Service Poster - Appendix A

5.0 Fire Incidents

There have been 15 fires across the Estate in the last twelve months. Five of which were started deliberately i.e. three in the mental health unit, one at Lansdowne Hospital and one in UHW C5 South, three were attributed to discarded smoking materials and the rest were the result of electrical faults.

The 6 incidents in Hafan Y Coed are of concern following prohibiting smoking which has resulted in illicit smoking and the need for patients to have ignition items as the electronic lighter have been removed. As a result of the fire incidents controlled smoking has been re-introduced and no further incidents have been recorded.

The C5 incident on May 9th 2019 was the subject of a cold de-brief arranged by Huw Williams (Emergency Preparedness Manager) and took place at 0930hrs on June 18th in the Cochrane building UHW. Huw has collated all the responses given by attendees and intends to disseminate the outcome of this de-brief in due course.

Lansdowne Hospital Incident

On Sunday 14th April 2019 at approximately 18:40 hrs a fire occurred at Lansdowne Hospital in or around a porta cabin located at the rear of the main premises, the cabin is abutted next to the north wing (which is one of five wings) of the premises. The fire quickly spread from the porta cabin to the roof space of the north wing of the premises then very rapidly to the roof space of the main building itself. The porta cabin, the north wing and the main roof was severely damaged by fire. 100% of the north wing roof and approximately 50% of the buildings main roof suffered a full collapse thus rendering the exterior walls structurally unstable. The porta cabin, the north wing roof and 90% of the main roof was completely destroyed by fire. The four remaining wings were slightly damaged by fire and the whole building was severely affected by smoke and heat damage.

The main cause of the fire is recorded by the fire service as the result of a heat source and combustible items brought together deliberately ignited by a person or persons unknown. The source of ignition was a naked flame most likely used to light paper or card but the item ignited first is also unknown. The items mainly responsible for spreading the fire were furniture/furnishings and other unspecified combustible materials.

Due to the structural stability of the building the fire service and the police scenes of crime officers did not carry out a full fire investigation but the fire is recorded as deliberate.
There were no casualties and to date no arrests have been made.

C5 South Incident

On Thursday 09th May 2019 at approximately 06:13 hrs a fire occurred in a single bedroom identified as room F5-152 Ward C5 South, Tower Block 1 at UHW. The fire was the result of a heavily medicated cardiothoracic patient lighting unidentified smoking materials whilst on oxygen. The fire quickly spread to the bed linen due to oxygen impregnation. The ward was quickly and successfully evacuated by the on duty clinical staff and security staff extinguished the fire which had developed in the bed linen by this time. Their efforts and presence of mind prevented the fire from developing, they contained the fire to the room of origin and they prevented further extensive damage to the ward. It is noteworthy that Ward C5 South and North was completely evacuated before the arrival of the fire service and the fire was extinguished. All

the clinical staff and security staff present are to be highly commended for their speedy reaction under very rapidly changing and challenging emergency conditions.

The main cause of the fire is recorded by the fire service as the result of a patient using smoking materials near an oxygen mask connected to medical gas pipe line. Four clinical staff and three security officers were admitted to A&E due to smoke inhalation and released after being given the all clear. One patient suffered non-life threatening injuries. Thirty eight patients were successfully evacuated. One arrest has been made.

Site / Address	Numbers
University Hospital of Wales, Heath Park, CARDIFF	6
Hafan Y Coed, Llandough Hospital, Penlan Road, LLANDOUGH	6
Lansdowne Hospital (Remainder), Sanatorium Road, Canton, CARDIFF	1
St David's Hospital (Cardiff), Cowbridge Road East, CARDIFF	1
5 - 11 Park Road, 5 - 11 Park Road, Whitchurch, CARDIFF	1
Total	**15**

6.0 Training

Historically fire training compliance has been around 50%. Following a number of initiatives the figures have increased to the current level of 69.50%.

Below are the compliance figures by Clinical/Service Board

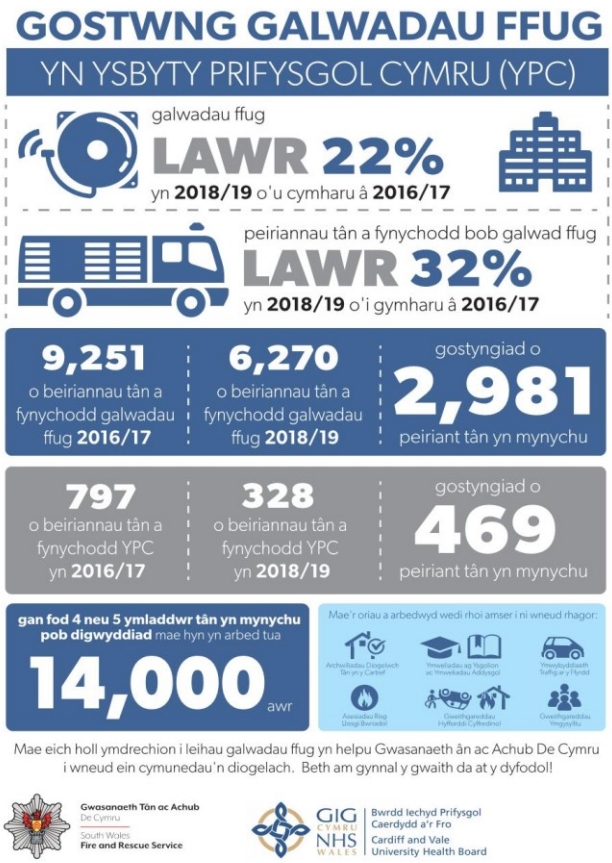
Clinical Boards	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-1
All Wales Genomics Service									78.14%	81.42
Capital, Estates & Facilities	65.84%	67.76%	72.90%	72.13%	77.85%	80.56%	81.83%	81.76%	83.22%	82.21
Children & Women	73.86%	72.83%	69.54%	67.94%	69.43%	68.96%	71.05%	71.95%	71.20%	73.34
CD&T	69.76%	68.99%	71.43%	74.58%	76.38%	77.54%	77.94%	77.97%	76.38%	75.86
Corporate	73.28%	69.97%	69.06%	68.44%	70.42%	71.75%	68.96%	70.70%	71.45%	74.85
Dental	82.22%	82.99%	79.10%	79.29%	76.45%	76.12%	75.38%	76.63%		
Medicine	67.48%	63.88%	62.50%	58.27%	55.94%	54.67%	55.10%	56.12%	59.16%	62.30
Mental Health	65.40%	64.90%	65.63%	65.22%	64.36%	63.88%	64.26%	63.71%	63.57%	65.58
PCIC	68.98%	66.85%	65.50%	64.40%	64.09%	64.19%	65.14%	65.86%	67.07%	66.23
Specialist Services	63.29%	60.86%	59.02%	58.22%	60.20%	61.01%	62.23%	63.54%	65.09%	66.41
Surgical Services	58.03%	57.14%	54.44%	55.70%	55.51%	56.86%	57.12%	57.70%	61.02%	62.26
UHB Total	**67.60%**	**66.34%**	**65.69%**	**65.50%**	**66.26%**	**66.65%**	**67.27%**	**67.89%**	**68.30%**	**69.50**

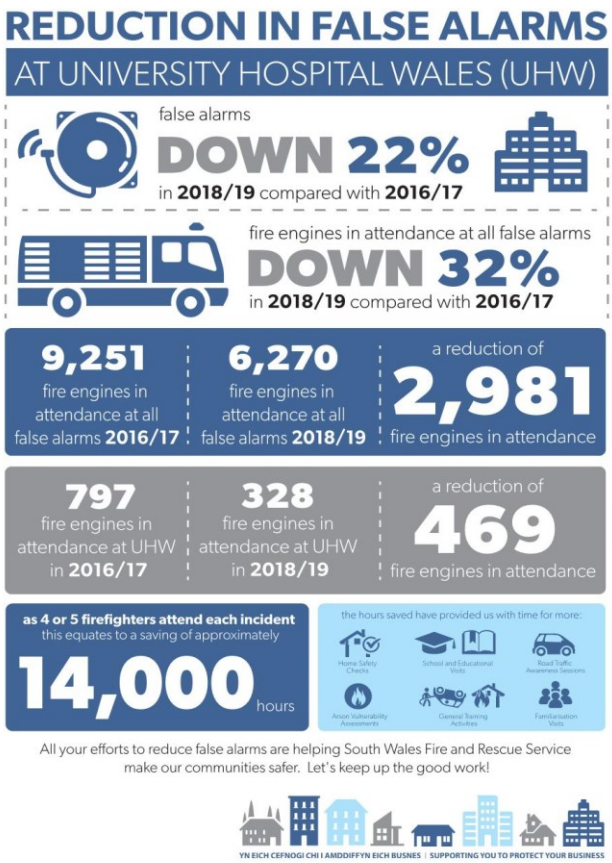
7.0 Fire Compartmentation

Currently the Health Board has engaged the services of a 3rd party accredited fire stopping company to intrusively survey fire compartmentation across the Estate and where deficiencies are identified to carryout installation of agreed fire stopping works using approved materials and workmanship.

Appendix A

South Wales Fire Service Poster





ASSURANCE is provided by:

- The issues identified as a consequence of Fire Service Audits are being appropriately managed.

RECOMMENDATION

The Committee is asked to:

- To consider on-going work to meet the requirements of fire safety enforcement compliance

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

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

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

Report Title:	Health and Safety Assurance Schedule and Priority Improvement Plan 2019/20						
Meeting:	Health and Safety Committee				**Meeting Date:**	09/07/2019	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	Director of Workforce and Organisational Development						
Report Author (Title):	Head of Health and Safety						

SITUATION

The Health and Safety Committee is required to give assurance to the Board that risks are being managed

The Health Board has initiated a Health and Safety Priority Improvement Plan (PIP) to monitor its progress on key health and safety strategic areas. This plan has been reviewed during the period to reflect planned changes to the Corporate Framework and builds upon the previously considered 2018/19 plan.

