Health and Safety Committee

21 January 2020, 09:00 to 12:00
Woodlands House, Ground Floor, Cefn Mably

Agenda

1
FOOD SAFETY PRESENTATION - SIMON WILLIAMS COMMERCIAL SERVICES MANAGER - CAPITAL, ESTATES AND FACILITIES SERVICE BOARD
1.1

2
Welcome and Introductions
Michael Imperato

3
Apologies for Absence
Michael Imperato

4
Declarations of Interest
Michael Imperato

5
Minutes of the Committee Meeting held on 8 October 2019
Michael Imperato

5.1
Add a subitem

Agenda Item 4 - Minutes of Meeting 8 October 2019.pdf (9 pages)

6
Action Log
Michael Imperato

Agenda Item 5 - Action Log.pdf (1 pages)

7
Chairs Action taken since last meeting
Michael Imperato

8
ITEMS FOR REVIEW AND ASSURANCE
8.1
Strategic Role of Health and Safety Committee - Overview
Michael Imperato

8.2
Risk Register for Health and Safety - discussion on the new approach
Martin Driscoll / Nicola Foreman

8.3
HSE Inspection of Violence and Aggression and Musculoskeletal Disorders in Healthcare 2018-19
Charles Dalton

Agenda Item 7.3 (i) - Health at Work Action Plan.pdf (6 pages)

Agenda Item 7.3 - HSE Well at Work Audit.pdf (3 pages)

8.4

Pedestrian Access Strategy - Update and Assurance

Geoff Walsh

Agenda Item 7.4 - Pedestrian Access Strategy.pdf (6 pages)

8.5

Enforcement Agencies Report

Charles Dalton

Agenda Item 7.5 - Enforcement Agency Report.pdf (3 pages)

8.6

Fire Enforcement and Managerment Compliance Report

Geoff Walsh

Agenda Item 7.6 - Fire Enforcement Compliance and Management Compliance Report.pdf (6 pages)

8.7

Health and Safety Assurance Schedule and Priority Improvement Plan 2019/20

Charles Dalton

Agenda Item 7.7 - Health and Safety Priority Improvement Plan.pdf (4 pages)

8.8

Updated Health and Safety Related Policies Schedule

Rachael Daniel

Agenda Item 7.8 - Policy Schedule.pdf (6 pages)

8.9

Environmental Health Inspection Report of Aroma Units, UHW - 28 November 2019

Geoff Walsh

Agenda Item 7.9 - EHO Report Aroma Units UHW.pdf (10 pages)

9

ITEMS FOR APPROVAL / RATIFICATION

9.1

Safe Working with Electricity Policy

Geoff Walsh

Agenda Item 8.1 - Safe Working with Electricity Policy.pdf (14 pages)

9.2

Sub Committee Minutes:

9.2.1

Operational Health and Safety Group - September 2019

Martin Driscoll

Agenda Item 8.2 (i) - Minutes of Operational Health and Safety Group.pdf (6 pages)

9.2.2

Fire Safety Group - October 2019

Geoff Walsh

Agenda Item 8.2 (ii) - Fire Safety Minutes.pdf (4 pages)

10

ITEMS FOR NOTING AND INFORMATION

10.1

Health and Safety Assurance Schedule and Priority Improvement Plan - in detail

Charles Dalton

Agenda Item 9.1- Health and Safety Priority Improvement Plan in detail.pdf (8 pages)

10.2

Waste Management Compliance Report

Geoff Walsh

10.3

Environmental Health Report of Food Production, Restaurant and Wards, University Hospital Llandough 19 September 2019

Geoff Walsh

Agenda Item 9.3 - EHO Report UHL Food Production.pdf (7 pages)

10.4

Environmental Health Inspection Report of Central Food Production Unit, University Hospital of Wales on 24 September 2019

Geoff Walsh

Agenda Item 9.4 - EHO Report Cental Food Production Unit.pdf (10 pages)

10.5

Environmental Health Inspection Report of Rookwood Hospital on 25 September 2019

Geoff Walsh

Agenda Item 9.5 - EHO Report Rookwood Hospital.pdf (8 pages)

10.6

Environmental Health Inspection Report of Bwyd Blasus Unit, UHW on 28 November 2019

Geoff Walsh

Agenda Item 9.6 - EHO Report Bwyd Blasus Unit.pdf (6 pages)

10.7

Environmental Health Inspection Report of Ward Based Catering, University Hospital of Wales on 2 December 2019

Geoff Walsh

Agenda Item 9.7 - EHO Report Ward Kitchens UHW.pdf (9 pages)

11

ITEMS TO BRING TO THE ATTENTION OF THE BOARD / COMMITTEE

Michael Imperato

12

REVIEW OF THE MEETING

Michael Imperato

13

DATE AND TIME OF NEXT MEETING

13.1

Tuesday, 7 April 2020 at 9.00am - Woodlands House, Ground Floor

UNCONFIRMED MINUTES OF THE HEALTH AND SAFETY COMMITTEE HELD ON 8TH OCTOBER 2019
NANT FAWR 2, GROUND FLOOR, WOODLANDS HOUSE, MAES-Y-COED

Present:		
Michael Imperato	MI	Independent Member – Legal (Chair)
Akmal Hanuk	AH	Independent Member – Community
Dawn Ward	DW	Independent Member – Trade Union
In attendance:		
Janice Aspinall	JA	Staff Safety Representative
Charles Dalton	CD	Head of Health and Safety
Martin Driscoll	MD	Director of Workforce and OD
Stuart Egan	SE	Staff Safety Representative
Fiona Kinghorn	FK	Director of Public Health
Lee Wyatt	LW	Head of Facilities
Ceri Butler	CB	Head of Learning and Education (for item HSC: 19/10/007)
Catherine Salter	CS	Senior Health and Safety Trainer (Strategic) (for item HSC: 19/10/007)
Secretariat:		
Rachael Daniel	RD	Health and Safety Adviser
Apologies:		
Carol Evans	CE	Assistant Director of Patient Safety and Quality
Nicola Foreman	NF	Director of Corporate Governance
Geoff Walsh	GW	Director of Capital, Estates and Facilities
Observer:		
Maggie Berry	MH	Swansea Bay University Health Board

HSC: 19/10/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting.	**ACTION**
HSC: 19/10/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
HSC: 19/10/003	**DECLARATIONS OF INTEREST** The Chair invited Committee Members to declare any interest in the proceedings included in the agenda. None were declared.	
HSC: 19/10/004	**MINUTES OF PREVIOUS MEETING** The minutes of the Health and Safety Committee held on the 9 July 2019 were reviewed. **The Committee resolved – that:**	

The Committee approved the minutes of the meeting held on 9 July 2019.

HSC: 19/10/005

COMMITTEE ACTION LOG

The Committee reviewed the action log from the meeting held on the 9th July 2019.

The Committee resolved – that:

(a) The action log and updates upon it be received and noted.

HSC: 19/10/006

CHAIRS ACTION TAKEN SINCE LAST MEETING

The Chair informed the Committee that the following had taken place since the last meeting:

(a) He had attended Swansea Bay University Health Board's Health and Safety Committee meeting which was chaired by Martyn Waygood (Interim Vice Chair) who was the previous chair of this Committee. Mr Imperato commented he was surprised health and safety was not a statutory committee and he would be urging other Health Boards to have a Health and Safety Committee.

The Independent Member – Trade Union commented she was a member of the Quality, Safety and Experience Committee which had a very busy and heavy agenda so if health and safety was part of that Committee it would not be able to give it due credence. The Staff Safety Representative (SE) advised if the Health Board didn't have a Health and Safety Committee the Safety Representatives would be demanding for one to be set up.

(b) Mr Imperato informed the Committee he had borrowed a lone worker device and took it on a patient safety walk around with District Nurses where it has been positively received.

HSC: 19/10/007

PRESENTATION – STRUCTURE AND PROCESS FOR STAFF HEALTH AND SAFETY TRAINING

The Chair welcomed Ceri Butler, Head of Learning and Education and Catherine Salter, Senior Health and Safety Trainer (Strategic) to the meeting.

Mrs Butler began the presentation by giving some background to the Electronic Staff Record (ESR) process, she explained:

- All staff had the 10 core mandatory modules linked to their ESR record.
- Unable to produce an accurate Training Needs Analysis (TNA) linked to individual staff requirements.
- Time consuming - manual update of training records from classroom and e-learning uploaded by Learning Education and Development (LED) team.

- Corporate Induction revised and staff completed mandatory training modules prior to attending bringing certificates as evidence.
- All Wales project introduced to automate e-learning to update ESR.
- Reduced the need for manual update of training records by LED team.
- Corporate Induction revised, LED were no longer required to check certificates of completion of mandatory training e-learning modules.
- Requirement to up-skill staff to enrol and access e-learning appropriately.

As a result of the above the following work was undertaken in 2018:

- ESR prompting all staff to complete all modules was in-accurate.
- in conjunction with Subject Matter Expert's (SME's) identify accurate training requirements for levels 1-4 training and upload specific training requirements for staff into ESR – mapping training to job roles and not the person.
- Decision for all payslips to be made available from ESR encouraged staff to access the ESR Portal which highlighted individual's mandatory training compliance.
- LED commenced work to upload Level 1 training into ESR.
- LED had almost completed the upload of Level 2-4 training into ESR.
- Every time LED upload a new module onto ESR – generates queries from across the organisation.
- LED are liaising with SME's to ensure those removed are appropriate.
- All Mandatory Training reporting via Workforce Information Team to avoid any reporting inconsistencies.

Mrs Butler advised as a result of undertaking the above the following benefits can already be seen:

- TNA can now be produced which will support HSE visit.
- Avoid time consuming completion of paper based TNA's.
- ESR Portal shows accurate compliance details for individual staff.
- Increased ownership of training and staff are less likely to duplicate training.
- Line Manager can monitor compliance for individuals with ESR alerts.
- ESR Inter Authority Transfer (IAT) ensure consistency of training across Wales and avoid duplication.

Mrs Salter informed the Committee of the project work being undertaken by the Health and Safety Department to improve the compliance for both manual handling and violence and aggression training.

	The project identified 5 primary drivers to improve compliance, these being; ESR (admin process), training module, link worker system, reporting & monitoring and communication and a number secondary drivers then fed from these which then ultimately led to specific ideas to test or change concepts. Mrs Salter added the scale of the project could not be under estimated. The Independent Member – Trade Union welcomed the approach being taken as it identified what training was essential for staff. She added the system was the answer but was still not quite right, she stated there were a range of job descriptions which potentially could be used for bespoke training and queried whether there was a timeframe for completion. Mrs Butler advised this was being led by Shared Services but she would investigate and feedback.	**CB**
	The Independent Member – Community acknowledged this was a vast project and queried whether the training was provided internally or externally. Mrs Salter advised the trainers were managed through the health and safety department so it was a health board resource. The majority of the training provided was classroom based but was looking to do more workplace training which should improve compliance. The project was also investigating the possibility of merging foundation and update training. The Head of Health and Safety added there was also a link worker system in place but there was a very small uptake percentage for this approach. Mrs Ward agreed that Link Workers was definitely the way forward but to learn lessons from other link worker roles where the time required to undertake the function had not been protected. **The Committee resolved that:** (a) the scale of the project be noted. (b) the quality of the data was key so that training could be targeted. (c) the Director of Workforce and OD update the Committee at the next meeting.	**MD**
HSC: 19/10/008	**RISK REGISTER FOR HEALTH AND SAFETY** The Director of Workforce and OD informed the Committee this item would be deferred to the next meeting.	
HSC: 19/10/009	**HSE INSPECTION OF VIOLENCE AND AGGRESSION AND MUSCULOSKELETAL DISORDERS IN HEALTHCARE 2018-19** The Head of Health and Safety informed the Committee that as yet there was no date for the proposed inspection. Mr Dalton assured the Committee that work was on-going in preparation for the impending inspection. A Health and Safety Adviser from the team had been allocated to co-ordinate a review of current status and develop an action plan for identified shortfalls. The Adviser had initiated a number of meetings and actions to give greater assurance of our risk with knowledge with particular emphasis	

	on status of risk assessments, management controls and training compliance. The Chair queried whether there was someone externally that could undertake a mock audit, Mr Dalton stated the health and safety department work independently and therefore would pick up the negatives as well as the positives, shortcomings have been identified and plans in place to address. Mr Imperato stated he was assured that the health and safety department's preparations were on track and requested he be informed as soon as the date was known. **The Committee resolved that:** (d) the report be noted. (e) a progress report be presented to the January meeting. (f) the Chair be informed as soon as the date was known.	**CD**
HSC: 19/10/010	**PEDESTRAIN ACCESS STRATEGY** The Head of Facilities informed the Committee the programme of works would be completed in January 2020 as planned. The Head of Health and Safety added the lockdown of the tunnels had been completed and a positive difference could already be seen. **The Committee resolved that:** (a) the report be noted. (b) an update of the Task and Finish Group Programme of Works be provided to the January meeting.	
HSC: 19/10/011	**FIRE SAFETY ANNUAL REPORT** The Head of Facilities informed the Committee the annual report identified that the number of false alarms had significantly improved. The Independent Member – Trade Union stated the strategic priorities had all been addressed in the report but queried whether the Deputy Fire Safety Managers were given dedicated time to undertaken this function in order for the role to be given credibility. The Head of Health and Safety advised the DFSMs were senior positions in the Clinical Boards and had delegated some of the responsibilities. **The Committee resolved that:** (a) the annual report be noted.	
HSC: 19/10/012	**ENFORCEMENT AGENCIES REPORT** The Head of Health and Safety informed the Committee there were no new issues since the last meeting. Mr Dalton advised the Committee the case in relation to the Contractor Fall had now come to its conclusion and the Health Board received a fine of £400,000.00. He advised a briefing report had	

	been prepared which included the main learning points from the case, the Chair requested that the report be shared with him. **The Committee resolved that:** (a) the report be noted. (b) the briefing report be shared with the Chair. (c) agreed that appropriate actions were being pursued to address the issues raised.	**CD**
HSC: 19/10/013	**FIRE ENFORCEMENT AND MANAGEMENT COMPLIANCE REPORT** The Head of Facilities informed the Committee the issues raised had been discussed in HSC: 19/10/011. **The Committee resolved that:** (a) the report be noted.	
HSC: 19/10/014	**HEALTH AND SAFETY ASSURANCE SCHEDULE AND PRIORITY IMPROVEMENT PLAN 2019/20** The Head of Health and Safety informed the Committee a lot of the actions were operational in nature and would be monitored through the Operational Health and Safety Group. The Independent Member – Trade Union stated she did take assurance from this report but did have a concern with the timescales for those items with limited assurance. **The Committee resolved that:** (a) the report be noted. (b) agreed that appropriate actions are being taken to address the issues raised.	
HSC: 19/10/015	**LONE WORKER DEVICES REPORT** The Head of Health and Safety informed the Committee new devices were currently been swapped for old so no usage compliance data was available at this time, he also assured that at no time during the transition period would anyone be without a working device. He added the contract had been renewed for a further 3 years. The Chair advised he had recently undertaken a patient safety walk around with community nurses and staff's opinion is that they do not need this level of protection. Mr Imperato stated there was a duty on staff to protect themselves and staff need to be educated that they must use these devices. The Staff Safety Representative (SE) added safety representatives class these devices as part of Personal Protective Equipment (PPE) and staff are duty bound to use them. The Independent Member – Trade Union stated these were fantastic devices that had significantly improved and staff placed a high value	

	on them, Clinical Boards need to sign up to the principle for them and ensure they are used. **The Committee resolved that:** (a) the report be noted.	
HSC: 19/10/016	**UPDATED HEALTH AND SAFETY RELATED POLICIES SCHEDULE** The Director of Public Health informed the Committee the Smoking Policy had not been updated as the Health Board were awaiting the Public Health (Wales) Act early next year. **The Committee resolved that:** (a) the updated schedule be noted.	
HSC: 19/10/017	**ENVIRONMENTAL HEALTH REPORT OF CATERING DEPARTMENT, ROOKWOOD HOSPITAL ON 25TH JULY 2019** The Head of Facilities informed the Committee a score of 3 had been awarded and a re-score had been applied for as the action had now been completed. **The Committee resolved that:** (a) the report and remedial actions taken be noted.	
HSC: 19/10/018	**ENVIRONMENTAL HEALTH REPORT OF WARD BASED CATERING, UNIVERSITY HOSPITAL OF WALES ON 13TH AUGUST 2019** The Head of Facilities informed the Committee a score of 3 had been awarded. Mr Wyatt stated the UHW site was very complex with lots of old kitchens, this inspection had generated a large action plan which is currently being worked through. The Director of Public Health expressed her disappointment with the scores and requested assurance that maintenance was of a high quality and the management issues had been re-emphasised and re-trained. Mr Wyatt advised they were engaging in a Joint Partnership Programme with Cardiff Council with independent management levels in place. Following further discussion it was agreed at the next meeting there would be a presentation on Food Safety. **The Committee resolved that**: (a) the report and remedial actions taken be noted. (b) there would be a presentation on food safety at the next meeting.	**LW/GW**

HSC: 19/10/019	**HEALTH AND SAFETY POLICY** The Head of Health and Safety advised the Policy had been slightly amended to reflect organisational changes. **The Committee resolved that:** (a) the Policy be RATIFED for onward approval by the Board.	**MD**
HSC: 19/10/020	**CONTRACTOR CONTROL POLICY** The Head of Facilities advised the Policy had been amended and updated to reflect the enhanced systems for contractor control holistically. **The Committee resolved that**: (a) the Policy be APPROVED.	
HSC: 19/10/021	**OPERATIONAL HEALTH AND SAFETY GROUP** **The Committee resolved that**: (a) the minutes of the Operational Health and Safety Group held in June 2019 be RATIFIED.	
HSC: 19/10/022	**HEALTH AND SAFETY PRIORTY IMPROVEMENT PLAN – DETAILED** **The Committee resolved that:** (a) the plan be NOTED.	
HSC: 19/10/023	**ENVIRONMENTAL HEALTH REPORT OF Y GEGIN, UNIVERSITY HOSPITAL OF WALES ON 20TH JUNE 2019** It was noted that a score of 4 had been awarded. **The Committee resolved that:** (a) the report be NOTED.	
HSC: 19/10/024	**ENVIRONMENTAL HEALTH REPORT OF AROMA PLAZA OUTLET, UNIVERSITY HOSPITAL LLANDOUGH ON 25TH JUNE 2019** It was noted that a score of 5 had been awarded. **The Committee resolved that:** (b) the report be NOTED.	

