Health & Safety Committee Meeting

Tue 27 July 2021, 09:00 - 12:00

Agenda

09:00 - 09:00
0 min

1. Welcome & Introductions

Akmal Hanuk

09:00 - 09:00
0 min

2. Apologies for Absence

Akmal Hanuk

09:00 - 09:00
0 min

3. Declarations of Interest

Akmal Hanuk

09:00 - 09:00
0 min

4. Minutes of the Committee Meeting held on 5th January 2021

Akmal Hanuk

04 - Unconfirmed minutes of HS Committee meeting 30.03.21 JE V2.NF clean copy.pdf (9 pages)

09:00 - 09:00
0 min

5. Action Log following the Meeting held on 5th January 2021

Akmal Hanuk

05 - Action Log AF.NF.pdf (1 pages)

09:00 - 09:00
0 min

6. Chair's Action taken since last meeting

Akmal Hanuk

09:00 - 09:00
0 min

7. Items for Review and Assurance

7.1. Health & Safety Overview – Verbal Update

Robert Warren

7.2. Priority Improvement Plan Update – Verbal Update

Robert Warren

7.3. Fire Enforcement Report

Geoff Walsh

7.3 Fire Enforcement Compliance and Management Report May 2021.pdf (15 pages)

7.4. Environmental Health Inspector Report

Geoff Walsh

- 7.4 Board Committee Report - EHO Inspections Update rev1.pdf (33 pages)
- 7.4a - Schedule B - Appendix 1.pdf (5 pages)
- 7.4b - Schedule B - Appendix 2.pdf (12 pages)

7.5. Enforcement Agencies Report

Robert Warren

- 7.5 2021-07 Enforcement Agencies Report.pdf (2 pages)

7.6. Waste Management Compliance Report

Geoff Walsh

- 7.6 Waste-Management-Compliance-Report-July 2021.pdf (3 pages)

7.7. Risk Register for Health and Safety – Verbal Update

Robert Warren

7.8. Lone Worker Device – Verbal Update

Robert Warren

09:00 - 09:00
0 min

8. Items for Approval/Ratification

8.1. Health and Safety Policy – Verbal Update

Robert Warren

8.2. Health and Safety Annual Report

Robert Warren

- 8.2 H&S Annual Report 2020-21- Live.pdf (15 pages)

09:00 - 09:00
0 min

9. Items for Noting and Information

9.1. Committee Effectiveness Survey results 2020-2021

Nicola Foreman

- 9.1 H&S Self Evaluation.pdf (11 pages)

9.2. Sub Committee Minutes:

Robert Warren / Geoff Walsh

i. Operational Health and Safety Group

ii. Fire Safety Group

- 9.2a 2021-03 OHSG Minutes of Meeting - Confirmed.pdf (11 pages)

09:00 - 09:00
0 min

10. Items to bring to the attention of the Board/Committee

09:00 - 09:00
0 min

11. Review of the Meeting

09:00 - 09:00
0 min

12. Date and time of next Meeting

12th October 2021 – 09:00am

MS Teams

UNCONFIRMED MINUTES OF THE HEALTH AND SAFETY COMMITTEE
30 MARCH 2021 9AM
VIA MS TEAMS

Chair:		
Akmal Hanuk	AH	Independent Member – Local Community (Committee Chair)
Michael Imperato	MI	Independent Member – Legal
Mike Jones	MJ	Independent Member – Trade Union
Rhian Thomas	RT	Independent Member - Estates
In Attendance		
Nicola Foreman	NF	Director of Corporate Governance
Fiona Kinghorn	FK	Executive Director of Public Health
Geoff Walsh	GW	Director of Estates, Capital and Facilities
Robert Warren	RW	Head of Health and Safety
Rachael Daniel	RD	Interim Head of Health and Safety
Stuart Egan	SE	Staff Safety Representative
Janice Aspinall	JA	Anaesthetics Nurse
Jacqueline Evans	JE	Interim Head of Corporate Governance
Secretariat		
Nathan Saunders	NS	Corporate Governance Officer
Apologies		
Rachel Gidman	RG	Assistant Director of Organisational Development

HS 21/03/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting including the new Interim Head of Corporate Governance (IHCG).	**Action**
HS 21/03/002	**Apologies for Absence** Members **noted** that apologies for absence had been received from Rachel Gidman, Assistant Director of Organisational Development.	
HS 21/03/003	**Declarations of Interest** No declarations of interest were noted.	
HS 21/03/004	**Minutes of the Committee Meeting held on 5 January 2021** The minutes of the meeting held on the 5 January 2021 were **received** and **confirmed** as a true and accurate record of the meeting. There were no matters arising that were not included on the agenda or the action log. The Independent Member – Estates (IME) noted that she had not received the meeting invitation for the meeting in January and it was recommended that this be recorded and reflected in the annual report. **The Committee resolved that:** (a) the minutes of the meeting held on 5 January 2021 be approved as a true and accurate record of the meeting.	

HS 21/03/005	**Action Log following the Meeting held on 5 January 2021** The action log was received and the Committee noted that the majority of the actions were on the agenda for discussion during the meeting.	
HS 21/03/006	**Chair's Action taken since last meeting** No Chair's Actions were noted.	
HS 21/03/007	**Health & Safety Overview – Verbal Update** The verbal Health and Safety overview update was received received and Robert Warren introduced himself as the newly appointed Interim Head of Health and Safety (HHS). The HHS advised that he was developing a new Health and Safety agenda for Cardiff and Vale University Health Board (CVUHB) to drive a positive safety culture within the organisation. The HHS gave an update on work undertaken to date and the Committee noted that: • The HHS had been in post for 8 weeks and was undertaking an assessment of the health & safety framework within the Organisation, • there were some areas that could provide improved value including undertaking instant investigations through the Datix reporting system, and having a standard audit system where the organisation could proactively identify shortcomings, assign appropriate actions and communicate swiftly, • The reporting of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) was being reviewed to strengthen the culture and reporting process, • Of the 12 RIDDOR incident reported in January 2021, one was due to a specified injury and the remaining 11 were as a result of 7 day absenteeism, • Going forward a behavioural safety programme where human reliability in relation to incidents will be considered, and a robust incident investigation tool was also being investigated. The Committee noted that an independent Health and Safety review had commenced, which was sponsored at Executive Director level with the full support of the Chief Executive Officer (CEO) to strengthen and develop Health & Safety Management with the aim of CVUHB becoming leaders in managing Health and Safety. The HHS advised the Committee that the outputs from the Health and Safety review would provide an evidence led platform to update the Health and Safety risk register, and other associated risk registers. The HHS thanked the Interim Head of Health and Safety (IHHS) for taking the lead on Health and Safety and for providing support to him and the Committee during her tenure. The Director of Corporate Governance (DCG) added that the independent Health and Safety review would report the outputs to the Health and	

	Safety Committee and the Board, and that the CEO was keen to raise the profile of Health and Safety across the Health Board. The Committee noted that the NHS Wales Health and Safety group were involved in reviewing the incident reporting module in the new Once for Wales Datix Concerns Management System which will improve the health and safety reporting process. **The Committee resolved that:** (a) the health & safety overview update be noted.	
HS 21/03/008	**Enforcement Agencies Report** The Enforcement Agencies report was received and the Committee noted the actions taken in response to correspondence from the Health and Safety Executive, specifically: • **Examination report** – Horizontal Multi-tubular steam boiler at University Hospital Llandough – an examination report had indicated that defects had been identified and the equipment was immediately removed from use. The estates department have reviewed their maintenance regime and confirmed that all required maintenance had been carried out as per the guidelines set. No further correspondence received from the HSE, • **Death of a member of staff** – CVUHB were working with the HSE, who was acting on behalf of the coroner in relation to the death of a member of staff who had tested positive for COVID-19. Following investigation the HSE concluded that the death was not RIDDOR reportable as they did not consider it to be a work related exposure to coronavirus. The HSE have informed HM Coroner South Wales of their decision, • **Face Fit Testing in a Nursing Home** – The PCIC Clinical Board received notification from the HSE in November 2020 in relation to face fit testing practices in a nursing home, the HSE met with the IPC department to address the concerns, and the Health Board has received a notice of contravention from the HSE in relation the face fit test reports and training, an action plan has been developed to address these issues and it has been shared with the HSE, and they have confirmed they are satisfied with the action being taken. The Staff Safety Representative (SSR) advised the Committee that organisations across the UK had received reports from the HSE following inspections and queried if the report sent to CVUHB would be followed up. The IHHS responded that the report was received one week ago and was currently being worked through and advised that any lessons that could be learned would be shared with the Committee and staff. The SSR advised the Committee that CVUHB had been advised to review all of its risk assessments in line with the new COVID-19 variants and noted that he was not assured that everybody had carried out those reviews, and added that ventilation was an ongoing issue.	**HSE**

	The IHHS responded that it was an important point to raise and the information would be sent back to all Clinical Boards and they be required to review their risk assessments. The HHS advised that the team were aware of the issues in relation to ventilation, it had been discussed at Personal Protective Equipment (PPE) cell meeting. **The Committee resolved that:** The Enforcement Agencies Report be noted.	
HS 21/03/009	**Lone Worker Devices Report** The Lone worker devices report was received and the Committee noted that the lone worker devices were issued to staff in the community that were at risk, and offered a system of calling for assistance, was monitored 24/7 and recorded when justified. The HHS advised that: • the device usage compliance had reduced by 21% during the period of the pandemic. The reduction in compliance was largely driven by changes in service delivery over the course of the pandemic • the service delivery was no affected during the period and the PROVIDER “Peoplesafe” continuously reviewed and improved Business Continuity plans to ensure services were provided to “key workers” and responses to alarms were not affected, • there were currently 700 active devices allocated to high risk lone workers, • the personal safety team are working to ensure managers receive bi-monthly usage reports to enable them to monitor compliance, manage devices and identify gaps in training needs, • remote device training and refresher sessions were being offered to staff, • in collaboration with the safeguarding team 10 lone worker devices had been funded by the CVUHB Charity “Make it Better Fund” for vulnerable staff affected by domestic abuse or stalking as a consequence of the ongoing lockdown situation. The IME asked if there was a distinction between devices loaned out to staff in the community and devices loaned out to staff due to personal circumstances. The HHS confirmed that devices were available for vulnerable staff affected by domestic abuse or stalking if required and that training would be provided to those staff members around the devices. The Committee noted that compliance of the use of lone worker devices had decreased during the COVID-19 pandemic and that there was a strategy in place to increase the numbers which involved training courses and a communications campaign. The Independent Member – Legal (IML) asked if responsibility for the use of lone worker devices should be placed on the line managers of staff.	

	The HHS responded that the onus was on the individual member of staff on whether they wanted to use the devices and that line managers could encourage use of the devices and promote them to safeguard staff. The Committee noted that the Health and Safety department issued monthly communications to staff which included information on incident statistics, RIDDOR reports and lone worker device usage. The Independent Member – Trade Union (IMTU) asked how confident the Health and Safety team were that staff knew about the lone worker devices that were available to them. The HHS responded that he was very confident that staff were aware and that line manager's had a responsibility for the messages to be cascaded. The IME suggested that the statistics on the use of lone working devices should be a standing item on the Health and Safety Committee agenda in future. The DCG responded that it would be picked up at each meeting. **The Committee resolved that:** The Lone Worker Devices Report be noted.	
HS 21/03/010	**Regulatory and Review Body Tracking Report** The Regulatory and Review Bodies Tracking report was received and the Committee noted the updates between 1 April 2019 – 20 March 2021, inlcuding food hygiene inspections undertaken by Local Authorities, Inspections/Audits undertaken by the HSE, and fore safety inpsections undertaken by South Wales Fire & Rescue Service (SWFRS). The IHHS advised that the report was presented to the Committee bi-annually and provided information on new inspections undertaken during the reporting period, and formal reports received during the period. The Committee noted that there had not been any environmental health inspections due to the ongoing COVID-19 pandemic. The Committee discussed the need to track and monitor risks and it was recognised that there was a need to consider if there were any issues or risks that needed to be captured on the corporate register, or linked to existing risks on the register. The DCG advised that any issues or risks would be brought to the attention of the Audit Committee and any relevant Health and Safety information would be presented to this Committee. **The Committee resolved that:** (a) The Regulatory and Review Body Tracking Report be noted.	
HS 21/03/011	**Risk Register for Health and Safety** The Risk Register for Health and Safety was received.	

	The HHS advised the Committee that an updated Risk Register would be provided following the independent Health and Safety review and would be brought to the July meeting. **The Committee resolved that:** (a) The Risk Register for Health and Safety be noted.	RW
HS 21/03/012	**Training Requirements and Compliance** The Training requirements and compliance report was received. The HHS advised the Committee that: • the Health and Safety team were now able to offer more training courses due to a drop off in COVID-19 work, • the health and safety team had worked closely with the Leading, Educating and Developing (LED) team on the Electronic Staff Record (ESR) and that work had progressed on ensuring that ESR had the correct competencies matched to staff and that the courses were recorded correctly, • the Link Worker system where staff are trained and then that training would be cascaded to other staff was being enforced, • a new Health and Safety dashboard would be made available to show compliance statistics amongst other information. The IME asked if training courses were allocated to staff of specific grades as opposed to their specific role. The HHS responded that individual assessments would be undertaken to assess a training need schedule against specific job roles and that discussions were being undertaken at a pan NHS Wales level concerning manual handling and moving to an all NHS Wales training passport. The IHHS advised that the LED team had looked at staff training needs assessments prior to the COVID-19 pandemic and had looked specifically at the roles and allocated training against those roles. This work was going to be re-visited. The CC advised that the fundamentals of training needed to be looked at and noted that larger organisations allocated mandatory training packages and stated that there was a need to work with the LED to increase the uptake of training across the Health Board. The CC queried the training dashboard and asked if it would provide detailed information for each Clinical boards, or if it was only one organisation wide dashboard. The HHS responded that the individual Clinical Boards could produce their own training compliance reports for their respective areas which would provide more meaningful information to be issued locally. The Director of Estates, Capital and Facilities (DECF) advised the Committee that there were a number of staff who did not have access to computers as part of their job role so time would need to be allocated for those to complete the relevant training.	

	The CC responded that the LED could develop a strategy to ensure that staff have access to computers, to ensure there was plan in place for all staff to receive the required training. **The Committee resolved that:** (a) The progress the project had made to date be noted**,** and the Committee supported the suggested direction of travel noted in Appendix 1, (b) The project's progress and recommendations that came out of the discussions with the Executive team be noted**.**	
HS 21/03/013	**Health and Safety Policy Update** The verbal Health and Safety policy update was **received.** The HHS advised the Committee that he had not completed the health & safety policy update as yet and that an update would be provided to a future meeting. He added that it was a key document that needed to be reviewed correctly and it would need to be endorsed by himself before being brought to the Committee and to the Board for assurance. The Committee noted that the existing statement of intent would be developed and strengthened and a one page standalone statement of intent would be produced outlining CVUHB's commitment to managing health and safety effectively. The document would be supported by a detailed charter which would be signed by each Executive Director. The HHS advised the Committee that the statement would be cascaded broadly to all staff and patients to raise awareness of the commitment to health & safety. The HHS advised that he had not any dialogue with the patient Health and Safety team as yet but would engage with them and share information and ideas to move the health and safety agenda forward. **The Committee resolved that:** The verbal update on health and safety policies be noted.	
HS 21/03/014	**Environmental Health Update** The verbal Environmental Health update was received. The DECF advised the Committee that at the time of writing the report no environmental health inspections had been undertaken due to the COVID-19 pandemic, however environmental health services had started to engage with CVUHB again. The Committee noted that an inspection had taken place in the food processing unit but no feedback had been received to date. The Committee noted that as COVID-19 restrictions ease, inspections would increase, and the DECF advised the Committee that an Environmental Officer had been appointed and had started undertaking work to review key areas of environmental health.	

	The Committee resolved that: (a) The verbal update on environmental be noted**.**	
HS 21/03/015	**Fire Enforcement and Management Compliance Report** The Fire Enforcement Compliance and Management compliance report was received and the DECF gave an update as follows: **Enforcing Authority audits** – there were no prohibition, enforcement or informal notices issued during this reporting period to the end of February 2021, **Fire incidents** – there had been no fire incidents recorded during the reporting period, **Unwanted Fire Signals (UwFS)** – in February 2021 there were 26 UwFS's which was had increased as a direct result of more activity on CVUHB sites. It was noted that UHW has the largest number of devices in the Health Board and that some of the devices needed to be changed, The DECF noted that CVUHB had been awarded £173K to address the replacement of devices in the tower block at the University Hospital of Wales (UHW) and had also secured monies for fire compartmentation work to be undertaken at community sites. The Committee noted that fire safety training needed to be improved and that significant falls in compliance had been identified as a consequence of COVID-19 despite electronic training being available through ESR. The DECF advised that the Microsoft Teams platform would be used to provide training going forward and that his team would work with the communications team to provide video based training sessions. He added that face to face training would be reintroduced over the course of the next couple of months which should improve compliance. The IME asked if the Executive Team needed to challenge the Clinical Boards on their training compliance figures and the HHS responded that it needed to be revisited as fire safety training was part of the statutory and mandatory training framework. He added that he would work with the communications team to provide a promotional piece explaining that fire safety is a statutory requirement and noted that ward managers could be held accountable for that training. The IML asked what other health boards were doing towards fire safety training. The DECF responded that NHS Wales had a compliance target of 85% compliance and that he could contact neighbouring health boards for comparison, however advises that other health boards were not doing anything vastly different from CVUHB. The Committee discussed the need for fire safety to be pushed to the forefront of health and safety compliance. The DCG responded that the executives did not have oversight of the statistics and noted that as part of the CEO's ambition to raise health and safety profile he had spoken to the HHS to request that a monthly report on	

	health and safety issues be submitted to Management Executive (ME) meeting so that performance and compliance could be monitored. In addition. The Board would receive assurance through the overall workforce dashboard which outlined compliance statistics. The DCG advised the Committee that the minutes of the Health and Safety Committee meeting and the Committee Chairs report were submitted to the Board for assurance and that the HSE would look at the governance processes in place in the event of an incident to assess who was made aware of health and safety issues and what actions were discussed. **The Committee resolved that:** • the report and the ongoing work being undertaken to ensure fire safety across the UHB be **NOTED.**	
HS 21/03/016	**Items for Approval/Ratification** No items for approval/ratification were received.	
HS 21/03/017	**Items For Noting and Information** **Sub Committee Minutes:** Operational Health and Safety Group **The Committee resolved that:** (a) The minutes of Operational Health & Safety Group be noted.	
HS 21/03/018	**Health & Safety Committee Annual Report 2020-2021** The Health and Safety Committee Annual Report 2020-2021 was received. The DCG presented the Health and Safety Annual Report 2020-2021 and advised the Committee that the document was for noting retrospectively as it had already been presented to the Board. She added that following today's meeting it would be updated to reflect items discussed today. **The Committee resolved that:** (a) The Health & Safety Committee Annual Report 2020-2021 be approved.	NS
HS 21/03/019	**Items to bring to the attention of the Board/Committee** The CC advised the Committee that the item concerning fire safety training would need to be brought to the attention of the Board and this would be highlighted within the Chairs report to the Board	NF/NS
HS 21/03/020	**11. Date and time of next Meeting** 27 July 2021 – 9am MS Teams	

ACTION LOG
FOLLOWING HEALTH AND SAFETY COMMITTEE MEETING
30TH MARCH 2021.