The Priority Improvement Plan is the Health Board's strategic approach to tackling significant health and safety risks and has proved successful at reducing risks and progressing on the basis of real risks and practical solutions. This can be demonstrated by the status of each milestone and the number of completed action areas (green) shown within the assessment paragraph and the Annual Report.

BACKGROUND

The Health and Safety Department has been working to integrate the plan with the Board Assurance Framework (BAF) ensuring that the risks identified within the PIP are being appropriately addressed and monitored.

A significant role of the Operational Health and Safety Group is to give assurance to the Health and Safety Committee that risks are being managed at Clinical/Service Board level. The priority improvement plan is the mechanism where these Boards monitor progress of the key health and safety risks within their areas.

To ensure suitable time is given to the review status of each Clinical/Service Board's PIP and Risk Register, the Operational Health and Safety Group will review the status of these plans. After review these plans will be considered at the Health and Safety Committee.

The Health Board's overarching PIP will continue to be monitored at each of the Operational Health and Safety Group meetings and progress reported at each Health and Safety Committee meeting.

The Plan has been amended to reflect the status of milestones within each of the core strategic areas which is evaluated in addition to the status of each of the identified actions. However the plan continues with the eight strategic areas.

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

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

ASSESSMENT

The assurance schedule below shows a staggered 4 month period from review at the Operational Health and Safety Group to the date for assurance to be considered at the Health and Safety Committee. This is aimed at allowing suitable time to progress any identified shortfalls.

HEALTH AND SAFETY PIP/RISK ASSESSMENT ASSURANCE SCHEDULE

Clinical/Service Boards	**Operational Health and Safety Group Review**	**Health and Safety Committee**
Mental Health Children and Women	September 2019	January 2020
Capital Estates Specialist Services	December 2019	April 2020
Surgery (inc Dental) PCIC (inc Dental)	March 2020	July 2020
Medicine CD&T	June 2020	October 2020
Mental Health Children & Women's	September 2020	January 2021

Overarching Health Board Priority Improvement Plan

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

To assist recognition of progress  has been added to those areas that has improved, equally  will be applied where the status has digressed.

	Total no of Milestones	Green	Amber	Red	Total Actions	Green	Amber	Red	Overall Strategy Status
Health and Safety Policy Management and Organisational Arrangement	8	0	7	1	16	5	8	3	Reasonable assurance
Violence and Aggression (inc Lone worker)	3	2	1	0	10	8	2	0	Substantial assurance
Manual Handling	10	2	8	0	13	6	7	0	Reasonable assurance
Health Issues	8	2	5	1	16	6	7	3	Reasonable assurance
Patient and Environment Health and Safety	8	2	5	3	15	7	3	5	Limited assurance
Fire Safety Management	6	2	3	1	9	5	3	1	Reasonable assurance
Estate Health and Safety Management	9	4	4	1	17	11	5	1	Reasonable assurance
Sharp Safety	1	0	1	0	1	0	1	0	Reasonable assurance
Total	53	14	34	7	97	48	36	13	

The plan identifies 53 milestones within the 8 strategic areas and 97 actions for improvement. These have been progressed with 14 milestones and 48 actions being completed.

During the period a total of 7 milestones and 22 actions were progressed sufficiently to enhance their status.

An additional item was added to the manual handling section of the plan, this relates to concerns about the status of LOLER inspection of hoist slings - item 3.7.

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

There was some significant progress in a number of red and ambers during the period, these include:

Ref	Subject	Progress
3.5	Hoverjacks	A successful bid had been submitted for the replacement of 2 hoverjacks
4.2	Improved compliance for Clinical Boards COSHH Co-ordinators	All areas have designated COSHH coordinators
4.4	HAV's monitoring	Progressed as a rolling programme based on risk priority
4. 5	DSEAR compliance development	DSEAR guidance considered at the Fire Safety Group and circulated to relevant areas
6.2	UWFS Status	Fire Service reports a significant reduction in UWFS
6.3	Fire risk from smoking within Mental Health	Since introducing controlled smoking no fires reported

6.4	Progress in resolving the long standing issues of evacuation device training	A working group has been formed to review training for equipment.

ASSURANCE is provided by demonstrating progress against each strategic area and highlighting milestones and further actions required within set timescales.

RECOMMENDATION

The Health and Safety Committee is asked to:

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

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**ALL AROMA COFFEE OUTLETS, UNIVERSITY HOSPITAL OF WALES (UHW) FOOD HYGIENE INSPECTION – 25th April 2019**								
Meeting:	**Health & Safety Committee.**					**Meeting Date:**	**9th July 2019**		
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**x**
Lead Executive:	**Director of Planning**								
Report Author (Title):	**Catering Services Manager**								

SITUATION

An inspection of the Aroma Coffee outlets at the University Hospital of Wales took place on 25th April 2019 the outcome of which was confirmed in writing in a letter report dated 29th April 2019 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 Coffee Outlets at UHW were given an overall score of **3 (Generally Satisfactory)** in the National Food Hygiene Rating Scheme.

BACKGROUND

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

It is clear that the level of scrutiny and audit is becoming more in depth in health facilities than perhaps the more general commercial providers. The EHO consider that as we provide food and drink to patients they are likely to more vulnerable to any potential contamination.

ASSESSMENT

It is acknowledged by the Service Board that the score received falls below their expectations and that of the UHB which aims to achieve a food hygiene rating of 4/5 (good/ very good).

On receipt of the report, immediate action was taken to address the issues identified with an action plan developed, as attached in appendix 1, complete with ‘close out’ dates.

The Catering Services Manager has been overseeing the actions to ensure that they have been completed within the target timescales or re-assessed with the dates amended where there are mitigating circumstances.

ASSURANCE is provided by:

The completion of the action plan and the closure of 18 out of the 19 issues identified with the remaining item completion imminent.

The Service Board is considering :

- Appointing a suitable qualified compliance officer to work across all catering services, including commercial and patient
- Applying for a re-inspection of the Aroma outlets

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.

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

Appendix 1

Action Plan from Food Safety Inspection on 25th April 2019 (Report dated 29th April 2019)

Schedule A – Legal Requirements

Food Hygiene and Safety Procedures Some non-compliance with statutory obligations and industry codes of recommended practice* that are not considered significant in terms of risk (but may become significant if not addressed). Standards are being maintained or improved.	**Response / Action**	**Time Scale**	**Update**
Women's Unit 1. At the time of the inspection, a pouch of D10 suma bac was found in the dispenser with an expiry date of November 2018. The expiry date is the date up until which the manufacturer guarantees the effectiveness of the cleaning chemical. Therefore you must ensure the expiry dates are checked on all cleaning chemicals and only cleaning chemicals within their expiry date are used.	Ensure all cleaning materials are in date on arrival at unit and dates are checked once a week. Link with cleaning schedules and staff training / instruction.	Immediate	Completed
It was also noted that the D10 pouch had been fitted into the D2 dispenser. You must ensure that the pouches are fitted to the correct dispensers to allow correct dilution. *Regulation (EC) No. 852/2004, Annex II, Chapter IX, Para 3*	Staff instructed to ensure that all pouches are fitted to the correct dispensers. D2 dispenser to be removed.	Immediate	Completed
Aroma Concourse *2.* At the time of the inspection the sterile probe wipes used for cleaning the temperature probe were dry. This makes the probe wipes ineffective as the sterilisation effect results from the wipes being soaked in alcohol solution. You must ensure that probe wipes are kept away from sources of heat that may dry them out and are wet and within date to ensure they are capable of suitably disinfecting the probe.	Ensure that all wipes are checked on a daily / weekly basis ensuring lids are closed and containers stored away from heat source.	Immediate	Completed

Regulation (EC) No 852/2004 Annex II Chapter IX paragraph 3 **X-Ray** 3. At the time of the inspection, the probe wipes being used had passed their use by date 24/11/2018. The expiry date is the date up until which the manufacturer guarantees the effectiveness of the cleaning chemical. Therefore you must ensure the expiry dates are checked on all cleaning chemicals and only cleaning chemicals within their expiry date are used. *Regulation (EC) No. 852/2004, Annex II, Chapter IX, Para*	Ensure that all wipes are checked for use by date on a daily / weekly basis.	Immediate	Completed
General 4. Wash hand basins were fitted with hand operable taps, which could increase the potential for cross contamination after handling food. Staff must ensure that the taps are turned off by using paper towels after hand drying has been carried out. Alternatively, lever style, non-hand operable taps must be fitted to the basin. This will avoid re-contaminating hands with dirty taps after washing. A member of staff was observed turning off the taps without using paper towel. *Regulation (EC) No 852/2004 Annex II Chapter VIII paragraph 1*	Staff re-instructed to wipe down WHB after hand washing with paper towel and dispose of. Signs to be displayed at every WHB across units. (The replacement of taps to lever style across catering areas will be reviewed and costed to assess impact).	Immediate	Completed

Structural / Cleaning Issues Some non-compliance with statutory obligations and industry codes of recommended practice* that are not considered significant in terms of risk (but may become significant if not addressed). Standards are being maintained or improved. *(*Where a relevant code / industry guide has been published.)*	Response / Action	Time Scale	Update
Rear Store (Concourse) 5. The door seal of fridge 2 and freezer 2 were split. Renew the door seals. *Regulation (EC) No 852/2004 Annex II Chapter V Para 1*	Maintenance request to be submitted to repair. Manager to follow up to ensure repair or replacement if necessary. (N.B. Fridge / Freezer replaced x 2)	31/5/19	Completed
6. There was a missing plaster board sheet to the ceiling above the staff lockers in the rear storeroom. 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)*	Maintenance request to be submitted to repair. Manager to follow up to ensure repair.	31/5/19	Completed
Concourse 7. There were spilt milk stains on the inside surface of fridge 1. Thoroughly clean the internal surface and maintain in a clean condition. *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*	Thoroughly clean fridge (externally / internally).	Immediate	Completed
8. The taps to the hand wash basin were dirty. Thoroughly clean the taps and maintain in a clean condition. *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*	Thoroughly clean taps and ensure maintained in clean condition. New to be ordered also for this WHB.	Immediate	Completed
Children's Hospital 9. The taps to the hand wash basin were dirty. Thoroughly clean the taps and maintain in a clean condition. *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*	Thoroughly clean taps and ensure maintained in clean condition.	Immediate	Completed