HSC: 19/10/025	**ENVIRONMENTAL HEALTH REPORT OF AROMA COFFEE OUTLET, WOODLANDS HOUSE ON 9TH AUGUST 2019** It was noted that a score of 5 had been awarded. **The Committee resolved that:** (c) the report be NOTED.
HSC: 19/10/026	**REVIEW OF MEETING** The Chair welcomed comments from the Committee. The Director of Public Health commented that too much detail is discussed at times, she appreciated the need to get the balance right but felt some discussions could be briefer. Mr Imperato requested members let him know of any issues they wished to be discussed at the Committee so that they could be considered as part of the agenda setting process. It was noted that there would be a presentation on food safety at the next meeting. The Staff Safety Representative (SE) requested the opportunity to have agenda items, Mr Imperato welcomed this approach and again requested any issues to be forwarded either to himself or Miss Daniel for the agenda.
HSC: 19/10/027	**DATE OF THE NEXT MEETING OF THE COMMITTEE** Tuesday 21st January 2020 at 9.00am, Cefn Mably Meeting Room, Woodlands House, Heath, Cardiff, CF14 4TT

ACTION LOG
FOLLOWING HEALTH AND SAFETY COMMITTEE MEETING
8 OCTOBER 2019

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Actions Completed					
HSC 19/10/007	Health and Safety Training	Timeframe for bespoke training to be linked to job descriptions	C Butler	21/01/20	**COMPLETED** - Shared Services are entering qualifications onto ESR if it's in the essential criteria of person specification
HSC 19/10/012	Contractor Fall Case	Briefing report including lessons learnt to be shared with the Chair	C Dalton	14/01/20	**COMPLETED**
HSC 19/10/018	EHO Reports	A presentation on Food Safety to be made to the Committee	L Wyatt/G Walsh	21/01/20	**COMPLETED.** This is on the agenda
Actions in Progress					
HSC: 19/10/007	Health and Safety Training	Update to be provided at the next meeting.	M Driscoll	21/01/20	Apologies received from Director of WOD - deferred to April meeting
HSC: 19/10/009	HSE Inspection	Chair to be informed of date of inspection	C Dalton	21/01/20	No date at time of writing
Actions referred to other Committees/Board					

HSE INSPECTION OF VIOLENCE AND AGGRESSION AND MUSCULOSKELETAL DISORDERS IN HEALTHCARE 2018 -19
as at DECEMBER 2019

Personal Safety

	Area	HSE Findings ABMU	HSE Findings Hywel Dda	Cardiff and Vale Status	Comments/Further Actions	Risk
	Violence and Aggression Training	Lack of tutor led training and compliance issues identified	Lack of suitable training for clinical staff	Good level of compliance to Level A and D. Level B and C require enhanced	Review of Training needs based off foreseeable risk. Greater offering of C only courses with B being completed on line	Compliance should be able to improve on level B, however level C is a risk
	Response to Violent and Aggressive Event	Too great a reliance on Police intervention, limited internal capability	Too great a reliance on Police intervention, limited internal capability	Direct police presence and co-operation on sites, good security set up, various alarm systems in place	Emergency calls systems will require assessment of who responds in health centre base	No HSE action expected
	Sharing of Information		Review mechanisms of sharing known violence and aggressive patient risks	Health Board operating hazard warning markers system onto patient record systems and shares known risk with GP		No HSE action expected
	Security	Lack of suitable security arrangements Lack of suitable training for those staff expected intervene	Lack of suitable security arrangements IN expected	Dedicated Uniformed Team, equipped with stab vests, 2 way radios and body cams. Mobile response for minor sites Security staff undertake SIMA level of compliance is reported at approx. 40% Local police presence at both sites	Considered highest standard in Wales, may comment on training compliance. However Security has a training plan for improving compliance with full compliance by April 2020.	No HSE action expected.

				Flexible response team for other sites		
	Lone Worker	Lack of suitable lone worker management	Lack of suitable lone worker management	Lone worker devices issued to community staff and utilised, mental health wards internal system, security 2 way, buddy system in operation lower risk areas. Call alarms in A&E.	Highest compliance in Wales. Will need to audit buddy system compliance in low risk areas.	No HSE action expected.
	CCTV	Lack of coverage, maintenance and monitoring at sites		1000+ cameras, 24/7 monitoring from staffed dedicated control room planned maintenance plan.		No HSE action expected.
	Adult Mental Health	Failed to have effective control for visitors		Modern building with internal monitoring and trained response team. Training compliance 70+	Mental Health will need to ensure visiting inspectors follow the visitor rules and are accompanied at all times	No HSE action expected
	Mental Health Room in A&E		Lack of suitable risk assessments	Mental Health Room is situated on a main corridor in the Emergency Unit.	Risk assessments have been reviewed by both Medicine and Mental Health Clinical Boards with input from Health and Safety Department	
	Portering	Porters expected to respond to violence and aggressive events no training		Porters are not considered part of violence and aggression response and have low reported violence. Porter training currently low however level B training considered sufficient	To meet minimum All Wales Standard level B online training considered sufficient, additional level B being set up.	Providing team meet training standards and have suitable risk assessments in place no HSE action related to violence and aggression expected

	Emergency Unit	Lack of direct support and training. Status of risk assessment	Lack of direct support and training. Status of risk assessment	Security presence 24/7 Police presence, staff training low.	B&C training considered necessary, current compliance requires enhancement. Work on risk assessments being progressed.	
	Clinical Based Staff		Issue raised relating to level of training and assessment.	Training compliance to level B/C reported low.	Medicine Health and Safety Group has mandated a review of their risk assessments (supported by personal safety and Health and Safety Adviser). Review of who needs what to meet minimum All Wales standard.	Vulnerable.

Manual Handling/MSD

	Area	**HSE Findings ABMU**	**HSE Findings Hywel Dda**	**Cardiff and Vale Status**	**Comments/Further Actions**	**Risk**
	Management of Bariatric Patients		Reviewed system and equipment in place outcome unknown	Bariatric patient equipment available on call, direct advice given by Manual Handling Advisers		
	Object Handling Health Records		Concerns raised in the movement, handling and storage of health records	Similar concerns have been raised in relation to storage and movement of health records		High risk of HSE intervention
	Manual Handing Risk Assessment review		Considered HB approach to Manual Handling Risk Assessment			
	Laundry		Weight, visibility of dirty laundry bags upon transportation	Similar concerns recognised	Further work to be undertaken with Linen Manager	

	Theatres	Concerns raised about techniques of supporting limbs during some operations	Concerns raised about transport of instruments trays between stores and theatre Posture of staff in theatre		Further work to be undertaken with Theatre Manager to assess level of risk	
	Mortuary		Reviewed risk assessment and handling equipment		No intervention likely	No HSE action expected

Estates/Asbestos

	Area	**HSE Findings ABMU**	**HSE Findings Hywel Dda**	**Cardiff and Vale Status**	**Comments/Further Actions**	**Risk**
	Asbestos	Not included	HSE closely examine compliance to asbestos requirements	Health Board has an Asbestos Policy, Plan Asbestos register and asbestos manager to progress compliance. There are some areas within the HB that has not been surveyed, these are controlled by activity and access.	Monthly workshops asbestos manager has completed training on new requirements and identified gaps in system. Resource secured to complete blank spaces 75% by October 90% Dec.	No HSE action expected
	Contractor Control	HSE highlighted with one HB contractors working without suitable controls (Non Estates staffing IT).	General concerns in relation to the management of contractors	Following contractor fall, much effort has been made to enhance contractor compliance, including induction, job registration form and non-estates contractors.	Contractor Control audit due by end of August by Shared Services - will further enhance assurance.	HSE will be actively looking at this following our court case. Providing systems are followed by both

						contractors and those managing activity.

Corporate Issues

	Area	HSE Findings ABMU	HSE Findings Hywel Dda	Cardiff and Vale Status	Comment/Further Action	Risk
	Policy Control	HSE requested copies of relevant policies	HSE requested copies of relevant policies	All health and safety policies are with compliance date and fit for purpose	Health and safety policies referred to in the Managing Safely Course.	Staff advising HSE they are not aware of relevant policies
	Risk Management	HSE requested Risk Management Policy	HSE requested Risk Management Policy	The Risk Management Policy and Procedure is out of date. However the Director of Corporate Governance has issued a Risk Management strategy which will co-ordinate the interrelationship between risk assessment, risk register and BAF.	Health and Safety Department has produced a Risk Assessment Procedure for health and safety risks.	
	Consultation with Unions	Reviewed system of consultation and membership of health and safety committees. Met directly with staff safety representatives and reacted to those discussions	Reviewed system of consultation and membership of health and safety committees. Met directly with staff safety representatives and reacted to those discussions	Chair and Deputy Chair of Staff Group Health and Safety Reps attend both the Operational Health and Safety Operational Group and Health and Safety Committee. Monthly meeting between Staff Safety		

				Representatives and Head of Health and Safety		
	Incident Reporting and Investigation	Assess the risks and implement adequate arrangements to report and investigate incidents so that lessons are learnt and acted upon	Assess the risks and implement adequate arrangements to report and investigate incidents so that lessons are learnt and acted upon	Similar status for HB. Whilst incidents are regularly reported the follow up and investigation process are not so regularly enacted upon		Vulnerable
	Health and Safety Management Training		Reviewed Directors and managers training status	Estates - high level of Manager training other CBs low. Managing safely course been corporately run since April 2019 with a good take up. There is low attendance for the 1 day Risk Assessment courses.	10 risk assessment courses a year are offered by the Health and Safety Department	
	Pedestrian Safety	The need to carry out a transport risk assessment considering in particular the safety and personal security of pedestrians moving around, within and between buildings		Pedestrian safety strategy has been discussed at the Health and Safety Committee since October 2018.	The HSE will review our Health and Safety Committee minutes and also their correspondence with us following a RIDDOR event.	

Report Title:	**HSE Audit of Violence and Aggression and Musculoskeletal Disorders in Healthcare 2018/19**								
Meeting:	Health and Safety Committee						**Meeting Date:**	21/01/2020	
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 two of these inspections - ABMU (now Swansea Bay Health Board) in late 2018 and had subsequently issued 9 improvement notices. They also inspected Hywel Da Health Board in July 2019 who were issued with 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.

Since the last meeting feedback has now been received from Hywel Da who received 2 improvement notices in relation to the management of violence aggression and specifically risks associated to those in the emergency department, 4 improvement notices in relation to the management of manual handling and specifically risks within health records, laundry, theatre staff and porters. 1 improvement notice related to the management of medical sharps and the final improvement notice related to inadequate arrangements to report and investigate incidents to ensure lessons are learnt.

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.

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	
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:	**PEDESTRIAN ACCESS STRATEGY – Progress Update**									
Meeting:	**Health and Safety Committee**							**Meeting Date:**	**21st January 2020**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**			**√**
Lead Executive:	**Director of Planning**									
Report Author (Title):	**Director of Capital Estates and Facilities (02921 836227)**									

SITUATION

The Health Board has undertaken a Pedestrian Access study at University Hospital of Wales. This report highlights the progress made including 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 Sustainable Travel and Transport strategy including Pedestrian Access and safety. This latter need is also reinforced as there has been a pedestrian incident at UHW. Whilst the strategy initially focused on UHW, the program has been 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 programs where services have transferred to this site but also associated with natural growth and changing models of Healthcare. UHW has four vehicle entrances/exits and a range of pedestrian access points and is flanked by a range of busy road networks serving Cardiff city and surrounding districts.

The UHB's Transport and Travel Team have been developing a range of promotional and

infrastructure measures to encourage patients, visitors and staff to consider alternative methods to travel to the UHB, to reduce traffic congestion, improve Health and Safety and curb vehicle emissions.

Pedestrian Incident

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

A Pedestrian Access Study was undertaken to act as a foundation to develop a Pedestrian Access strategy. 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 provided a range of recommendations to be implemented at UHW which are summarised below:

- 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/condition 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/crossing points require modification to improve visibility and minimise conflict/collision between vehicles and pedestrians.
- Access to buildings and Heath Park to be improved and signage/road markings need 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.

Sustainable Travel and Transport Strategy

In order to develop a program to support and encourage patients, visitors and staff to consider and adopt alternative methods of travel to the UHB, a Sustainable Travel and Transport Strategy is being developed for the UHB which will include:

- Policy Development

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

An external Highways and Engineering Consultant ADL has been appointed to undertake this entire package of work and the pedestrian access recommendations are being reviewed and blended into the strategy. These pedestrian requirements will be developed for all main UHB sites and the strategy is being managed by the Sustainable Transport and Travel Steering Group.

The project commenced in April 2019 and is scheduled for completion in February 2020. The study also includes the Pedestrian Access Strategy.

ASSESSMENT

Progress on the Pedestrian Access elements of the Sustainable Travel and Transport Strategy include the completion of Pedestrian Environment and Safety Audits at a number of sites including:

- UHW
- UHL
- Rookwood
- Barry
- St David's Hospital

The findings of the draft final audits issued in December 2019 are currently being assessed however there are common issues to all sites:

- Condition/provision of footways needs to be improved including: ***Widening pathways, removal of obstructions and trip hazards, installation of ramped footways etc.***
- New paths/footways: ***To be provided where appropriate to follow 'desire lines' of pedestrians.***
- Crossing points to be improved including: ***Relocation/additional crossing points are required and improved condition of crossing points, road markings, tactile paving, Belisha beacons and pedestrian crossing landscapes.***
- Signage and road markings to be improved including: ***Repaint road markings, review requirements and content of signage and replace/renew signs.***
- Vehicle parking obscuring visibility or interfering with pedestrian access: ***Install bollards/wheel stops and barriers and realign zebra crossings to improve visibility.***
- Good housekeeping/general management: ***Remove waste/debris in certain areas, replace missing drain cover/grills, general maintenance etc.***

The Audits including findings and recommendations were presented to the UHB at the January 2020 Sustainable Transport and Travel Steering group including risk rating and budget costs.

The actions are being reviewed with ADL to formulate a practical action plan for implementation which will be completed March 2020. An extract of the action plan is as follows;

Site	Remedial Measures	Comments	Approximate Costs	Timescale
All sites	Clarify recommendations and costings with ADL Consultants.	N/A	N/A	January/ February 2020
All sites	Establish Project Team and resources and develop detailed design and tender for recommendations.	N/A	N/A	March/April 2020
UHW, UHL, Barry, St Davids, CRI and Rookwood	Condition/provision of footways needs to be improved including: ***Widening pathways, removal of obstructions and trip hazards, installation of ramped footways etc.***	Most of the actions identified have a medium to high risk rating, therefore the works would be prioritized accordingly.	£225k (includes £50k for CRI car park repairs and £100k Rookwood pedestrian route refurbishment).	May 2020 to December 2020
Mainly UHW and UHL	New paths/footways: ***To be provided where appropriate to follow 'desire lines' of pedestrians.***	Most of the actions identified have a medium to high risk rating, therefore the works would be prioritized accordingly.	£30k	June 2020 to December 2020
Mainly UHW, UHL, Barry,	Crossing points to be improved including: ***Relocation/additional crossing points are required and improved condition of crossing points, road markings, tactile paving, Belisha beacons and pedestrian crossing landscapes.***	Most of the actions identified have a medium to high risk rating, therefore the works would be prioritized accordingly.	£70k	June 2020 to December 2020
Mainly UHW, UHL, Barry, St David's and CRI	Signage and road markings to be improved including: ***Repaint road markings, review requirements and content of signage***	Most of the actions identified have a medium to high risk rating, therefore the works would be prioritized accordingly.	£55k	June 2020 to September 2020

	and replace/renew signs.			
Mainly Barry, CRI and Rookwood	Vehicle parking obscuring visibility or interfering with pedestrian access: ***Install bollards/wheel stops and barriers and realign zebra crossings to improve visibility.***	Most of the actions identified have a medium to high risk rating, therefore the works would be prioritized accordingly.	£45k	June 2020 to December 2020
UHW, UHL, Barry, St Davids, CRI and Rookwood	Ongoing Good housekeeping/general management: ***Remove waste/debris in certain areas, replace missing drain cover/grills, general maintenance, access improvements etc.***	Most of the actions identified have a medium to high risk rating, therefore the works would be prioritized accordingly.	£25k	April 2020 onwards
Total			£450k	

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:	Enforcement Agencies Report						
Meeting:	Health and Safety Committee					**Meeting Date:**	21/01/2020
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 were 5 new issues raised relating to enforcement by the Health and Safety Executive (HSE), one of these resulted in the issuing of two Improvement Notices:

1 Over exposure of radiation to an employee in Radiography – Improvement Notices
2 Notification of pressure vessel inspection failure
3 Failure of hydraulic lift inspection
4 Failure of 2 passenger lift inspections
5 Amendment to the preventative maintenance scheme for the heating boilers at UHW
6 Water safety/legionella controls – Barry Hospital

This report updates the Committee on progress for previous correspondence or events.

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/Pedestrian Safety Control 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 been progressed by the Director of Capital, Estates and Facilities. The outline plan was considered at the July Health and Safety Committee, both in terms of long term plan and immediate actions deliverable within the resources available. Subsequently some key short term resolutions have been implemented on Residential Drive.

Radiation Exposure

The HSE visited the Health Board on the 29th October and identified contraventions of the ionisation radiation regulations 2017and subsequently issued two Improvement Notices, they also identified two further material breaches.
The visit arose as a result of an employee involved in interventional radiology having received a

dose in excess 1msv in a calendar month that was not investigated for several months.

Secondly, they identified that the mechanisms used for assessing eye dose using a collar dose meter was not a suitable technique.

In addition they found that the department had not undertaken suitable risk assessments in relation to restricting exposure and that the department's Consultant Radiologist did not have any documented training since their induction; this was in contrast to radiographers and other members of staff who receive periodic refresher training.

The HSE required information to be given to them regarding the remedial action taken by the 9th December 2019, the response and action plan was submitted within time and the remedial actions considered at the Operational Health and Safety Group.

Pressure Vessel Inspection Failure
The Health Boards appointed independent inspector reported to the HSE a failure of the autoclaves examinations. Subsequently the HSE required confirmation that the device was taken out of service and not used, there was planned repairs to the defect and the preventative maintenance for these devices had been revised in light of the failure. Confirmation was received from the Estates Engineer which was forwarded to the HSE inspector.

No further action - the Head of Estates Compliance has been asked to give assurance the amended preventative plan has been implemented.

Lift Inspection Failure Report
The estates department was contacted by the HSE following their receipt of a report of a hydraulic lift inspection failure report.

