HEALTH AND SAFETY COMMITTEE

9.30am on Tuesday 10 July 2018
Corporate Meeting Room, Headquarters, UHW

CARING FOR PEOPLE
KEEPING PEOPLE WELL

Health and Safety Committee
9.30am on 10th July 2018
Corporate Meeting Room, Headquarters, University Hospital of Wales
AGENDA

STAFF STORY **Personal Safety/Case Management Support** **Carl Ball, Personal Safety Adviser and Emma Foley, Case Management Officer**		
PART 1: ITEMS FOR ACTION		
1	Welcome and Introductions	Oral *Chair*
2	Apologies for Absence	Oral *Chair*
3	Declarations of Interest	Oral *Chair*
4	Minutes of the Health and Safety Committee meeting held on 10 April 2018	*Chair*
5	Action Log Review	*Chair*
6	Review of the Committee's Terms of Reference – ***Deferred to October Meeting***	*Chair*
Deliver Outcomes that Matter to People		
Our Service Priorities		
Sustainability		
7	Corporate Risk Assurance Framework (CRAF)	**Oral Update** *Head of Corporate Governance*
8	Health and Safety 2017/18 Annual Report	*Head of Health and Safety*
9	Pedestrian Access Safety Strategy Update	**Oral Update** *Head of Estates and Facilities*
10	Fire Safety Report	*Head of Estates and Facilities*
11	Update on the Action Plan of the Shared Services Fire Safety Audit of University Hospital Llandough	*Head of Estates and Facilities*
12	Proposal for Statutory and Mandatory Training	*Director of Workforce and OD*
13	Enforcement Agencies Correspondence Report	*Head of Health and Safety*
14	Health and Safety Improvement Plan	*Head of Health and Safety*
15	Health and Safety Issues Relating to Medical Records Storage	*Health and Safety Staff Lead*

Culture and Values		
16	Fire Safety Policy – for approval	*Head of Estates and Facilities*
17	Asbestos Management Policy – for approval	*Head of Estates and Facilities*

PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE Papers are available on the Health Board website		
18	Work Programme 2018/19	*Head of Health and Safety*
19	Progressing Smoking Cessation in the Cardiff and Vale Population – paper presented to Board on 31st May 2018	*Deputy Director of Public Health*
20	Waste Compliance Report	*Head of Estates and Facilities*
21	Environmental Health Inspection Report of Hafan y Coed, University Hospital Llandough on 9th February 2018	*Head of Estates and Facilities*
22	Environmental Health Inspection Report of Barry Hospital on 15th March 2018	*Head of Estates and Facilities*
23	Environmental Health Inspection Report of Central Food Production Unit on 14th March 2018	*Head of Estates and Facilities*
24	**Minutes from other Committees/sub-Committees/Groups** Operational Health and Safety Group – February 2018 Fire Safety Group – January 2018 Water Safety Group – February 2018	*C Dalton* *G Walsh*
25	Updated Health and Safety Related Policies Schedule	*Head of Health and Safety*
26	Review of the Meeting	Oral *Chair*
27	To note the date, time and venue of the next meeting:- • 9.30am on Tuesday 9th October 2018 in the Corporate Meeting Room, Headquarters, University Hospital of Wales.	

4

UNCONFIRMED MINUTES OF THE HEALTH AND SAFETY COMMITTEE HELD AT 9.30am on 10 APRIL 2018 IN THE CORPORATE MEETING ROOM, HEADQUARTERS, UNIVERSITY HOSPITAL OF WALES (UHW)

Present:

Michael Imperato	**Independent Member – Legal (Chair)**
Charles Janczewski	Independent Member (Vice Chair)

In attendance:

Martin Driscoll	Director of Workforce and OD
Stuart Egan	Health and Safety Staff Lead
Fiona Jenkins	Director of Therapies and Health Sciences
Maria Roberts	Patient Safety Manager
Geoff Walsh	Director of Capital, Estates and Facilities
Peter Welsh	Director of Corporate Governance
Ian Wile	Head of Operations and Delivery – Mental Health Clinical Board (agenda item HSC: 18/124)

Apologies:

Steve Allen	CHC Representative
Charles Dalton	Head of Health and Safety
Carol Evans	Assistant Director of Patient Safety and Quality
Abigail Harris	Director of Planning
Fiona Kinghorn	Deputy Director of Public Health

Secretariat:

Rachael Daniel	Health and Safety Adviser

PART 1

HSC: 18/120 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

HSC: 18/121 DECLARATIONS OF INTEREST

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

HSC: 18/122 MINUTES OF PREVIOUS MEETING

The minutes of the Health and Safety Committee held on the 23rd January 2018 were **APPROVED** and **ACCEPTED** as a true record.

HSC: 18/123 UPDATED ACTION LOG

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

- HSC: 17/058 – the Patient Safety Manager informed the Committee the intention was to scope the e-datix risk module during July to September and then go live later in the year, however this was dependent on the completion of the corporate review of the risk management process. The Project Board would also be re-established as there would need to be co-operation from the Clinical Boards.

  The Director of Corporate Governance informed the Committee the new risk management process would be launched in the near future.

  The Chair requested a short update on timescales at the July meeting.

  ACTION – Mrs M Roberts/Mrs C Evans/Mr P Welsh

- HSC: 18/010 – the Director of Therapies and Health Sciences advised she would liaise with the Director of Public Health as they had both been appointed as joint Executive Lead for Obesity and would consider where bariatric patient care best fitted.

  ACTION – Mrs F Jenkins

- HSC: 18/010 – the Vice Chair queried the timescale for milestones to be included as part of the Priority Improvement Plan, the Health and Safety Adviser confirmed it would be July 2018.

  ACTION – Mr C Dalton

HSC: 18/124 MENTAL HEALTH SMOKING CESSATION 2017/18

Mr Ian Wile, Head of Operations and Delivery for the Mental Health Clinical Board thanked the Committee for inviting him to present to them. Mr Wile updated the Committee on the pilot being undertaken to ban smoking in mental health premises.

Mr Wile explained mental health in patients were currently exempt from the smoking ban that was in operation for all other healthcare settings and public buildings. The Clinical Board debated why mental health patients should be exempt when smoking was just as harmful to their wellbeing, if not greater to those with serious mental health problems. He added that ethical, public and professional viewpoints supported a position that on balance the Mental

Health Clinical Board should pilot a smoking ban within mental health for 6 months. This would commence the first week in January 2018 with a formal review of its impact every 8 weeks. It was noted that e-cigarettes were allowed in the gardens during this pilot period.

Mr Wile advised the 1st evaluation of the pilot took place on the 25th March 2018 with Ward Managers and Project Manager. The evaluation identified that some service users were taking leave to smoke off ward areas rather than use the leave for recovery purposes. Whilst this was being looked at sympathetically it resulted in staff having to spend a lot of their time at the ward doors and patients smoking in their rooms posing a fire risk. Alongside this the number of service users being referred to the smoking cessation service was low.

Access to e-cigarettes is a problem for detained patients without time off wards and often little family support, so this often fell to ward staff to obtain for them. As result discussions were on-going with Public Health as to whether e-cigarettes could be sold on site.

Mr Wile acknowledged that as a result of the smoking ban, smoking had now moved to the front of Hafan y Coed and the main building which was proving difficult to control and manage.

Mr Wile informed the Committee staff were asked whether they wanted to reverse the smoking ban which they did not, there was support from both staff and service users to continue with this approach.

The Chair thanked Mr Wile for his presentation and invited comments from Committee members.

The Health and Safety Staff Lead referred to page 20 and noted there was a slight increase in the number of violence and aggression incidents relating to smoking and stressed that these would need to be continued to be monitored.

The Director of Corporate Governance informed the Committee that the current Litter/Smoking Enforcement Officer was employed by Cardiff City Council and cannot work in two different counties so discussions with the Vale Council were on-going, as a result of this there was not currently an Enforcement Officer at Llandough Hospital.

The Director of Therapies and Health Sciences congratulated Mr Wile and his team for taking this challenging issue forward. Mrs Jenkins stated smoking on Health Board grounds was still problematic and more help needed to be given to staff so that they could challenge smokers with confidence.

Mr Imperato advised the prison sector has very similar challenges and queried whether any liaison had been undertaken with comparable organisations. Mr Wile stated the prison sector had been very helpful and whilst other organisations had claimed they had banned smoking this wasn't evident on visits.

Mr Wile also added that the prison sell e-cigarettes through vending machines and following discussions with Sharon Hopkins, Director of Public Health she has agreed this is an option the Clinical Board can pursue. The Director of Capital, Estates and Facilities supported this approach as there was a significant fire risk from patients smoking in the building and e-cigarettes would help in reducing this risk.

The Independent Member (Vice Chair) supported the initiative and commended the engagement process, he was pleased this was also supported by staff and believed there were lessons to be learnt for the whole organisation.

Mr Wile was happy to suggest the pilot had now been completed and to continue with this approach to embed as normal service delivery. This was **AGREED** and **SUPPORTED** by the Committee.

HSC: 18/125 PATIENT MANUAL HANDLING PROACT EQUIPMENT AUDIT ACTION PLAN

The Health and Safety Adviser informed the Committee following the presentation of the Arjo ProACT Audit at the last meeting an action plan had been developed to address the findings.

Miss Daniel advised funding had been secured to replace those hoists which would become obsolete from June 2018. Miss Daniel also informed the Committee discussions were on-going in relation to the re-distribution of hoists to meet service needs and the requirement for an equipment library.

The Director of Therapies and Health Sciences stated whilst she recognised the obsolete equipment needed to replaced, it resulted in a reprioritisation of the medical equipment budget. Mrs Jenkins stressed the need for this equipment to be better maintained in the future and supported the recommendation of equipment being used where it was needed, she also added the Health Board cannot be in this position again. Miss Daniel stated the company had been made aware that they must provide the Health Board with a significant lead in time if equipment was to become obsolete in the future in order for it to be built into budgetary plans.

The Director of Capital Estates and Facilities informed the Committee Clinical Engineering was prepared to take over the maintenance of hoists as long as the required resources were in place.

The Arjo ProACT Audit Action Plan had been **RECEIVED** and **NOTED** by the Committee.

ASSURANCE was provided by:

- Progress shown against the action plan

HSC: 18/126 PEDESTRAIN ACCESS SAFETY STRATEGY

The Director of Capital, Estates and Facilities informed the Committee an external consultancy (Arup) with the necessary expertise and experience had been appointed to develop a Pedestrian Access Strategy on behalf of the Health Board. Mr Walsh stated the report was expected by the end of May 2018.

The Independent Member (Vice Chair) queried whether the exercise would include proposed future developments and whether the consultancy costs could be met from charitable funds as it was addressing the safety needs of staff, public etc.

Mr Walsh stated it would include those known schemes during the next two years. The Director of Corporate Governance added as this was a legal requirement the costs could not be met from charitable funds.

The Chair queried whether it would take into account the car park changes. Mr Walsh stated there would be no physical changes to car parks but would take into account pedestrian access.

The Health and Safety Staff Lead stated the survey could potentially identify real changes needed to be made to the site which would inevitably result in significant investment. The Director of Workforce and OD stated if this was the case then a prioritisation of the work required would need to be undertaken.

Mr Imperato requested the results of the survey be brought to the July Committee Meeting.

ACTION – Mr G Walsh

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

HSC: 18/127 FIRE SAFETY REPORT

The Director of Capital, Estates and Facilities informed the Committee there had again been an increase in fire training compliance and the figures were now broken down by Clinical Board. He was pleased to note there were currently no fire enforcement notices.

The Independent Member (Vice Chair) agreed there was an overall improvement in fire training compliance but was concerned some Clinical Boards were performing better than others. Mr Walsh stated these figures do get raised at Clinical Board Performance Reviews. The Director of Workforce and OD added the fire training data gets enshrined into the overall mandatory training figures but is in fact a statutory requirement so this data would be separated for future performance reviews.

The Health and Safety Staff Lead requested the data for e-learning and direct training be separated as he was concerned that a greater level of e-learning was taking place whilst clinical staff required direct training. Mr Walsh would investigate with LED who provide the figures.

ACTION – Mr G Walsh

The Director of Therapies and Health Sciences considered the Committee had more assurance now than it had in the past.

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

ASSURANCE was provided by:

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

HSC: 18/128 SHARED SERVICES FIRE SAFETY AUDIT OF UNVERSITY HOSPITAL LLANDOUGH

This item was deferred to the next meeting.

HSC: 18/130 HEALTH AND SAFETY MANDATORY TRAINING REQUIREMENTS

This item was deferred to the next meeting.

HSC: 18/130 ENFORCEMENT AGENCIES CORRESPONDENCE REPORT

The Director of Corporate Governance informed the Committee of 3 new event which had occurred since the last meeting, these being;

- A reported examination of a boiler at Rookwood Hospital resulting in a potential danger under the Pressure System Safety Regulations 2000.
- Concerns raised about enhanced manual handling risks as a result of a lift being out of action.
- Concerns raised following an asbestos inspection carried out by the HSE Inspector on a specialist contractor working on the X-ray Department in University Hospital of Wales.

The Health and Safety Adviser informed the Committee responses had been provided to the HSE for the 3 events. The HSE had responded that no further action would be pursued for the 1st two events as they were satisfied with the actions taken by the Health Board and a response was awaited in relation to the 3rd event.

The Independent Member (Vice Chair) stated how valuable he found this paper to be in keeping members informed of on-going enforcement actions within the Health Board.

The report was **RECEIVED** and the Committee **AGREED** that appropriate actions were being pursued to address the issues raised.

ASSURANCE was provided by:

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

HSC: 18/131 HEALTH AND SAFETY IMPROVEMENT PLAN

The Director of Corporate Governance informed the Committee the Improvement Plan was undergoing a full review which would be brought back to the next meeting.

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

REASONABLE ASSURANCE was provided by:

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

HSC: 18/132 CONTROL OF CONTRACTORS IN NON ESTATES ACTIVITIES

The Director of Corporate Governance informed the Committee that as a result of reviewing contractor control arrangements across the Health Board it was evident that other Departments outside of Estates were also bringing contractors onto site and the same arrangements needed to be in place for managing these contractors. The paper had also been presented to Management Executive to secure extra resources to undertake contractor control outside of estates.

The Director of Workforce and OD advised following Management Executive it was agreed that he would meet with the Head of Health and Safety to take this forward.

ACTION – Mr M Driscoll

The Director of Therapies and Health Sciences stressed the importance of having consistent arrangements across the Health Board.

The paper was **NOTED** and **SUPPORTED** by the Committee

RESONABLE ASSURANCE was provided by:

- Actions being taken to address the issues raised.

HSC: 18/133 MANAGEMENT OF CONTRACTORS AND JOB REGISTRATION FORM

The Director of Capital, Estates and Facilities informed the Committee he had a team of 4 – 5 staff who undertake this role within the Service Board and the paper gave an indication of the depth and amount of work undertaken to control contractors.

The Chair stressed it was very important for the Health Board to demonstrate the resources dedicated to monitoring contractor control.

The Director of Therapies and Health Sciences stated it was important that this paper was read alongside the previous agenda item as assurance was provided that contractors were being monitored in estate functions but not in other areas of the Health Board.

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

ASSURANCE was provided by:

- The continuing and on-going actions undertaken by the Estates Department to manage and monitor contractors on site.

PART 2

HSC: 18/133 COMMITTEE WORK PROGRAMME FOR 2018/19

The Work Programme for 2018/19 was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 18/134 REGULATORY AND REVIEW BODY TRACKING REPORT

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

HSC: 18/135 LONE WORKER SYSTEM PROGRESS REPORT

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

HSC: 18/136 OPERATIONAL HEALTH AND SAFETY GROUP MEETING OF DECEMBER 2017

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

HSC: 18/137 SECURITY AND PERSONAL SAFETY STRATEGY GROUP MINUTES OF DECEMBER 2017

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

HSC: 18/138 HEALTH AND SAFETY RELATED POLICIES SCHEDULE

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

HSC: 18/139 REVIEW OF THE MEETING AND ITEMS TO BRING TO THE ATTENTION OF THE BOARD OR OTHER COMMITTEES

Mr Imperato advised there had been a number of very useful discussions and welcomed Mr Wile's presentation on the implementation of a smoking ban in mental health premises. Mr Imperato stated the Committee had received good detailed reports and he personally was more assured on health and safety matters than six months ago when he first came in to post.

Mr Janczewski acknowledged the value of the Committee and that it was fundamental to patient and staff safety. He personally appreciated the significance of the Committee and stressed the need for Executive Directors to be present to give their input.

HSC: 18/140 DATE AND TIME OF NEXT MEETING

The next meeting will be held at 9.30am on Tuesday 10th July 2018 in the Corporate Meeting Room, HQ, University Hospital of Wales.

Signed ……

Date ……

5

UP DATED ACTION LOG

NB: Following presentation to the Committee meeting in April 2018, those actions completed have been removed

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
HSC: 17/058	18/07/17, 24/10/17, 23/01/18 & 10/04/18	CRAF - E-Datix Risk Module	To clarify the status of the e-datix risk module.	Mrs Carol Evans/Mr Peter Welsh	**ACTION STILL UNDERWAY** Update on timescales to be provided to the July meeting
HSC: 17/090	24/10/17, 23/01/18, & 10/04/18	Shared Services Fire Safety Audit of UHL	To remain on the agenda until all actions have been completed	Mr Geoff Walsh	**COMPLETED** Agenda Item
HSC: 18/007	23/01/18 & 10/04/18	Fire Enforcement and Management Compliance	A review of statutory and mandatory health and safety training to be considered at a future meeting.	Mr Martin Driscoll	**COMPLETED** Agenda Item

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
HSC: 18/010	23/01/18 & 10/04/18	Health and Safety Improvement Plan	Improvement Plan to include milestones.	Mr Charles Dalton	**ACTION STILL UNDERWAY** A full review of the improvement plan is being undertaken in conjunction with the CRAF. Full document to be presented to October meeting.
HSC: 18/126	10/04/19	Pedestrian Access Safety Strategy	Results of the survey to be brought to the July Meeting.	Mr Geoff Walsh	**ACTION STILL UNDERWAY** Oral update to be provided to the meeting as survey results will not be received until 4/7/18.
HSC: 18/132	10/04/18	Control of Contractors in Non Estates Activities	Director of Workforce and OD to meet with Head of Health and Safety to progress recommendations of the report.	Mr Martin Driscoll/Mr Charles Dalton	**COMPLETED** Health and Safety Adviser recruited.

5

HEALTH AND SAFETY ANNUAL REPORT 2017/18
Name of Meeting : Health and Safety Committee **Date of Meeting:** 10/07/2018

Executive Lead : Director of Governance
Author : Head of Health and Safety - 43751
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
• **Financial impact :** Not applicable
Quality, Safety, Patient Experience impact: The Annual Report covers staff and patient H&S risks with specific reference to the 8 strategic areas.
Health and Care Standard Number 2.1
CRAF Reference Number 8.1.4, 6.4.7, 6.4.5 and 6.4.4.
Equality and Health Impact Assessment Completed: Not applicable

8

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Health and Safety aspects being appropriately monitored and progressed as detailed within the report

The Health & Safety Committee is asked to:

- **NOTE** the contents of this report

SITUATION

This report has been prepared to provide assurance to the Committee that the Health Board's health and safety risks have been appropriately managed during 2017/18.

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

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

1. Health and Safety Management Structure (including incident reporting)
2. Violence and Aggression Management
3. Manual Handling

4. Health Issues
5. Environment Safety and Health and Safety Patient Issues
6. Fire Safety Management (Subject of separate Annual Report)
7. Health and Safety Estates Management.
8. Sharps Safety

The report covers the period the 1st April 2017 to the 31st March 2018, however it also refers to progress made since this date.

BACKGROUND

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

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

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

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

The previous 2016/17 report was considered at the July 2017 Health and Safety Committee.

ASSESSMENT

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

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

Key issues highlighted included:

1. Health & Safety Management

- Health and Safety Committee and its sub- goups have continued to meet on its responsibilities.

- The HSE were very active in visiting the Health Board taking up significant departmental resource. Although it has not received any Enforcement Action during the year, they have continued to pursue the investigation into the Contractor Fall, this required the Health Board to

take formal legal advice – HSE has made no decision if legal action warranted.

- Personal injury claims are proportionately higher than other Health Boards at 22% of All Wales claims whilst employing 16% of healthcare staff.

- Incident data collated from the Datix system is showing a high level of close out and management involvement (93% of the staff health and safety incidents were closed out and only 4 of nearly 3752 remain as awaiting review) .

- The number of RIDDOR events has remained constant over the previous years with little change in either by injury type or Clinical Board performance.

- Staff reported incidents show that violence and aggression accounts for 52% of all events. During the year, there was a significant increase by 30% in contact injuries.

- Mandatory training of health and safety has significantly improved, with 4 clinical boards achieving the 85% target.

- Conversely tutor led training compliance for both manual handling and violence and aggression has reduced, although a review of the requirement is being progressed.

- The introduction of fees for failing to attend to tutor led health and safety training has proved successful in significantly reducing the level of failure to attend on the day.

2. Personal Safety/Violence and Aggression

- The number of prosecutions and other police inventions improved during the period with an 8 year average of 1 conviction a week and a further 2 per week other actions. The Health Board is working closely with the Police, Crown Prosecution Service and Shared Services Legal to improve the Memorandum of Understanding between all parties.

- The lone worker devices continue to be highly valued by staff with average usage being at 73% and devices in great demand.

3. Manual Handling

- Following the completion of a Manual Handling Proact Audit, the age and quality of patient hoists has significantly improved with 60 new hoists purchased at the commencement of the year and a further 39 ordered ensuring that all obsolete hoists will be replaced.

4. Health

- The Health Board retained Gold of the Corporate Health Standard.
- COSHH compliance remains at 62% with some areas as low as 30%. Environmental Monitoring has continued on a prioritised basis.

5. Patient Environment

- A mental health ligature audit was completed and the findings implemented.
- Mental Health Clinical Board introduced a complete ban on smoking both within its grounds and ward areas.
- A project to improve Bariatric patient care has been initiated.

7. Estates

- Notably consistently high Environmental Health Star ratings of food preparation areas and restaurants was achieved during the period.
- Estates continue to enhance contractor control and implementing the same standards for contractor working in other areas is being pursued.

8. Sharps Safety

- Needle stick and sharp incidents slightly increased during the period but is still significantly lower than previous to implementing the safer sharps programme. The numbers of needlestick claims remain lower than the All Wales average.

APPENDIX 1

SITUATION

This report has been prepared to provide assurance to the Committee that the Health Board's health and safety risks have been appropriately managed during 2017/18.

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

The reports covers the period the 1st April 2017 to the 31st March 2018, however it also refers to planned advancements and progress since this date.

BACKGROUND

The report takes the structure of the 8 Strategic Areas, these being:

(1) Health and Safety Management
(2) Personal Safety (Violence and Aggression)
(3) Manual Handling
(4) Health Aspects
(5) Environmental Safety and Patient Safety
(6) Fire Safety Management
(7) Health and Safety Estate Management
(8) Sharps Safety

Although it should be noted that fire safety will be the topic of a separate annual report submitted to a future Committee meeting.

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

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

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

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

The previous 2016/17 report was considered at the July 2017 Health and Safety Committee. E Datix (Electronic Incident reporting) has allowed the report to be brought again to the Committee's attention at its July meeting.

ASSESSMENT

1.0 HEALTH AND SAFETY MANAGEMENT

Health and Safety Management is the parental overarching approach which underpins the specific risks. It requires both pro-active and reactive strategies to prevent accidents and ill health. This includes measuring health and safety performance, improving standards, compliance to our legal obligations, good communication, high levels of competence and accountability through effective policy control.

1.1 Health and Safety Management Structure

Senior Management commitment is perhaps the most important aspect of encouraging a positive safety culture, by the Board clearly stating its intentions, expectations and beliefs in relation to health and safety.

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

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

ATTENDANCE **Table 1**

		April 17	July 17	October 17	January 18
IM – Legal (Chair)		√	√	√	√
IM – Trade Union		√	√	√	√
IM – Vice Chair					√
Director H&S Lead		√	√	√	√
Other Executive Directors		**1**	**1**	**1**	**3**
Staff Safety Representative		**2**	**2**	**2**	**1**

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

Health and Safety Committee Reporting Structure

Chart 1

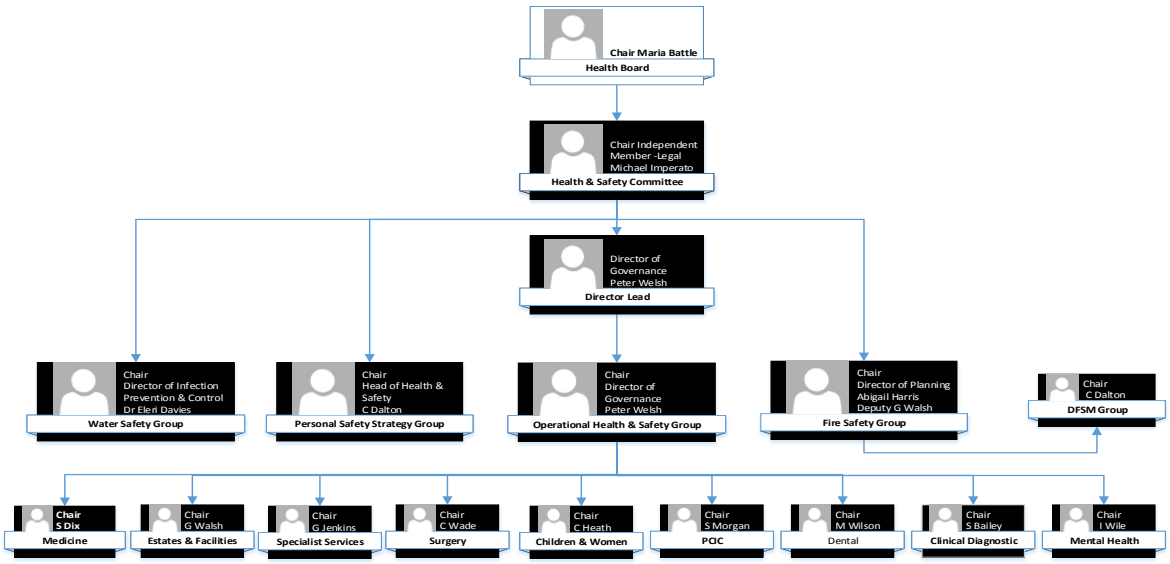


Chart 1 shows those groups reporting to the Health and Safety Committee.

During the period the membership changed as the Independent Members had completed their terms of office. Consequently a new chair of the Independent Member Legal was appointed. Also the Staff Group Vice Chair of the Health and Safety Representatives took up a new role within the Royal College of Nursing in January 2018 and subsequently the position became vacant and is in the process of being recruited into.

In addition the Water Safety Group was added as a sub group of the Committee due to the legionella risk and HSE actions.

The Director Lead for Health and Safety is the Director of Corporate Governance who chairs the Operational Health and Safety Group.

Table 2 shows all sub groups of the Health and Safety Committee and the number of meetings and deficiencies during the period.

Table 2

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

In addition to the Fire Safety Group meetings, a sub group (Deputy Fire Safety Manager Meeting) has been established to progress and close out managerial actions that are generated from the fire risk assessments and fire audits. This group meets 3 monthly and met 4 times during the period.

Clinical/Service Board Health and Safety Meetings **Table 3**

Health & Safety Group	Chair	Agreed Frequency	Meeting per year	Actual	Deficiency
Estates/Facilities	G Walsh	3 monthly	4	8	+4
Medicine	S Dix	3 monthly	4	1	-3
Specialists	Gareth Jenkins	3 monthly	4	4	0
Surgery	C Wade	3 monthly	4	5	+1
C&W	C Heath	3 monthly	4	4	0
PCIC	S Morgan	3 monthly	4	3	-1
CD&T	S Bailey	3 monthly	4	3	-1
Dental	M Wilson	3 monthly	4	3	-1
Mental Health	I Wile	3 monthly	4	4	0

Information based off Health and Safety Advisory invitation

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

Advisory Team
Establishment during 2017/ 18 **Table 4**

Position	WTE In-post	WTE Post Establishment
Head of Health and Safety	1	1
Health & Safety Advisers (inc of Specialist Environmental Adviser (0.7wte)	2.2	2.4
Assistant Health and Safety Adviser	0.6	0.6
Manual Handling Advisers	1.38	1.38
Personal Safety/Case Management	1.9	1.9
Manual Handling/Violence and Aggression Trainers	3.2	4.77

Table 4 excludes admin staff and Health and Safety Advisory staff directly employed within the Estates Compliance Department to manage asbestos and contractor control (3 WTE). Table 4 demonstrates that the Health and Safety Department is below its establishment, this is due to staff movement and some element of budget restraint.

1.2 Health and Safety Priority Improvement Plan

The Priority Improvement Plan continued to operate during the period, however development of the revised Corporate Risk Assurance Framework has resulted in some variances. The table below demonstrates the changes during the period and milestones being worked to.

Table 5

	Total no of requirements	Green	Amber	Red	Overall Strategy Status
Health and Safety Policy Management and Organisational Arrangement	4	0	2	2	Reasonable assurance
Violence and Aggression (inc Lone worker)	12	2	8	2	Limited assurance

Manual Handling	10	1	7	2	Reasonable assurance
Health Issues	6	1	3	2	Reasonable assurance
Patient and Environment Health and Safety	8	3	4	1	Limited assurance
Fire Safety Management	3	1	1	1	Reasonable assurance
Estate Health and Safety Management	8	1	2	5	Reasonable assurance
Sharp Safety	1	1	0	0	Substantial assurance
Total	52	10	27	15	

As can be seen from the above table 37 of the 52 actions/milestones have been effectively progressed during the period with 15 areas still requiring priority action. These will be progressed in conjunction with the reviewed Corporate Risk Assessment Framework, which planned to more easily demonstrate the level of progress made

8

Areas Added and Progressed During the Period

Table 6

	Mile Stone	Action/Progress	Action required	Accountable Lead	Status
1.4	The HB has confidence that the health and safety responsibilities of managers are understood and adhered to	Safety Management Training is included in risk assessment and some areas have trained managers to IOSH Managing Safety. A training course for managers is being developed specifically around ensuring they recognise their duties under the relevant h & s policies and their broader legislative compliance duties	Training course under development with an aim of offering the course during September/ October 2018	Head of Health and Safety	Red
2.5	All assistance is given to staff in dealing with Violent events both pro-actively and reactively	A working group is set up nationally to revise the MOU to include these events. Develop further guidance on non gratuitous violent incidents to demonstrate enhanced support to staff on violent events relating to patient medical conditions where legal intervention is inappropriate	Issues around releasing staff to attend training. Commitment to undertake training required from EU and Security Services.	Personal Safety Manager	Amber
3.3	Suitable and sufficient patient handling equipment is available	60 replacement hoists and 10 new shower chairs have been purchased and delivered to each area	Verify that the additional hoists has significantly improved status of Pro-act audit findings	Head of Health and Safety	Green
4.5	Staff wellbeing and stress support is developed in a proactive mode	The annual report identified there are areas where staff shortage and stresses exist which are being tackled via sub groups in HR, Patient Safety and Occupational Health	A meeting to be established with health and safety to consider joint approaches of proactive intervention in stress management.	Head of Health and Safety	Red
4.6	Staffing/patient safety compromised	Audit report of mental Health identified that staff rotas were not including any breaks Audit Committee recommended this be progress to	Mental health to review rotas to include sufficient staff to allow staff to take breaks	Director of Operations Mental Health	Red

		appropriate committee			
5.6	Bariatric patient care is delivered with the minimum to risk to both staff and patient	Identified manual handling risks in the delivery of care to bariatric patient care. Pilot being developed with manual handling and Medicine CB staff to design and develop an improved care model	Internal Medicine and Manual Handling to work closely in actioning an ward area better designed to care for bariatric patients	Senior Nurse Medicine/Head of Health and Safety	Red
5.8	Monitoring Schedule	A programme of sampling has been initiated but due to demands on the Environmental Adviser it has not met its full monitoring programme.	A priority monitoring programme has been introduced to ensure that these areas of risk are completed.	Head of Health and Safety	Amber
7.6	Development of a pedestrian strategy for the 2 major HB sites in relation to their traffic risks	Pedestrian safety tunnel being pursued by Estates Department.	An overall strategic approach to be developed.	Director of Capital, Estates and Facilities	Red

1.3 Health and Safety Related Policies Table 7

POLICY	UHB REFERENCE	AUTHOR/LEAD	SUBMISSION TO HEALTH & SAFETY COMMITTEE	REVIEW DATE
Management of Stress & Mental Health Wellbeing in the Workplace	UHB 071	Employee Wellbeing	July 2014 (2nd review)	July 2017
Management of Asbestos	UHB 072	Director of Planning	July 2014 (2nd review)	July 2017
Fire Safety	UHB 022	Director of Planning	July 2015 (2nd review)	July 2018
Latex Allergy	UHB 127	Health and Safety Adviser	October 2015 (2nd review)	October 2018
Environmental	UHB 143	Director of Planning	October 2015 (2nd review)	October 2018
Closed Circuit Television (CCTV)	UHB 303	Head of Health and Safety	October 2015	October 2018
Security Services	UHB 037	Head of Health and Safety	January 2016 (2nd review)	January 2019
Contractor Control	UHB 163	Director of Planning	July 2016 (3rd review)	July 2019
Health & Safety	UHB 021	Head of Health and Safety	July 2016	November 2019
Safe Working with Electricity	UHB 208	Director of Planning	October 2013 (3rd review)	January 2020
Management of Violence & Aggression	UHB 035	Personal Safety Adviser	January 2014 (3rd review)	April 2020
Lone Worker	UHB 034	Health and Safety Adviser	January 2014 (3rd review)	April 2020
Minimal Manual Handling	UHB 036	Manual Handling Advisers	January 2014 (2nd review)	April 2020
Waste Management	UHB 038	Patient Experience Manager	January 2014 (2nd review)	April 2020

All policies that were due for review have been approved by the Health and Safety Committee with the exception of:

- Management of Stress and Mental Health Wellbeing in the Workplace – this is currently being reviewed with a suite of HR Policies it is understood that the final draft is being prepared and the policy is planned to be submitted to the October Committee meeting.
- The Management of Asbestos Policy was deferred to reflect the enhancement of contractor control and will be presented to the July 2018 Committee for approval.

Below is a list of those policies reviewed during the year 2017/18.

Table 8

POLICY	REF NO	SUBMISSION TO H&S COMMITTEE	REVIEW DATE
Water Safety (previously Control of Legionella)	UHB 091	April 2017	April 2020
First Aid at Work	UHB 093	July 2017	July 2020
Sharps Management Policy	UHB 269	July 2017	July 2020
Incident, Hazard and Near Miss Reporting	UHB 138	July 2017 - previously Quality & Safety	July 2020

8

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

Table 9

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

As can be seen four of the above documents are outside of their review period, this could leave the Health Board vulnerable to Health and Safety Executive and civil action.

1.4 Health and Safety Executive/Enforcement Agencies actioned during the period

Consistent with the HSE policy of greater enforcement and implementing Fees for Intervention where justified, HSE actively pursued 8 issues relating to both the current and the previous year. As can been seen all but one of these events have subsequently being closed out.

There has been no enforcement or other formal actions during the period. However the HSE continue to actively pursue the Contractor Fall event and we await notice as to whether they intend to progress legal action.

Table 10

Date	Description	Type	Status
1/17	Legionella C4	Improvement Notice	Closed
9/16	Hydrotherapy Pool Rookwood	Investigation – FOI	Closed
9/16	Contractor fall from height	Full Investigation - FOI	Decision Awaited
3/17	Road Traffic Accident at UHW	No Fees for intervention (FOI)	Closed
10/17	Assault in Mental Health	No Fees for intervention	Closed
3/18	Asbestos inspection Xray	2 Visits No FOI	Closed
1/18	Histopathology Laboratory	No Fees for intervention	Closed
11/17	Pressure Vessels examination of the boiler at Rookwood	No Fees for intervention	Closed

Legionella C4

The HSE had issued in early 2017 an Improvement Notice under the COSHH regulations following a Legionella event on Ward C4North at UHW. The main requirement of the notice being to enhance the management of Legionella in particular the flushing of infrequently used outlets. An approved action plan was implemented during the period which included a review of the audit and reporting arrangements of the Water Safety Group. HSE confirmed compliance met.

Hydrotherapy Pool

The HSE visited Rookwood Hydrotherapy Pool on 19th September 2016 to establish appropriate regulations were being applied. A review of protocols and modifications were necessary across all Hydrotherapy pools. This has been completed during 2017/18 and the item closed.