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Actions Completed					
HSC: 21/01/008	H&S Overview	New Head of Health and Safety to provide an overview on thoughts about current H&S situation.	R Daniel	30/03/21	**COMPLETE** Robert Warren to present **Agenda Item 7.1**
HS 21/01/014	Environmental Health Update	New Environmental Health Officer to provide update re: internal audits	G Walsh	30/03/21	**COMPLETE** Geoff Walsh to present **Agenda Item 7.8**
HS 21/03/015	Health & Safety Update	To provide a report to Management Exec every third Monday of the month	R Warren	19/04/21	Ongoing – **Complete**
Actions in Progress					
HS 21/03/013	Health and Safety Policy Update	To bring an update on the Health and Safety Policy	R Warren	27/07/21	To be provided at **July** Meeting – Agenda Item 8.1
HS 21/03/011	Risk Register Update	Risk Register Update provided following H&S review.	R Warren	27/07/21	To be provided following H&S Review Bring to **July** Meeting – Agenda Item 7.7
HS 21/03/009	Lone Worker Device Update	To provide an update on the statistics of devices being used.	R Warren	27/07/21	Statistics to be provided at **July** Meeting – Agenda Item 7.8
HSC: 19/10/009	HSE Inspection	Chair to be informed of date of inspection	R Daniel	21/01/20	No date at time of writing **Update required from R Daniel**
Actions referred to other Committees/Board					
HS 21/03/015	Fire Safety Training	Discuss the reintroduction of executive challenges to clinical boards around fire safety training due to low compliance.			No date at time of writing

Report Title:	**Fire Enforcement Compliance and Management Report June 2021**						
Meeting:	**Health and Safety Committee**				**Meeting Date:**	**27/07/2021**	
Status:	**For Discussion**		**For Assurance**	✓	**For Approval**		**For Information**
Lead Executive:	**Executive Director Responsible for Fire Safety**						
Report Author (Title):	**Senior Fire Safety Officer**						

Background and current situation:

South Wales Fire and Rescue Service (SWFRS) agree a program of visits with the University Health Board's (UHB's) Senior Fire Safety Officer (SFSO) to enable them to undertake fire safety audits PAN Estate. Audits may result in written notices being served on the responsible person for Cardiff and Vale University Health Board (C&V UHB) by the enforcing authority where they deem that the UHB has failed to comply with current fire safety legislation i.e. the Regulatory Reform (Fire Safety) Order 2005 (FSO).

The UHB has a statutory responsibility to protect persons from the risk of injury or death from fire. The enforcing authority of current fire safety legislation is the local Fire and Rescue Authority i.e. South Wales Fire and Rescue Service (SWFRS) is lawfully empowered to monitor and enforce compliance of all fire safety matters under the FSO

Once a fire safety audit is completed SWFRS will either confirm that all relevant fire safety matters are satisfactory or if not issue a written notice detailing all fire safety deficiencies that are identified during the audit. The notice of deficiencies will take the form of a Prohibition Notice (this will prohibit the use of an area or premises), an Enforcement Notice (a serious breach of fire safety standards), an Informal Notice (IN01- fire safety deficiencies that are deemed not so serious to warrant enforcement action and time limited, usually twelve months) or they may issue an Informal Notice (IN02 - advisory fire safety deficiencies no time limit).The FSA04 is also an official notice that confirms the standard of fire safety appeared to comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005 at the time of audit, no further action is therefore required to be taken by the Local Fire and Rescue Authority.

Executive Director Opinion /Key Issues to bring to the attention of the Board/ Committee:

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

1. **Enforcing Authority Audits/Inspections**
2. **Fire Incidents and Unwanted Fire Signals (UwFS's)**
3. **Fire Risk Assessments**
4. **Fire Safety Training**

(See **Appendix 1** – Pages 3 to 9 **Essential Supporting Documentation**)

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.)

- Assurance is provided to the committee that all identified fire enforcement compliance, estates and management matters are being appropriately managed safely to enable C&V UHB to fulfil its legal duty to minimise the risk of reputational damage to as low as reasonably practicable.

RECOMMENDATION

The Committee is asked:

- To consider on-going efforts to meet the requirements of fire safety enforcement action

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

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

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

APPENDIX 1

Essential Supporting Documentation

1.0 Enforcing Authority Audits/Inspections

Following receipt of an anonymous written complaint addressed to South Wales Fire and Rescue Authority (SWFRA) regarding a number of serious fire safety contraventions a fire service enforcement officer made an unannounced site visit on Wednesday 14th April 2021. As a consequence of this inspection SWFRA is of the opinion that Cardiff and Vale University Health Board (C&V UHB) failed to comply with the provisions of the Regulatory Reform (Fire Safety) Order 2005 (FSO) because people were unsafe in case of fire. They therefore served two Enforcement Notices (EN) addressed to the Clerk to Chief Executive Officer in respect of illicit smoking, control of ignition sources and basic fire safety management for Hafan-Y-Coed (HYC) at University Hospital Llandough (UHL), both EN's were dated 21st April 2021.

- Enforcement Notice EN3/21 was issued for non-compliance with Article 8 of the FSO **(Duty to take general fire precautions).** Steps to remedy identified failures are detailed in the schedule of this notice and must be satisfactorily completed by 19th May 2021 to avoid further action. Therefore a 'Day After EN ends' inspection was made by SWFRA on Thursday 20th May 2021 and very disappointingly the conditions found on the day did not reflect a satisfactory outcome. Therefore, I have to report that consequently SWFRA intend to issue an EN03 i.e. 'Enforcement Notice' not complied with'

- Enforcement Notice EN4/21 was issued for non-compliance with Article 8 **(Duty to take general fire precautions)**, Article 14 **(Emergency routes and exits),** and Article 17 **(Maintenance of equipment)** of the FSO. Steps to remedy the identified failures are detailed in the schedule of this notice and must be satisfactorily completed by 20th July 2021.

See Action Plan, Appendix 2 on pages 14 and 15

N.B.

Failure to comply with any requirement imposed by an enforcement notice served under Article 30 of the FSO within the time specified in the notice (or such time as the Fire and Rescue Authority may, at their discretion, grant) is a criminal offence under Article 32(d) of the FSO.

A person guilty of such an offence shall be liable,

(a) on summary conviction to a fine not exceeding the statutory maximum;

or

(b) on conviction on indictment, to a fine or to imprisonment for a term not exceeding two years, or both.

2.0. Fire Incidents and Unwanted Fire Signals (UwFS's)

2.1 Fire incidents

It is very pleasing to report that there has only been one fire incident recorded in this reporting period and in fact it is the first fire incident recorded in 2021.

This incident occurred on 29th April 2021 at 1300 hrs. A small fire broke out in a tumble dryer caused by a build-up of fluff but was quickly extinguished by a member of staff using a portable carbon dioxide fire extinguisher after he isolated the power supply. Unfortunately, the staff member did not raise the alarm as per C&V UHB procedure but informed his line manager, thus the incident went unreported. A member of the fire safety team subsequently investigated the incident and reiterated the correct procedure to the staff member concerned and his line manager. The incident occurred in a detached single storey building housing six industrial washing and drying machines. The affected appliance suffered very minor scorching and was permanently isolated and taken out of use until it is replaced.

2.2 Unwanted Fire Signals (UwFS's)

False alarms and unwanted fire signals lead to disruption of service/patient care, increased costs and unnecessary risk to those required to respond to the alarm.

In this reporting period there were 47 UwFS's PAN Estate giving a mean average of 15.6 pre-month compared with the figures for the previous rolling 12 months of 295 giving a mean average of 24.6 UwFS's per month. This figure reflects the size and age of our fire alarm and detection system and the complexity of our largest sites however we have seen a decline in these figures over the preceding years with a significant reduction in 2020 on the back of a similar reduction in 2019. This reporting period has seen a steady reduction in false alarms attended by the fire service due to a reduced workforce, reduced numbers of contractors on site and fewer visitors attending our premises PAN estate as a consequence of the National emergency. (See Table 1 below and Table 2 on page 5)

Table 1

Performance Indicators for Cardiff & Vale University HB for UwFS between 01/03/2021 and 31/05/2021 Unwanted Fire Signals only (attendance by Fire Brigade)

Hospital	UwFS only	Actuation devices	Grade
Llandough Hospital	5	6500	Performance level 1
Rookwood Hospital	1	425	Performance level 1
University Hospital of Wales	41	20000	Performance level 1
Total	47	26925	

Table 2

Performance Indicators for Cardiff & Vale University HB for UwFS's between 01/06/2020 and 31/05/2021 Unwanted Fire Signals only (attendance by Fire Brigade)

Hospital	UwFS's only	Actuation devices	Grade
Barry Hospital	9	562	Performance level 1
Cardiff Royal Infirmary	7	2000	Performance level 1
Hafan Y Coed	21	1274	Performance level 1
Llandough Hospital	65	6500	Performance level 1
Rookwood Hospital	7	425	Performance level 1
St David's Hospital (Cardiff)	3	600	Performance level 1
University Hospital of Wales	181	20000	Performance level 1
	295	31361	

3.0 Fire Risk Assessments and Annual Audit

The principle fire safety legislation applicable to all the Health Board's premises is the Regulatory Reform (Fire Safety) Order 2005 (FSO) enforced by the Local Fire Authority. To be compliant with this legislation a Fire Risk Assessment must be completed for every building or ward or department. Currently there are 450 risk assessment reports that are being repeatedly assessed and reviewed by members of the fire safety management team either annually, bi or tri-annually or they may be amended whenever materials alterations or significant changes in use take place in terms or service or staff.

The findings of the risk assessments are divided into three areas of responsibility: Estates and Compliance findings are managed and resolved by each of these teams with Management findings monitored and resolved predominantly by the manager responsible for the assessment area.

3.1 The 4 most common management failings relate to

- Training compliance,
- Fire resisting doors being wedged open or propped open,
- Illicit storage in corridors, plant rooms and risers,
- Obstructions to fire escape routes.

3.2 The 4 most common estates failings relate to

- Fire door defects, seals, gaps, door signage, self-closing devices defective and damage
- A range of fire signage, FAN, directional and hazard signage
- Manual call points and Emergency door release protective covers

3.3 The 5 most common compliance failings relate to

- Fire alarm deficiencies, alarm addressing, cause and effect confirmation and panel faults
- Emergency lighting testing and maintenance confirmation
- Fire damper type, testing and maintenance
- Cavity barrier installations and fire stopping deficiencies
- Portable appliance testing
- Up to date fire strategy drawings

Currently we have 8 assessments overdue and 9 ward-based assessments that have been put back due to Covid 19

3.4 Annual Audit Submission

As detailed in WHTM05/01 Managing Healthcare Fire Safety all NHS Organisations are required to conduct an annual fire audit utilising the online Fire Safety Audit System.

These audits are carried out for the previous calendar year by the Senior Fire Safety Officer. Once completed they are submitted by the Executive Director responsible for Fire Safety to Shared Services Partnership, Specialist Estates Services (SES). On receipt SES prepare an all Wales report for the Welsh Government.

This year 9 sites and premises were audited i.e.

- Barry Hospital, Colcot Road, Barry
- Cardiff Royal Infirmary, Newport Road, Cardiff
- Dental Hospital (University Hospital of Wales), Heath Park
- Hafan Y Coed, Llandough Hospital, Penarth
- Llandough Hospital, Penlan Road, Penarth
- Llanrumney Clinic, Llanrumney Avenue, Cardiff
- Pentwyn Health Centre, Brynheulog, Cardiff
- St David's Hospital (Cardiff), Cowbridge Road East, Cardiff
- University Hospital of Wales, Heath Park, Cardiff

These audits are due to be submitted before the next reporting period.

4.0 Fire Safety Training

Data supplied by Workforce Information for 1st June 2020 – 31st May 2021

Table 3

Clinical Board	Directorate	Assignment Count	Achieved	Compliance %
All Wales Genomics Service	AWG Directorate	254	193	75.98%
All Wales Genomics Service Total		**254**	**193**	**75.98%**
Capital, Estates & Facilities Total		**1324**	**601**	**45.39%**
Children & Women Total		**2278**	**1316**	**57.77%**
Clinical Diagnostics & Therapeutics Total		**2353**	**1355**	**57.59%**
Corporate Executives Total		**887**	**473**	**53.33%**
Medicine Total		**1863**	**994**	**53.35%**
Mental Health Total		**1508**	**800**	**53.05%**
Primary, Community Intermediate Care Total		**1481**	**749**	**50.57%**
Specialist Services Total		**2002**	**1096**	**54.75%**
Surge Hospitals Total		**48**	**27**	**56.25%**
Surgical Services Total		**2349**	**1171**	**49.85%**
Grand Total		**16347**	**8775**	**53.68%**

The compliance figures outlined in **Table 3** above relates to a rolling 12-month period, the fire safety e-learning package, classroom, locality based & Fire Warden training. All fire safety training records are recorded on the staff personal records Electronic Staff Records (ESR)

database. LED collates all statistical information in relation to Fire Training and notifies workforce development. It can be seen that 53.68% of staff received fire training in the previous 12 month period ending 31st May 2021.

Mandatory fire training sessions at UHW & UHL conducted by members of the Fire Safety Team are organised by LED, with information in relation to venues, dates and times being available on the intranet. Whilst it is acknowledged that the current training figures have been significantly reduced due to Covid further initiatives to try to increase this figure are being proposed.

Requests to members of the Fire Safety Management Team from managers to carry out on-site training will be accommodated where possible and appropriate. It will be the responsibility of the organiser for the training to ensure that sufficient numbers of staff attend (normally minimum of 12) and that a suitable room to carry out the training is available and set up prior to arrival.

It should also be understood that due to the fire safety team having numerous other fire safety duties, it will not always be possible to accommodate requests for on-site fire training. In these circumstances, staff will be referred to attend mandatory training drop in sessions arranged by LED either at UHW or UHL and facilitated by the fire safety management team.

It is also noteworthy that Managers report the matter of releasing staff to attend tutor led fire safety sessions is still a real and ongoing challenge.

N.B.

Current training needs analysis (TNA) dictates the frequency of fire safety training required to be delivered to all staff groups. The analysis requires that the majority of clinical staff are mandated to attend statutory classroom-based fire safety training either annually or by exception bi-annually. With this in mind a request was made to workforce development to examine the available data for the previous three years and the figures on **Table 4** below show some worrying trends.

Table 4 - Analysis supplied by workforce development with three caveats outlined below:

		Financial Year		
Staff category	**Delivery Mode**	**2017-18**	**2018-19**	**2019-20**
Clinical	Face to Face	1967	2553	2238
	Online e-Learning	4528	5163	5910
Clinical Total		**6495**	**7716**	**8148**
Non-Clinical	Face to Face	859	989	642
	Online e-Learning	1353	1705	2138
Non-Clinical Total		**2212**	**2694**	**2780**

1. Staff in the Administrative & Clerical, Estates & Ancillary and Student Staff Groups have been categorised as 'non-clinical'. All other staff have been categorised as 'clinical'.

2. The report shows the current employment status of staff who have undertaken training in the last three years and therefore includes some staff who have subsequently left the Health Board but replaced by new starters The Staff Group which consists of six members of staff is

not recorded, so it cannot be determined whether they are 'clinical' or 'non-clinical' and therefore they have been removed from the analysis.

3. Records which indicate in any way that the learning was incomplete, or courses were cancelled have also been removed. This equates to 2289 enrolments, for 1577 staff.

In March 2018 the overall Fire training compliance was 65.32%. In 2019 it was 67.89% and in 2020 it was 67.03%. It should be noted that the total figures in **Table 4** above represent only 67.03% of the total workforce at the time of reporting.

The majority of clinical staff are mandated to attend a face to face session annually

In year 2019-20 the UHB employed 15691 (See **Table 5** on page 9) of which 10,517 staff were recorded as receiving some form of fire safety training and 5174 i.e. 33% were recorded as receiving no fire safety training of any kind and were therefore non-compliant.

Data supplied by Workforce Information for **1st April 2019 to 31st March 2020**

Table 5

Clinical Board	Directorate	Assignment Count	Achieved	Compliance %
All Wales Genomics Service	AWG Directorate	235	179	76.17%
All Wales Genomics Service Total		**235**	**179**	**76.17%**
Capital, Estates & Facilities	Capital Planning & Admin	46	44	95.65%
Capital, Estates & Facilities Total		**1212**	**885**	**73.02%**
Children & Women Total		**2318**	**1634**	**70.49%**
Clinical Diagnostics & Therapeutics	Clinical Diagnostics and Therapeutics Management	7	6	85.71%
Clinical Diagnostics & Therapeutics Total		**2371**	**1808**	**76.25%**
Corporate Executives	Chief Executive Officer	45	25	55.56%
Corporate Executives Total		**842**	**596**	**70.78%**
Medicine Total		**1852**	**1042**	**56.26%**
Mental Health Total		**1500**	**1013**	**67.53%**
Primary, Community Intermediate Care	Localities Cardiff North West	273	211	77.29%
Primary, Community Intermediate Care Total		**1066**	**749**	**70.26%**
Specialist Services Total		**1893**	**1207**	**63.76%**
Surgical Services	ENT & Dental Hospital	496	358	72.18%
Surgical Services Total		**2402**	**1404**	**58.45%**
Establishment Grand Total		**15691**	**10517**	**67.00%**
Non-compliant total **15691 – 10517 = 5174 i.e. 33.00%**				

Of the 67% who were compliant **Table 4 Page 8** shows that only 2880 staff i.e.27% actually attended a face to face session. When the numbers of staff who were non-compliant are included i.e. 5174 this compliance figure is significantly reduced i.e. only 18% of all staff are

compliant more worryingly only 14.3% of clinical staff are truly compliant in attending a face to face session in 2019-20 (See **Table 10** on Page 13, Exemplar training needs matrix)**.**

It is clear that these figures reveal alarming noncompliance with this statutory duty. It should also be noted at the time of reporting a complete suspension of classroom based training was introduced across the board due to the Covid 19 pandemic. Therefore, it must be expected that the above compliance figures will be further reduced over the coming months. However, with the proactive introduction by the fire safety team of Covid safe training organised by the requester and facilitated by the fire safety team, **Table 6** on page 10 shows the figures for May. **Table 7** on page 11 shows cascade training figures for April 2021 onwards. **Table 8** on page 11 shows training dates organised by Learning, Education and Development (LED) and **Table 9** on page 12 indicates fire training commitments organised by the fire safety team from May onwards.

Table 6

Data supplied by Fire Safety Management Team

Figures for 01/03/2021 to 31/05/2021

Hospital Name	Date	Training Requestor	Department	Name of Training	Name of Trainer	Total Attending
Cochrane Building UHW	15/03/2021	Nicola Giles	Health Care Workers	Fire Training	Stuart Rookes	11
Cochrane Building UHW	25/03/2021	Nicola Giles	Health Care Workers	Fire Training	Stephen Bennett	11
HYC	06/04/2021	Casey Keegans	Health Care Workers	Fire Training	Ben Perrett	11
HYC	12/04/2021	Casey Keegans	Health Care Workers	Fire Training	Ben Perrett	18
Rookwood	12/04/2021	Pam Jenkin	Staff	Fire Training	Stuart Rookes	7
Rookwood	12/04/2021	Pam Jenkin	Staff	Fire Training	Stuart Rookes	9
UHW	13/04/2021	Sandra Watts	B6	Cascade Training	Stuart Rookes	2
UHW	14/04/2021	Sandra Watts	B6	Cascade Training	Stuart Rookes	2
Cochrane Building UHW	15/04/2021	Nicola Giles	Health Care Workers	Fire Training	Stuart Rookes	9
Dental	16/04/2021	Emma Stone	Dental	Training/F2F and on T	Stephen Bennett	17
BCH	16/04/2021	Linda Edwards	Staff	Fire Training	Ben Perrett	10
UHW	20/04/2021	Calum Davies	All Wales Medical Genomic Service	Fire Warden Training	Stephen Bennett	3
UHW	20/04/2021	Calum Davies	All Wales Medical Genomic Service	Fire Warden Training	Stephen Bennett	6
Cochrane Building UHW	21/04/2021	Nicola Giles	Health Care Workers	Fire Training	Stephen Bennett	11
BCH	19/04/2021	Linda Edwards	Staff + Estates	Fire Training	Ben Perrett	14
Rookwood	22/04/2021	Pam Jenkin	Staff	Fire Training	Stuart Rookes	8
Rookwood	22/04/2021	Pam Jenkin	Staff	Fire Training	Stuart Rookes	8
UHW	22/04/2021	Sandra Watts	Duffie Ward	Cascade Training	Stuart Rookes	3
Dental	23/04/2021	Emma Stone	Dental	Training/F2F and on T	Stephen Bennett	52
Dental	23/04/2021	Emma Stone	Dental	Fire Training	Stephen Bennett	7
UHW	27/04/2021	Sandra Watts	A5	Cascade Training	Stuart Rookes	1
BCH	26/04/2021	Linda Edwards	Staff	Fire Training	Ben Perrett	11
UHW	29/04/2021	Sandra Watts	SAU	Cascade Training	Stuart Rookes	3
UHW	30/04/2021	Sandra Watts	B2N	Cascade Training	Stuart Rookes	1
UHW	30/04/2021	Phil Cable	Porters	Albac Mats	Stephen Bennett	4
Rookwood	05/05/2021	Linda Hull	Staff	Fire Training	Stuart Rookes	6
Cochrane Building UHW	06/05/2021	Nicola Giles	Health Care Workers	Fire Training	Stephen Bennett	10
UHW	06/05/2021	Phil Cable	Porters	Albac Mats	Stuart Rookes	6
HYC	10/05/2021	Casey Keegans	Health Care Workers	Fire Training	Ben Perrett	17
UHL Clinical Skils	12/05/2021	Nicola Giles	Health Care Workers	Fire Training	Ben Perrett	7
UHL Clinical Skils	17/05/2021	Nicola Giles	Health Care Workers	Fire Training	Ben Perrett	6
UHL Clinical Skils	24/05/2021	Nicola Giles	Health Care Workers	Fire Training	Ben Perrett	10
UHW	26/05/2021	Phil Cable	Porters	Albac Mats	Stephen Bennett	6
HYC	27/05/2021	Casey Keegans	Health Care Workers	Fire Training	Ben Perrett	4
SDH/Riverside HC	28/05/2021	Wendy Davies	Dietitians	Fire Training	Stuart Rookes	10
					Total	321