10. The internal surface of the back fridge was dirty. Thoroughly clean the internal surface and maintain in a clean condition. *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*	Thoroughly clean fridge (externally / internally).	Immediate	Completed
11. The door seal of the back freezer was dirty. Clean the door seal. *Regulation (EC) No 852/2004 Annex II Chapter V Para 1*	Thoroughly clean fridge (externally / internally).	Immediate	Completed
12. The ceiling mounted extractor fan was dusty, along with the extractor and air conditioning unit. They must be thoroughly cleaned and maintained in a clean condition. *Regulation (EC) No 852/2004 Annex II Chapter I Para 1*	Thoroughly clean extractor fan and maintain in clean condition.	Immediate	Completed
13. The floor was coming away from the wall behind the dishwasher. Reaffix the floor covering and leave in a sound easy to clean condition. *Regulation (EC) No 852/2004 Annex II Chapter II Para. 1(a)*	Maintenance request to be submitted to repair. Manager to follow up to ensure repair. (N.B. MR submitted – No. 733712)	31/5/19	Matter progressing. 21 June completion.
Women's Unit 14. The waste pipe below the wash hand basin was dirty. Thoroughly clean the waste pipe and maintain in a clean condition. *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*	Thoroughly clean waste pipe and maintain in clean condition.	Immediate	Completed
X-Ray 15. The floor covering 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*	Thoroughly clean floor areas and maintain in clean condition.	Immediate	Completed
Express 16. The external surface of the jacket potato warmer was dirty. Thoroughly clean the surface and maintain in a clean condition. *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*	Thoroughly clean the equipment and maintain in a clean condition.	Immediate	Completed
17. The door handles to fridge 1 and 2 were dirty along with the internal base of fridge 1 and seals of fridge 3. Thoroughly clean the door handles, seals and internal	Thoroughly clean fridge (externally / internally).	Immediate	Completed

surfaces and maintain in a clean condition. *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*			
Production Kitchen for Aroma Units (near Y Gegin Restaurant) 18. The external surface of the probe wipe container required cleaning. *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*	Ensure probe cleaned / wiped after use	Immediate	Completed
General 19. A number of spray nozzles to the D10 bottles were becoming dirty and require thorough cleaning. It was also noted that the crevices and ridges on many of the bottles were becoming dirty. Ensure that all D10 bottles are maintained in a clean condition. *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*	Bottles to be thoroughly cleaned / wiped down on regular basis in each service area / Aroma Unit. (Cleaning material supplier to be contacted regarding types of bottles used).	Immediate	Completed

Confidence in Management / Control Procedures	Response / Action	Time Scale	Update
Satisfactory record of compliance. Access to relevant food safety advice source and/or guides to good practice or assurance scheme commensurate with type of business. Understanding of significant hazards and control measures in place. Has implemented satisfactory food safety management procedures or is making satisfactory progress towards documented food safety management procedures, commensurate with type of food business. Making satisfactory progress towards documented food safety management procedures commensurate with type of business. A score of 10 can be awarded for more than one intervention cycle if: • the previous non-compliances have been addressed but different non-compliances have arisen; and, • the overall risk has not increased.			
20. You have put in place a documented Food Safety Management Procedure based on HACCP principles. However, I would make the following observations;			
• There were a number of occasions when the fridges at different units were on a defrost cycle so no temperatures were recorded. As discussed, if the fridges or freezers are on a defrost cycle then staff must re-check after a short time to ensure they are operating below your critical limit of 5°C, this check must then be recorded in the corrective actions box. The same was noted with display chillers operating over your critical limit of 5°C, staff documented that the thermal blind was pulled down but no additional checks were documented to demonstrate that the temperature had returned to below 5°C;	Review monitoring form to ensure it is clear to ALL staff to retake temperatures especially if on defrost cycle and in addition, ensure all corrective action is recorded. All staff to be reinstructed in respect of completion of monitoring forms including ANY corrective action.	31/5/19	Completed
• Staffs were relying on the digital displays for monitoring the temperatures of the fridges and freezers. I suggest an independent thermometer is used to check the temperatures of the fridges and freezers on a weekly basis. This ideally would involve using the probe thermometer to test the temperature of a dummy food (such as a clearly labelled bottle of water) it should be clear on the monitoring sheets when independent testing has taken place;	As part of HACCP review, produce a monitoring form to record an independent thermometer probing of a dummy food on a weekly basis for all fridges. Ensure proforma is fit for purpose to reflect independent testing.	31/5/19	Completed
• It does not make it clear what your critical control points are;	As part of HACCP document review, all	31/5/19	Completed

	critical control points will be identified and listed.		
• Temperatures above your critical limit of 5°C had been recorded for a number of fridge and chiller units in many of the Aroma units. However no corrective actions had been recorded. You must ensure that staff document any corrective actions carried out;	All staff to be reinstructed in respect of completion of monitoring forms including ANY corrective action.	31/5/19	Completed
• Your HACCP states that raw poultry is to be delivered at 4°C. In practice you don't receive deliveries of raw poultry. As discussed you should amend this to reflect that all raw meat to be delivered at 5°C or below;	HACCP documentation to be amended to reflect no deliveries of raw chicken.	31/5/19	Completed
• The hot water temperature method for probe calibration states for the tip of the thermometer probe to be placed into the steam of a boiling kettle. This is not an adequate method for hot water calibration of the probe. Hot water calibration must be undertaken using water on a rolling boil. I was pleased to see that this had been updated on the monitoring forms but not in your HACCP. You must ensure that thee HACCP is amended. I note that probe calibration keys have been purchased, your HACCP needs to be amended with this also;	Monitoring forms to be amended to reflect use of calibration keys and included in HACCP document.	31/5/19	Completed
• Not all D10 bottles were being date labelled, so it wasn't clear how long they had been diluted. D10 concentrate once diluted into a spray bottle has a 7 day shelf life. You must ensure that bottles are either dated with a made on date, or alternatively fresh bottles are mixed on a set day every week. Whatever route you choose, this must be documented in your HACCP;	All D10 bottles to be labelled with date of refill and expiry date i.e.7 days. HACCP document to be amended to reflect refilling of D10 bottles with expiry date. Staff to be reinstructed with changes.	31/5/19	Completed
A number of the points noted above were raised at the time of your last inspection. Whilst I understand there has been a delay in reviewing your HACCP due to Woodlands House coming online, you must ensure these points are actioned before your next planned inspection or they will adversely affect your confidence in management score. *Regulation (EC) 852/2004 Article 5*	HACCP document to be reviewed to include all points highlighted within EHO report.	31/5/19	Completed
21. Ensure that your staff are trained in effective disinfection methods. Staff must know when disinfection is essential and how to do it properly. It is therefore critical that all staff are trained and verified as competent in disinfection techniques before being asked to dilute and apply disinfectants, or to undertake hot water or steam disinfection.	Ensure all staff have adequate training on disinfection methods. D10 posters to be displayed within all units and follow up checks undertaken by management / supervisors.	31/5/19	Completed

The following issues were noted at the time of inspection; • Many staff unclear on where the water fill line on the D10 bottles was; • Some staff dispensing 2 pumps of concentrate into the bottle; • Confusion as to whether the bottle is filled with water first or concentrate (if concentrate is added first then the bottle filled to the fill line this will be a stronger concentration than if the water is filled to the fill line then concentrate added) *Regulation (EC) No 852/2004 Annex II Chapter V paragraph 1a*			

Schedule B – Recommendations and Advice

Recommendations	Response / Action	Time Scale	Update
These recommendations provide advice on good practice:-			
1. A small number of dry mouse droppings were noted under the wooden pallets in the storeroom. I was pleased to note no evidence pest activity noted within the food preparation areas and pest control records support this. As discussed you must remove any old mouse droppings completely so you and staff are able to spot new activity.	Pest control company to revisit site and ensure area is free from any mouse droppings. Ensure all staff are vigilant, report any sightings and adopt 'clean as you go' approach.	Immediate	Completed
2. It was noted that green faux grass matting was still in place in the display chiller in the Women's unit. During a previous inspection it was believed that this matting was having an impact on cool air being able to circulate. I would strongly suggest you remove this matting.	Remove all green faux grass matting from area.	Immediate	Completed
3. The hot water at the wash hand basin in x-ray was 62°C and 57.4°C in the Women's unit. This temperature may hamper good hand hygiene. I would strongly suggest you consider installing mixer taps with non-hand operable handles at all hand wash basins.	Submit maintenance request for attention to temperature and / or fit mixer taps. (The replacement of taps to lever style across catering areas will be reviewed and costed to assess impact as above).	31/5/19	In progress / under review ref. change in taps.
4. There was a build-up of ice in freezer 1 and 2 in the concourse storeroom. I recommend you defrost them fully.	Ensure that all freezers are fully defrosted once a month minimum.	Immediate	Completed
5. You must ensure that blue roll and paper towels are fitted into their dispensers and not allowed to sit on work surfaces where they may become contaminated / wet. It was also noted that a new sealed blue roll was placed on the lid of a bin. Cleaning materials must not be placed on surfaces likely to cause contamination.	Blue roll to be stored within the correct dispenser; spare rolls to be stored within all units cleaning cupboards. Ensure staff are aware of contamination risks with placing items e.g. blue roll on a lid of bin.	Immediate	Completed

Version 1 – Draft ref. SB/SD (9/5/19)
Version 2 – Draft Update ref. SW/RA/LH (22/5/19)
Version 3 – Final Update ref. SW/SB/LH (31/5/19)