Contractor fall from height on the Women's Unit

The HSE continued to pursue their investigation into the above event during the period. They have now completed their investigation. The Health Board has sought legal advice and a formal submission made prior to the HSE

making any decision in relation to any further action. The Health Board is awaiting the HSE to review and respond.

New Issues Raised 2017/18

Road Traffic Accident

A member of staff was knocked over by a van when she was walking down the emergency admissions access road on UHW site, fracturing her nose and her right arm. An internal investigation was passed to the HSE who also advised on the need for pedestrian strategy. The HSE confirmed that no further correspondence was required and the incident was closed out.

Assault in Mental Health

A member of staff was assaulted by a patient during an episode of restraint on Alder Ward, Psychiatric Intensive Care Unit. The incident was reported to the HSE who required a copy of the patient's care plan and risk assessment and a copy of the wards violence and aggression risk assessment, these were sent and no correspondence has since been received.

Asbestos Inspection

The HSE wrote to the Health Board following an inspection it had undertaken of a licenced asbestos contractor who was working on UHW. The Inspector requested the Health Board investigate whether better arrangements could have been made and to justify that this was the only access route available for the contractors. Subsequently a team from HSE revisited the site together with health and safety & estates staff. HSE agreed that best available route had been taken and no further action was needed.

Histopathology Laboratory

All lifts around the Histopathology department were broken. This was reported to the HSE by a third party who requested maintenance and risk assessment information. Based on the response provided to the HSE no further action was taken.

Examination of a boiler at Rookwood Hospital

The HSE received an examination report from the British Engineering Services that a boiler at Rookwood Hospital should be removed from service under regulation 9 of the Pressure System Safety Regulations 2000. Confirmation was given that the boiler was not back in action and a new package boiler was installed. No further correspondence and item closed.

1.5 Incident Data

1.5.1 E-datix

The Health and Safety Department together with the Patient Safety Team continue to monitor and manage the E-datix system. The following data has been collated from this system.

There were 22097 incidents reported through the system during 2017-18. A breakdown of incident type can be seen in Table 11.

Table 11

2017/18 @ 19.04.18	Submitted Awaiting Review	In Progress	Closed	Rejected	Total
Patient Incidents	242	1378	13895	1052	16567
Staff/Contractor/Vendor Incidents	4	274	3404	70	3752
Organisational Incidents	41	149	1396	52	1638
Public/Visitors Incidents	2	9	122	7	140
Total	289	1810	18817	1181	22097

1.5.2 RIDDOR

There were 118 reported RIDDORs during the period.

Table 12

Staff RIDDORs	Total 2015/16	Total 2016/17	Total 2017/18
Contact with Sharps	4	4	5
Contact/Collision with Object/Animal	16	22	15
Entrapment	2	1	1
Lifting/Manual Handling	34	32	30
Slip/Trip or Falls	27	27	36
Inappropriate/Aggressive Behavior	31	28	28
Exposure to unhygienic Environmental Conditions	1	0	0
Exposure to unsafe Environmental Conditions	1	1	3
Other	0	1	0
Workplace Stressors/Demands	1	0	0
Total	**117**	**116**	**118**

Table 12 and 13 demonstrates there has been a consistency with the number of reported RIDDORS over the past three years. Equally Mental Health Clinical Board and Capital, Estates and Facilities Service Board remain the highest reporting areas across the Clinical Boards.

The type of incidents that account for the majority of RIDDORs reported over the past three years are:-

- Lifting/Manual Handling
- Slip Trips and Falls
- V&A

Table 13

	Accidents/Falls			Violence and Aggression			Total		
	15/16	**16/17**	**17/18**	**15/16**	**16/17**	**17/18**	**15/16**	**16/17**	**17/18**
Mental Health	11	6	**12**	16	15	**15**	27	21	**27**
Surgical Services	12	12	**10**	4	2	**1**	16	14	**11**
Capital, Estates & Facilities	27	25	**24**	2	1	**2**	29	26	**26**
Specialist Services	10	15	**17**	4	1	**3**	14	16	**20**
Medicine Services	9	15	**12**	4	7	**6**	13	22	**18**
Children and Women's	4	5	**4**	1	1	**0**	5	6	**4**
Clinical Diag and Therapies	5	2	**4**	0	0	**0**	5	2	**4**
PCIC	3	5	**1**	0	0	**0**	3	5	**1**
Executive and Corporate Services	4	2	**3**	0	1	**1**	4	3	**4**
Dental Services	1	1	**3**	0	0	**0**	1	1	**3**
Total	82	88	**90**	30	28	**28**	117	116	**118**

1.5.2 Staff Incidents

8

There was 3682 staff incidents reported from 1st April 2017 - 31st March 2018. This is an increase of 145 incidents against the previous year. 52% of these incidents relate to behavioral (violence and aggression), with a further 30% relating to accidents (including falls). See Table 16 and Chart 4.

Table 14

Staff, reported date, Tier 1	Total
Behaviour (Including Violence and Aggression)	1932
Accidents/Falls	1116
Exposure to Environmental Hazards	540
Property	66
Exposure to Environmental Hazards (other)	28
Total	**3682**

Chart 2

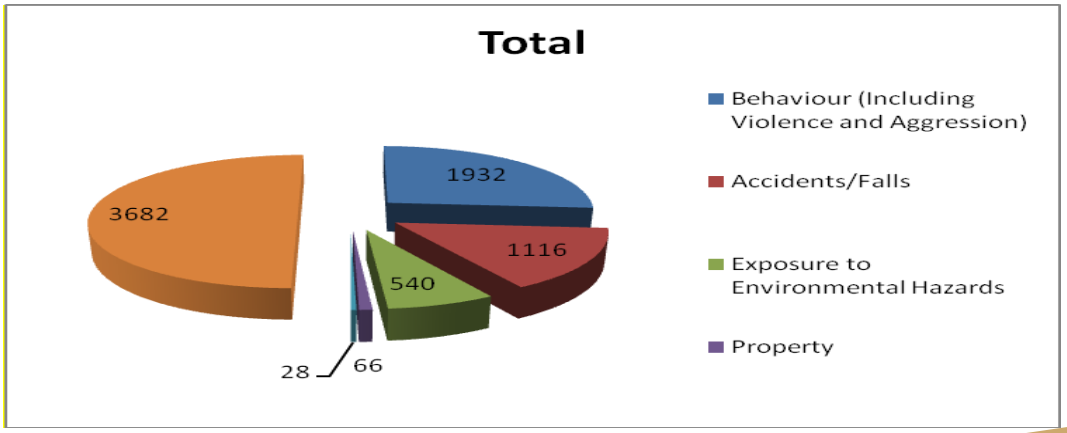
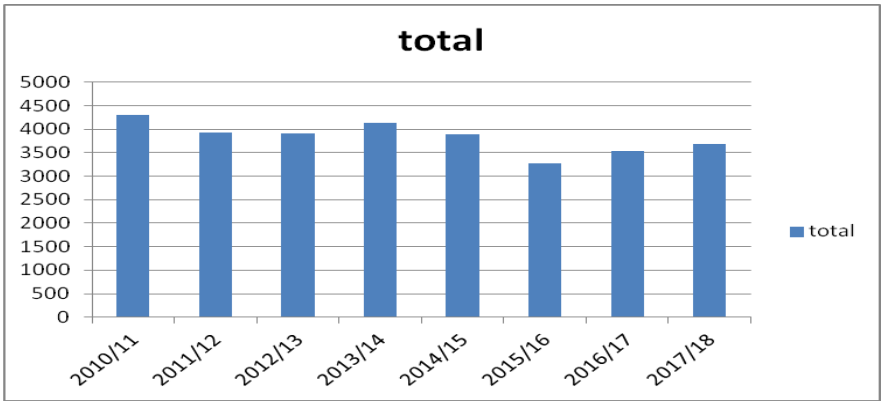


Chart 3



As can be seen in chart 3, staff incidents have increased slightly over the past three years, however as can be seen below this does not relate to an increase in one individual category.

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

	Staff injury inc needle stick	Cuts	Exposure to Unsafe Environ/Unhygienic/ Substances	Slips, trips and falls	Lifting, handling	Contact/entrapment /Struck By eg object	Contact with potential infectious material	Other	Work related ill health	Workplace stressor demands	Behaviour	Total
10/11	398	41	153	300	469	281	5	64	17	0	2546	4297
11/12	324	62	152	251	341	219	10	67	53	0	2436	3929
12/13	445	63	135	261	351	197	7	99	18	0	2318	3907
13/14	413	52	116	212	361	207	11	115	15	0	2610	4137
14/15	311	44	102	197	266	185	11	101	13	0	2643	3891
15/16	298	NA	255	198	211	246	0	85	0	196	1790	3279
16/17	258	NA	293	216	229	226	61	54	0	241	1959	3537
17/18	277	NA	319	234	255	293	57	66	0	249	1932	3682

Table 15 is a breakdown by category looking at incident data since 2010/11. It highlights the following:-

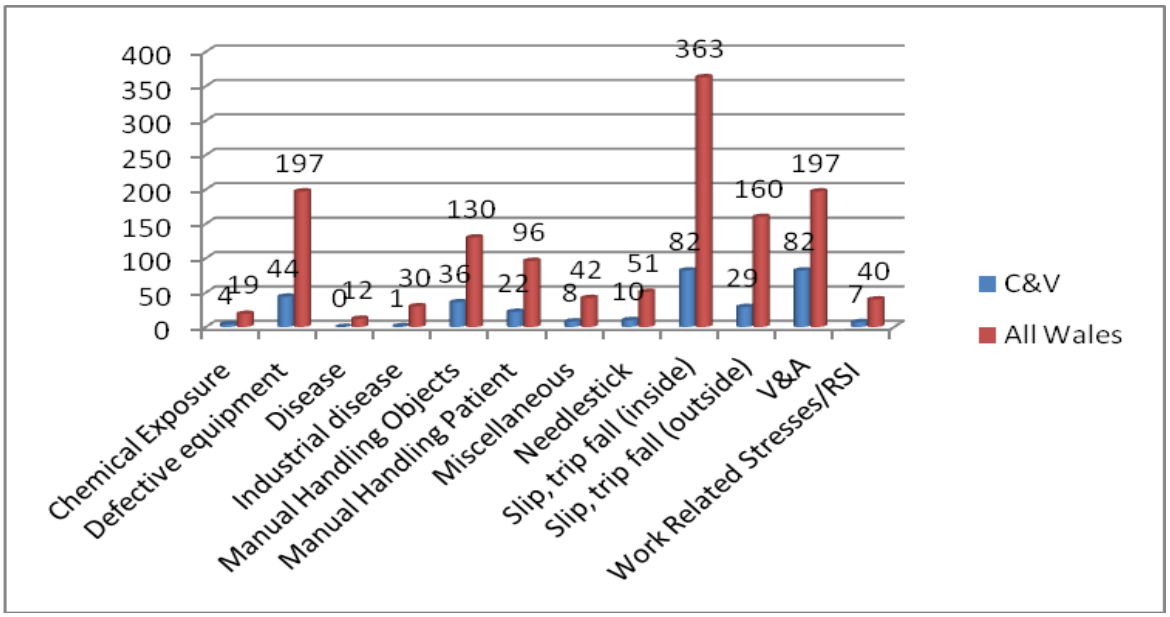
- The reporting of needlestick injuries has been at its lowest over the past three years, however there is a slight increase in 2017/18. (A more detailed analysis can be found under section 9 of this report).
- There has been an increase in the number of reported incidents relating to Exposure to Unsafe Environment/Unhygienic/ Substances, with 166 more incidents reported in 2017/18 than in 2010/11.

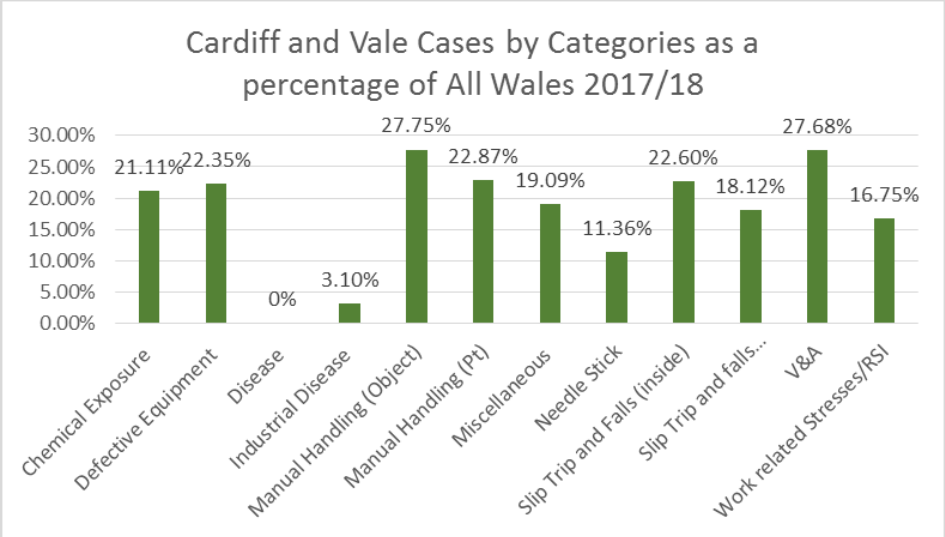
- Contact with potential infectious material incidents have increased dramatically over the past 8 years, however 2017/18 shows a slight improvement on the following year.
- The table shows an increase in the number of reported incidents in relation to workplace stressor demands over the past 3 years. It is noted that the reporting of staff shortages is included in these figures.

1.6 Legal Risk Personal Injury Reviews

Number of Personal Injury Claims for Wales and Cardiff and Vale

Chart 4





Cardiff and Vale employs 16% of NHS Wales workforce whilst accounting for 22% of all claims.

Needlestick and Disease claims are lower than the All Wales average based on the proportion of health care workers employed.

Cardiff and Vale PI Claims by Area **Chart 5**

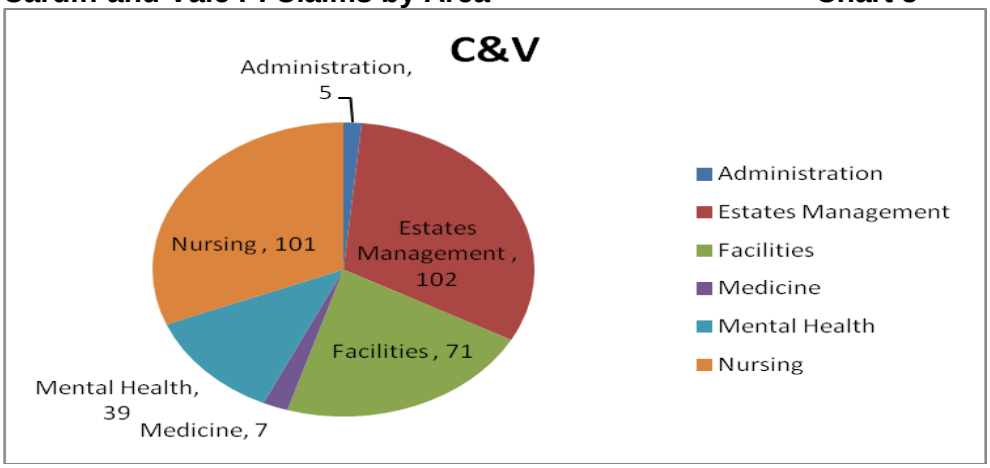


Chart 5 shows the breakdown of claims by area for Cardiff and Vale identifying that there were 325 claims during the period

The Estates and Facilities Department employs 8.23% of the Health Boards workforce. However the above demonstrates that they account for 56.3 % of all Cardiff and Vale claims. The total claims for All Wales were 1473 with Facilities/Estates accounting for 54% of these.

Chart 6

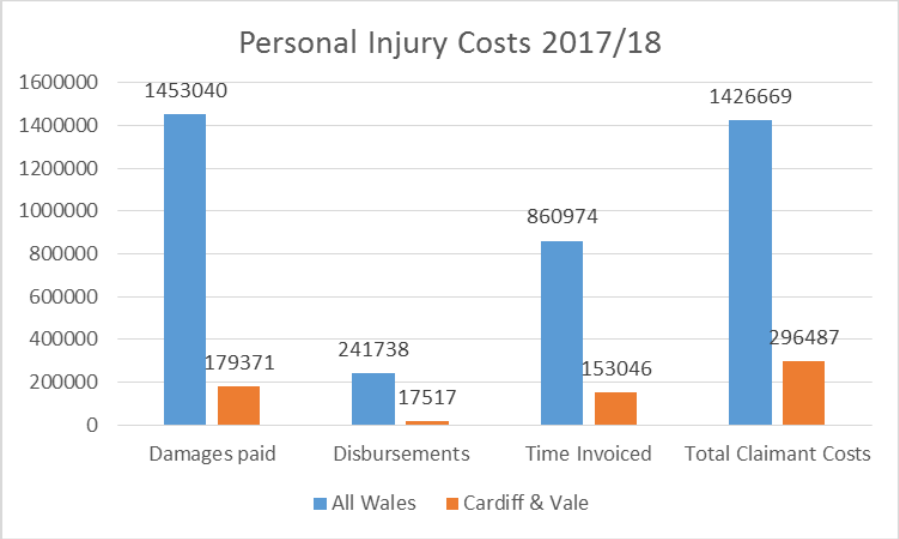


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Chart 6 highlights that Personal Injury claims for NHS All Wales in terms of damages paid and total claimant costs were £2.88 million of which Cardiff and Vale costs were £476K, this equates to 16.5% of the total. This is slightly above the 16% average based on the proportion of healthcare workers employed.

1.7 Health and Safety Training

Mandatory Training Compliance **Table 16**

Clinical Boards	Headcount 31st March	Trained	Compliance - %
Children & Women	2094	1771	84.57%
Capital, Estates & Facilities	1230	903	73.41%
CD&T	2366	2089	88.29%
Corporate	793	700	88.27%
Dental	555	510	91.89%
Medicine	1847	1381	74.77%
Mental Health	1397	1111	79.53%
PCIC	908	781	86.01%
Specialist Services	1828	1416	77.46%
Surgical Services	2010	1386	68.96%
UHB Total	**15028**	**12048**	**80.17%**

Mandatory training of health and safety has significantly improved with 4 clinical boards achieving the 85% target.

There have been several changes this past year with a view of improving training compliance. Firstly, the frequency of training in manual handling and violence and aggression training has been amended to every 2 years; with staff having the option of either attending a tutor-led update course or having an assessment by a Link Worker or Trainer for most manual handling and violence and aggression training courses. The aim of this change is to enable departments to have a competent workforce with minimal disruption. The prediction is that the number of assessments will increase and the number of update courses will decrease, moving towards a more work-based competence model.

This is also reflected in reviewing the frequency of mandatory training modules offered as e-learning. For example, both the manual handling Module A and violence and aggression modules A and B e-learning courses are now only to be completed on induction.

Data demonstrates that a large number of staff have completed e-learning modules unnecessarily; 5383 completed module A manual handling, 3171

completed module A violence and aggression and 721 completed module B violence and aggression.

Learning Education Department (LED) are in the process of updating ESR to allocate training competencies to employees. Once this valuable piece of work has been completed, training compliance will be recorded and reported more accurately. By empowering managers on health and safety the need for frequent training at employee level may be reduced.

In order to maximise the spaces offered by the health and safety department several changes have been made to address the issue of DNA's (staff who book training places and do not attend on the day). A fee was implemented in January 2018 to each department where members of staff were booked to attend training and did not attend without giving the department notice (up to the day of training). There is an appeals process in place.

As you can see in the training statistics provided in this report, the numbers of DNA's have significantly reduced compared to the same period in the previous year. This enables the spaces offered to be fully utilised and the income generated from DNA's to be re-allocated into the training provision offered.

Chart 7

Looking forward it can be predicted the health and safety department will continue to provide essential training to ensure the UHB has a safe and healthy workforce; however the delivery model is under review with more focus on workplace competency assessments.

Security staff will be training alongside in-patient mental health staff in Hafan Y Coed on violence and aggression module D. The emergency unit clinical staff have re-assessed their training needs to no longer requiring module D. This was a 2 day course run by the health and safety department which will no longer be required.

FIRST AID AT WORK COURSE **Table 17**

Month	Places Offered	Places Booked	Attended	FTA	Pass
3 Day FAW Totals	36	33	91%	1	100%
2 Day Requalification	60	22	36%	0	100%
Total	96	55	63%	1	100%

During the period the provider of our first aid training changed from Cardiff Council to Better (GILL LTD) in-line with the takeover of many of the leisure facilities in Cardiff.

Subsequently, Better (GILL LTD) continued to provide the Health Board's First Aid Training, however this came to an end in February 2018 as they were no longer providing this service. As a result two members of the training team attended a course in April 2018 to qualify as First Aid Trainers to deliver in-house training to Health Board staff.

The Health and safety training team will deliver First Aid at Work training in-house. This will increase the demand on the training team, however the department is in the process of recruiting an additional trainer. The training department (recognised as a Centre of Excellence) offers external training utilising unused provision. The resource generated from this has been used to benefit the UHB and enhance the training provided.

Risk Assessment/Working Safely Course

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

Table 18 demonstrates that 11 courses were arranged during the period, of which a total of 98 members of staff were trained.

Table 18

No of Courses	Places Offered	Places Booked	Number of Attendees	FTA
11	176	117	98	19

The above total number of courses includes 3 additional courses that were run specifically for Dental (x2) and Mental Health (x1) as requested by these Clinical Boards.

The health and safety department are keen to improve managers' knowledge around their health and safety responsibilities for themselves, their staff and their workplaces, and would like to offer a dedicated course to support this vision if resources become available. The health and safety department has seen a reduction in their staffing resource in training over the past 12 months

due to retirement, maternity leave and a reduction in hours. An internal reorganisation of staff within the department has been made to support and enhance the administration and organisation of training.

Income Generation 2017/18 **Table 19**

	Velindre NHS Trust	College of Medicine	Cardiff University	**Total Income**
Manual Handling Courses	£2160	£5634.29	£0	£7,794.29
Violence & Aggression Courses	£0	£6078.55	£14,980.86	£21,059.41
Total	£2160	£11,712.84	£14,980.86	**£28,853.70**

Table 19 identifies that to support the training programme the Department has generated £28.8K of income.

2.0 VIOLENCE AND AGGRESSION MANAGEMENT

2.1 Personal Safety

Violence and Aggression Incident Statistics Table 20

BEHAVIOUR	Total
Inappropriate/Aggressive Behaviour towards Staff by a Patient	1595
Inappropriate/Aggressive Behaviour towards Staff by a Visitor	185
Inappropriate/Aggressive Behaviour towards Staff by Staff	98
Other	48
Persons Performing Unauthorised Acts	5
Use/Possession of Prohibited/Stolen Goods	1
Total	1932

During the period 1932 violence and aggression incidents were reported. 1595 of these incidents relates to inappropriate/aggressive behaviour towards staff by a patient

Table 21

Staff behaviour, Tier 3	Capital, Estates and Facilities	Children and Women	CD&T	Dental	Executive/Corporate	Medicine	Mental Health	Other	PCIC	Specialist Services	Surgical Services	No value	Total
Other	4	2	4	1	2	7	2	0	5	4	16	7	54
Physical contact	38	18	4	0	73	202	452	0	3	74	36	30	930
Physical threat (no contact) total	26	6	2	0	11	47	199	0	4	12	9	18	334
Psychological abuse (bullying and harassment) total	4	11	6	2	6	25	7	1	3	6	6	5	82
Sexual (including harassment and indecent exposure) total	0	0	3	0	3	3	14	0	4	2	1	0	30
Verbal Abuse	23	45	23	11	8	111	78	1	53	32	36	31	452

Verbal abuse with disability content	0	0	0	0	0	0	0	0	0	0	1	0	1
Verbal abuse with gender content	1	0	0	0	1	5	1	0	1	0	0	1	10
Verbal abuse with racial content	3	7	3	0	1	10	9	0	0	1	4	1	39
No value	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**99**	**89**	**45**	**14**	**105**	**410**	**762**	**2**	**73**	**131**	**109**	**93**	**1932**
Total 2016/17	**54**	**92**	**64**	**18**	**101**	**410**	**731**	**1**	**70**	**134**	**112**	**51**	**1838**

Table 21 demonstrates 48% of the reported events were physical contact (assault) and the highest reported violence and aggression incidents occur within both Mental Health (39.4%) and Medicine (21.2%) Clinical Boards.

It also highlights that during the period based off the 2016/17 data there has been a 50% increase in violence and aggression incidents within the Capital, Estates and Facilities Service Boards. This may be related to the security function being relocated to this Service Board.

The three highest reported violence and aggression type categories were physical contact (930), verbal abuse (452) and physical threats (no contact 334).

8

Violence and Aggression Tutor Led Training 01/04/2017- 31/03/2018

Table 22

COURSE	Module D (Yearly)	Care Control (Inc Paeds & update)	1 Day B&C (Inc. Refresher)	E-learning module A
Total spaces offered	950	375	1271	N/a
Total Spaces booked	938	247	881	N/a
Total Spaces Attended	935	163	507	3171
Positive Evaluation (TFA) completed	0	0	40	N/a
Total Trained	935	163	547	3171
TNA (annualised)	1714	688	2821	434
Current year % Compliance	55%	24%	19%	**729%**
Overall Compliance based on 2yrly refresher	55%	27%	27%	

Table 22 shows low level of compliance to B&C training and large numbers of staff completing the E learning where it was not necessary. This may be because by completing module A on line their compliance will be shown as green on the ESR system although their competence would not have been improved.

LED are in the process of updating ESR to allocate training competencies to employees. Once this valuable piece of work has been completed, training compliance will be recorded and reported more accurately. By empowering managers on health and safety the need for frequent training at employee level may be reduced.

2.2 Communication

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

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

2.2.1 Direct Victim Support

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

2.3 Violent Warning Markers

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

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

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

Table 23 details the alerts that have been received by the Case Management Team and actions taken.

Table 23

	Alerts Received	No action	Alerts	Violent markers	Safe Haven Markers	Violent Markers Removed
2014/15	527	136	193	63	32	15
2015/16	465	147	228	74	16	16
2016/17	431	132	241	68	15	19
2017/18	480	149	256	63	26	17

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

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

Alerts –where staff have indicated the only risk is to working in the community. (Alert on PARIS only).

Violent Markers – decision has been made to apply markers to both PARIS & PMS and where GP's and Out of Hours GP's have also been notified.

Safe Haven Markers - markers applied in line with Safe Haven referrals from GP practices.

Violent Markers Removed - on review the decision to remove the marker due to de-escalation of risk.

2.4 Case Management

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

The service operates in addition to existing support arrangements within the Health Board. Case management is not a clinical or counseling service and must not impede the support relationship offered by local management or formal support services.

The team adopts a sympathetic approach to the victim and operates as a 'listening friend', albeit one who can provide practical advice to both the victim and their manager. Strong emphasis is placed upon the advantages of formal support mechanisms for staff that are experiencing ongoing difficulties.

Case management service continues to support victims following violence either through the criminal system or by internal sanctions and support. During the period more than 3 persons per week had police or internal interventions and 1 person per week were convicted of violence against our

staff. Statistics continue to show Cardiff and Vale as the most active and successful case management service

A review of the Memorandum of Understanding between the NHS, Police and Crown Prosecution has been initiated to reflect changes since original inception. The new Memorandum of Understanding will be launched in October 2018 with an all Wales Media Launch.

Criminal Sanctions **Table 24**

Year	No referred to Police	Number of Convictions	Other Sanction ASBO, Internal etc
2009/10	27	17	2
2010/11	118	55	130
2011/12	176	58	121
2012-13	110	48	47
2013 -14	97	49	55
2014-15	132	57	86
2015- 16	171	57	195
2016-2017	94	27	27
2017-2018	153	50	57
Totals	1078	418	720

Table 24 demonstrates sustained police action and criminal convictions since the intervention of case management and illustrates ongoing support and partnership work with the CPS (Crown Prosecution Service) and the Police to the revised Memorandum of Understanding.
Table 25 further demonstrates prosecutions and other criminal sanctions applied.

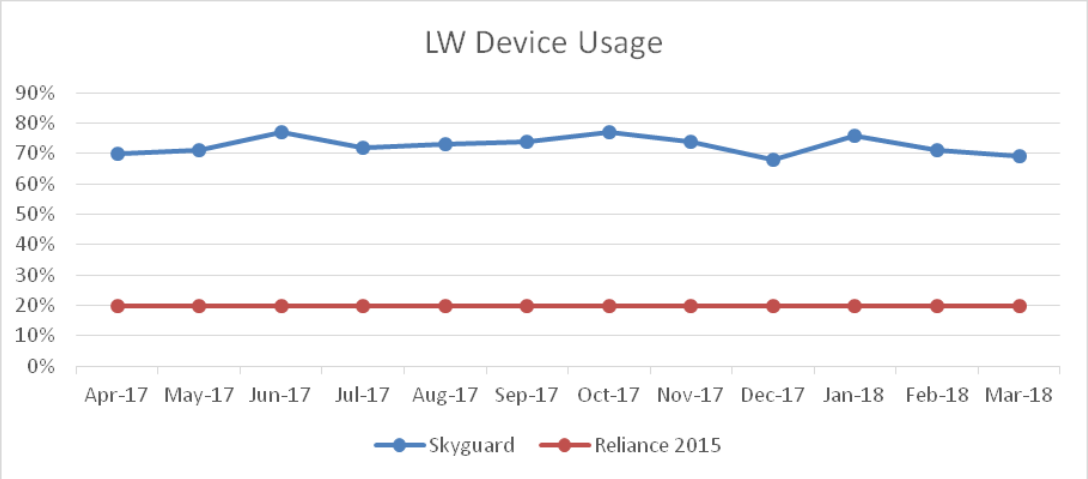
Health Board Successful Outcomes April 2009 to March 2018 **Table 25**

Year	Cautions	ASBO Referrals	PNC	Convictions	Restraining Orders/Crasbos	Police actions
2009 - 2010	2	0	2	17	0	21
2010 - 2011	5	23	2	55	1	86
2011 - 2012	8	136	6	58	1	306
2012 - 2013	10	29	8	48	2	90
2013 - 2014	15	29	11	49	0	104
2014-2015	4	68	2	57	1	132
2015-2016	11	80	7	57	1	171
2016-2017	6	9	1	27	0	94

2017-2018	2	8	0	50	0	153
Totals	73	382	39	418	6	1157

A successful prosecution worthy of noting was heard at Cardiff Magistrates Court on the 28th November 2017. The case involved a person who had regular appointments at UHW but had become very abusive and threatening over time. The person was subsequently arrested and charged with assaulting staff and was given a 8 week custodial sentence.

2.5 Lone Working **Chart 8**



As can be seen from Chart 8 the overall percentage compliance shows that the current Skyguard system is valued by users of the device with an average usage of 73% in 2017/18, which is measured against device activity and movement. This has sustained the significant improvement over the previous contract which had a low usage average of 20%.

The success of the current system and device has resulted in an increase of demand. All 638 devices have now been allocated to staff. Departments are asked to look at their current device allocation and consider reallocating unused devices or the possibility of sharing devices where logistically possible.

During the period genuine incidents were raised. The users found comfort in having the device at hand and incidents were closed safely without utilising the emergency services.

The Health and Safety Department has worked with Clinical Board Management and device users to improve the system within the financial restraints of the budget and the Operational Health and Safety Group continues to monitor usage by Clinical Board and Sub Group.

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

The allocation of devices has also been extended to victims of Domestic Abuse. Issuing mobile and discreet personal safety alarms provides increased protection and increases the confidence and safety of the member of staff.

3.0 MANUAL HANDLING

Manual Handling Progress

The Manual Handling Advisers offer specialist assessment, advice and risk control measures to all areas of the Health Board.

They help fulfil the organisation's duties under Lifting Operations and Lifting Equipment Regulations 1998 (LOLER), Provision and Use of Work Equipment Regulations (PUWER) and Management of Health and Safety at Work Regulations.

The Health Board and Local Authority Manual Handling Advisers provide specialist joint update training for District Nurses and Occupational Therapists in the more appropriate environment of the Local Authority training rooms. The integration of training and approach to manual handling has benefitted the skill levels of those involved and ensured a more joined up approach between the organisations.

Provision of Suitable flat Glide/Slide Sheets for In-Patients

Following incidents of staff injury when using "paper" style slide sheets to move patients, 1200 yellow fabric slide sheets were purchased and distributed throughout the organisation in June 2016. Their unique colour has greatly improved their return from Greenvale Laundry and reduced the annual spend of 28k on paper slide sheets for the past 2 years.

It has not been possible to accurately audit the number of slide sheets in current circulation as they are in a continual process of being used on the wards, being laundered and returned. Recently specific areas have contacted the Manual Handling Advisers about a shortfall. This has been addressed by redistributing unused slide sheets from other areas and e-mail circulated in January 2018 asking for the co-operation of all areas to check any spare stock and return into the system.

A visual examination of the slide sheets in circulation was conducted and it was noted that many of them are now beginning to showing signs of deterioration of the fabric which could result in an increase of friction/effort

when sliding patients. It is recommended that slide sheets are replaced every 3 years dependent on use.

An update paper went to the Operational Health and Safety Group in September2017 recommending the central purchase of large reusable sheets.

Repair and Maintenance of Hoists

Concerns continue to be raised regarding the length of time broken hoists are taking to be repaired by ward/department staff. The current arrangements can take 14 action points from the ward identifying equipment is defective to getting the equipment fixed. This issue has been exacerbated by the lack of a maintenance contract in the UHB for the service and repair of hoisting equipment, resulting in some wards having equipment out of use for a number of months, which has a direct impact on patient care.

UHB Compliance under LOLER

The Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) require equipment lifting people and accessories to be “thoroughly examined” at 6 month intervals. Patient slings have previously been internally inspected; however HSE has indicated recently that this must be an independent assessment.

The Department has recommended that slings are included in the maintenance contract with hoists; this has not been implemented so the current internal inspection arrangements are still in place. The training for inspecting slings is included as part of the Manual Handling Link Worker Course.

Implementation of the Revised All Wales NHS Manual Handling Passport and Information Scheme

The Manual Handling Advisers have implemented the revised All Wales Manual Handling Passport and Information Scheme (revised 2017) within the manual handling training package in Cardiff and Vale and continue to award credits of learning through Agored Cymru for all foundation courses.

Management of Bariatric Patients

Manual Handling Advisers continue to provide day to day advice, guidance and support with the management of bariatric patients in relation to equipment provision and specialist techniques both whilst patients are in hospital and at home. They also offer a weighing service to ensure patients are within the safe working load of equipment used within the organisation.

They are involved in a multi disciplinary approach to the management of this group of patients, and are currently working alongside others to create a

bariatric pathway and identifying an appropriate environment with suitable equipment where care can be provided.

Pro-Act Audit

60 patient hoists (39 passive and 21 active) were replaced and 10 high specification mechanical shower chairs were delivered in June 2017 from funding secured from the Welsh Government end of year monies 2016.

A follow up audit was carried out in July 2017 establishing the current stock of hoists, including ceiling track, walking, pool hoists and accessories (fabric/reusable slings, batteries and chargers). In addition the audit recorded bath tubs and chairs, shower chairs/trolleys and transport aids such as the Stedy or Quick move.

The result of the 2017 audit identified 26 Opera and Tempo hoists that would not be able to be serviced or repaired in the future and an additional 13 Encore and Chorus hoists that have now been discontinued. A discretionary capital bid was submitted to replace these hoists in February 2018. A follow up audit has been planned for November 2018.

The 2017 ProAct audit identified an increase in patient dependency putting a greater demand on equipment and staff to provide care.

3.1 Manual Handling Training and Statistics

During the period 255 staff incidents were reported in relation to lifting and manual handling, of which 30 were reported as RIDDOR reportable events.