Table 7

Cascade Fire Safety Training

Figures for 01/03/2021 to 31/05/2021

Date of training	Ward	Staff	Cascade trainer	training venue	e-mail address	date of review	Fire Advisor
13/04/2021	B6	54	Louise Tugwell	B6	louise.tugwell@wales.nhs.uk	13/04/2022	stuart rookes
13/04/2021			Sarah Barnes	B6	sarah.barnes6@wales.nhs.uk	13/04/2022	stuart rookes
14/04/2021			Richard Ducroq	B6	richard.ducroq@wales.nhs.uk	14/04/2022	stuart rookes
14/04/2021			Helen Johns	B6	helen.johns4@wales.nhs.uk	14/04/2022	stuart rookes
22/04/2021	Duffy Ward	30	Elizabeth Strafford	Duffy Ward	elizabeth.cox@wales.nhs.uk	22/04/2022	stuart rookes
22/04/2021			Guiseppe Pecora	Duffy Ward	harriet.cansdale@wales.nhs.uk	22/04/2022	stuart rookes
22/04/2021			Harriet Cansdale	Duffy Ward	guiseppe.pecoza@wales.nhs.uk	22/04/2022	stuart rookes
27/04/2021	A5	18	Harriet Nawrocki	A5	Hannah.Nawrocki@wales.nhs.uk	27/04/2022	stuart rookes
28/04/2021	A2	50	James Parsons	A2	James.parsons@wales.nhs.uk	28/04/2022	stuart rookes
28/04/2021	A2		Laura Bonelle	A2	Laura.bonelle@wales.nhs.uk	28/04/2022	stuart rookes
29/04/2021	SAU	38	Sally Pearson	SAU	sally.oxenham@wales.nhs.uk	29/04/2021	stuart rookes
29/04/2021	SAU		Lyndsay Armour	SAU	lyndsay.amour@wales.nhs.uk	29/04/2021	stuart rookes
29/04/2021	SAU		Rhian Evans	SAU	rhian.evans52@wales.nhs.uk	29/04/2021	stuart rookes
30/04/2021	B2N	31	Laura James	B2N	laura.james@wales.nhs.uk	30/04/2022	stuart rookes
04/05/2021	East 4	40	Samantha Baker	East 4	Samantha.Baker@wales.nhs.uk	04/05/2022	stuart rookes
	Total	261					

Table 8

Mandatory July Fire Training Organised by Learning, Education and Developments

		Reg	10.00 - 11.00	11.10 - 12.10	1.00 - 2.00	2.10 - 3.10
Mon 5/07/2021	Cochrane Building, 5, 6 & 7	09.30 - 10.00	Fire	HS	IPC	VAW
		Reg	10.00 - 11.00	11.10 - 12.10	1.00 - 2.00	2.10 - 3.10
Wed 07/07/2021	Cochrane Building, 2 & 4	09.30 - 10.00	Fire	HS	IPC	Equality
		Reg	10.00 - 11.00	11.10 - 12.10	2.00 - 3.00	
Mon 12/07/2021	Lecture Theatre 3, Main Hospital	09.30 - 10.00	Fire	HS	Equality	
		Reg	10.00 - 11.00	11.10 - 12.00	2.00 - 3.00	
Thurs 15/07/2021	Lecture Theatre 3, Main Hospital	10.00 - 10.30	HS	Fire	IPC	
		Reg	10.00 - 11.00	11.10 - 12.10	1.00 - 2.00	2.10 - 3.10
Tues 20/07/2021	Cochrane Building, 2 & 4	09.30 - 10.00	Fire	HS	IPC	Equality
		Reg	1.00 - 2.00	2.10 - 3.10	3.20 - 4.20	
Fri 23/07/2021	Cochrane Building, 5, 6 & 7	12.30 - 1.00	HS	Equality	IPC	
		Reg	10.00 - 11.00	11.10 - 12.10	1.00 - 2.00	2.10 - 3.10
Mon 26/07/2021	Cochrane Building, 5, 6 & 7	09.30 - 10.00	Fire	HS	IPC	Equality

Table 9

Fire Team Training Commitments
May 2021 to March 2022

Fire Team Training Commitments						
Hospital Name	Date	Training Requestor	Department	Name of Training	Name of Trainer	Cancelled
UHW	06/05/20	Nicola Giles	Health Care Workers	Fire Training	SR/SB	
UHL	10/05/2021	Casey Keegans	Mental Health Staff	Fire Training	BP	
UHL	12/05/2021	Nicola Giles	Health Care Workers	Fire Training	BP	
UHL	14/05/2021	Nicola Giles	Health Care Workers	Fire Training	BP	NG Cancelled
UHL	17/05/2021	Nicola Giles	Health Care Workers	Fire Training	BP	
UHL	20/05/2021	Nicola Giles	Health Care Workers	Fire Training	BP	NG Cancelled
UHL	24/05/2021	Nicola Giles	Health Care Workers	Fire Training	BP	
UHL	27/05/2021	Nicola Giles	Health Care Workers	Fire Training	Ben Perrett	NG Cancelled
SDH	28/05/2021	Wendy Davies	Dieticians	Fire Training	SR	
SDH	03/06/2021	Wendy Davies	Dieticians	Fire Training	SR	
UHL	04/06/2021	Casey Keegans	Mental Health Staff	Fire Training	SR	
UHL	07/06/2021	Casey Keegans	Mental Health Staff	Fire Training	SR	
UHW	16/06/2021	Emma Stone	Dental	Fire Training	SR/SB	
UHL	16/06/2021	Casey Keegans	Mental Health Staff	Fire Training	SR	
UHL	18/06/2021	Casey Keegans	Mental Health Staff	Fire Training	BP	
UHL	18/06/2021	Casey Keegans	Mental Health Staff	Fire Training	SR	
UHW	22/06/2021	Rebecca Cobin	LED	Fire Warden Training	SR/SB/BP	
UHL	23/06/2021	Casey Keegans	Mental Health Staff	Fire Training	SR	
UHW	25/06/2021	Emma Stone	Dental	Fire Training	SR/SB	
UHL	26/06/2021	Casey Keegans	Mental Health Staff	Fire Training	BP	
UHW	29/06/2021	Emma Stone	Dental	Fire Training	SR/SB	
UHW	05/07/2021	Rebecca Cobin	LED	Fire Training	SB	
UHW	07/07/2021	Rebecca Cobin	LED	Fire Training	SB	
UHL	09/07/2021	Casey Keegans	Mental Health Staff	Fire Training	SR	
UHW	12/07/2021	Rebecca Cobin	LED	Fire Training	SB	
UHL	12/07/2021	Casey Keegans	Mental Health Staff	Fire Training	SR	
UHL	13/07/2021	Casey Keegans	Mental Health Staff	Fire Training	SR	
UHL	14/07/2021	Casey Keegans	Mental Health Staff	Fire Training	SR	
UHW	15/07/2021	Rebecca Cobin	LED	Fire Training	SB	
UHL	16/07/2021	Casey Keegans	Mental Health Staff	Fire Training	SR	
UHL	06/07/20221	Casey Keegans	Mental Health Staff	Fire Training	SR	
UHW	20/07/2021	Rebecca Cobin	LED	Fire Training	SR	
CHOW	20/07/2021	Julie Armstrong	Childrens Intensive Care	Fire Training	SB/SR	
UHL	21/07/2021	Casey Keegans	Mental Health Staff	Fire Training	SR	
UHW	23/07/2021	Rebecca Cobin	LED	Fire Training	SR	
UHW	26/07/2021	Rebecca Cobin	LED	Fire Training	SR	
UHL	28/07/2021	Casey Keegans	Mental Health Staff	Fire Training	SR	
UHW	17/09/2021	Emma Stone	Dental	Fire Training	SR/SB	
UHW	21/09/2021	Rebecca Cobin	LED	Fire Warden Training	SR/SB/BP	
UHW	24/09/2021	Emma Stone	Dental	Fire Training	SR/SB	
UHW	23/11/2021	Rebecca Cobin	LED	Fire Warden Training	SR/SB/BP	

Welsh Health and Technical Memorandum – 05-01 Managing Healthcare Fire Safety

Table F1 Page 18 - Exemplar training needs matrix

Table 10

Table F1 Exemplar training needs matrix

Key: a = upon commencement of work in an area x = upon commencement of work for the organisation 12 = 12-month interval between training 24 = 24-month interval between training 36 = 36-month interval between training Note: Where a member of staff has attended a fire lecture in theprevious 12-month period, the use of e-learning is not required. The use of e-learning for fire safety training is described inChapter 11; it should not be used as the sole method of delivering fire safety training.	Fire safety induction (Local)	Fire safety induction (Corporate) 45 minutes)	General fire safety (e-learning)	General fire safety (classroom session) (30 minutes)	Combustibles, flammables & equipment (15 minutes)	Fire safety including medical gases (30 minutes)	Fire & smoke spread etc (30 minutes)	Using fire extinguishers (Practical) (1 hour)	Fire evacuation drill	Assisting independent patients & visitors. (15 minutes)	Evacuating dependent patients (Theory) (30 minutes)	Evacuating dependent patients (Practical) (1 hour)	Evacuating very high dependency patients (Theory)(30 mins)	Evacuating very high dependency patients (Practical) (1 hour)
An administrator that works in an office and does not enter patientor public access areas as part of their role	a	x	12	36					12					
An administrator that is ward-based or often enters ward areas	a	x		12						12				
A member of ward housekeeping staff	a	x		12	12					12				
A member of the food delivery catering staff.	a	x		12	12					12				
A member of the nursing staff on a general ward.	a	x		12		12					12	24		
A member of nursing staff on a critical care unit.	a	x		24		24	24	24					24	24
A member of working in an operating theatre	a	x		24		24	24	24					24	24

Appendix 2

HYC – SWFRS Enforcement Notice

Action Plan

Actions	Who is responsible to complete	Date completed
EN3/21 Timescale for completion 17th May 2021 Smoking policy not being adequately managed		
1. Evidence of illicit smoking found throughout the premises	Dr Mark Jones Directorate Manager Paul Williams Deputy Directorate Manager **MJ/PW**	12/05/2021
2. Ensure that **smoking and ignition sources** are controlled and monitored	**MJ/PW**	12/05/2021
3. All ozilite flameless cigarette lighter to be repaired	**MJ/PW** to raise an MR Estates to carry out repairs Paul has raised an order to purchase 10 ozilite flameless cigarette lighters as a floating stock to enable any damaged device to be speedily replaced. Six repaired. Parts for other 4 on order. Delivery due 14/6/21	18/6/2021
4. Evidence that all staff are adhering to the Daily on-site Environment/Fire Safety Check List V0.1/Feb'1	**MJ/PW**	12/05/2021
5. Metal smoking bins to be located in the courtyards	**MJ/PW**:- On order 5 to 10 working days delivery	04/06/2021
6. Cleaning regime to be increased	Mark Branch Estates Engineering Manager **MB**	12/05/2021

Actions	Who is responsible to complete	Date completed
EN4/21 Timescale for completion 20th July 2021		
1. Fire and smoke resisting doors were being held in the open position with wedges	**MJ/PW**: - Audit on operation of automatic floor springs to be completed by 28th May. Remedial works will be carried out as required. All works to be completed within two weeks dependant on parts required / delivery.	11/06/2021
2. Emergency exit doors between the enclosed secured compound areas cannot be easily and immediately opened in an emergency	Chris Watts Deputy Estates Manager Peter Cox Acting Supervisor **CW/PC**	04/06/2021
3. The fire alarm system is inadequately maintained	**CW/PC** Carry out routine maintenance in conjunction with C&V UHB incumbent fire alarm engineers	04/06/2021
4. Multiple cross corridor Fire resisting doors propped open by using blocks of 2x 4 sections of wood.	**CW** On-site carpenter has identified automatic hold open devices currently fitted to these door sets are defective. **CW** to raise MR's to enable repairs to be carried out as a matter of priority	11/06/2021

Report Title:	**7.4 Environmental Health Inspection Report**						
Meeting:	Health and Saftey Committee				**Meeting Date:**	27/07/2021	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**	√	**For Information**
Lead Executive:	Director of Finance						
Report Author (Title):	Director of Capital, Estates and Facilities						

Background and current situation:

It is a legal requirement that each hospital / food unit is registered as a food premises with the Local Authority and are therefore subject to an inspection by the Environmental Health Officers (EHO).

During the pandemic, EHO inspections of these facilities were suspended. The risk to the inspectors was deemed an unacceptable risk as they would be required to visit the sites to undertake the inspection.

Since March 2021 the process has recommenced and the following UHB premises have been visited and inspected;

Premises	Inspection Date	Previous rating	Current rating	Description of Rating
Central Food Processing Unit, (CFPU), UHW	17/03/2021	4	3	Generally Satisfactory
Aroma Coffee Outlet – Barry Hospital	27/05/2021	N/A	5	Very Good
Barry Hospital – Ward Based Catering	27/05/2021	5	5	Very Good
Cardiff Royal Infirmary	03/06/2021	N/A	5	Very Good
Terry Bear Nursery - UHW	07/07/2021	5	5	Very Good

The Central Food Processing Unit (CFPU) rating of 3 falls below the Health Boards expectations of food hygiene ratings of 5/4 (very good and good). The other inspected areas have achieved the required standards of the UHB.

On receipt of the respective reports, action plans were developed to address issues raised. These action plans are attached to the report for information purposes.

CFPU;
The Local Authority Officer advised that works required to meet the environmental standards needed to be completed within ten weeks from the date of their report. Due to the nature and complexity of the works, the timescale could not be met and the UHB advised the EHO and requested an extension of time to complete certain elements. Confirmation has been received that this is acceptable.

Further to the initial inspection on 17th March 2021, an additional two visits to review the CFPU Product Recall Procedure and a Re-visit Inspection were undertaken on 12th April and 29th April 2021 respectively by the EHO.

The action plan was revised to include both reports dated 13th April and 8th May 2021 with the actions required to redress the issues raised.

Executive Director Opinion /Key Issues to bring to the attention of the Board/ Committee:

- The acknowledgement of the achievement of premises of a score of 5 food hygiene rating and the supporting action plans.
- The acknowledgement that the Central Food Processing Unit inspection did not achieve the expectations of the University Health Board.
- The works that has been instigated in a short period of time to implement the required close out of the action plan that addresses the concerns raised by the report in relation to the CFPU.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

To allow the service to fall below a 3 Food Hygiene Rating would provide significant reputational damage to the UHB.

Failure to comply with the actions highlighted within the CFPU action plan could potentially result in closure of the unit and the cessation of food production at the UHW site, until remedial action is taken. This would result in a significant financial cost for providing the services from other sources plus potential significnat reputational damage to the organisation.

The works to the structure of the building to comply with the action plan to date is circa £240,000 including VAT.

The works carried out to date have been completed with no material impact on the service provided to the patient and has been managed with the cooperation of the dieticians.

Recommendation:

The Health and Safety Committee are asked to:

NOTE the content of the report and the achievements of those facilities with a Food Hygiene Rating of 5

NOTE the failing of the CFPU to achieve an acceptable rating of 4/5

SUPPORT The work undertaken identified in the action plan to ensure that the facility meets the standards required by the EHO.

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

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

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

Appendix 1

Action Plan from Food Safety Inspection for Central Food Production Unit (CFPU), UHW Undertaken on 17th March 2021 (Report dated 31st March received on 1st April 2021)

Schedule A – Legal Requirements

Food Hygiene and Safety Procedures Some non-compliance with statutory obligations and industry codes of recommended practice* that are not considered significant in terms of risk (but may become significant if not addressed). Standards are being maintained or improved. *(*Where a relevant code / industry guide has been published.)*	**Response / Action**	**Time Scale**	**Lead Responsibility**	**Update**
Goods In 1. In Freezer 1 there was a box of Spotted Dick Puddings whose outer cardboard packaging was damaged – the individual packages of the desserts appeared intact however they were dented. Please ensure that checks at goods in identify these issues and take appropriate action. Article 5 (1) of Regulation (EC) No 852/2004  Saunders,Nathan 07/20/2021 14:14:26	Food items to be disposed of. Stores person to receive refresher retraining in receiving of goods and corrective action to be taken. Goods in checks will be monitored daily. Supervisor 'Daily Check' list will be created and implemented.	Immediate 9th April 2021 Immediate 15th April 2021	Catering Services Manager Catering Services Manager Asst. Team Manager Team Manager	Completed Completed Completed Completed

Dry Store 2. There was an opened pack of chocolate chips. There was no end use date applied to the product. The manufacturer's instructions (e.g. use by once opened) or your own stock control policy should be applied to each label to facilitate stock rotation. Clare Stock stated at the time of inspection that all products in this dry store should be stored unopened. Please review your policy. Article 5 (1) of Regulation (EC) No 852/2004	Food items to be disposed of. The Food Safety Statement within the HACCP document will be reviewed and amended to reflect requirement for Dry Stores. In-house training to be delivered for all CFPU ref. stock management.	Immediate 15th April 2021 30th April 2021	Asst. Team Manager Team Manager Catering Services Manager	Completed Completed Completed
Low Risk Chiller 3. As above, the following items were open but had no end use by date on the attached label. Gravy browning, garlic puree, ginger puree. Article 5 (1) of Regulation (EC) No 852/2004	Food items to be disposed of. The Food Safety Statement within the HACCP document will be reviewed and amended to reflect requirement for Chiller. In-house training to be delivered for all CFPU staff ref. stock management.	Immediate 15th April 2021 30th April 2021	Asst. Team Manager Team Manager Catering Services Manager	Completed Completed Completed
Pot Store 4. Condensation was accumulating in clean plastic storage containers and lids when stacked. This is due to the equipment not being dried properly before stacking. This will encourage the growth of microorganisms. Ensure that	Instruction given to staff to ensure all items are stored in dry condition.	Immediate	Asst. Team Manager.	Completed

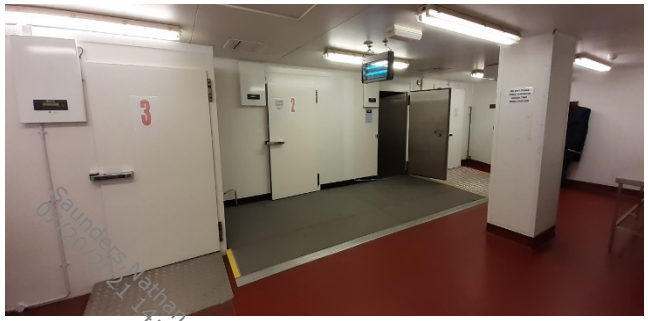
all equipment is dried thoroughly before being placed in storage. Regulation (EC) No 852/2004 Annex II Chapter IX paragraph 3	Blue paper holder in situ. Additional blue paper towel holder to be installed via Estates Maintenance. Daily Equipment check list will be introduced and monitored by supervisors.	22nd April 2021 15th April 2021	Team Manager Team Manager	Completed Completed
Lift Area 5. Outdoor clothing (coats/jackets) were stored on top of food storage boxes adjacent to the goods lift. This presents a hazard of contamination. Ensure staff use the facilities provided for clothing. Regulation (EC) No 852/2004 Annex II Chapter IX paragraph 3 	Instruction given to staff to not store outdoor clothing on top of food storage boxes and to use Facilities available.	Immediate	Asst. Team Manager	Completed