A response was 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. **Item Closed**

Passenger Lift Failures in UHW
The Health Board appointed independent inspector notified the HSE of a failure to 2 lifts at Merioneth as being of "serious imminent danger" although the lifts were subject to a routine maintenance inspection regime. The Health Board confirmed that the lifts were immediately taken out service and repairs effected – **HSE informed no further action**.

Changes to maintenance regime of heating boilers
The HSE are required under the pressure vessels regulations to be notified if our planned maintenance scheme was to be modified. Modification was necessary as taking the heating boiler out for service would result in no heating for a significant part of the UHW. The system has a second boiler however this was already out of service. Our pressure vessels competent person supported the review. HSE was informed and no further correspondence - **Item Closed**

Water Safety/Legionella controls at Barry Hospital
The HSE contacted the Health Board as part of a local initiative of monitoring legionella controls in the area of Barry. A response was prepared and subsequently further data requested – no further correspondence has been received.

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	
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:	**Fire Enforcement Compliance and Management Report**						
Meeting:	**Health and Safety Committee**				**Meeting Date:**	**21/01/2020**	
Status:	**For Discussion**		**For Assurance**	✓	**For Approval**		**For Information**
Lead Executive:	**Executive Director of Finance**						
Report Author (Title):	**Senior Fire Safety Officer**						

SITUATION

Cardiff and Vale University Health Board (C&V UHB) has a statutory obligation to protect persons from the risk of fire. The enforcing authority of current National fire safety legislation is the local Fire Authority i.e. South Wales Fire and Rescue Service (SWFRS) who is lawfully empowered to monitor and enforce compliance of all fire safety matters under the Regulatory Reform (Fire Safety) Order 2005 (FSO).

A fire safety audit is completed by an Inspecting Officer of SWFRS. On completion of the audit the inspector is authorised to confirm that all relevant fire safety matters are satisfactory or if they are not the inspector is empowered to issue a written notice detailing all fire safety deficiencies found at the time of the audit. The notice of deficiencies will either take the form of an Enforcement Notice (a serious breach of fire safety standards) or an Informal Notice (**IN01**- fire safety deficiencies that are deemed not so serious to warrant enforcement action but have a time limit, usually twelve months) or an Informal Notice (**IN02** - advisory only – very minor fire safety deficiencies with no time limit).

This paper also provides an update on the progress and actions relating to five key fire safety compliance and management themes i.e.

1. Fire Risk Assessments
2. Enforcing Authority Audits
3. False Alarms and Unwanted Fire Signals (UwFS's)
4. Fire Incidents
5. Training

(See **Appendix 1** – Pages 3 & 4 **Essential Supporting Documentation**)

BACKGROUND

South Wales Fire and Rescue Service (SWFRS) agree a program of visits with C&V UHB's Senior Fire Safety Officer (SFSO) to enable Inspectors to undertake fire safety audits PAN Estate accompanied by a member of the fire safety management team. Audits may result in written reports being served on C&V UHB by the enforcing authority where they deem that the UHB has failed to comply with current fire safety legislation i.e. the FSO.

This report provides information about Notices served by the enforcing authority.

ASSESSMENT

During the preceding three months SWFRS has carried out one fire safety audit resulting in an informal notices being issued for fire safety deficiencies. This notice applies to Main Theatres at UHW (See **Appendix 2** – Page 5 attached for **IN01Schedule of Works Required for UHW**)

ASSURANCE is provided:

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

RECOMMENDATION

The Committee is asked to:

- To consider on-going efforts to meet the requirements of fire safety enforcement, compliance and management action.

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.

Appendix 1

Essential supporting documentation

1.0 Fire Risk Assessments

The principle fire safety legislation applicable to all C&V UHB premises is the FSO and is enforced by the Local Fire Authority. To be compliant with this legislation a Fire Risk Assessment must be completed for every building or ward or department. Currently there are 442 risk assessment reports that are assessed, reviewed and updated by members of the fire safety management team. The review frequency of assessment is focused on risk and therefore varies from six monthly, annual, bi or tri-annual or whenever materials alterations or significant changes occur in the assessment area or when a change of use or service takes place.

The findings of all fire risk assessments are divided into three areas of responsibility: Local Management, Estates Management and Compliance concerns. Each area has a data base to enable management and progress monitoring. Quarterly meetings of Deputy Fire Safety Managers are held to monitor and progress all local managerial actions.

At the time of reporting we have 10 assessments overdue, however assurance is given that arrangements have been put in place to complete all outstanding assessments before the next reporting period

2.0 Enforcing Authority Audits

South Wales Fire and Rescue Service (SWFRS) continue to visit our premises to carry out fire safety audits of pre-arranged areas under the FSO including auditing and requesting copies of the appropriate fire risk assessments completed by members of the fire safety management team.

3.0 False Alarms and Unwanted Fire Signals (UwFS's)

Performance Indicators for False Alarms and Unwanted Fire Signals
for Cardiff & Vale UHB for UwFS's between 01/10/2019 and 31/12/2019

Hospital	False alarms including UwFS's	Actuation devices	Grade
Barry Hospital	3	562	A - performance should be maintained
Cardiff Royal Infirmary	2	2000	A - performance should be maintained
Hafan Y Coed	4	1274	A - performance should be maintained
Llandough Hospital	11	5843	A - performance should be maintained
Rookwood Hospital	0	425	no incidents
St David's Hospital (Cardiff)	0	600	no incidents
University Hospital of Wales	48	17000	A - performance should be maintained
Whitchurch Hospital	0	2059	no incidents

PAN estate this reporting period saw 68 UwFS's recorded and is well within the performance parameters expected for the size and complexity of our fire alarm systems as indicated by the grades in the above table. This number equates to an

average of 22 activations per month which is a reduction of 8 on our 2019 average of 30 per month. It is pleasing to note that the trend is still reducing (See **Appendix 3** - Page 6 current **South Wales Fire and Rescue Service False Alarm Poster**)

4.0 Fire Incidents

There has been one recorded fire PAN estate in this reporting period which was a minor event. The incident occurred on 8th October 2019 in an office located in TB1, 4F Room 152 at UHW.

A Nurse Practitioner returned to her office 4F room152 and noticed an electrical smell. She then noticed some puffs of smoke coming from the monitor a GNR TS700, Asset No. UHW 356564. She immediately isolated the equipment and dialed 3333. No other alarm was raised as she felt that the risk had now been reduced. A member of the fire safety management team was immediately contacted and attended the scene. A check of the monitor & PC was carried out using a Thermal Imaging Camera (TIC) and the display monitor was permanently removed. IM&T were been informed of the incident. No external emergency services were required.

Site / Address	Numbers
University Hospital of Wales, Heath Park, CARDIFF	1
Total	**1**

5.0Training

Below are the fire safety training compliance figures by Board/Directorate.

Clinical Board	Directorate	Assignment Count	Achieved	Compliance %
All Wales Genomics Service	AWG Directorate	204	156	76.47%
All Wales Genomics Service Total		**204**	**156**	**76.47%**
Capital, Estates & Facilities Total		**1205**	**792**	**65.73%**
Children & Women Total		**2342**	**1723**	**73.57%**
Clinical Diagnostics & Therapeutics Total		**2358**	**1747**	**74.09%**
Corporate Executives Total		**821**	**583**	**71.01%**
Medicine Total		**1846**	**1130**	**61.21%**
Mental Health Total		**1479**	**1007**	**68.09%**
Primary, Community Intermediate Care Total		**1088**	**769**	**70.68%**
Specialist Services Total		**1862**	**1231**	**66.11%**
Surgical Services Total		**2389**	**1460**	**61.11%**
Grand Total		**15594**	**10598**	**67.96%**

Data supplied by Workforce Information for 01st December 2018 – 30th November 2019

APPENDIX 2

INO1 SCHEDULE OF WORKS REQUIRED for UHW

OPERATING THEATRES

SWFRS AUDIT on 30/10/2019

1 **Article 8 Duty to take general fire precautions.**

1.1 **The standard of fire separation provided is not adequate.**

1.1.1 During the inspection it was noted several ceiling tiles were missing in various areas. These tiles should be replaced to prevent unwanted smoke and fire movement away from detection in these areas into the ceiling voids above.

2 **Article 14 - Emergency routes and exits**

2.1 **Inappropriate storage within escape routes.**

2.1.1 Corridors and stairways that form part of escape routes should be kept clear and hazard free as is practically possible at all times. Damaged trolley beds located along main corridor must be removed, with all other trollies (some found to be housing oxygen cylinders) stored in a more suitable location.

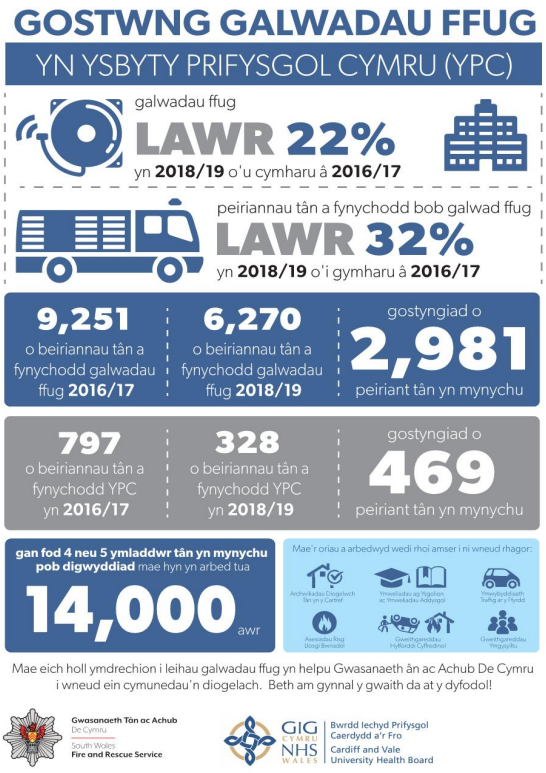
3 **Article 17 Maintenance**

3.1 **The structural fire precautions are not adequately maintained.**

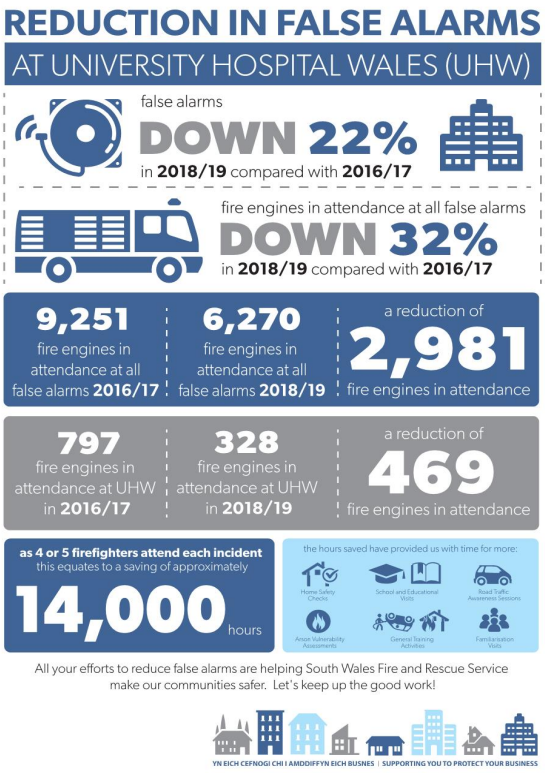
3.1.1 Double leaf fire doors leading onto the emergency staircase adjacent to theatre 10 require repair or replacement.

Appendix 3

Current South Wales Fire and rescue Service Poster



Mae eich holl ymdrechion i leihau galwadau ffug yn helpu Gwasanaeth ân ac Achub De Cymru i wneud ein cymunedau'n diogelach. Beth am gynnal y gwaith da at y dyfodol!



All your efforts to reduce false alarms are helping South Wales Fire and Rescue Service make our communities safer. Let's keep up the good work!

Report Title:	Health and Safety Assurance Schedule and Priority Improvement Plan 2019/20						
Meeting:	Health and Safety Committee				**Meeting Date:**	21/01/2020	
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 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 draft risk register has been developed which is consistent with above BAF procedures and includes the following PIP items scored 12 and above

PIP Ref	H&S Risk Register summary above 12	Initial Risk	Current Risk	Target risk
1.2	Failure to **communicate relevant health and safety** policies, procedures and information to all staff.	20	16	4
1.5	**Managers failure** to undertake their health and safety role.& maintain suitable Risk assessments	16	16	4
7.4	Failure to properly evaluate **backlog maintenance** in those areas which potentially affect safety compliance.	20	16	8
7.5	Failure to maintain enhanced **pedestrian and tunnel safety**.	16	16	4
7.8	Loss of lift provision where there is an identified life risk	25	15	5
3.3	Failure to have adequate systems in place to **safely handle bariatric patients.**	16	12	4
3.4	Failure to implement a scheme of **replacing obsolete hoists** leading to insufficient equipment for local needs.	12	12	4
4.1	Failure to review all **health compliance related risks** to ensure appropriate control measures are in place.	16	12	4
6.4	Failure to establish mechanism for delivery of training and refresher training in the **use of evacuation chairs and mats.**	16	12	4
7.2	Failure to ensure **contractor control** within remit of **estates** has effective mechanisms for monitoring and reacting to safety breaches.	16	12	4

2.2	Failure to have adequate mechanisms in place to protect **lone workers**.	15	12	6
3.7	Failure to provide a more robust mechanism to demonstrate **LOLER sling inspections** are being carried out.	12	12	3
4.3.1	Failure to ensure that the Health Board to have in place suitable response mechanisms to staff experiencing **workplace stress** and demands.	16	12	6

This register will be confirmed against each of the Clinical/Service Board Risk Registers.

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 Issue
(5) Environment Safety and Health and Safety Patient Issues
(6) Fire Safety Management
(7) Health and Safety of the Estate Management
(8) Sharps Safety

ASSESSMENT
An assurance schedule is being progressed with each of the Clinical Boards to identify an agreed date for both submission to the Operational Health and Safety Group and subsequently to the Health and Safety Committee.

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	8	1	6	1	10	5	4	1	Reasonable assurance

Management and Organisational Arrangement									
Violence and Aggression (inc Lone worker)	2	0	2	0	4	1	3	0	Substantial assurance
Manual Handling	9	0	9	0	10	5	4	1	Reasonable assurance
Health Issues	7	0	5	2	14	8	5	1	Reasonable assurance
Patient and Environment Health and Safety	5	0	3	2	9	3	4	2	Limited assurance
Fire Safety Management	3	0	2	1	3	2	1	0	Reasonable assurance
Estate Health and Safety Management	6	0	5	1	9	3	5	1	Reasonable assurance
Sharp Safety	1	0	1	0	1	0	1	0	Reasonable assurance
Total	38	1	30	7	63	28	29	6	

The plan identifies 38 milestones within the 8 strategic areas and 63 actions for improvement. These have been progressed with 1 milestone and 28 actions being completed. The full plan contains details of each of the identified requirements.

During the period a total of 15 actions were progressed sufficiently to enhance their status; these include:

Ref	Subject	Progress
1.1	Health and Safety Policies - develop register of safety legislation to provide gap analysis	Register of legislation utilised, project lead reviewing findings using Barbour information system ensuring any changes or new legislation incorporated into policies and procedures. **GREEN**
1.2	Health and Safety Policies - implement new BAF format	**GREEN**
1.3	Mangers Safely Couse - monitoring and support of health and safety management improvements post course.	Guidance and support being delivered as part of follow up to trainees. **GREEN**
2.2	Lone Worker Advances lone worker protection	Working group formed to review lone worker relating to non-violence and aggression. and health care premises **AMBER**
3.1	Ensure manual handling training is based on need by risk assessment	Joint review with LED completed. **GREEN**
3.6	Enhanced stock of material glide sheets to replace wear and tear	A paper has been prepared and considered at the Operational Health and Safety Group in December 2019. **AMBER**
3.7	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	All reusable slings have been tagged to be uniquely identified. Costs related to external inspections pursued. Discussion of best means of meeting compliance discussed and agreed at Operational Group. **AMBER**
4.1	Review of all health related risks to ensure appropriate controls are in place	Review of programme and being reported to each Health and Safety Committee. **AMBER**
4.3	The Health Board to have in place suitable response mechanism to staff experiencing stress and demands.	Procedure has been agreed. Revised Risk Assessment form produced. **GREEN**
4.3.1	The Health Board has proactive approaches to identify areas of hotspots and diminish stressors prior to the acute event.	Funding has been secured from Health Lottery for additional wellbeing practitioners for a period of 2 years; these are currently being progressed. **AMBER**
4.4	Activities which use devices at risk of hand arm vibration are assessed	Programme of work has been initiated and is being progressed. **GREEN**
4.5	DSEAR compliance - identification and full DSEAR assessment for complex areas to be completed by local areas	**GREEN**
5.4	Low use water outlets are flushed at agreed intervals	Reported improved attendance at Water Safety Group. Review of database initiated to improve flush monitoring. **AMBER**
6.4	Establish mechanism for training and refresher training in the use of evacuation chairs and mats	Fire Safety Group reviewed team approach to evacuation chairs agreed. **GREEN**

6.5	Enhanced commitment to evacuation drills	A3 evacuation undertaken. **GREEN**

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

RECOMMENDATION

The Committee is asked to:

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

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

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

UPDATED HEALTH AND SAFETY RELATED POLICIES SCHEDULE

POLICY	UHB REFERENCE NO	AUTHOR/LEAD RESPONSIBLE OFFICER	SUBMISSION TO HEALTH & SAFETY COMMITTEE	APPROVAL DATE	REVIEW DATE	COMMENTS
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	
Waste Management	UHB 038	Waste and Compliance Manager	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
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	
Closed Circuit Television (CCTV)	UHB 303	Director of Capital, Estates and Facilities	January 2019 (3rd review)	January 2019	January 2019	

POLICY	UHB REFERENCE NO	AUTHOR/LEAD RESPONSIBLE OFFICER	SUBMISSION TO HEALTH & SAFETY COMMITTEE	APPROVAL DATE	REVIEW DATE	COMMENTS
Security Services	UHB 037	Director of Capital, Estates and Facilities	April 2019 (3rd review) **4th review****	April 2019	April 2022	
Contractor Control	UHB 163	Director of Capital, Estates and Facilities	October 2019 (4th review)	October 2019	October 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	Approved May 2019	May 2022	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)	Approved January 2019	January 2022	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

Report Title:	**AROMA COFFEE OUTLETS, UNIVERSITY HOSPITAL OF WALES FOOD HYGIENE INSPECTION - 28th NOVEMBER 2019**						
Meeting:	**Health & Safety Committee.**				**Meeting Date:**	**21st January 2020**	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	**Director of Finance**						
Report Author (Title):	**Commercial Services Manager**						

SITUATION

An inspection of the Aroma Coffee Outlets at University Hospital of Wales (UHW) took place on 28th November 2019 the outcome of which was confirmed in writing in a letter report dated 29th November 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 listed service area at UHW was awarded a score of **3 (Generally Satisfactory)** in the National Food Hygiene Rating Scheme.