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

UPDATED HEALTH AND SAFETY RELATED POLICIES SCHEDULE

POLICY	UHB REFERENCE NO	AUTHOR/LEAD RESPONSIBLE OFFICER	SUBMISSION TO HEALTH & SAFETY COMMITTEE	APPROVAL DATE	REVIEW DATE	COMMENTS
Contractor Control	UHB 163	Director of Capital, Estates and Facilities	July 2016 (3rd review)	July 2016	July 2019	
Health & Safety	UHB 021	Head of Health and Safety	July 2016	November 2016 (Board approval)	November 2019	
Safe Working with Electricity	UHB 208	Director of Capital, Estates and Facilities	January 2017 (3rd review)	January 2017	January 2020	
Management of Violence & Aggression	UHB 035	Personal Safety Adviser	April 2017 (3rd review)	April 2017	April 2020	
Lone Worker	UHB 034	Health and Safety Adviser	April 2017 (3rd review)	April 2017	April 2020	
Minimal Manual Handling	UHB 036	Manual Handling Advisers	April 2017 (3rd review)	April 2017	April 2020	

POLICY	UHB REFERENCE NO	AUTHOR/LEAD RESPONSIBLE OFFICER	SUBMISSION TO HEALTH & SAFETY COMMITTEE	APPROVAL DATE	REVIEW DATE	COMMENTS
Waste Management	UHB 038	Waste and Compliance Manager	April 2017 (3rd review)	April 2017	April 2020	
Water Safety (previously Control of Legionella)	UHB 091	Estate Asset Manager	April 2017	April 2017	April 2020	
First Aid at Work	UHB 093	Head of Health and Safety	July 2017 (3rd review)	July 2017	July 2020	
Sharps Management Policy	UHB 269	Head of Health and Safety	July 2017 (2nd review)	July 2017	July 2020	
Incident, Hazard and Near Miss Reporting	UHB 138	Head of Health & Safety	July 2017 - previously Quality & Safety (2nd review)	July 2017	July 2020	
Management of Asbestos	UHB 072	Director of Capital, Estates and Facilities	July 2018 (3rd review)	July 2018	July 2021	
Fire Safety	UHB 022	Director of Capital, Estates and Facilities	July 2018 (3rd review)	July 2018	July 2021	
Latex Allergy	UHB 127	Health and Safety Adviser	January 2019 (3rd review)	January 2019	January 2022	
Environmental	UHB 143	Director of Capital, Estates and Facilities	January 2019 (3rd review)	January 2019	January 2022	

POLICY	UHB REFERENCE NO	AUTHOR/LEAD RESPONSIBLE OFFICER	SUBMISSION TO HEALTH & SAFETY COMMITTEE	APPROVAL DATE	REVIEW DATE	COMMENTS
Closed Circuit Television (CCTV)	UHB 303	Director of Capital, Estates and Facilities	January 2019 (3rd review)	January 2019	January 2019	
Security Services	UHB 037	Director of Capital, Estates and Facilities	April 2019 (3rd review)	April 2019	April 2022	

POLICY	UHB REFERENCE NO	AUTHOR/LEAD RESPONSIBLE OFFICER	APPROVING COMMITTEE	APPROVAL DATE	REVIEW DATE	COMMENTS
Safe Use of Ionising Radiation	UHB 031	Superintendent Radiographer	Quality, Safety & Experience	December 2016	December 2019	
Safety Notices & Important Documents	UHB 069	Head of Corporate Risk & Governance	Quality, Safety & Experience	December 2017	December 2020	
No Smoking and Smoke Free Environment	UHB 073	Head of Health Promotion	UHB Board	July 2016	July 2019	
Occupational Health	UHB 103	Business Manager, Workforce & OD	Workforce & OD	March 2012	March 2015	Agreed at Strategy and Delivery Committee 5/3/19 now rescinded
Mandatory Training Procedure	UHB 080	Learning Education & Development Manager	Workforce & OD	June 2013	June 2016	Has already been reviewed but won't be operational until a new online toolkit has been built to support it
Risk Management	UHB 023	Head of Corporate Risk & Governance	Audit	July 2013	July 2016	

Working Time Procedure	UHB 168	Business Manager, Workforce & OD/Unison	People, Performance & Delivery	July 2014	July 2017	Going to EPSG on 15 May for approval
Domestic Abuse, Violence against Women & Sexual Violence Procedure	UHB 167	Senior HR Policy & Compliance Officer	People, Performance & Delivery	March 2015	March 2018	Currently linking in with Safeguarding hopefully out for consultation within the next month
Management of Stress & Mental Health Wellbeing in the Workplace	UHB 071	Employee Wellbeing	July 2014 (2nd review)	July 2014	July 2017	Agreed at Strategy and Delivery Committee 5/3/19 this would now be procedure under the Employee Health and Wellbeing Policy

NOTE: Workforce and OD are having a complete review of Policies – there will now be 6 key policies with procedures feeding out of these:

(1) LED Policy

(2) Health and Wellbeing Policy
(3) Agile Workforce Policy
(4) Maternity Policy
(5) Equality Policy
(6) Recruitment and Selection Policy

Health and Safety Committee Work Plan 2019 - 20					
A -Approval D- discussion I - Information	Exec Lead	Apr-19	Jul-19	Oct-19	Jan-20
Agenda Item					
Standard Items					
Priority Improvement Plan	MD	D	D	D	D
Fire Enforement Report	MD	D	D	D	D
Environmental Health Inspector Report	MD	D	D	D	D
Enforcement Agencies Report	MD	D	D	D	D
Waste Management Compliance Report	MD		D		D
Lone worker Devices Report	MD	D		D	
Regulatory and Review Body Tracking Report	MD	D		D	
Risk Register for Health and Safety	MD	D	D	D	D
Standards for Health Services in Wales relevant to Health and Safety	MD				D
Strategies					
Pedestrian Safety Strategy	MD				A
Health and Safety Strategy	MD	A			
Annual Reports					
Health and Safety Annual Report	MD		A		
Fire Safety Annual Report	MD			A	
Policies					
Health and Safety Policy	MD			A	
Latex Alergy Policy	MD				A
Closed Circuit Television Policy	MD				A
Contractor Control Policy	MD		A		
Security Services Policy	MD	A			
Safe working with Electricity Policy	MD				A
Environmental Policy	MD				A
Governance					
Annual Work Plan	NF				A
Self assessment of effectiveness	NF		D		
Induction Support for Committee Members	NF				
Review Terms of Reference	NF				A
Produce annual Health and Safety Committee Annual Report	NF				A
Minutes of Health and Safety Committee Meeting	NF	D	D	D	D
Action log of Health and Safety Committee Meeting	NF	D	D	D	D

MINUTES OF THE OPERATIONAL HEALTH AND SAFETY GROUP HELD AT 9AM on THURSDAY 28th FEBRUARY 2019 – CORPORATE MEETING ROOM, HQ UHW

Present:

Charles Dalton- Chair	Head of Health and Safety
Frank Barrett	Senior Fire Adviser
Jon McGarrigle	Estates Services
Karen Lewis	Claims Manager
Nicky Bevan	Occupational Health
Rachael Daniel	Health and Safety Adviser
Stuart Egan	Staff Representative

Clinical/Service Board Representatives

Clare Wade	Surgery
Cath Heath	Women and Children
Rowena Griffiths	Dental Services
Sarah Congreve	PCIC

Apologies:

Martin Driscoll	Executive Director of Workforce and O D
Caroline Murch	Environmental Health and Safety Adviser
Ian Wile	Mental Health
Janice Aspinall	Staff Representative
Jonathan Davies	Health and Safety Adviser
Matthew Price	Specialist
Peter Welsh	General Manager
Rhys Davies	Primary, Community and Intermediate Care
Rachael Sykes	Health and Safety Adviser
Sue Bailey	CD&T

In Attendance:

Zoe Brooks	Health and Safety

OHSG: 01/19 Review of Health and Safety Arrangements

The Head of Health and Safety informed the Group that the Chief Executive had appointed Mr Martin Driscoll- Executive Director of Workforce and Organisational Development as the Executive lead for health and safety. He had confirmed that he would be chairing future meetings but has expressed his thanks to the outgoing chair Mr Peter Welsh for all his achievements and work within Health & Safety.

OHSG: 02/19 Minutes of the Meeting held May 2018

The minutes of the meeting held on the 12th December 2018 were accepted as a true record.

OHSG: 03/19 Action Log

- **OHSG 24/18 – Work Place Stressors**
  The Health and Safety Adviser – Ms R Daniel informed the Group that there were a number of areas/Clinical Boards looking at staff wellbeing and reported that she would be linking in with these groups to discuss existing projects and establish a joint working strategy across the Health Board.

- **OHSG 25/18 Medical Records**
  Staff representative Mr S Egan reported that he was still waiting on feedback with regards to his paper sent to the Management Executive meeting.

- **OHSG: 35/18 Poor Condition of Community Buildings**
  No update on this item due to no representative for Mental Health and other Clinical Boards involved unaware of the status.

  Staff Representative Mr S Egan, however reported that he had received a copy of the report and forwarded it on to PCIC.

  The Head of Health and Safety agreed to contact Mr I Wile for further update and felt that the Priority Improvement Plan be enhanced to include this concern, to escalate further.

- **OHSG:41/18 Portable Heaters**
  The Head of Health and Safety confirmed that a meeting took place between Health and Safety, Staff Side and Estates. The meeting concluded that minimum temperatures should meet the national guidance of 23 oC for office work. Portable Heaters were not permitted to be used unless they met the Fire Safety requirements (oiled filled radiators) and staff should not bring in heaters from home. It was however agreed that areas where a comfortable temperature could not be achieved, managers should contact Estates, who will either look at the general heating of the area to set a higher temperature or provide suitable point source heaters.

OHSG: 04/19 Anti-Violence Collaborative

The Head of Health and Safety highlighted that Clinical Board's had been informed of the review of the Memorandum of Understanding and renaming to Obligatory Responses to Violence in Health care at previous meetings. It was noted that the newly formed Anti- Violence collaborative Group, meets monthly to implement the Obligatory Responses to Violence in Healthcare.

It was reported that the Personal Safety Team had been carrying out road shows to inform staff of these changes.