Structural / Cleaning Issues Some non-compliance with statutory obligations and industry codes of recommended practice* that are not considered significant in terms of risk (but may become significant if not addressed). Standards are being maintained or improved. *(*Where a relevant code / industry guide has been published.)*	**Response / Action**	**Time Scale**	**Lead Responsibility**	**Update**
Meat Decanting Room 6. At the time of our visit there was no water supply to the hand wash basin to the Meat Decanting Room. The room was not in use. Staff informed us that it was working earlier that day and thought that there must be some works being carried out that had interrupted supplies. Ensure that a full supply of hot and cold water is returned to the hand wash basin and investigate the cause of this failure to prevent a future occurrence. Regulation (EC) No 852/2004 Annex II Chapter I paragraph 4	Instruction given to staff to ensure all hand wash basin and sinks are tested in the morning daily to ensure hot and cold water supply. Hot water checks for WHB and equipment sinks will be included on the Supervisor Daily check lists. N.B. It should be noted that contractor works on staff changing rooms down stairs had interrupted the hot water flow on the day. EHO's were informed.	Immediate 15th April 2021	Team Manager Team Manager	Completed Completed
7. The seal at the wall floor junction of the meat decanting room was damaged and should be repaired or replaced. Regulation (EC) No 852/2004 Annex II Chapter II paragraph 1 a & b	Maintenance request submitted to Estates Maintenance for repair. Estates to complete repair fully.	22nd April 2021	Catering Services Manager / Estates Manager	Completed

8. There are three chillers in this area – Meat Room 1, Meat Room 2 and Poultry Room, All showed signs of internal damage due to wear and tear. Areas of mould growth and dirt were observed in hard to reach areas, corners, wall/floor junctions, wall/ceiling junctions, edging of panelling, fan guards, etc. Carry out works to make good any damage and thoroughly clean and disinfect these rooms. Recladding/ fitting these rooms is the best option due to their age. Regulation (EC) No 852/2004 Annex II Chapter I paragraph 1 	Thorough and regular cleaning of area to be undertaken. Maintenance request submitted to Estates Maintenance for repair. Estates to complete repair fully. Area to be surveyed for full recladding of chillers in this area and work undertaken via Estates & Planning.	Immediate 22nd April 2021 21st June 2021	Asst. Team Manager Catering Services Manager / Estates Manager Catering Services Manager / Estates Manager	Completed Completed Completed
Low Risk Area / Low Risk Chiller 9. The first chamber of the chiller was out of order. Ensure that this unit is returned to working order. Regulation (EC) No 852/2004 Annex II Chapter I paragraph 1	Maintenance request submitted to Estates Maintenance for repair. Repair completed but unit required further attention hence out of order. Estates to complete repair fully.	22nd April 2021	Catering Services Manager / Estates Manager	Completed
10. The ceiling was dirty to the rear of the fan unit and the fan unit was also dirty. This must be thoroughly cleaned and disinfected. 	Thorough and regular cleaning of area to be undertaken. Maintenance request submitted to Estates Maintenance for review /	Immediate 22nd April 2021	Asst. Team Manager Catering Services Manager	Completed Completed

Regulation (EC) No 852/2004 Annex II Chapter I paragraph 1	repair following cleaning. Estates to advise and complete repair fully.		/ Estates Manager	
11. There is a small square of panelling in the wall of the low risk chiller, which has been dislodged and requires replacing. Regulation (EC) No 852/2004 Annex II Chapter II paragraph 1 b	Maintenance request submitted to Estates Maintenance for repair. Estates to complete repair fully.	22nd April 2021	Catering Services Manager / Estates Manager	Completed
High Risk Area 11. The handset of the telephone adjacent to the cooking area was dirty. This is a touch point for pathogenic bacteria etc. in addition to COVID 19. This handset requires disinfection after each use.  Regulation (EC) No 852/2004 Annex II Chapter II paragraph 1f	Thorough and regular cleaning of phone to be undertaken.	Immediate	Asst. Team Manager	Completed

13. The handle of the water hose spray attachment used to clean the boiler was dirty. Thoroughly clean and disinfect this the handle. Regulation (EC) No 852/2004 Annex II Chapter II paragraph 1 f	Thorough and regular cleaning of spray attachment to be undertaken.	Immediate	Asst. Team Manager	Completed
14. The condition of utensils which were stored on racking in a tray was poor, including the damaged white handle of knife, a cracked yellow handle of a knife and a worn wooden handle of a knife. I was advised by staff that these utensils are no longer used. I required that these were removed and disposed of. The condition of utensils has been raised at previous inspections and failure to manage this issue will negatively impact your "confidence in management" score at the next inspection. Regulation (EC) No 852/2004 Annex II Chapter V paragraph 1 b 	Items of small equipment removed and discarded. Daily Equipment check list will be introduced and monitored by supervisors.	Immediate 15th April 2021	Asst. Team Manager Team Manager	Completed Completed
15. The soap dispenser in the pot wash area was not working. There was a soap cartridge in place. The failure was mechanical.	A replacement hand soap dispenser will be installed.	15th April 2021	Asst. Team Manager	Completed

Ensure that there is always an adequate supply of hand washing facilities to every hand wash basin. There were other basins available in this room. Regulation (EC) No 852/2004 Annex II Chapter I paragraph 4	Hand soap dispenser checks will run parallel to the daily wash hand basin checks.	15th April 2021	Team Manager	Completed
16. The condition of the black paint was flaking in places on the painted legs and lower support posts of preparation tables. Please renew these surfaces to ensure that they remain in a sound easy to clean condition. Regulation (EC) No 852/2004 Annex II Chapter V paragraph 1 b	Maintenance request submitted to Estates Maintenance for repainting. Estates to complete fully. Tables to be replaced in area.	22nd April 2021 21st June 2021	Catering Services Manager / Estates Manager Catering Services Manager / Estates Manager	Completed Completed
Blast chill room 17. The fly killing unit to this room is situated above where trolleys of open food are transported into the chilling units 1 & 2. This presents a hazard of contamination. Relocate this unit to a location where there is no risk of contamination. Replacing electrified units with sticky pads will mitigate this hazard. Regulation (EC) No 852/2004 Annex II Chapter IX paragraph 3  Holding Freezer 2	Request submitted to Estates to relocate existing insecta flash. Estates to complete fully. N.B. Alternatives being explored with main Pest Control Contractor including sticky pads. This will need to be fully assessed and reviewed as implications to all catering areas which number in excess of 100.	29th April 2021	Catering Services Manager / Estates Manager	Completed

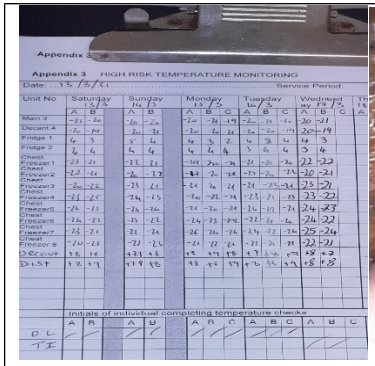
18. The painted floor to this area was badly worn in most areas. There was also a strip of floor sealant peeling away at the entrance to the holding freezer. This floor surface should be renewed. Regulation (EC) No 852/2004 Annex II Chapter II paragraph 1 a	Maintenance request submitted to Estates Maintenance for repair of strip of floor sealant. Estates to repair fully. **N.B.** Clarity to be sought from EHO's regarding the holding freezer referred to. Holding freezer 2 has had floor replaced previously in 2020. The main storage holding freezer is no. 3 where the observation is probably applicable to (?). The renewal of the floor surface in the main holding freezer will be a major undertaking. Plans will be developed to undertake necessary works which will have impact to food production cycle. Further discussion to be held with EHO's. Major works to be progressed to floor.	22nd April 2021 21st June 2021	Catering Services Manager / Estates Manager Head of Catering Services / Catering Services Manager	Completed Completed
19. The strip curtains to the holding freezer were damaged and require replacement. Regulation (EC) No 852/2004 Annex II Chapter I paragraph 1	Upon review this refers to holding freezer 3 not 2. Strip curtain to be replaced via Estates and maintenance request.	29th April 2021	Catering Services Manager	Completed
Lift Area 20. The internal surfaces of the goods lift carriage requires cleaning. Regulation (EC) No 852/2004 Annex II Chapter I paragraph 1	Thorough and regular cleaning of goods lift to be undertaken.	Immediate	Asst. Team Manager	Completed

	Cleaning schedule will be reviewed to ensure daily monitoring of area.	15th April 2021	Team Manager	Completed
Decanting Room 21. An electric fly killer unit was located above “the ready to eat products decant table”. This presents a hazard of contamination. This unit presents a hazard of dead insects landing in ready to eat food. Remove the unit from its current location. The use of a sticky pad to the rear of the UV light unit will mitigate the risk associated with this hazard. Regulation (EC) No 852/2004 Annex II Chapter IX paragraph 3 	Upon review, the decant tabling has been relocated away from under the insect flash unit negating the need to relocate the unit.	Immediate	Asst. Team Manager	Completed
External Area 22. The housekeeping area outside the goods dock is badly maintained. There was an accumulation of leaves and debris around and under the compactor and an accumulation of litter and packing waste around the cold store unit. This will attract and provide harbourage for pests. Ensure that this area is always kept clean. Regulation (EC) No 852/2004 Annex II Chapter I paragraph 1	Thorough and regular cleaning of area to be undertaken. Liaison with Waste Management / Contractor to be undertaken in order to gain access in, under and around waste card compactor to clean thoroughly and safely. Further clean completed.	Immediate 31st May 2021	Asst. Team Manager Catering Services Manager / Estates Manager	Completed Completed

23. The lid to the waste wheelie bin was left open and black waste bags were exposed. Ensure that waste is kept covered as required. Regulation (EC) No 852/2004 Annex II Chapter VI paragraph 2	Staff re-instructed to ensure waste bin lids are kept closed.	Immediate	Asst. Team Manager	Completed
Confidence in Management / Control Procedures	**Response / Action**		**Lead**	**Update**

Satisfactory record of compliance. Access to relevant food safety advice source and/or guides to good practice or assurance scheme commensurate with type of business. Understanding of significant hazards and control measures in place. Has implemented satisfactory food safety management procedures or is making satisfactory progress towards documented food safety management procedures, commensurate with type of food business. Making satisfactory progress towards documented food safety Management procedures commensurate with type of business. A score of 10 can be awarded for more than one intervention cycle if: • the previous non-compliances have been addressed but different non-compliances have arisen; and, • the overall risk has not increased.		**Time Scale**	**Responsibility**	
Local implementation Goods In 24. During my discussion with Steve O'Grady regarding the Goods In procedures it was established that Steve prefers not to use an infra-red thermometer. He uses his hands and checks if he believes the product is not cold enough. Steve will do a destructive test with a temperature test if he believes that the product is not cold enough. While the senses are an important asset, this method is outside the scope of your own procedures. Please provide training for Goods In staff on the correct procedures. The use of a between pack probe may be beneficial where borderline results are found using an infrared thermometer. Regulation (EC) No 852/2004 Article 5 paragraph 2 d Regulation (EC) No 852/2004 Annex II Chapter XI paragraph 1	Member of staff met with to outline and review initial verbal findings from EHO's and inspection. Member of staff instructed to follow and adhere to existing HACCP procedures. Follow up meeting to be held on receipt of report to discuss points raised by EHO's. Staff member to be retrained on SOP's for 'Receiving Deliveries & Distribution to Stores' and 'Stock Control, Delivery & Storage.'	Immediate 9th April 2021	Catering Services Manager Catering Services Manager	Completed Completed

	Additionally, correct use of laser probe and needle probes. (Further follow up to be undertaken with staff member). Although member of staff in receipt of Level 2 Food Hygiene certificate (August 2019), he will undertake certified food hygiene training again.	21st June 2021	Catering Services Manager	Delayed due to staff member off work.
25. Freezer 5 and 6 in the decanting room were in the process of defrost. It is not clear why.	Freezer defrost cycles will be checked.	Immediate	Asst. Team Manager	Completed
26. The noon checks had been completed and were recorded at -23°C and -22°C. Freezer 5 contained fish portions and temperatures ranged from -9.1°C to -2.6°C. Freezer 6 contained omelettes and had a range of 2.6°C to -0.1°C. Once identified the food was disposed of. Please retrain staff in monitoring procedures and increase supervisory checks until you are satisfied that checks are carried out thoroughly. Regulation (EC) No 852/2004 Article 5 paragraph 2 Regulation (EC) No 852/2004 Annex II Chapter XII paragraph 1 Saunders,Nathan 07/04/2021 14:14:26	Food items to be disposed of. Matter will be followed up and further investigated. Notwithstanding above, staff will be retrained and re-instructed in the taking and recording of temperatures in adherence to HACCP policy. This will include reporting any discrepancies to Management. Supervisors to monitor as part of daily checks.	Immediate 22nd April 2021 22nd April 2021	Asst. Team Manager Catering Services Manager Team Manager	Completed Completed Completed

 				
Please Note 27. Cardiff & Vale University Health Board has a Primary Authority Agreement in place with Shared Regulatory Services. The HACCP and associated food safety procedures are under ongoing review as part of the primary authority agreement. This inspection focused on local implementation of food safety procedures rather than the suitability of the HACCP itself. I have not yet been involved in this partnership due to demands on the service. To maintain consistency, I will discuss my observations thoughts with my colleagues Leah Harris and Rhian Carter who have provided advice and put them in writing to you once reviewed.	Liaison to continue with PAP Team in Shared Regulatory Services. Information requested on day of inspection i.e. Lab Test results, current HACCP documentation and product recall examples forwarded to EHO's.	Immediate Immediate	Catering Services Manager Catering Services Manager / Team Manager	Progressing Completed

Schedule B – Recommendations and Advice

Recommendations	Response / Action	Time Scale	Lead Responsibility	Update
1. Blue coloured dishwasher rack – has slightly deteriorated/worn plastic – monitor condition of dishwasher racks.	Replacement racks to be purchased.	30th April 2021	Team Manager	Completed
2. Where rooms such as the portioning room are temperature controlled, consider placing an air lock doorway system to prevent changes in temperature at busy times.	Discussion to be held in Capital, Estates & Facilities Service Board between Senior managers.	July 2021	Head of Catering Services	Subject to further discussion with Food Safety Advisor.
3. Blue is the colour code worn by staff in Low Risk – Decant. In the Meat decant area a blue disposable apron is worn over the blue cloth apron worn by staff. I recommend that this is reviewed. A white plastic apron worn over the blue cloth apron in the meat decant room will assist staff in preventing cross contamination. I anticipate that when busy, it will be very easy for staff to work between the two areas and forget to remove the disposable apron.	Disposable red aprons to be purchased and implemented for meat decanting in the meat room only. Following discussions with Food Safety Assurance Manager on 26th April, decision agreed that new yellow disposable aprons to be used in meat decanting area.	15th April 2012 30th April 2021	Catering Services Manager Assistant Team Manager	Completed Completed
4. I strongly recommend that you increase the frequency of audit at this unit.	Increased weekly audits to be implemented and undertaken by management.	15th April 2021	Catering Services Manager	Completed
5. The rooms adjacent to High Risk including the room where liquid feeds are kept are large cluttered and mostly undisturbed. This is an ideal location for pests to prosper. I strongly recommend that the area is decluttered and regular checks are carried out for pests in this area.	Area to be decluttered and items removed via waste management. Regular checks as part of audit to be undertaken.	29th April 2021 15th April 2021	Catering Services Manager Catering Services Manager	Completed Completed

	Response / Action			Update

Additional Visits by Local Authority Officer with Recommendations		Time Scale	Lead Responsibility	
Product Recall Procedure visit (12th April 2021) – report dated 13th April 2021 attached (Schedule B – Appendix 1). 727102 Letter re product recall notifi	Actions agreed to redress issues: • Product Recall Procedure to be amended to reflect requirement. • Full CFPU HACCP review to be undertaken. • Standard Operating Procedure (SOP) for CFPU – SOP 04 "Procedure for Undertaking Weekly Environmental & Food Samples" and "Procedure for the Recall of Food Products" to be completed. • Review SOP for Sampling Program *per se*. • Undertake aggressive review of environmental sampling and failed listeria results.	17th May 2021	Catering Services Manager / Food Safety Assurance Manager	Completed
Re-visit Inspection (29th April 2021) – report dated 8th May 2021 attached (Schedule B – Appendix 2). 727102__SRSFH003-Revisit Letter CFPU Saunders,Nathan 07/20/2021 14:14:26	Actions agreed to redress issues as per numbered listings: 1. Cease current practice of delivery of raw meat / poultry to the high risk (HR) area. Replace process as recommended. 2. Apply same controls for vegetables as no. 1. 3. Ensure dedicated PPE is provided to staff cleaning drains.	8th May 2021 8th May 2021	Catering Services Manager / Food Safety Assurance Manager	Completed Completed Completed

	Full review of cleaning methods to be completed. Re-contact chemical suppliers to assist with detailed cleaning schedule and implement.	17th May 2021	CPU Supervisors/ Catering Services Manager	
	4. Blue hosepipe to be stored on suitable mounted bracket.			
	5. Adjust hose pressure to avoid unnecessary water droplet splash back.	17th May 2021	CPU Supervisors	Completed
	6. Drain camera survey to be scheduled to report on condition to assist decision making process on renewal or repair to food manufacturing safety standards. All necessary equipment e.g. brushes to clean drains to be in place.	17th May 2021 23rd May 2021	Assistant Team manager Catering Services Manager	Completed Completed
	7. Drain survey to be undertaken as per no. 6.			
	8. Ensure as part of cleaning review that application of chlorine as a disinfectant at the end of the day prior to other cleaning processes is considered.	23rd May 2021 17th May 2021	Capital Planning Team Manager	Progressing - Drain survey delayed until 10/07/21. Completed
	9. Remove any redundant equipment from HR area.			
	10. Remove any pieces of equipment and utensils in HR area which have deteriorated e.g. stirring paddles. Audits to be in place to ensure food	8th May 2021 17th May 2021	Assistant Team Manager CPU supervisors	Completed Completed

	contact equipment is in a sound clean and easy to disinfect condition. 11. Undertake further audits of HR and other CFPU areas to ensure are in good repair. Any fails to be addressed during shutdown in June. 12. Full review of CFPU HACCP which identifies and addresses all hazards. 13. Carry out review of cleaning and disinfection at the CFPU. SOP to be amended to reflect any changes. 14. Implement informal training programme based on revised procedures and record attendance, etc. Training must reference Listeria, how to mitigate the hazard and how to destroy it.	8th May 2021 17th May 2021 15th June 2021 21st June 2021	Team Manager Catering Services Manager/ Food Safety Assurance Manager Catering Services Manager / Team Manager	Completed Completed Completed Part completed

Appendix 2

Action Plan from Food Safety Inspection for Barry Aroma Coffee Shop
Undertaken on 27th May 2021 (Report dated 4th June 2021 received on 4th June 2021)

Schedule A – Legal Requirements

Food Hygiene and Safety Procedures Some non-compliance with statutory obligations and industry codes of recommended practice* that are not considered significant in terms of risk (but may become significant if not addressed). Standards are being maintained or improved. *(*Where a relevant code / industry guide has been published.)*	**Response / Action**	**Time Scale**	**Lead Responsibility**	**Update**
1. The blue roll in the serving area was placed on the work top. As discussed this poses a risk of contamination as the blue roll becomes wet or dirty. You must ensure the blue roll is fitted into a designated dispenser. I was told that a dispenser has been requested. Regulation (EC) No 852/2004 Annex II Chapter IX para 3	A blue roll dispenser has been fitted and in use. Staff instructed to ensure this is used at all times	Immediate	Catering supervisor	Completed

Structural / Cleaning Issues Some non-compliance with statutory obligations and industry codes of recommended practice* that are not considered significant in terms of risk (but may become significant if not addressed). Standards are being maintained or improved. *(*Where a relevant code / industry guide has been published.)*	**Response / Action**	**Time Scale**	**Lead Responsibility**	**Update**
2. The joints to the rinser tap in the pot wash of the main kitchen were becoming dirty. Thoroughly clean and maintain in a clean condition. Regulation (EC) No 852/2004 Annex II Chapter I Para 1	This has been thoroughly cleaned and being maintained and monitored with daily visual inspections	Immediate	Catering supervisors	Completed

Confidence in Management / Control Procedures	Response / Action	Time Scale	Lead Responsibility	Update
Satisfactory record of compliance. Access to relevant food safety advice source and/or guides to good practice or assurance scheme commensurate with type of business. Understanding of significant hazards and control measures in place. Has implemented satisfactory food safety management procedures or is making satisfactory progress towards documented food safety management procedures, commensurate with type of food business. Making satisfactory progress towards documented food safety Management procedures commensurate with type of business. A score of 10 can be awarded for more than one intervention cycle if: • the previous non-compliances have been addressed but different non-compliances have arisen; and, • the overall risk has not increased.				
3. You have put in place a documented Food Safety Management Procedure based on HACCP principles. However, I would make the following observations: • The 6am preparation fridge temperature hadn't been recorded; • Whilst Megan probed the sausages to ensure a core temperature of 80˚C was reached, these checks weren't being recorded. You must ensure the cooking temperatures are recorded; • Ensure a disposable apron is worn by staff when traying up the bacon and sausage; Regulation (EC) 852/2004 Article 5	Staff instructed to ensure all verification forms are completed correctly, supervisors will monitor daily. Staff disposable aprons are in situ and staff instructed to use, supervisors will monitor daily.	Immediate Immediate	Catering Supervisors Catering supervisors	Completed Completed

Saunders,Nathan
07/20/2021 14:14:26

Schedule B – Recommendations and Advice

Recommendations	Response / Action	Time Scale	Lead Responsibility	Update
No contraventions noted at time of visit.				