REPORT

BACKGROUND

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

ASSESSMENT

On receipt of the letter report, an action plan was developed by the Commercial Services Catering Management team and reviewed by the Commercial Services Manager to address the issues raised. The Commercial Services Officer advised that work, or work considered equally effective to address issues raised must be completed by 31st December. The action plan is attached as appendix 1 to this report which will be monitored within the service by the Service Board Compliance team.

It is acknowledged by the Service Board that the scoring falls below the health boards expectations of food hygiene ratings of 5/4 (very good and good). The immediate actions as per the action plan, outline what has been completed in the short term to bring the scores back up to 4/5. A rescore application will be submitted in early 2020 upon completion of all actions as listed.

ASSURANCE is provided by:

- The maintenance of the Food Hygiene rating score of 3 (Generally Satisfactory) and actions taken immediately to bring score up to 4/5 level.
- A rescore application to be submitted to Local Authority in January 2020 to improve rating.

- All UHB and agency catering staff to be written to advising of both their legal and moral obligations of fully adhering to food safety legislation including the service's safe assured HACCP system and documentation.
- The establishment of a Primary Authority Partnership with Local Authority Environmental Health team to strengthen the Service Board approach and UHB position to food safety and formal inspections.
- The Service Board progressing with the recruitment and appointing of its own Food Safety Assurance Manager in early 2020.

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 for Aroma Coffee Outlets, UHW on 28th November 2019 (Report Dated 29th November 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. *(*Where a relevant code / industry guide has been published.)*	**Response / Action**	**Time Scale**	**Update**
General 1. 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 number of staff were observed turning off the taps without using paper towel, or using the towel to turn off taps prior to drying hands. *Regulation (EC) No 852/2004 Annex II Chapter VIII paragraph 1*	Whilst hand operable taps are in situ, signs are displayed at every WHB across units re: correct hand washing procedure. All UHB and agency staff written to regarding hand washing / food safety matters and re-instructed to wipe down WHB after hand washing with paper towel and dispose of. (The replacement of taps to either lever style or similar across catering areas will be reviewed with Estates Maintenance to assess impact).	31 Dec. 2019	Completed
2. There was evidence of food debris on the blade of the heavy-duty can opener in the kitchen, this may cause contamination of the food in the next tin opened. This part of the can opener must be cleaned and sanitised regularly. *Regulation (EC) No 852/2004 Annex II Chapter V Para 1(a)*	Can opener in constant use. Blade of heavy-duty opener to be thoroughly cleaned.	Immediate	Completed

3. There was no hygienic hand drying facilities for example paper towels at the wash hand basins in X Ray and Women's unit as the new single towel dispenser was jammed. Wash hand basins must be provided with hygienic hand drying facilities. *Regulation (EC) No 852/2004 Annex II Chapter I Para 4*	Blue paper in situ but hand towels supplied and single towel dispensers checked / repaired.	Immediate	Completed
4. Whole red onions are being prepared in the production kitchen. One staff member said they would top, tail and peel the onions on a brown board before washing and chopping on a green board, whilst another staff member said they would do everything on the green chopping board. Preparing the onions on a green board only creates a risk of cross contamination. You must ensure that all staff are aware that the peeling of the onions must be done on the brown board, then the washed onions sliced on a green board. Due to the nature of production and size of the kitchen I would strongly suggest that any raw onion is prepared either prior to production or post production with a 2 stage clean of the work surface after use. *Regulation (EC) No 852/2004 Annex II Chapter IX para 3*	Staff to be re-instructed with the colour coding of boards and knives. They have also been instructed to prepare the raw red onion at the end of the late prep shift (4:30-5pm)	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**
Concourse 5. The green colour coded board in the concourse kitchen was becoming scored and can no longer be thoroughly cleaned / disinfected. Replace the affected board. *Regulation (EC) No 852/2004 Annex II Chapter V Para 1(c)*	Board to be disposed of and replaced with new. (NB new boards ordered pre-visit but delivered day after inspection).	Immediate	Completed
6. The rinser tap nozzle and handle to the sink next to the dishwasher in the kitchen was dirty, thoroughly clean the rinser tap paying attention to the nozzle and handle. It was also noted that the base of the pipe was becoming rusty and will require replacing. *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*	All items listed to be cleaned and staff instructed to ensure they follow agreed cleaning schedules. Pipe to be replaced.	Immediate 31 Dec. 2019	Completed Completed
Children's Hospital 7. The following were dirty and required thorough cleaning: • There was lime scale building up around the tap from the hot water dispenser; • There were food splashes on the outside surface of the soup kettle (despite it not being in use at the time of visit); • The ceiling mounted extractor fan was dusty; • The handle to the dishwasher; • There were food splashes to the splash back behind the sink; • The blade to the table mounted tin opener in the kitchen-unit hasn't got one? *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*	All items listed to be cleaned and staff instructed to ensure they follow agreed cleaning schedules. Not applicable – the unit does not have a table mounted tin opener.	Immediate	Completed

8. There were areas of bare wood on the sliding doors from the serving area. air and decoration. The doors must be redecorated to provide a surface which is smooth and non-absorbent and easy to clean. *Regulation (EC) No 852/2004 Annex II Chapter II Para. 1(e)*	Area to be redecorated / painted to ensure surface fit for purpose	31 Dec 2019	Completed
Women's Unit 9. No contraventions.	Nil action required.	N/A	N/A
X-Ray 10. The following were dirty and required thorough cleaning: • There was lime scale building up around the tap from the hot water dispenser; • The ceiling mounted air conditioning unit was dusty; *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*	All items listed to be cleaned and staff instructed to ensure they follow agreed cleaning schedules.	Immediate	Completed
Express 11. The following were dirty and required thorough cleaning: • There was lime scale building up around the tap from the hot water dispenser; • There were food splashes on the outside surface of the soup kettle (despite it not being in use at the time of visit); • The divider between the sinks was damaged and dirty; • The bottom of the door seal to the middle fridge was dirty; *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*	All items listed to be cleaned and staff instructed to ensure they follow agreed cleaning schedules. Divider to be repaired /replaced. – has not been fixed but MR placed	Immediate 31 Dec 2019	Completed Completed
Production Kitchen 12. There were 3 brown marks on the wall near the wash hand basin. Clean the wall and maintain in a clean condition. *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*	Wall to be cleaned and staff instructed to ensure they follow agreed cleaning schedules.	Immediate	Completed

Confidence in Management / Control Procedures 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.	Response / Action	Time Scale	Update
13. 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; • 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	Staff to be re-instructed to take temperature reading and record any corrective action taken to redress any temperatures above critical limit especially post defrost cycle. Staff written to as part of adherence requirements to food safety legislation. As part of HACCP review, ensure monitoring form in situ to record an independent thermometer probing of a dummy food on a weekly basis for all fridges. Ensure proforma is fit for purpose	31 Dec. 2019 31 Dec. 2019	Completed Completed

the monitoring sheets when independent testing has taken place;	to reflect independent testing. All UHB and agency staff written to for adherence to monitoring of temperatures, independent probe checks and recording corrective action taken.		
• 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;	Staff to be re-instructed to record any corrective action taken to redress any temperatures above critical limit. Staff written to as part of adherence requirements to food safety legislation.	31 Dec. 2019	Completed
• There were a number of occasions where cleaning schedule items hadn't been completed at Aroma Children's and Aroma Women's unit. You must ensure cleaning schedule are completed as required and that a Supervisor is signing off that checks have been completed, as a number of forms hadn't been signed off;	Staff previously trained and information displayed regarding cleaning. Management to ensure all staff have received training but more so are verified as competent. Follow up checks to be undertaken by management / supervisors and signed off.	31 Dec. 2019	Completed
It is disappointing to note that a number of the points noted above were raised at the time of your last inspection and require immediate action. *Regulation (EC) 852/2004 Article 5*	All UHB and agency staff written to ensuring awareness of temperature monitoring, recording corrective actions and cleaning regimes is correct including adherence to cleaning schedules.	31 Dec. 2019	Completed
14. 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.	Staff previously trained and information displayed regarding cleaning. Management to ensure all staff have received training but more so are verified as competent. Follow up checks to be undertaken by management / supervisors and signed off.	31 Dec. 2019	Completed

The following issues were noted at the time of inspection; • Some staff were unclear on the correct contact time required; • Some staff were unclear on the 2 stage cleaning process, staff must ensure that food debris is removed prior to disinfecting with the D10; *Regulation (EC) No 852/2004 Annex II Chapter V paragraph 1a*	All UHB and agency staff written to ensuring awareness of cleaning regimes is correct including adherence to cleaning schedules and contact time of cleaning products i.e. D10.	31 Dec. 2019	Completed

Schedule B – Recommendations and Advice

Recommendations	Response / Action	Time Scale	Update
.			
15. The hot water at the wash hand basins in the Children's Hospital and X ray kitchen was too hot. Excessive water temperature may hamper good hand hygiene. Whilst there was a separate cold water tap that staff could turn on I would strongly suggest you consider installing mixer taps with non hand operable handles at all hand wash basins.	Whilst hand operable taps are in situ, signs are displayed at every WHB across units re: correct hand washing procedure. All UHB and agency staff written to regarding hand washing / food safety matters and re-instructed to wipe down WHB after hand washing with paper towel and dispose of. The replacement of taps to either lever style or similar across catering areas will be reviewed with Estates Maintenance to assess impact.	Immediate	Completed
16. 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. A blue roll was noted on the work surface in the Aroma preparation kitchen.	Blue roll and paper towels to be fitted into dispensers.	Immediate	Completed

17. The plastic bag for collecting recycling was hanging from the taps to the hand wash basin in the Women's unit. Nothing should be placed on or around the hand wash basin.	Plastic bag removed during inspection.	Immediate	Completed
18. The electric insect killer in the preparation kitchen was not working. I recommend it is repaired and maintained in good working order.	Insecta flash unit to be repaired via Estates Maintenance.	31 Dec. 2019	Completed

Reference Number: *TBA unless document for review* **Version Number:** 2	**Date of Next Review:** *September 2022* **Previous Trust/LHB Reference Number:** *Trust 178*

Policy for Safe Working with Electricity

Policy Statement

The use of electricity in health care premises is a common and potentially hazardous process, which makes it essential that all electrical systems are managed without giving rise to danger. Inadequate control and or improper use of electricity are a danger to life and property. The Cardiff and Vale University Health Board (hereinafter referred to as the UHB), and its officers are responsible for electrical services as duty holders, and accountable for ensuring control. They are also responsible for ensuring the safe management, design, installation, operation and maintenance of the UHB's electrical systems.

This policy seeks to establish the conditions whereby the use of both electrical power generally, and in particular equipment connected to the electrical installation will be adequately controlled in all work related activities, to ensure so far as is reasonably practicable the health and safety of those affected. This Policy is the UHB's response to meet the requirements of providing a safe system of work for all electrical services within its properties.

Policy Commitment

To achieve the requirements of the Policy statement, the UHB will implement a range of procedures, protocols and safe systems of work for the safe working with electricity. For the benefit of patients, visitors and staff the main objective is to ensure that a safe electrical system is operated throughout the UHB buildings. The following highlights the key commitments of this Policy:

- The system will only be worked upon by electrically competent staff.
- The necessary safeguards will be in force at all times, to ensure that only electrically competent persons are allowed to work on and have access to the UHB's electrical systems.
- The electrical system will be operated within its capacity so that overloading does not occur and overheating of cables is avoided.
- A systematic regular maintenance programme will be conducted on all key electrical systems.
- Procedures and protocols for the electrical systems compliment this policy.

Supporting Procedures and Written Control Documents

The following documents should be read in conjunction with this Policy:

Legislation

- Health and Safety at Work etc. Act 1974

- Electricity Act 1989
- The Electricity at Work Regulations 1989
- Electricity Safety, Quality and Continuity Regulations 2002
- Provision and Use of Work Equipment Regulations 1998
- The Electrical Equipment (Safety) Regulations 1994
- The Plugs and Sockets etc. (Safety) Regulations 1994
- Workplace (Health, Safety and Welfare) Regulations 1992

Welsh Health Estates Guidance

- WHTM 06-01: Electrical services supply and distribution
- HTM 06-02: Electrical safety guidance for low voltage systems
- HTM 06-02: Electrical safety handbook
- HTM 06-03: Authorised Person's Logbook
- HTM 06-03: Electrical safety guidance for high voltage systems

Scope

This policy applies to all of our staff and all buildings/locations including those with honorary contracts

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be no impact

Policy Approved by	Health and Safety Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Operational Health and Safety Committee
Accountable Executive or Clinical Board Director	Director of Capital Estates and Facilities

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Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	1st December 2016	TBA	*Revised Document updated in line with Service Board and Legislative changes*
2	09th of December 2019	TBA	*Revised document updated in line with service board and legislative changes*

Policy for the Safe Working with Electricity

Reference No.		Version No.	1	Previous Trust / LHB Ref No:	Trust - 178

Documents to read alongside this Policy, Procedure etc.	

Classification of document: Corporate

Area for Circulation: UHB Wide

Author(s): Director of Capital, Estates & Facilities

Executive Lead Executive Director of Finance

Group Consulted Via/Committee: Operational Health and Safety Group

Ratified by: Health and Safety Committee

Date Published December 2019

Version Number	Date of Review	Reviewer Name	Completed Action	Approved By	Date Approved	New Review Date
2	09/12/2019	Philip Mackie				December 2022

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OUT OF DATE POLICY DOCUMENTS MUST NOT BE RELIED ON

Policy for Safe Working with Electricity

1.0 INTRODUCTION

The use of electricity in health care premises is a common and potentially hazardous process, which makes it essential that all electrical systems are managed without giving rise to danger. Inadequate control and or improper use of electricity are a danger to life and property. The Cardiff and Vale University Health Board (hereinafter referred to as the UHB), and its officers are responsible for electrical services as duty holders, and accountable for ensuring control. They are also responsible for ensuring the safe management, design, installation, operation and maintenance of the UHB's electrical systems.

This policy seeks to establish the conditions whereby the use of both electrical power generally, and in particular equipment connected to the electrical installation will be adequately controlled in all work related activities, to ensure so far as is reasonably practicable the health and safety of those affected.

This Policy is the UHB's response to meet the requirements of providing a safe system of work for all electrical services within its properties.

2.0 POLICY STATEMENTS

2.1 MAIN SAFETY OBJECTIVES

For the benefit of patients, visitors and staff the main objective is to ensure that a safe electrical system is operated throughout the UHB buildings. The system will only be worked upon by electrically competent staff.

The necessary safeguards will be in force at all times, to ensure that only electrically competent persons are allowed to work on and have access to the UHB's electrical systems.

The electrical system will be operated within its capacity so that overloading does not occur and overheating of cables is avoided.

A systematic regular maintenance programme will be conducted on the following systems:-

- Low Voltage Systems
- High Voltage Systems
- Standby Generators
- Fire Alarms
- Emergency Lighting
- Portable Appliance Testing (PAT)
- Emergency Backup (UPS)
- Passenger & Platform Lifts
- Lightning Protection Systems
- Any other appropriate system covered by this policy.

Procedures and protocols for each of the above electrical systems underpin this policy.

2.2 MONITORING OF PERFORMANCE

The Head of Estates & Facilities will have the responsibility to ensure that the electrical systems and equipment installed within the UHB's premises are safe to use. Any equipment found on inspection to be unfit shall be removed from operational service until it has been repaired by an electrically competent person. Any system found to be unsafe shall be switched off and isolated from service until the fault is found and rectified. (Locked off tagged off- Loto)

The Head of Discretionary Capital & Compliance will have responsibility to ensure assets are regularly updated and all statutory inspections are carried out. Detailed records of inspections shall be maintained with remedial actions taken when any defects found pose a Health & Safety risk.

3.0 LEGAL REQUIREMENTS

Employers General Duties

It shall be the duty of the employer to comply with the provisions of "The Electricity at Work Regulations 1989" insofar as they relate to matters which are within their control.

Employees General Duties

It shall be the duty of every employee while at work -

(a) To co-operate with his employer so far as it is necessary to enable any duty placed on that employer by the provisions of the Electricity at Work Regulations 1989 to be complied with; and

(b) To comply with the provisions of the Electricity at Work Regulations 1989 insofar as they relate to matters which are within their control.

Employers Specific Duties

It is the responsibility of the owners and occupiers of premises; Chief Executives and General Managers to ensure that their premises comply with all statutes.

Employers have a general duty, under the Health and Safety at Work etc. Act 1974 (HSW Act 1974), as far as is reasonably practicable, to ensure the health, safety and welfare of their employees, residents and visitors to their premises. These duties are legally enforceable, and the Health and Safety Executive have successfully prosecuted occupiers of premises under this statute. It is incumbent upon both owners and occupiers of premises to ensure that there is a management regimen for the proper purchase, design, installation and operational management of plant, equipment and systems.

Employees Specific Duties

Every employee who has to work with electricity must:

(a) Make full and proper use of all protective equipment supplied by UHB and satisfy themselves that services are isolated before they work on the system.

(b) Report any defect in the electrical system or plant owned or used by the Health Board to their line manager.

(c) When a permit to work system is required or in force, the employee must ensure that he/she adheres to the UHB's safety procedure.

4.0 ROLES AND RESPONSIBILITIES

4.1 UHB RESPONSIBILITY

The UHB recognises its responsibility to implement in full the safe management of electricity in UHB premises. The UHB has a responsibility to ensure that only electrically competent persons are allowed to work on or near any electrical systems or apparatus and that regular network tests are performed, results recorded with risk assessments being performed on the findings and then action taken to remedy any defects in a priority and safe order.

The UHB has a duty to ensure that the electrically competent persons allowed to work on their systems/networks are properly trained via an ongoing training regime to ensure staff are fully conversant with the electrical regulations in force at all times.

4.2 DELEGATED RESPONSIBILITY

The Chief Executive as the Duty Holder for the premises has the overall authority and responsibility for Health and Safety and as such, to ensure compliance with the requirements under the Health and Safety at Work etc. Act 1974, the Workplace (Health, Safety and Welfare) Regulations 1992 and in particular, the Electricity at Work Regulations (1989) and any associated standards and guidelines. This responsibility may be assigned or delegated by agreement to other senior executives within the organisation, however ultimate accountability remains with the Duty Holder.