Table 26

Year	Total
10/11	469
11/12	341
12/13	351
13/14	361
14/15	266
15/16	211
16/17	229
17/18	255

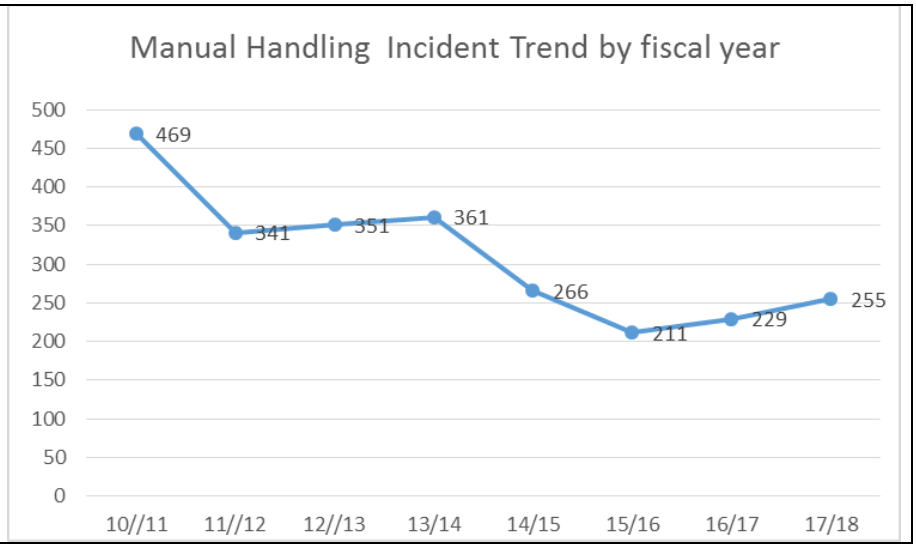
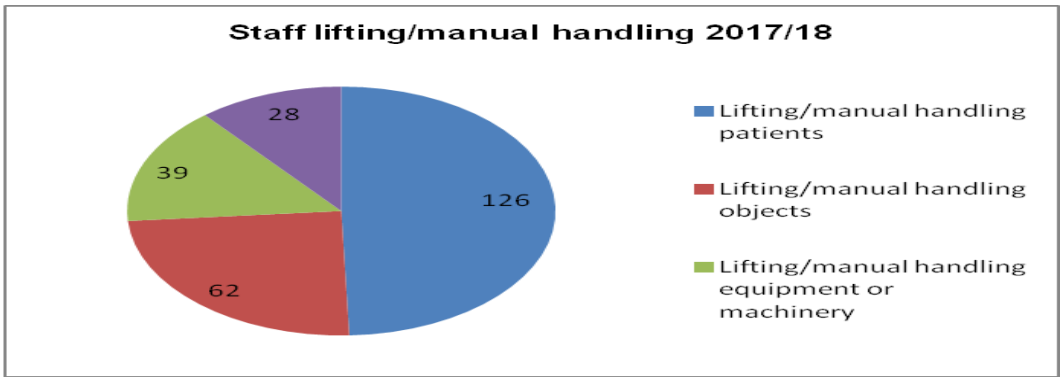


Table 26 show a positive trend in the reduction of manual handling incidents.

Chart 9



Manual Handling Tutor Led Training 01/04/2017 - 31/03/2018 Table 27

COURSE	Patient Foundation	Patient Update (inc. Outpatients)	Inanimate Foundation	Inanimate Update	TFA By Trainers
Total spaces offered	627	1578	382	443	100
Total Spaces booked	527	1689	346	457	55
Total Spaces Attended	301	1119	215	296	38

There are around 14887 employees within the Health Board. During the period 3030 training spaces was offered for manual handling, of these 3030 spaces 1931 members of staff attended training during the year which equates to a 63% uptake.

4.0 HEALTH ISSUES

4.1 Health and Wellbeing

The Health Board successfully retained Gold of the Corporate Health Standard in September 2017 of which health and safety is a key participant.

The Corporate Health Standard Team were runner up in the Health at Work & Wellbeing Category in the 2017/18 Staff Recognition Awards and were also nominated in the Going the Extra Mile Category.

4.2 Control of Substances Hazardous to Health (COSHH)

The Health Board is required to complete risk assessments for all hazardous substances in use. This is to ensure sensible steps are taken to prevent ill health. Progress has been made in meeting this requirement; there are currently 3211 materials with 8943 COSHH assessments on the SYPOL database.

There are approximately 271 work areas identified within the UHB and 253 COSHH co-ordinators in place.

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

Table 28

Clinical Board	No. COSHH Co-ordinators	Approx No. Identified Areas	No. of Areas Compliant/ in date	Compliance 15/16	Compliance 16/17	Compliance 17/18	Change since last year
Children and Women	34	36	32	88%	84%	89%	↑
Clinical Diagnostics & Therapies	47	47	26	74%	66%	55%	↓
Dental	4	4	4	100%	100%	100%	↔
Medicine	32	42	25	51%	57%	60%	↑
Mental Health	51	52	42	62%	77%	81%	↑
PCIC	7	7	2	67%	50%	29%	↓
Specialist Services	34	34	20	76%	61%	59%	↓
Surgery	34	39	13	46%	28%	33%	↑
Other (Exec, CEF)	10	10	4	50%	50%	40%	↓
Total	253	271	168	66%	62%	62%	↔

8

4.3 Monitoring and Occupational Hygiene

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

Table 29

Higher Risk Survey Type	Total
Hazardous Substances	19
Temperature /Humidity	6
Noise	7
Lighting	2
Office Environment/Space	8
Total	42

4.3.1 Environmental Monitoring March 2017 – April 2018

Hazardous Substances **Table 30**

Survey	Dept/Location	Site	Date
Nitrous Oxide	Surgery 2, dental	St David's	09.05.17
Chloroform	Cellular pathology	UHW	27.06.17
Peracetic acid	Theatres	CHfW	12.07.17
Peracetic acid	Endoscopy/urology	UHW	05.07.17
Peracetic acid	Endoscopy/main theatres	UHW	12.07.17
Peracetic acid	Endoscopy	UHW	25.07.17
Peracetic acid	Endoscopy	UHL	20.08.17
Peracetic acid	Endoscopy	UHL	20.09.17
Sevoflurane	Theatres	UHL	04.10.17
Formaldehyde	Mortuary	UHW	17.10.17
Nitrous oxide	Dental	St Davids	24.10.17
Formaldehyde	Fetal pathology	UHW	31.10.17
Sevoflurane	CHFW theatre 4	CHfW	10.11.17
Sevoflurane	Recovery	UHL	29.11.17
Nitrous Oxide	Dental	Pontypridd	06.12.17
Nitrous Oxide	Dental Paeds	UDH	13.12.17
Nitrous Oxide	Dental Adults	UDH	06.12.17
Nitrous Oxide	Midwifery Led Unit (MLU)	UHW	08.03.18
Dust	Dental Prod. Lab.	UDH	20.03.18

Noise **Table 31**

Survey	Dept/Location	Site	Date
Noise	Estates	UHW	27.09.17
Noise	CHFW kidney centre	CHfW	07.11.17
Noise	UHW GF607	UHW	08.11.17
Noise	Mobile MRI Unit UHW	UHW	14.11.17
Noise	Mobile MRI Unit UHL	UHL	13.12.17
Noise	C4 Neurology	UHW	13.12.17
Noise	Dental Prod. Lab.	UDH	20.03.18

Thermal Comfort **Table 32**

Survey	Dept/Location	Site	Date
Thermal comfort	T&O	UHW	30.05.17
Thermal comfort	Urology lab	UHW	22.06.17
Thermal comfort	Radiology	UHW	19.07.17
Thermal comfort	Pelican Ward	CHfW	20.10.17
Thermal comfort	Cardiology Admin Office UGF	UHW	18.01.18
Thermal comfort	Dental Lab 4th Floor (UNI)	UDH	28.03.18

Office Environment **Table 33**

Survey	Dept/Location	Site	Date
Space assessment	Dental production lab	UDH	14.06.17
Slip assessment	Physio hydrotherapy pool	UHW	11.10.17
Slip assessment	Mortuary	UHW	01.11.17
Space	Cardiology Admin Office UGF	UHW	18.01.18
Slip Assessment	Critical Care – A3, B3 & A3 lk	UHW	01.02.18
Slip Assessment	Physio Gym	HyC	29.03.17
Space	Pt Experience Team C Block	UHW	23.03.18
Space assessment	Roath clinic/ District Nursing	Community	03.05.17
Lighting	Tunnels	UHW	17.05.17
Lighting	Dental Production Lab	UDH	08.03.18

A substantial number of informal visits/responses to queries have also been undertaken.

During this period of intensive intervention by the HSE environmental monitoring was prioritised based on risk and some items postponed until 2108/19. This item was added to the Health and Safety Priority Improvement Plan and communicated in the Health and Safety Committee.

4.4 Workplace Welfare and Ergonomics

An improved ergonomic approach within Housekeeping and Ward Based Catering to reduce Muscular Skeletal Disorders and Repetitive Strain Injuries has been enhanced with:

- Improved storage for housekeeping and catering equipment.
- The purchase of a battery operated truck for delivering stores to wards.
- Purchasing smaller fridges /freezers which are easier and safer to transport.
- Purchasing 4 x scrubber drying machines for cleaning large areas.
- An electric tug is now being used to deliver all stores to the outside buildings as opposed to delivering manually where muscular skeletal injuries are prevented.

4.5 Display Screen Equipment

During the year the Health and Safety Department has re launched a bespoke electronic Display Screen Equipment training and assessment package, this facilitates the assessment as to whether a person using a computer is a defined user under the Display Screen Equipment Regulations and delivers training and assessment for users.

Chart 10

This has been rolled out to Executive Services and the Capital, Estates and Facilities Service Board where over a 1000 computer users have been identified. As seen in chart 10, 303 users completed the online training and assessment. We are in the process of expanding this into non corporate departments.

5.0 ENVIRONMENTAL & HEALTH AND SAFETY PATIENT ISSUES

5.1 Ligature Assessments in Mental Health

Hanging is a significant method of suicide for mental health service users. The Department of Health *Preventing Suicide in England Strategy (DoH 2012)* states that regular assessments of inpatient wards/clinical areas to identify and remove potential risks, i.e. ligatures and ligature points should be undertaken. The National Patient Safety Agency *Preventing Suicide – a toolkit for mental health services (NRLS 2009)* details eight standards, with audit procedures, looking at the process of admission through to discharge of a working age adult from the ward environment. Standard 2 requires that wards are audited at least annually to identify and minimise opportunities for hanging or other means by which service users can harm themselves. The Health and Safety Executive (2004) also directs Health Services responsible for caring for patients and service users who may exhibit self-harm behaviour in reducing possible risks associated with potential ligatures and anchor points.

Ligature audits have been undertaken annually for many years within the Mental Health Clinical Board but there has been no documented procedure. The Health and Safety Adviser who supports the Mental Health Clinical Board documented a procedure for audit and assessment to assist staff to address ligature risk in a balanced, objective and systematic way using an audit tool. This procedure was ratified at the Clinical Board Quality and Safety meeting in June 2017 (UHB ref 383).

In collaboration with Ward Managers, Team Leaders and Advanced Nurse Practitioners, the Health and Safety Adviser undertook audits in all mental health inpatient wards and facilities accessible to mental health inpatients (i.e. therapies areas and day patients). The Capital and Planning Department had submitted a bid to Welsh Government for funding to address ligature risks and were successful – the ligatures identified in the audit process were scrutinised

and the Health and Safety Adviser worked closely with the Clinical Board and Capital and Planning Department to identify a prioritised programme of anti ligature works. This work commenced early this year and is ongoing.

5.2 Mental Health Smoking Cessation 2017/18

The Director of Operations for Mental Health reported to the Committee that smoking legislation and policies did not prevent mental health patients from smoking in NHS premises. The MHCB, following 12 months of preparation banned smoking in all its settings in January 2018 being warned that there would be an increase in incidents of violence and aggression against staff and other patients. The CB concluded that there remained significant harm from smoking to the individual and those near them. Ethical, public and professional viewpoints supported a position that on balance as a mental health service the CB should pilot a period of a smoking ban in mental health for 6 months starting the first week in January 2018 with a formal review of its impact every 8 weeks.

5.3 Water Safety/Legionella

In April 2107 the Health and Safety Committee approved the revised Water Safety Policy and Water Safety Plan.

In December 2017 the Director of Infection, Prevention & Control (Chair of Water Safety Group) wrote to all Clinical Boards outlining the revised Water Safety Plan and with changes to flushing requirements and details of how to flush. Highlighting for action that:

- If a water outlet or group of outlets are not used regularly in their department/ward area, the water contained within starts to become stagnant and the growth of potentially harmful micro-organisms such as legionella or *pseudomonas aeruginosa* can occur. To avoid this, flushing of little used outlets must be carried out to replenish water within the pipes and fittings.
- If outlets are no longer required, it is safer to remove these outlets altogether.
- Irrespective of levels of use, ALL showers MUST be flushed three times a week in accordance with the Health Board Water Safety Plan.
- Flushing of outlets needs to be documented, a “LITTLE USED OUTLET & EVALUATION RECORD” is provided in the guidance. Periodic flushing audits will be conducted by the Estates/Health and Safety Departments.
- Ensure all documentation is available for inspection.
- Ensure that all areas are aware of the requirement to flush our water systems according to the Health Board Water Safety Plan.
- Ensure that flushing records are kept and are available for inspection during flushing audits.

- Ensure that their clinical board is appropriately represented on the Water Safety Group.

The Water Safety Group has continued to meet on a quarterly basis and review the findings of the water safety and flushing audits carried out.

To further advance compliance, the Capital and Estates Department has progressed a compliance report of all the identified outlets to assist areas in continuing to meet their flushing responsibilities

5.4 Clinical environments

There have been significant capital works that have taken place in the last 12 months to improve the environment and facilities for our patients and staff. This includes:

Surgical Wards/Theatre Areas

- At UHW, wards B6 and B2 have had a total refurbishment essential for the client groups on these two wards that often have significant mobility and cognitive impairments and the environments have been adapted to facilitate these needs.
- Ward A3L has undergone a refurbishment program to replace the floors and upgrade the toilet and shower facilities.
- There are plans to refurbish ward A2 in the summer of 2018
- A new modular theatre has opened in University Hospital Llandough following £1.7m worth of funding from the Welsh Government with plans to build two more theatres.
- At UHW theatre the changing room facilities for staff are being upgraded along with a fully refurbished admissions corridor.

5.5 Patient Risk (external falls from height UHL) project

Estates Capital and Compliance Department has carried out a patient risk assessment relating to external falls from height at UHL identifying areas where patients could gains access to external areas and risk harm from falls.

6.0 FIRE SAFETY

Fire Safety is subject of a separate Annual Report

7.0 ESTATES & FACILITIES HEALTH AND SAFETY COMPLIANCE

7.1 Food Hygiene

During the period there have been a total of 5 Environmental Health Inspections of kitchens or cafés within the Health Board, as can be seen from Table 34 the inspections score attained either the highest level of 5 or 4.

Table 34

Kitchen	Aroma Café UHW	Aroma Café UHL	SPAR SHOP, UHL	Teddy Bear Nursery	UHW Central FPU	UHL	Llanfair Unit	Rookwood	Y Gegin	Whitchurch	I Jones	West Wing	St Davids	Barry	Average
Score 13/14			N/A	5	N/a	4		4	5	4	4	4	5	5	4.25
14/15			N/A	5	N/a	4	5	4			4		5	4	4.5
15/16		5	N/A	4	(2)(3) 5	5		4	5	5	4		5	5	4.66
16/17		5	5	4	(5) 5	4		5	5	N/A		N/A	5		4.75
17/18	4	5			5								4	5	

7.2 Waste Compliance

Compliance to the environmental requirement for waste is considered at six monthly intervals by the Committee. The report to the January 2018 Committee gave assurance that the overall compliance with the Hazardous Waste (England and Wales) (Amendment) Regulation 2016 was 99%.

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Table 35

2017	Orange Bags	Tiger bags	Yellow bags	Cytotoxic bags	Black bags	Clear bags	Yellow sharps	Orange sharps	Purple sharps
Compliance %	**100**	**100**	**100**	**100**	**99.7**	**100**	**99.3**	**98.8**	**98.8**

7.2 The Estates and Facilities Internal advances

The Estates and Facilities Departments have continued to enhance health and safety compliance both within its own staff and under its corporate responsibilities. These improvements include:

- Enhanced level of Mandatory Training Compliance across all departments.
- Statutory Compliance Audit Report 11th September 2017 – Substantial Assurance.
- An additional Estates /Facilities Safety Adviser has been employed.
- Security Control Room modernisation - centralised CCTV monitoring in UHW AND UHL. Significant investment in CCTV, panic buttons and access control across the UHB with greater health and safety benefits for staff/patients and visitors.
- PUWER assessments carried out and supported.
- Tunnel safety and security working group established.

7.3 Contractor Control

A number of high risk construction related activities have been carried out over the past 12 months and significant resource into these activities has been provided by the Capital, Planning and Estates Health and Safety Team High degree of contractor control now being implemented across the Cardiff and Vale estate for the Capital, Estates and Facilities Service Board activities, this includes:

- Contractor audit programme firmly in place. Average number of contractor site visits carried out for the first four months of 2018 has significantly increased to 81 site visits per month.
- Overhaul of the Cardiff and Vale UHB Permit to Work System carried out. The following permits have been reviewed, amended, trialed and implemented within the compliance and discretionary capital team – hot works, working at height, permit to dig and confined spaces.
- Contractor related documentation now scrutinised further by estates health and safety team, in particular the suitability of their submitted risk assessments and method statements for high risk activities.
- Staff refresher training on the UHB Control of Contractors Policy V2 completed for the Compliance and Discretionary Capital Service Team.
- Completed refresher training on the control of contractors for management and supervisors in the Compliance and Discretionary Capital Service Team..

7.4 Future plans 2018/19

- Investigate practicality of utilising safety in procurement scheme for all contractors employed by Capital, Estates and Facilities Service Board.
- New format permits to be introduced across Estates.
- Expand contractor control audits to include KPIs agreed with the estates team
- Complete refresher training on the UHB Control of Contractors Policy for Estates and Facilities team.
- Review training needs analysis and consider IOSH training for all managers in Compliance and Discretionary Capital Service Team.
- Further develop prioritised safety improvement plan in line with corporate guidance.
- Assist estates team in reviewing risk registers and coordinate risk registers for other departments in the service board.
- Engaging consultants to provide a pedestrian safety strategy for UHW site.
- Introducing new asbestos database (MICAD) that will enable more robust auditing.

- Remediate asbestos high risk areas (regulation 18) areas by end of 2019.
- Create contractor control related safety KPIs and ensure they are fully communicated.
- Training plan for all Authorised Persons.

8.0 SHARPS MANAGEMENT

Table 36

	12/13	13/14	14/15	15/16	16/17	17/18
Staff needlestick injury	268	265	234	167	164	196

It can be seen from the above trend statistics the number of needlestick incidents have increased for the first time since the introduction of the Safer Sharp project, however it is still significantly lower then prior to the initiative.

Chart 11

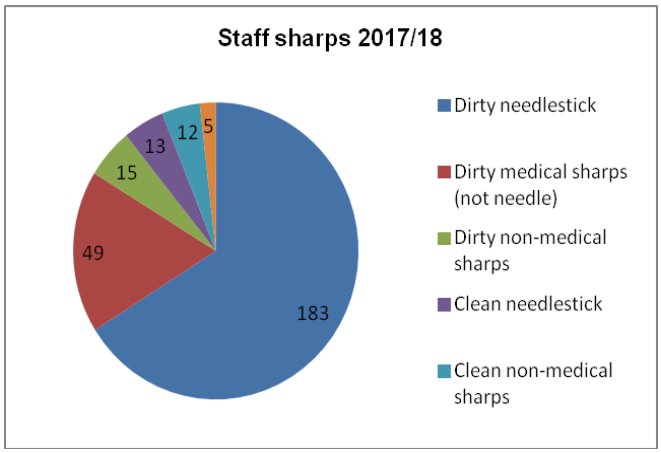


Table 37

Staff sharps 2017/18	
Total	277

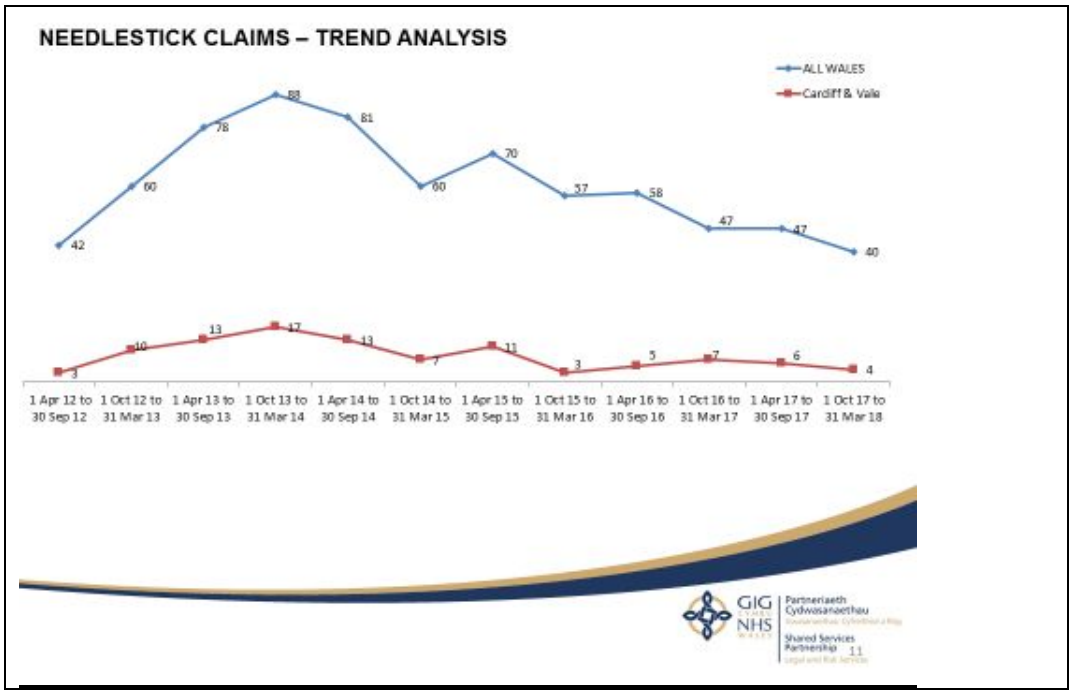
Total events were 277 of which dirty needle accounts for the higher type of sharps injury at 183 or 66%. This is dissapointing given the efforts over the previous years to introduce safety devices

Table 38

	Estates Facilities	Child &Women's	C D & T	Dental Services	Exe & Corporate	Medicine	Mental Health	PCIC	Specialist	Surgical	No value	Total
2017/18	22	19	26	43	6	47	8	15	38	42	11	277
2016/17	11	21	42	48	2	30	12	9	30	46	7	258

Reduction in number of incidents regarding incorrect disposal of sharps in the Dental Clinical Board seen following communication from Head of School and also improved sign off procedure for disposal in oral surgery. Cut resistant gloves also introduced for collection staff.

Chart 12



Although the number of incidents have increased the above chart shows a continued and significant reduction in the number of personal injury claims.

8

FIRE SAFETY REPORT
Name of Meeting: Health and Safety Committee **Date of Meeting:** 10th July 2018

Executive Lead: Director of Planning
Author : Senior Fire Safety Advisor 02920 742292
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact: The report is strategic with direct cost being identified as required.
Quality, Safety, Patient Experience impact: The fire safety action plan will improve fire safety and reduce the fire risk.
Health and Care Standard Number: 2.1
CRAF Reference Number: 6.4.5
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- That issue identified in the fire risk assessments and the audits carried out by the Fire Authority and NHS Wales Shared Services Partnership - Specialist Estates Services are being appropriately managed.
- To continue discussions with SWFS regarding the attendance at alarm activations.
- Address issues identified in the fire risk assessments and external audits with a rolling programme of structural improvements and monitoring through the Fire Safety Group.
- Continue measures to reduce the number of unwanted fire signals by investigating all incidents and upgrading the fire alarm systems.
- Continue the steady improvement in fire training compliance by linking pay progression to compliance and providing additional face to face training sessions to offer more opportunities for staff to attend.

The Health and Safety Committee is asked:

- to **CONSIDER** the report

SITUATION

This paper provides an update on the relevant fire safety issues.

Key issues:

- Fire Risk Assessments

10

- Fire Service Response
- Enforcement Notices
- Fire Service Audits
- Fires and Unwanted Fire Calls
- Fire Training
- Fire Compartmentation

BACKGROUND

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

ASSESSMENT

1.0 Fire Risk Assessments

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

2.0 South Wales Fire Response

South Wales Fire Service (SWFS) continue to send one appliance to any automatic fire alarm activation during the hours 08.00 and 18.00 unless they receive confirmation that it is a fire.

We have twice requested a meeting with SWFS to discuss their current response and the possibility of them providing no response in future but they have failed to respond with a date.

3.0 Enforcement Notices

There are no Enforcement Notices in force at the present time.

4.0 Fire Service Audits

A number of fire audits have been carried out by SWFS and we are fully aware of the issues raised such as the lack of compliant fire dampers and breaches in our fire compartmentation both of which are being addressed in a rolling program of fire safety upgrades. In addition where areas are being refurbished they are upgraded to the latest fire safety standards.

A further concern highlighted in the fire audits is storage in escape routes. This is an escalating problem which needs to be addressed by the Health Board.

5.0 Unwanted Fire Signals (UwFS)

A total of 460 UwFS occurred in the last twelve months with the major causes being equipment failure, smoking, cooking, contractors and accidental activation.

Listed below is the number of UwFS recorded by site.

Location	Value
15 - 17 Park Road	2
34 Wordsworth Avenue	1
5 - 11 Park Road	1
Amy Evans CMHT	2
Barry Hospital	8
CRI - West Wing	1
Cardiff & Vale Therapy Centre	1
Cardiff Royal Infirmary	14
Dental Hospital (University Hospital of Wales)	7
Global Link	2
Hafan Y Coed	25
Iorwerth Jones Centre	1
Lansdowne Hospital (Remainder)	2
Llandough Hospital	64
Riverside Health Centre	1
Rookwood Hospital	14
St David's Hospital (Cardiff)	4
Unit B5	1
University Hospital of Wales	296
Whitchurch Hospital	13

A major issue identified is the volume of UwFS occurring in old detectors for no apparent reason. Some of the detectors in the Heath are over 20 years old which is in excess of their expected operational use. Following the detection upgrades in Llandough and Rookwood have resulted in a significant reduction in UwFS.

Following a quote for a further upgrade in the fire alarm system at the Heath a business case is being prepared to for consideration.

6.0 Fire Incidents

There have been 15 fires on our sites in the last twelve months. Three of which were started deliberately in the mental health unit, one discarded smoking materials and the rest were the result of electrical faults.

Item	Value
Hafan Y Coed	5
Llandough Hospital	2
Riverside Health Centre	1
Rookwood Hospital	1
University Hospital of Wales	6

7.0 Training

There has been a marked improvement in the fire training figures available from Learning and Education Department. There has a been an increase every month since August of last year and well done to the Dental Hospital who have achieved the Health Board target of 85% compliance.

The table below clearly shows an upward trend:

Clinical Boards	November	December	January	February	March	April
Children & Women	64.23%	67.02%	69.83	72.02	73.11%	74.92%
Capital, Estates & Facilities	56.34%	58.88%	61.22	62.25	61.79%	55.74%
CD&T	73.05%	72.18%	72.22	71.93	70.88%	72.73%
Corporate	67.69%	68.82%	70.51	74.38	75.28%	77.11%
Dental	78.27%	79.93%	82.47	79.30	81.08%	85.56%
Medicine	52.63%	55.87%	61.22	63.61	64.70%	66.50%
Mental Health	54.75%	54.53%	56.01	58.97	60.77%	65.30%
PCIC	64.81%	64.97%	64.48	66.82	65.64%	67.77%
Specialist Services	55.07%	55.20%	56.99	57.85	57.17%	59.91%
Surgical Services	48.90%	51.29%	51.79	52.45	54.38%	55.96%
UHB Total	**60.16%**	**61.55%**	**63.37**	**64.70**	**65.17%**	**66.81%**

8.0 Fire Compartmentation

The rolling program of remedial work continues having just completed extensive repairs to Women's Hospital. The next stage to be surveyed are the Link Blocks at the Heath where there is a sleeping risk. Once this element has been completed it will conclude all the sleeping risk areas above the ground floor on the Heath site.

The other factor in restricting the spread of fire and smoke are the fire and smoke dampers many of which do not comply with current standards. We have now completed a full survey of the dampers and they will be upgraded as areas are refurbished.

10

SHARED SERVICES FIRE AUDIT UHL REPORT
Name of Meeting : Health and Safety Committee **Date of Meeting** 10/07/2018

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

ASSURANCE AND RECOMMENDATIONS

ASSURANCE is provided by:

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

The Health and Safety Committee is asked:

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

SITUATION

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

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

BACKGROUND

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

ASSESSMENT

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

The action plan is attached as an appendix.

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

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

6.3.3	The Board should continue to ensure the current high standard of general house-keeping within the patient areas is maintained and improve the aspects identified through this report and the fire risk assessments including management cooking facilities.	**M**	LW	Completed
6.3.4	The Board should continue with its endeavours to improve cylinder management, ensure schematics of medical gas pipe routing are available and the ASVUs labelled, protected/maintained.	**L**	Pharmacy	Completed
6.3.5	The Board should ensure uncontrolled smoking practices are managed accordingly.	**M**	CD	Completed
6.3.6	The Board should ensure the measures to mitigate the potential arson and security risk are maintained.	**L**	CD	Completed
6.3.7	The Board should ensure portable appliance testing is conducted for all equipment as necessary, and ensure electrical risks are detailed in the fire risk assessments and prioritised for action accordingly.	**M**	TW	Completed
6.3.8	The Board should continue to improve training performance.	**M**	Department Heads	Compliance figures showing continues improvement now at 67%

7.3.1	The Board should undertake a full review of the fire alarm installation and system infrastructure to reconfigure and establish zoning arrangements that reflect the compartmentation and departmental boundaries.	**H**	GE	The changes to the fire alarm zoning and cause and effect to be completed in January 2019 when the fire alarm tender is issued.
7.3.2	The Board should review the device address descriptions to remove any ambiguity as to the location of the individual devices and reflect the zoning arrangements.	**M**	GE	The changes to the fire alarm zoning and cause and effect to be completed in January 2019 when the fire alarm tender is issued.
7.3.3	The Board should ensure accurate zone plans are displayed adjacent to all fire alarm panels.	**L**	TW	The changes to the fire alarm zoning and cause and effect to be completed in January 2019 when the fire alarm tender is issued.

7.3.4	The Board should develop a C&E schedule detailing all ancillary devices interfaced with the fire alarm and ensure the C&E is fully validated on an annual basis.	**M**	GE	The changes to the fire alarm zoning and cause and effect to be completed in January 2019 when the fire alarm tender is issued.
7.3.5	The Board should ensure a full set of accurate as installed drawings is available which also details the interfaces to any ancillary equipment linked to the fire alarm system.	**L**	GE	The changes to the fire alarm zoning and cause and effect to be completed in January 2019 when the fire alarm tender is issued.
7.3.6	The Board should continue with a phased programme to replace the obsolete detectors and upgrade to an L1 standard where necessary.	**M**	GE	Completed
7.3.7	The Board should ensure the fire risk assessments address the omission of the magnetic lock over-ride facilities as required by BS 7273:4.	**L**	GE	Completed

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

8.3.2	The Board should instigate a procedure that ensures designated elements of fire construction achieve the requisite period of fire resistance and are adequately fire stopped with suitable materials.	**M**	TW	The phased programme in place is targeting the high rise sleeping areas in the Heath as a priority. Llandough to be reviewed in 2019
8.3.3	The Board should ensure the potential for external fire spread and space separation requirements are reflected in the response procedures and addressed in the fire risk assessment with action prioritised as necessary.	**L**	FB	Completed
8.3.4	The Board should conduct a survey of the ventilation system and prepare an up-to-date set of 'as installed' drawings illustrating the whole ventilation system, following which fire damper provisions should be assessed accordingly.	**M**	TW	Completed
8.3.5	The Board should review the maintenance regime for the mechanical ventilation to ensure maintenance/testing of fire dampers is conducted at least annually in accordance with BS9999.	**M**	TW	Completed

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

8.3.11	The Board should review the escape lighting testing regime to ensure compliance with BS5266 including the annual 3 hour duration testing and continue to ensure any future upgrades include self-testing facilities to support future maintenance.	**L**	TW	Now going out to tender for external contractor to complete. Tender returns due in October.
8.3.12	The Board should ensure that all facilities for fire fighting purposes are referenced in the fire manual as well as the fire risk assessments which should also consider the benefit of extending the internal fire main along the street.	**L**	FB/TW	Completed
9.3.1	The Board should undertake a complete review of the Llandough response procedures which should then be reflected in site specific documentation.	**H**	FB	Completed
9.3.2	The Board should develop department specific procedures, particularly for areas accommodating very high dependency patients and areas where a higher level of control may be required.	**L**	FB	Completed
9.3.3	The Board should develop and display fire evacuation plans complying with the principles of BS ISO 23601.	**L**	TW	Part of the fire alarms programme to be completed in January 2019

9.3.4	The Board should review the arrangements for vertical evacuation ensuring availability of suitable evacuation aids recognising the patient's condition (including bariatric) and the location and likely number of aids required for effective evacuation of mobility impaired persons.	**H**	CD	Completed
9.3.5	The Board should ensure that revised any procedures are disseminated to staff and reflected in the training syllabus, including the use of evacuation aids and lift operations.	**M**	FB	Completed
9.3.6	The Board should conduct scenario based evacuation exercises including interaction with the Fire and Rescue Service.	**M**	TW	Unable to completed without full support of the departments.
9.3.7	The Board should continually review and update its procedures to reflect the outcomes of future exercises.	**L**	FB	Completed

PROPOSAL FOR STATUTORY AND MANDATORY TRAINING
Name of Meeting : Health and Safety Committee Date of Meeting 10th July 2018

Executive Lead : Executive Director of Workforce and OD
Author : Assistant Director of OD, 47535
Caring for People, Keeping People Well: This report underpins the 'Great place to work and learn' elements of the Health Boards Strategy.
Financial impact : not applicable
Quality, Safety, Patient Experience impact : This report aims to ensure staff receive the right statutory and mandatory training at the right time to develop the knowledge and skills to ensure a safe and healthy workplace
Health and Care Standard Number, 2.1, 2.4, 2.7, 7.1
CRAF Reference Number, 5.2, 6.2, 6.4, 8.1
Equality and Health Impact Assessment Completed: Not applicable

RECOMMENDATION

The Board is asked to:

AGREE;

- To the reduction of level 1 training
- To develop a robust training needs analysis by July 2018
- To establish a competence based pathway, which is aligned to individual's electronic staff record.

12

SITUATION

The Workforce and Organisational Development (WOD) agenda is currently promoting and leading on the 'Core Skills Training Framework' (CSTF). This National initiative focuses on our staff to ensure they are fully compliant and safe within their role. This paper reviews the current model employed by Cardiff and Vale University Health Board and suggests a new compliance matrix which is applicable to relevant staff groups across the organisation.

BACKGROUND

In 2013 the Health Board agreed to support the "Once for Wales" approach to allow training to be inter transferable between Health Boards and Trusts. In principle this should create a consistent standard across Wales, however, different interpretation nationally has prevented this from being achieved. The CSTF supports 10 core e - learning modules. In 2016 Cardiff and Vale University Health Board agreed to add an additional 3 modules following a mandate presented by the Welsh Assembly Government (WAG). The Health

Board adopted a 'blanket approach' requiring all staff, in all professions to complete all 13 modules. This misrepresented the government's mandate by instructing inappropriate staff groups to complete e-learning modules not applicable to their role. This has led to duplication and unrealistic training for staff developing an ineffective picture of compliance.

ASSESSMENT AND ASSURANCE

The mandatory steering training group (MSTG) have been challenged with reviewing the CSTF document to understand how it has been interpreted locally compared to other Health Boards in Wales. It is worth noting that staff who have undertaken level 2/3 training are not required to complete level 1 competences.
The table below sets out the current requirement and proposes the changes for clinical and non-clinical staff.

CSTF Module	**LEVEL 1 TRAINING**			**LEVEL 2 AND ABOVE TRAINING**
	Current	**Proposal**		
		Non Clinical	**Clinical**	
Fire Safety	Annual training for all staff	e learning Yearly	Ward Based- Staff Yearly Classroom Non Ward Based Staff – Yearly e Learning then Classroom	
Information Governance	Two yearly	Two Yearly	Two Yearly e learning	
Resuscitation	Yearly	Once only e learning	BLS Minimum	Advanced dependent on role ILS for Ward Based Nurses
Manual Handling	Two yearly	No e learning unless in a role that moves objects then attend class room	No e learning Classroom training only	Level 2 Classroom only every 2 years Inanimate for Non Clinical Patient Handling for Clinical Staff
Infection control	Three yearly	e learning three yearly	No e learning Yearly level 2	
Health and safety	Three	Three	Three Yearly	

12

	yearly	Yearly		
Equality (Treat me Fairly)	Three yearly	Three yearly e learning	Three yearly E learning	
Safeguarding adults	Three yearly	e leaning three yearly	No e learning	Level 2 or 3 Class room
Safeguarding Children	Three yearly	e learning three yearly	No e learning	Level 2 or 3 class room
Violence and aggression	Three yearly	Once only e learning	Once only e learning	If in area of Risk Breakaway Skill
Additional modules mandated in 2016				
Mental Capacity	Three yearly	No e learning	e learning three yearly or workshop not both	
Dementia	Three yearly	e learning Once only	Three yearly training. If their level of training is above what they require they will be automatically compliant	
Domestic Violence against Women	Three yearly	e learning three yearly	e learning three yearly	

Caveat: There will be Mandatory May/Sept/Nov for staff who are unable to use a computer.