Additional Visits by Local Authority Officer with Recommendations	Response / Action	Time Scale	Lead Responsibility	Update
No recommendations at this time.				

Appendix 3

Action Plan from Food Safety Inspection for Barry Hospital Kitchen
Undertaken on 27th May 2021 (Report dated 28th May 2021 received on 4th June 2021)

Schedule A – Legal Requirements

Food Hygiene and Safety Procedures Some non-compliance with statutory obligations and industry codes of recommended practice* that are not considered significant in terms of risk (but may become significant if not addressed). Standards are being maintained or improved. *(*Where a relevant code / industry guide has been published.)*	**Response / Action**	**Time Scale**	**Lead Responsibility**	**Update**
1. At the time of the inspection, unwashed salad items were being stored alongside washed salad items in the walk-in chiller. This poses a risk of contamination. You must ensure washed salad items are stored separate to unwashed salad items. You should also ensure the plastic sleeve on the cucumber is fully removed before washing the cucumber. Regulation (EC) No. 852/2004, Annex II, Chapter IX, Para 3	All salad items now stored separately once washed and stored in a separate sealed container	Immediate	Catering supervisor	Completed

Structural / Cleaning Issues Some non-compliance with statutory obligations and industry codes of recommended practice* that are not considered significant in terms of risk (but may become significant if not addressed). Standards are being maintained or improved. *(*Where a relevant code / industry guide has been published.)*	**Response / Action**	**Time Scale**	**Lead Responsibility**	**Update**
2. The joints to the rinser tap in the pot wash of the main kitchen were becoming dirty. Thoroughly clean and maintain in a clean condition. Regulation (EC) No 852/2004 Annex II Chapter I Para 1	The has been thoroughly cleaned and being maintained and monitored with daily visual inspections	Immediate	Catering supervisors	Completed
3. There are gaps down the middle of the double exit doors outside the office. Fully pest-proof this door and ensure you have adequate procedures in place to control pests and reduce the risk of pests from gaining access into the premises. Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 2(c)	Maintenance request submitted and works completed. Doors fitted with controls to prevent access to pests	11th June	Catering supervisors	Completed

Confidence in Management / Control Procedures Satisfactory record of compliance. Access to relevant food safety advice source and/or guides to good practice or assurance scheme commensurate with type of business. Understanding of significant hazards and control measures in place. Has implemented satisfactory food safety management procedures or is making satisfactory progress towards documented food safety management procedures, commensurate with type of food business. Making satisfactory progress towards documented food safety Management procedures commensurate with type of business. A score of 10 can be awarded for more than one intervention cycle if: • the previous non-compliances have been addressed but different non-compliances have arisen; and, • the overall risk has not increased.	**Response / Action**	**Time Scale**	**Lead Responsibility**	**Update**
4. You have put in place a documented Food Safety Management Procedure based on HACCP principles. However, I would make the following observations: • The fridge temperatures hadn't been recorded for the morning of the 27th May, as discussed, the temperatures should be checked first thing in the morning before any food preparation is undertaken • I would suggest stating that the Green board is used for washed fruit and salad to avoid staff using it for unwashed salad and fruit • Cold storage during service needs to be included on the flow chart, and chilled products should be kept chilled during service in line with the listeria guidance • Page 16 states to store raw products separately – you may wish to expand to describe the kinds of raw products for example raw meat, eggs etc you must also ensure that washed and unwashed fruit and salad are stored separately, there have been instances of washed and unwashed being stored together (as there was yesterday with salad items) • P19 the thawing of food would usually take place	Recording and completion of verification forms addressed with all staff Notice implemented and staff trained on the use of the green board A full review of the HACCP including flowchart document will be completed in liaison with the Food Safety Assurance Manager	Immediate 9th June 2021 30th June 2021	Catering Supervisors Catering supervisors Operational Services Manager Food Safety Assurance Manager	Completed Completed Progressing

prior to cooking so I would suggest moving this process step to after storage • The delivery of sandwiches and salads on the trolleys needs to be included in the HACCP chart, currently only hot food is covered Regulation (EC) 852/2004 Article 5				

Schedule B – Recommendations and Advice

Recommendations	Response / Action	Time Scale	Lead Responsibility	Update
No contraventions noted at time of visit.				

Additional Visits by Local Authority Officer with Recommendations	Response / Action	Time Scale	Lead Responsibility	Update
No recommendations at this time.				

Appendix 4

Action Plan from Food Safety Inspection Aroma Cardiff Royal Infirmary
Undertaken on 03rd June 2021 (Report dated 04th June 2021)

Schedule A – Legal Requirements

Food Hygiene and Safety Procedures Some non-compliance with statutory obligations and industry codes of recommended practice* that are not considered significant in terms of risk (but may become significant if not addressed). Standards are being maintained or improved. *(*Where a relevant code / industry guide has been published.)*	**Response / Action**	**Time Scale**	**Lead Responsibility**	**Update**
1. The box of disposable gloves was being stored on the side of the hand wash basin. As discussed, this poses a risk of contamination as the gloves may become splashed when staff wash their hands. You must ensure the gloves are stored away from sources of contamination. Regulation (EC) No 852/2004 Annex II Chapter IX para 3	Boxes of gloves to be moved from wash basin area. And placed in a dedicated place from now on. Staff to check each day nothing is left in the area and if so move immediately.	Immediate	Team supervisor	Completed
2. The air temperature of the sandwich display fridge varied from 3.8℃ to 8.1℃. Foods stored in this fridge are high-risk and				

will support the growth of food poisoning bacteria and/or their toxins. Your fridge must operate at a temperature that will keep high-risk foods at or below 5°C in line with the manufacturers storage instructions for sandwiches. You must either adjust the refrigerator, or store the sandwiches on higher shelves (which appeared to be colder at the time of my visit). Food Safety and Hygiene (Wales) Regulations 2006 Schedule 4 para 2 (1)	Remove all (Real wrap sandwich's) from the fridges and store in display cabinet or main fridge and customers can ask to purchase. Looking into purchasing fridges with doors to contain temperature control. Which will result in all sandwiches being in the guideline temp zone.	Immediate Immediate	Team supervisor Senior retail manager Head of catering services	Completed On going

Structural / Cleaning Issues Some non-compliance with statutory obligations and industry codes of recommended practice* that are not considered significant in terms of risk (but may become significant if not addressed). Standards are being maintained or improved. *(*Where a relevant code / industry guide has been published.)*	**Response / Action**	**Time Scale**	**Lead Responsibility**	**Update**
3. The level of ventilation in the store room housing the backup fridges and freezers was insufficient. Provide an additional means of mechanical or natural ventilation to this room. I was told that works are currently in hand to have additional ventilation provided. Regulation (EC) 852/2004 Annex II Chapter I para 5	Estates are placing fly screens over the windows which we then help with the ventilation going forward .	June 30th	Estates Manager/ Team supervisor Senior retail manager	Ongoing (Ordered)

Confidence in Management / Control Procedures Satisfactory record of compliance. Access to relevant food safety advice source and/or guides to good practice or assurance scheme commensurate with type of business. Understanding of significant hazards and control measures in place. Has implemented satisfactory food safety management procedures or is making satisfactory progress towards documented food safety management procedures, commensurate with type of food business. Making satisfactory progress towards documented food safety Management procedures commensurate with type of business. A score of 10 can be awarded for more than one intervention cycle if: • the previous non-compliances have been addressed but different non-compliances have arisen; and, • the overall risk has not increased.	Response / Action	Time Scale	Lead Responsibility	Update
4.You have put in place a documented Food Safety Management Procedure based on HACCP principles. However, I would make the following observations:				
• Some of the deliveries are coming via UHW or Woodlands House, your HACCP needs to reflect this;	Update HACCP book	Immediate	Team supervisor	Complete
• It wasn't always clear when a probe was being used to check the fridge and chiller temperatures instead of the digital display, ensure your records show when independent probe checks are being carried out	Keep probe in fridges at all time, Or use water bottle to take the temperature correctly.	Immediate	Team supervisor	Complete
• There is one sink in the serving area which is generally used for rinsing tomatoes and cucumber first thing (in a colander) then used to rinse utensils during service before	Update HACCP book	Immediate	Team supervisor	Complete

they are washed in the dishwasher, whilst a 2 stage clean was undertaken of the sink area, the dual using of the sink needs to be included in your HACCP; • The air temperature of the sandwich display was above 5 ℃ on the bottom 2 shelves where the sandwiches were being displayed, however the temperature was much cooler on higher shelves, ensure you are keeping the sandwiches on shelves capable of storing the sandwiches below 5 ℃. It was noted that the digital display on the display chiller was showing 3 ℃, therefore you can't rely on this for checking temperatures and an independent probe must be used, you HACCP needs to reflect this.	All sandwiches to be moved to the higher levels, Or Real wrap sandwiches to be moved to main fridge and taken out when needed.	Immediate	Team supervisor	Complete

Shared Regulatory Services
Gwasanaethau Rheoliadol a Rennir

Bridgend County Borough Council · Cardiff Caerdydd · Vale of Glamorgan Bro Morgannwg

Mr Simon Swanton
Lakeside CPU
University Hospital Of Wales
Heath Park Way
Heath
Cardiff
CF14 4XW

Gwasanaethau Rheoliadol a Rennir / Shared Regulatory Services

Deialu uniongyrchol / Direct line: **07710 763145**
Gofynnwch am / Ask for: **Paddy Horan**
Ein cyf / Our ref: C / **PH5 / 13.04.2021**
Eich cyf / Your Ref:
Dyddiad / Date: **13 April 2021**

REGULATION (EC) NO 852/2004
FOOD HYGIENE (WALES) REGULATIONS 2006
GENERAL FOOD REGULATIONS 2004 & REGULATION (EC) NO. 178/2002
FOOD HYGIENE RATING (WALES) ACT 2013
LAKESIDE CENTRAL PRODUCTION UNIT, UNIVERSITY HOSPITAL OF WALES, HEATH PARK WAY, HEATH, CARDIFF, CF14 4XW

I write with regard to the product recall, instigated by yourselves on the 20th October 2020 following the detection of *Listeria monocytogenes,* from a swab which was taken from a meat slicing machine on 13th October 2020. I understand the affected product was **Batch no.30 Roast Lamb** and possibly turkey.

I have discussed the incident with Stuart Davies - Catering Manager on the afternoon of Monday 12th April, together with my concerns and the best way forward. These are set out below.

I must impress upon you that the requirements of this letter must be complied with and failure to do so may jeopardise your status as an 'Approved Premises' under the relevant legislation.

1. When a food business operator instigates a product recall for the purpose of food safety, "*A food business operator shall immediately inform the competent authorities if it considers or has reason to believe that a food, which it has placed on the market may be injurious to human health*." Shared Regulatory Services (SRS) being the competent authority was not informed of this incident. Please ensure that your procedures are amended to reflect this requirement. Further reference is made below. My colleagues will provide you with an email

address which is monitored daily and a telephone number to call to make this process more straight forward.

EC Regulation 178/2002 Article 19 (3)

2. A file has been put together, which contains internal correspondence etc. regarding this incident. There does not appear to be any analysis of the source of contamination, or evaluation of the timeliness, or effectiveness, of the product withdrawal. It is essential that a review takes place in order to take steps to eliminate or mitigate the hazard. The effectiveness of your own procedures should also be evaluated and improvements made where any short comings are found. Stuart Davies has begun this process and has advised that he will update me when the review is complete.

   Regulation (EC) No 852/2004 Article 5 paragraph 2 (f)

3. I have reviewed the section "Controlling Listeria" in the HACCP document that you are currently working to, which is the March 2021 version. This document needs to be reviewed, together with the Standard Operating Procedure CFPU -SOP 04 "Procedure for Undertaking Weekly Environmental & Food Samples" together with CFPU "Procedure for the Re-call of Food products"

   In particular: -

   a) The corrective action for the detection of Listeria above the set values in the floor drains or on equipment is "*On receipt of adverse result from PHLS, supervisor must inform manager and product recall procedure implemented for all sites*" I believe that you have had at least 5 occasions in 2021 where Listeria was detected. To my knowledge there has not been a product withdrawal since the incident in October 2020.
   b) The corrective action in the same section, for the detection of Listeria on high risk equipment above the set values is *"Contaminated foods are removed from general population and marked clearly with 'Do Not Use' until further testing results and EHO advice are obtained"* However the guidance in the SOP states "*In the event that the product is unsuitable for consumption, the senior management team, Head of Commercial Services, the Commercial Services Manager and the Environmental Health Officer will be informed*". There is a disconnect between the two. If a food item fails microbiological testing, and is unfit for human consumption, a recall must be instigated as required. I would refer to my first point in this letter that the competent authority must be informed. A product recall

should mean the senior management are notified without delay to oversee the recall and Shared Regulatory Services should be notified as required.

c) In the sampling SOP the guidance is to escalate to senior management etc. These points are not exhaustive.

Please review this documentation to ensure that the corrective actions are realistic, effective, timely and consistent.

4. It is my opinion as discussed with Stuart Davies, that the sampling program needs to be urgently reviewed. The only environmental sampling that takes place throughout the CFPU is for Listeria. The focus of this sampling is on the 5 drains throughout the unit and a slicing machine. This is not adequate. The scope of sampling must include a full range of pathogens and hygiene indicators.

   Other measures such as the use of (ATP) Adenosine Triphosphate or Bioluminescence units / kits to confirm satisfactory cleaning, would further reinforce food safety.

   You must carry out a review of the sampling program together with the values set out in the HACCP and with your SOP's. The SOP for sampling lacks detail. This begs the question is there a detailed work instruction of sampling in the CFPU? If there is then please review to ensure that staff are familiar with the process and that the process is monitored as part of your own verification procedures. Poor sampling technique will lead to inaccurate results.

   Regulation (EC) No 852/2004 Article 5 paragraph 2 (f)

5. Listeria has been present in the CFPU for several years. This is not an acceptable position. During the period November 2015 to January 2018, Listeria was only detected once in and that was in July 2017. Providing the sampling was carried out effectively, this informs me that the presence Listeria is not inevitable.

   Examples of questions that must be asked are:

   - Are the drains in disrepair and are they able to harbour Listeria?
   - Is the cleaning process completed as required, with correct dilutions and contact times?
   - Is this checked as part of your verification procedures?
   - Is the source of Listeria external to the high-risk area? For example, are the wheels of the meat decant containers, introducing pathogens to the floor of the high-risk area?

- Are the mobile racks used to carry cooked meat from the ovens through to the chilling process cleaned adequately?
- Is the slicer becoming contaminated because steel trays holding chilled product are removed from the mobile racks and placed on to the work surface adjacent to the slicer?
- Are staff maintaining the correct hygiene procedures during production and cleaning. etc.

There is plenty of guidance on managing Listeria in food production units. Together with the review of environmental sampling you must conduct an aggressive review of the continued failed Listeria results.

Regulation (EC) No 852/2004 Annex II Chapter IX paragraph 3
Regulation (EC) No 852/2004 Article 5 paragraph 2 (f)

6. As indicated in my inspection letter following the inspection of the CFPU on the 17th March 2021, the inspection was based and assessed on local implementation. Primarily because we wished to spend as little time on site, to minimise the risk both to us and to your staff and patients. Also, because the HACCP has been under review by SRS and yourselves and was a work in progress, which has been delayed for several reasons including the pandemic. The documentation provided since the inspection, has identified that the current HACCP dated March 2021, together with the standard operating procedures, are not robust. To address this, you must complete a full HACCP review including the points already raised by the **17th May 2021**. I have not been involved in the Primary Authority process. I am happy to assist and answer questions etc. If you require further assistance based on the primary authority agreement on a paid-for basis, you should discuss any assistance that you may need with my colleagues. In the first place, Jemma Cox – Business Engagement Officer. Jemma is the Officer that oversees the PA agreement between SRS and the Health Board.
   Regulation (EC) No 852/2004 Article 5 paragraph 1 & 2.

Please note that failure to complete the necessary work within the time period given will result in further enforcement action being taken by this Authority. A copy of our Compliance and Enforcement Policy is available on request.

For any queries relating to this letter do not hesitate to contact me on the above number or by e-mail at phoran@valeofglamorgan.gov.uk

Saunders Lawman 07/05/2021 14:14:26

I am on leave until Wednesday 21st April 2021. Please contact my colleagues copied in on distribution.

Yours faithfully,

PADDY HORAN
Business Engagement & Training Officer

Shared Regulatory Services
Gwasanaethau Rheoliadol a Rennir

Bridgend County Borough Council · Cardiff Caerdydd · Vale of Glamorgan Bro Morgannwg

Mr Stuart Davies
Lakeside CPU
University Hospital of Wales
Heath Park Way
Heath
Cardiff
CF14 4XW

Gwasanaethau Rheoliadol a Rennir / Shared Regulatory Services
Deialu uniongyrchol / Direct line: **07710 763145**
Gofynnwch am / Ask for: **Paddy Horan**
Ein cyf / Our ref: C / **PH5 / 927101**
Eich cyf / Your Ref:
Dyddiad / Date:8th **May 2021**

Dear Mr Davies,

REGULATION (EC) NO 852/2004
FOOD HYGIENE (WALES) REGULATIONS 2006
GENERAL FOOD REGULATIONS 2004 & REGULATION (EC) NO. 178/2002
FOOD HYGIENE RATING (WALES) ACT 2013
LAKESIDE CENTRAL PRODUCTION UNIT, UNIVERSITY HOSPITAL OF WALES, HEATH PARK WAY, HEATH, CARDIFF, CF14 4XW

I write to confirm my revisit of the above premises carried out on the **29 April 2021** at 1.15 pm. This was in the presence of Ms Clare Stock, Mr Stuart Davies, and Mr Simon Swanton. Mr Simon Williams attended the closing meeting where the visit was discussed.

Listeria monocytogenes has been an unwelcome visitor at the Central Food Production Unit (CFPU) for several years. The records I have seen, indicate it was present as far back as 2012. It has been identified on the floor, in the drains and on equipment in the CFPU. It was found in cold desserts in 2015, which has led to the cessation of ready to eat food in the CFPU. Listeria was found in cooked meat in food in March 2018 and recently on a meat slicer in October 2020, which led to a product recall.
The primary focus of my revisit was the issue of Listeria, its introduction to the high-risk area of the CFPU, continued presence and methods in place to mitigate the hazard it presents.

Please find the food hygiene revisit report attached. Schedule A details the work needed to comply with food safety law. It is divided into three sections representing the three areas you are scored against for the Food Hygiene Rating Scheme. **Any issues that relate to hygiene and cleaning should be addressed as a matter of urgency. All other time scales will be found in the issues identified below.**

Please note that failure to complete the necessary work within the time given will result in further enforcement action being taken by this Authority. A copy of our Compliance and Enforcement Policy is available on request.

I intend to revisit the premises in approximately 2 weeks to check on compliance, progress and that those issues identified as urgent have been addressed. **Please note:** A new rating will not be given on this revisit. If you would like a re-rating, you must request one in writing.

For any queries relating to this letter do not hesitate to contact me on the above number or by e-mail at **phoran@valeofglamorgan.gov.uk .**

We are always keen to improve the services we provide and value the feedback we receive. If you wish to provide feedback on the inspection you received from us, please go to https://www.srs.wales/en/Tell-Us-What-You-Think/Tell-us-what-you-think.aspx and complete the SRS Inspection Survey.

Yours faithfully,

Paddy Horan, Business Engagement & Training Officer

Mae'r Cyngor yn croesawu gohebiaeth yn Gymraeg a Saesneg a byddwn yn sicrhau ein bod yn cyfathrebu â chi yn yr iaith o'ch dewis, boed yn Saesneg, yn Gymraeg neu'n ddwyieithog cyhyd â'n bod yn ymwybodol o'ch dewis. Cysylltwch â safonaucymraeg@bromorgannwg.gov.uk i nodi dewis iaith. Os na fyddwn yn derbyn eich dewis iaith, byddwn yn parhau i gyfathrebu â chi yn unol â'r weithdrefn bresennol. Ni fydd gohebu yn Gymraeg yn creu unrhyw oedi.