The Duty Holder shall appoint in writing, a person or persons to take executive responsibility for the management and control for the safe use of the electrical systems and equipment installed within the UHB's premises. This person shall be known as the Designated Person

The Designated Person is an individual appointed by the healthcare organisation (a board member or a person with responsibilities to the board) who has overall

authority and responsibility for the implementation of safe systems of work outlined in this policy and any other associated procedures & protocols.

He/she has a duty under the Health and Safety at Work etc. Act 1974 to prepare and issue a statement on Health and Safety at Work, including the organisational arrangements associated with this policy.

The Designated Person shall:

- Ensure that appropriate systems are in place to implement the requirements of this Policy and its procedures for all premises under their control.

- Periodically review the effectiveness of the policy and procedures in association with the Head of Estates & Facilities and Head of Discretionary Capital and Compliance where they impact on his/her areas of responsibility.

- Approve and authorise any changes to the policy and procedure guidance as advised by the Heads above.

- Appoint an Authorising Engineer, who will advise the UHB on all safety aspects associated with high and low voltage installations, and also the appointment of suitable Authorised Persons.

The Head of Estates & Facilities has operational responsibility to ensure observance of the statutory requirements imposed upon the UHB by "The Electricity at Work Regulations 1989", and shall ensure that there are sufficient competent in-house or contract staff available at all times to work safely on the electrical system should a failure or hazard occur. He shall ensure that sufficient safety testing equipment and protective clothing are kept and maintained in a safe place.

The Head of Estates and Facilities shall ensure that his technical staff are fully conversant with any variations or updates on the Safety Regulations, and act upon any Health and Safety directives, Hazard Notifications issued appertaining to the UHB's electrical services.

The Head of Estates and Facilities shall operate a "Permit-to-Work" procedure for both high voltage and low voltage systems.

The Head of Estates and Facilities shall ensure that adequate training is regularly provided to competent staff to ensure that they are at all times trained to work in a safe manner on any part of the system.

The Head of Discretionary Capital & Compliance has responsibility to ensure observance of the statutory requirements imposed upon the UHB by "The Electricity at Work Regulations 1989", with regard to statutory compliance inspections. He shall ensure that regular safety inspections are carried out and records kept and update accordingly.

[An organisational flow chart for electricity is illustrated in Diagram 1 on page 14]

4.3 CONTRACTORS

The UHB will ensure that Contractors and Sub-contractors fully comply with this Policy, the UHB's Control of Contractors Policy and any other related policy/procedure, either through compliance with their own approved Policy or through full integration into the UHB's policy. The control of work undertaken by subcontractors and its supervision will be the same as for UHB staff.

4.4 PROCUREMENT, DESIGN AND INSTALLATION OF ELECTRICAL SYSTEMS AND EQUIPMENT.

The design and installation of systems and equipment will be to standards not less than those contained in the current edition of the UHB's Electrical Specification, which will be updated as required to reflect compliance with British and European Standards, Codes of Practice and IEE Wiring Regulations (current edition).

The electrical design specification for new works and for alterations to existing installations will be carried out by suitably qualified and experienced persons. Major/complex electrical work involving the production of design specifications will be developed and validated by an appropriate Chartered Electrical Engineer in conjunction with the UHB Manager responsible for the work.

Complete records of design and acceptance tests, installed drawings and tests results, will be maintained and made available, as required to those responsible for the operation and maintenance of all electrical systems, plant and equipment.

Electrical equipment, fittings, materials, and components specified, procured and installed by the UHB will comply with appropriate British and/or European standards.

5.0 RESOURCES

The resources for the management, maintenance, testing, training, operation, monitoring and auditing of performance for electrical systems are already in place. These are an integral part of the Estate Maintenance revenue allocation however further investment may be required on a phased basis to fully conform to any future changes in the

legislative requirements for electrical installations and the implementation of this policy.

6.0 TRAINING REQUIREMENTS

The UHB will ensure through its managerial arrangements, that all employees and contractors who work with or on electrical services, receive adequate training and are competent to discharge their duties. Before any individual is put to work or placed in an environment which has the risk of electrical hazards the level of training, experience and competence will be formally assured so as to obviate, so far as is reasonably practical, the risk of danger.

Training needs shall conform to the requirements as defined in The Electricity at Work Regulations 1989 and HTMs 06-01/02/03, to standards imposed by the Institute of Electrical Engineers current Edition and by the use of appropriate safety testing apparatus. Competent staff will be trained to use and operate a "Permit-to-Work" system when working on high/low voltage systems, switch gear and transformers or when working on "live" installations or plant. Training will be provided as part of any specific skill requirements, and shall be designed to enable employees to deal competently with all aspects of electrical maintenance and installation.

7.0 FURTHER INFORMATION

Legislation

- Health and Safety at Work etc. Act 1974
- Electricity Act 1989
- The Electricity at Work Regulations 1989
- Electricity Safety, Quality and Continuity Regulations 2002
- Provision and Use of Work Equipment Regulations 1998
- The Electrical Equipment (Safety) Regulations 1994
- The Plugs and Sockets etc (Safety) Regulations 1994
- Workplace (Health, Safety and Welfare) Regulations 1992

Welsh Health Estates Guidance

- WHTM 06-01: Electrical services supply and distribution
- HTM 06-02: Electrical safety guidance for low voltage systems
- HTM 06-02: Electrical safety handbook
- HTM 06-03: Authorised Person's Logbook
- HTM 06-03: Electrical safety guidance for high voltage systems

8.0 EQUALITY

We have undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. We wanted to know of any possible or actual impact that this policy may have on any groups in respect of gender, race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment found that there was no impact to the equality groups mentioned. Where appropriate will make plans for the necessary actions required to minimise any stated impact to ensure that we meet our responsibilities under the equalities legislation.

9.0 AUDIT

The Policy is largely technical in nature with particular relevance for Estate Maintenance, Major/Discretionary Capital and Compliance & Performance Management. Adherence to the requirements of this procedure will be monitored via a number of different methods e.g. a testing regime carried out on a regular basis upon electrical switch gear, protection and earthing facilities, review of incident statistics, audits of databases etc. Records will be maintained by Estate Maintenance and management audits conducted via Compliance & Performance Management.

Technical Audits will also be undertaken by the Authorising Engineers, Authorised Persons and Competent Persons as part of their duties.

10.0 DISTRIBUTION

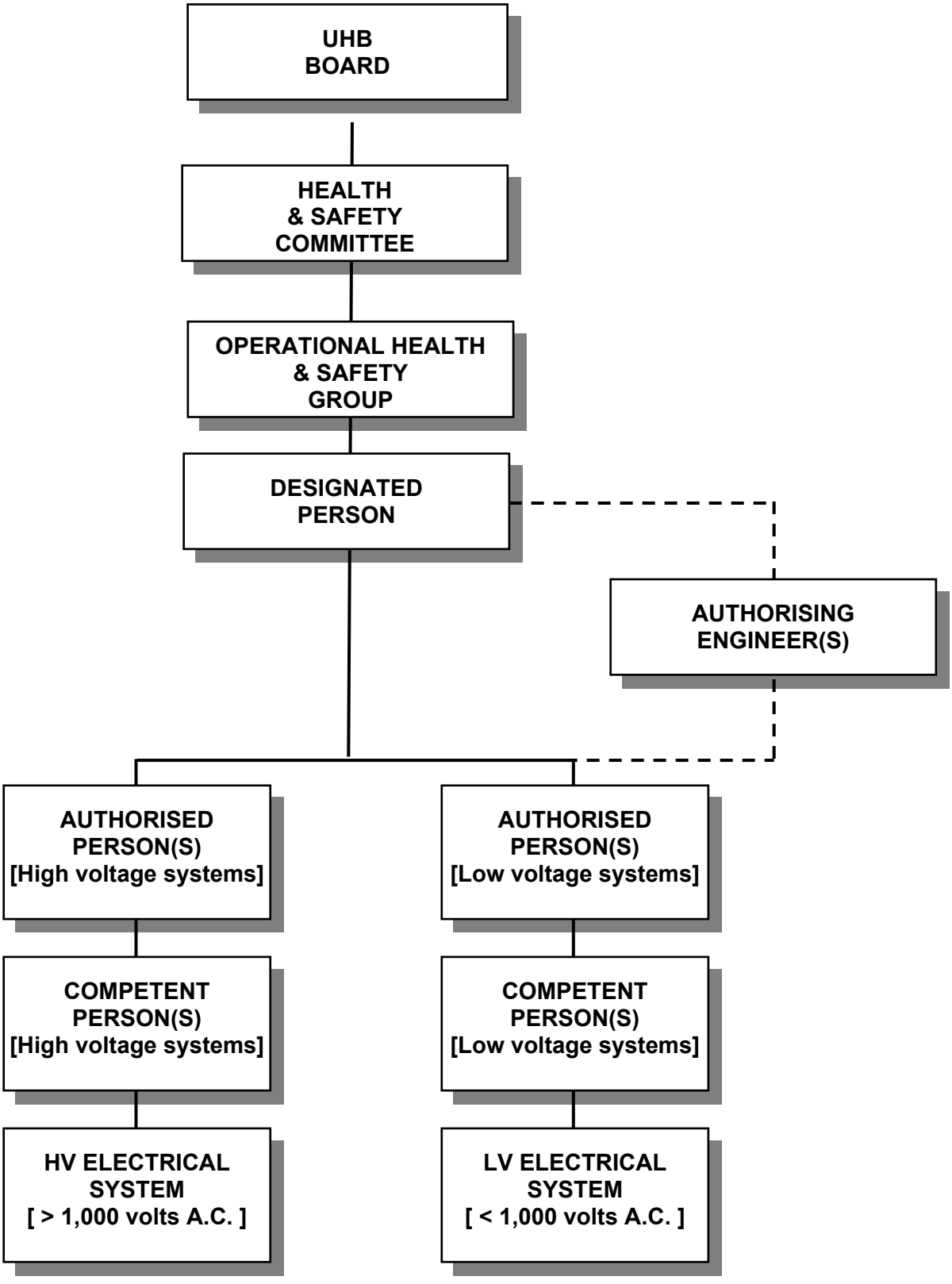
This Policy will be posted on the UHB Intranet. The Capital Planning, Estates and Facilities Department is responsible for ensuring that all relevant staff have access to this document, particularly Authorising Engineers, Authorised Persons and Competent Persons.

11.0 REVIEW

This procedure will be reviewed every 3 years, or more frequently if required, to ensure continued compliance with electrical regulations, health technical memoranda – HTM's, relevant codes of practice and best practice as appropriate.

Diagram 1

ELECTRICITY - Organisational Relationships



MINUTES OF THE OPERATIONAL HEALTH AND SAFETY GROUP HELD AT 9AM on WEDNESDAY 4TH SEPTEMBER 2019 – CEFN MABLY, WOODLAND HOUSE

Present:

Martin Driscoll	Executive Director of Workforce and O D
Charles Dalton	Head of Health and Safety
Caroline Murch	Environmental Health and Safety Adviser
Jonathan Davies	Health and Safety Adviser
Janice Aspinall	Staff Representative
Karen Lewis	Claims Department
Mal Perrett	Senior Fire Adviser
Rachael Sykes	Health and Safety Adviser
Rachael Daniel	Health and Safety Adviser
Stuart Egan	Staff Representative
Clinical/Service Board Representatives	
Alicia Christopher	Women and Children
Rhys Davies	Primary, Community and Intermediate Care
David Pitchforth	Medicine Clinical Board

Apologies:

Clare Wade	Surgery
Ian Wile	Mental Health
Jon McGarrigle	Estates Services
Matthew Price	Specialist
Nicky Bevan	Occupational Health
Peter Welsh	General Manager
Rowena Griffiths	Dental Services
Sue Bailey	CD&T

In Attendance:

Zoe Brooks	Health and Safety

OHSG: 30/19 Minutes of the Meeting held May 2018

The minutes of the meeting held on the 3rd June 2019 were accepted as a true record.

OHSG: 31/19 Action Log

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

- OHSG 03/19 – Poor condition of Community Buildings. It was noted that the Health and Safety Adviser had visited the Mental Health Community building and plans were in place to move staff out. It was also advised that this item had been added to the Priority Action Plan.

The Staff Side Representative highlighted that this was an issue for a number of community settings within Primary care also and felt that the Health Board needed to do more for the welfare of staff working in these poor conditions.

- OHSG 21/19 – Fire Training Compliance. The Chair requested that suggestions by the Senior Fire Adviser be brought forward to this Group on how the Health Board can improve Fire Training compliance. The Senior Fire Adviser agreed to give this some thought and bring back to the next meeting.

  The Head of Health and Safety agreed to also take this to the next Fire Safety Group for further discussion. **Action MP/CD**

- OHSG 26/19 – Staff Restaurant. The previous meeting discussed the notices put up in The Gegin and canteen at Llandough, prohibiting staff to eat food that they had brought in, in these areas.

  The Head of Health and Safety reported that he had discussed this with the Director of Capital Planning and facilities, who responded that other areas were available to staff.

  Staff Side Representative raised concern with the areas that had been suggested for staff and requested that a further discussion is had to look into this decision.

  The Chair agreed that this issue needed to be addressed; the Head of Health and Safety agreed to take this back to the Director of Planning and Facilities for resolution. **Action CD**

OHSG: 32/19 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 – RD highlighted that a number of items were on the agenda for the meeting and the report was submitted for information purposes.

The Chair asked if there was anything the members wanted to raise from this report or had any questions. No items raised.

OHSG: 33/19 Health and Safety Annual Report Presentation

A presentation was provided by the Head of Health and Safety on incident statistics as well as performance/interventions of the Health and Safety department for April 2018-April 2019.

The following items were raised:-

- 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.
- 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.
- 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.
- 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.

The Group **NOTED** the findings of the annual report.

OHSG: 34/19 Health and Safety RIDDOR's

A report was provided highlighting the number of RIDDOR events during the period as well as well as first quarter statistics.

The Group were informed that the Health Board had reported 18 RIDDOR events reportable to the Health and Safety Executive during the period of April – July 2019. It was considered that this figure was high based off the Annual reports reported figure for April 18 – March 2019 of 118.

The Chair queried if this included all lost time accidents relating to industrial injury.

It was noted that the report only highlighted RIDDOR events where the member of staff had taken over 7 day's absence and did not include this information.

The Chair felt that it was important for this Group to have these figures, to look at number of lost days due to industrial injury, cause and patterns. He also highlighted the need for more action to be taken to improve these figures.

The Health and Safety Adviser – CM reported that a route cause analysis had been discussed and was a topic for further discussion at the Health and Safety away day planned for later that day.

The Head of Health and Safety agreed to look into where this information is kept and include in the next report. **Action CD**

OHSG: 35/19 Enforcement Agencies Correspondence Report

The report was received and noted by the Group.

It was noted that there were no HSE correspondence during the period, however the case relating to the Contractor Fall was heard in court on the 15th July 2019. It was reported that the Health Board was fined £400K as being medium culpability and the Contractor Company was found to be of High Culpability. It was also highlighted that the Health Board incurred intervention charges of around 10k.

The Group were asked to note the content of the report.

OHSG: 36/19 Fire Safety Report

The report was received and noted by the Group.

The Senior Fire Safety Adviser reported that there had been no Enforcement notices issued during the period, however the Health Board had received three Informal Notices relating to Anwen Ward, Llandough, Ward C5 and Ward B7 at UHW.

It was highlighted that during the period a minor fire incident occurred at Hafan Y Coed on the 4th July 2019. It was noted that the fire was the result of a patient deliberately setting fire to vegetation in the external garden using a lit cigarette; on arrival of the fire service they reviewed the area and were happy that the fire was fully extinguished.

The Senior Fire Adviser raised concerns relating to the condition of the vegetation, as a subsequent investigation had revealed that there is no planned maintenance of the grounds and gardens and as such a similar event could well take place again. It was noted that the Deputy Directorate Manager for Mental Health was progress this matter as a matter of urgency.

The Senior Fire Adviser also reported on unwanted Fire signals statistics, highlighting that the Health Board generated 34 false alarms across all sites in July; with a total of 335 in the last 12 months. The Group were informed that although this number was fairly high, the figure is a reflection on the size and age of the fire alarm and detection system. It was also noted that this is a significant reduction against previous years and the Health Board continues to work with South Wales Fire Service to look at ways to continue to reduce these figures.

The Chair asked for this item to be put on to the Group Work Plan for 2020.

OHSG: 37/19 Health and Safety Priority Improvement Plan

The report was noted and accepted by the Group.

The Head of Health and Safety reported that during the period 53 milestones were identified within the 8 strategic areas, with 97 actions for improvement. It was noted that a total of 7 milestones and 22 actions were progressed sufficiently to enhance their status.

Equally, an additional item was added to the manual handling section of the plan, this related to concerns around the status of LOLER inspection of hoist slings - item 3.7 within the report.

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

It was highlighted that Clinical Board will in turn, bring their Action Plans to this meeting to benchmark and ensure concerns are being addressed.

The Representative for Women and Children commented that the Clinical Boards would welcome clarification of what is expected of them; the Head of Health and Safety suggested that the Health and Safety Department could look at holding a workshop.

It was reported that the Terms of Reference and membership would also be reviewed.

OHSG: 38/19 Health and Safety Well at Work Audit

An update was given on the potential HSE Audit. It was noted that the audit may take place sometime between October and December, however no correspondence had been received from the HSE to suggest this.

The Group were informed that Hywel Dda Health Board had recently been audited, where a number of actions were identified.

The Health and Safety Adviser highlighted that the key findings were, training compliance, Risk Assessments not being reviewed.

It was noted that the findings from both Hywel Dda and Swansea Bay Health Board were being looked at by the Health and Safety Department in-order to review our own processes and performance. Subsequently, Clinical Boards would be contacted and given guidance.

The Group were informed that it is believed the Health Board will be given four weeks' notice prior to the commencement of the audit and may request information and statistics.

The Chair re-iterated the importance of planning and having an action in place.

Clinical Boards were advised to contact Health and Safety for further information and support.

OHSG: 39/19 Staff Side Concerns/items

Concerns were raised around poor condition of buildings and cleanliness of wards and areas. It was reported that a meeting would take place with Staff Side and Head of Estates and Facility to discuss these concerns.

Staff Side Representative – Mr S Egan highlighted that there are a number of general areas within the Health Board where there is no identified responsible person, and therefor unable to get concerns resolved.

The Head of Health and Safety reported that the same issue was raised with regards to Fire Risk Assessments at the Fire Safety Group, where a programme was pulled together for inspections.