To support this recommendation a training needs analysis (TNA) will be developed to identify specific staff groups and their training requirements. This will be illustrated through their individual Electronic Staff Record allowing for effective monitoring and management. This process will ensure that the relevant level of training is accurate for each individual staff group. The TNA process is due to be completed in July 2018.

12

ENFORCEMENT AGENCIES REPORT
Name of Meeting: Health & Safety Committee **Date of Meeting:** 10/07/2018

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

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

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

The Health and Safety Committee is asked to:

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

SITUATION

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

13

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

a) Concerns raised following HSE Audit of the Public Health Laboratories at UHW & UHL

This report updates the Committee on progress for each event.

BACKGROUND

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

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

ASSESSMENT

Road Traffic Accident at UHW

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

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

The remedial actions and the pedestrian strategy have progressed as reported by the Director of Capital, Estates and Facilities at the April Committee meeting.

Hydrotherapy Pool

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

A Working Group of Therapies, Estates and the Health and Safety Department was formed to actively pursue the required actions this group has now confirmed all the requirements have been met - item closed.

Contractor Fall

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

Legal advice was sought and a formal submission made on the 14th February 2018. We are still awaiting the HSE to review and respond.

Asbestos inspection carried out by the HSE Inspector on a specialist contractor working on the X-ray Department in UHW

On 22nd March 2018 the HSE wrote to the Health Board following an inspection it had undertaken of a licenced asbestos contractor who was working on UHW, their location was on the outer windows of the x-ray corridor. This work was planned to be done as some windows were going to be replaced.

The Inspector requested the Health Board investigate whether better arrangements could have been made so contractors were not having to carry tools and waste materials long distances, and to justify that this was the only access route available for the contractors, as it introduced a lot of manual handling issues and risks if asbestos bags ripped .

A response was prepared outlining that the extended route was required to ensure that the disruption to the x-ray service was minimised and no services cancelled.

A team from the HSE subsequently revisited the site, together with health and safety and estates staff, they concluded that the best available route had been taken - item closed.

New Item - Inspection of Public Health Laboratories at UHW & UHL

The HSE inspected the Public Health Laboratories (PHW) at both UHW and UHL at the beginning of May. The Health Board has a service agreement for the maintenance of the Laboratory and the pressure vessels (autoclaves).

The inspector had raised a number of concerns in relation to the lack of containment of the level 3 laboratory at UHL and lack of communication/co-operation between the Health Board and PHW and was minded to issue an **Improvement Notice** against both organizations.

The information given is that work in sealing the laboratory was undertaken with the job completed on the 19th December 2017. This would have then required PHW to retest for leaks and confirm if further work was required. However due to a lack of communication, PHW had identified the need for further sealing, and as such formal retest by Arena would have not been justified. They considered that the Health Board was aware of this and were therefore waiting for the repairs to be made, whilst we considered that the work was completed until a further retest was completed. The Health Board gave a commitment to put in place an improved communication plan with PHW which will be formalized.

The HSE has agreed that given the above an Improvement Notice would not be justified, but the Health Board will receive a letter holding us to the formal agreed plan and the formal letter is awaited. It is understood that an Improvement Notice has been issued to PHW.

HEALTH AND SAFETY PRIORITY IMPROVEMENT PLAN 2017/18
Name of Meeting: Health & Safety Committee **Date of Meeting:** 10/07/2018
Executive Lead : Director of Corporate Governance
Author : Head of Health and Safety 02920 743751
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy
Financial impact : The report is strategic with direct cost being identified as required
Quality, Safety, Patient Experience impact: The Priority Action Plan covers patient health and safety, with specific reference to the patient environment and falls.
Health and Care Standard Number 2.1
CRAF Reference Number 8.1.4,6.4.7,6.4.5,6.4.4
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

REASONABLE ASSURANCE is provided by:

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

RECOMMENDATION

The Health and Safety Committee is asked to:

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

SITUATION

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

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

BACKGROUND

The Health and Safety Department has been working to integrate the plan with the Corporate Risk Assurance Framework ensuring that the risks identified within the Priority Improvement Plan are being appropriately addressed and monitored such that strategically health and safety is progressing.

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

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

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

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

ASSESSMENT

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

As can be seen from the above table 52 actions/milestones have been effectively progressed during the year with 15 areas still requiring action.

These will be progressed in conjunction with the reviewed Corporate Risk Assessment Framework, which plans to more easily demonstrate the level of progress made.

The revised overall priority improvement plan will be completed in time for the October meeting to facilitate the inclusion of the renewed Corporate Risk Assessment Framework and actions arising out of the annual report. This plan will include milestones, completion dates and progress.

Key Milestone Actions Progressed During Period

	Mile Stone	Action /Progress	Action required	Accountable Lead	Status
1.4	The Health Board has confidence that the H&S responsibilities of managers are understood and adhered to.	A training course for managers is being developed specifically around ensuring that they recognise their duties under the relevant H&S policies and their broader legislative compliance duties. During the period an Adviser was recruited whose remit includes delivery of the above.	Training course under development to be completed with an aim of offering the course during September/ October 2018	Head of Health and Safety	Red
2.5	All assistance is given to staff in dealing with Violent events both pro-actively and reactively.	A working group is set up nationally to revise the MOU to include these events. Commitment for Security Services to be trained with Mental Health on safe techniques agreed.	MOU revised date set for October 2018 Staff to attend training.	Security Manager	Amber
3.3	Suitable and sufficient patient handling equipment is available.	39 replacement hoists have been purchased and delivered to each area.	Verify that the additional hoists have significantly improved status of Pro-act audit findings - re audit November 2018.	Head of Health & Safety	Green
3.3	Suitable and sufficient patient handling equipment is available.	Review of servicing contract for hoists has delayed required LOLER inspection. Transfer of service to Clinical Engineering delayed and new contract signed.	Complete planned inspection	Director of Capital, Estates & Facilities	Green
5.6	Bariatric patient care is delivered with minimum risk to both staff and patients.	Identified manual handling risks in the delivery of care to bariatric patients. Pilot being developed with manual handling and Medicine CB staff to design and develop an improved care model.	Internal Medicine and Manual Handling are working closely in putting forward better designed to care for bariatric patients	Senior Nurse Medicine/ Head of Health & Safety	**Red**
5.8	Monitoring Schedule	A programme of sampling has been initiated but due to demands on the Environmental Adviser it has not met its full monitoring programme.	A priority monitoring programme has been introduced to ensure that these areas of risk are completed.	Head of Health and Safety	**Amber**
7.6	Development of a pedestrian strategy for the 2 major HB sites in relation to their traffic risks.	Pedestrian safety tunnel being pursued by Estates Department. An overall strategic approach is being developed, joint meeting with Consultants and health and safety to progress strategy. Tunnel safety user group has met and	Establish user group and implement findings	Director of Capital, Estates and Facilities	**Amber**

		produced action plan			
7.8	Contractor Control Standard is universally applied across all areas of the Health Board	Recruitment of corporate adviser to implement same standard as introduced within estates has taken place	Position starting August 2108	Head of Health and Safety	Amber

HEALTH AND SAFETY ISSUES RELATING TO MEDICAL RECORDS STORAGE
Name of Meeting: Health and Safety Committee **Date of Meeting:** 10/07/2018

Executive Lead :
Author : Health and Safety Staff Lead - 25400
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy
Financial impact: Potential costs relating to personal injury claims. Cost to fully digitalise medical records.
Quality, Safety, Patient Experience impact: This report is fundamental to the safety and quality of both staff and patients.
Health and Care Standard Number 2.1
CRAF Reference Number 8.1.4
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

LIMITED ASSURANCE is provided by:

- The continued actions undertaken by the Medical Records Management Team in working towards it's action plan.

The Health and Safety Committee is asked to:

- **RECOMMEND** the full digitalisation of medical records
- **NOTE** the content of this report

SITUATION

The Health Board has insufficient storage for medical/health records and the facilities that are available are not fit for purpose. This results in health, safety and fire issues due to lack of storage space and the continual growth in new files being created.

BACKGROUND

There is insufficient storage for all records, particularly in relation to archived records in the community

Medical Records, University Hospital of Wales (UHW) is situated in the former underground car park which wasn't designed for storing records and as such the environment itself is a constant challenge as space is very limited and thus creates tripping hazards.

Within the main filing library in UHW the mechanical shelving is broken and there have been a number of accidents reported where staff have been trapped between the isles. This also impacts on manual handling as staff have to manually move the shelving to access the medical/health record files.

The old maternity unit, University Hospital Llandough (UHL) is now full of medical records and due to the relocation of Rookwood Hospital this area will need to be cleared.

ASSESSMENT

To mitigate the problems of lack of storage space the management team for medical records has produced an action plan to which progress is being made. The Health Board has now given authority for case notes to be destroyed and to date 3000 boxes have been moved to long term storage with a further 9000 to be removed. The Health and Safety Staff Lead is visiting the Department regularly to ensure the actions are being progressed.

Building work is underway in Medical Records, UHW for a reception area as part of closing access to the library and a click and collect service is being trailed for Medical Records.

External premises have been obtained in Carmarthen and Treforrest to house medical records. However both of these premises are either now full or have limited capacity.

Some notes have been scanned but the Health Board does not have a full digitalised service, notes can often not be located which then results in duplicate notes being created and unless notes are digitalised the problem will just expand. The continuing growth of the population will further compound the problem.

Health and safety issues are not just restricted to the Medical Records Departments, it has a knock on effect for all wards and clinics as records are often stored inappropriately in these areas in contravention of the GDPR. A number of incidents have been reported in these areas where staff have either tripped over the records or sustained a manual handling injury. Health and Safety Staff Representatives fully participate in Joint Workplace Inspections, these are carried out in all areas of the Health Board both inpatient facilities and in the Community Health Centres and Clinics and these inspections often highlight the inappropriate storage of records.

Records are not only stored within the central medical records department as many areas also have their own medical records rooms.

There is also a patient safety risk if records cannot be found at the time of the appointment as not all clinical information will be available.

APPROVAL OF FIRE SAFETY POLICY	
Name of Meeting: Health and Safety Committee	**Date of Meeting:** 10/07/2018

Executive Lead : Director of Planning
Author : Head of Health and Safety – 02920 743751
Caring for People, Keeping People Well: This policy underpins the Health Board Strategy in avoiding harm whilst delivering outcomes that matter to them.
Financial impact: The implementation of this policy will be undertaken within the resources of the UHB and any identified additional resource requirement will be brought to the Committee for approval.
Quality, Safety, Patient Experience impact: The policy requirements impacts on all services of the Health Board and directly relates to both patients and staff care and safety.
Health and Care Standard Number: 2.1
CRAF Reference Number: 8.1
Equality and Health Impact Assessment Completed: Yes

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The continual monitoring of fire safety management through Fire Safety Group and the Deputy Fire Safety Manager Group.

The Health and Safety Committee is asked to:

- **APPROVE** the Policy
- **APPROVE** the full publication of the [insert document title] in accordance with the UHB Publication Scheme

SITUATION

The Health Board has a statutory obligation under the Health and Safety at Work Act 1974, to prepare and review its Health and Safety Policies. This requirement includes Fire Safety. The Health Board is mandated under Welsh Assembly and NHS standards or guidance of Fire Code to produce a Fire Safety Policy.

The policy is revision UHB 3 and was previously reviewed in July 2015. The South Wales Fire Service considers the Fire Policy as the core key Fire Safety document to implement appropriate fire arrangements.

BACKGROUND

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

THE AIM OF THE FIRE SAFETY POLICY

This Fire Safety Policy is intended to provide an unambiguous statement applicable to all premises used by the UHB and premises where UHB patients receive treatment or care.

The aim of the Fire Safety Policy is to ensure that it:-

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

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

Achieving these aims will ensure the UHB acts within the legislative and regulatory framework, complies with: The Regulatory Reform (Fire Safety) Order 2005 Firecode Suite of Documents; and where applicable Health & Safety, Building and Smoke Free legislation:

ASSESSMENT

Wide consultation has taken place to ensure that the policy meets the needs of our stakeholders and the Health Board. The consultation undertaken specific to this document was as follows:-

- The document was added to the Policy Consultation pages on the intranet between 29th May 2018 and 25th June 2018;
- The document was shared with the Fire Safety Group and the Operational Health and Safety Group.
- Comments were invited via individual e-mails from Fire Safety Group and Operational Health and Safety Group.

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

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

Amendments to the policy made relate mainly to:

Separating the Policy Statement from the Procedural Arrangements Organisational structural changes.

Amendments to the supporting Policy Procedural Arrangement Relate to:

1. General Changes in Management Arrangements
2. Revision of the Deputy Fire Safety Managers arrangements to ensure a greater direct responsibility link to Clinical/Service Service Boards rather than the previous geographic approach.
3. Revision to reflect changes in smoking control within mental health.
4. Closure of Whitchurch Hospital for inpatient care and the opening of Hafan y Coed

Equality Impact Assessment reviewed to reflect actions taken:

6.2 Persons with a disability as defined in the Equality Act 2010 for those staff and patients with sensory and mobility conditions, through personal evacuation plans and training provided to staff in areas caring for these patients.

6.5 Women who are expecting a baby may have mobility aspects and if identified, staff would be subject of a personal evacuation plan and patients through training staff in patient evacuation

6.6 People of a different race, nationality including non-english speakers. Through the use of evacuation signage which is in picture format and conforms to BS 5499-1 a recognized standard.

6.9 People who communicate in Welsh as 6.6 above

Reference Number: *UHB022* **Version Number: 4**	**Date of Next Review:** June 2021 **Previous Trust/LHB Reference Number:**

FIRE SAFETY POLICY

Policy Statement

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

Policy Commitment

This Fire Safety Policy is intended to provide an unambiguous commitment applicable to all premises used by Cardiff &Vale University Health Board and premises where Cardiff & Vale University Health Board patients receive treatment or care.

Supporting Procedures and Written Control Documents

- Fire Policy Procedural Arrangements
- CRI Fire Procedure
- Acute Hospital Fire Procedure
- Community Hospital Fire Procedure
- Health Centres and Clinics Fire Procedure
- St David's Hospital Fire Procedure

Other supporting documents are:

- NHS Estate Firecode
- Safe Management of Medical Gas Cylinders
- Health & Safety Policy
- No Smoking & Smoke Free Environment Policy
- Major Incident Plan

Scope

This policy applies to all of our staff in all locations including those with honorary contracts

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be a positive impact.

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

Document Title: *Fire Safety Policy*	2 of 18	Approval Date: dd mmm yyyy
Reference Number: UHB022		Next Review Date: dd mmm yyyy
Version Number: 4		Date of Publication: dd mmm yyyy
Approved By:		

Director	

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Nov 2010	04/01/2011	Replace previous Trust version reference no 36
2	23 April 2013	22/05/2013	Policy reflects changes required to meet the requirements of the Enforcement Notice issued by South Wales Fire Service in relation to the management of smoking in Mental Health premises.
3	28 July 2015	28/07/2015	Policy reflects organisational structural changes. A review of the arrangements with regards to Deputy Fire Safety Managers for UHW. It reflects site closures and amendments and continues to reflect the requirements imposed by the Fire Service in relation to Whitchurch Hospital site.
4	09/05/2018		

Equality & Health Impact Assessment for

Fire Safety Policy

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Fire Safety Policy UHB022
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Executive Services Head of Health and Safety 02920 743751
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The aim of the Fire Safety Policy is to ensure that it:- • Minimises the incidents of fire and all unwarranted fire signals throughout all properties used by Cardiff & Vale University Health Board. • Minimises the impact from fire on life, safety, delivery of service, the environment and property. Achieving these aims will ensure that the UHB acts within the legislative and regulatory framework, complies with: The Regulatory Reform (Fire Safety) Order 2005 and applicable legislation.
4.	Evidence and background information considered. For example	Fire Safety Group and the subgroups includes representation from

Document Title: *Fire Safety Policy*	4 of 18	Approval Date: dd mmm yyyy
Reference Number: UHB022		Next Review Date: dd mmm yyyy
Version Number: 4		Date of Publication: dd mmm yyyy
Approved By:		

	• population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	• All Service/Clinical Boards • Staff Safety Representatives group • Cardiff University • South Wales Fire & Rescue Service The Fire Safety Manager and The Senior Fire Adviser are members of the South Wales Fire Safety Concordat which includes representation from all South Wales Health Boards and Trust, as well the Fire & Rescue Service and NHS Specialist Services. Fire Policy is Available on the Health Board Web pages
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	The Policy aims to protect Staff, Patients and all users of Health Board premises.

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

Document Title: *Fire Safety Policy*	5 of 18	Approval Date: dd mmm yyyy
Reference Number: UHB022		Next Review Date: dd mmm yyyy
Version Number: 4		Date of Publication: dd mmm yyyy
Approved By:		

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	No Impact		
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Staff with sensory disabilities may need a fire alarm bringing to their attention which would be identified in a personal evacuation plan , patient areas with known audio impairment may be equipped with visual flashing lights to support the Audio Alarm		Those staff and patients with sensory and mobility conditions, through personal evacuation plans and training provided to staff in areas caring for these patients Evacuation aids and training on

Document Title: *Fire Safety Policy*	6 of 18	Approval Date: dd mmm yyyy
Reference Number: UHB022		Next Review Date: dd mmm yyyy
Version Number: 4		Date of Publication: dd mmm yyyy
Approved By:		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	Some staff/ patients may need assistance in the event of a fire evacuation **Impact control /minimised**		their use is provided within all relevant areas
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or	No Impact		

Document Title: *Fire Safety Policy*	7 of 18	Approval Date: dd mmm yyyy
Reference Number: UHB022		Next Review Date: dd mmm yyyy
Version Number: 4		Date of Publication: dd mmm yyyy
Approved By:		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
Transgender			
6.4 People who are married or who have a civil partner.	No Impact		
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	Women who are expecting a baby may have mobility aspects **Impact Minimised**		When identified within staff these would be subject of a Personal Evacuation Plan and patients through training staff in patient evacuation
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers,	People of a different race, nationality including non-English speakers/ reading. **Impact Minimised**		Through the use of evacuation signage which is in picture format and conforms to BS 5499-1 a recognized standard

Document Title: *Fire Safety Policy*	8 of 18	Approval Date: dd mmm yyyy
Reference Number: UHB022		Next Review Date: dd mmm yyyy
Version Number: 4		Date of Publication: dd mmm yyyy
Approved By:		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
gypsies/travellers, migrant workers			
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief			
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)			
6.9 People who communicate using the Welsh language in terms of	Welsh speaking /reading staff, visitors and patients		Through the use of evacuation signage which is in picture format and conforms to BS

Document Title: *Fire Safety Policy*	9 of 18	Approval Date: dd mmm yyyy
Reference Number: UHB022		Next Review Date: dd mmm yyyy
Version Number: 4		Date of Publication: dd mmm yyyy
Approved By:		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	may need to be assisted in evacuation this controlled through **Impact Minimised**		5499-1 a recognized standard
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	No Impact		
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access	No Impact		

Document Title: *Fire Safety Policy*	10 of 18	Approval Date: dd mmm yyyy
Reference Number: UHB022		Next Review Date: dd mmm yyyy
Version Number: 4		Date of Publication: dd mmm yyyy
Approved By:		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
services and facilities			
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	None Identified		

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to	No Impact		

Document Title: *Fire Safety Policy*	11 of 18	Approval Date: dd mmm yyyy
Reference Number: UHB022		Next Review Date: dd mmm yyyy
Version Number: 4		Date of Publication: dd mmm yyyy
Approved By:		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales			
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on	No Impact		

Document Title: *Fire Safety Policy*	12 of 18	Approval Date: dd mmm yyyy
Reference Number: UHB022		Next Review Date: dd mmm yyyy
Version Number: 4		Date of Publication: dd mmm yyyy
Approved By:		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	No Impact		
7.4 People in terms of their use of the physical environment:	Mobility Access considered in relation to public and patient areas. Loss of lifts in the		Service providers consider Evacuation needs of patients and may redirect to service on

Document Title: *Fire Safety Policy*	13 of 18	Approval Date: dd mmm yyyy
Reference Number: UHB022		Next Review Date: dd mmm yyyy
Version Number: 4		Date of Publication: dd mmm yyyy
Approved By:		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	event of a fire has an impact on service and patient fire risk **Impact minimised**		ground floor. Horizontal Evacuation taught Evacuation Chairs and Evacmats located in risk areas ,training given to staff in their use
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles;	No Impact		

Document Title: *Fire Safety Policy*	14 of 18	Approval Date: dd mmm yyyy
Reference Number: UHB022		Next Review Date: dd mmm yyyy
Version Number: 4		Date of Publication: dd mmm yyyy
Approved By:		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities			
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally	No Impact		

Document Title: *Fire Safety Policy*	15 of 18	Approval Date: dd mmm yyyy
Reference Number: UHB022		Next Review Date: dd mmm yyyy
Version Number: 4		Date of Publication: dd mmm yyyy
Approved By:		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
responsible Wales			

Document Title: *Fire Safety Policy*	16 of 18	Approval Date: dd mmm yyyy
Reference Number: UHB022		Next Review Date: dd mmm yyyy
Version Number: 4		Date of Publication: dd mmm yyyy
Approved By:		

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Personal Evacuation Plans and Staff Training minimises Equality impact on person with disabilities. Picture signage assists persons with language barriers

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?				
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	No			

Document Title: *Fire Safety Policy*	17 of 18	Approval Date: dd mmm yyyy
Reference Number: UHB022		Next Review Date: dd mmm yyyy
Version Number: 4		Date of Publication: dd mmm yyyy
Approved By:		

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

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

FIRE SAFETY POLICY PROCEDURAL ARRANGEMENTS

Introduction and Aim

- The policy takes into account the requirements of statutory obligations, policies, and Health Board site specific fire procedures. It applies to all Health Board personnel and all other occupants and users of Health Board owned premises. Cardiff University (CU) share a number of Health Board premises. Where this occurs, the policy will apply to the CU occupants of such premises.

- The Health and Safety at Work etc. Act 1974 imposes a general duty on employers to protect the health, safety and welfare of their own employees and others that may be affected by their activities. This includes the provision of safe means of access and egress. Employers are responsible for providing such information, instruction, training and supervision as is necessary to ensure the health and safety at work of their own employees and others.

- Further specific duties relating to fire safety are imposed by The Regulatory Reform (Fire Safety) Order 2005.

- The Fire Safety Policy is intended to provide an unambiguous commitment applicable to all premises used by Cardiff &Vale University Health Board and premises where Cardiff & Vale University Health Board patients receive treatment or care.

  The Health Board will also ensure, so far as is reasonably practicable, that work undertaken on its premises and on its behalf by contractors, will be conducted in a manner that is safe and without risk to its employees and others who may be affected by the contractors activities.

Objectives

The principle objectives are to:

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

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

The following measures will also be implemented in order to ensure, so far as is reasonably practicable that the policy statement of intent, aims and objectives are achieved:

- All premises used or occupied by Cardiff & Vale University Health Board fall within the scope of the policy and procedural arrangements
- The Health Board is committed to comply with all statutory fire safety standards.
- When commissioning new buildings, leasing new buildings or occupying buildings under a PPP/PFI contract, the Health Board must be satisfied that such buildings comply with legislation relating to fire safety.
- Appropriate advice and guidance through the Firecode suite of guidance documents issued by the Welsh Assembly's Department of Health and Social Services will be used for all matters related to fire safety.
- All contracts for health services placed by commissioners must contain clauses to ensure that premises comply with, and will continue to comply with, all statutory fire safety provisions and where appropriate, Firecode.

Scope

This policy procedural arrangements applies to all of our staff in all locations including those with honorary contracts

Equality Health Impact Assessment	*An Equality Health Impact Assessment (EHIA) has/has not been completed. (please delete as necessary) Where it has not been completed indicate why e.g. 'This is because a procedure has been written to support the implementation the …….. Policy. The Equality Impact Assessment completed for the policy found here to be a negative/positive/no impact.*
Documents to read alongside this Procedure	**Supporting Procedures and Written Control Documents** • Fire Safety Policy • CRI Fire Procedure • Acute Hospital Fire Procedure • Community Hospital Fire Procedure • Health Centres and Clinics Fire Procedure • St David's Hospital Fire Procedure **Other supporting documents are:** ○ Safe Management of Medical Gas Cylinders ○ Health & Safety Policy ○ No Smoking & Smoke Free Environment Policy ○ Major Incident Plan
Approved by	*Fire Safety Group*

Accountable Executive or Clinical Board Director	*Executive Director of Planning*
Author(s)	*Head of Health and Safety*

16

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Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1	*09/05/2018*		

16

Fire Safety Policy Procedural Arrangements

Contents

16

1.0 RESPONSIBILITIES/ IMPLEMENTATION

1.1 The Chief Executive

Responsibility for the organisation of fire safety arrangements within the Health Board rests with The Chief Executive in respect of all premises within the Health Board. The Chief Executive may appoint an Executive Director at board level who will have the nominated responsibility for fire safety matters. It will be the responsibility of the Chief Executive together with the Executive Director, to ensure:

1.1.1 The Health Board has an effective Fire Safety Management system.

1.1.2 Fire safety will be a standing agenda item at the Health Boards Executive Board meetings.

1.1.3 Agreed programmes of investment in fire safety improvements are accounted for in the Health Boards business plan.

1.1.4 An annual audit of fire precautions will be undertaken to advise the Executive Board on the current state of the fire precautions within the Health Boards premises.

1.2 Executive Director

The Executive Director with responsibility for Fire is the Director of Planning. The Executive Director in conjunction with the fire safety policy/procedure groups will be responsible for the preparation and upkeep of fire safety policies and the uniform co-ordination of fire safety management throughout the Health Board. The Director will make arrangements to;

1.2.1 Ensure appropriate arrangements for Fire are in place within each of the Clinical Boards.

1.2.2 Act as the Executive Leads for each of the Hospital sites so as to provide a focus for each site outside of the management accountability structure that will provide staff with an identified senior person to whom concerns can be raised.

1.2.3 Establish arrangements for each site to support the site Executive Lead function. This includes the appropriate numbers of Deputy Fire Safety Officers (DFSM).

1.3 Fire Safety Manager

Firecode document – 'Fire Safety in the NHS – (WHTM 05-01) Managing Healthcare Fire Safety', requires the appointment of a Fire Safety Manager.

The Health Board has subsequently appointed the Head of Health & Safety as the Health Board Fire Safety Manager to undertake these responsibilities.

The Fire Safety Manager will be responsible to work within the defined role within the Firecode Guidance including the structure of the Management of Fire within the Health Board and the role of the Deputy Fire Safety Managers. These include:

- Ensuring that programmes are in place to provide fire safety training for all staff appropriate to their duties and place of work.

- Ensuring that procedures are in place to undertake fire risk assessments and monitor them to make sure they remain relevant.

The Fire Safety Manager will receive reports of all fire incidents from the Health Board's Fire Safety Adviser and inform the Executive Director and, where appropriate, Cardiff University Vice Chancellor, of their contents and arrange for any action required.

The Fire Safety Adviser will be responsible for assisting the Fire Safety Manager in discharging his/her roles and duties as outlined in the Firecode Technical Memorandum. The Fire Safety Manager will have sufficient authority and resources to discharge their functions.

1.4 Deputy Fire Safety Manager (DFSM)

Deputy Fire Safety Manager together with one or more deputies will be appointed to ensure that there is adequate co-ordination and control of the fire arrangements on each of the main sites as follows:

Each Clinical Board will appoint a Deputy Fire Safety Manager for areas under their control as shown in Appendix V1.

Estates, Capital and Facilities Departments will appoint DFSM(s) for areas under their control including refurbishments. Capital projects and Public Areas

Community premises- The Clinical Board with the major presence will be responsible for nominating a DFSM for each Community premises. However actions identified relating to specific Clinical/Service Board activities within the premises will still remain be the responsibility of that Clinical/Service Board DFSM

They will be supported as necessary by Health and Safety Advisers and Fire Safety Advisers. The Deputy Fire Safety Manager will be appointed to:

1.4.1 Monitor the effectiveness of the day-to-day upkeep of the established Fire Safety Policy. As the Deputy Fire Safety Manager may not be "onsite" on a day-to-day basis, this

responsibility will be delegated to the relevant Line Managers/Heads of Department to monitor day-to-day upkeep of the established Fire Safety Policy for their areas.

1.4.2 Ensure that for all areas within their control, emergency evacuation procedures are in place.

1.4.3 Verify that for all patient areas, appropriate fire response teams are established, this is detailed in the relevant site fire procedure.

1.4.4 Verify, via relevant Heads of Department/Line Managers, that for all patient areas within their control, mechanisms are in place for adequate staff to be available at all times to provide assistance with patient evacuation in a fire emergency.

1.4.5 Establish that appropriate training is given to the fire response team and other staff who are involved in patient evacuation in their place of work.

1.4.6 Be responsible during office hours for the co-ordination and direction of staff actions at a serious fire incident in accordance with the emergency plan. Out of hours response, being provided via agreed arrangements established with the relevant line managers or in line with the normal out of hours on site escalation procedure.

1.4.7 Ensure that Fire Risk Assessments are monitored and remain relevant.

1.4.8 Receive reports of all fire incidents and support the arrangement of any actions required.

1.4.9 Appointed Deputy Fire Safety Manager will receive appropriate training on their role requirements.

1.5 Senior and Fire Safety Advisers

The Health Board has the services of Fire Safety Advisers working under the direction of the Director of Planning. The Fire Safety Advisers will be responsible for advising the Fire Safety Manager, Deputy's and management on professional and technical fire matters and for monitoring the condition of fire precautions in the Health Board premises. The responsibilities and duties will include:

1.5.1 Advising on the application of the provisions of legislation, Firecode and other guidance.

1.5.2 Liaising with Facilities Management staff and Planning Teams, Local Building Control and Fire Authorities in the specification of fire precautions in new and existing premises.

1.5.3 Advising management of their initial and continuing responsibilities in respect of Health Board premises falling within the scope of The Regulatory Reform (Fire Safety) Order 2005.

1.5.4 Assisting Capital and Asset Management and Facilities Management staff and others in fire risk assessments, audit and the preparation of reports to management.

1.5.5 Prepare training programmes in conjunction with the Learning and Education Department, organising regular fire drills and staff training, witnessing the effectiveness or otherwise of fire exercises/drills.

1.5.6 Recommending remedial action where necessary and arranging in conjunction with the Fire Safety Manager, Deputy Fire Safety Managers and the Learning Education & Development Department for accurate records of staff training and fire drills to be produced and maintained.

1.5.7 Ensuring in conjunction with Capital and Asset Management and Facilities Management staff that contractors working in existing premises use the Health Board's 'permit to work' system.

1.5.8 Keeping accurate records of all fire incidents, investigating fires in conjunction with the local fire and police authorities and insuring that fire reports are forwarded to NHS Wales Shared Services Partnership – Specialist Estates Services

1.5.9 The Senior Fire Adviser will be responsible for ensuring that a programme of Risk Assessments are completed throughout the organisation. These Assessments will be reviewed at the Fire Safety Group and deficiencies will be brought to the attention of the Executive Director of Planning and Fire Safety Manager.

1.5.10 The Senior Fire Adviser will liaise with the Estates Department to ensure that the Enforcement Notice Database is updated in a timely manner with regard to Estates based actions.

1.6 Fire Wardens

Fire Wardens, and an appropriate number of Deputies, will be appointed in all wards and departments. In ward areas a named Ward Fire Warden should be appointed for carrying out the general duties. In the event of a fire the most senior member of the nursing staff on duty will assume Fire Warden status in order to co-ordinate actions.

In non-patient areas the Fire Wardens will be named individuals who will be appointed by, and responsible to, the Head of the Department. Fire Wardens will be made aware of the precise location, which they will be expected to cover, and the extent of their responsibilities within that location. These responsibilities are detailed in the relevant local Fire Safety Procedures.

1.7 Responsibility of Heads of Department /Line Managers

Managers must ensure that co-operation of staff and management is encouraged from the highest level. Line Managers have a responsibility under Article 5(3) of the Regulatory (Fire Safety) Order for ensuring fires are prevented and fire safety duties relating to matters within their control are maintained in good order. Records of fire training and routine fire inspections made within the ward/department are to be kept up to date. Any defects found in fire precautionary measures that are not within their control must be reported to their Line Managers.

1.7.1 Ensure arrangements are in place, within their designated areas of control, for effective day-to-day upkeep of the established Fire Safety Policy

1.7.2 Ensure that all staff are appropriately trained in fire safety management

1.7.3 Ensure that there are identified Fire Safety Wardens for all identified areas.

1.7.4 Ensure that all staff working within their designated area of control are aware/conversant with the agreed emergency evacuation procedures for the site

1.7.5 Contribute as requested to the provision and maintenance of a fire response team for the site.

1.7.6 Ensure that for all patient areas within their control, mechanisms are in place for adequate staff to be available at all times to provide assistance with patient evacuation in a fire emergency.

1.7.7 Ensure that actions identified via Fire Risk Assessment are actioned without delay or escalated to Fire Safety Manager where necessary.

1.7.8 Ensure all Fire Service Notices and Enforcement Actions are actioned without delay and communicated with the Fire Safety Manager and relevant Fire Adviser.

1.7.9 Ensure all relevant shortcomings are communicated to the Deputy Fire Safety Manager.

1.8 Responsibility of all Staff

All staff have the legal responsibility to co-operate with the Health Board to provide and maintain a 'Fire Safe' workplace. This includes participating in training, taking part in fire risk assessments and following Health Board policy. Co-operation is required from all levels of the organisation and every member of staff without exception should ensure an understanding of their part in the arrangements.

1.9 Responsibility of Other Authorised Users, Students, Contractors etc.

The co-operation of every authorised user of the Health Board premises is expected, so as to ensure they understand their part in the arrangements.

1.10 Contractors

Contractors carrying out any work have a duty under Article 5(3) & (4) of the Regulatory Reform (Fire Safety) Order for ensuring that the work they do relating to fire safety matters within their controls are carried out in good order. Additional control measures may be implemented by means of permits to work. These will be issued by Estates Management at the relevant premises.

1.11 Health Board Fire Safety Group

The Health Board Fire Safety Group will determine the standards of fire prevention/protection throughout the Health Board and will oversee the implementation of the Fire Safety Policy on the various sites.
The meeting reports as a sub group of the Health and Safety Committee.

The terms of reference of the Fire Safety Group will include:

- Overall responsibility for fire precautions in the Health Board sites.
- Developing an action plan to deal with a fire emergency.
- Fire prevention measures.
- Overseeing the effectiveness of fire training, and
- Maintaining contact with Line Managers on fire precautions.

The Executive Director with responsibility for Fire will chair the Group and membership will comprise of:

- Director of Planning (Deputy Chair)
- Fire Safety Manager
- Deputy Fire Safety Managers
- Health & Safety Adviser
- Cardiff University Representative
- Senior Fire Safety Adviser
- Trade Union/Staff Representatives

- Fire Service Representative
- Strategic Emergency Planning Officer

1.12 Deputy Fire Safety Manager (DFSM) Group

The DFSM Group aim is to give assurance to the Executive Director for Fire and the Fire Safety Group that the risks and actions identified as a result of Fire Inspections and Fire Risk Assessments are progressed and implemented. The group will monitor both the status of management and estates actions. The group will include representative appointed as Deputy Fire Safety Managers for each of the agreed fire areas.

The Group will report to the Fire Safety Group

The terms of reference of the Fire Safety Group will include:

- A review of the Status of the Fire Risk Assessment and any actions arising
- Review the Status of any management actions identified as a result of the Fire Service Inspections or Audits
- Agree responsibilities for areas of multiple occupancy
- Developing an action plan to deal with a fire emergency.

- Review the status of fire training and develop actions for enhanced compliance.

The Fire Safety Manager will chair the Group and membership will consist of :

- Senior Fire Safety Adviser
- Fire Advisers
- Deputy Fire Safety Managers
- Estate Management

1.13 Health and Safety Committees

The Health and Safety Committee and the Cardiff University Occupational Health Safety and Environment Committee advise the Health Board and CU Senate respectively on fire, safety and health matters. In conjunction with Clinical Board/Directorate Health and Safety Groups they provide the necessary means by which management will consult with staff about fire precautions in their location and keep them under review.