The Council welcomes correspondence in English or Welsh and we will ensure that we communicate with you in the language of your choice, whether that's English, Welsh or in Bilingual format as long as we know which you prefer. Please contact welshstandards@valeofglamorgan.gov.uk to register your language choice. If we do not receive your language choice, we will continue to correspond with you in accordance with current procedure. Corresponding in Welsh will not lead to any delay.

The Freedom of Information Act -*The content of this report may be disclosed to third parties upon request. If you believe that it is in not in the public interest to release this information please specify your objection in writing to the Team Manager Food Safety at the address on the bottom of the first page.*

Data Protection & Information Sharing *-The information that the Council holds in relation to Inspection Reports maybe shared with other Council Services in accordance with the requirements of the Data Protection Act 1998. If you have any queries please contact: Shared Regulatory Services at the above appropriate address.*

Saunders,Nathan
07/20/2021 14:14:26

FOOD HYGIENE INSPECTION REPORT

Name of Business:	Lakeside Central Food Production Unit
Address of business:	University Hospital of Wales, Heath Park Way, Heath, Cardiff, CF14 4XW
Date and Time of Revisit:	29 April 2021at 13:15
Food Authority:	Cardiff The County Council of the City and County of Cardiff

SCHEDULE A – LEGAL REQUIREMENTS

You are required to address the following contraventions of food safety law before the highest rating can be given: -

Food Hygiene & Safety Procedures

1. At the time of my visit, we discussed the method of delivering raw meat and poultry to the high-risk area. The method described, was to wheel it in a large container from the raw meat decant area, into the high-risk area of the kitchen. The container is plastic and could deliver 120Kg of meat to the cooking area of the kitchen.
   The raw meat or poultry is then transferred manually by staff using scoops, from the transport vessel to the cooking unit.
   This practice increases the hazard of the introduction of Listeria and other significant pathogens such E. coli 0157 and Salmonella etc, to the floor of the high-risk cooking area from the wheels of the raw meat transport vessel. These pathogens will inevitably contaminate the drains and any other surface to which they are spread either by staff or cleaning methods.
   I have asked for this practice to cease and have been reassured that this is the case.
   I have required that raw meat and poultry is decanted from the plastic container into several food grade containers. This should take place within the raw meat decant area.
   A trolley can then take this to the door of high-risk area where high-risk staff can (with correct PPE) place the raw meat containers onto a dedicated and labelled raw food surface. This is in line with the E. coli 0157 guidance issued by the Food Standards Agency. This could be a steel table or trolley. When required these smaller containers can then be poured into the cooking vessel. This reduced handling will also eliminate the practice of using scoops, which also increases the risk of contamination.
   This process may need refining, or a similar process put in place.
   Regulation (EC) No 852/2004 Annex II Chapter IX paragraph 3

2. The above steps regarding the control of pathogens entering the high-risk area of the CFPU must be applied to other ingredients. From recent discussions with Stuart Davies, I understand that all vegetables are delivered pre-cut and frozen from your supplier Slice & Dice.
   Although frozen, these present the hazard of contamination by Listeria and E. coli 0157.
   In a recent article found in International Journal of Food Microbiology Volume 334, 2 December 2020, 108849 **Occurrence of *Listeria* and *Escherichia coli* in frozen fruit and vegetables collected from retail and catering premises in England 2018–2019** ***(Willis et al 2020)***
   The key findings include

- Microbiological quality of >1000 frozen fruit and vegetables was investigated.
- ***Listeria* were detected in 2% of fruit and 24% of vegetables.**
- Ten clusters of L. *monocytogenes* were identified indicating a common origin.
- In eight of the clusters, isolates were recovered from a single type of vegetable.
- ***L. monocytogenes* strains from vegetables were also isolated from infected patients.**

In order to ensure that raw vegetables do not become a vehicle of Listeria, E. coli 0157 and other pathogens you must review how the vegetables are handled, before being introduced to high risk and also how they are transported and delivered into high risk. The same controls will be required as for raw meat and poultry as above. It would also be prudent to discuss whether your suppliers carry out testing on the product they supply you with.

Regulation (EC) No 852/2004 Annex II Chapter IX paragraph 3

3. During my visit I asked to observe the cleaning process for the drains to assess its effectiveness and consider further routes of contamination. During this time, I observed that staff wore the same pair of yellow marigold gloves to remove floor drain grills and handle items which have been in contact with the drain and then go on the carry out other tasks in the high risk area without changing gloves.

   This presents a significant risk of contamination from the drains to all other areas of the kitchen. I have required that this practice cease with immediate effect and that dedicated PPE is provided to staff when dealing with the drains. This should include colour coded gauntlets and aprons etc. It is very likely that this practice has led to the meat slicer parts becoming contaminated after passing through the dish washer and rehandled with dirty gloves. I have asked for staff training and significantly increased staff supervision to prevent a reoccurrence.

   Figure 1

Figure 1 shows a drain gully outlet discharging into the into the drain below. The lip inside the outlet will trap water and harbour bacteria. The area highlighted by the blue circle illustrates visible biofilms and strings of slime stretching down to the concrete drain surface. This is further evidence that cleaning is not effective.

It has been confirmed that the cleaning method was reviewed, staff trained and new dedicated PPE for use with the drains the day after my visit. As discussed, a full review of cleaning methods should take place. This must include a stage of mechanical agitation to disrupt biofilms and expose pathogens to the biocides applied during the cleaning process. Your cleaning chemical suppliers should be invited to advise you in this process. They should also be able to assist with a detailed cleaning schedule.

Regulation (EC) No 852/2004 Annex II Chapter IX paragraph 3

Regulation (EC) No 852/2004 Annex II Chapter I paragraph 1

Regulation (EC) No 852/2004 Annex II Chapter I paragraph 2 (a) (b) & (c)

4. The blue hosepipe located in the wet room, adjacent to the dishwasher, is left stored on the floor of that area in contact with a drain cover.

Figure 2

This will lead to contamination of the hose and in turn the staff that use it. Mount a suitable bracket etc to hold the hose away from the floor. The hose should also be identified on your cleaning schedule.

Regulation (EC) No 852/2004 Annex II Chapter IX paragraph 3

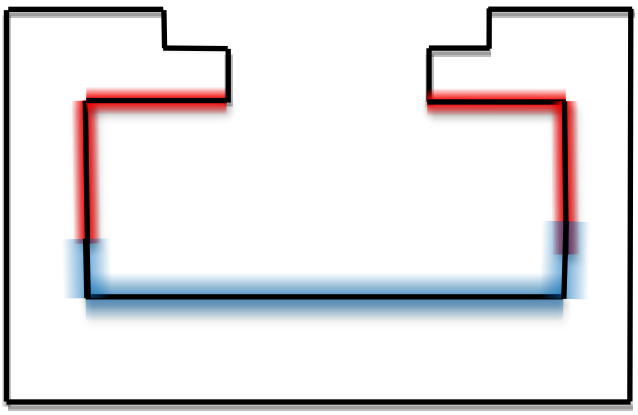
5. The pressure on the hose with a nozzle attached is too high for rinsing down. I held the hose approximately half a metre from a wall and could feel droplets splashing back. These droplets can redistribute harmful bacteria from dirty surfaces including the floor and drain gullies onto food contact surfaces. The hose should be adjusted for rinsing down, to apply rinse water with less energy.

Regulation (EC) No 852/2004 Annex II Chapter IX paragraph 3

Structural / Cleaning Issues

6. The drain gullies in the kitchen are not fit for purpose. They are in poor repair, badly designed and very difficult to clean. This provides the right environment for Listeria and other pathogens to survive, grow and the potential to spread within the kitchen environment.

Figure 3



The Figure 3 is an illustration of a cross section of the drain gully. The area in blue can be agitated by manual cleaning with equipment currently in use. This is required to disrupt biofilms which protect pathogens such as Listeria, Salmonella and E. coli 0157.

The area in red is where biofilms can form and remain undisturbed. These will shed pathogens which can go on to contaminate the food production unit. Chlorination and sanitising foams will not penetrate established biofilms. A brush has been ordered which will reach into the red zone. However, this area should be designed out when the drain gullies are replaced.

Figure 4

Figure 4 is a photograph showing the cross section in the gully. The overhang can be clearly seen.

Figure 5

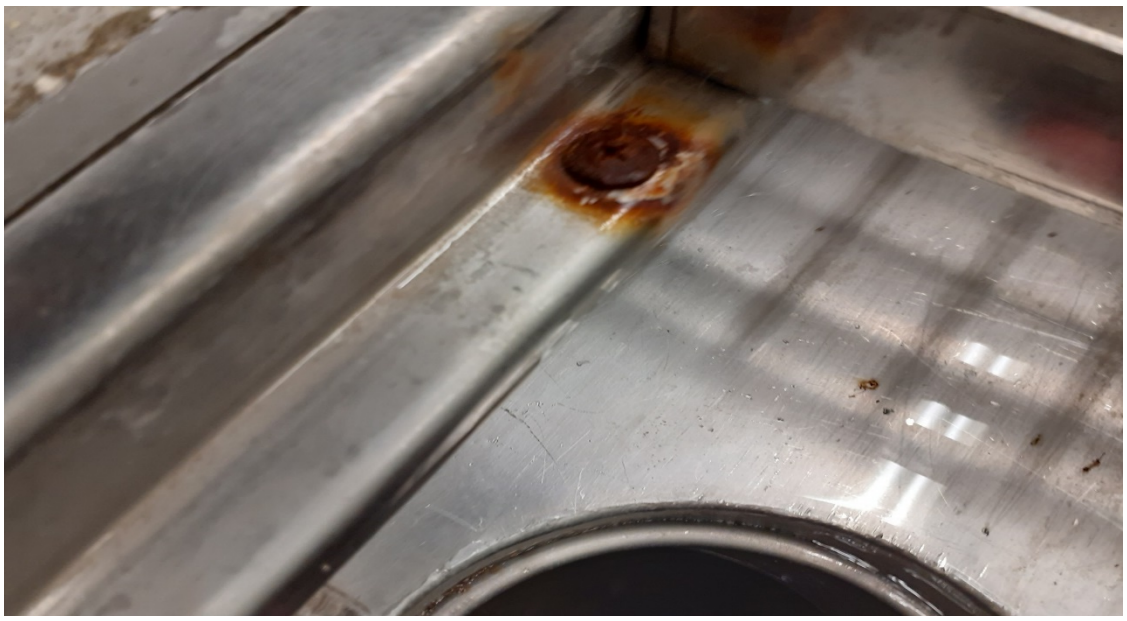


Figure 5 shows a rusting screw which is an ideal surface for pathogenic bacteria to cling to. There is a lip to the gully outflow which should not be present. Please refer to figure 1.

Figure 6

Figure 6 demonstrates repairs carried out to the gully housing. These repairs are not to the standard required and will also provide harbourage for pathogenic bacteria.

The drain gullies must be designed for use in a food production room and able to withstand a range of corrosive cleaning chemicals. They should be food grade and very easy to clean with no raised weld seams and free from fixings that will allow bacteria to colonise and become a source of contamination. **The drain gullies must be replaced during the 2-week shut down at the end of May 2021.**

Regulation (EC) No 852/2004 Annex II Chapter I paragraph 8

7. During the visit it was identified that Campden BRI carried out a review of the drains and concluded that the concrete drains below the kitchen floor were contaminated with Listeria monocytogenes and that it will always be the case. The drains are rough concrete with well-established colonies.
   Carry out a review and survey of the drains at the CFPU, with a view to putting in place pipe work to bypass the old drains. Or any other solution that presents itself to mitigate the presence of Listeria. The review should take place without delay. Once the drain survey is complete, you will be better informed about the best way forward to mitigate the risk.
   Regulation (EC) No 852/2004 Annex II Chapter I paragraph 2 (a)

8. The method for chlorinating the drains involves filling the drains with water, (previously described) and sprinkling chlorine tablets into the gully which dissolve.
   I have several concerns regarding this process besides the water level in the drain by-passing the mop head.
   - The volume of the drains must be properly calculated. Th easiest method is to record the number of litres of water required to fill the drain gullies to the brim. Once the volume is calculated the correct dosing of chlorine can be applied for it to be effective.
   - Sprinkling chlorine tablets into the drain gully may lead to an uneven concentration of chlorine throughout the drain. Dissolving the tablets in a known volume of water and then applying to the drain gully will create a more even distribution and assist with correct dilutions. (A health and safety risk assessment should be carried out to ensure whatever process used is safe and staff wear appropriate PPE).
   - Chlorine is being applied prior to any prior cleaning. This means that organic soils such as food, fat, and proteins etc will neutralise some of the chlorine in solution.
   - The chlorine solution will not be effective against biofilms which are intact. *"L. monocytogenes* biofilms are difficult to eradicate as the biofilm protects the organism from environmental stresses. Although the majority of *L. monocytogenes* are attached to the biofilm, the cells in the upper layer can move around". (*Truelstrup, H.L. et al (2011). Desiccation of adhering and biofilm Listeria monocytogenes on stainless steel: survival and transfer to salmon products. Int J Fd Micro, 146, 88-93.)*
   - "Chlorine has a short residual effect after disinfecting. Rule of thumb: if chlorine is used as a sanitiser prior to production, the equipment should be used within one hour after disinfection".
     (Food & Biocides Industry Group (2016) Biocides in Cleaning and Disinfection – Working Document (v2.0)

   The application of chlorine as a disinfectant at the end of the day prior to other cleaning processes should be considered in your cleaning review.
   Regulation (EC) No 852/2004 Annex II Chapter IX paragraph 3
   Regulation (EC) No 852/2004 Annex II Chapter I paragraph 1

9. There some redundant pieces of equipment in the high-risk cooking area which must be removed to prevent them from becoming sources of contamination. There are several units similar to the picture below. Figure 7

These units are in poor repair and cannot be easily cleaned or disinfected.
Regulation (EC) No 852/2004 Annex II Chapter I paragraph 1

10. There still pieces of equipment and utensils in the high risk cooking area which have deteriorated and should be removed because they present a foreign body hazard and will be difficult to clan and disinfect. Figure 8

These include the scraping blade used in the boilers as seen in Figure 8 above and the manual stirring paddles. It is important to ensure that mechanical energy is used when cleaning these

items of equipment. Regular audits should take place to ensure that all food contact equipment is maintained in a sound clean ad easy to disinfect condition.

Regulation (EC) No 852/2004 Annex II Chapter V paragraph 1 (a) (b) & (c)

11. The structure of the high-risk area of the CFPU is old and showing signs of wear and tear. Over time, repairs have been carried out but not always to the required standard. Some areas are damaged and will provide a space where Listeria can survive.

Figure 9

Figure 7 Shows a trolley wheel, the trolley is adjacent to the dish wash area. The wheel and housing are dirty, and the housing is rusting and no longer able to be kept clean.

Figure 10

Figure 10 shows a wall floor junction opposite the wet washroom. This appears to have been previously repaired. This is another example of where Listeria can find sanctuary.

Figure 11

Figure 9 shows the butt end of the same wall at the wall floor junction. It appears that the floor has expended past the protective flashing, exposing a rough area ideal for harbouring bacteria.

As a priority, carry out a full audit of the high-risk area and ensure that all areas are in good repair and can be kept clean and disinfected. Those areas which fail should be addressed during the two-week shutdown. I will be happy to discuss timescales for any works that are significant based on the hazard they present.

The same process must then take place for the rest of the CFPU. All repairs should be carried out with food safety, cleaning and disinfection in mind.

Regulation (EC) No 852/2004 Annex II Chapter I paragraph 1

Confidence in Management / Control Procedures

12. As previously required, fully review the HACCP for the CFPU. The most recent visit highlights areas that need to be addressed.

For clarity, I am not requesting a fully documented food safety management system, with food safety policies and preamble etc. at this stage.

What must be achieved as a minimum, is a basic solid HACCP which identifies and addresses all hazards at the CFPU. The prerequisites of HACCP must be in place and documented in such a way, that they are easily understood and are realistic.

The standard operating procedures must have sufficient detail to ensure that staff can follow them.

The HACCP should be validated. Verification procedures must be in place to ensure that the prerequisite program is effective and fully implemented and that critical limits are monitored.

Once you have this implemented and have gained control over the hazards associated with the process and the environment, this can be refined and improved, which is part of the cycle of continuous improvement. **This must be completed by the 17th May 2021.**

Regulation (EC) No 852/2004 Article 5 paragraphs 1 & 2

13. As previously indicated, you must carry out a review of cleaning and disinfection at the CFPU. This must include schedules, materials, chemicals, method, and training etc.
The Health Board spends significant amounts of money on cleaning chemicals. It is quite common within the food manufacturing industry, for chemical suppliers to provide advice in cleaning methods and write cleaning schedules. It would be good to discuss the use of different chemicals, techniques and approaches to cleaning and disinfection. This should include for example the use of steam, ozone, fogging and other novel approaches. Once a review is complete, your prerequisite programme and SOP's will require amending to reflect any changes. This should be completed before 15th June 2021.

Regulation (EC) No 852/2004 Article 5 paragraphs 1 & 2

14. I understand that Simon Swanton is in the process of reviewing and implementing a formal food hygiene training programme for staff. This will take some time to put in place in part due to the ongoing pandemic.
Because training has been identified as an urgent requirement at the CFPU, you must implement as a minimum an informal training programme which is job specific, based on the procedures you are implementing and make a record of the training completed.
This training must include reference to Listeria, the threat it presents, how to mitigate the hazard of Listeria and how to destroy it. All staff should be retrained before the CFPU reopens in June 2021

Regulation (EC) No 852/2004 Annex II Chapter XII paragraph 1

Report Title:	Enforcement Agencies Correspondence								
Meeting:	Heath and Safety Committee						**Meeting Date:**	27/07/21	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	✓	
Lead Executive:	Chief Executive Officer (interim basis)								
Report Author (Title):	Health and Safety Adviser								

Background and current situation:

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

During the period there were 2 new issues raised relating to enforcement by the Health and Safety Executive (HSE).

Death of Member of Staff

The HSE on behalf of the coroner contacted the Health Board on 24th February 2021 requesting information following the death of a member of staff who had tested positive for Covid-19.

The HSE have now fully investigated this event and have concluded the death was not RIDDOR reportable as they did not consider it to be a work related exposure to coronavirus.

Ventilation in Clinics and Theatres

The Health Board received communication from the HSE on the 24th May 2021 in relation to a concern that was raised with them.

The details of the concern is as follows:

'Ventilation in clinics and theatres in Heath Hospital is by air con. pre covid these clinics were packed and returning to anywhere near norm will mean returning to the spread of aerosols and bacteria as staff were constantly picking them up and being sick themselves. I understand that the air con system is not maintained, for example filters in the system were not changed for 16 years. I don't believe there has been adequate work done to assess the air changes required or adequate maintenance of the systems. Please can an investigation be done to ensure the ventilation is suitable and sufficient for the number of people using and working in the environment at all times and not just post covid.'

A response was prepared by Capital, Estates and Facilities Service Board and forwarded to the HSE by their deadline of 9th June 2021. The HSE were provided with information in relation to:

- Air Handling Units Quarterly and Yearly Inspections and Maintenance
- Annual Validation of Critical Air Plant
- Air Conditioning Bi Annual Inspections and Maintenance

The HSE subsequently responded to the Health Board on the 9th June 2021 advising they would not be taking any further action and the case was closed.

Executive Director Opinion /Key Issues to bring to the attention of the Board/ Committee:

Assurance is provided to the Health and Safety Committee that all concerns are actively investigated to address the issues raised.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

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

Recommendation:

The Health and Safety Committee is asked to:

- **NOTE** the content of this report

Shaping our Future Wellbeing Strategic Objectives
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1.	Reduce health inequalities		6.	Have a planned care system where demand and capacity are in balance	
2.	Deliver outcomes that matter to people	x	7.	Be a great place to work and learn	x
3.	All take responsibility for improving our health and wellbeing	x	8.	Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4.	Offer services that deliver the population health our citizens are entitled to expect		9.	Reduce harm, waste and variation sustainably making best use of the resources available to us	
5.	Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10.	Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

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

Prevention		Long term		Integration		Collaboration		Involvement	

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

Ymddiriedaeth ac uniondeb | Cyfrifoldeb personol

Report Title:	**Waste Management Compliance Report**								
Meeting:	Health & Safety Committee						**Meeting Date:**	27th July 2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**X**
Lead Executive:	**Executive Director of Finance**								
Report Author (Title):	**Director of Capital Estates & Facilities**								

Background and current situation:

The Health Board Waste Department continues to operate at increased volumes due to the requirement of PPE across all of the estate as a result of the COVID19 pandemic. In addition to the increased waste, there has been a reduction in segregation as the majority of the waste is being treated as contaminated.