Also the lack of CCTV throughout the Health Board, Cardiff Royal Infirmary was highlighted as a concern. It was noted that the equipment was in place however not installed.

Staff Side Representative – Mr S Egan proposed that a full report on the location of CCTV throughout the Health Board would be useful. The Head of Health and Safety was asked by the Chair that this is discussed with the Head of Security. **Action CD**

Representative for Women and Children raised concern around Maternity Lifts; this is a long standing issue. It was noted that the lifts do not have an alarm, but prompts users to phone switch in case of emergency/breakdown of lift, however there is no signal inside the lift for phones to be used.
It was highlighted that this has been on the Clinical Boards Risk Register for a number of years and is raised at local meetings regularly.

The Group were informed of an incident where a patient was stuck in a lift with a member of staff, however fortunately not in active labour. The Head of Health and Safety reported that there is a programme in place for the replacement of lifts, however was not in a position to comment of timeframe or priority areas. The Head of Health and Safety agreed to discuss this with Estates. **Action CD**

OHSG: 40/19 Lone Worker

The Head of Health and Safety informed the Group that new devices were being issued and users were asked to return their old devices to the company.

It was noted that during this period the reporting function will be unavailable as staff will be link to two devices to ensure continuity of service.

OHSG: 41/19 Policies and Procedures

The following Procedures/documents were Approved at this meeting:-

- DSEAR Guidance
- Hand Arm Vibration Procedure
- Health and Safety Risk Assessment Procedure
- DSE Procedure

The Group was informed that the Thermal Comfort Procedure was due for review, however due to a number of comments being received, this document was postponed and would be brought to the December's meeting for approval.

It was noted that the following documents would be taken to the Health and Safety Committee in October. It was requested that any comments be sent to the author by the 20th September 2019.

- Contractor Control Policy

OHSG: 42/19 For Information

The Chair asked that the Part 2 of the Agenda be recorded as received and noted for information.

This included:-

Health and safety Related Procedure Schedule.
Pro Act Audit Report
The full report of the Priority Implementation Plan

OHSG: 43/19 DATE AND TIME OF NEXT MEETING:-
11th December 2019 - Ground Floor - Nant Fawr Un (1) Woodland House – 9:30am

MINUTES OF THE FIRE SAFETY GROUP HELD AT 9AM ON 14th OCTOBER 2019 – WOODLAND HOUSE

Present:	Geoff Walsh	Dir of Capital, Estates and Facilities **(Chair)**
	Charles Dalton	Head of H&S/Fire Safety Manager
	Mal Perrett	Senior Fire Safety Adviser
DFSM	Ian Wile	Mental Health
	Ian Fitsall	Estates
	Rowena Griffiths	Dental /Nurse Manager
	Scott Gable	CD&T
	Sarah Lloyd	Specialist
	Sarah Congreve	PCIC Vale
Apologies:	Abigail Harris	Executive Director of Planning
	Cheryl Evans	Women and Children
	David Pitchforth	Medicine
	Stuart Egan	Staff Side Representative

In Attendance:

19/34 Minutes of the Meeting

The minutes of the meeting held on the 25th June 2019 were **APPROVED** and **ACCEPTED** as a true record with the exception of 19/24 Fire Team – which should read March 2020 not October 2019.

19/35 Action Log

The Group **RECEIVED** the Updated Action Log from the previous meeting; all actions were completed or Agenda items.

19/36 Matters Arising

No Matters arising.

19/37 Enforcement Notice Status/ IN01-02

The Senior Fire Adviser reported that there were no Enforcement Notices in place at that time, however there were four INO1 raised relating to B5, B7 and C5 at UHW. It was also noted that an IN02 had been issued for Anwen Ward Llandough; actions for the above areas were being progressed in a timely manner.

The Chair requested that future meetings receive a report on IN01, IN02 and improvement notices issued including their current status. **Action MP**

19/38 Fire Risk Assessment Status

The Fire Safety Manager presented the summary of the Managerial actions. In relation to the recorded 12+ rated, these had been progressed and resolved by enhancing management and ownership by the local DFSMs.

DFSM – Mental Health stated that key storage had been improved but had not been totally resolved; he was continuing to progress.

It was noted that the Estates actions following the assessment are being progressed. The Senior Fire Adviser reported on the Estates actions and confirmed that future meetings would receive a detailed report.

19/39 Fire Training

A Fire Training Compliance report was presented to the Group, showing an overall compliance of 69.24%; highest record to date. The Chair commented that he was disappointed in the current level of compliance for Estates, as previously much work had been done to enhance their compliance to above 80% and that together with the DFSM for Estates/Facilities would be taking urgent action to enhance status.

DFSM – Dental requested that although Dental had been integrated into surgery Clinical Board it would be useful to segregate them for the purposes of their Health and Safety and Fire meetings.

19/40 False Alarms

The Senior Fire Safety Adviser reported that year to date there were 120 reported false alarms; this is around the same as the previous year.

The Fire Safety Manager reported that there was a planned Fire Concordant Meeting with the Fire Service, of which the continued improvement of reducing false alarms would be on the agenda, It was highlighted that 2018/19 had resulted in a 30% reduction in the number of these events for Cardiff and Vale.

19/41 Evacuation Drills

The Senior Fire Adviser reported that they were progressing two evacuation drills prior to the end of this fiscal year; the first of these being Ward A3 Link in November. It was reported that the outcome would be brought to the next meeting. **Action MP**

19/42 Evac Chairs and Mats

The Fire Safety Manager and Senior Fire Adviser presented a proposal that porters be trained to facilitate evac chair evacuation. It was noted that this would involve training around 50 staff initially on a one day course followed by a half day refresher each year.

It was considered that this was more likely to lead to compliance than the current arrangements and had been discussed and supported by the Fire and Rescue Service. Equally, the Portering Management had agreed to commit to both training and response function.

The Group were informed that the cost of this would be around £6250 for the first year, but would save significant sums in not having to release ward staff for training.

It was agreed to implement this approach and progress the relevant training. **Action MP**

19/43 C5 Fire

The C5 fire action plan was considered and progress reported. After discussion it was felt that a more concise document of lessons learnt be produced, that each DFSM's could take back to their areas. **Action MP/CD**

19/44 South Wales Concordant Meeting

The meeting was informed that a joint meeting of the South Wales Fire and rescue service, specialist services and Fire Advisers and Fire Managers from those Health Boards within the South Wales area, had been arranged for later this month.

19/45 NWSSP Audit

It was confirmed that the annual audit had been completed, signed off and submitted to NWSSP.

19/46 Fire Annual Report

The Fire Annual report was submitted and considered. The Group were also informed that this had been discussed at the October's Health and Safety Committee.

The report highlighted that between the 1st of September 2018 and 31st August 2019 there were 14 reported fires and 320 unwanted fire signal. It noted that action had been taken in regards to smoking controls within Mental Health to reduce the number of fires and that there was a 32% reduction in the unwanted fires in the previous year.

It also highlight that there had been 6 fire evacuation exercises during the period. It identified that there were a total of 236 Managerial actions required of with 27 were rated as 10 or above. These were being progressed through the DFSM meeting.

The Fire Safety Manager reported that the Committee required greater assurance that Deputy Fire Safety Managers arrangements were comprehensive and that they were actively implementing their responsibilities following fire risk assessments; reassurance to this is given via the DSFM meetings.

19/47 Any Other Business

DFSM – Estates requested an asbestos and DSEAR assessments for the tunnel area. The Fire Safety Manager considered that external advice maybe necessary but would progress this aspect. **Action CD/IF**

DFSM Mental Health requested advice with regards to Risk Assessment actions, which had been completed but then returned in the next or future inspections. The Fire Safety Manager considered that for those areas where there were repeated events that the actions should consider mechanisms for preventing re-occurrence.

19/48 Date of Next Meeting
13th January 2020, Taff Room 1st Floor, Woodland House – 1PM

Health and Safety Assurance Schedule and Priority Improvement Plan 2019/20

Health & Safety Management

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 Health and Safety team to complete analysis.	Green	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	Green	Head of Head and Safety	Jan 20
		Health and Safety Policies are appropriately reviewed and communicated to all relevant staff	Amber	Status of related Health and Safety Policies approved by other committees requires progress through relevant committees	Director of Corporate Governance has circulated shortfalls for review.	Amber	Director of Corporate Governance	Apr 20
1.2		Health and Safety Risk Assessments are included within the Board Assurance Framework (BAF) register	Amber	Implement new BAF format		Green	Director of Corporate Governance/ Head of Risk Governance	Jan 20
				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	Revised H&S risk register progressed	Amber	Head of Health and Safety	Apr 20
		Managers maintain suitable and sufficient Risk Assessments Identify some common high risk activities and produce some generic risk assessment pro-forma for local use	Red	Utilise E Datix System to monitor progress of controls identified within risk assessments	Plans to develop E Datix agreed – progress subject to patient safety resource.	Red	Director of Corporate Governance/ Head of Risk Governance	Apr 20
1.3	**Managers Safety Course**	Managers competency in their health and safety role is enhanced	Amber	Monitoring and support of health and safety management improvements post course.	Guidance and support being delivered as part of follow up to trainees	Green	Head of Health and Safety	Jan 20

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.	Project initiated. Item agenda for Health and Safety Committee.	Amber	Director of WOD	Apr 20
		Mandatory training compliance - Health Board target 85%	Amber	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 20
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	Green	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

2. Violence and Aggression

REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
2.2	**Lone Worker Advances Lone worker protection**	Ensure those at risk within both the community and on healthcare premises have systems in place for device or suitable assessment	Amber	Review of Lone Worker risks within healthcare premises	Working group formed to review Lone worker relating to non V&A	Amber 	Head of H&S	Apr 19
2.3	**Violence & Aggression response competence**	Ensure sufficient trained staff to respond to violence & aggression events	Amber	Review of training to ensure sufficient trained staff to respond.	Internal review with specialist trainers of violence & aggression to ensure response and capabilities.	Amber	All	Apr 20
				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 on effectiveness of training	Clinical Board meetings to include training status	Amber	Head of Health and Safety	Apr 20

3. Manual Handling

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**	Implementation of the Revised All Wales NHS Manual Handling Passport and Information Scheme	Amber		Action plan initiated to meet required standards by December. Progress being monitored by LED, Agored Cymru and Health and Safety.	Green	Head of Health and Safety/H	Dec 18

	Passport and Information Scheme				Review Complete		ead of LED	
		Ensure manual handling training is based on need by risk assessment	Amber	Review training against TNA	Joint review with LED completed	Green 	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
3.3	**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	Apr 20
3.5	**Management of Hoverjacks**	Suitable quantities of equipment to respond to fallen patients' needs	Amber	Validation of suitable Hoverjack quantities to respond to fallen patients' needs	New Hoverjacks purchased via Capital Funds.	Green	Assistant Director of Nursing	Jan19
		Hoverjacks considered and maintained as a lifting compliance under LOLER	Amber	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	Amber	Ownership of existing stock is established.	As above	RED	Assistant Director of Nursing	Apr 20
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 has been prepared and considered at the Operational Health and Safety Group in December 2019	Amber 	Head of procurement	Apr 20
3.7	**Sling inspections to meet Lifting Operations Lifting Equipment Regulations (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	Amber	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 meeting compliance discussed and agreed at Operational grouo	Amber 		Apr 20
3.8	**Hoisting equipment**	A number of Hoists have been identified has becoming obsolete and will no longer be usable from 2020	Amber	Bid submitted for capital funding for replacement hoists 31 hoists	Awaiting funding	Amber		Apr 20

4. Health Issues

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	Apr 20
				Identify status of Stress, Musculoskeletal Disorder , Display Screen Equipment, Workplace Environmental, Menopausal Effects	Review of programme and being reported to each Health and Safety Committee.	Amber 	Head of Health and Safety	Apr 20
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	Director of WOD	Apr 19
				Risk Assessments are valid	As above	Green	Director of WOD	Apr 19
				Monitoring that ensures high risk areas have complete compliance.	Personal Monitoring Plan established for high risk areas to ensure compliance with workplace exposure limits.	Amber	Head of Health and Safety	Apr 20
		Identified Control Measures are implemented	Amber	Mechanism for minimising the effects of hazardous substances.	Action plans are being developed for high risk areas following monitoring to determine any gaps in control measures	Amber	Head of Health and Safety	Apr 20
				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. Revised Risk Assessment form produced	Green 	Director of WOD/Head of Occupational Health	Jan 19
		The Health Board 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	Apr 20

							and Safety	
				Specialised group to monitor and develop proactive actions	Funding has been secured from Health Lottery for additional wellbeing practitioners for a period of 2 years; these are currently being progressed.	Amber 	Head of Occupational Health /Head of Health and Safety	Apr 20
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	Programme of work has been initiated and is being progressed.	Green 	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 DSEAR Guidance approved at the Fire Safety Group and Operational Health & Safety Group and being implemented through each clinical board as appropriate.	Amber	Identification and full DSEAR assessment for complex areas to be completed by local areas		Green 	Clinical Board Leads	Apr 19

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

REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
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			Green		

		Survey of windows undertaken and restrictors fitted		Anti-tamper devices fitted to all restrictors	Review of restrictors in self harm areas to fit anti tamper screws	Red	Director of Planning	Apr 20
5.4	**Local Control of Water Safety**	Low use water outlets are flushed at agreed intervals	Red	Audit and monitoring of flushing mechanisms	Reported improved attendance at Water Safety Group. Review of database initiated to improve flush monitoring.	Amber 	Local Health Board Leads	Apr 20
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 needs undertaken, further work required to diminish fire, staff and dignity issues	Amber	Assistant Director of Nursing	Apr 20
				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 20
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 20
		Progress an enhanced programme to electronically store, where possible medical record	Red	Progress an enhanced programme to electronically store, where possible medical records	Project under review	Red	Head of Medical Records	Apr 20

6. Fire Safety Management

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	Apr 20

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	Fire Safety Group reviewed team approach to evacuation chairs .agreed	Green 	Senior Fire Adviser/Fire Safety Manager	Jan 20
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	A3 evacuation undertaken	Green 	Director of Planning	Jan 20

7.1 Health and Safety Estates Management.

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	Apr 20
7.2	**Contractor Control**	Contractor control within remit of **estates** has effective mechanisms for monitoring and reacting to safety breaches	Amber	Reported at Operational Health and Safety Group	Reported at Operational Health and Safety Group	Green	Director of Planning	Oct 18
		Permit system in place for contractor work of specified high risk areas	Amber		Enhanced permit system under development	Amber	Director of Planning	Apr 20
7.3	**Asbestos**	Asbestos database to ensure that Asbestos Register has evaluated asbestos status for all areas	Amber	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 20
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 20
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	Definitive plan for zone 1 access control system initiated for October 2019.	Amber	Director of Planning	Apr 20
				Implement pedestrian safety within identified key high risk areas	Within cost restriction being progressed	Amber	Director of Planning	Apr 20

8. Sharps Safety

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	Jan 20

Report Title:	**UNIVERSITY HOSPITAL LLANDOUGH (MAIN SITE) FOOD PRODUCTION, RESTAURANT and WARDS FOOD HYGIENE INSPECTION - 19th September 2019**						
Meeting:	**Health & Safety Committee.**				**Meeting Date:**	**21st January 2020**	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	**Director of Planning**						
Report Author (Title):	**Commercial Services Manager**						

SITUATION

An inspection of the Food Production, Restaurant and Ward areas at University Hospital Llandough (UHL) took place on 19th September 2019 the outcome of which was confirmed in a letter/report dated 30th September 2019 from the Commercial Services Officer, Food and Port Health, Bridgend, Cardiff and Vale of Glamorgan Shared Regulatory Services.

The report noted that the listed service areas at UHL were awarded a score of **5 (Very Good)** in the National Food Hygiene Rating Scheme.

REPORT

BACKGROUND

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

ASSESSMENT

An action plan has been produced by the UHL Catering Management teams across the Commercial & Facilities Services and reviewed by the Commercial Services Manager to address the issues raised. The plan is attached as appendix 1 to this report which will be monitored within the service by the Service Board Compliance team, to ensure that all actions are completed by the agreed dates.

ASSURANCE is provided by:

The maintenance of the Food Hygiene Rating score of **5 (Very Good)** and corrective actions taken immediately.

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.
- Monitoring of the Action Plan will be undertaken by the CEF Compliance team who are independent from the commercial services directorate.