It was also reported that in-line with the above, the Security and Personal Safety Group had been reviewed to look at membership and terms of reference; the title of the group had also been changed to the Anti- Violence Group.

OHSG: 05/19 Feedback from Health and Safety Committee

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

The Health and Safety Adviser – Ms R Daniel gave an overview of the reports, highlighting that the Committee received a presentation from Nicky Bevan on Employee Wellbeing. It was also noted that three policies where approved these being Latex Allergy, Environmental Policy and Closed Circuit Television (CCTV) Policy.

OHSG: 06/19 Health and Safety RIDDOR's

A report was tabled and noted by the Group.

The Head of Health and Safety reported that 76 RIDDOR's had been reported between April and December 2018, predicting that there will be around 100 for the year; this would be consistent with the average reduction achieved across the previous years of 115 in 2016/17 and 121 in 2017/18.

It was highlighted that V&A remains one of the highest reported categories, however slip, trips and falls and Manual Handling have dropped over the past three years.

The Head of Health and Safety informed the Group that RIDDORS's would be a standard agenda item at each of these meetings, looking at reported RIDDOR's during the period, however the information would be enhanced to include by Clinical Board.

OHSG: 07/19 Enforcement Agencies Correspondence Report

The Health and Safety Adviser reported that there were two items raised during the period, these being:-

Firstly, Hand Arm Vibration (HAV) regulatory requirements following the submission of a RIDDOR event within Dental Services. It was reported that following extensive work of assessment and monitoring, this identified a number of gaps within the Health Board.

Continuous monitoring had taking place and the HSE were happy with the Health Boards response. Item Closed.

The Head of Health and Safety reported that a Hand Arm Vibration Procedure was being established and would be brought to the next meeting.

Second issue raised was Workplace concerns around Vehicles and Pedestrians. It was reported that the HSE wrote to the Health Boards highlighting concerns around vehicle and pedestrian safety onsite, in particular around the Dental Hospital.

It was reported that this area had been hatched, informing visitors and staff not to wait or park on the yellow lines.

The Health Board responded to the HSE, informing them of strategy's put in place as well as the pedestrian safety project. Item Closed

The Group were informed that full details could be found in the report.

OHSG: 08/19 Fire Safety Management and Enforcement Report

The report was received and noted by the Group.

The Senior Fire Adviser informed the Group that the Fire Service had wrote to the Health Board on the 7th February informing of changes that they had put in place on the 4th February, whereby they would only be sending one appliance at normal road speed to investigate in the event of an alarm, if a confirmed fire had not been received.

The Senior Fire Adviser raised concerns at response times, with these changes.

It was reported that the Health Board had achieved an 11% reduction in unwanted fire signals (uwfs) based off last year's report, with 413 uwfs reported in the last 12 month period.

The Senior Fire Adviser also reported 15 fire incidents within the last 12 months, 6 of these occurred within Hafan Y Coed; three of which were started deliberately. Following these concerns, the Fire Service issued an Enforcement Notice, which had been lifted following a re-visit in December 2018.

The Group were informed that the Fire Training Compliance was at 66%, an improvement on previous figures that were hovering around 50%.

OHSG: 09/19 Pedestrian Safety

It was noted a paper went to the Health and Safety Committee in January on the progress of the pedestrian access strategy.

Mr J McGarrigle gave an overview of the report highlighting the following recommendations:-

- Additional pedestrian crossing points are required at certain locations.
- Improve pedestrian continuity for certain footways including widening narrow paths and ensuring paths have continuous levels. Additional footpaths are required at certain locations.
- Pathways created by pedestrian desire lines to be formalised where possible.
- Rationalise/remove parking bays adjacent to crossing points and/or areas of poor road visibility.
- Certain junctions require modification to minimise conflict/collision between vehicles and pedestrians.
- Access to buildings and Heath Park to be improved and signage needs to be enhanced.
- Wheel stops provided to ensure parked vehicles do not impede footpaths.

It was also noted that the identified higher risk areas was Allensbank Road entrance, Residential Road/ Heath Park Way deliveries as well as access via A48.

Mr J McGarrigle informed the Group that a project group is to be formed to look at the recommendations and cost as well as implementation of work.

Health and Safety Adviser – Ms R Daniel queried if a deadline for completion, had been agreed.

Mr J McGarrigle reported that there wasn't a confirmed deadline as yet, however would update her as soon as this had been agreed.

OHSG: 10/19 Health and Safety Priority Improvement Plan

The report was noted and accepted by the Group.

The Head of Health and Safety gave an overview of the report highlighting areas of improvement and progressing; full details can be found in Agenda item 18.

It was noted that a summary of Clinical Boards Action Plans would be brought to future meetings; a schedule to be established to rotate between Clinical Boards at each meeting.

Concerns were raised in relation to the lack of evacuation chair/mat training. It was highlighted that no training is being offered to staff and those previously trained to cascade these technique have either moved on or lost confidence due to no updated training.

Representative for Surgery – Ms C Wade re-iterated the concern of the lack of training and felt that this shortfall was putting staff and patients at risk.

It was suggested that on ward training be sought, however Ms C Wade highlighted that wards were highly likely to be able to release four members of

staff at a time as evacuation training required two handlers a casualty and an assessor, leaving wards short to release staff to undertake this type of training.

A long discussion took place; it was agreed that a paper be pulled together to look at taking these concerns forward.

OHSG: 11/19 Managing Safely Course

The Head of Health and Safety reported that the course had been developed and was being piloted in April 2019. It was agreed that the outcome of the course and feedback, to be brought to the next meeting.

OHSG: 12/19 Items Raised by Staff side

Staff Side Representative – Mr S Egan raised concern around work being carried out at Llandough. It was reported that Contractors had blocked off footpaths around the Maternity Unit and no signage was visible.

Reprehensive for PCIC – Ms S Congreve highlighted similar concerns at CRI, where Contractors had blocked access to a fire exit.

Mr S Egan also informed the Group of an incident within the Mental Health room within Emergency Unit, where a member of staff had been attacked. It was noted that on visiting the area the alarm was not working and the second door was locked, leaving only one escape route. It was highlighted that an incident form had been completed.

It was also noted that doors in the tunnels had been broken for two months, allowing anyone access to the tunnels. Mr J McGarrigle agreed to report back to Estates.

OHSG: 13/19 Lone Worker

It was reported that the contract is under review and that the Health Board will continue to use Skyguard devices.

OHSG: 14/19 Clinical/ Service Board Feedback

Surgery – Concerns were raised in relation to leaks and drainage within newly refurbished areas; this is an ongoing issue. Mr J McGarrigle agreed to report this back to Estates.

Dental – Issues raised around the ongoing issues with lifts. It was reported that only one lift is working, causing backlogs and a number of complaints by patients and visitors.

Occupational Health – Ms N Bevan queried whether a Corporate Health and Safety Group would be established?

Health and Safety Adviser – Ms R Daniel reported that Mr J Davies – Health and Safety would be leading on this as there was no current arrangements in place.

OHSG: 15/19 Policies and Procedures

Policies Out for consultation are:-

Security Services Policy

OHSG: 16/19 DATE AND TIME OF NEXT MEETING:-
3rd June 2019 – Corporate Meeting Room – HQ – 10AM

MINUTES OF THE FIRE SAFETY GROUP HELD AT 11AM ON 25th MARCH 2019 – 2nd FLOOR, LAKESIDE UHW

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

19/11 Minutes of the Meeting

The minutes of the meeting held on the 3rd December 2018 were **APPROVED** and **ACCEPTED** as a true record.

19/12 Action Log

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

18/03 DSEAR
Agenda item

18/14 Evacuation Drills
The Chair confirmed that Chief Operating Officer had been made aware of the concerns around the lack of commitment from Clinical Boards with regards to Evacuation Drills.

19/13 Enforcement Notice Status/ IN01-02

The Senior Fire adviser reported that no Enforcement Notices were issued during the period. He highlighted the excellent work and efforts made by the Mental Health Clinical Board, in relation to actions taken to lift the Enforcement Notice that was in situ for Hafan Y Coed, and reported that there had been no reported incidents since.

The Group was informed that a re-inspection took place in December 2018 where the Fire Service confirmed they satisfaction with the actions taken. The Enforcement Notice has now been removed.

19/14 Fire Service Response to Calls

The South Wales Fire Service (SWFS) Representative reported on the revised arrangements in relation to attendance in the case of a fire alarm. It was noted that appliances would be dispatched at normal road speed unless a fire is confirmed; this change was agreed based on a risk analysis by the Fire Service.

The DFSM – Specialist Services queried what this meant in time.

The SWFS Representative advised that he did not know what this meant in time as this would be monitored and reviewed, however if a fire is confirmed then emergency protocols would resume with a blue light approach.

It was also noted that only one tender would be sent during day time hours.

The Fire Safety Manager raised concerns around the risk this could present and felt that there needed to be agreement based off high/low risk areas with sleep in patient areas to be considered as high risk and other measures put in place.

The Chair also raised concerns about this approach and particularly in respect of UHW where the inpatient areas were on the upper floors. The acuity of patients and their mobility made evacuation of these floors more difficult and any delays in attendance by the SWFRS could have significant consequences.

The Senior Fire Adviser highlighted that both Fire Policy and Procedures include call to SWFS to confirm fire.

19/15 Fire Risk Assessment Status

It was noted that the DFSM's continue to meet to discuss the Fire Risk Assessments, in relation to Managerial actions. The Group were informed that there were 25 areas assessed during the period September – December 2018, where 122 managerial actions were identified.

In addition, it was also noted that one of these actions were assessed as being a risk rating of 15+ and related to Maple Ward at Hafan Y Coed. The Fire Safety Manager confirmed that this was due to evidence of smoking in October 2018.

The Senior Fire Adviser added that this item had been closed out in-line with the removal of the Enforcement Notice and efforts made at Hafan Y Coed by the members of staff.

19/16 DSEAR

The Fire Safety Manager informed the Group that DSEAR - Dangerous Substances and Explosive Atmospheres Regulations 2002 had been on the agenda for some time. He reported that the Health and Safety Adviser – Mr J Davies had been on a training course and had pulled together a guidance and risk assessment.