The Estate and Facilities Performance Management System (EFPMS) data shows the reduction and increases of those Waste Streams affected by the Pandemic, and the team continue to work with Clinical Board and Departments to re-establish and increase waste segregation throughout the Health Board.

Field	Units	2019/2020	2020/2021	Actual Difference	% Difference
High Temperature Disposal Waste Weight	Tonnes	399.24	267.5577	-131.68	-49.21%
High Temperature Disposal Waste Cost	£	189462.30	136030.88	-53431.42	-39.28%
Non Burn Treatment (Alternative Treatment Plant) Disposal Waste Weight	Tonnes	855.24043	1583.4315	728.19107	45.99%
Non Burn Treatment (Alternative Treatment Plant) Disposal Waste Cost	£	288001.36	519685.34	231683.98	44.58%
Non-infectious Offensive Waste Weight	Tonnes	600.796	323.788	-277.008	-85.55%
Non-infectious Offensive Waste Cost	£	120870.02	76667.04	-44202.98	-57.66%
Landfill Disposal Waste Weight	Tonnes	1271.06	1104.324	-166.736	-15.10%
Landfill Disposal Waste Cost	£	151175.56	166381.75	15206.19	9.14%
Waste Electrical and Electronic Equipment (WEEE) Weight	Tonnes	36.00	28.1	-7.90	-28.11%
Waste Electrical and Electronic Equipment (WEEE) Cost	(£)	24313.40	20600.88	-3712.52	-18.02%
Waste recovery/recycling w eight	Tonnes	563.97	497.64	-66.33	-13.33%
Waste recovery/recycling cost	£	£114,253.00	59617.38	-54635.62	-91.64%
Total Waste Weight	Tonnes	3726.30	3804.8412	78.54	2.06%
Total Waste Cost	£	£888,075.64	978983.27	£90,907.63	9.29%

Clinical Waste:

NHS Wales' sole contractor for the collection and disposal of Clinical Waste (Stericycle Ltd) cannot currently maintain its standard collection schedules under the current All Wales contract, as the company appear generally unable to manage the increasing volumes of waste being generated

across its NHS customer base. This has resulted in a backlog of waste developing at a number of hospital sites across NHS Wales recently, predominantly in the south of the country, although the north is also affected.

Stericycle Ltd. have reviewed the service provided which has resulted in them being able to increase collections to address the backlog situation.

Non-Hazardous Waste Services:

Following a number of management changes within the Waste Department, significant work has progressed with our local procurement teams to establish the current situation and guidance on relevant service contracts. As a result, it has been demonstrated that a number of service contracts are due or have recently expired. Following this the new Waste & Compliance Manager is working closely with procurement in establishing a suitable tender specification and route for compliance.

Waste Breaches & Compliance Audit:

The Waste Department is reporting 1 breach notice at the University Hospital of Wales, as a result of medicinal waste being identified in orange lidded sharps boxes. The Ward/Department have been notified accordingly.

Throughout the pandemic, direct ward/area audits had been suspended. The waste team are working with clinical colleagues with a view to reintroducing the audits to improve the waste segregation across the estate.

Executive Director Opinion /Key Issues to bring to the attention of the Board/ Committee:

Clinical Waste:

As a result of the coronavirus pandemic, the volume of PPE being utilised within the Health Board has meant that, whilst tonnage has not increased significantly, the volume of waste has increased further.

This has presented a challenge to Stericycle over the course of the pandemic, given the pressures that exist within the market already. There is much concern at this moment in time across NHS Wales regarding Stericycle's collection and disposal capacity. Notwithstanding the network issues and pressures upon Stericycle as one of the main contractors in the UK market, their inconsistency in providing clear, detailed information as and when these issues arise is of concern.

This along with significant damage to the Health Boards reputation, demonstrates that the Health Board along with its NWSSP and Consortium Partners must act to support the ongoing business continuity through to a minimum of the end the current financial year 20/21.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

Clinical Waste:

Concern arises if a potential spike in COVID-19 were to occur to a point where increased waste is seen regularly in the future.

Non-Hazardous Waste Services:

The waste contracts which were awarded in 2015 are due to expire shortly. Following the retender exercise the Health Board is likely to see an increase in cost associated with waste disposal.

Recommendation:

Health and Safety Committee are asked to:

NOTE The content of the report and in particular the increase in waste and decrease in segregation

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Health and Safety Annual Report 2020/2021**						
Meeting:	**Heath and Safety Committee**				**Meeting Date:**	27/07/21	
Status:	**For Discussion**		**For Assurance**	✓	**For Approval**		**For Information**	✓
Lead Executive:	Chief Executive Officer (interim basis)						
Report Author (Title):	Head of Health and Safety						

Health and Safety Annual Report 2020/2021

OVERVIEW

A Health and Safety annual report has been created and completed, for provision to the Executive Health and Safety Committee to provide an overview of the breadth of work undertaken by the Health and safety team, and offers assurance that areas of high priority were identified and managed during a particularly challenging time for all UK Health Boards given the COVID-19 global pandemic. Several risk assessed operational changes were introduced in order to best support the organisation throughout this period, such as varied specific COVID-19 operational controls and compliance extensions for policies and training. Further support was provided in the field of PPE, particularly respiratory. As with other functions, a large degree of flexibility was demonstrated by the H&S team to ensure safe, day to day operations continued.

SIGNIFICANT CHANGES

The former Head of Health and Safety retired in September 2020 with the post being filled on an interim basis until February 2021 when the present incumbent was appointed.
The Executive Director for Workforce and Organisational Development left the organisation in February, resulting in the Head of Health and Safety reporting into the Chief Operating Officer. This post has now been filled and has been retitled Executive Director of People and Culture however, at present the Head of H&S continues to report into the COO.

A UHB wide independent Health and Safety review, sponsored at executive director level was conducted from March to May 2021. It made 16 recommendations based on current operating practices and identified several other opportunities for improvement. The Health and Safety risk register will require a review as a result and priority improvement plan updated. A working group including Executive Directors has been set up to determine which recommendations are to be taken forward for implementation.

ASSESSMENT

The 2020-21 Annual Report considers trends in incidents, training and management processes and progress in 8 strategic areas. It concludes that the trends of incidents and management processes continue to show progress in improving staff and health and safety risks. The Health and Safety Team have had to make significant changes to their ways of working, and the services provided due to the pandemic, and this is reflected throughout the report.

Table of Content

1. Health & Safety Management

1.1 Health and Safety Management Structure

Table 1.1.1 H&S Committee Meetings Attendance

H&S Committee Meetings 2020-21	Apr	Nov	Jan	Mar
IM – Legal	1	1	1	1
IM –	3	2	1	3
IM – Vice Chair	0	1	0	0
H&S Lead	0	1	1	2
Executive Directors	2	3	3	4
Staff Safety Representative	0	2	1	1

Please note that due to staffing changes, the meeting chairs for the Operational group and the Personal safety group are no longer as stated.

Table 1.1.2 Operational Level Group Meetings

Health and Safety Strategic Groups	Chair	Agreed Frequency	Meeting per year	Actual	Deficiency
Operational	M Driscoll	3 monthly	4	3	-1
Fire Safety	G Walsh	3 monthly	4	4	0
Personal Safety	C Dalton	3 monthly	3	2	-1
Water Safety	E Davies	3 monthly	3	3	0

The Personal Safety and Security Strategy group was changed to the Anti Violence Group by the previous head of Health and Safety to better reflect the Obligatory Response to Violence paper and also the changes to both the departmental and wider health board approach to anti-social behaviour. Due to COVID-19, the last meeting held was February 2020 however, when the new Executive Director for Health and Safety is confirmed it is the intention to commence these meetings with the relevant internal interested parties to then feed back into the Health and Safety Committee.

Table 1.1.3 Clinical/Service Board Health and Safety Meetings

Health & Safety Group	Chair	Agreed Frequency	Meeting per year	Actual	Deficiency
All Wales Medical Genetics	H Logan	2 monthly	6	6	0
Capital, Estates & Facilities	T Ward	3 monthly	4	6	+2
Medicine	R Aylward	3 monthly	4	0	-4
Specialists	Gareth Jenkins	3 monthly	4	1	-3
Surgery	C Wade	3 monthly	4	3	-1
C&W	C Heath	3 monthly	4	3	-1
PCIC	L Dunsford	3 monthly	4	0	-4
CD&T	S Bailey	3 monthly	4	6	+2
Mental Health	I Wile	3 monthly	4	3	-1

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.

The right table shows the work time resource available at the advisory and trainer levels within the H&S department, but does not cover administrative support roles.

Table 1.1.4 H&S WTE Posts

Position	WTE In-post
Head of Health and Safety	1
Health & Safety Advisors	3.3
Assistant Health and Safety Advisor	1
Manual Handling Advisors	1.38
Personal Safety/Case Management	1.9
Health & Safety Trainers	4.6

1.2 Health and Safety Priority Improvement Plan

The work streams of the Priority Improvement Plan have continued to operate during the period, and the detail of each work stream is detailed in this report, however with a new head of department and the health and safety review this document is on a priority review list, along with the departmental risk register.

A new updated priority improvement plan informed by the health and safety review, and by the changing service needs will be presented to the H&S committee and executive board, allowing for accurate tracking of progress and assurance for new and ongoing priority improvements.

1.3 Health and Safety Related Policies

The policies and procedures that have passed review date have been moved to the time bound cooperate action plan.

Table 1.3.1 Health and Safety Related Policies

POLICY	UHB REF NO	LEAD RESPONSIBLE OFFICER	APPROVAL DATE	REVIEW DATE
Management of Stress & Mental Health Wellbeing in the Workplace Procedure	UHB 071	Employee Wellbeing	January 2019 (version 3)	Jan 2022
Security Services Policy	UHB 037	Director of Capital, Estates and Facilities	April 2019 (Version 4)	Apr 2022
Control of Contractors Policy	UHB 163	Director of Capital, Estates and Facilities	Oct 2019 (Version 3)	Oct 2022
Health & Safety	UHB 021	Head of Health and Safety	November 2019 (Version 4)	April 2021
Safe Working with Electricity	UHB 208	Director of Capital, Estates and Facilities	September 2019 (Version 2)	April 2021
Management of Violence & Aggression Policy	UHB 035	Personal Safety Advisor	April 2017 (Version 3)	April 2021
Lone Worker Policy	UHB 034	Health and Safety Advisor	April 2017 (Version 3)	April 2021
Minimal Manual Handling Policy	UHB 036	Manual Handling Advisors	April 2017 (Version 3)	April 2021
Waste Management Policy	UHB 038	Waste and Compliance Manager	April 2017 (Version 3)	April 2021
Water Safety Policy *Previous Control of Legionella Policy 091*	UHB 369	Estate Asset Manager	April 2017 (Version 1)	April 2021
First Aid at Work Policy	UHB 093	Head of Health and Safety	July 2017 (Version 3)	July 2021
Sharps Management Policy	UHB 269	Head of Health and Safety	July 2017 (Version 2)	July 2021
Incident, Hazard and Near Miss Reporting	UHB 138	Head of Health & Safety	September 2018 (Version 3)	July 2021
Management of Asbestos Policy	UHB 072	Director of Capital, Estates and Facilities	July 2018 (Version 3)	July 2021
Fire Safety Policy	UHB 022	Director of Capital, Estates and Facilities	July 2018 (Version 4)	July 2021
Latex Allergy Policy	UHB 127	Health and Safety Advisor	January 2019 (Version 3)	January 2022
Environmental Policy	UHB 143	Director of Capital, Estates and Facilities	January 2019 (Version 3)	January 2022
Closed Circuit Television (CCTV) Policy	UHB 303	Director of Capital, Estates and Facilities	January 2019 (version 2)	January 2022

1.4 HSE/Enforcement Agencies actioned during the period

The Health Board was contacted by the HSE on the number of occasions during the period; Table 1.4.1 demonstrates the concerns and their status.

Table 1.4.1 Enforcement Actions

Meeting Date	Description	Type	Status
Jan 21	Notice of Contravention. Two contraventions received in relation to PPE fit testing in a care home.	1. Please ensure that the Respirator Fit Test Report is revised to ensure that it contains all information required. 2. Please review the training provided on face fit testing, to ensure that fit testers are receiving adequate instruction and training on key areas as outlined within HSE guidance INDG479 'Guidance on respiratory protective equipment (RPE) fit testing' (page 5). Please then develop a plan for quality assurance to ensure the competence of staff and consistency of fit testing being carried out, in line with the training provided. Both actions have been satisfactorily closed.	Closed
24th Feb 2021	Death of a Staff Member	HSE executive contacted the Health Board on behalf of the coroner requesting information following the death of a member of staff who had tested positive for Covid-19. The HSE have now fully investigated this event and have concluded the death was not RIDDOR reportable as they did not consider it to be a work related exposure to coronavirus.	Closed

1.5.1 E-datix Incident data

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

Table 1.5.1.1 Total Incidents Recorded

2020/21 @ 22.06.21	Awaiting review	Being reviewed	Final approval	Rejected	2018/ 2019 Total	2019/ 2020 Total	2020/ 2021 Total
Patient Incidents	45	760	16018	1848	18113	19177	18671
Staff/Contractor/ Vendor Incidents	18	113	3186	44	3441	3525	3361
Organisational Incidents	5	57	1418	33	1761	2002	1513
Public/Visitors Incidents	1	7	68	5	146	125	81
Totals:	69	937	20690	1930	23461	24829	23626

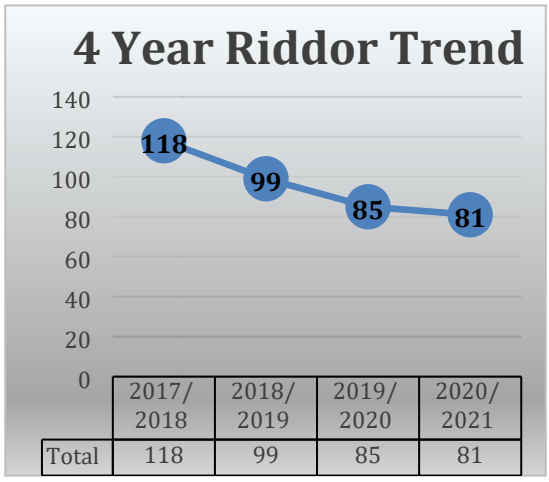
1.5.2 RIDDOR

Table 1.5.2.1 RIDDORS by Incident Type

Staff RIDDORs	2018/ 19 Total	2019/ 20 Total	2020/ 21 Total
Contact with Sharps	6	5	2
Contact/Collision with Object/Animal	7	15	8
Entrapment	0	1	0
Lifting/Manual Handling	32	29	29
Slip/Trip or Falls	22	19	19
Inappropriate/Aggressive Behavior	30	16	22
Exposure to unhygienic Environmental Conditions	0	0	0
Exposure to unsafe Environmental Conditions	2	0	0
Other	0	0	1
Workplace Stressors/Demands	0	0	0
Total	**99**	**85**	**81**

Chart 1.5.2.1 Riddor Trend

The RIDDOR trend shows a consistent decrease over the last 4 years with a slowing curve (imaged right).
There is a consistent 2 year level of Manual Handling, Slips, and Violence and Aggression RIDDORS showing these areas should be of continuing focus to reduce the impact on staff.



It is important to note there were no Stress related RIDDORs in the reporting period, while it is hard to conjecture why this is we must give our staff respect for rising to the challenges of COVID 19 and understand that as noted by the Occupational Health team in the recent Operational Health and Safety Group, that staff may experience a sudden increase in expressed stress levels when they have a chance to pause and process the previous year.

1.5.3 All Staff Incidents

The table right shows a breakdown by level of harm of all staff incidents over the last three reporting periods, showing a reasonably stable number of incidents, with a slight reduction over all and an approximate ~23% reduction in major incidents from 2018 to present.

Table 1.5.3.1 incidents by Severity of Harm

Levels of Harm - Staff Incidents	01: No harm	02: Minor	03: Moderate	04: Major	05: Catastrophic	Total
2018-2019	1368	1651	365	17	0	**3401**
2019-2020	1471	1634	368	11	0	**3484**
2020-2021	1341	1596	367	13	0	**3317**

Incidents can also be broken down by type and right we see the staff incidents broken down by tier 1 type, the overarching type of incident. This shows a significant slant towards behaviour based incidents which includes verbal, abusive, harassing and violent behaviour toward staff by any group.
Of the behavioural total 759 were classified as assaults and 33 were classified as sexual related behaviour reports.

Table 1.5.3.2 Incidents by Tier 1 Type: numeric

Staff, reported date, Tier 1	2020/21 Total
Behaviour (Including Violence and Aggression)	**1665**
Accidents/Falls	**806**
Exposure to Environmental Hazards	**810**
Property	**36**
Total	**3317**

Also provided is a more detailed graphic break down of these tier 1 areas.

Chart 1.5.3.1 Incidents by Tier 1 Type

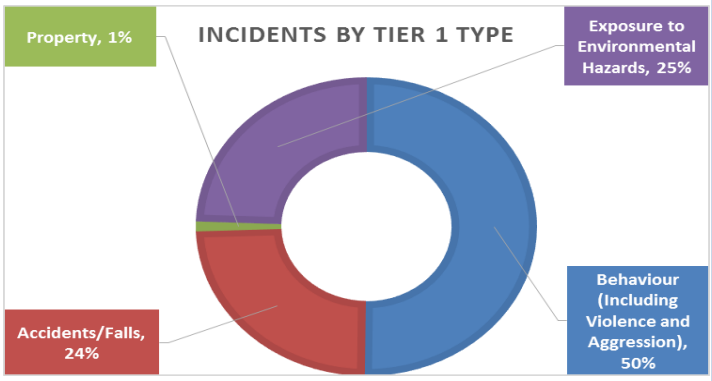


Chart 1.5.3.2 Property Incidents by type 2

Chart 1.5.3.3 Exposure Incidents by type 2

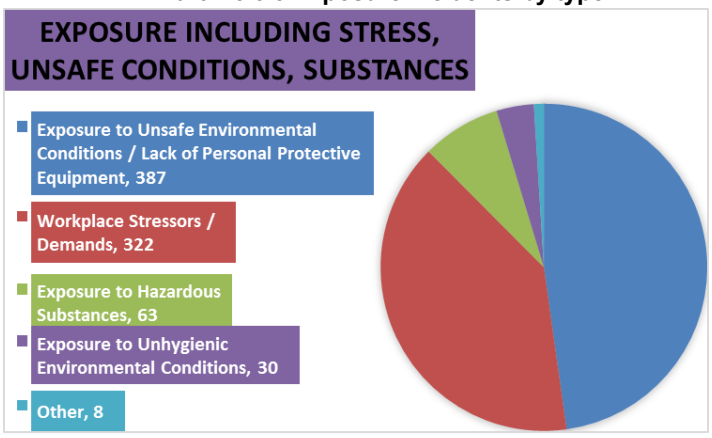


Chart 1.5.3.4 Accidents/Fall Incidents by type 2

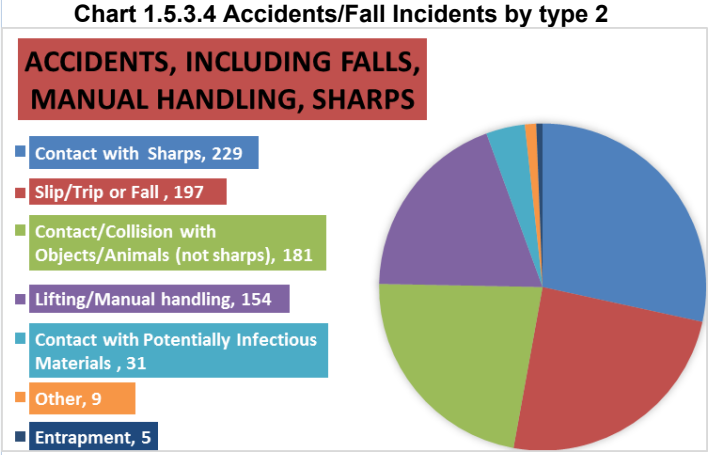
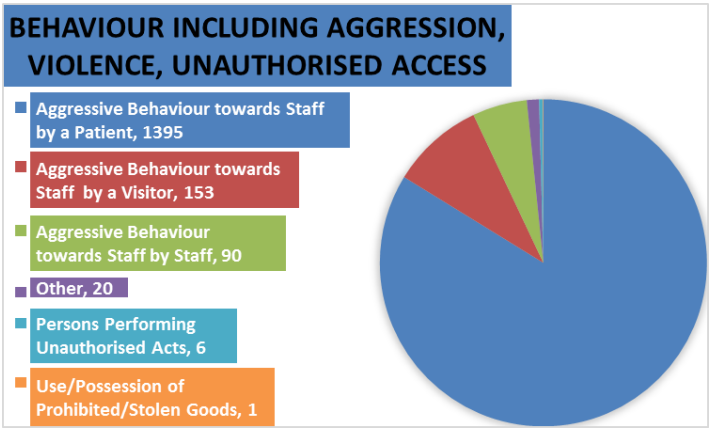


Chart 1.5.3.5 Behaviour Incidents by type



1.6 Legal Risk Personal Injury Reviews

The personal injury claims report details for 2020-2021 financial year are currently unavailable, NWSSP Solicitors team are currently working on this report.