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 at University Hospital Llandough on 19th Sept. 2019 (Report Dated 30th Sept. 2019)

Schedule A – Legal Requirements

Food Hygiene and Safety Procedures High standard of compliance with statutory obligations, and industry codes of recommended practice, with only minor contraventions.	**Response / Action**	**Time Scale**	**Update**
1. An Egg Mayonnaise sandwich was found in the fridge of West Ward 1 which was past its use-by date by one day. The use-by date is the date until which the manufacturer of the food guarantees it is safe to eat. Food sold beyond its use-by date may be of poor quality or unfit. It is an offence to sell or expose for sale food with an expired use by date. You must check your stock daily and dispose of any out of date food. I am aware that the sandwich had been labelled with a patients details and was probably brought in by a visitor specifically for the patient however all foods need to be checked to ensure they are not used past their shelf life. *Article 14(1) of (EC) 178/2002*	Sandwich disposed of immediately.	Immediate	Completed
2. Washed and cut plated salad had been plated next to individual portions of pre wrapped cheese and Branston Pickle and then covered with cling film. This may create a risk of cross contamination; you may consider wrapping the salad separately to the cheese and pickle. *Regulation (EC) No 852/2004 Annex II Chapter IX para 3*	Salad to be wrapped separately from cheese and pickle individual portions. Additionally, any other condiments e.g. mayonnaise sachets supplied separately.	Immediate	Completed
3. To prevent any possible cross contamination, ensure the probes are stored in the pouches provided when not in use at ward level. *Regulation (EC) No 852/2004 Annex II Chapter IX para 3*	Ward staff instructed to store probes as per recommendations.	Immediate	Completed

Structural / Cleaning Issues High standard of compliance with statutory obligations, and industry codes of recommended practice, with only minor contraventions.	Response / Action	Time Scale	Update
4. The following items and equipment were dirty: • The Plastic dispenser in general preparation area of the Main Kitchen • The seals of the fridges in Ward West 1 & 2 Kitchens • The seals to the dishwasher in Ward West 1 Kitchen • The Spray nozzles to two sinks in the Pot Wash room • There was a Lime scale build up around tap inserts and groves at ward level and in the Restaurant area. These must be thoroughly cleaned and maintained in a clean condition. *Regulation (EC) No 852/2004 Annex II Chapter V Para 1(a)*	All items / equipment listed to be cleaned and staff instructed to ensure they follow agreed cleaning schedules and maintain 'clean as you go' ethos.	Immediate	Completed
5. The condition of the white ceramic dish in the Kitchen has deteriorated and can no longer be thoroughly cleaned / disinfected. Do not use the white ceramic dish and remove from the premises. *Regulation (EC) No 852/2004 Annex II Chapter V Para 1(c)*	The ceramic dish had minor chip and was removed at time of inspection.	Immediate	Completed
6. The seal to the dishwasher in Ward West 2 and the white trolley in the Main Kitchen were damaged and cannot be adequately cleaned. Repair or renew the Dishwasher seal and the trolley to allow it to be thoroughly cleaned and where necessary disinfected. *Regulation (EC) No 852/2004 Annex II Chapter V Para 1(c)*	New dishwasher to be purchased for ward. White trolley to be disposed of.	30 Nov 2019	Completed
7. The door seal of the Aroma refrigerator in the Main Kitchen was split, renew the door seal. *Regulation (EC) No 852/2004 Annex II Chapter V Para 1*	The refrigerator to be re-inspected by Estates Maintenance and seal repaired / replaced as required.	30 Oct 2019	Completed

8. Some of the raw plugs to the tiles in the Main Kitchen were not filled. Fill the Raw plugs to leave a sound easy to clean surface. *Regulation (EC) No 852/2004 Annex II Chapter II Para. 1(b)*	Maintenance requests submitted to Estates Team for repairs to be undertaken. Clarification to be sought from EHO's as to actual location of raw plugs.	30 Nov 2019	Completed
Confidence in Management / Control Procedures Good record of compliance. Food safety advice available in-house or access to, and use of, technical advice from a Primary or Home Authority, trade associations and/or from Guides to Good Practice or assurance scheme commensurate with type of business. Effective management control of Hazards. Having effective self-checks with satisfactory documented food safety management procedures commensurate with type of business. Audit by Food Authority confirms general compliance with procedures with minor non-conformities not identified as critical to food safety.	**Response / Action**	**Time Scale**	**Update**
9. At the time of Inspection I looked at the Food Safety Management documentation and associated monitoring records. The following were noted in the Food Production & Restaurant Services Food Safety Management Document:			
• In Section 7.1: Cleaning Sanitising and disinfection you should include the shelf life of D10 once diluted and to ensure staff check the dates on the D10 pouches to ensure the sanitiser is not used beyond its shelf life	HACCP document to be amended accordingly to reflect D10 requirements Re: shelf life.	Immediate	Completed
• If any raw foods are defrosted for the restaurant the Thawing of frozen food table on page 26 should clarify where and how raw foods are defrosted e.g. defrost raw meat in the raw meat fridge in a container etc.	HACCP document to be amended accordingly to reflect thawing of foods requirements as outlined.	Immediate	Completed
• Include in the document that Carrot Batons and grated carrot are not ready to eat foods items and to confirm the cleaning/washing	HACCP document to be amended accordingly to reflect that both pre-packed baton and grated carrots are not ready to	Immediate	Completed

procedure required if any if they are ever used raw as they come in pre- bagged. More detail is also required on the instruction sheet for the brown/green board use as detailed in Section 9.1, also include in Section 9.1 that a clean knife is to be used once staff proceed to the green chopping board. *Regulation (EC) 852/2004 Article 5*	eat foods and require washing. The same will apply to pre-packed sliced red onions. Procedure to be updated for brown / green boards and use of knife.		
10. I note that the control measure in the HACCP table for Ward Hot Meal Trolley Storage and Food Plating states cold holding sandwiches removed from refrigeration on request of patient. Include to point 6 (page 5) of the Ward Catering Food Safety Management Document (HACCP) that following transportation to the wards sandwiches are taken from the trolley and put into the fridges in the Ward Kitchens. *Regulation (EC) 852/2004 Article 5*	Amendment to be made to Ward Catering HACCP document.	Immediate	Completed
11. Ensure all monitoring forms are correctly completed: • The Freezer records at 12:30 for the 16/09/19 have corrective actions but no temperatures were recorded for areas 2 & 3.	All staff to be reinstructed in respect of completion of monitoring forms including recording of temps.	Immediate	Completed
• On 16/09/19 Frozen Egg was delivered and recorded at -16.9°C with no corrective action recorded. There were no temperature requirements on the delivery forms that I looked, having specified temperatures on the form would aid staff and ensure compliance with your Food Safety Management System. *Regulation (EC) 852/2004 Article 5*	All staff to be reinstructed in respect of completion of monitoring forms including ANY corrective action if temperatures above critical limit.	Immediate	Completed

Schedule B – Recommendations and Advice

Recommendations	Response / Action	Time Scale	Update
1. I recommend blocks of patients personal cheese are dated when opened.	Original package to be retained and an 'opened on date' to be put on the package. Manufacturer's instruction followed for use by date. Increase staff awareness to this at ward level.	Immediate	Completed
2. I recommend reflective film (or similar) is fitted to some of the ward Kitchen windows to help with keeping the Kitchens cool.	Liaison with Estates to continue to ensure blinds are ordered and fitted where required.	31 March 2020	In progress
3. I recommend the alarm of the external probe to the fridges on the wards is set to 5°C rather than 8°C to ensure consistency and having regard to Listeria. I am aware the temperature of the fridges at ward level were below 5°C and the monitoring records showed operating temperatures to be at 5°C or below.	Ward Based Catering to set temperature tolerance levels to 5°C order. New probe for inside the fridge to be ordered (if / as required) if alarm on current probe does not reduce to 5°C.	30 Nov 2019	Completed but continue to review.
4. I recommend a yellow board and knife is used to cut cooked meat in the restaurant rather than the bread board and knife which was in use at the time of inspection.	Both white and yellow handle knives and boards to be used to ensure segregation when cutting products e.g. cooked sausages, bread rolls.	Immediate	Completed

Version 1 – Draft ref. SW / JP / LN / JS (5/10/19)
Version 2 – Final SW / JP / LW / JS (6/12/19)

Report Title:	**CENTRAL FOOD PRODUCTION UNIT, UNIVERSITY HOSPITAL OF WALES (UHW) FOOD HYGIENE INSPECTION – 24th September 2019**						
Meeting:	**Health & Safety Committee.**				**Meeting Date:**	**21st January 2020**	
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 24th September 2019 the outcome of which was confirmed in a letter / report dated 3rd October 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.

An action plan has been produced by the Catering Services Manager to address the issues raised and is attached as an appendix 1 to this report**.** This will be monitored, by the Service Board compliance team to ensure that all actions are completed by the agreed dates.

ASSURANCE is provided by:

- The maintenance of the Food Hygiene Rating score of **4 (Good).**
- Monitoring of the Action Plan will be undertaken by the CEF compliance team, who are independent of the Commercial Services Directorate.

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 24th September 2019 (Report dated 3rd October 2019)

Schedule A – Legal Requirements

Food Hygiene and Safety Procedures		Time Scale	Update
At the time of inspection, a plastic handled ladle was removed from use as the plastic cover had deteriorated and pieces of the plastic covering were missing. Equipment checks must be more rigorous and damaged or deteriorating utensils/ equipment removed from use. Damaged utensils/ equipment cannot be effectively cleaned and pose a risk of contamination to foods from possible foreign body contamination. **Regulation (EC) No 852/2004 Annex II Chapter V para 1**	• This was removed at the time of inspection and the introduction of a visual inspection check list in place and will form part of the reviewed HACCP document	30/11/19	Completed
In holding freezer 1, a delivery of boxed frozen raw fish had been placed on top of a box of frozen ciabatta rolls. Whilst this is not permanent storage and both items were boxed, it is poor practice as discussed and staff must be reminded to ensure that all raw and ready to eat foods are kept separate at all times due to the potential risk from cross contamination. **Regulation (EC) No 852/2004 Annex II Chapter IX para 3**	• This was corrected at time of inspection and staff have been retrained on the separation of raw and cooked foods.	22/11/19	Completed
In the despatch room, boxes of picked items for ward delivery were at ambient temperature awaiting delivery. Within the boxes were a range of products but which included cooked meats and sandwich fillings which according to labels and your HACCP must be stored at no more than 5 deg C. An infra red	• All ready to eat products requiring temperature control are now delivered in the thermos carts and not on the top, ensuring temperature control throughout the delivery process	11/10/19	Completed

reading taken as indication showed more than 7 deg C. Staff must ensure that such products are not held at ambient but are transferred in accordance with the chill chain. **The Food Hygiene (Wales) Regulations 2006 Schedule 4**			

Structural / Cleaning Issues	Response / Action	Time Scale	Update
The covered wall socket in the pot wash area of the high risk area was damaged with broken plastic casing evident. Replace the damaged casing and leave in a sound, safe condition. **Regulation (EC) No 852/2004 Annex II Chapter I para 1**	• Socket replaced and in a safe sound condition	11/10/19	Completed
The trolley in the portioning room was damaged. Repair/ replace the shelf to the trolley and leave in a sound, easily cleansable condition. **Regulation (EC) No 852/2004 Annex II Chapter V para 1**	• Trolley disposed and new one purchased	11/10/19	Completed
The condenser tray in Holding freezer 2 was damaged resulting in a large ice buildup. Repair/ replace as necessary and leave in a sound, working condition. Remove excess ice buildup. It is noted that this has been reported to maintenance teams. **Regulation (EC) No 852/2004 Annex II Chapter V para 1**	• Condenser tray replaced and ice build-up removed	15/11/19	Completed

Confidence in Management / Control Procedures	Response / Action	Time Scale	Update
I have reviewed your food safety management system following its latest review and have concentrated on those elements requiring updates following the last inspection in March 2019 but also having regard to the issues identified above and recent ward catering storage concerns. As follows: - You have chosen to include the ward despatch facilities and processes within the main CPU HACCP. Whilst you have now developed a flow chart for processes for rte despatch / ambient despatch there does not appear to be a haccp chart for these processes and there is nothing within the main CPU process HACCP that will cover this as despatch is limited to the frozen meals for regeneration (which is as it should be). Within the rte flow diagram you have listed 4 CCP's however their numbering clashes with those of the CPU main processes e.g. CCP2 is both cooking of high risk for CPU products and also storage of rte in the ward despatch area. This is confusing. - You must develop a haccp chart for the despatch ward activities and this must also include the rewrapping of the frozen products (those that are split into smaller bags for the wards. - I would strongly advise that you completely separate	• A full review of the CFPU HACCP to be completed by Catering Services Manager. This will be shared with the Primary Authority Partnership now in place to review. • HACCP training will be completed with all CFPU staff once new document completed.	31/12/19 30/01/20	In progress In progress

out the activities. The CPU is a stand alone approved facility for the production of cook/ freeze meals and the HACCP must be for this alone. Any other activities such as storage of retail/ storage and despatch to ward/ rewrapping of frozen foods for wards etc should be taken out of the main CPU HACCP and have their own HACCP which can run alongside. Rewrapping is an approvable activity but sits to one side of the main production HACCP. To try to amalgamate all the activities in the one HACCP has resulted in processes being missed and a duplication of CCP's which then causes confusion. - The reporting of sample results to EH Department. There are numerous references to this in the HACCP document in relation to micro and environmental swabbing. Some have been updated but they are not all consistent. As a department we would like to receive results on a monthly basis, or sooner if an unsatisfactory result is received, which allows us to have an oversight in relation to our responsibilities to approved premises. At present there are references in the document to receiving all results which are weekly to unsatisfactory results only - We have recently discussed the issue of the wards defrosting frozen meals and reheating from defrost due to an issue with their freezers. We were advised that this was not agreed with you and the meals are regen from frozen only. The label confirms this and the regen times are based on a frozen product. However, having re read your freezer breakdown instructions in the HACCP in light of this issue, I note that the CPU HACCP allows for the product to be used once defrosted should there be a freezer breakdown. The HACCP gives a range of instructions based on the freezer temperatures. As the product would then be	• Two separate HACCP documents to be created, CFPU production, CFPU decanting and distribution and reviewed by Primary Authority Partnership. • Sample swab results will be shared monthly or earlier if results are unsatisfactory • Freezer breakdown procedure to be discussed at next compliance meeting (11-12-19) as it affects all UHB HACCP documentation.	31/12/19 30/11/19 31/12/19	In progress Completed In progress

used from chilled, your labels and regen instructions will be incorrect. You must therefore decide which is the correct route and if the product can be used from chilled then you will need to amend labelling, regen instructions etc and also validate this through appropriate sampling - You will note above that at the time of inspection a damaged ladle was found in the high risk area. On 3 of the last 4 inspections we have found damaged utensils in the high risk area that have had to be removed at our request. Your HACCP states that utensils/ equipment are' maintained in good working order at all times. The maintenance of equipment however must be properly monitored and controlled'. In my opinion this is not the case as such damaged equipment should be removed by staff and we should not be repeatedly finding such items upon inspection. - You will note the issue as detailed above with regards the ward foods being stored outside of temperature control contrary to your requirements - CCP 3 – portioning/ blast chill. I note that the product is given 30 minutes to reach between 65 / 70 deg C before going into the blast chiller. On page 27 a corrective action is given as extending for another 30 minutes before blast chilling if this temperature is not achieved. This is contrary to current cook/ chill/ freeze guidance which states that 1 period of 30 minutes can be given before blast chill. This will need review and update. - At the time of inspection, the dishwasher rinse temperature in the high risk area was checked a number of times and reached 79deg C and 80 deg C. We were advised that it had recently been calibrated and the records have been forwarded which show 84 deg C being reached on the rinse cycle. The records	• New visual inspection equipment checklist in place and monitored by supervisors • Ready to eat products for ward delivery distributed in the temperature controlled trollies and no longer on top • Blast chill procedure reviewed and monitoring forms amended to reflect the changes • Staff to be formally retrained on the recording of temperatures and corrective actions required and monitored regularly.	30/11/19 11/10/19 11/10/19 31/12/19	Completed Completed Completed Completed

for 20/09 and 23/09 show 81 deg C. Your HACCP monitoring form on p46 requires action to be taken if the temperature does not reach 82 deg C, however no action was recorded. - The wall poster in the portioning room refers to a cook temperature of 70 – 75 deg C; this is contrary to your HACCP which states 75 for 30 seconds or 82 for 6 seconds. This poster must be amended or removed. - The records for roast beef cooked on 23/09 gave a cook temperature of 75 – 78 deg C as an average for the joints cooked. It would be preferable for each joint to be recorded rather than a range given. - I note that with regards training, the HACCP states that all Cooking staff 'are trained to Intermediate level'. This is now Level 3 and as far as I'm aware the majority if not all cooking staff have level 2 contrary to the HACCP. - With regards admin, it would appear that the review has knocked the pages out of sync with the front index re page numbering/ feed areas are still included on audits and on page 24 Having regard to the above, which is not exhaustive, you must review the HACCP fully. There are a number of instances where that stated in the HACCP is not being followed/ in place and this needs to be rectified as a matter of urgency as either staff must follow the HACCP processes or the processes be amended to complement practice. You will note that all the issues detailed in the 'food hygiene and safety procedures' above are actions contrary to those detailed in your HACCP. Failure to address these issues could have a significant impact on the hygiene rating following your next inspection. **Regulation (EC) No 852/2004 Article 5**	• The poster has been removed • Monitoring forms to be amended to reflect the introduction of probing a higher proportion of joints. • Food safety training level 3 to be completed by all cooks and supervisors and is currently being scheduled. • This will be amended during the review and creation of the new HACCP documentation	03/10/19 30/11/19 30/01/20 31/12/19	Completed Completed In progress In progress

Schedule B – Food Standards Inspection Report
Legal Requirements

Recommendations	Response / Action	Time Scale	Update
Not assessed on this inspection			

Schedule C – Health and Safety Advice
These recommendations provide advice on good practice:-

Recommendations	Response / Action	Time Scale	Update
Not assessed on this inspection			

Schedule D – Recommendations and Advice
<u>These recommendations provide advice on good practice:-</u>

Recommendations	Response / Action	Time Scale	Update
There was an airlock to the hot water tap to the hand wash basin in low risk resulting in slow/ poor water flow to the hot tap with delayed water. This should be remedied to allow for immediate hot water.	• Maintenance called and repair completed	11/10/19	Completed
There was a small amount of paint damage to the wall and pillar in the low risk area that should receive attention to prevent further deterioration.	• Maintenance called and repair completed	11/10/19	Completed
The varnish coating to the wooden shelving to the dry stores is starting to deteriorate and should receive attention to prevent further deterioration.	• Maintenance called and repair scheduled.	31/12/19	In progress
Ice buildup was noted to Holding freezer no 1 which should receive attention to ensure efficiency is maintained.	• Maintenance called and build-up of ice removed	11/10/19	Completed

Report Title:	**ROOKWOOD FOOD HYGIENE RE-INSPECTION – 25th November 2019**						
Meeting:	**Health & Safety Committee.**				**Meeting Date:**	**21st January 2020**	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	**Director of Planning**						
Report Author (Title):	**Operational Services Manager**						

SITUATION

A re-inspection of the Ward Kitchens and Main Kitchen at Rookwood Hospital took place on 25th November, 2019 the outcome of which was confirmed in a letter / report dated 26th November, 2019 issued by the Commercial Services Officer, Food Safety and Port Health, Shared Regulatory Services, Bridgend, Cardiff and Vale of Glamorgan,.

The report noted that the Kitchens at Rookwood received an overall score of **5 (Very Good)** in the National Food Hygiene Rating Scheme.

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 action plan has been produced by the Operational Services Manager to address the issues raised and is attached as an appendix 1 of this report**.**
The plan will be monitored by the Operational Services Manager, to ensure all action are completed by the agreed dates.

ASSURANCE is provided by:

- The maintenance of the Food Hygiene Rating score of **5 (Very Good).**
- Monitoring of the Action plan will be undertaken by the CEF Compliance team, who are independent from the Facilities Directorate.