2.0 RESOURCES

It is likely that issues will arise as a result of implementation of the policy, which may require resources to monitor effective standards of fire safety. This resource need will be considered at the Fire Safety Group and taken to the

Executive Director of Planning for resolution or progression, on to the relevant Board Committee.

3.0 TRAINING

3.1 It is the responsibility of the Chief Executive to provide training for each category of staff. However, Line Managers are responsible for ensuring that fire safety policies and particular instructions are brought to the attention of their staff observed by them. They must make provisions such that every member of staff can participate in fire safety training and drills.

3.2 Fire safety training will be included as part of both local and corporate staff induction courses. Departmental induction should include fire safety issues such as location of fire exits, fire alarms, location of fire assembly points and oxygen isolation valves etc.

A mandatory Training E Learning Package has been developed which will be utilized in accordance with the guidance given in the new WHTM management Document 05-01. In effect the frequency and method of training will be based on the level of risk and responsibilities of employees in their workplace.

Ward based training sessions may be offered to staff, these will be initially undertaken by the Fire Adviser but may be cascaded down to staff by other competent trainers approved by the Senior Fire Adviser.

3.3 Permanent records of instruction training received will be kept on the Electronic Staff Record database maintained by the Learning Education & Development Department and made available to each departmental area as appropriate.

3.4 Compliance to fire training will be monitored at the Fire Safety Group, Operational Health and Safety Group and other relevant Clinical Board/Departmental meetings.

3.5 Assurance of compliances will be given to the Board via regular reports to the Health and Safety Committee and People, Planning and Performance Committee.

3.6 Part-time staff, agency staff, students and ancillary workers will be included in the training. Additional training will be provided for key staff e.g. Deputy Fire Safety Manager, staff involved in maintenance of fire alarms and so on.

3.7 Major Fire Emergencies Exercises will be held periodically by the Fire Adviser to practice the entire Emergency Fire Procedure. This will allow key personnel to practise their roles.

4 FURTHER INFORMATION

The relevant evidence base for the document is listed below:

- The Regulatory Reform (Fire Safety) Order 2005;
- Firecode Suite of Documents;
- Building Act 1984;
- Building Regulations 2000;
- Health and Safety at Work etc. Act 1974;
- The National Health Service & Community Care Act 1990;
- The Management of House in Multiple Occupation (Wales) Regulations 2006;
- Furniture and Furnishings Fire Safety Regulations 1988;
- The Health & Safety (Safety Signs and Signals) Regulations 1996;
- The Disability Discrimination Act (2005);
- The Construction (Design and Management) Regulations 2007;
- The Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR);
- The Management of Health and Safety at Work Regulation 1999.

5 FIRE SAFETY PROCEDURES

5.1 Reporting of Fire Incidents

- All fires no matter how small, even if extinguished, must be reported to the Fire Safety Adviser for investigation and action.
- Details of all outbreaks of fire to which the fire service is called must be reported promptly to NHS Wales Shared Services Partnership – Specialist Estates Service.
- A fire report which is now available via the Fire and Unwanted Fire Signal (UwFS) Information Reporting System on the NHS Wales Shared Services Partnership – Specialist Estates Services intranet site is to be completed by the Fire Safety Adviser and the Senior Fire Safety Adviser informed.
- The Senior Fire Safety Adviser will review the report via the web site and forward a copy electronically to NHS Wales Shared Services Partnership – Specialist Estates Services. The report is to reach NHS Wales Shared Services Partnership – Specialist Estates Services within 48 hours of the incident.
- A copy of the report will be forwarded to the respective Deputy Fire Safety Officer who will forward a copy through the Executive Director to the Chief Executive. In addition, a copy of the report will be sent to the Cardiff University Vice Chancellor if University property or personnel are involved.
- In the event of a serious fire incident developing where disruption to services and patient care are likely, the senior

person present should consider whether to initiate the "Health Board Major Incident Plan".

- In addition, fires involving multiple deaths, multiple injuries or damage on a very large scale are to be notified immediately to the Director of the NHS in Wales, National Assembly for Wales, Health Service and Management Division, Cathay's Park, Cardiff, CF1 3NQ by the Health Board Chief Executive Officer or Executive Director on call, depending on availability. The Health and Safety Executive must also be advised in the nearest regional office.
- Details of all false alarm calls to which the fire service is called must also be reported to NHS Wales Shared Services Partnership – Specialist Estates Services. The False Alarm Report which is now available via the Fire and UwFS Information Reporting System on the NHS Wales Shared Services Partnership – Specialist Estates Services intranet site, is to be completed by the respective Fire Safety Adviser for each call and forwarded electronically to NHS Wales Shared Services Partnership – Specialist Estates Services
- Switchboard operators will complete a Fire Call Report Form (Appendix II) for every fire call (including false alarms) received. These will be forwarded to the appropriate Fire Safety Adviser and the Senior Fire Safety Adviser.
- In the event of a serious fire involving property or life, senior management and Health Board members will be informed in accordance with the site fire procedures. The Vice Chancellor will be informed of serious fires involving CU personnel or property.
- Other users of Health Board premises such as National Public Health Service for Wales (NPHS), Concourse Units etc. will be informed of fires in their areas of responsibility.
- The Senior Fire Safety Adviser will maintain the fire statistics for the Health Board and submit quarterly reports to the Health and Safety Committee.

5.2 Maintaining Adequate Levels of Physical Fire Precautions

- The Health Board needs to ensure it has an extensive programme for installing and satisfactorily maintaining an adequate level of physical fire precautions designed to prevent the occurrence, ensure the detection, and stop the spread of fires. If required further specialist advice in the preparation of this programme will be obtained from the Senior Fire Safety Adviser.
- The Chief Executive is responsible for the strategic organisation of fire safety arrangements. The Senior Fire Safety Adviser is to be informed of any proposals that could affect such arrangements.

- The Senior Fire Safety Adviser must be consulted prior to any changes to the structure, use/function, layout, furniture, fittings or decoration, or to procedures and staffing levels to determine if such changes will have a bearing on fire safety.
- The Senior Fire Safety Adviser will arrange for systematic inspections, at prescribed intervals, to be undertaken by the Fire Safety Advisers of all areas of the Health Board.
- Site Fire Plans are to be kept by the Head of Capital & Asset Management showing the following:

  - Fire resisting construction.
  - Periods of fire resistance.
  - Location of fire fighting equipment.
  - Location of fire alarm call points, detectors, sounders and panels.
  - Fire locks.
  - Location of fire action notices.
  - Arrangements for means of escape.
  - Location of exit signs.
  - Emergency lighting points.

5.3 Maintenance and Testing of Fire Appliances, Alarms etc.

The maintenance of all fire appliances such as alarms, fire doors, emergency lighting and mechanical ventilation etc. is a legal requirement under the Regulatory Reform (Fire Safety) Order 2005. It is the responsibility of the Assistant Director of Planning (Capital & Estates) and is implemented by designated trained engineers. These defined policies, procedures and programmes of work; maintenance and training are essential, irrespective of any designation of hospitals or other premises under the Regulatory Reform (Fire Safety) Order 2005. All such policies, procedures and programmes should be reviewed annually and brought up to date. Equipment is to be maintained and tested by the staff of Facilities Management in accordance with the following standards:

Portable fire extinguishers	BS 5306 Part 3
Fire blankets	BSEN 1869
Hydrants, dry risers and hose reels	BS 5999
Fire alarms	BS 5839 Part 1
Emergency lighting	BS 5266 Part 1
Sprinkler systems	BSEN 12845
Lightning protection systems	BS 6651:

Mechanical ventilation systems and Fire Dampers	BS 9999:
Fire doors	BS 8214
Smoke control systems	BS 7346-2

The results of tests and examinations of this equipment, together with any subsequent remedial actions, are to be recorded in a logbook. The Estates Maintenance Manager will keep the logbook available for inspection by the Fire Safety Group or the Fire Service. These records are to be retained for three years.

5.4 Project Design/ Building Works

5.4.1 The Project Design Protocol is to be followed for all Capital and Revenue projects and schemes undertaken by the Design Group, Facilities Management, and Cardiff University.

The Health Board Senior Fire Safety Adviser should be consulted during the design and construction of all Private Finance Initiative (PFI) Design and Build schemes to ensure that compliance with Firecode and the Health Board Fire Safety Strategy.

During building works:

- The site of the activities should be strictly supervised and controlled, even during small works and sporadic maintenance visits.
- Capital & Asset Management and Estate Maintenance staff must ensure that all necessary precautions against fire are taken.
- The Fire Safety Adviser should give guidance and keep in regular contact with such activities to check compliance with fire safety policy.
- The ‘permit to work’ and ‘hot work permits’ policy issued by the Estates Department is to be used for removal/covering of fire detectors, and use of flame producing equipment for cutting, welding and grinding.
- The use of open waste skips is not permitted unless authorised by the Fire Safety Adviser. Enclosed lockable skips will be used and positioned in safe areas away from buildings and boundaries.
- The Loss Prevention Council booklet ‘Fire Prevention on Construction Site’ is a useful checklist of fire precautions, which contractors should observe and must be included as part of the contract documents.

5.4.2 Fire Alarm Systems - All Health Board buildings will be protected by analogue addressable fire alarm systems designed to the current BS 5839: Fire Detection and Alarm Systems for Building Category L1 standard as supplemented by the current Firecode WHTM 05-03 Operational Provisions Part B-Fire Detection and Alarm Systems. Some deviations from this policy may be considered e.g. small clinic buildings.

5.5 Escape Routes

5.5.1 Escape routes from each area are to be adequate, clearly marked and free from obstruction.

5.5.2 A simple outline plan is to be displayed in each area as appropriate, showing the relevant escape routes and fire barriers.

5.5.3 The duty to maintain escape routes, which includes corridors, staircases, lobbies and doors, is laid down in the Regulatory Reform (Fire Safety) Order 2005.

5.5.4 It is the responsibility of individual managers – or persons delegated on their behalf – to ensure that escape routes are maintained. These include external fire routes, which are the responsibility of the Estates Department.

5.5.5 A visual inspection at the start of the working day or shift should be made by staff working in a given area and any obstruction or defect found must be dealt with immediately.

5.5.6 A further check should be made at the end of the working period to ensure that appropriate doors are shut, locked or secured as appropriate and the site cleared.

5.6 Fire Safety Signs

5.6.1 Fire Action Notices detailing the action to be taken on discovering a fire and on hearing the fire alarm are to be displayed throughout the sites adjacent to each manual fire alarm call point. The information contained in the notices will identify the methods of:

- Raising the alarm.
- Informing the switchboard by emergency number.
- Controlling the fire.
- Evacuation procedure – assembly point (where appropriate)
- Testing of the fire alarm.

5.6.2 Fire Safety Signs meeting the requirements of The Health and Safety (Safety Signs and Signals) Regulations 1996 will be displayed to indicate locations of fire exits, and fire alarm and fire fighting equipment, where required.

5.7 Fire Service Access

Access for the Fire Service is to be kept available at all times and fire hydrants and dry riser inlets are not to be obstructed. A copy of the Site Fire Plans and Evacuation Procedures are to be given to the Fire Service so that, where possible, the routes to be used by the service for fire fighting do not conflict with escape routes. The Fire Service is to be made aware of any special hazards on site e.g. radiation and biological hazards, during inspections made by them and they are to be kept up to date with any developments in this field by the Fire Safety Advisers.

5.8 Restricted Smoking Policy/ Sources of Ignition

The smoke-free Regulations in force from 2nd April 2007 prevents smoking in all enclosed public places. The Regulations cover all workplaces, including health-care premises. All staff, visitors and patients are expected to comply with the Regulations and Smoking Policy.

5.8.1 MENTAL HEALTH AREAS

Under current arrangements there are no areas for smoking set aside within mental health which are designated as smoking areas, either internally or within the grounds.

5.8.2 NON MENTAL HEALTH AREAS

Smoke free regulations apply at all times.

5.9 Furniture and Textiles

5.9.1 It is essential that the contents of premises comprising furniture, textiles, fixtures and fittings, including mechanical and electrical equipment, receive careful consideration and selection in order that they will fulfil the aims of the fire strategy.

5.9.2 Any new or replacement furniture and textiles should be requisitioned through the Procurement Department who must ensure that they comply with the detailed guidance contained Firecode WHTM 05-03 Operational Provisions Part C – Textiles and Furniture.

5.9.3 Damaged furniture and textiles must be removed and repaired or replaced to meet the above guidance.

5.9.4 Donated furniture or textiles from whatever source must meet the above standards. The Fire Safety Adviser should be consulted if there is any doubt about the suitability of any item.

5.9.5 All soft toys in Paediatric Wards and Children's Centres should comply with the above guidance. Commercially produced toys should already meet the requirements; however, donations of homemade toys and other donations should not be accepted if they do not comply with the requirements.

5.10 Staffing Levels

The presence of an adequate number of staff that has received training in fire safety is the best line of defence against fire. This is particularly important at night when levels of activity may be reduced and staffing levels are lower. It is the responsibility of management to achieve an agreed safe level of staffing sufficient to deal with the consequences of fire in its early stages. A minimum of two fire-trained staff is required to be on duty at all times. This number may need to be supplemented if patients are highly dependent and to ensure that there are at least two trained people quickly available at all times, for example during meal breaks, to carry out evacuation procedures in the event of fire.

5.11 Communications

5.11.1 An effective and efficient fire reporting communications system is essential in healthcare facilities. All controls and indicators should be sited in a location, which is staffed 24 hours a day, typically a switchboard or continuously staffed reception. Where this is impracticable, a procedure should be developed to ensure that the panel is attended immediately the alarm has been raised.

5.11.2 In all Health Board premises when the alarm has been raised, a designated person will summon the Fire Service by voice communication using the 999 emergency system. This is defined as the primary method.

5.12 Arson

5.12.1 Hospitals and their externally and internally located storage areas are vulnerable to arson attacks from intruders, patients with disturbed patterns of behaviour, employees and others who may enter sites, including contractors. Stores, including those with pharmaceuticals, may be targets for theft and fires may be started to conceal the theft. Attention to housekeeping, for example management of waste collection, storage and disposal,

and security arrangements can make a very positive contribution to the prevention of arson.

5.12.2 Security systems and procedures are already in place to keep unauthorised persons out of vulnerable areas e.g. lower ground floor at UHW. These systems must not be abused by personnel taking or allowing unauthorised persons into restricted areas without the necessary authority.

5.12.3 Identification badges must be worn at all times, including contractors and servicing personnel.

5.12.4 All fire incidents that are staff related, either by accident or intent, will be investigated in accordance with the Health Board Disciplinary Procedure.

5.12.5 Arson prevention and control measures are contained in site-specific Fire Safety Procedure Documents, which can accessed via the Health Board intranet, as below:

- Open the Cardiff & Vale web page;
  - Click on Site index button;
  - Click on 'Fire Safety' on the alphabetical list;
  - On the next page, open the 'Health Board Fire Safety Policy' or 'Health Board Fire Procedures' links.

5.13 Car Parking

The designated fire roads on all Health Board premises are maintained clear of obstruction by a site-specific car parking procedure.

5.14 Waste Management

It is important to keep all circulation areas clear of storage and combustible materials, to maintain the means of escape provisions and reduce the risk of arson attacks.

Waste, including trolleys and containers, must not be left unattended in lobbies to lift shafts and staircases, unless approved by the Fire Service. It is acknowledged that waste trolleys and containers will be placed in corridors for collection; however, it should be ensured that arrangements are in place to have them removed for disposal as soon as possible. This is of particular importance in the lower ground floor (basement) areas. Trolleys and containers should not be overfilled to ensure that the lids can be properly closed.

The collection, storage and disposal of waste will be undertaken on a regular basis according to the need and in accordance with the Waste Management Policy.

6 EQUALITY

An equality impact assessment has been undertaken to assess the relevance of this policy to equality and potential impact on different groups, specifically in relation to the Equality Act 2010 and including other equality legislation. The assessment identified that the policy presented a low risk to the Health Board.

7 AUDIT

7.1 The Chief Executive is required to ensure that the management policies regarding fire safety comply with the provisions of Firecode Fire Safety in the NHS WHTM 05-01: Managing Healthcare Fire Safety Section 4. To assist with this mandatory requirement, an annual fire safety audit, as recommended in WHTM03-03 Part A, covering all Health Board in-patient care premises will be arranged.The fire audit team must have full access to the relevant staff, records, buildings and plant.

7.2 The Fire Audit Information System developed by Welsh Shared Services Health Estates will be used as the reporting mechanism for the audit.

8 DISTRIBUTION

This policy and accompanying guidance will be available on the Health Board Intranet site.

To access the document:

- Open the Cardiff & Vale web page;
  - Click on Site index button;
  - Click on ‘Fire Safety’ on the alphabetical list;
  - On the next page, open the ‘Health Board Fire Safety Policy’ or ‘Health Board Fire Procedures’ links

Appendix I

PART 1. Brief précis of the Regulatory Reform (Fire Safety) Order 2005.

Article 1. This order came into force on 1st October 2006.

Article 3. The 'Responsible Person' is the employer (this is the Chief Executive of the Health Board).

Article 4. General Fire Precautions means:

(a) measures to reduce the risk of fire on the premises and the risk of the spread of fire on the premises;

(b) measures in relation to the means of escape from the premises;

(c) measures for securing that, at all material times, the means of escape can be safely and effectively used;

(d) measures in relation to the means for fighting fires on the premises;

(e) measures in relation to the means for detecting fire on the premises and giving warning in case of fire on the premises; and

(f) measures in relation to the arrangements for action to be taken in the event of fire on the premises, including

(i) measures relating to the instruction and training of employees;

and

(ii) measures to mitigate the effects of the fire.

Article 5. The Responsible Person must ensure that these Regulations are compiled with. For the purposes of this Health Board the Chief Executive is the 'The Responsible Person'.

In addition, under Article 5 (3) any person who has to any extent any control is also responsible for complying with the fire safety duties relating to the matters within their control.

Article 6. Application to premises – this Order applies to all Health Board premises.

16

PART 2. FIRE SAFETY DUTIES

Article 8. Duty to take precautions to safeguard employees and persons in the premises not in his employment.

Article 9. A written fire risk assessment must be carried out in each work area if 5 or more are employed.

Article 10. Duty to prevent fires.

Article 11. The Chief Executive and all persons who have any control must ensure arrangements are effective for planning, organisation, control and monitoring of fire safety measures and the keeping of records of all these measures.

Article 12. Where dangerous substances are present there must be measures to eliminate, reduce or control these substances.

Article 13. Appropriate fire fighting equipment must be provided and adequate training of nominated persons. Appropriate fire detection must be provided.

Article 14. Emergency and exit routes must be provided and kept clear, fitted with signs and suitable easy to use fastenings.

Article 15. A sufficient number of persons must be nominated to implement procedures for evacuation and provide training of these persons.

Article 16. In respect of dangerous substances to ensure information on emergency arrangements is available and made available to the emergency services.

Article 17. A suitable system of maintenance must be in place and fire precaution measures must be maintained in efficient working order and in good repair.

Article 18. Persons must be appointed to assist with fire precaution measures.

Article 19. All employees must be provided with information on the risks, fire safety measures and precautions.

Article 20. Employees from outside organisations must also be given information on risks, fire safety measures and precautions.

Article 21. Adequate fire training must be given to employees including part time and temporary staff, and young persons.

Article 22. Where two or more Responsible Persons share, an area or premises, each person must co-operate and co-ordinate with regards to fire safety arrangements.

Article 23. Every employee must take reasonable care for the safety of themselves and other persons.

Other mandatory/statutory obligations may be imposed on the Health Board by the following:

- Firecode Suite of Documents;
- Building Act 1984;
- Building Regulations 2000;
- Health and Safety at Work etc. Act 1974;
- The National Health Service & Community Care Act 1990;
- The Management of House in Multiple Occupation (Wales) Regulations 2006;
- Furniture and Furnishings Fire Safety Regulations 1988;
- The Health & Safety (Safety Signs and Signals) Regulations 1996;
- The Disability Discrimination Act (2005);
- The Construction (Design and Management) Regulations 2007;
- The Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR);
- The Management of Health and Safety at Work Regulation 1999.

Document Title: Fire Safety Policy	25 of 37	Approval Date:
Reference Number: UHB 022		Next Review Date: 2018
Version Number: 1		Date of Publication:

Appendix II

ELECTRICIAN FIRE CALL REPORT FORM UHW

The following Switchboard Fire Call Reporting Form is required to be completed after every Fire Alarm activation

The alarm is to be recorded according to type i.e.

Part 1 - to be completed every time

Part 2 - False Alarm

Part 3 - Actual Fire

Part 1

Date: ……..…… Day: ……..…… Time: ……..……..…..

(Please tick relevant box)

UHW		**CRI**		**Rookwood**		**UHL**		**HYC - UHL**	
Lansdowne		**Iorwerth Jones**		**Barry**		**St Davids**		**Whitchurch**	
Other (please specify									

Fire Alarm address:- **Node/ Panel**: ……..… **Loop**: ..…… **Add**: ….…… **Zone**: …… **RV Point:** ……..…..

Building / Department / Ward Description: ……

Room N^{o}/Name: ……

The fire alarm was raised by: Detector: ☐ MCP/BGU: ☐ Telephone: 3333 ☐ Other method: ☐

Full notification Procedure	**Yes** ☐	**No** ☐	**Time initiated**	**Did Fire Service Attend**	**Yes** ☐	**No** ☐
Fire Adviser Informed	**Yes** ☐	**No** ☐	**Time Informed**	**Fire Alarm System reset**	**Yes** ☐	**No** ☐
Switchboard notified by 3333	**Yes** ☐	**No** ☐	**Time Informed**	**Informed by Whom**	**Ext.**	

Part 2

False alarm caused by: (please tick relevant box as identified by the Fire Service)

Deliberate		**Good intent**		**Accidental**		**Patient or Public**		**Unknown**	
Contractors		**Alarm/System Fault**		**Insects**		**Fumes from cooking / toaster etc**		**Aerosol Sprays**	
Smoking		**Flood / Water leak / Steam**		**Other (please specify**					

16

Document Title: Fire Safety Policy	26 of 37	Approval Date:
Reference Number: UHB 022		Next Review Date: 2018
Version Number: 1		Date of Publication:

		Leak			

……

PTO

Part 3

In the event of an actual fire please indicate the most likely cause etc, as identified by the Fire Service and inform the site Fire Safety Officer at the earliest opportunity. Please provide as much additional information as possible.

Please note that if smoke is given off and has activated the alarm automaticly then it is classed as an actual fire (apart from burnt toast)

Cause of Fire Please indicate with a tick in the relevant shaded box

Deliberate		**Contractors**		**Equipment Failure (Elec)**		**Equipment Failure (Mech)**		**Wire cable (fixed**	
Hot Work		**Smoking**		**Lighting**		**Cooking Appliances**		**Wire Cable (leads)**	
Central heating		**Naked lights**		**Space heating**		**Unknown**			
Other (please specify)									

Material first ignited

Raw Materials		**Bedding, mattress**		**Fittings**		**Decoration, soft toys**		**Vegetation**	
Upholstery		**Food**		**Cleaning Materials**		**Clothing on person**		**Other Furnishings**	
Electrical Insulation		**Waste**		**Structure**		**Unknown**		**Other (please specify)**	

Method of Extinguishment

None		**Fire Hose**		**Smothering**		**Portable Extinguisher**		**Self Extinguished**	
Dousing with Water		**Removal**		**Equipment Isolated**		**Fire Service**		**Co2 Inert Gas etc**	
Sprinkler		**Other (please specify)**							

Additional information:

……

……

……

……

……

……

……

……

……

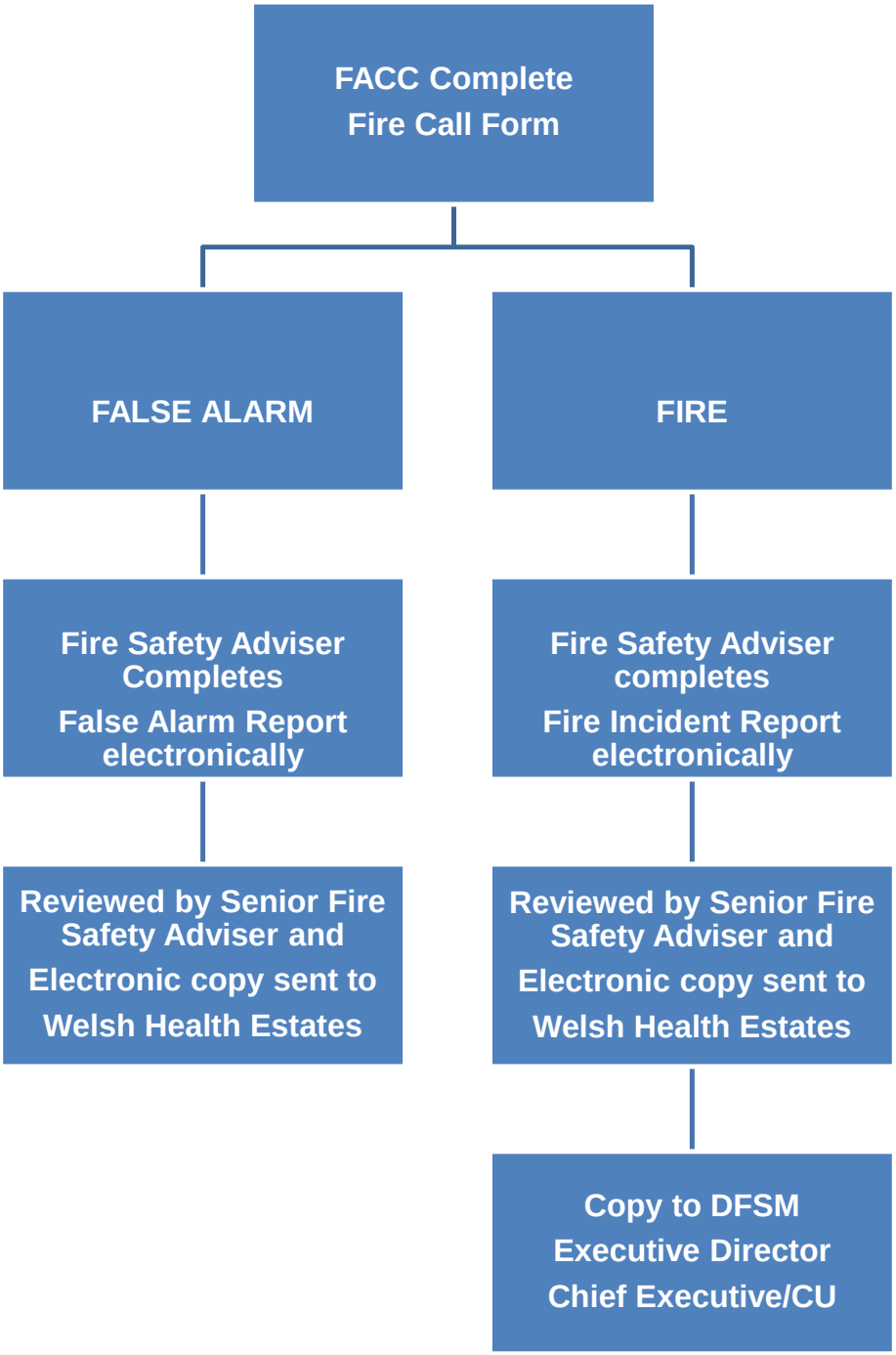
Name-…….. Signature-…… Position-……..

16

Document Title: Fire Safety Policy	27 of 37	Approval Date:
Reference Number: UHB 022		Next Review Date: 2018
Version Number: 1		Date of Publication:

Appendix III

FIRE REPORTING PROCEDURE



16

Document Title: Fire Safety Policy	28 of 37	Approval Date:
Reference Number: UHB 022		Next Review Date: 2018
Version Number: 1		Date of Publication:

Appendix IV

FIRE SAFETY ORGANISATION

16

Document Title: Fire Safety Policy	29 of 37	Approval Date:
Reference Number: UHB 022		Next Review Date: 2018
Version Number: 1		Date of Publication:

PROJECT DESIGN PROTOCOL FOR FIRE SAFETY Appendix V

Are there FIRE SAFETY implications Involved with the project scheme?

NO → **This protocol therefore not applicable.**

↓

Has the Senior/Fire Safety Adviser (SFSA/FSA) been consulted?

NO → **Consult with the Senior/Fire Safety Adviser (SFSA/FSA)**

↓

Has the Fire Plan been consulted?

NO → **Fire Plan to be consulted.**

↓

Have Fire Risk Assessments been consulted for fire safety elements?

NO → **Fire Risk Assessments to be Consulted for fire safety elements**

↓

Develop drawings detailing all fire protection features of scheme

↓

Has the SFSA/FSA checked drawings and particulars of scheme?

NO → **SFSA/FSA to check**

↓

Meeting with SFSA, FSA Building Control and Fire Service to discuss scheme.

↓

Submit full plans for Building Regulations Approval to L.A. Building Control & S/FSA

↓

Notify start date and contract particulars to the SFSA

↓

Notify SFSA/FSA of completion of project/scheme

↓

Carry out handover inspection – SFSA/FSA and Project Manager

↓

Compile 'snagging list' of any remedial works required.

↓

L.A. Building Control issue certificate of practical completion.

↓

Copies of as fitted drawings to be submitted to SFSA for central records

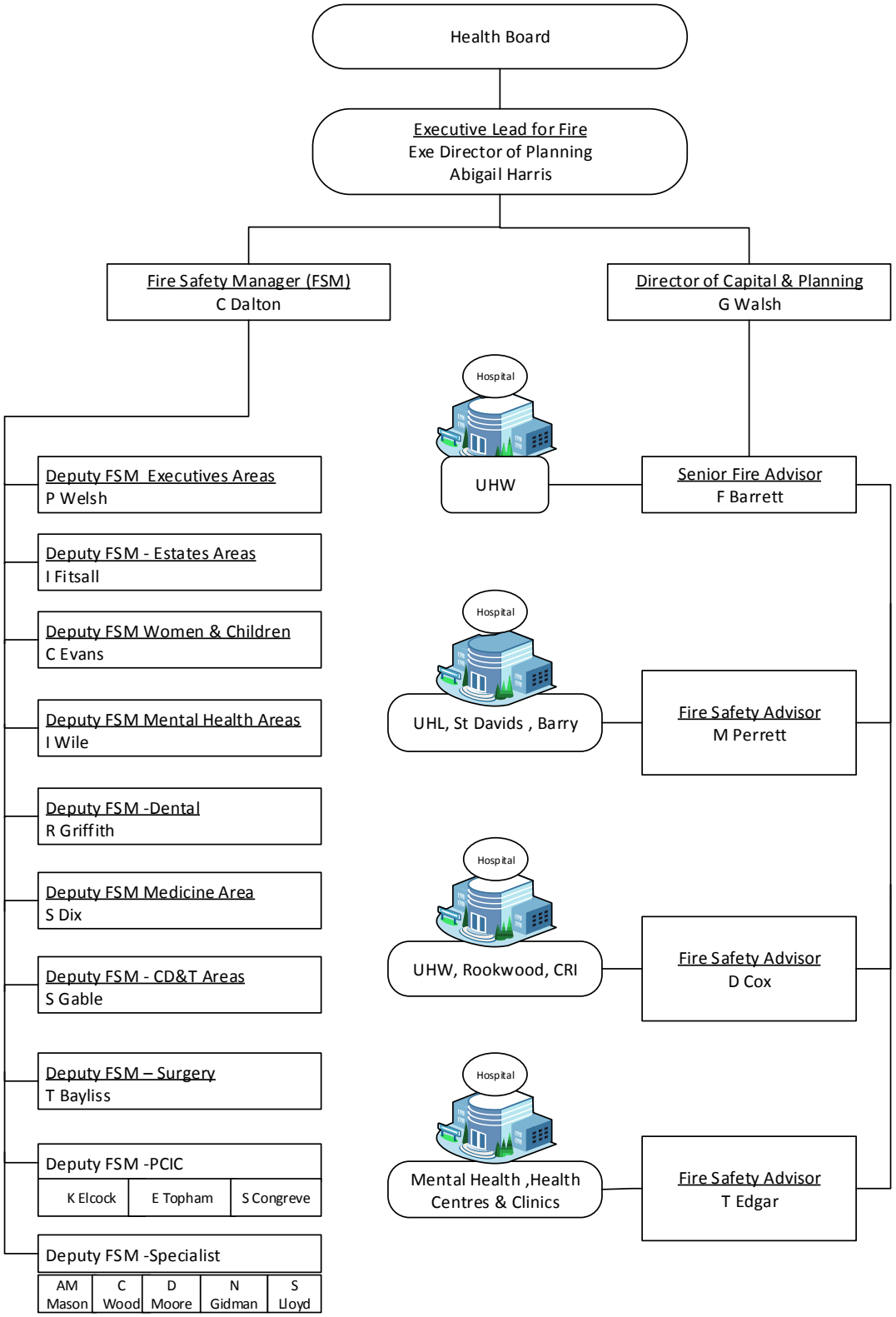
↓

Fire drawings to be suitable amended

Document Title: Fire Safety Policy	30 of 37	Approval Date:
Reference Number: UHB 022		Next Review Date: 2018
Version Number: 1		Date of Publication:

Fire Safety Management Structure

Appendix VI



16

Document Title: Fire Safety Policy	31 of 37	Approval Date:
Reference Number: UHB 022		Next Review Date: 2018
Version Number: 1		Date of Publication:

APPENDIX Vii LOCATION	FIRE ALARM TEST	REDCARE	STAND ALONE	Day Tested	ESTATES STAFF FROM	FIRE ADVISER
UHW	WKLY	YES		TUESDAY AM	CONTRACTOR	David Cox
LLANDOUGH HOSPITAL	WKLY	YES		MONDAY AM	LLANDOUGH	Mal Perrett
BARRY HOSPITAL	WKLY	YES		FRIDAY AM	LLANDOUGH	Mal Perrett
AMY EVANS	WKLY	YES		WEDNESDAY AM	LLANDOUGH	Trevor Edger
BROAD ST	WKLY		YES	WEDNESDAY AM	LLANDOUGH	Trevor Edger
COLCOT	WKLY		YES	WEDNESDAY AM	LLANDOUGH	Trevor Edger
DINAS POWYS	WKLY		YES	WEDNESDAY AM	LLANDOUGH	Trevor Edger
PEN YR YNYS	WKLY		YES	WEDNESDAY AM	LLANDOUGH	Trevor Edger
BUTETOWN	WKLY		YES	WEDNESDAY AM	LLANDOUGH	Trevor Edger
GRANGETOWN	WKLY		YES	WEDNESDAY AM	LLANDOUGH	Trevor Edger
ROYAL HAMADRYAD	WKLY		YES	WEDNESDAY AM	LLANDOUGH	Trevor Edger
STANWELL ROAD	WKLY		YES	WEDNESDAY AM	LLANDOUGH	Trevor Edger
GABALFA	WKLY		YES	WEDNESDAY AM	LLANDOUGH	Trevor Edger
CARDIFF ROYAL INFIRMARY	WKLY	YES		THURDAY AM	C.R.I	David Cox
CRI House 54/56 & LINKS bdg	WKLY	YES		THURSDAY AM	C.R.I	David Cox
ROOKWOOD	WKLY	YES		FRIDAY AM	ROOKWOOD	David Cox
TRENEWYDD	WKLY	YES		FRIDAY AM	ROOKWOOD	Trevor Edger
PENDINE	WKLY		YES	TUESDAY AM	WHITCHURCH	Trevor Edger
LANSDOWNE	WKLY		YES	TUESDAY AM	WHITCHURCH	Trevor Edger
RIVERSIDE	WKLY		YES	TUESDAY AM	WHITCHURCH	Trevor Edger
ROATH	WKLY		YES	TUESDAY AM	WHITCHURCH	Trevor Edger
LLANEDERYN	WKLY		YES	TUESDAY AM	WHITCHURCH	Trevor Edger
PENTWYN	WKLY		YES	TUESDAY AM	WHITCHURCH	Trevor Edger
LLANRHUMNEY	WKLY		YES	TUESDAY AM	WHITCHURCH	Trevor Edger
LLANISHEN	WKLY		YES	WEDNESDAY AM	WHITCHURCH	Trevor Edger
TREFOREST	WKLY		YES	WEDNESDAY AM	WHITCHURCH	Trevor Edger
RHIWBINA	WKLY		YES	WEDNESDAY AM	WHITCHURCH	Trevor Edger
IORWERTH JONES	WKLY	YES		WEDNESDAY AM	WHITCHURCH	Trevor Edger
RADYR	WKLY		YES	WEDNESDAY AM	WHITCHURCH	Trevor Edger
WEQAS	WKLY		YES	WEDNESDAY AM	WHITCHURCH	Trevor Edger
ST DAVIDS	WKLY	YES		TUESDAY AM	CONTRACTOR	Mal Perrerr

Appendix Viii

Protocol for the Management of Smoking
In the Adult In-Patient setting

Introduction

The incidence of smoking amongst service users in Mental Health is very high. However Mental Health Services has moved to be as smoke free and safe as possible for both service users and staff.