The Chair queried if this had yet been rolled out.

The Health and Safety Adviser reported that areas needed to be identified; therefore would be taken to Committees and Health and Safety Groups for circulation and information.

The Chair requested that this be circulated to the Group for comment. **Action: JD/ZB**

19/17 False Alarms, Automatic Detectors and Responses

It was noted that the Health Board continues to meet with the Fire Service to look at ways to improve Un-wanted fire signals. It was highlighted that figures continue to improve year on year; aided by upgraded alarm systems in place and the closure of Whitchurch Hospital.

The Fire Safety Manager reported that improved figures were also evident in UWFS due to contractors as a result of greater contractor control.

19/18 Evacuation Drills – Evac Chairs and Mats

The Group were informed that a meeting had been planned for 2nd April, for the Fire Safety Manager and Senior Fire Adviser to discuss Evac mat training. It was noted that concerns had been raised around lack of training and the difficulty of areas releasing staff.

The Chair requested an update at the next meeting in June.

19/19 NWSSP-FS Audit Return

The 2018/19 Audit is due in May 2019; the Senior Fire Adviser reported that he was waiting on responses.

19/20 Any Other Business

The Chair introduced Mr Mal Perrett to the Group, who had recently been appointed to the post of Senior Fire Safety Advisor following the pending retirement of Frank Barrett.

The Chair thanked Mr Barrett for the advice and support he had provided to himself and the UHB over the years and wished him a happy retirement.

It was noted that during the period a Fire Adviser had left the Health Board and as a result a new Fire Adviser had been appointed. In addition it was reported that an advert to also replace Mr M Parrett would be issued.

19/21 Date of Next Meeting

14th October 2019 – Location TBC

Health and Safety Priority Improvement Plan

Health & Safety Management

Change	REF	Area of Improvement	Milestone	M/stone Status	Actions Requirement	Progress/Assurance	Action Status	Lead	Date Due
	1.1	**Health and Safety Policies**	Comprehensive range of Health and Safety Policies covering all legislative requirements	Amber	Gap analysis of policies by reviewing policies and procedures of other health boards	Project lead identified within the Heath and Safety team to complete analysis.	Amber	Head of Health and Safety	Apr 19
					Develop register of safety legislation to provide gap analysis and ensure any changes or new legislation incorporated into policies and procedures	Register of legislation utilised, project lead reviewing findings using Barbour information system ensuring any changes or new legislation incorporated into policies and procedures	Amber	Head of Health and Safety	Apr 19
			Health and Safety Policies are appropriately reviewed and communicated to all relevant staff	Amber	Ensure link to all current health and safety policies and procedures are on health and safety web page	Departmental review of health and safety polices undertaken. Reviewed at each Health and Safety Committee and approved policies add to web	Green	Director of Corporate Governance	
					Status of related Health and Safety Policies approved by other committees requires progress through relevant committees	Those policies outside of review period identified	Amber	Director of Corporate Governance	Jan 19
	1.2	**Risk Assessments**	Health and Safety Risk Assessments are included within the Board Assurance Framework (BAF) register	Amber	Implement new BAF format	BAF pilot project of Dental and Capital Planning & Estates progressed. Rollout of revised risk register approach being progressed	Amber	Director of Corporate Governance/ Head of Risk Governance	Apr 19
					Review health and safety items on clinical / service board's risk register and ensure high risk health and safety items included on priority improvement plan	Being progressed jointly with above	Amber	Head of Health and Safety	Apr 19
			Managers maintain suitable and sufficient Risk Assessments	Red	Utilise E Datix System to monitor progress of controls identified within risk assessments	Plans to develop E Datix agreed	Red	Director of Corporate Governance/ Head of Risk Governance	Apr 19
					Identify some common high risk activities and produce some generic risk assessment pro-forma for local use	Project co-ordinator identified with health and safety to progress risk assessment status and control measures for health and safety issues.	Amber	Head of Health and Safety	Jun 19

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

2. Violence and Aggression

CRAF	REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
	2.1	**Working within the scope of the Memorandum of Understanding for violence and aggression**	Review of the MOU to meet service needs and support guidance based off NHS Chief Executive's launch together with police and the prosecution service.	Green	Review current practise against revised approach	Health Board taking lead with partnerships, new document being appropriately progressed following Cardiff and Vale practice. Launch planned November 2018	Green	Senior Manager Lead for Health and Safety	Nov 18
					Monitor CPS and Police outcomes for comparison of criminal sanctions,	Annual report identified suitable sub divisions, national group progressing	Green	Senior Manager Lead	Apr 19

					community resolutions and police actions	comparative standards across Health Boards		for Health and Safety	
					Pursue non criminal sanctions and monitor, including violent warning markers, victim interviews and perpetrator internal sanctions	Personal Safety section reviewing its monitoring to demonstrate efforts made within non criminal sanctions.	Green	Head of Health and Safety	Jan 19
	2.2	**Lone Worker Devices**	Ensure those at risk within the community have systems in place for device or suitable assessment	Green	Monitor for consistent use, demonstrating effective management of device allocation	Regular reports submitted to Health and Safety Committee	Green	Head of Health and Safety	Oct 18
					Review of contract due in 2019 to reflect current demands	Meeting with Procurement to establish specification in readiness for contract renewal in April 2019	Green	Head of Procurement	Apr 19
					Local Management to establish appropriate risk assessment for justification	Local Management approaching for additional devices are being supported by Advisory team and advice that items can be progressed by local funding	Green	Head of Health and Safety	Oct 18
					Current devices with battery fault to be resolved by both identification and remedial action	Three devices of the 650 in operation found to have faulty batteries associated with their age. Investigation initiated. Replacement of whole batch been agreed by supplier and completed	Green 	Head of Health and Safety	Jan 18
	2.3	**V&A response competence**	Ensure sufficient trained staff to respond to V&A events	Amber	Review of training to ensure sufficient trained staff to respond.	Internal review with specialist trainers of violence and aggression to ensure response and capabilities.	Amber 	All	Apr 19
					Mechanism to monitor training against Training Needs Analysis (TNA)	Health and Safety department advising Clinical Boards of compliance status	Green	Head of Health and Safety	Apr 19
					Monitoring and support to local areas to give assurance effectiveness of training	Clinical Board meetings to include training status	Amber	Head of Health and Safety	Apr 19

3. Manual Handling

CRAF	REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
	3.1	**Working to Revised All Wales NHS Manual Handling Passport and Information Scheme**	Implementation of the Revised All Wales NHS Manual Handling Passport and Information Scheme	Amber	Review of manual handling passport delivery to meet Agored Cymru standards.	Action plan initiated to meet required standards by December. Progress being monitored by LED, Agored Cymru and Health and Safety. Review Complete	Green	Head of Health and Safety/Head of LED	Dec 18
			Ensure manual handling training is based on need by risk assessment	Amber	Review training against TNA	Joint Review with LED completed	Amber	Head of Health and Safety	Apr 19
					Monitor compliance against TNA requirements	Health and Safety department advising Clinical Boards of compliance status	Green	Head of Health and Safety	Apr 19
	3.2	**Pro-Act Audit**	Audit compliance of Hoisting and hygiene equipment against patient requirements.	Green	Proact re-audit during winter demands	Re-audit progressed and agreed with proact to commence in November 2018, with report coming to April Health and Safety Committee	Green	Head of Health and Safety	Apr 19
					Review of audit findings and action shortfalls.	As above	Amber	Head of Health and Safety	Apr 19
					Review of slings against suitability of current slings used	Within Proact audit	Amber	Head of Health and Safety	Apr 19
	3.3	**Bariatric patient compliance**	Assessment of bariatric patient compliance against manual handling aspects.	Amber	Undertake an assessment of bariatric patient compliance against manual handling aspects	Manual Handling Adviser working with Medicine Clinical Board to assess best practice including proact audit	Amber	Head of Health and Safety	Jan 19
	3.4	**Lifting Operatios Lifting Equipment Regulations (LOLER)**	Meet LOLER inspection requirements	Green	Audit of mechanisms to meet LOLER inspection requirements. Previous reports identified shortfall in LOLER inspection regime	Action taken by Director of Planning to rectify LOLER inspection programme. All equipment re examined.	Green	Director of Planning	Oct 18
	3.5	**Management of the Hoverjacks**	Suitable quantities of equipment to respond to fallen patients needs	Amber	Validation of suitable Hover jacks quantities to respond to fallen patients needs	New Hover jacks purchased via Capital Funds .	Green	Assistant Director of Nursing	Jan19
			Hoverjacks considered and maintained as a lifting compliance under LOLER		Hoverjacks considered and maintained as a lifting compliance under LOLER	As above	Green	Assistant Director of Nursing	Jan 19
			Ownership of existing stock is established		Ownership of existing stock is established.	As above	Amber	Assistant Director of Nursing	Jan 19

	3.6	**Suitable Glide/Slide Sheets**	Enhanced stock of material glide sheets to replace wear and tear	Amber	Savings made from non use of paper glide sheets are converted into enhanced stock of material glide sheets to replace wear and tear	A paper went to the Operational Health and Safety Group in September 2017 recommending the central purchase of large reusable sheets	Amber	Head of procurement	Apr 19
	3.7	**Sling inspections to meet LOLER**	Proact audit identified a higher than needed number of reusable slings and that a more robust mechanism was needed to demonstrate LOLER inspections were being carried out		Rationalise slings to greater use of disposable and review of ward based sling inspections	All reusable slings have been tagged to be uniquely identified .Costs related to external inspections pursued . Discussion of best means of monitoring initiated	Amber 		