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

DRAFT

Action Plan from Food Safety Inspection on 25th November 2019 (Report dated 26th November 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. High standard of compliance with statutory obligations, and industry codes of recommended practice, with only minor contraventions.	**Response / Action**	**Time Scale**	**Update**
During the inspection, a few metal containers were being stacked while still wet in the main kitchen. This will support microbiological growth you must ensure all equipment is dried thoroughly and allowed to cool before being stacked *Regulation (EC) No. 852/2004, Annex II, Chapter IX, Para 3*	Supervisors and staff have been met with and daily check sheet updated. New laminated notice being placed next to racking	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**

The plastic Tupperware container storing cereal in the ward kitchen for wards 4&5 had cracked and cannot be adequately cleaned. Replace the damaged container *Regulation (EC) No 852/2004 Annex II Chapter v Para 1(c)*	Plastic container replaced on day of inspection	Immediate	Completed
There was gaps noted in the following areas			
To the ceiling and pipe above the raw preparation table in the main kitchen	Repaired on the day of Inspection	Immediate	Completed
Around pipework running through the wall In ward 7	Gaps filled on 3rd December 2019	Immediate	Completed
Ensure these gaps are filled to ensure any possible pest entry into the premises *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 2 (c)*			
The door seal of freezer 2 in the main kitchen was dirty clean the door seal *Regulation (EC) No 852/2004 Annex II Chapter v Para. 1(a)*	Cleaned on the 25/11/19	Immediate	Completed
A number of door handles to the fridges and freezers in the kitchen were sticky .ensure that all the hand contact points are cleaned and disinfected regularly *Regulation (EC) No. 852/2004, Annex II, Chapter v, Para 1 (a)*	Supervisors checking on daily kitchen checks Cleaned on the 25/11/19	Immediate	Completed
All areas where food is stored or handled must have lighting of sufficient intensity to allow food preparation to be carried out safely and cleaning to be carried out thoroughly			
The lighting in the dry goods store off the main kitchen wasn't bright enough . *Regulation (EC) No 852/2004 Annex II Chapter 1 Para 7*	Light bulb changed on 26th November	Immediate	Completed

There was lime scale build up on the ends of the hot water taps in ward 5 and ward 7 Kitchens *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1* The pipework in the following areas need cleaning and/or redecoration; The pipes below the D10 dispensers in the pot wash area were dirty and peeling paint; The pipes on the wall behind the chopping board rack in the salad preparation area were flaking paint. *Regulation (EC) No 852/2004 Annex II Chapter I Para 1*	Taps cleaned on day of inspection and placed on cleaning scheduled. Pipes cleaned and painted	Immediate Immediate	Completed Completed
Confidence in Management / Control Procedures **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.	**Response / Action**	**Time Scale**	**Update**

Audit of the current food safety policy document and monitoring records identified the following:			
Your HACCP specifies that food held in a hot part of the new trolleys must be kept above 63c you must also ensure chilled food in the trolleys is kept at 5c or colder I suggest the use of dummy food and not relying on the digital displays.	Dummy water bottles to be used to ensure temperatures are at the correct level.	Immediate	Completed
The delivery temperature hadn't been recorded for a frozen delivery on the 22/11 and a milk delivery on the 4/11 all staff are required to monitor and record the delivery temperature then a specific temperature needs to be recorded	Staff have been met with and the importance of recording temperatures and completing corrective actions has been discussed and potential severity of outcome explained to them.	Immediate	Completed
There are some areas in your HACCP where the word should has been used instead of must if a control has to be carried out then staff must do this and not should do;	Wording in HACCP document has been changed.	Immediate	Completed
Staffs are required to wear red disposable aprons when handling or preparing raw meat. This needs to be included in your HACCP *Regulation (EC) No. 852/2004 Article 5*	H.A.C.C.P document to be reviewed and changed.	Immediate	Completed

Schedule B – Recommendations and Advice

Recommendations	Response / Action	Time Scale	Update
These recommendations provide advice on good practice:-			
Bottles of squash were being stored in the same cupboard under the sink in the kitchen serving wards 4&5 I recommend you move the squash from the cupboard	Bottles moved to an alternative cupboard in the kitchen	Immediate	Completed
The microwave in the John Pathy kitchen was dirty, whilst the microwave is made available for staff use only, you must ensure that it is maintained in a clean condition	Unit manager spoken to supervisors will check microwave on a regular basis	Immediate	Completed
I understand the external pipework and drains outside ward 7 kitchen are being repaired on the 26/11/19 please update when these works have been completed	Pipe work completed 26/11/19 and new drain cover with reinforced wiring put in place	Immediate	Completed

Report Title:	**BWYD BLASUS CATERING UNIT, CONCOURSE, UNIVERSITY HOSPITAL OF WALES FOOD HYGIENE INSPECTION - 28th NOVEMBER 2019**						
Meeting:	**Health & Safety Committee.**				**Meeting Date:**	**21st January 2020**	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	**Director of Finance**						
Report Author (Title):	**Commercial Services Manager**						

SITUATION

An inspection of the Bwyd Blasus Catering Unit at University Hospital of Wales (UHW) took place on 28th November 2019 the outcome of which was confirmed in writing in a letter report dated 2nd December 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 listed service area at UHW was awarded a score of 4 **(Good)** in the National Food Hygiene Rating Scheme.

REPORT

BACKGROUND

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

ASSESSMENT

On receipt of the letter report, an action plan was developed by the Commercial Services Catering Management team and reviewed by the Commercial Services Manager to address the issues raised. The Commercial Services Officer advised that work, or work considered equally effective to address issues raised must be completed by 31st December. The action plan is attached as appendix 1 to this report which will be monitored within the service by the Service Board Compliance team.

ASSURANCE is provided by:

The maintenance of the Food Hygiene Rating score of **4 (Good)** and corrective actions taken to redress any contraventions.

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 for Bwyd Blasus Catering Unit, UHW on 28th November 2019 (Report Dated 2nd December 2019)

Schedule A – Legal Requirements

Food Hygiene and Safety Procedures High standard of compliance with statutory obligations, and industry codes of recommended practice, with only minor contraventions.	**Response / Action**	**Time Scale**	**Update**
General 1. 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 number of staff were observed turning off the taps without using paper towel. *Regulation (EC) No 852/2004 Annex II Chapter VIII paragraph 1*	Whilst hand operable taps are in situ, signs are displayed at every WHB across units re: correct hand washing procedure. All UHB and agency staff written to regarding hand washing / food safety matters and re-instructed to wipe down WHB after hand washing with paper towel and dispose of. (The replacement of taps to either lever style or similar across catering areas will be reviewed with Estates Maintenance to assess impact).	31 Dec. 2019	Completed
2. There was evidence of food debris on the blade of the heavy-duty can opener in the kitchen, this could cause contamination of the food in the next tin opened. This part of the can opener must be cleaned and sanitised regularly. *Regulation (EC) No 852/2004 Annex II Chapter V Para 1(a)*	Can opener in constant use. Blade of heavy-duty opener to be thoroughly cleaned.	Immediate	Completed

Structural / Cleaning Issues High standard of compliance with statutory obligations, and industry codes of recommended practice, with only minor contraventions.	Response / Action	Time Scale	Update
3. The green colour coded board in the concourse kitchen was becoming scored and can no longer be thoroughly cleaned / disinfected. Replace the affected board. *Regulation (EC) No 852/2004 Annex II Chapter V Para 1(c)*	Board to be disposed of and replaced with new. (NB new boards ordered pre-visit but delivered day after inspection).	Immediate	Completed
4. The rinser tap nozzle and handle to the sink next to the dishwasher in the kitchen was dirty, thoroughly clean the rinser tap paying attention to the nozzle and handle. It was also noted that the base of the pipe was becoming rusty and will require replacing. *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*	All items listed to be cleaned and staff instructed to ensure they follow agreed cleaning schedules. Pipe to be replaced.	Immediate 31 Dec. 2019	Completed Completed
5. The following were dirty and required thorough cleaning: • There was lime scale building up around the tap from the hot water dispenser; • The blade to the table mounted tin opener in the kitchen; • The cling film dispenser. *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*	All items listed to be cleaned and staff instructed to ensure they follow agreed cleaning schedules.	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.			
6. You have put in place a documented Food Safety Management Procedure based on HACCP principles. However, I would make the following observations; • Staffs were relying on the digital displays for monitoring the temperatures of the fridges and freezers and then carrying out independent probe checks on a monthly basis. As discussed, weekly probe checks would be more appropriate; • Temperatures above your critical limit of 5°C had been recorded for a number of fridge and the display chiller, however no corrective actions had been recorded. You must ensure that staff document any corrective actions carried out; *Regulation (EC) 852/2004 Article 5*	As part of HACCP review, ensure monitoring form in situ 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. All UHB and agency staff written to for adherence to monitoring of temperatures, independent probe checks and recording corrective action taken.	31 Dec. 2019	Completed

7. 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. The following issues were noted at the time of inspection; • Some staff were unclear on the correct contact time required; • Some staff were unclear on the 2 stage cleaning process, staff must ensure that food debris is removed prior to disinfecting with the D10; *Regulation (EC) No 852/2004 Annex II Chapter V paragraph 1a*	Staff previously trained and information displayed regarding cleaning. Management to ensure all staff have received training but more so are verified as competent. Follow up checks to be undertaken by management / supervisors and signed off. All UHB and agency staff written to ensuring awareness of cleaning regimes is correct including adherence to cleaning schedules and contact time of cleaning products i.e. D10.	31 Dec. 2019	Completed

Schedule B – Recommendations and Advice

Recommendations	Response / Action	Time Scale	Update
8. A cup of coffee was noted in the preparation kitchen during the inspection. Staff must be reminded that eating and drinking is not permitted in food handling areas.	Member of staff was courteous and escorted EHO to service area and whilst looking for manager placed cup of coffee on table. Cup removed immediately.	Immediate	Completed

Report Title:	**WARD BASED CATERING, UNIVERSITY HOSPITAL OF WALES (UHW) FOOD HYGIENE INSPECTION – 2nd December, 2019**						
Meeting:	**Health & Safety Committee.**				**Meeting Date:**	**21st January 2020**	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	**Director of Planning**						
Report Author (Title):	**Operational Services Manager (North)**						

SITUATION

A Re-inspection of the ward kitchens at the University Hospital of Wales took place on 2nd December, 2019, the outcome of which was confirmed in a letter including a report on the findings dated 4th December 2019 issued by the Commercial Services Officer, Food and Port Health, Bridgend, Cardiff and Vale of Glamorgan Shared Regulatory Services.

The report noted that the Ward Kitchens at UHW received an overall score of **4 (Good)** in the National Food Hygiene Rating Scheme.

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 action plan has been produced by the Operational Services Manager to address the issues raised and is attached as an appendix 1 of this report**.** The plan will be monitored by the Services Board Compliance team, to ensure all actions are completed by the agreed dates.

ASSURANCE is provided by:

- The maintenance of the Food Hygiene Rating score of **4 (Good)** and actions taken.
- Monitoring of the action plan will be undertaken by the CEF compliance team, who are independent from the Facilities Directorate.

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

DRAFT

Action Plan from Food Safety Re-Inspection on 2nd December 2019 (Report dated 4th December 2019)

Schedule A – Legal Requirements

Food Hygiene & Safety Procedures High standard of compliance with statutory obligations, and industry codes of recommended practice, with only minor contraventions.	**Response / Action**	**Time Scale**	**Update**
During the inspection, single use plastic cups were noted on the dishwashing drainer area. Anita Patel said that the plastic cups had been washed prior to use. These cups are stored in packaging in the storeroom and do not require washing prior to use. *Regulation (EC) No. 852/2004, Annex II, Chapter IX, Para 3*	Staff member Met with and refresher training commenced on 06/12/19 Removed all disposable cups from ward kitchens on day of inspection Team Manager to meet with ward managers regarding storage of disposable cups	2 weeks Training Immediate Immediate	Completed and signed off by senior manager Completed 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.	Response / Action	Time Scale	Update
The following pieces of kitchen equipment required cleaning: The handle on the hot water dispensers in C1 and A2 kitchens;	C1 and A2 Hot water dispenser (calomax) handles cleaned on day of inspection.	Immediate	Completed
The wheels to the equipment sink in ward B2;	B2 arranged to be deep cleaned and steam clean all wheels, edges and behind sink area.	Immediate	Cleaning scheduled in place
The extractor filters above the oven in ward B2 was dusty;	Maintenance Request (MR) placed to clean B2 Kitchen oven extractor fan.	December 20th	Awaiting Estates.
The wall under the sink and hot water dispenser in ward C5;	Cleaned on day of inspection	Immediate	Completed
The area under the hot water dispenser in ward B2;	Cleaned on day of inspection	Immediate	Completed

There was debris noted around the stand holding pipes up under the sink in ward A2 kitchen. Thoroughly clean the area and maintain in a clean condition.	A2 deep cleaned with vacuum cleaner and steam cleaner 06/12/19	Immediate	Cleaning scheduled in place
It was also noted that the protective covering was still visible on some freezers and dishwashers, I understand works are currently underway to remove all protective coverings from equipment in all ward kitchens on site. *Regulation (EC) No 852/2004 Annex II Chapter V Para 1a* *Regulation (EC) No 852/2004 Annex II Chapter I Para 1*	All covering on freezers and dishwashers have now been removed.	Immediate	Completed
The following pieces of equipment were damaged and require repair or replacing; The tip of the green handled knife in ward C1 had broken off; The tip to the small black handled knife in B4 Haematology had broken off;	Knives removed from C1 & B4H kitchens on day of inspection. (Audit of all kitchen knives undertaken on 6-12-19, all unsuitable knives replaced)	Immediate	Completed
The plastic container storing pasta in the Children's hospital dry store was cracked;	Plastic container replaced on day of inspection	Immediate	Completed
The lid to the container storing porridge oats in the Children's Hospital dry store was split along the seal; *Regulation (EC) No 852/2004 Annex II Chapter V Para 1(c)*	Plastic container replaced on day of inspection	Immediate	Completed

Confidence in Management / Control Procedures 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.	Response / Action	Time Scale	Update
Audit of the current food safety policy document and monitoring records identified the following:			
Probe calibration check of the freezer B in ward C1 on 2nd December had been recorded at -17.5°C but there were no corrective actions recorded; There were numerous occasions where freezer temperatures on various wards were being recorded at warmer temperatures than your critical limit of -18°C but no corrective actions were being recorded;	Staff have been met with and the importance of recording temperatures and completing corrective actions has been discussed and potential severity of outcome explained to them.	Immediate	Ongoing programme
There were occasions where supervisors weren't signing off monitoring sheets. Supervisor checks must be carried out and they should be noting the issues that myself and Victoria are picking up relating to lack of corrective actions when elevated storage temperatures are recorded, or missing checks, lack of minus sign etc.;	Supervisors met with and discussed importance of checking monitoring sheets, new procedure in place to ensure all paperwork is checked by supervisor, senior supervisors and team managers.	Immediate	Ongoing programme
Staffs must ensure they use the minus sign when recording freezer temperatures. Failure to use the minus sign indicates ambient temperatures are being recorded;	Review current H.A.C.C.P training and Organize H.A.C.C.P re training for all staff and supervisors.	Immediate	Completed
A cooking temperature of 73°C had been recorded (fish in sauce) on the 27/11 on ward C1. Staffs must ensure that all food is cooked to at least 75°C for 30 seconds (ideally 80°C for 6 seconds);	The temperature was recorded at 93°C, but writing unclear.		

Quiche in ward B4 Haematology was defrosting in the fridge. The packaging on the foils state that they are not to be thawed but to be cooked from frozen;	Staff member and supervisors met with and discussed importance of following guidelines from CFPU regarding cooked products.	Immediate	Completed
The fridge temperatures on ward B2c was consistently recorded at 5°C, during the day you would expect some fluctuation in temperatures, if a digital display is being used for monitoring purposes and the temperature is always the same, I would suggest an independent check is carried out to verify that the temperature is ok;	Fridge monitored, consistent temperatures of 5 degrees due to new fridge that is not opened often and is not used by ward staff. Ad hoc fridge temperature checks being undertaken, checks verify that digital temperature is correct.	Immediate	Completed
There were occasions where temperature checks had been missed, Maternity UG 28/11 pm, A7 missing 26/11, ward C7 w/c 15/11;	Supervisors met with regarding checking of monitoring sheets, new procedure in place to ensure all paperwork is checked by supervisor, senior supervisors and team managers.	Immediate	Completed
I suggest a check is introduced to the monitoring sheets where staff are required to check that utensils and equipment are in good repair, this may reduce damaged or defective equipment being highlighted during inspections;	New checklist has been created for supervisors to ensure all utensils and equipment is checked on kitchen audits.	Immediate	Ongoing programme
Your HACCP states that when sandwiches are brought back from service in the insulated boxes then a sandwich is to be probed to check whether they are 5°C or colder, some wards are probing the dummy water and not destructive probing of a sandwich. I suggest you carry out sandwich testing and probe testing alongside one another to ensure the water gives an accurate indication of sandwich temperature. If the temperatures are accurate then you may consider changing the wording	Dummy water bottle and destructive probing of sandwich carried out simultaneously to ensure water bottle temperature is accurate. H.A.C.C.P document to be reviewed and changed if necessary.	Immediate	Completed

within your HACCP so that dummy food/water can be probed. Until such times you must ensure staff are destructively probing a sandwich.			
You must ensure that staff are properly trained and are aware of the controls they need to carry out. Staff must also be supervised and checked as necessary, so you are sure that all controls that are critical to food safety are being properly implemented and maintained. *Regulation (EC) No. 852/2004 Article 5*	Review current H.A.C.C.P training and organise H.A.C.C.P re training for all staff and supervisors. Supervisors to carry out E.H.O audits weekly asking staff common questions to give staff confidence for future inspections.	Immediate	Ongoing programme
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. The following issues were noted at the time of inspection;			
Some staff were unclear on the correct contact time required; Some staff were unclear on the 2 stage cleaning process, staff must ensure that food debris is removed prior to disinfecting with the D10;	Review current H.A.C.C.P training and organise H.A.C.C.P re training for all staff and supervisors. Supervisors to carry out E.H.O audits weekly asking staff common questions to give staff confidence for future inspections.	Immediate	Completed
Some staff were unclear that D10 bottles must be re filled every Sunday. *Regulation (EC) No 852/2004 Annex II Chapter V paragraph 1a*	New procedure put in place for refilling of D10 bottles. New information signs placed in all kitchens and supervisors to ensure all staff are aware of changes.	Immediate	Completed

Schedule B – Recommendations and Advice

These recommendations provide advice on good practice:-	Response / Action	Time Scale	Update
Ensure cleaning cloths aren't placed in or on wash hand basins. When arriving at ward B2 a green cloth had been placed on the wash hand basin. Anderson Principe the ward based cater said he had been cleaning when we arrived and placed it there to answer our questions. He did acknowledge he should have placed it in the sink.	Staff Member met with and explained the importance of following all procedures and the correct storage of kitchen items including cloths.	Immediate	Completed
The cold water tap in ward B4 Haematology wasn't working. Whilst it was noted that the hot water was being dispensed at an acceptable temperature for thorough hand washing, the cold water tap should be repaired.	Tap repaired	Immediate	Completed