The risks associated with smoking also relate to the availability of ignition sources. This is controlled in some clinical areas but the majority of service users are allowed to leave the ward / site as part of their recovery and are free to purchase tobacco, lighters etc. This can have a significant impact upon the safety of service users, staff and the public, and there have been numerous incidents of fire on the in-patient unit.

Aims

- To reduce the incidence of fire and smoking related incidents by restricting access to ignition sources.
- To reduce the impact of secondary smoking for service users and staff.

Procedure

1. All service users will be asked to hand in their lighters / matches etc. upon admission. These items will be stored securely in the ward office and returned when the service user has leave / is discharged from the ward or, where service user has carers / relatives visiting, they will be asked to take the items away.
2. A poster will be displayed advising both service users and visitors that lighters / matches etc. are not permitted on the ward to maintain the safety and security of those on the ward. .
3. Service users will be asked upon return to the ward to hand in any ignition sources.
4. Service users found smoking in any area other than a designated smoking area, may be liable to prosecution.
5. Service users who are known to smoke, but who decline to hand in an ignition source may be searched as per the Search of Patient – Persons and Belongings Policy and Procedure. (Procedural Guidance attached as Appendix 1).
6. Information leaflets for service users will be provided regarding smoking cessation.
7. An information sheet for Nicotine Replacement Therapy options is provided by the UHB Smoking cessation service.

Procedural guidance for:

Search of Patient – Person and belongings

Search Procedures

Alternative Interventions

- Alternative approaches must be used to give the patient the opportunity to hand over any items of concern. This is due to the serious nature of undertaking a search and the potential harm to the therapeutic relationship.
- Alternative approaches include:
- Negotiation
- Nursing separately
- Accompanied by staff allowing time for individual to hand over the item
- Giving time for the individual to express their concern
- Contacting police – would be essential if there were any potential risk to the safety of staff or others.

Principles of Undertaking a Search

The search procedure, which by its very nature is highly intrusive of a person's privacy and dignity, should not be exercised merely on a `hunch' (Gunn 1992). The rights of the patient must be adhered to at all times. The member of staff must have reasonable grounds for suspecting that a patient is in possession of an article, such as a weapon or illicit drugs, which could be used to cause serious harm to self or others.

If staff suspect an informal patient of possession of a harmful object the individual may be asked whether this is the case, and if they confirm this they can be asked to hand it over for safe keeping. The legal justification for such an action is to prevent a breach of the peace. Consideration should be given to involving the Police if the patient refuses to hand over the object.
If a client is being assessed under Section 136 of the Mental Health act the police have powers to search a patient if they are suspected of possession of a harmful object.

Routine and random searching without cause of detained patients may take place only in exceptional circumstances. (Code of Practice Para: 16.12. page 135) e.g. where the dangerous or violent criminal propensities of patient's create a self-evident and pressing need for additional security.

13.1 Searching Patients without consent
Consideration should always be given to The Mental capacity Act 2005 when assessing a patient's capacity to consent to a search (see section 6).
If a patient does not consent to a search, the most senior staff member on duty must make one of the following decisions (based on the principle of necessity

{Gunn 1992}): -

- a) To search the patient against their will on the grounds that there was immediate risk of serious harm to self or others that necessitated immediate action. Necessity does not limit the action of search to emergency situations only, but extends to action taken in order to prevent serious harm to self or others. An example of this would in removing an article such as a knife from a patient's pocket or illicit drugs / alcohol
- b) To delay the search and seek advice of the patient's consultant and / or the clinical manager or deputy
- c) To involve the police

A situation may arise where a patient undergoing a search procedure withdraws their consent the member of staff in charge of the procedure must then decide how to proceed, using the criteria in section 13.1

Any search carried out against the patient's will or without the patient's consent must be carried out with the minimum force necessary. The Code of Practice 2008 identifies the basic principles for the use of restraint (Chapter 15.)

If a patient physically resists a search of either his / her person or property, a multidisciplinary decision by those present should be made as to the need to carry out a search using physical interventions. If the decision is not to proceed, then the following options should be discussed.

- Postpone the search, if safe to do so – no immediate threat to the patient or others and discuss the issue with his / her care team at the first opportunity to decide on further action.
- If the incident is of an important nature and if there is the possibility of someone becoming injured (including the patient), the police should be notified and asked to provide assistance.

. **Communication**

- A person being searched or whose possessions are the subject of a search should be kept informed of what is happening and why. If they do not understand or are not fluent in English, the services of an interpreter should be sought unless their risk of harm to the individual or others. The specific needs of people e.g. sensory impairment, learning disability. The nature of the search should be explained fully and how it will proceed
- If the person refuses to agree to such a search being carried out, the nurse in charge, Consultant, Deputy or senior clinical nurse, should consult to decide whether or not a search should be enforced

If a search of a patient or their belongings is to be carried out, the following issues must be prioritised.

• Staff should have due regard for the dignity of the person concerned and the need to carry out the search in such a way as to ensure the maximum privacy and minimum invasiveness. A minimum of two people shall be present on any occasion where a search is undertaken and at least one should be of the same sex, this should be discussed with the individual concerned.
• That the reasons for the search are clearly explained
• That a safe environment is maintained

13.2 Any search of a personal nature must be undertaken by persons of the same gender as the patient, wherever possible, unless necessity dictates otherwise.
13.3 The patient must not be unaccompanied at any stage of the search procedure.

13.4 Staff should be aware of the potential implications and outcomes of a search and should use clinical judgement in deciding immediate future management following a search.

13.5 Unless there are exceptional circumstances (i.e. patient unwell, demonstrating aggressive behaviour or would present a risk to the staff searching), patients must be asked if they wish to be in attendance when a search of their belongings is undertaken.

13.6 The search must be the minimum required to achieve the objective and may start or stop at any of the authorised stages.

13.7 For each of the following types of search, consent and/or authorisation must be obtained, unless otherwise stated.

13.8 Cultural and religious issues must be identified when considering and undertaking a search. If staff are unsure what these issues could be they must take advice from senior staff.

13.9 Types of Search

a) Search of Ward/Department/Surrounding area - Not including patient's belongings or personal space. A patient's consent is not required for this search, but where appropriate it is good practice to inform patients that a search is about to take place.

b) Search of patient’s property and personal space - which includes: bedroom furniture, cases, bags, and bed space area**.**

- The patient will be fully informed of any decision to undertake a search of his/her room and property. Members of staff will always seek to secure the patient’s consent and invite the patient to be present. These

matters will be recorded in the nursing and medical records by the respective members of staff.

- Two staff should be involved in the search and should be of the same sex as the patient wherever possible. One nurse must be a first level RMN.
- When searching belongings, the patient must always be allowed to witness this. They should always be offered the opportunity to have an independent person present, a friend or family member not acting in a legal capacity.
- The search should be carried out, taking extreme care not to damage and be respectful of all of the patient's belongings. .Any damage should be fully documented and the patient advised and assisted in claiming for the loss or damage to any property.
- If belongings are removed, the patient must always be informed of where they will be kept. Any items or substances removed should be fully documented and the patient informed. The patient will be given a receipt for all items/substances that are removed.
- If illicit drugs or substances are suspected the use of sniffer dogs should be considered in conjunction with Appendix 2 of The management of patients/visitors in possession of alcohol or illegal drugs policy.
- Illicit drugs should be disposed of in accordance with The management of patients/visitors in possession of alcohol or illegal drugs policy.
- A comprehensive account of the incident must be recorded in PARIS notes and incident form completed

c) Search of patient's clothing -

i) The patient may be requested to turn out their pockets.
ii) The patient may be asked to remove clothes worn close to the body, (e.g. shirts, blouses, and trousers, underwear). In these circumstances the patient would be provided with a dressing gown to wear whilst his/her clothing was searched.

d) Personal Search: -

- In some circumstances the risks to the patient or others are considered so serious that it would be appropriate to seek assistance from the Police. This is likely to be when a patient is thought to be in possession of an offensive weapon or dangerous substances. Any such request for assistance from the Police should be identified, if possible, at the initial agreement to search stage. All the above issues should be fully documented in the patient's records as well as the nurse in charge completing the clinical incident report forms.
- Any items removed from the patient must be documented in the property book. For disposable of illicit substances please refer to the management of patients/visitors in possession of alcohol or illegal drugs policy.

Within the context of personal search, the following stages may be identified.
i) Looking for objects attached to skin, or concealed in the mouth or ears
ii) The patient may be asked to remove superficial clothing that can be removed without impacting on their dignity, (e.g. coat, jacket, shoes)
iii) Touching the patient to look for objects. Wherever possible the patient should assist staff, thus reducing the need to touch the patient. An example of this is by asking the patient to run their fingers through their hair or to lift folds of skin
iv) Intimate search - including body orifices (excluding mouth or ears). More intimate searches are deemed to be beyond the capabilities of the mental health team and liaison with other agencies / parts of the organisation may be necessary.

13.10 Record Keeping
Details of all searches are to be recorded in the patients clinical notes and incident form completed. This should include:
a) The reasons of risk which informed the decision to ask for permission to search.
b) Reasons why any decisions to enforce a search are made.
c) The outcome of the search, including items\substances removed and their disposal. Also any damage caused to patient's belongings during the process of search.
d) Physical and psychological effects which are observed in relation to the patient and the care of that person managed accordingly (incident forms should be completed as necessary).
e) The incident should be reviewed by all concerned including the patient involved. This will ensure that effective evaluation and best practice is promoted.
f) Identifying times of searches, staff involved names of Police Officers attending.
There should be support for patients and staff who are affected by the process of searching involving physical intervention.

APPROVAL OF ASBESTOS MANAGEMENT POLICY	
Name of Meeting: Health and Safety Committee	**Date of Meeting:** 10/07/18

Executive Lead : Director of Planning	
Author : Estates Health, Safety & Asbestos Officer	Tel no: 02920 742720
Caring for People, Keeping People Well: This Policy underpins the UHB Strategy for Caring for People, Keeping People Well by improving Health and Safety through improved Asbestos Management for Patients, Visitors and Staff	
Financial impact : £ 600,000 per annum	
Quality, Safety, Patient Experience impact: This Policy will improve Quality, Safety and Patient Experience by enhancing Health and Safety through improved Asbestos Management for Patients, Visitors and Staff	
Health and Care Standard Number: 2.1	
CRAF Reference Number 6.4	
Equality and Health Impact Assessment Completed: Yes	

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The Policy continuing to provide enhanced asbestos management and improved control.

The Health and Safety Committee is asked to:

- **APPROVE** the Asbestos Management Policy

and

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

SITUATION

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements regarding the management of asbestos transparently and consistently, the UHB will take all reasonable precautions to protect patients, staff and the general public from exposure to asbestos containing materials on the UHB's premises.

The Asbestos Management Policy and the associated Asbestos Management Plan document the risks from asbestos, the various processes for managing and controlling them and the hierarchy of responsibility for each element. The Policy was due a periodic review and while the majority of the content has remained unchanged, amendments to reflect changes in the structure of the

Capital, Planning & Facilities Department have been made.

BACKGROUND

Cardiff And Vale University Health Board (UHB), accepts responsibility under the Health and Safety at Work Act etc. 1974 and the Control of Asbestos Regulations 2012 (as amended), to take all reasonable precautions to prevent or control the harmful effects of airbourne asbestos fibres on residents, patients, staff and other persons working at or using its premises.

The UHB has a significant estate and due to the age of the buildings has a significant asbestos legacy of almost 9000 separate asbestos containing materials. The Asbestos Policy and associated Asbestos Management Plan outline the steps required to identify new materials, monitor changes to the condition of known materials, remove or remediate asbestos containing materials based on the priority risk assessments and to provide all staff, contractors and interested parties with all of the relevant information and training required to work safely with or alongside asbestos containing materials.

This policy once approved will replace the current version of the Asbestos Management Policy.

ASSESSMENT

Consultation has taken place to ensure that the policy/procedure meets the needs of the UHB and our stakeholders and was prepared in conjunction with Capital Estates and Facilities professionals.

The consultation undertaken specific to this document was as follows:-

- The document was added to the Policy Consultation pages on the intranet between 29th May 2018 and 25th June 2018;
- The document was shared with the Operational Health and Safety Group.
- Comments were invited via individual e-mails from the Operational Health and Safety Group.

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

The Policy will be reviewed every 3 years unless legislation, guidance, the UHB or other factors dictate otherwise. Approval will then be sought from the Health and Safety Committee.

The primary source for dissemination of the Asbestos Management Policy within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

The Asbestos Management Policy will continue to provide enhanced asbestos management and improved control. This will improve the Health and Safety of all patients, visitors, staff and stakeholders who use/visit the UHB's premises. An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be no impact.

Reference Number: *UHB 072* **Version Number:** 3	**Date of Next Review:** *April 2020* **Previous Trust/LHB Reference Number:** *T/114*

ASBESTOS MANAGEMENT POLICY

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will take all reasonable precautions to protect patients, staff and the general public from exposure to all known deposits of asbestos containing materials on the UHB's premises and sites.

Policy Commitment

It is the policy of the UHB to treat all asbestos as hazardous and to control or manage that hazard in accordance with statutory regulations in force.
The aim of this Policy is to introduce to the UHB, a structured Procedure and Reporting Schedule, for the Management and Control of Asbestos, in order to:

- Conform to current asbestos legislation.
- Ensure that when it is essential and necessary for continuing patient care, that only competent persons, with approved control measures in place and adequately protected with respiratory and personal protective equipment are exposed to asbestos.
- Control works and maintenance activities carried out within UHB controlled premises.
- To maintain a register of approved asbestos removal and analysis companies.
- Provide and maintain an Asbestos Database detailing ACM location and analytical identification of the types of asbestos on each site
- Implement an effective and positive Asbestos Management Plan so that appropriate measures, such as sealing, labelling, inspection or removal of the material are undertaken.
- Provide regular up to date training for all staff who may have reason to work near asbestos in the event of an emergency arising in the interests of continuing patient care.

Supporting Procedures and Written Control Documents

Other supporting documents are:

- Asbestos Management Plan
- The Health & Safety at Work Etc. Act 1974
- Control of Asbestos Regulations 2012
- L143 Managing and working with Asbestos, Approved Code of Practice and guidance

Document Title: *Asbestos Management*	2 of 28	Approval Date: dd mmm yyyy
Reference Number: UHB 072		Next Review Date: dd mmm yyyy
Version Number: 3		Date of Publication: dd mmm yyyy
Approved By:		

Scope This policy applies to all of our staff in all locations including those with honorary contracts	
Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and it was found there to have no impact. ***Note: Policies will not be considered for approval without an EHIA***

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

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1		23/08/2011	Replaces previous Trust version 114
2	17/04/2014		Replaces T/114 version 1. Updates made to terminology, wording and dates throughout document.
3	20/04/2017		Minor updates made to wording and terminology in places. Significant alterations made to Legislation section due to the amalgamation of 2 no. ACOPs to form a single ACOP.

Document Title: *Asbestos Management*	3 of 28	Approval Date: dd mmm yyyy
Reference Number: UHB 072		Next Review Date: dd mmm yyyy
Version Number: 3		Date of Publication: dd mmm yyyy
Approved By:		

Document Title: *Asbestos Management*	4 of 28	Approval Date: dd mmm yyyy
Reference Number: UHB 072		Next Review Date: dd mmm yyyy
Version Number: 3		Date of Publication: dd mmm yyyy
Approved By:		

1.0 INTRODUCTION

The Control of Asbestos Regulations 2012 define Asbestos as any of the following silicate minerals, or any mixtures containing them - crocidolite, amosite, chrysotile, fibrous anthophyllite, fibrous actinolite and fibrous tremolite.

Asbestos is considered as a significant occupational health hazard throughout the workplace because of the risks associated with the inhalation of fibrous dust and its dispersion within the lungs and other parts of the body. These are enhanced when the Asbestos dust is combined with air borne pollutants such as those absorbed by the body when smoking. Unlike many other occupational diseases, Asbestos - related diseases manifest themselves over a long latent period of between fifteen and sixty years. As a consequence, the present numbers of disease and deaths are attributable to past control methods and to dust levels which obviously were injurious.

Unfortunately, many of the buildings within the UHB's built estate are known to have had asbestos materials used in their construction in the form of cladding, sheet boards and pipe-work insulation and numerous other products. In light of this, the UHB Asbestos Management Plan, Asbestos Management Policy and supporting documents are the UHB's response to meet the requirements of providing a safe system to manage asbestos.

2.0 POLICY STATEMENT AND AIM

Cardiff and Vale University Local Health Board, hereinafter known as the UHB, accepts its responsibility under the Health and Safety at Work Act etc. 1974 and the Control of Asbestos Regulations 2012 to take all reasonable precautions to protect patients, staff and the general public from exposure to all known deposits of asbestos containing materials on the UHB's premises and sites.

It is the policy of the UHB to treat all asbestos as hazardous and to control or manage that hazard in accordance with statutory regulations in force.

The aim of this Policy is to introduce to the UHB, a structured Procedure and Reporting Schedule, for the Management and Control of Asbestos, in order to:

- Conform to current asbestos legislation.
- Ensure that when it is essential and necessary for continuing patient care, that only competent persons, with approved control measures in place and adequately protected with respiratory and personal protective equipment are exposed to asbestos.

- Control works and maintenance activities carried out within UHB controlled premises.
- To maintain a register of approved asbestos removal and analysis companies.
- Provide and maintain an Asbestos Database detailing ACM location and analytical identification of the types of asbestos on each site
- Implement an effective and positive Asbestos Management Plan so that appropriate measures, such as sealing, labelling, inspection or removal of the material are undertaken.
- Provide regular up to date training for all staff who may have reason to work near asbestos in the event of an emergency arising in the interests of continuing patient care.

2.1 The Estate

The Estate comprises all the buildings currently owned or occupied (leases, with maintenance responsibility) by the UHB. A full list of properties/buildings and status of occupation is available on request from the Capital, Estates and Facilities Department.

3.0 ROLES AND RESPONSIBILITIES

3.1 General Responsibilities

3.1.1 Employer's Duties

General duties under the Health and Safety at Work etc Act 1974 (HSWA)

The general duty of employers under the Health and Safety at Work etc., Act 1974 applies generally to working with Asbestos as it applies to other kinds of work. The act places a duty on every employer to ensure so far as is reasonably practicable, the health, safety and welfare at work of all his employees (HSWA 2(1)) moreover all employers must:

1. Provide and maintain plant and systems of work that are, so far as is reasonably practicable, safe and free from health risks (HSWA 2(2)(A)).
2. Make arrangements for ensuring, so far as is reasonably practicable, safety and absence of health risks in connection with the use, handling, storage and transportation of articles and substances. (HSWA 2(2)(B)).
3. Provide such information instruction, training and supervision as is necessary to ensure so far as is reasonably practicable, the health and safety at work of their employees [HSWA 2(2)(C)].
4. Provide a safe working environment [HSWA 2(2)(E)].

5. Those in control of premises must ensure that they are safe and that any plant or substances do not endanger health (i.e. of patients, staff or visitors etc.,) HSWA. sect.4.

Specific Legal Requirements under The Control of Asbestos Regulations 2012 (Reg.4)

No employer shall carry out work which exposes, or is liable to expose their employees to asbestos containing materials - ACMs unless first, they:

1. Take reasonable steps to find out if there are materials containing asbestos in non-domestic premises, and if so, its amount, where it is and what condition it is in;
2. Presume materials contain asbestos unless there is strong evidence that they do not;
3. Make, and keep up-to-date, a record of the location and condition of the asbestos containing materials – or materials which are presumed to contain asbestos;
4. Assess the risk of anyone being exposed to fibres from the materials identified;
5. Prepare a plan that sets out in detail how the risks from these materials will be managed;
6. Take the necessary steps to put the plan into action;
7. Periodically review and monitor the plan and the arrangements to act on it so that the plan remains relevant and up-to-date; and
8. Provide information on the location and condition of the materials to anyone who is liable to work on or disturb them.

There is also a requirement on anyone to co-operate as far as is necessary to allow the dutyholder to comply with the above requirements.

3.1.2 Employees Duties

Employees - General duties under the Health and Safety at Work

etc., Act 1974

By virtue of Section 7 of the Health and Safety at Work Act, employees are under a duty to take reasonable care of their own and others 'safety' when handling and using substances hazardous to health as well as during any other work activity. Employees must also co-operate with their employer so far as is necessary to enable that employer to comply with any statutory duty or requirement, e.g. by following safe systems of work and by using and/or wearing personal protective equipment.

Specific Legal Requirements under The Control of Asbestos

Regulations 2012 (Reg.4)

Every person shall cooperate with the duty holder so far as is necessary to enable the duty holder to comply with his duties under this regulation.

3.2 Delegated Responsibilities

The UHB delegates to the Chief Executive, responsibility for the safe management of asbestos. In practice, the responsibility is designated to through the UHB Divisions and Directorates as outlined in the UHB overall Health and Safety Policy.

Furthermore, the UHB has appointed an Asbestos Management Team, from whom advice and information on asbestos can be sought. *[An organisational chart for the management of Asbestos is illustrated in Appendix 1]*

The Asbestos Management Team will act on notification that asbestos has been located or is suspected of being present and will:

1. Establish the presence or other wise of asbestos;
2. Will carry out a risk assessment;
3. Will arrange to remove or adequately manage the hazard;
4. Will review the assessment periodically or sooner if there is valid reason to do so;
5. Will maintain records and a database of asbestos within the UHB.
6. Will keep management and accredited staff health and safety representatives informed on matters concerning asbestos.

4.0 RESOURCE IMPLICATIONS

The revenue costs associated with the effective control and management of asbestos across the UHB are of the order of £650k per annum, which is to be funded via the estate maintenance revenue allocation. The capital costs of asbestos management and control schemes are in the order of £650k per annum (over the next three years), which is to be funded via discretionary capital programme.

Reference should be made to the accompanying *UHB Operational Procedures for the Control of Asbestos* for full details including contractor selection.

Document Title: *Asbestos Management*	8 of 28	Approval Date: dd mmm yyyy
Reference Number: UHB 072		Next Review Date: dd mmm yyyy
Version Number: 3		Date of Publication: dd mmm yyyy
Approved By:		

5.0 TRAINING REQUIREMENTS

Training must be given to staff so that they can action the following:

1. That the Estates Managers and Supervisors are capable of planning the duties involved when essential work must be actioned on or near asbestos containing materials. They must ensure adequate precautions are in place or effected, prior to work being performed on or near asbestos containing materials. That the necessary authorisation (i.e. permit to work) is obtained prior to the work being undertaken. They must be capable of planning, monitoring and supervising the work on or near asbestos in a safe manner.

2. That all staff are capable of working in such a manner that they do not expose themselves and all others to asbestos containing dust when they have reason to work on or near known deposits of asbestos.

3. That the Asbestos Management Team are capable of supervising the work of the approved asbestos removal contractors and ensuring that strict observance and adherence is made to the UHB Asbestos Operational Procedures and Protocols Manual.

6.0 POLICY RATIFICATION

It is The UHB's Policy, to meet the full obligations of the Control of Asbestos Regulations 2012. In order to meet the obligations of the Control of Asbestos Regulations 2012, with respect to the introduction of premises holders 'duty to manage', the UHB has put in place the following initiatives in order to effectively manage asbestos containing materials - ACMs within UHB premises.

1. Manage the asbestos database, with requests for information on ACMs only from authorised UHB / University personnel.
2. Provide requisite on-going training seminars in support of the above for all relevant personnel.
3. Carry out periodic re-inspections of all known ACMs in UHB/University premises to ensure database is up to date.
4. Update database with information received via site personnel, where ACM's have been removed, discovered or other changed circumstances etc., utilising an agreed update procedure.
5. Develop comprehensive 'Asbestos Management Plan procedures' for the management of ACMs within the UHB.

6. Guided by the recommendations of the reinspections, carry out remediation works as necessary and where ACMs are of a lower risk, put in place safe systems of work.

7.0 FURTHER INFORMATION

7.1 Main Legislation and Guidance

7.1.1 General

The Health and Safety at Work Etc. Act 1974 (HSAWA) requires every employer to ensure, so far as is reasonably practicable, the Health, safety and welfare at work of all employees. Section 2 states that employers, the self-employed and occupiers must conduct their undertaking and keep their premises in such a condition as to ensure that others are also not exposed to risk (sections 3 and 4)

The Management of Health and Safety at Work Regulations 1999 (MHSR) require employers and self employed people to make an assessment to the risks to the health and safety of themselves, employees and people not in their employment arising out of or in connection with the conduct of their business – and to make appropriate arrangements for protecting those people's health and safety.

The Workplace (Health, Safety and Welfare) Regulations 1992 require employers to maintain workplace buildings so as to protect occupants and workers.

The Construction (Design and Management) Regulations 2007 (CDM) requires the client to pass on information about the state or condition of any premises (including the presence of hazardous materials such as asbestos) to the planning supervisor before any work begins and to ensure that the health and safety file is available for inspection by any person who needs the information.

The Defective Premises Act 1972 in England and Wales or The Civic Government (Scotland) Act 1982 in Scotland places duties on landlords to take reasonable care to see that tenants and other people are safe from personal injury or diseases caused by a defect in the state of the premises. Any premises in such a state is prejudicial to health and constitutes a statutory nuisance under section 79 of the Environmental Protection Act 1990. An abatement notice can be

served by local authorities on the owner or occupier of premises requiring prevention or restriction of the nuisance.

There are two principle sets of regulations and four guidance documents, as follows:

Employers must consult safety representatives appointed by recognised trade unions under with regard to health and safety issues. Employees not covered by such representatives must be consulted, either directly or indirectly, via elected representatives of employee safety, according to The Health and Safety (Consultation with Employees) Regulations 1996.

The Health & Safety at Work Etc. Act 1974

Control of Asbestos Regulations 2012 (CAR2012)

L143 Managing and working with asbestos, Approved Code of Practice and guidance. *(This amalgamates the previous ACOPs L127 & L143,and replaces L27, L28 and the Asbestos (Licensing) Regulations 1983, L11.)*
HSG 210 Asbestos Essentials: A task manual for building maintenance and allied trades on non-licenced asbestos work.
HSG 247 Asbestos: The licensed contractors guide.
HSG 248 Asbestos: The analysts guide for sampling,

7.1.2 The Control of Asbestos at Work Regulations 2012 (CAR2012)

This applies to all work activities involving asbestos-containing materials. It places duties on an employer, including the self-employed, who carries out “any work which exposes or is liable to expose any of his employees to asbestos…..” to protect all employees and anyone else who may be affected by the work.

CAR2012 is supported by an Approved Codes of Practice that gives practical guidance on how to comply with the law. Although failure to observe any of the provisions of an ACOP is not in itself an offence, that failure may be taken by a court in criminal proceedings, as proof that a person has contravened the regulations to which the provision relates. The onus would then be on that person to show that they have complied with the regulations in an equally effective way. The ACOP is:

Managing and Working with Asbestos (L143) amalgamates the two previous ACOPs L127 (The management of asbestos in non-domestic premises) and L143 (Work with asbestos containing materials). It explains the duties to building owners, tenants and any other parties who have any legal responsibility for the premises. It also sets out what is required of people who have a duty to co-operate with the main duty holder to enable them to comply with the regulation. It also applies to any work on, or which disturbs, or is liable to disturb, materials containing asbestos. It also covers the requirements for asbestos sampling and laboratory analysis. It is particularly relevant to those who are responsible for the maintenance and repair of non-domestic premises where asbestos-containing materials are or are likely to be present. It replaces the previous ACOPs, L27 and L28. It also replaces the guide to the Asbestos (Licensing) Regulations 1983, L11.

7.2 Further Guidance

More detailed guidance may be found in the ***"UHB Operational Procedures for the Control of Asbestos"*** Document.

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 we will make plans for any 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 Capital, Estates & Facilities Department, although all users within the UHB have a part to play. Adherence to the requirements of this policy will be monitored via a number of different methods e.g. internal audit programme, review of database statistics, and regular re-surveys of UHB ACMs etc.

A regular audit/inspection will be undertaken to check that the Asbestos Database has been kept up to date. The audit/inspection shall be organised by the Asbestos Management Team or his

nominated representative. Audits will be conducted by suitably trained asbestos surveyors who have undergone suitable training.

10. DISTRIBUTION

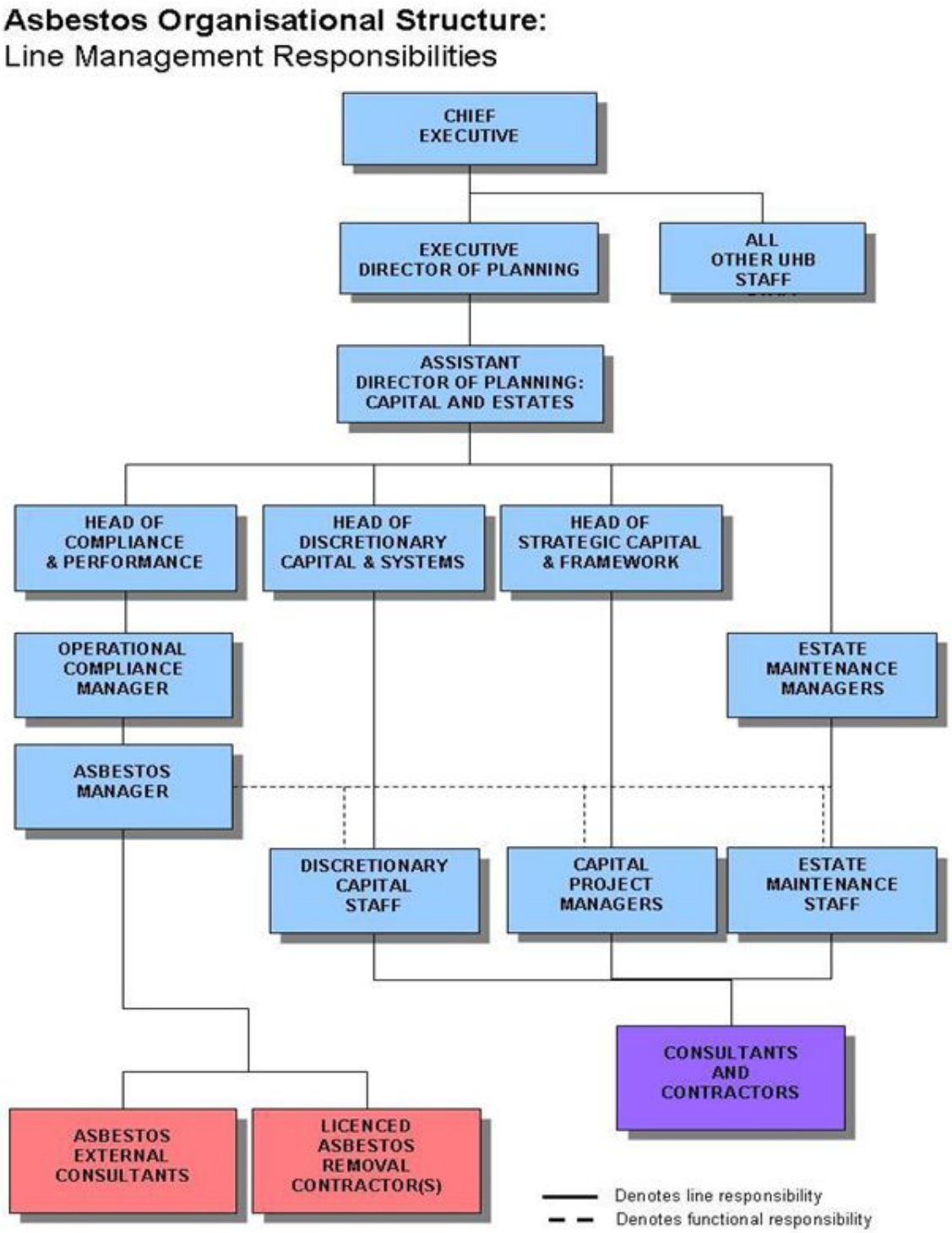
This Policy will be posted on the UHB Intranet.

11. REVIEW

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

Document Title: *Asbestos Management*	13 of 28	Approval Date: dd mmm yyyy
Reference Number: UHB 072		Next Review Date: dd mmm yyyy
Version Number: 3		Date of Publication: dd mmm yyyy
Approved By:		

APPENDIX 1



17

17

Equality & Health Impact Assessment for

ASBESTOS MANAGEMENT POLICY

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Asbestos Management Policy UHB 072
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Capital, Estates & Facilities Owen Davies Estates Health Safety & Asbestos Support Officer (02920) 742720
3.	Objectives of strategy/ policy/ plan/ procedure/ service	To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will take all reasonable precautions to protect patients, staff and the general public from exposure to all known deposits of asbestos containing materials on the UHB's premises and sites.
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research	The Policy is largely technical and closely follows the legislative requirements set out in the Control of Asbestos Regulations 2012. It would apply in full to all members of staff engaged in maintenance or refurbishment work within UHB premises or those managing others undertaking these tasks.

Document Title: *Asbestos Management*	15 of 28	Approval Date: dd mmm yyyy
Reference Number: UHB 072		Next Review Date: dd mmm yyyy
Version Number: 3		Date of Publication: dd mmm yyyy
Approved By:		

	• good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	No background information was required as evidence.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	This is technical documentation and is only relevant to maintenance staff, contractors and those project managing or organising maintenance activities within UHB sites.

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

Document Title: *Asbestos Management*	16 of 28	Approval Date: dd mmm yyyy
Reference Number: UHB 072		Next Review Date: dd mmm yyyy
Version Number: 3		Date of Publication: dd mmm yyyy
Approved By:		

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	It should have no age related impacts.	N/A	
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	It should have no disability related impacts.	N/A	

Document Title: *Asbestos Management*	17 of 28	Approval Date: dd mmm yyyy
Reference Number: UHB 072		Next Review Date: dd mmm yyyy
Version Number: 3		Date of Publication: dd mmm yyyy
Approved By:		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	It should have no gender related impacts.	N/A	
6.4 People who are married or who have a civil partner.	It should have no impact on married people or those within a civil partnership.	N/A	

Document Title: *Asbestos Management*	18 of 28	Approval Date: dd mmm yyyy
Reference Number: UHB 072		Next Review Date: dd mmm yyyy
Version Number: 3		Date of Publication: dd mmm yyyy
Approved By:		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	It should have no pregnancy related impacts.	N/A	
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	It should have no ethnicity related impacts	N/A	

Document Title: *Asbestos Management*	19 of 28	Approval Date: dd mmm yyyy
Reference Number: UHB 072		Next Review Date: dd mmm yyyy
Version Number: 3		Date of Publication: dd mmm yyyy
Approved By:		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	It should have no religious related impacts.		
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	It should have no sexual preference related impacts		
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design	This policy is only available in English and could therefore have a negative impact on a non English speaker.	The policy could be translated into Welsh or other languages as required.	

Document Title: *Asbestos Management*	20 of 28	Approval Date: dd mmm yyyy
Reference Number: UHB 072		Next Review Date: dd mmm yyyy
Version Number: 3		Date of Publication: dd mmm yyyy
Approved By:		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A Wales of vibrant culture and thriving Welsh language			
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	This has no impact on people with low income or no income.		
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	This policy has no regional bias.		

Document Title: *Asbestos Management*	21 of 28	Approval Date: dd mmm yyyy
Reference Number: UHB 072		Next Review Date: dd mmm yyyy
Version Number: 3		Date of Publication: dd mmm yyyy
Approved By:		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	None applicable		

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation	Not applicable.		

Document Title: *Asbestos Management*	22 of 28	Approval Date: dd mmm yyyy
Reference Number: UHB 072		Next Review Date: dd mmm yyyy
Version Number: 3		Date of Publication: dd mmm yyyy
Approved By:		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
and/or those experiencing health inequalities Well-being Goal - A more equal Wales			
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight	Not applicable.		

Document Title: *Asbestos Management*	23 of 28	Approval Date: dd mmm yyyy
Reference Number: UHB 072		Next Review Date: dd mmm yyyy
Version Number: 3		Date of Publication: dd mmm yyyy
Approved By:		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	Not applicable.		
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food,	This should have a positive impact by reducing the likelihood of being exposed to airbourne pollutants (namely asbestos).		