4. Health Issues

CRAF	REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
	4.1	**Review of Health compliance**	Review of all health related risks to ensure appropriate controls are in place	Red	Initiate a review of all health related risks to ensure appropriate controls are in place	Health and Safety Adviser co-ordinating a review to reflect concerns raised about all health initiatives	Amber	Head of Health and Safety	Jul 19
					Identify status of Stress, Musculoskeletal Disorder , Display Screen Equipment, Workplace Environmental, Menopausal Effects	Working group being progressed	Red	Head of Health and Safety	Jul 19
	4.2	**Control of Substances Hazardous to Health (COSHH)**	Suitable and Sufficient Risk Assessments in Place	Amber	All areas has designated COSHH coordinators	Shortfall status tabled at each Clinical Board Health and Safety Group for resolution Improvement in compliance to above 80%	Green 	Chair of Operational Health and Safety Group	Apr 19
					Risk Assessments are valid	As above	Amber	Chair of Operational Health and Safety Group	Apr 19
					Monitoring that ensures high risk areas have complete compliance.	Review of risk assessments to establish high risk substance activities are ongoing, with enhanced descriptions	Amber	Head of Health and Safety	Apr 19
			Identified Control Measures are implemented	Amber	Mechanism for minimising the effects of hazardous substances.	As above	Amber	Head of Health and Safety	Apr 19
					Safe use of peracetic acid in sterilisation of medical instruments	Health and Safety Adviser working with Clinical Board to establish best practice	Green	Head of Health and Safety	Oct 19
	4.3	**Work Place stressors**	The Health Board to have in place suitable response mechanism to staff experiencing stress and demands.	Amber	Review Policy and access to Employee Wellbeing Service. Policy has now been reviewed as a procedure.	Procedure has been agreed.	Green	Director of WOD/Head of Occupational Health	Jan 19

			The HB has proactive approaches to identify areas of hotspot and diminish stressors prior to the acute event.	Red	Proactive approaches to identify areas of hotspot and diminish stressors prior to the acute event initiated	Wellbeing Working group has ceased, health and safety working towards identifying criteria with specialist partners on mechanism for identifying potential events.	Red	Head of Occupational Health /Head of Health and Safety	Jan 19
					Specialised group to monitor and develop proactive actions	As above	Red	Head of Occupational Health /Head of Health and Safety	Jan 19
	4.4	**Hand arm vibration**	Activities which use devices at risk of hand arm vibration are assessed	Amber	Review of activities which use devices at risk of hand arm vibration	HAVs identified within Dental and Estates Areas. Full survey initiated in Dental, identification mechanisms developed in Estates, other areas to be progressed	Green	Head of Health and Safety	Apr 19
					Assessment of those areas requiring direct monitoring	Progressed as a rolling programme based on risk priority	Green	Head of Health and Safety	Jan 19
					Complete monitoring to these areas	As above	Amber	Head of Health and Safety	Apr 19
	4.5	**Dangerous Substances & Explosive Atmosphere Reg (DSEAR) compliance to regulations**	DSEAR compliance to regulations requires areas of potential explosives to be assessed and control measures in place	Amber	Assessment of DSEAR requirements against simple demand areas through localised assessments and remedial actions	Risk assessment approach adopted based on industry standard	Green 	Head of Health and Safety	Apr 19
					Identification and full DSEAR assessment for complex areas	As above	Amber	Clinical Board Leads	Apr 19
	4.6	**Muscular Skeletal Risks**	Meet DSE Requirements	Green	Maintain assessment of display screen equipment database and complete assessment for those defined users	Revised Database implemented	Green	Head of Health and Safety	Oct 18

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

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

					Implement findings to minimise self harm risk	Meeting established with health and safety and estates to verify status of remedial work Review completed	Green r 	Mental Health Lead	Jan 19
	5.2	**Mental Health Smoking Cessation**	Implementation of an absolute smoking cessation approach with mental health establishment	Green 	Smoking cessation implemented	Smoking cessation implemented however increased reports of fire and violence and aggression events	Green 	Mental Health Lead	Jan 19
					Review of increased reports of fire and violence and aggression events		Green 	Mental Health Lead	Jan 19
			Suitable support mechanisms for patients and access to safe electronic smoking and other devices	Red	Project plan required non charging e-cigarettes E-cigarette chargers if used must be in suitable flame proof areas	Fire Officer reported e-cigarette chargers are being permitted against national advice	Red	Mental Health Lead	Jan 19
					Monitor smoking cessation compliance and report on enhanced staff risk related to fire and violence and aggression	Reports of increased lighters being smuggled in and increased violence and aggression related to control	Red	Mental Health Lead	Jan 19
	5.3	**Window Closures**	All windows at a height which may be a self harm or fall risk is fitted with suitable window restrictors.	Amber	Survey of windows undertaken and restrictors fitted	Survey of windows undertaken and restrictors fitted.	Green	Director of Planning	Oct 18
					Anti tamper devices fitted to all restrictors	Review of restrictors in self harm areas to fit anti tamper screws	Red	Director of Planning	Apr 19
	5.4	**Local Control of Water Safety**	Low use water outlets are flushed at agreed intervals	Red	Audit and monitoring of flushing mechanisms	Complete audit tool and improve attendance at Water Safety Group	Red	Local Health Board Leads	Jan 19
	5.5	**Management of Bariatric Patients**	Suitable mechanisms in place to care for bariatric patients with dignity and without enhanced risk to staff	Amber	Assessment of patient need	Assessment of patient need undertaken further work required to diminish fire, staff and dignity issues	Amber	Assistant Director of Nursing	
					Specialised beds, hoisting and other support equipment are available as needed	Bariatric care package in place with access to a range of equipment	Green	Assistant Director of Nursing	Oct 18
					Mechanisms of implementing care with dignity for bariatric patients that go beyond our standard profile	Project to improve care being progressed between Manual Handling and Medicine Clinical Board	Amber	Assistant Director of Nursing	Apr 19

	5.6	**Record Storage**	There is agreed policy for retaining paper records	Amber	Progress Policy	The organisation has the requirement to safely store its mandated records for the agreed periods. Policy approved	Green	Director of Corporate Governance	Oct 18
					There are suitable controls implemented within record storage areas to ensure that manual handling and fire risks are not breached	Work undertaken to improve condition of storage in short term	Amber	Head of Medical Records	Apr 19
			Progress an enhanced programme to electronically store, where possible medical records	Red	Progress an enhanced programme to electronically store, where possible medical records	Project under review	Red	Head of Medical Records	Apr 19

6. Fire Safety Management

CRAF	REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
	6.1	**Fire Compartmentation**	Review and maintain compartmentation system	Amber	Implement a prioritised programme for reviewing and maintaining its compartmentation system	Priority plan being progressed	Amber	Director of Planning	Jul 19
	6.2	**Unwanted False Signals (UFS)**	UFS's are minimised, investigated and monitored	Green	Work jointly with SWFRS and Specialist Services to reduce UFS	Joint working group results show 30% improvement	Green	Director of Planning	Apr 19
					Those UFS associated with aged automatic alarm systems are progressed through a prioritised approach	Enhanced programme of replacement agreed	Green	Director of Planning	Apr 19
					UFS associated with inappropriate contractor work is diminished through enhanced job allocation form	Fire Adviser working with Estates to enhance dust and hot work controls	Green	Director of Planning	Apr 19
					Mechanism to notify the fire service to stand down if known false alarm	Fire Service progressing direct line number for speedier contact. Training includes message relating to informing switchboard	Green	Director of Planning	Apr 19

	6.3	**Fire Incidents within Mental Health**	Fire incidents in mental health associated with the smoking cessation campaign is minimised through effective controls	Amber 	Fire incidents in mental health associated with the smoking cessation campaign is minimised through effective controls: a) removal of ignition sources, b) meeting health care guidance on use of charging devices and c) local monitoring of internal areas	New Lead and improved compliance	Amber 	HOD Mental Health /Director of Planning	Jan 19
	6.4	**Evacuation Mat/Chairs Training**	Establish mechanism for training and refresher training in the use of evacuation chairs and mats	Red	Cascade training given several years ago, further demand identified	Review of training need initiated	Red	Senior Fire Adviser/Fire Safety Manager	Apr 19
	6.5	**Evacuation Fire drills**	Enhanced commitment to evacuation drills	Amber	Fire Safety Group to devise an agreed programme of evacuation drills and local areas to co-operate in participation		Amber	Director of Planning	Jan 19
	6.5	**Fire Audit - Annual Submission**	Annual submission of Fire audit is submitted within a timely manner	Green	Submit Annual Audit	2018 audit submitted	Green	Director of Planning	Oct 18

7.1 Health and Safety Estates Management.

CRAF	REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
	7.1	**Water Safety/Legionella**	Water Safety Plan Implemented with increased assurance of compliance against flushing need	Amber	Legionella Survey and Risk Assessment audit package under development for completion by all area managers identifying all outlets and usage or flushing regime	Package developed on MICAD System for dissemination to local areas	Green	Director of Planning	Oct 18
					Water Safety Group has effective representation from all related areas	Current Clinical Board representation is improved but not total	Amber 	Clinical Board Leads	Jan 19
					Compliance against water safety plan and policy is reported to the Health and Safety Committee	Included within work programme	Green	Director of Public Health	Oct 18
	7.2	**Contractor Control**	Contractor control within remit of **estates** has effective	Amber	Reported at Operational Health and Safety Group	Reported at Operational Health and Safety Group	Green	Director of Planning	Oct 18

			mechanisms for monitoring and reacting to safety breaches						
			Permit system in place for contractor work of specified high risk areas			Enhanced permit system under development	Amber	Director of Planning	Jan 19
			Contractor control within remit of **non estates** has effective mechanisms for monitoring and reacting to safety breaches	Amber	Enhance non estates to same standard as estates contractor control	Health and Safety Adviser appointed to progress same standard of work. Has actively progressed backlog since appointment	Amber	Head of Health and Safety	Jan 19
	7.3	**Asbestos**	Asbestos database to ensure that Asbestos Register has evaluated asbestos status for all areas	Green	Review of asbestos database to ensure that asbestos register has evaluated asbestos status for all areas	External review undertaken	Green	Director of Planning	Oct 18
					Effective asbestos management for all intrusive work within asbestos identified areas	As above	Green	Director of Planning	Oct 18
					Action plan for resolving those areas not surveyed as part of the asbestos register	Report 94 of the 8000+ areas surveyed Work on non surveyed areas halted until resurvey undertaken , report to progress "Black Areas " being prepared	Amber	Director of Planning	Apr 19
	7.4	**Back Log Maintenance**	Backlog maintenance to evaluate those areas which potentially affect their safety compliance.	Red	Review of backlog maintenance to evaluate those areas which potentially affect their safety compliance	Resources available to estates in line with an increasing burden of ageing physical infrastructure, bringing increased maintenance costs and increased refurbishment costs	Red	Director of Planning	Apr 19
	7.5	**Pedestrian and Tunnel Safety**	Enhanced pedestrian and tunnel safety.	Amber	Undertake complete survey and specialist advice on enhancing pedestrian and tunnel safety	Survey undertaken	Green	Director of Planning	Apr 19
					Implement phased approach to zoning tunnel areas and minimising usage	Plans being progressed	Amber	Director of Planning	Apr 19
					Implement pedestrian safety within identified key high risk areas	Within cost restriction being progressed	Amber	Director of Planning	Apr 19
	7.6	**Estates Compliance to Lifting Operations Lifting Equipment Regs (LOLER) Requirements.**	Estates compliance to LOLER requirements are maintained for lifting equipment.	Green 	Planned transfer of LOLER responsibilities to Clinical Engineering	Gold contract established with Arjo	Green 	Director of Planning/ Director of Therapies and Health Sciences	Apr 19