Document Title: *Asbestos Management*	24 of 28	Approval Date: dd mmm yyyy
Reference Number: UHB 072		Next Review Date: dd mmm yyyy
Version Number: 3		Date of Publication: dd mmm yyyy
Approved By:		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging;	Not applicable.		

Document Title: *Asbestos Management*	25 of 28	Approval Date: dd mmm yyyy
Reference Number: UHB 072		Next Review Date: dd mmm yyyy
Version Number: 3		Date of Publication: dd mmm yyyy
Approved By:		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities			
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	Not applicable.		

Document Title: *Asbestos Management*	26 of 28	Approval Date: dd mmm yyyy
Reference Number: UHB 072		Next Review Date: dd mmm yyyy
Version Number: 3		Date of Publication: dd mmm yyyy
Approved By:		

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	The impact of improving the physical environment by reducing peoples exposure to pollutants (namely asbestos) is likely to be a very positive impact. The only negative was the lack of bilingual alternative for the policy and supporting documentation. This has not previously been raised as an issue but should it be in the future, then measures would need to be taken to translate it into Welsh in order to not impact upon those who only speak Welsh.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	Not applicable.			

Document Title: *Asbestos Management*	27 of 28	Approval Date: dd mmm yyyy
Reference Number: UHB 072		Next Review Date: dd mmm yyyy
Version Number: 3		Date of Publication: dd mmm yyyy
Approved By:		

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	No. The negative impacts are believed to be minimal so further assessment would not be beneficial.			

HEALTH AND SAFETY COMMITTEE WORK PROGRAMME 2018 - 2019

Meeting Date / Agenda Item	**January 2018**	**April 2018**	**July 2018**	**October 2018**	**January 2019**
Presentation/Staff Story	Arjo Proact Survey Findings	Mental Health CB – Trial of No Smoking	Case Management Support – Case Study		Stress Management
Review of Committee's Term of Reference			√		√
Priority Improvement Plan – **CRAF No's: 8.1.4, 6.4.7, 6.4.5, 6.4.4**	√	√	√	√	√
Policy Schedule **- CRAF No: 8.2.3**	√	√	√	√	√
Fire Enforcement Report – **CRAF No: 6.4.5**	√	√	√	√	√
Environmental Health Inspection Report – **CRAF No: 8.1**	√	√	√	√	√
Corporate Risk Assurance Framework Exceptions Report – **CRAF No: N/A**	√	√	√	√	√
Health & Safety Annual Report and presentation - **CRAF No's: 8.1.4, 6.4.7, 6.4.5, 6.4.4**			√		
Minutes from Other Committees/SubCommittees/Groups – **CRAF No: 8.1**	√	√	√	√	√
Regulatory and Review Body Tracking Report – **CRAF No: 8.1**		√		√	

Meeting Date / Agenda Item	January 2018	April 2018	July 2018	October 2018	January 2019
Enforcement Agencies Report – **CRAF No: 8.1.4**	√	√	√	√	√
Pedestrian Safety Strategy – **CRAF No: 8.1.4**	√	√	√		
Review of Statutory and Mandatory Health and Safety Training – **CRAF No**:			√		
Review of Fire Safety Policy - **CRAF No: 8.2.3**			√		
Review of Asbestos Management Policy – **CRAF No: 823**			√		
Review of Latex Allergy Policy - **CRAF No: 8.2.3**				√	
Review of Environmental Policy - **CRAF No: 8.2.3**				√	
Review of Closed Circuit Television (CCTV) Policy – **CRAF No: 8.2.3**				√	
Review of Security Services Policy **– CRAF No: 8.2.3**					√
Waste Management Compliance Report – **CRAF No: 8.1.1**	√		√		√
Fire Safety Annual Report - **CRAF No: 6.4.5**				√	
Healthcare Standards – **CRAF No: 5.16**					
Public Health Targets – Smoking - **CRAF No: 1.2.1**			√		

Meeting Date / Agenda Item	January 2018	April 2018	July 2018	October 2018	January 2019
Internal Audit Reports with Health & Safety Inference – **CRAF No: 8.1**					
Lone Worker Devices Report – **CRAF No: 9.2**		√		√	
Health and Safety Management Audit – **CRAF Nos: 8.1.4, 6.4.7, 6.4.5, 6.4.4**					
Shared Services Fire Audit – UHL – **CRAF No: 6.4.5**	√		√		
Contractor Control – **CRAF No: 8.1.14**		√			

Progressing smoking cessation in the Cardiff and Vale population
Name of Meeting : Board **Date of Meeting:** 31st May 2018

Executive Lead:	Executive Director of Public Health
Author:	Principal Health Promotion Specialist Tel: 029 2183 2125
Caring for People, Keeping People Well: The report supports the Health Board's Mission Statement (Keeping People Well) and underpins the Outcomes, Priorities and Values elements of the Health Board's Strategy	
Quality, Safety, Patient Experience impact: Impact on patient experience as a result of increased recording of smoking status and referrals. Patient impact in respect to the current pilot to remove an existing exemption to the No Smoking and Smoke Free Environment Policy	
Health and Care Standard Number : 1.1 Health promotion, protection and improvement	
CRAF Reference Number:	1.2, 4.3
Equality and Health Impact Assessment Completed: Not applicable as no change in policy	

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Prevalence of smoking within the Cardiff and Vale population is below the WG target
- quarterly monitoring reports to Welsh Government on the Tier 1 Smoking Cessation Target
- monthly monitoring within clincial board and public health department performance review
- Monthly monitoring of the implementation and enforcement of the UHB's No Smoking and Smoke Free Environment Policy

The Board is asked to:

PROVIDE continued visible leadership and support to drive forward:

- work to reduce the prevalence of smoking in disadvantaged areas across Cardiff and the Vale of Glamorgan
- action to increase routine recording of smoking status and referral to specialist smoking cessation services and the enforcement of the No Smoking and Smoke Free Environment Policy
- action to support the pilot of the removal of the exemption (relating to mental health patients smoking in enclosed, outside areas) relating to the

No Smoking and Smoke Free Environment Policy

SITUATION

Cardiff and Vale University Health Board (UHB) is committed to delivering the Well-being of Future Generations Act (Wales) 2015 in line with its' statutory duty. Prevention is one of the five key sustainable development principles within the Act and is also a core element throughout the UHB's 10 year *'Shaping Our Future Wellbeing Strategy'.*

In Cardiff and the Vale of Glamorgan, as in the rest of Wales, smoking remains the biggest cause of avoidable mortality and is the primary reason for the gap in healthy life expectancy, being linked with a wide range of health issues including low birth weight, heart disease, respiratory disease and a variety of cancers. Reducing smoking prevalence is therefore a key public health priority. Whilst Smoking rates in Cardiff and Vale continue to fall (from 19% in 2015-2016 to 15% in 2016-2017), they remain high in areas of high deprivation and for certain population groups such as specific ethnic groups, those with mental health conditions, pregnant smokers, prisoners and individuals identifying as lesbian, bisexual, gay or transgender.

This paper summarises work to reduce smoking prevalence, including increasing access to smoking cessation in the community and in hospital, and highlights local priorities for action.

BACKGROUND

Local partners (Local Authorities, primary care providers and Third Sector) have successfully worked together with the UHB and its predecessor organisations over many years to develop and implement programmes to improve access to NHS smoking cessation support services and reduce smoking prevalence. Whist the UHB has already achieved Welsh Government's 2020 16% smoking prevalence target, it is acknowledged that the rate of smoking remains high within areas of deprivation and certain population groups; these smokers are often the most difficult to engage and require targeted smoking cessation support. To ensure all smokers can be offered support to quit smoking, UHB residents are able to access three specialist smoking cessation providers; the hospital in-house Smoking Cessation Service, Stop Smoking Wales (SSW) and Level 3 Enhanced Service Community Pharmacies. Twenty of 21 community based smoking cessation groups run by SSW Wales are held within GP practices and 80% of these are in areas of high deprivation.

Since 2010, the UHB has led developments aimed at addressing tobacco control and strengthening access to smoking cessation:

- Cardiff and Vale UHB was one of the first health boards to introduce a full ban on smoking across all grounds in 2013

- Introduction of a Level 3 (L3) Enhanced Smoking Cessation Service for Community Pharmacies based in areas of high deprivation (20 pharmacies are participating from a total of 25 in the target areas)
- Development of the UHB's Optimising Outcomes Policy (OOP) which expects all patients recorded as a being a smoker to have been offered, accepted and completed a smoking cessation support programme prior to elective surgery
- Adapting the hospital electronic patient management system to allow routine record smoking status and onward electronic referral into the hospital based smoking cessation service
- Targeted communication campaigns using traditional and new media. The latest campaign, 'Care to Quit', (a follow-on campaign to the UHB's 2016 'Tobacco 20 Challenge') was launched in January 2018 and aims to increase referrals to the in-house Smoking Cessation Service from Clinical Boards, increase the number of GP Practices e-referrals and reduce the incidence of smoking across hospital sites
- Improving the engagement of pregnant women who smoke with smoking cessation services
- Deliver programmes to prevent young people taking up smoking and reduce environmental exposure to second hand smoke in community and school settings

The nationally led Help Me Quit (HMQ) Call Centre was launched in April 2017, which provides a single point of access for smokers and signposts them into community or hospital based smoking cessation programmes as appropriate. All local GP Practices have direct e-referral access and over 60% of all contacts from Cardiff and Vale to HMQ use this method (HMQ, April 2017- December 2017).This reinforces the important role the GP has in helping the quit attempt.

The UHB has both informed and contributed to the shaping of national tobacco control strategy and our local work aligns well. Welsh Government (WG) published it's most recent three year *Tobacco Control Delivery Plan for Wales 2017-2020* in September 2017. Overall outcomes include a focus on reducing prevalence – especially in areas of high deprivation, reducing the number of women that smoke in pregnancy and reducing smoking in young people.

WG has recognised that smoking cessation services are led and managed differently both across Wales and within health boards. It has therefore commissioned a Smoking Cessation Service Review to consider three options, including remaining with the current 'status quo' (with development). Options 2 and 3 suggest that either health boards or Public Health Wales manage all specialist smoking cessation services. The UHB considers that one fully integrated NHS smoking cessation service is preferable, pending further detail on all three options.

ASSESSMENT AND ASSURANCE

Health Boards have a Tier 1 Smoking Cessation target for 5% of smokers to become 'treated smokers' annually (i.e. attend at least one treatment session and set a firm quit date) and of those, at least 40% to quit smoking at 4 weeks (CO verified). This target has not been met by any health board in Wales to date and Wales achieved 2.9% against the 5% target for 2016-2017 The UHB achieved 1.3% against this target and yet our prevalence is the lowest in Wales. It is estimated that over 8,000 smokers need to be referred in Cardiff and Vale of Glamorgan to meet this target. In order to reach more smokers and to reduce further our smoking prevalence, the UHB is focusing on three main areas of work for 2018-19.

1. **Reducing smoking prevalence in deprived areas and high prevalence groups**

Ensuring on-going publicity of SSW and L3 Community Pharmacy services to both professionals and the public is a key priority. A Communication Plan has been developed and members of the Local Public Health Team are working with GP Cluster leads to promote e-referral to smoking cessation support, offer training on smoking cessation and provide quarterly monitoring of referral numbers.

2. **Inpatient settings/ smoke free hospital environment**

The UHB has a key role in identifying patients who smoke, offering support and referring them into the hospital based smoking cessation service. A systematised pathway for asking and recording of smoking status is being implemented with Clinical Boards. Monthly monitoring of the electronic patient management system shows that referral numbers are increasing. Specific smoking cessation programmes aimed at pregnant women and mental health patients are in place and are also being monitored monthly.

Since October 2014, over 10,000 individuals have been challenged for smoking on hospital premises, most of whom are visitors (60%) and patients (26%). This provides an on-going challenge. Through the Local Authority, the UHB have employed a No Smoking and Waste Enforcement Officer on the UHW and UHL sites (a unique role in Wales) in anticipation of a legal duty to prohibit smoking on NHS grounds as part of the Public Health (Wales) Act 2017. Funding for the post has been secured until December 2018.

3. **Mental Health In-patient Services**

From January 2018, the Mental Health Clinical Board has removed the exemption on the No Smoking and Smoke Free Environment Policy which permits mental health in-patients to smoke outside, in enclosed gardens as part of an on-going pilot. This aims to ensure equity of access to smoking cessation support. The UHB is the first health board in Wales to take this step. The implementation is being closely monitored by a stakeholder Steering Group.

The UHB's Health and Safety Committee, which met on 10th April 2018, fully supported the work that had taken place and requested that this be 'mainstreamed' as part of normal policy procedures. However, specific elements relating to this work are on-going and if adopted, the Policy may need to be amended and some elements of the pilot will need to be discussed further in terms of their wider impact on in-patients across hospital sites.

WASTE COMPLIANCE	
Name of Meeting: Health and Safety Committee	**Date of Meeting:** 10 July 2018

Executive Lead : Director of Planning
Author : Waste and Compliance Manager, 029 20743988
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Service Priorities" elements of the Health Board's Strategy.
Financial impact : £1k and £250k per offence for non compliance
Quality, Safety, Patient Experience impact : • Sharps boxes not identifiable to the area where waste is being produced • Contamination of landfill sites may result with a significant financial cost to the UHB for disinfection. • Waste not packaged for transportation correctly • UHB reputation could be brought in to disrepute through negative press or illegal disposal of waste.
Health and Care Standard Numbers 1.1, 2.1, 2.4, 2.6, 2.8, 2.9 and 3.1
CRAF Reference Number 8.1.1
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE RECOMMENDATION

The Health and Safety Committee is asked to approve the Waste Compliance report as assurance of compliance against the Hazardous Waste (England and Wales) (Amendment) Regulation 2016 and other associated waste Legislation.

Overall compliance with the Hazardous Waste (England and Wales) (Amendment) Regulation 2016 and other waste legislation remains consistently high at 98.4%. Compliance has remained consistent to the previous report presented to the Health and Safety Committee in January 2018.

ASSURANCE

During the period November 2017 and April 2018 a total of 213 internal waste audits have been undertaken, 5073 samples were taken to assess compliance with the Hazardous Waste (England and Wales) (Amendment) Regulation 2016, the overall compliance was 98.4%.

Of the 5073 samples taken 41 non conformities (0.8%) were identified against the Environmental Protection (Duty of Care) Regulations (1991) and Hazardous Waste (England and Wales) (Amendment) Regulation 2016 were identified, of those;

- 14 orange sharps (34%) were identified as containing medication or unidentifiable to the area.

- 19 yellow sharps (46%) were unidentifiable to the area where waste was produced.
- 3 black bags (7%) were identified as containing recyclable materials and/or waste not appropriate for landfill.
- 2 orange bag (5%) contained waste unsuitable for alternative heat treatment.

Samples audited:-

Orange Bags	Tiger bags	Yellow bags	Cytotoxic bags	Black bags	Clear bags	Yellow sharps	Orange sharps	Purple sharps
807	806	16	18	1085	544	884	648	265

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

2017-18	Orange Bags	Tiger bags	Yellow bags	Cytotoxic bags	Black bags	Clear bags	Yellow sharps	Orange sharps	Purple sharps
November	100	100	100	100	100	99	100	98	100
January	100	100	100		100	100	100	98	100
February	100	100	100		100	100	100	100	100
March	100	100			100	100	96	97	100
April	99	100	100	83	99	100	92	93	100
Total	**99.8**	**100**	**100**	**91.5**	**99.8**	**99.8**	**97.6**	**97.4**	**100**

The table below shows comparative compliance per waste stream between November 2016 and April 2017, compliance against the Environmental Protection (Duty of Care) Regulations 1991 and Hazardous Waste (England and Wales) (Amendment) Regulation 2016 was 99%.

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

Overall compliance with the Hazardous Waste (England and Wales) (Amendment) Regulation 2016 and other waste legislation remains consistently above 98%.

FOOD HYGIENE INSPECTION HAFAN Y COED PATIENT CATERING SERVICE UNIVERSITY HOSPITAL LLANDOUGH
Name of Meeting: Health and Safety Committee. **Date of Meeting:** 10/07/2018
Executive Lead: Director of Planning
Author: Assistant Operational Services Manager (South)
Caring for People, Keeping People Well: Consistent implementation of the documented Food Safety Management System will ensure compliance with Food Safety Regulations and a safe patient environment.
Financial impact: N/A
Quality, Safety, Patient Experience impact: N/A
Health and Care Standard Number: 1.1 Health Promotion, Protection and Improvement 2.1 Managing Risk and Promoting Health and Safety 2.4 Infection Prevention and Control 2.5 Nutrition and Hydration
CRAF Reference Number: N/A
Equality and Health Impact Assessment Completed: Not Applicable

ASSURNCE AND RECOMMENDATION

ASSURANCE provided by:

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

The Health and Safety Committee is asked to:

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

SITUATION

An inspection of the patient catering service at Hafan y Coed was carried out on 9th February 2018, the outcome of which was confirmed in writing in a letter report dated 13th February 2018, from Mr Rowan Hughes, Commercial Services Officer, Food and Port Health Bridgend, Cardiff and Vale of Glamorgan Shared Regulatory Services.

In this report it was noted that the patient catering service at Hafan y Coed was awarded a score of 5 (Very Good) under the Food Hygiene Rating (Wales) ACT 2013.

BACKGROUND

It is a legal requirement for Hospitals to register as a food premises with the Local Council and therefore subject to an annual inspection by the Environmental Health Agency Commercial Services Officer.

ASSESSMENT AND ASSURANCE

On receipt of the letter report from the Commercial Services Officer, an action plan was developed by the Operational Services Assistant Manager (South) to address the matters raised and is attached as an appendix to this report.

This will be monitored within Facilities by the Estates Manager (South) on behalf of the Director of Capital, Estates and Facilities.

Hafan Y Coed Food Safety Inspection 9th February 2018 Action Plan

Schedule A – Legal Requirements

Schedule A High standard of compliance with statutory obligations, industry codes of recommended practice and minor contraventions of food hygiene regulations. Some minor non-compliance with statutory obligations and industry codes of recommended practice.			
Food Hygiene and Safety Procedures	**Management Response / Action**	**Time Scale / Update**	**Lead**
1/. There are partially stuck on labels on the stainless steel food containers used as part of the regeneration system. These are a possible source of contamination. Ensure that they are scrapped off before they go in the dishwasher as this is not adequately removing the old labels. ***(Annex II Chapter IX para 3)***	Labels removed 14.02.18 - Staff retraining commenced 14.02.18 - signed training sheet to senior supervisor on completion	Completed 19/02/18	OSM
2/. There was a container of soup in the main kitchen refrigerator which appeared to be beyond the Use By Date 5th February 2018. However on further investigation I understand that it was a member of staff's homemade soup in an old container. 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 may not meet food safety requirements. 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. *(Article 14 of Regulation (EC) No 178/2002)* 3/. Food must be protected against any	Soup consumed by staff 09.02.18 Fridge acquired to provide staff access to a fridge located externally to the patient main kitchen	Completed 09/02/18 Completed 14/05/18	OSM OSM

contamination likely to render the food unfit for human consumption. There were plastic food containers and jugs which were badly scored and stained and no longer in a state where they can be readily cleaned in the Main Kitchen / Maple Ward Kitchen /Oak Ward Kitchen and split fruit bowl in Willow Ward Kitchen. To prevent cross contamination of food, plastic food containers, mixing bowls and jugs must be maintained in a state where they can be readily cleaned. *(Annex II Chapter IX para 3)*	Plastic containers to be replaced (Ordered raised 12.02.18, number 725540366) Plastic fruit bowl requires replaced (Ordered raised 13.02.18, number Cb750 bowl) Plastic jugs to be replaced (Order raised 12.02.18, number 725540366)	Completed 19.02.18 Completed 16.02.18 Completed 19.02.18	OSM OSM OSM
Structural / Cleaning Issues High standard of compliance with statutory obligations, industry codes of recommended practice and minor contraventions of food hygiene regulations. Some minor non-compliance with statutory obligations and industry codes of recommended practice.			
Structural / Cleaning Issues	**Management Response / Action**	**Time Scale / Update**	**Lead**
4/.The condition of the microwaves in Willow Ward Kitchen / Maple Ward Kitchen / Oak Ward Kitchen have deteriorated due to rust and can no longer be thoroughly cleaned/disinfected. Do not use these microwaves, replace and remove from the premises. *(Annex II Chapter V Para 1(c))*	10 commercial microwaves ordered to replace all ward kitchen Microwaves (Order raised 13.02.18, number 725540551). Delivered 16/02/2018.	Completed 16.02.18	OSM
5/.The extract vent in Willow Ward Kitchen was dirty. Thoroughly clean and maintain in a clean condition. *(Annex II Chapter V Para 1(c))*	MR submitted for all high level Extractor Fans to be cleaned replaced, submitted 13.02.18 (number 674587)	Completed 21.06.18	OSM
6/.There were scorch marks / burnt sections on the underside of the cupboards where the toaster is used		Under review with Estates	OSM

in Willow Ward Kitchen / Alder Ward Kitchen / Oak Ward Kitchen. Restore damage to the underside of these cupboards and either move the toasters to a more appropriate position or fix a protective plate (e.g stainless steel) on the underside of the cupboards to prevent further damage. *(Annex II Chapter 1 Para 1)* 7/.There was some slight high level cleaning (To the top of cupboards) required in some of the Ward Kitchens including Oak Ward Kitchen. *(Annex II Chapter 1 Para 1)* 8/.There are some disused old equipment items in a cupboard in the main kitchen including kettles and blender. Either thoroughly clean and keep or dispose of. *(Annex II Chapter 1 Para 1)*	Cleaned 12.02.18 Disposed of 12.02.18	Completed 12.02.18 Completed 12.02.18	OSM OSM
Confidence in Management / Control Procedures Good record of compliance. Technical advice available in-house or access to, and use of, technical advice from a Primary Authority, trade associations and/or from Guides to Good Practice or assurance scheme. 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.			
Confidence in Management / Control Procedures	**Management Response / Action**	**Time Scale / Update**	**Lead**
9/. You have a documented HACCP food safety procedure and associated general record keeping is good. However it appears to have been last fully reviewed in April 2016. Please ensure that it is fully reviewed and is tailored to your Regeneration System 'Socamel' system and reflects your actual	HACCP document review undertaken to amend as appropriate and to reflect the use of the 'Socamel' regeneration system / trolleys	Completed 12.02.18	OSM

system rather than traditional catering. Ensure that there is adequate stock control of dry food goods that are only used occasionally like the Branston Pickle (Best Before Nov 2017). These arrangements if continued should represent compliance with the current requirements. The review of procedures, particularly when menu items or suppliers etc change, will remain an ongoing part of your obligations as a food business operator. *(Regulation (EC) 852/2004 Article 5 para 1)*	Branston pickle disposed of 09.02.18 Supervisory staff reminded of stock control procedure and their responsibilities in maintaining standards	Completed 09.02.18 Completed 13.02.18	OSM OSM
Schedule B – Recommendations, Advice and Information These recommendations provide advice on good practice:-			
10/. It is recommended that you review the use of the large fridge in the main kitchen which the staff are using and ensure that out of date items are removed promptly. 11/. Guidance in relation to how to comply with the allergen labelling requirements can be found at https://www.food.gov.uk/business-industry/allergy-guide. An interactive food allergy training tool can be found at food.gov.uk/allergy-training	Fridge acquired to provide staff access to a fridge located externally to the patient main kitchen Food allergy refresher training provided via UHB dietetic service. In house Facilities food safety training includes: Common allergens. UK allergen labeling requirements. Communication of allergen information. How your actions help prevent allergenic contamination of food.	Completed 14/05/18 Completed / Ongoing	OSM OSM

21

22

Food Hygiene Inspection **Barry Hospital Patient Catering Service**
Name of Meeting: Health and Safety Committee. **Date of Meeting:** 10/07/2018
Executive Lead: Director of Planning
Author: Assistant Operational Services Manager (South)
Caring for People, Keeping People Well: Consistent implementation of the documented Food Safety Management System will ensure compliance with Food Safety Regulations and a safe patient environment.
Financial impact: N/A
Quality, Safety, Patient Experience impact: N/A
Health and Care Standard Number: 1.1 Health Promotion, Protection and Improvement 2.1 Managing Risk and Promoting Health and Safety 2.4 Infection Prevention and Control 2.5 Nutrition and Hydration
CRAF Reference Number: N/A
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

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

The Committee is asked to:

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

SITUATION

An inspection of the patient catering service at Barry Hospital was carried out on 15th March 2018, the outcome of which was confirmed in writing in a letter report dated 26th March 2018, from Ms Jane Peatey Team Manager Food Safety & Port Health, Commercial Services Food and Port Health Bridgend, Cardiff and Vale of Glamorgan Shared Regulatory Services.

In this report it was noted that the patient catering service at Barry Hospital was awarded a score of 4 (Good) under the Food Hygiene Rating (Wales) ACT 2013.

BACKGROUND

It is a legal requirement for Hospitals to register as a food premises with the Local Council and therefore subject to an annual inspection by the Environmental Health Agency Commercial Services Officer.

ASSESSMENT AND ASSURANCE

On receipt of the letter report from the Commercial Services Officer, an action plan was developed by the Operational Services Assistant Manager (South) to address the matters raised and is attached as an appendix to this report.

This will be monitored within Facilities by the Estates Manager (South) on behalf of the Director of Capital, Estates and Facilities.

Barry Hospital Food Safety Inspection 15th March 2018 Action Plan

Schedule A – Legal Requirements

Schedule A High standard of compliance with statutory obligations, industry codes of recommended practice and minor contraventions of food hygiene regulations. Some minor non-compliance with statutory obligations and industry codes of recommended practice.			
Food Hygiene and Safety Procedures	**Management Response / Action**	**Time Scale / Update**	**Lead**
1. At the time of the inspection, two bottles of D10 suma bac were found in the cleaning chemical store with an expiry date of 18/11/2017. These bottles were disposed of at the time of the inspection. The expiry date is the date up until which the manufacturer guarantees the effectiveness of the cleaning chemical. Therefore you must ensure the expiry dates are checked on all cleaning chemicals and only cleaning chemicals within their expiry date are used. ***Regulation (EC) No. 852/2004, Annex II, Chapter IX, Para 3***	• D10 cleaning chemical bottles disposed of at the time of the inspection (15.03.18). • Staff met with 15/03/18 and reminded of the procedure to be followed. Senior Supervisor to undertake monthly hygiene inspections with local supervisory team to ensure compliance.	Completed 15.03.18 Completed 15.03.18	OSM OSM
2. The plastic water jugs stored in the Sam Davies unit were found all stacked together in the cupboard still wet. Water can harbour bacteria. Therefore you must ensure the water jugs are dried fully before being stacked together. ***Regulation (EC) No. 852/2004, Annex II, Chapter IX, Para 3***	• Staff met with 04/04/18 and reminded of the procedure to be followed to dry water jugs prior to storage to prevent the risk of water contamination. Senior Supervisor to undertake monthly hygiene inspections with local supervisory team to ensure compliance. • Staff met with 04/04/18 to remind that scoops are not to be stored in products	Completed 04.04.18 Completed 04.04.18	OSM OSM

22

3. The scoops used for the gravy mix, porridge and dried milk are stored within the products. This poses a risk of contamination to the food. You must ensure the scoops are stored separate to the food once they have been used. ***Regulation (EC) No. 852/2004, Annex II, Chapter IX, Para 3***	to prevent the risk of contamination. Senior Supervisor to undertake monthly hygiene inspections with local supervisory team to ensure compliance.		
Structural / Cleaning Issues	**Management Response / Action**	**Time Scale / Update**	**Lead**
Kitchen			
4. The following areas are dirty and require cleaning and maintaining in a clean condition:			
• Around the joins of the handle to the disused hot holding trolley is dirty;	• Disused hot holding trolley disposed of (04/04/18).	Completed 04.04.18	OSM
• The seals to chest freezer 2 are dirty;	• Freezer seals cleaned (15.03.18).	Completed 15.03.18	OSM
• The seals to the tall freezer are mouldy;	• Freezer seals cleaned (15.03.18).	Completed 15.03.18	OSM
• The rims of the extraction canopy above the fryers are greasy;	• Extraction canopy rim cleaned (15.03.18).	Completed 15.03.18	OSM
• The joins of the rinser tap are dirty. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	• Rinser tap joins cleaned (15.03.18).	Completed 15.03.18	OSM
5. The handle of chest freezer 2 is loose and damaged. Replace the handle and ensure it is maintained in good repair and condition. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	• Original maintenance request (672350) submitted 29/01/2018, handle replaced - new maintenance request (681466) submitted 06/04/18.	Completed 27.04.18	OSM
6. The metal fly chain to the green double door is broken in several areas and does not the reach the full length of the door. You must repair or replace the fly chain and maintain in good repair and condition.	• Replacement fly chain fitted 10/04/18 to the green double door.	Completed 10.04.18	OSM

Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1			
7. The food mixer has areas of flaking paint and rust. You must ensure the food mixer is kept in such good order, repair and condition as to minimise any risk of contamination. ***Regulation (EC) No. 852/2004, Annex II, Chapter V, Para 1(b)***	• Food mixer not used in the food preparation process disposed of 10/04/18.	Completed 10.04.18	OSM
8. The tap to the wash hand basin in the washing-up area is loose. Secure the tap and maintain in good repair and condition. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	• Maintenance request (679344) submitted 19/03/18 to repair / replace loose tap.	Completed 20/3/18	OSM
9. One of the yellow dishwasher trays is cracked in several areas. Replace the dishwasher tray and maintain in good repair and condition. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	• Cracked trays replaced 06/04/18.	Completed 06.04.18	OSM
10. The water pressure to the wash hand basin in the cooking area was low compared with the other wash hand basins resulting in a dribble of water coming out. You must ensure there is an adequate supply of water running from the wash hand basin tap in order for food handlers to adequately wash their hands. You must also ensure the wash hand basin is maintained in good repair and condition. ***Regulation (EC) No. 852/2004, Annex II,***	• Original maintenance request (679343) submitted 15/03/2018 to correct water pressure - further maintenance request (681517) submitted 06.04.18.	Completed 06.04.18	OSM

Chapter I, Para 1 & Chapter I, Para 4			
11. The following items are dirty and require cleaning and maintaining in a clean condition:			
• Both the probe thermometers are dirty with engrained debris - ensure the probes are cleaned before and after each use;	• Probe thermometers cleaned (15.03.18). Staff met with 15/03/18 to remind that probes must be cleaned before / after use.	Completed 15.03.18	OSM
• There is heavy build-up of debris on the heavy duty tin-opener; and	• Heavy duty tin-opener cleaned (15.03.18).	Completed 15.03.18	OSM
• There is a build-up of limescale on the hot water urn tap.	• Lime scale build up remover / cleaned (15.03.18).	Completed 15.03.18	OSM
Regulation (EC) No. 852/2004, Annex II, Chapter V, Para 1(a)	• Senior Supervisor to undertake monthly hygiene inspections with local supervisory team to ensure compliance.	Completed 15.03.18	OSM
12. The tip of the blade of the yellow handle knife has broken off. You must dispose of this knife and ensure that all knives are maintained in such good order, repair and condition as to minimise any risk of contamination. ***Regulation (EC) No. 852/2004, Annex II, Chapter V, Para 1(b)***	• Yellow handled knife disposed of and new knife ordered (2926915) 09/04/18.	Completed 15.04.18	OSM
St Barrucs Unit 1			
13. The seals to the fridge are dirty. Thoroughly clean the seals and maintain in a clean condition. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	• Fridge seals cleaned (15.03.18).	Completed 15.03.18	OSM
14. The top of the wall behind the door is damaged	• Maintenance request (681210)	Completed 05.05.18	OSM

with exposed plaster and flaking paint. You must ensure the wall is maintained in good repair and condition. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	submitted 05/04/18 to repair and paint.		
St Barrucs Unit 2 **15.** Around the joins of the handle to the hot holding trolley are dirty. Thoroughly clean the handle and maintain in a clean condition. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	• Hot holding trolley handle cleaned (15.03.18).	Completed 15.03.18	OSM
16. The probe is broken. Replace the probe and ensure it is maintained in good repair and condition as to enable it to be kept clean. ***Regulation (EC) No. 852/2004, Annex II, Chapter V, Para 1(c)***	• Broken probe replaced 05/04/18.	Completed 05.04.18	OSM
St Barrucs Unit 3 **17.** The seal behind the sink is dirty with a build-up of mould. Thoroughly clean the seal and maintain in a clean condition. ***Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1***	• Maintenance request (681517) submitted 05/04/18 to replace seal.	Completed 18/6/18	OSM
Confidence in Management / Control Procedures	**Management Response / Action**	**Time Scale / Update**	**Lead**
18. Whilst reviewing your current HACCP, I identified the following which must be addressed: • The last review date was February 2017; • It does not make it clear what your critical control points are; • It does not state how often probe calibration	Reviewed / Amended May 2018 Review / Amendments to reiterate critical control points HACCP 'Weekly Probe Calibration Testing	Completed May 2018 Completed May 2018 Completed 16.04.18	OSM OSM OSM

	should be done; and	Verification Form', states weekly probe calibration undertaken, HACCP document to be amended to reiterate this.		
	• The cleaning schedule does not include all items of equipment and structure to be cleaned. ***Regulation (EC) No. 852/2004, Chapter II, Article 5, Para 1***	Weekly / daily cleaning schedule reviewed and amended accordingly.	Completed 16.04.18	OSM
19.	There is confusion over the weekly/daily cleaning schedule as it does not make it clear what items must be cleaned daily and what items must be cleaned weekly. The current cleaning schedule in place during the inspection was dated 12th March 2018 and the majority of the items listed had already been ticked. You must ensure the cleaning schedule is revised and amended to clearly state out what items must be cleaned daily and what items must be cleaned weekly. ***Regulation (EC) No. 852/2004, Chapter II, Article 5, Para 1***	Weekly / daily cleaning schedule reviewed and amended accordingly.	Completed 16.03.18	OSM
20.	Whilst reviewing your probe calibration records, I identified that only boiling water checks are being made to carry out the probe calibration and these checks are being recorded on a different form to that included in the HACCP. You must ensure the weekly probe calibration testing verification form as part of the HACCP is being used and iced water checks are also being made at the same time as the boiling water checks. ***Regulation (EC) No. 852/2004, Chapter II,***	• Appropriate 'Weekly Probe Calibration Testing Verification Form' as per HACCP reinstated 15/03/18. • Staff reminded only the appropriate form can be used and any previous forms must be disposed of 15/03/18. • Senior Supervisor to undertake monthly hygiene inspections with local supervisory team to ensure compliance.	Completed 15.03.18	OSM

	Article 5, Para 1			
21.	There is some confusion over date labelling food once it has been opened. Some food handlers are dating the food with a day dot of when the food was opened, some food handlers are dating the food with the day dot of when it needs to be used-by and some food handlers are writing the opened date and the use-by date. You must ensure all food handlers are aware of your date coding policy and date the opened food with the date the product was opened and the date the product is to be used by. ***Regulation (EC) No. 852/2004, Chapter II, Article 5, Para 1***	• Staff reminded of the correct day dot procedure to be used in compliance with the HACCP document 04/04/18. • Senior Supervisor to undertake monthly hygiene inspections with local supervisory team to ensure compliance.	Completed 10.04.18	OSM
22.	During the inspection, I identified the following temperatures had been recorded for the walk-in freezer: • 10th March 2018 = -2°C at 6am, -10°C at 12noon and -9°C at 6pm; • 11th March 2018 = -15°C at 6am, -9°C at 12noon and 0°C at 6pm. It was only when the temperature reached 0°C at 6pm on the 11th March 2018 that corrective action was recorded. You must ensure that when the freezer temperature goes warmer than your critical limit then corrective action is taken and recorded. ***Regulation (EC) No. 852/2004, Chapter II, Article 5, Para 1***	• All staff reminded of the freezer brake down procedure within the HACCP document to be followed at all times 10/04/18 • Senior Supervisor to undertake monthly hygiene inspections with local supervisory team to ensure compliance.	Completed 10.04.18	OSM

SCHEDULE B – RECOMMENDATIONS				
1	Guidance in relation to how to comply with the allergen labelling requirements can be found at https://www.food.gov.uk/business-industry/allergy-guide. An interactive food allergy training tool can be found at food.gov.uk/allergy-training	• Food allergens identified on the reverse of all UHB menus to inform staff of food contents and provide guidance.	Completed	OSM
2	I recommend all food handlers have up-to-date food hygiene training.	• Food hygiene training commenced 15.06.18.	Completed 21.06.18	OSM
3	I strongly recommend you store a supply of disposable aprons and disposable gloves in the raw meat preparation area and these are only to be used for preparing raw meat. I also recommend you store a bottle of D10 sanitiser in the raw meat preparation area and this is only used within this area.	• Disposable aprons / gloves and a bottle of D10 sanitiser stored in raw meat area for single usage (16.03.18)	Completed 16.03.18	OSM
4	I strongly recommend you choose a day of the week where all bottles of D10 sanitiser are emptied and replenished to ensure the cleaning chemicals being used are active.	• Supervisor to undertake each Tuesday.	Completed 16.03.18	OSM
5	There is a build-up of frost and ice to freezer 2. I recommend this freezer is defrosted.	• Freezer 2 defrosted 10/04/18	Completed 10.04.18	OSM

CENTRAL FOOD PRODUCTION UNIT, UNIVERSITY HOSPITAL OF WALES (UHW) **FOOD HYGIENE INSPECTION – 14th MARCH 2018**
Name of Meeting: Health & Safety Committee. **Date of Meeting:** 10 July 2018

Executive Lead: Director of Planning
Author: Catering Services Manager
Caring for People, Keeping People Well: Consistent implementation of the documented Food Safety Management System will ensure compliance with Food Safety Regulations and provide a safer experience for all stakeholders.
Financial impact: N/A
Quality, Safety, Patient Experience impact: N/A
Health and Care Standard Number: 2.1 and 2.5
CRAF Reference Number: N/A
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

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

The Health and Safety Committee is asked to:

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

SITUATION

An inspection of The Central Food Production Unit at the University Hospital of Wales took place on the 14th March 2018 the outcome of which was confirmed in writing in a letter report dated 27th March 2018 from the Commercial Services Officer, Food and Port Health, Bridgend, Cardiff and Vale of Glamorgan Shared Regulatory Services.