					Comprehensive maintenance and inspection schedule maintained	Gold contract established with Arjo	Amber 	Director of Planning/ Director of Therapies and Health Sciences	Apr 19
	7.7	**Category 3 Laboratories compliance**	Appropriate mechanisms are implemented to ensure risks presented to the Health Board from these areas is controlled	Green	Appropriate mechanisms are implemented to ensure risks presented to the Health Board from these areas is controlled by effective maintenance of their internal pressurised containment	Regular meeting established	Green	Director of Planning	Oct 18
					Formal mechanisms of communications between the relevant parties are formalised and recorded	Regular meeting established	Green	Head of Health and Safety	Oct 18

8. Sharps Safety

CRAF	REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
	8.1	**Safety Needles**	Requirement of Safety Sharps legislation are maintained	Amber	Re-engage staff in enhanced safe needles controls and appropriate disposal	Health and Safety Advisers are pursuing through Clinical Boards Health and Safety Groups	Amber	Clinical Board Leads	Apr 19

Report Title:	**CENTRAL FOOD PRODUCTION UNIT, UNIVERSITY HOSPITAL OF WALES (UHW) FOOD HYGIENE INSPECTION – 20th March 2019**							
Meeting:	**Health & Safety Committee.**					**Meeting Date:**	**9th July 2019**	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**	
Lead Executive:	**Director of Planning**							
Report Author (Title):	**Catering Services Manager**							

SITUATION

The purpose of this report is to provide the committee with the outcome of any recent Environmental Health inspections undertaken at any of the UHB registered outlets and provide a plan in respect of any remedial actions that may have been identified during the process.

REPORT

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

An inspection of The Central food Production Unit at the University Hospital of Wales took place on the 20th March 2019 the outcome of which was confirmed in writing in a letter report dated 27th March 2019 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 **4 (Good)** in the National Food Hygiene Rating Scheme.

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.

ASSURANCE is provided by:

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

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

Appendix 1

Action Plan from Food Safety Inspection on 20th March 2019 (Report dated 27th March 2019)

Schedule A – Legal Requirements

Food Hygiene and Safety Procedures		Time Scale	Update
One of the food scoops was removed from use at our request due to rust. As discussed, staff must ensure that they carry out visual checks and remove such equipment from use to prevent any possible contamination of foods. The need to conduct visual checks of food contact equipment in the high risk area was brought to your attention previously. **Regulation (EC) No 852/2004 Annex II Chapter IX para 3 & Chapter V para 1**	• Scoop removed on the day of inspection, staff and supervisors informed to complete visual checks daily	20/03/19	Completed
A cloth cap and a shoe box had been left on the window ledge in the Aroma storeroom. It was removed at the time of inspection. Staff must be reminded to not take personal items into food storage areas within the unit. **Regulation (EC) No 852/2004 Annex II Chapter IX para 3**	• Shoe box and cloth cap removed during inspection, supervisors informed to complete visual checks of all store rooms daily	20/03/19	Completed
It was noted that frozen burger buns and frozen fish fingers were being stored next to each other in the decant freezer and raspberry mousse slices next to raw sausage rolls in the back up freezer. Whilst all are packaged this is not good practice due to potential contamination on the outside of the raw foods packaging. Raw and ready to eat foods must always be stored	• Designated shelving created and labelled for Ready to eat products only. Note added to monitoring sheets appendix sheet 38 to include visual daily checking of correct storage	03/04/19	Completed

separately to reduce the risk of cross contamination. This was brought to your attention previously. **Regulation (EC) No 852/2004 Annex II Chapter IX para 3** A damaged plastic storage container was found in the low risk ingredient area. Whilst it was empty and had been marked with an X, it wasn't clear if this had been removed from use. Any damaged equipment must be removed immediately to prevent possible use. **Regulation (EC) No 852/2004 Annex II Chapter IX para 3 and Chapter V para 1**	• Damaged container removed on the day of inspection, all staff and supervisors instructed to visually check all areas and dispose of equipment if damaged	03/04/19	Completed

Structural / Cleaning Issues	Response / Action	Time Scale	Update
The diffuser fitted to the light fitting in the pot wash area was dirty. Remove the diffuser and clean and maintain in a clean condition. **Regulation (EC) No 852/2004 Annex II Chapter I para 1**	• Maintenance request placed to replace with new diffuser	03/04/19	Completed
The tap inserts were missing to the sink in the pot wash area and some debris build up was noted. Provide tap inserts or similar to provide a smooth, easily cleansable surface. **Regulation (EC) No 852/2004 Annex II Chapter I para 1**	• Maintenance request placed previously, additional request made to replace both sets of taps.	27/04/19	Not completed
One of the ceiling panels to the high risk area was loose and requires to be repaired/ resecured. Leave in a sound condition.	• Ceiling panel secured and left in a sound	03/04/19	Completed

Regulation (EC) No 852/2004 Annex II Chapter I para 1 The grill and housing to the fans in the portioning and decant areas were dusty and require to be cleaned. Maintain in a clean condition. **Regulation (EC) No 852/2004 Annex II Chapter I para 1** The door seal to freezer unit 1 in the portioning area was loose at the base. Resecure/ replace the seal and leave in a sound condition. **Regulation (EC) No 852/2004 Annex II Chapter V para 1** The temperature probe handle in the portioning room had a small amount of food debris on it. Clean and disinfect and maintain in a clean condition. **Regulation (EC) No 852/2004 Annex II Chapter V para 1** There was a small amount of damage to the wall (paint and plaster) to the rear of chest freezer 1. Make good and leave in a sound, smooth, easily cleansable condition. **Regulation (EC) No 852/2004 Annex II Chapter I para 1** I note that the 6 monthly deep clean is due and the fan housing and diffusers will be cleaned at this time.	condition • Cleaning of the fans and housing completed in the portioning room. Supervisors instructed to complete visual checks weekly • Maintenance request placed and door seal replaced and repaired • Cleaned following inspection and staff instructed to clean prior to and after use • Maintenance request placed following inspection, painted and repaired • 6 monthly deep clean completed 08/04/19 by kingfisher, email received confirming	27/04/19 27/04/19 20/03/19 27/04/19 27/04/19	Completed Completed Completed Completed Completed

Confidence in Management / Control Procedures	Response / Action	Time Scale	Update
I note that the food safety management system was reviewed following our last inspection and comments made have been taken on board. We discussed further improvement to include amending the roast meat record form to reflect that the process is over 2 days with the slicing on the second day ie cook / chill is day 1, slice and pack is day 2. This would provide an accurate flow of the product through the production process. It would be preferable to keep the 1 form rather than develop a second as for traceability and production purposes all the information is retained together. Further work is also required in relation to the repacking of foods for the wards in the despatch area and this needs to be included in more detail. **Regulation (EC) No 852/2004 Article 5**	• Noted • Roast meat record sheet amended to reflect recommendations • HACCP control measures updated to include the introduction of the separated area for decanting of ready to eat foods	20/03/19 27/03/19 27/04/19	 Completed Completed

Schedule B – Recommendations, Advice & Information

Recommendations	Response / Action	Time Scale	Update
The painted surface to the food mixers should receive attention to prevent further deterioration.	• Requested contractor to remove, repaint and return	27/04/19	Completed
The floor to the high risk area is starting to crack in places and should receive attention to prevent further deterioration.	• Flooring repaired and to be monitored and reported constantly	27/04/19	Completed
Blast chiller 5 had recently been damaged externally resulting in minor paint loss. This should receive attention to prevent further deterioration and rusting.	• Maintenance request placed, damage repainted and made good	27/04/19	Completed
The floor to the main freezer should receive attention to prevent further deterioration.	• Continues to be reported on Maintenance request list, however major job and agreed to continue to keep clean and monitor.	27/04/19	Not completed
The door strips to the delivery doors are starting to split on one side and should receive attention to prevent further deterioration	• Maintenance request placed, contractor engaged to replace	27/04/19	Completed
The paint to the walls in the Aroma storage area is starting to peel in places (minimal) but should receive attention to prevent further deterioration.	• Maintenance request placed and painter made surface good.	27/04/19	Completed
Some of the mastic to the ceiling panels in the low risk area was starting to come loose and should receive attention to prevent further deterioration.	• Maintenance request placed to make good	27/04/19	Completed
In light of the supply of corned beef trim I would advise	• Matter discussed with	03/04/19	Completed

that you discuss this matter with your procurement team to identify if any other of your suppliers are acting as brokers from a traceability purpose.	procurement and Environmental Health Department, no contravention by ourselves by decision made to use an alternative product following the results of the investigation.		