In this report it was noted that the Central food Production Unit at The University Hospital of Wales were given a score of **5 (Very Good)** in the National Food Hygiene Rating Scheme.

BACKGROUND

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

ASSESSMENT AND ASSURANCE

On receipt of the letter report, an action plan was developed by the Catering Services Manager to address the issues raised and is attached as an appendix 1 to this report**.** This will be monitored within the service.

Appendix 1

Action Plan from Food Safety Inspection on 14th March 2018 (Report dated 27th March 2018)

Schedule A – Legal Requirements

Food Hygiene and Safety Procedures	Response / Action	Time Scale	Update
• The plastic shroud that was in use to cover cooling food had torn and potentially is a risk of contamination to the open foods it is intended to protect. As the plastic is clear and thin it would be difficult to detect in/ on food. As discussed, the shroud must either be thicker to reduce the risk of tearing or be coloured so is easily visible.	• A coloured disposable shroud has been sourced and in use.	Immediate	Completed
• One of the plastic utensils in the high-risk area was cracked and damaged and removed from use at the time of our visit. All equipment must be sound and easily cleansable and staff reminded to be vigilant. **Regulation (EC) No 852/2004 Annex II Chapter IX para 3**	• All Equipment checked daily before use and all staff aware to be more vigilant.	Immediate	Completed
Regulation (EC) No 852/2004 Annex II Chapter V para 1 • The guard to the slicer in the portioning room was cracked. Replace the guard to prevent contamination from the damaged plastic.	• New guard purchased and replaced	Immediate	Completed

Aroma Units UHW September 2017

23

Structural / Cleaning Issues	Response / Action	Time Scale	Update
• The door to the delivery area could not be closed to check the positioning of the brush strips however, I note that there is an on-going issue with the positioning of the strips which was highlighted on previous inspections. I understand that the floor to the delivery bay may be resurfaced and if a secure seal cannot be made with the strips then the new flooring will be ensuring a tight seal. As discussed, ensure that this area is pest proofed to ensure that there is no access from the compacter area.	• The flooring will not be resurfaced at this time, a new plastic strip has been purchased and replaces the brushes	Immediate	Completed
• A small amount of paint to the wall adjacent to the insectocutor in the high-risk area was missing exposing the plaster. Repaint as necessary to leave a sound, impervious, easily cleansable surface.	• Estates called and the surface has been prepared and resurfaced.	Immediate	Completed
• The wall corner coving adjacent to the wash area in high risk was damaged with a missing screw evident. Make good the damage and leave in a sound condition.	• Estates called, screw replaced and damaged area renewed.	Immediate	Completed
• A small amount of mould growth to the ceiling of the wash area was noted. Clean to remove the mould and maintain in a mould free condition.	• Mould removed and deep clean of the area completed.	Immediate	Completed
• The floor to the portioning room was patched in places with masking tape, I do however note that this is due to be replaced over the Easter break.	• All flooring replaced by contractor and in a sound condition	Immediate	Completed

Regulation (EC) No 852/2004 Annex II Chapter I para 1			

Confidence in Management / Control Procedures	Response / Action	Time Scale	Update
• As you are an approved premises a reference to Regulation (EC) No 853/2004 must be included in your HACCP where you have referenced other legislation and guidance. **Regulation (EC) No 852/2004 Article 5**	• HACCP documents amended and forwarded to EHO.	Immediate	Completed

Schedule B – Recommendations, Advice & Information

Recommendations	Response / Action	Time Scale	Update
• Guidance in relation to how to comply with the allergen labelling requirements can be found at https://www.food.gov.uk/business-industry/allergy-guide. An interactive food allergy training tool can be found at food.gov.uk/allergy-training	• Food Allergen Training scheduled for all staff	Immediate	Completed
• On the 28th November 2016 The Food Hygiene Rating (Promotion of Food Hygiene Rating) (Wales) Regulations 2016 came into effect. The regulations relate to printed take away menus and other printed publicity materials detailing the price and description of foods and how a customer may purchase food other than by visiting your premises. The regulations stipulate that all such printed material must include the following statement: **"Ewch i food.gov.uk/ratings i ganfod sgôr hylendid bwyd ein busnes neu gofynnwch inni beth yw ein sgôr hylendid bwyd wrth archebu.** **Go to food.gov.uk/ratings to find out the food hygiene rating of our business or**	• N/A		

	ask us for our food hygiene rating when you order". The statement must conform to the following specifications— the type size must be of at least 9 points as measured in font 'Times New Roman' not narrowed; and the space between text lines must be at least 3mm. You must ensure that all applicable printed materials include the relevant statement. Any printed materials that you currently have may be over-stickered with the statement until such time as new printed materials are printed.			
•	Mould growth was noted to the seal to freezer 8 which appears to be ingrained into the rubber. I would advise that this be replaced in time.	• Chest Freezer 8 has been replaced.	Immediate	Completed
	The floor to the main freezer is worn in places and should re resurfaced/ replaced.	• The replacement of the flooring will be considered at the next service board meeting, in the meantime we will ensure the area is brushed and monitored to remove any excess materials	Ongoing	Completed

MINUTES OF THE OPERATIONAL HEALTH AND SAFETY GROUP HELD AT 9.30AM on WEDNESDAY 28th FEBRUARY 2018 – CORPORATE MEETING ROOM - UHW

24.1

Present:

Peter Welsh- Chair	Director of Corporate Governance
Charles Dalton	Head of Health and Safety
Claire Wade	Surgery
Frank Barrett	Senior Fire Adviser
Jon McGarrigle	Estates Services
Karen Lewis	Claims Manager
Rachael Daniel	Health and Safety Adviser
Rachael Sykes	Health and Safety Adviser
Stuart Egan	Staff Representative

Clinical/Service Board Representatives

Ian Wile	Mental Health
Rhys Davies	Primary, Community and Intermediate Care
Rowena Griffiths	Dental Services
Heather Gater	Women and Children
Sue Bailey	CD&T
Gareth Jenkins	Specialist Services

Apologies:

Caroline Murch	Environmental Health and Safety Adviser
Claire Mahoney	Associate Infection Prevention Control Nurse
Emma Stone	Dental
Matthew Price	Specialist Services
Tina Bayliss	Surgery Services
Sue Morgan	Primary, Community and Intermediate Care
Sarah Dix	Medicine Clinical Board
Nicola Bevan	Occupational Health

OHSG: 01/18 Minutes of the Meeting held December 2017

The minutes of the meeting held on the 4th December 2017 were accepted as a true record.

OHSG: 02/18 Action Log

Item 35/17:- It was noted that the Assistant Director of Planning had looked at a strategy to improve pedestrian safety which includes appointment of an External Consultant. It was highlighted that this would include a two phase approach, which in the first instant a brief be put forward followed by a development of a strategy and policy.

The Head of Health and Safety added that in addition to this, a meeting had taken place with Cardiff University and Procurement, to look at safety around deliveries.

Item 38/17.4:- The representative for Mental Health Mr I Wile updated the Group on the progress of the implementation of the smoking ban within mental health.

He informed the Group that after a lot of preparation involved in the introduction of the smoking ban, it is now in place and reported that although there is general improvement to the ward environment, smoking had become a problem at the front of the building; these challenges are being discussed and solutions sought.

It was also noted that there had been no evidence to show that aggression towards staff had increased as a result of the ban.

OHSG: 03/18 Feedback from Health and Safety Committee

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

The Health and Safety Adviser – Ms R Daniel gave an overview of this report, highlighting that Pedestrian Safety was high on the agenda and the Committee requested a full report be taken to the next meeting in April.

It was also reported that a Pro-Act audit was presented to the Committee in January and the Committee asked that an action plan be established to take this forward. **Action:** Priority Action Plan to be brought to the next meeting for information. **CD**

OHSG: 04/18 Pro-Act Audit Presentation

It was noted that this report was presented to the Health and Safety Committee in January 2018.

The Head of Health and Safety reported that a pro-act audit was conducted in 2017 to allow for a comparison against its 2015 findings.

He highlighted that the number of patients requiring full aid support had increased by 23% over the two years, which requires the use of additional equipment, however added that the first audit was carried out in June 2015, whereas the 2017 audit was conducted in October/November 2017 and the increase could be as a result of winter demands.

He gave an overview of the audit and highlighted the key findings:-

- 1775 Patients were assessed during the audit.

- 10% of equipment was now discontinued, it may still be working well but should a fault develop it could not be repaired as the parts were no longer available.
- 4% of equipment was well beyond its lifespan.
- 10% of equipment was just beyond its lifespan.
- In respect of equipment condition – 7% was in poor condition and 28% was in a satisfactory condition.
- In respect of washable slings – 54% were well beyond their lifespan and 7% was just beyond their lifespan.
- 55 hoists will require replacing during 2018.
- 266 slings will require replacing during 2018.

The Head of Health and Safety reported that the Manual Handling Adviser is working through the report and will circulate the findings to each Clinical Boards. It was also noted that an Action Plan is being established and taken to the Health and Safety Committee in April 2018.

OHSG: 05/18 Enforcement Agencies Correspondence Report

The report was received and noted by the Group and the Head of Health and Safety reported that many of the items, although no longer requiring Health and Safety Executive input, are still on the agenda due to ongoing progress.

It was highlighted that during the period the Health Board had received a letter from the HSE in relation to the Contractor Fall asking for a response on their findings; a response had been sent and awaiting further correspondence.

It was also reported that during the period the HSE had written to the Health Board with concerns around the failing of a vessel boiler at Rookwood Hospital. It was noted that this has been replaced and has now been resolved.

The Health and Safety Adviser Miss R Daniel informed the Group that in addition to the above further correspondence from the HSE has been received in light of a complaint relating to issues in histopathology.

OHSG: 06/18 Fire Safety Management and Enforcement Report

The Senior Fire Advisor submitted a report to the Group and highlighted that a further meeting had been planned for the 5th March 2018 with the Health Board and Fire Service to discuss fire response, the Senior Fire Adviser agreed to report back at next meeting. **Action**: FB

It was noted that there were two enforcement notices in place relating to Hafan Y Coed, however these have now been lifted and no further enforcement notices issued during the period.

The Senior Fire Adviser reported that there were a total of 450 unwanted fire signals over the past 12 months and although the figure is high in comparison to other Health Boards in Wales, UHW is larger in size.

He also reported that Fire Training statistics are showing an improvement in compliance with the latest figure at 62%.

The Staff Side Representative – Mr S Egan raised concerns around training competency, in that are staff receiving the right level of training based off their job role and location.

The Senior Fire Adviser reported that this had been raised at the Mandatory Training Meeting and is being addressed.

The Head of Health and Safety added that this is being looked at for all training competency levels and to ensure staff are getting the appropriate level of training.

The Chair asked for an update at the next meeting. **Action**: CD

The Health and Safety Adviser – Miss R Daniel highlighted that it was reported at the last Health and Safety Committee that a planned evacuation had been arranged for October 2017, however did not go ahead due to the lack of staff commitment.

The Senior Fire Adviser confirmed that this was the case.

The Chair asked members to take this feedback back to their areas and re-iterated the importance of carrying out planned evacuations.

OHSG: 07/18 Health and Safety Priority Action Plan

No Report was submitted on this occasion. The Head of Head of Health and Safety reported that this document is being reviewed in line with the Risk Register.

OHSG: 08/18 PI Claims Report

A report was received and noted by the Group.

The Claims Manager informed the Group that the report shows statistics for period Jan 2017 to Feb 2018; during this time 34 PI claims were settled of which 18 were defended and 1 case went to trial.

It was noted that although the Health Board had a strong case for defence at the trial and a number of witnesses, the judgment was against the Health Board.

The Head of Health and Safety raised concern in relation to the number of needlestick cases reported and felt that 6 cases were disappointing after all the hard work involved in the safety sharps project.

It was noted that this did not relate to one area and the Claims Manager offered to provide the Health and Safety Adviser with a report on these incidents.

OHSG: 10/18 Staff Group Inspections - Medical Records

The Staff Side Representative – Mr S Egan reported that he continues to visit the Medical Records Department on a monthly basis and highlighted that improvements are being made.

The Chair confirmed that the disposal of records policy had been approved; however Mr S Egan reported that some areas were not aware of this and was continuing to send notes to Treforest.

The Senior Fire Advisor informed the Group that the area had been assessed recently and agreed to send the new Fire Risk assessment for Medical Records to Mr S Egan.

Mrs S Bailey reported that a click and collect system is being trialled within Urology for the retrieving and the return of medical records; any updates will be reported back to the next meeting. **Action**: SB

OHSG: 11/18 Contractor Control Guidance

The Group were reminded of the guidance and procedures for Contractor Control. It was noted that standards of the policy is to be adopted by all areas and not just Estates Department.

It was noted that a Group had been formed to look at implementing the procedure and the chair asked that the members take this back to their Health and Safety Groups for information.

OHSG: 12/18 Lone Worker

The Head of Health and Safety highlight the continued improvement of the use of the devices; there are 635 active devises. The report noted a drop in December; however this reflects the Christmas period and annual leave taken at this time.

OHSG: 13/18 Clinical/ Service Board Feedback

Representative Surgery – Mrs C Wade reported that the Surgery H&S meeting is planned for a weeks' time and stated that flushing will be on the agenda. She queried whether the cleaning of the showers on a regular basis by Housekeeping was part of the flushing regime and that if this is being

carried out by the Housekeeper, does this need to be done again by the ward area.

The Head of Health and Safety advised that is the responsibility of the area Manager to delegate the flushing regime to a member of their staff.

Representative Mental Health – Mr I Wile reported that staff sickness had been highlighted as a concern for mental health with figures highest in the Health Board. It was noted that this is being look at as a priority this year for improvement.

OHSG: 14/18 Policies and Procedures

Patient Hoist and Sling Inspection Procedure - The Group were asked to approve this procedure. It was noted that no updates had been made other than an amendment to the format - The Group were happy to approve this procedure.

OHSG: 15/18 DATE AND TIME OF NEXT MEETING
29th May 2018 – 9AM – Boardroom Llandough Hospital

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

MINUTES OF THE FIRE SAFETY GROUP HELD AT 9:30AM ON 15 JANUARY2018 IN THE CORPORATE MEETING ROOM, UHW

24.2

Present:	Geoff Walsh	Dir of Capital, Estates and Facilities **(Chair)**
	Charles Dalton	Head of H&S/Fire Safety Manager
	Catherine Salter	Staff Side Representative
	Stuart Egan	Staff Side Representative
	Frank Barrett	Senior Fire Safety Adviser
	Dick Jones	South Wales Fire Service
	Tony Ward	Estates Representative
DFSM	Ian Wile	Mental Health
	Ian Fitsall	Estates & Facilities
	Sarah Maggs	Estates & Facilities
	Fiona Kear	Specialist Services
	Nick Gidman	Specialist Services
	Sarah Congreve	PCIC Vale
	Emma Thomas	Representative PCIC
	Kate Leney	Women and Children
Apologies:	Abigail Harris	Executive Director of Planning
	Cheryl Evans	DFSM C&W– O&G Directorate
	Dale-Charlotte Moore	DFSM - Critical Care
	Lynne Topham	DFSM - PCIC
	Peter Welsh	DFSM Executives - Director of Governance
	Richard Steed	Cardiff University – Fire Adviser OSHEU
	Rowena Griffiths	DFSM Dental /Nurse Manager
	Scott Gable	DFSM – CD&T
In Attendance:		
	Zoe Brooks	Health and Safety

18/01 Minutes of the Meeting

The minutes of the meeting held on the 7th August 2017, were accepted as a true record.

18/02 Action Log

16/23 Fire Warden Training (Fire Safety Manager to see if Fire Warden Training can be reported through the new ESR 2) - The Fire Safety Manager reported that Fire Warden Training is currently included in ESR and can identify all staff that has been trained. However, it cannot validate compliance but status only. **Item Closed**

16/29 Fire Training Stats (Concerns with accuracy of compliance figures) It was noted that Workforce and Organisational Development (WOD) has undertaken an exercise with all Directorates to validate their scoring. The Fire Safety Manager had received confirmation that raised anomalies had been progressed and the WOD consider that there is no backlog. **Item Closed**

17/32 Tunnels (items being discarded in the tunnels)
DFSM – Estates & Facilities Mrs S Maggs informed the Group that Clinical Boards had been reminded of the correct procedures of discarding equipment and waste and that nothing should be taken to the tunnels and left. It was noted that although items are still being dumped, there had been an improvement. It was also noted that CCTV is being used to identify where the items are coming from.

The Chair reported that a lot of working was being carried out in relation to access to the Tunnels. Concerns were raised in relation to significant pedestrian safety in particular, and it was highlighted that a number of near missed and incidents involving pedestrians and waste trucks had occurred over the past few months. It was noted that access will be restricted for operational service use only, such as waste and stores and any departments requiring access will need to request this with justification of use.

The Chair highlighted that the above will improve any issues with discarding of items in the tunnels.

18/03 DSEAR

The Fire Safety Manager informed the Group that a check list is being developed by the Health and Safety Department to give guidance on risks associated with Dangerous Substances and Explosive Atmospheres (DSEAR). It was reported that any high risk areas may need further guidance from external sources as this was outside of the expertise of the H&S Department; the checklist will be circulated once developed. **Action:** CD to circulate to the Group.

18/04 Enforcement Notice Status

It was reported that no Enforcement notice was in place; Whitchurch Hospital Enforcement Notice had been lifted. The Senior Fire Safety Adviser highlighted that there were five audits carried out during the period, where actions were raised; work is either being carried out or has been completed.

18/05 Fire Risk Assessment Status

The report was received and noted by the Group.

The Fire Safety Manager informed the Group that the DFSMs continue to meet to discuss Fire Risk Assessments and reported that November's meeting identified that there were 28 areas assessed during the period July 2017 –September 2017 of which 187 Managerial actions were raised.

It was noted that these Managerial actions are discussed, with many closed out by the DFSMs.

18/06 False Alarms, Automatic Detectors and Responses

The Chair briefed the Group on the Estates Forum meeting that he had recently attended.

He highlighted that a presentation was delivered by the South Wales Fire Service, where false alarms was high on the agenda; concerns were raised in relation to the number of false alarms generated by the Health Board and the presentation highlighted risks associated with these false alarms.

The Chair felt that the message needed to be cascaded to the Health Board wide and informed the Group that the Fire Service had offered to attend the UHW and possibly UHL to speak to staff on this issue.

The Chair also confirmed that one appliance would be cascaded between office hours i.e. 9AM – 5PM and then the full three appliances outside of these hours.

18/07 Medical Records Department UHW

The Staff Side Representative – Mr S Egan raised concerns in relation to the storage of patient notes in Medical Records.

A number of pictures were circulated to the Group, showing notes on the floor and doors being obstructed. Mr S Egan highlighted that he had escalated this to the Chief Executive and the Executive Team.

It was noted that records are being re-located to Treforest storage, however a visit in November identified that there are still issues in particular around Fire Safety. Mr S Egan requested a copy of the Fire Risk Assessment for Medical Records UHW. **Action**: FB to provide SE with a copy of the last Fire Risk Assessment for this area.

The Fire Safety Manager reported that The Board Secretary had also raised this at Board level to look at a Policy for disposal/scanning of records.

The Chair agreed to ask the Director of Planning, who has responsibility for Fire Safety for write to the Clinical Board for response. **Action:** GW

DFSM for PCIC Mrs S Congreve also reported that there are issues at Avon House with Archiving.

18/08 Evacuation Drills

It was reported that no Evacuation Drill was carried out during the period. The Senior Fire Safety Adviser raised concerns around the lack of commitment from areas to release staff. He highlighted that the last drill scheduled had to be cancelled due to the lack of bodies.

The Chair agreed to take this back to the Executive Team**. Action:** GW

The Fire Safety Manager brought the Groups attention to the Fire Safety Training statistics; where there had been a month on month improvement of 10% with the overall compliance rate as of December showing 61%.

18/09 Fire, Storage at Llandough

The Fire Safety Manager reported that a meeting had taken place during the period in relation to storage at Llandough. Concerns were raised around the volume of equipment being left in non occupied areas, which is causing a fire and security risk.

It was noted an improvement group has been formed to look at how best to address this issue as these areas are soon to be occupied with the re-location of wards at Rookwood. It was also noted that change of security access was being looked at to improved access and egress to these areas.

18/10 NWSSP-FS Audit 17/18

It was noted that the NWSSP-FS Audit for 2017/18 is due to be signed off and submitted by the Executive Director of Planning.

18/11 Any Other Business

Mental Health – The DFSM Mr I Wile reported on the introduction of the No smoking at Hafan Y Coed and other Mental Health settings.

He reported that E-Cigarettes are permitted to be used outside of the building and provisions for charging must be made off site.

It was also reported that there has been no increase in verbal abuse as a result of the ban; however it was causing smoking and litter issues around the front of the building. It was agreed that this would be reported back to the No Smoking Group.

Staff Side Representative – Mrs C Salter requested a copy of the response to the Letter from Andrew Goodall. **Action: GW**

18/12 Date of Next Meeting

22nd May 2018- Meeting Room 1, 2nd Floor Lakeside Offices, UHW – 9AM

Water Safety Group

Date of meeting: Wednesday 14th February 2018

Time of meeting & Venue: 10:00 am, Geoff Newman Room, UHW

Present:

Name	Title
Eleri Davies (ED), Chair	DIPC
Mike Quest (MQ)	Authorising Engineer (Water)
Keith Sims (KS)	Maintenance Engineer, Responsible Person for Cardiff University
Debbie Charles (DC)	PHW Scientific Head FW&E Lab
Jon McGarrigle (JMcG)	Head of Energy Performance
Norman Mitchell (NM)	Responsible Person for Water, Estates Manager
Ian Fitsall (IF)	Responsible Person for Water, Facilities Manager
Greg Williams (GW)	Senior BMS, Microbiology
Alun Morgan (AM)	Assistant Director of Therapies & CD&T
Heather Gater (HG)	Therapy Manager, Acute Child Health
Maxine Gronow (MG)	NW locality Ops Manager, PCIC
Paul Bracegirdle (PB)	Deputy Directorate Manager, Dental
Jim Blackie (JB)	DTS
Paul Morgan (PM)	Legionella Supervisor
Tony Ward (TW)	Head of Discretionary Capital and Compliance

In attendance: Reanne Reffell (minutes)

Apologies: Melanie Wilson, Sarah Maggs, Julie Woolls, Anthony Powell, Paul Davies, Jonathan Davies, Dean Matthews, Mark Campbell, Annette Beasley, Judith Smith, Ben Durham, Orla Morgan, Gareth Simpson, Ceri Chinn, Charles Dalton, Rishi Dhillion, Victoria Daniel, Sue Bailey

		Actions
1.	**Welcome/introductions** Introductions were made around the table and ED welcomed all to the meeting.	
2.	**Apologies** were noted as above.	
3.	**WSG Personnel / Appointment changes** ED noted disappointment that there was a lack of representation from Specialities, Surgery, Medicine, Dental and Mental Health clinical boards despite circulating a recent letter asking for improved clinical board attendance. It was noted that Gareth Simpson, estates manager for the north is in the process of being appointed as an Approved Person. YH advised that Adrian Lewis will no longer be a representative at the group, but Jim Blackie will highlight any clinical engineering related.	

4.	**Minutes of previous meeting (29.11.17)** The minutes of the previous meeting were agreed as an accurate record subject to the adjustment of Keith Sims name.	
5.	**Matters arising/Actions from previous meeting (29.11.17)** The action summary from the previous meeting was updated. *Refer to page 5 for ongoing actions.* MQ to make slight amendments to 7.8 (PFI line) and 7.9 (third parties) of the WSP. JMcG to upload the final plan to the intranet. **Action: Complete** ED to clarify the PFI responsible person in order for them to attend the WSG. *Engine have been invited to the meetings and sent the dates for 2018.* **Action: Complete** ED agreed to send out an email to the clinical board regarding updated flushing arrangements, the audit tool and to highlight the requirement for improved attendance at the WSG. *ED has circulated a letter to the clinical boards (included in the meeting papers) and will re-highlight the need for improved attendance.* **Action: Complete** NM will re-audit UHL next week to see if there are any improvements. *NM re-audited and noted that there has been some improvement in knowledge.* **Action: Complete**	
6.	**<u>Water Safety Plan</u>** The updated Water Safety Plan is now available and on the intranet.	
7.	**<u>Current / Closed Incidents for consideration</u>** **<u>Legionella counts PHW microbiology laboratories, update of actions</u>** ED read out an update from Lisa Chichester, Microbiology lab manager. The contracted work has been completed, but there are concerns regarding other little used outlets which could be removed. ED advised that MR's will need to be submitted for work outside of the original contract. **Action: Greg Williams** The group agreed that the refurbished outlets can be re-tested, and if subsequently negative, flushing can be stood down from daily to three times weekly as long as compliance is monitored. As control measures are in place, the gram stain sinks can be used as normal and the use of sterile water stopped. **Action: Paul Morgan / Greg Williams** ED advised that CD&T may want to review their laboratory and flushing. Discussion took place on the wider issue of single taps across the health board that are too hot to hand wash, and therefore are not flushed, where	**GW** **PM / GW**

	responsibility / ownership lies, as this may not be picked up on the risk assessments.	
8	**Risk Assessments** **Risk Assessment Action Plan (Legionella)** TW advised that the risk assessment action plan is 65% complete, and should be completed by May, but the ongoing work list will be prioritised according to the risk and area. **Risk assessment- Pseudomonas aeruginosa** It was agreed that the water safety plan will be updated to include the movement of NICU to C2. **Action: Mike Quest** **Scalding** n/a	**MQ**
9. **9.1**	**Water Sampling Results:** **Legionella Team** PM provided an update on the Bacteriological sampling overview for 2017.	

SAMPLE TYPE	HOSPITAL	SAMPLES	FAILS	% FAIL
LEGIONELLA SURVEILLANCE	UHW	736	72	10%
LEGIONELLA SURVEILLANCE	LLANDOUGH	263	131	50%
LEGIONELLA SURVEILLANCE	CHW	158	0	0
LEGIONELLA SURVEILLANCE	ROOKWOOD	48	28	58%
PSEUDOMONAS	UHW	92	0	0
PSEUDOMONAS	LLANDOUGH	0	N/A	N/A
PSEUDOMONAS	CHW	140	4	3%
TOTAL SAMPLES	ALL HOSPITALS	1435	235	16.4%

Pseudomonas counts at the CHfW2 were thought to be due to temperature control issues.
Corrective action was undertaken on the Legionella failures at UHW, and all were re-sampled and passed.
PM noted that UHL is of major concern, with 50% failure rate. It was noted the Chlorine Dioxide plan is due for tender.

PM advised on a programme of work undertaken since July '17 to remove point of use filters on B7. 8 of the 29 filters have been removed so far. PM advised that remedial works were carried out on the filters and counts reduced to 100, but 5 weeks later the counts were back to 10,000, indicating that the outlets were not being flushed. Of particular problem is the store room, which contains equipment that may provide a barrier to the showers being flushed. YH noted that HIW require the ward to have a certain number of showers, and that the ward manager has confirmed via email that flushing is being undertaken, although the flushing records were not to hand at the audit. NM advised that lots of work has been undertaken on B7 which is compromised due to the lack of flushing.

ED will contact the clinical board and highlight the high cost of the filters

	per year. YH will also discuss with the ward sister and senior nurse for the area. PM advised that going forward, the estates / Legionella team will now focus on specific risers (12 in total), 4 have been sorted and sampled, and work will be taken forward on the others.	
9.2	**Other water sampling** • **Rinse Water** No issues to note • **Heater Cooler Unit (H/C unit)** ED highlighted that there is ongoing discussion as to whether the decontamination process can be reduced while the machines are outside of theatres, but the current process will be maintained at present. • **Hydrotherapy pool** Reports on the safety walk-around of the hydrotherapy and plan room in the adult physiotherapy and children's hospital were circulated prior to the meeting. Alun Morgan thanked the estates team for all of their hard work in helping to close out the HSE. The action plan has been completed and signed off. Some issues need to be worked through regarding cryptosporidium testing. GS is in the process of undertaking estates maintenance and a testing plan. Discussion also took place regarding the medium flow and maintenance of normal filters. AM asked for Estates assurance in writing. NM agreed to re-send previous assurance and confirmation provided. **Action: Norman Mitchell** It was agreed that the Hydrotherapy user group will report to this group quarterly or bi exception.	**NM**
10.	**Water Control Measures- Out of Specification Results & Action Taken** NM provided an update on the CHfW. Progress has been made but there are still some contractual issues, which is why estates are still undertaking flushing in the CHfW. Estates will look to resample once all work is complete. Jim Blackie advised of a water wastage issue with the water dialysis plant on T5, as 'pure' water is going down the drain, and the pipe work may be affected in the future. IF will pick up with GS after the meeting. **Action: Ian Fitsall**	**IF**
11.	**Department Updates:**	
11.1	IPC- YH was happy to note the good engagement with capital on any new refurbs.	
11.2	Estates – JB advised on work due to be undertaken on Pelican ward. Pelican will become the main children's kidney unit.	

	NM highlighted that the Estates department do not support water dispensers and advised on an incident whereby staff drank cleaning fluid from a piped water bottle. ED to contact the clinical boards and corporate areas in order to request an audit of their areas. Keith Sims agreed to forward to ED the detail of actions undertaken within his areas. **Action: Eleri Davies / Keith Sims**	**ED / KS**
11.3	HSDU/SSU- PM advised that it will cost £1600 to repair the chlorine dioxide system in UHW, and queried whether it was necessary. This will be looked at outside of the meeting. TW advised that an OJO procurement contract for Legionella control measures will be out in July.	
	Clinical Diagnostics & Therapeutics- no issues to note.	
11.8	Primary Care & Intermediate Care- MG highlighted issues that may arise in community buildings in terms of identifying outlets and recording	
11.10	flushing, particularly in terms of ownership where by the building may be used by several different organisations / depts. The standardised paperwork must be used.	
	PB advised that Bethan Jones, dental nurse has been appointed as an IP&C lead alongside Emma Stone.	
11.12	Discussion took place regarding the water sampling undertaken within the dental hospital. Although sampling is not a legal requirement, ED would advise that if sampling is undertaken, it should be done an accredited level. PB to discuss with Melanie Wilson. **Action: Paul Bracegirdle**	**PB**
11.13	Work is ongoing within Cardiff University to identify taps of low usage and ensure flushing.	
12.	**Flushing Audits** TW advised of a new flushing record, which is being rolled out to areas. The new form identifies each outlet in the department, and wards will need to tick to indicate they are in use, or being flushed. YH noted that the health board is a seven day health service and wards may want to flush at the weekend. TW to consider putting in 7 days or leaving the dates blank so that wards can fill in the three days they wish to undertake flushing. The group clarified the action of JMcG to contact IPC to discuss training needs of ward managers. YH advised that flushing responsibilities are brought up at numerous meetings, and it would be helpful to provide further training to ward mangers. The Legionella presentation could be updated and presented at the ward managers forums and sent out to the clinical boards etc. JMcG to update the presentation and discuss with IPC which forums to present to. **Action: Jon McGarrigle / Yvonne Hyde**	**JMcG / YH**
13.	**Property Occupation Changes** N/A	

14	**Changes to Augmented Care Areas- IP&C** N/A	
15.	**Training / Competence Matters** N/A	
16.	**Audit Status / Progress with Action** N/A	
17.	**Action Plan / next steps** See Action summary below	
18.	**Any other business** N/A	
19.	**Date & Time of Next Meeting:** Wed 9th May 2018, 10:00 am, Geoff Newman Room	

Action Summary (Water Safety Group): 14.02.18

All actions due by next meeting unless otherwise stated.

	Action	Who	Status
	Microbiology Laboratory The contracted work has been completed, but there are concerns regarding other little used outlets which could be removed. ED advised that MR's will need to be submitted for work outside of the original contract. The group agreed that the refurbished outlets can be re-tested, and if subsequently negative, flushing can be stood down from daily to three times weekly as long as compliance is monitored. As control measures are in place, the gram stain sinks can be used as normal and the use of sterile water stopped.	**Greg Williams** **Paul Morgan / Greg Williams**	
	Risk assessment- Pseudomonas aeruginosa It was agreed that the water safety plan will be updated to include the movement of NICU to C2.	**Mike Quest**	
	Hydrotherapy pool Discussion also took place regarding the medium flow and maintenance of normal filters. AM asked for Estates assurance in writing. NM agreed to re-send previous assurance and confirmation provided.	**Norman Mitchell**	
	Water Control Measures- Out of Specification Results & Action Taken Jim Blackie advised of a water wastage issue	**Ian Fitsall**	

	with the water dialysis plant on T5, as 'pure' water is going down the drain, and the pipe work may be affected in the future. IF will pick up with GS after the meeting.		
	NM highlighted that the Estates department do not support water dispensers and advised on an incident whereby staff drank cleaning fluid from a piped water bottle. ED to contact the clinical boards and corporate areas in order to request an audit of their areas. Keith Sims agreed to forward to ED the detail of actions undertaken within his areas. Discussion took place regarding the water sampling undertaken within the dental hospital. Although sampling is not a legal requirement, ED would advise that if sampling is undertaken, it should be done an accredited level. PB to discuss with Melanie Wilson.	**Eleri Davies / Keith Sims** **Paul Bracegirdle**	
	Flushing Audits TW advised of a new flushing record, which is being rolled out to areas. TW to consider putting in 7 days or leaving the dates blank so that wards can fill in the three days they wish to undertake flushing. The group clarified the action of JMcG to contact IPC to discuss training needs of ward managers. YH advised that flushing responsibilities are brought up at numerous meetings, and it would be helpful to provide further training to ward mangers. The Legionella presentation could be updated and presented at the ward managers forums and sent out to the clinical boards etc. JMcG to update the presentation and discuss with IPC which forums to present to.	**Tony Ward** **Jon McGarrigle / Yvonne Hyde**	

UPDATED HEALTH AND SAFETY RELATED POLICIES SCHEDULE

POLICY	UHB REFERENCE NO	AUTHOR/LEAD RESPONSIBLE OFFICER	SUBMISSION TO HEALTH & SAFETY COMMITTEE	APPROVAL DATE	REVIEW DATE
Management of Stress & Mental Health Wellbeing in the Workplace	UHB 071	Employee Wellbeing	July 2014 (2nd review)	July 2014	July 2017
Management of Asbestos	UHB 072	Director of Planning	July 2014 (2nd review)	July 2014	July 2017
Fire Safety	UHB 022	Director of Planning	July 2015 (2nd review)	July 2015	July 2018
Latex Allergy	UHB 127	Health and Safety Adviser	October 2015 (2nd review)	October 2015	October 2018
Environmental	UHB 143	Director of Planning	October 2015 (2nd review)	October 2015	October 2018
Closed Circuit Television (CCTV)	UHB 303	Head of Health and Safety	October 2015	October 2015	October 2018
Security Services	UHB 037	Head of Health and Safety	January 2016 (2nd review)	January 2016	January 2019
Contractor Control	UHB 163	Director of Planning	July 2016 (3rd review)	July 2016	July 2019

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

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