1.7 Health and Safety Training

Table 1.7.1 – Percentage Training Compliance on 31st March 2021

Clinical Board	Manual Handling E learning	Manual Handling Inanimate	Manual handling Patient	V&A Module A - E Learning	V&A Module B - E Learning	V&A Module C - Breakaway techniques
All Wales Genomics Service	95.55%	66.67%		89.07%	69.85%	60.00%
Capital, Estates & Facilities	82.34%	12.79%		81.89%	61.90%	1.85%
Children & Women Clinical Board	90.21%	50.78%	22.22%	88.39%	63.25%	23.98%
CD&T	90.94%	23.55%	44.88%	90.31%	66.37%	22.21%
Corporate Executives	86.39%	56.52%	32.20%	84.20%	62.21%	15.79%
Medicine Clinical Board	81.91%	0.00%	33.52%	78.08%	49.28%	17.83%
Mental Health Clinical Board	86.69%	42.86%	23.06%	91.06%	53.73%	40.74%
PCIC	68.95%	34.48%	31.23%	63.37%	62.57%	20.05%
Specialist Services Clinical Board	81.40%	15.79%	33.39%	78.63%	50.89%	11.45%
Surge Hospitals	37.14%			20.00%		
Surgical Services Clinical Board	77.18%	28.69%	31.95%	74.10%	54.46%	7.88%

The table above show total compliance percentage against currently identified training needs for each directorate with grey cells being where no training of that type has been identified by LED for that directorate.

Income generation and re-introducing Did Not Attend (DNA) fees for H&S training

The H&S team have continued to deliver training to local NHS staff and University students to generate income for the department (which is reinvested into the training provision for the UHB). Some courses were cancelled due to COVID. DNA fees were stopped due to the pandemic, however they were reintroduced on the 1st May 2021.

Training compliance

Due to classroom based training compliance being low, the H&S team ran a training compliance project which identified 5 key areas of improvement. Whilst the full benefit of these changes may not be felt immediately, the team have continued to implement the recommended changes within the constraints of the pandemic as summarised below. The project has now closed, with the ongoing monitoring and continuous improvement work being undertaken as business as usual;

1. The booking process and ESR – H&S and LED have been working closely together to ensure that ESR has the correct competencies matched to staff and that the courses are recorded correctly. ESR Self-serve (online booking) has now been introduced for all manual handling and violence and aggression courses instead of the previous telephone/email booking system.
2. The training Model – some change ideas have been implemented, such as reducing the duration of courses, however due to the pandemic, all standard manual handling and Violence & Aggression courses were temporarily stopped, to enable the H&S training team to be re-allocated to face fitting duties, and to run bespoke COVID patient handling courses for the large number of temporary staff who joined the UHB during the pandemic, as well as some existing staff who were temporarily redeployed. These COVID courses were shortened introductory level sessions to educate staff on the basic principles of patient handling, and therefore did not award staff with competencies as they did not meet the standard of the All Wales Passport and Information Scheme. All standard courses have since been reintroduced with limited numbers per course however, the spaces per course are gradually being increased.

3. The Link worker system – a decision was made to stop the current LW system as of the 1st Sept 2020 and trial a new Workplace competency assessor system in Spring 2021 with an improved governance and support structure in place, the trial has started and has been well received to date.
4. Reporting – H&S attendance training stats continue to be shared with clinical boards at their H&S meetings, however a new H&S monthly dashboard style report will now be generated containing H&S training stats and will be shared to a wider audience across the UHB
5. Communication –a communications plan for the H&S department is under development, and captures all of the ideas generated through this work stream to progress. The H&S webpage has been updated and continues to be used as a central resource for staff to access information with regards to training

Inanimate manual handling training

The H&S team will no longer be running separate foundation and update courses for inanimate training. Module A is now to be completed as an e-learning module (no need to be repeated), and Module B will be delivered in the classroom in 1.5 hours as general inanimate training. Module B training needs to be repeated every 2 years.

Table 1.7.3 Inanimate Training Chart

Clinical Board	Inanimate Handling Foundation	Inanimate Handling Update	Inanimate Training Freq. Assessment
AWMGS	27		
C, E&F	47	4	
Children and Women	19	15	3
CD&T	69	18	3
Corporate	2		
Medicine	1		
Mental Health	3	4	2
PCIC	3		
Specialist services	12	7	
Surgical	14	11	
None Board Staff	18	2	
Total Staff Trained	**215**	**61**	**8**

Patient manual handling training

The patient handling foundation course has been reduced from 2 days to 1.5 days as Module A can now be completed as an e-learning module (no need to be repeated). Patient handling updates will then be 1 day in duration and will need to be undertaken every 2 years.

Table 1.7.4 Patient Handling Training Chart

Clinical Board	COVID19 Manual Handling	Patient Foundation	Patient Update	Patient Training Freq. Assessment
AWMGS	4			
C, E&F	18	3		
Children and Women	56	25	44	34
CD&T	86	74	75	14
Coporate	2	10	8	
Medicine	27	63	123	28
Mental Health	5	34	23	1
PCIC	9	14	22	
Specialist services	29	38	100	5
Surgical	35	62	63	16
None Board Staff	240	70	68	2
Total Staff Trained	**511**	**393**	**526**	**100**

Violence & Aggression Module C

The H&S team will no longer be running separate foundation and update courses for Module C. Module A is now to be completed as an e-learning module (no need to be repeated), and Module B is also to be completed as an e-learning module (need to be repeated every 3 years), with Module C being delivered in the classroom in 3 hours as general Module C training to be repeated every 2 years.

C+C refers to care and control.

Table 1.7.5 V&A Training Chart

Clinical Board	2 Day C+C Older People	Mod B&C	Mod C	Mod C Update	C+C older people foundation	C+C older people update	C+C Paeds foundation	C+C Paeds Update
Children and Women		17	30	12			29	3
CD&T		34	84	26	1			1
Corporate		5	4	1				
Medicine	6	10	59	12	28	12	8	4
Mental Health		2	10	5				
PCIC		6	12	2				
Specialist services	39	8	48	14		5		
Surgical		3	36	6				
None Board Staff		1	25					
Total Staff Trained	**45**	**86**	**308**	**78**	**29**	**17**	**37**	**8**

N.B – AWGMS and C,E&F had no figures for classroom based training in the reporting period and have been left off this table. Online training has continued as demonstrated in table 1.7.1. And these Clinical Boards also have some elements of board specific training in place not overseen by H&S.

First Aid Training

Courses numbers have been reduced from 12 to 6 to comply with social distancing guidelines. The Health & Safety department have procured additional Manikins to allow each participant to be allocated their own CPR Annie for the duration of the course.

Table 1.7.6 First Aid Training Chart

First Aid Courses Delivered 20-21	Trained Staff
First Aid Refresher Training - 3 Hour - UHW	2
First Aid Requalification Training - 2 Day	12
First Aid Training - 3 Day	3
Grand Total	**17**

The HSE had previously given a grace period for re-validating certificates during the covid-19 pandemic, however; this has period has now lapsed.

First Aid Refresher Training – 3 Hour course is not required for qualification as a first aider and due to low attendance (only 2 attendees during 2020/21 this course is currently being reviewed for value to the Health Board.

2. Personal Safety/Violence and Aggression/Case management

The Case Management team have continued to focus on reducing Violence and Aggression within the health board. Providing practical support and sign posting to formal support services; with a target of meeting with members of staff within 48 hours of an incident report. The team has also continued assisting individuals investigating violence and aggression incidents.

Case Management has continued to improve ties with Occupational Health and Wellbeing services leading to increased uptake of counselling by colleagues; and Occupational Health has continued supporting staff

members involved in incidents. The feedback on the service has been positive, with increased feelings of support being specifically noted.
Successes have led to the team taking on support of colleagues experiencing domestic violence.

Datix
The body of Datix forms involving violence and aggression have been reviewed to inform risk management practices. The DATIX form is being revised to include enhanced case management function in 2021.

Internal reports
Monthly reports are compiled as necessary under the Obligatory Responses to Violence in Healthcare but were not provided to the Lead Director and Health and Safety Manager during 2020. Going forward these will be provided to the new Lead Director of Violence and Aggression when appointed. These reports will contain, the number of staff assaults by patients, Incidents of Verbal abuse and Threat, Flagging of issues and Police Attendances by purpose.

Escalations
The Health Board has raised dissatisfaction with **1** Police investigation, and **0** Crown Prosecution Service cases.
The Case Management Team continue to progress the Assaults on Emergency Workers Act 2018 with the Crown Prosecution Service. During the reporting period there were **13** notable successful prosecutions resulting in custodial sentencing, and details of these will be shared with colleagues through the monthly Health and Safety Dashboard.

Promoting the Obligatory Responses to Violence
The 2018 Obligatory Responses to Violence are at the core of the Welsh Governments approach to reducing violence across healthcare services. The case management team previously promoted this among staff with roadshows and communications; these were suspended during 2020 due to COVID 19 but will be restarting again during 2021 once it is reasonable to do so.

Case Management Statistics

Criminal Sanctions

Table 2.1 Criminal Sanctions

Year	No. referred to Police-verbal warnings or no further action	Number of Convictions	Other Sanction ASBO, Internal VWM
2018/19	150	81	54
2019/20	183	58	5
2020/21	213	77	65
Total	**699**	**268**	**175**

Police and Crown Prosecution Service
The Team continued its strong working relationship with the South Wales Police and the Crown Prosecution Service. Continued open communication with both on and offsite policing teams over the reporting period. Several restraining orders have been obtained successfully through the Crown Prosecution Service.

Internal Sanctions - Violent Warning Markers
Case management continue to administrate a violent warning marker system reviewing alerts, placing and removing violent markers. These markers warn staff of possibly violent or aggressive patients but cover both intentional and unintentional violence and do not imply criminal responsibility but are rather a way of warning staff so proper safety precautions can be assessed. These can cover behavior by a patient, or those associated with a patient such as a guardian or visitor.

Table 2.2 Internal Sanctions

Year	Alerts	No Marker	Violent Marker Placed	Safe Haven Markers	Violent Markers Removed
2018/19	126	74	52	6	84
2019/20	112	88	24	10	77
2020/21	157	91	66	7	115

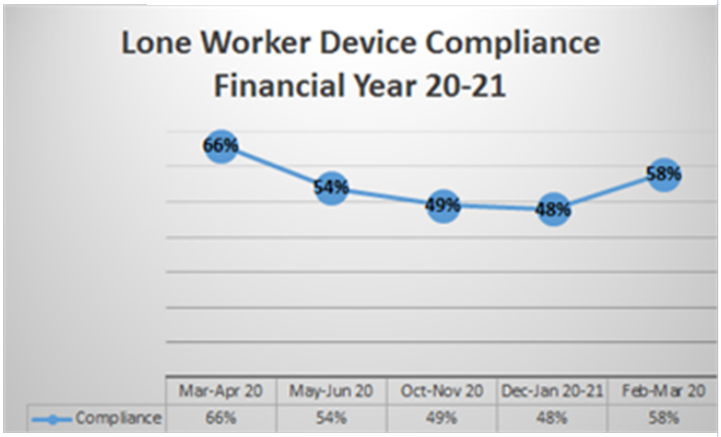
Lone Worker Report

Prior to the COVID 19 Pandemic the overall percentage compliance showed consistent high utilisation with an average usage of 60 - 70% month on month measured against device activity and movement.

Chart 2.1 Lone Worker Device Compliance

The device has seen a reduction in usage as shown in the trend (right). Usage compliance has largely been driven by a change in service delivery over the course of the pandemic.

N.B Reports were suspended for the period July – September 2020. During the period the team in collaboration with Safeguarding procured 10 lone worker devices funded by the Cardiff and Vale Health Charity 'Make it Better Fund'. These devices are available for staff affected by domestic abuse or stalking as the ongoing lockdown situation increases their vulnerability.



3. Manual Handling

Advisors Report

Significant support provided to the challenging projects throughout 2020, in particular the Dragon's Heart and Lakeside surge hospitals and latterly the new neuro/spinal unit at Llandough. This included preparing equipment and providing manual handling project support and training around 400 beds in Lakeside and an estimate of up to 1500 beds in Dragon's Heart hospital.

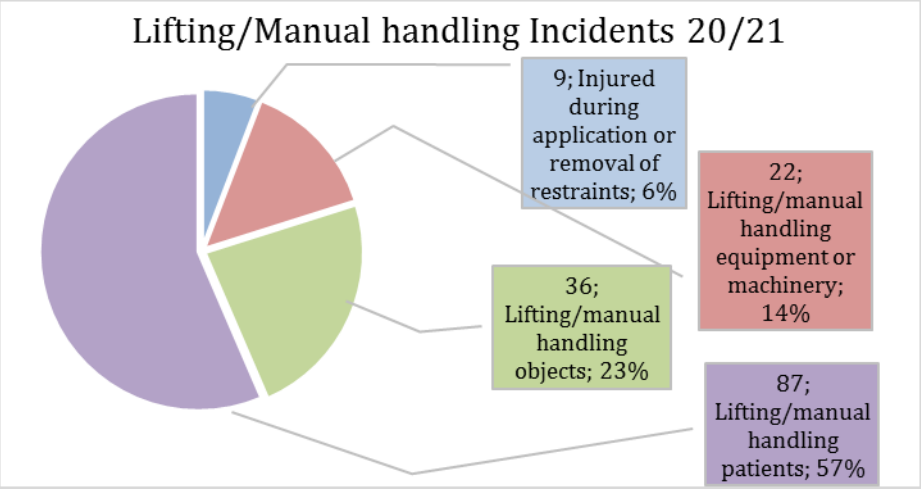
Additional work includes;

- Successful pilot on medicine ward at Barry hospital in the use of patient specific slings for bathing, negating the need for LOLER inspections and reducing the risk of cross infection. This has been promoted across the UHB as a risk reduction measure
- Successful bid for replacement of 25 obsolete hoists. This is in relation to the last annual report in which 5% of our stock or 21 lifting aids were found to be obsolete or beyond the manufacturers recommended working life
- Several streamlining initiatives involving the procurement of lifting accessories
- Responding to an increasing call for advice and assistance with bariatric patients

ProACT equipment audit was postponed due to COVID but has since been conducted.

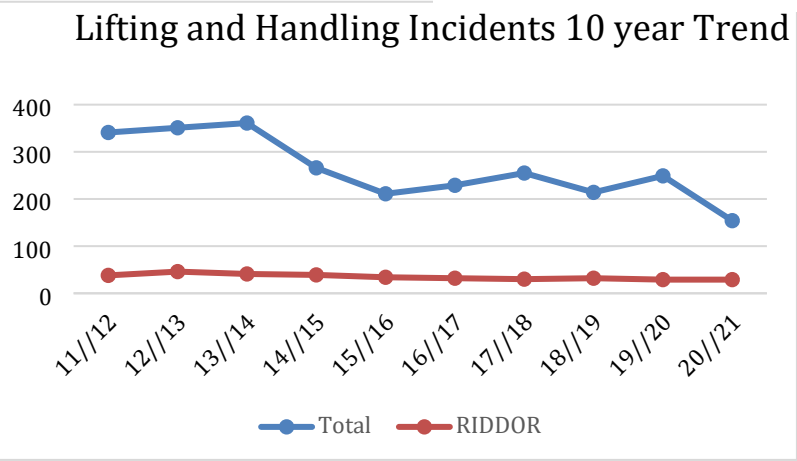
Manual handling Incidents

Chart 3.1 Lifting and Handling Incidents



Lifting and Manual Handling incidents primarily occurred around the lifting and handling of patients, this makes up a majority of the lifting and handling performed on UHB property.

Chart 3.2 MH 10 Year Trend



Incident data shows a continuing downward trend in reported Lifting and Handling incidents. Showing the success of Manual handling initiatives and training in the Health Board.

Compared with the previous annual report incident data for the type of manual handling incident remains consistent across the reporting periods as a percentage of each incident type.

4. Environmental Health

4.1 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 reasonable precautions are taken to prevent ill health. Progress has been made in meeting this requirement; there are currently 3690 materials with 10276 COSHH assessments on the SYPOL database.

There are approximately 277 work areas identified within the UHB and 268 COSHH coordinators in place. As you can see below 86 % compliance has been maintained in 2020/21 despite a very challenging year for all with the COVID pandemic.

Safety Advisors will continue to take this information to clinical board quarterly meetings to monitor compliance levels.

Table 4.1.1 Substance Compliance

Clinical Board	No. of COSHH Co-ordinators	Approx No. Identified Areas	No. of Areas Compliant/ in date	Compliance 18/19	Compliance 19/20	Compliance 20/21	Change since last year
Children and Women	36	37	34	92%	92%	92%	↔
Clinical Diag. & Therapies	47	47	41	67%	83%	87%	↑
Medicine	35	40	33	76%	81%	83%	↑
Mental Health	51	51	49	92%	94%	96%	↑
PCIC	11	11	9	88%	91%	82%	↓
Specialist Services	35	35	30	91%	88%	86%	↓
Surgical Services	39	41	34	83%	88%	83%	↓
Other (Exec, CEF)	14	15	9	50%	58%	60%	↑
Total	**268**	**277**	**239**	**82%**	**86%**	**86%**	↔

4.2 Environmental Monitoring

4.2.1 Monitoring and Occupational Hygiene

Environmental monitoring was suspended to respond to varied risks and competing demands during the COVID 19 pandemic. This has since been reconvened in May 2021.

4.2.2 Face Fitting and PPE

Significant support was provided to meet the organisation requirements in this area, the reduction in training courses being offered, freed up resource to fulfil this. Previously led by IP&C responsibility has now gravitated to H&S.

Two fit testing contraventions issued to the Health Board on the back of an investigation in to an outbreak of COVID at a care home (See also Table 1.4.1). In response the H&S department;

- Achieved industry best practice face fit accreditation for four members of staff
- These personnel now train fit testers across the UHB
- Follow up compliance audits conducted across the UHB in April and May 2021
- Central on line repository for policy documents and SOP's

Summary of CVUHB actions to manage face fitting through the pandemic

- PPE Cell formed chaired by Director of nursing, to provide strategic support
- Operational PPE group formed chaired by head of Health and Safety, to implement the strategy.
- H&S departmental PPE team formed led by Head of H&S, supported by H&S advisors to provide day to day advice and support
- Approx 1600 staff issued with powered air purifying respirators
- Priority database established to track issuing of powered hoods
- 3M 7000 and JSP Reusable respirators procured to support stock of disposable respirators
- SOPs, online training and toolbox talks developed for reusable respirators
- In house 2 year maintenance contract established with clinical engineering as duraflow PAPR product discontinuing
- Industry recognised fit testing "Fit to fit" accreditation for 4 health and safety team fit testers
- Fit testing audit and training program established

5. Patient Environment

5.1 Ligature Assessments in Mental Health

Ligature audits in mental health inpatient settings were put on hold due to the COVID-19 pandemic, as a result none were conducted independently of the ward teams by the H&S department. With the relaxation in ward access controls, the programme priority has been elevated and the department have conducted seven since April 2021 with an on-target completion during Q3.

The UHB H&S lead for this audit is working with an all Wales task and finish group, being facilitated by the Delivery Unit in Welsh Government, tasked with developing an all Wales policy position for ligature risk assessments in line with guidance and best practice. This work is ongoing with our own procedures providing considerable input into the draft documents to date.

6. Fire

Note - Fire Safety is subject of a separate Annual Report which is compiled externally to the H&S Team.

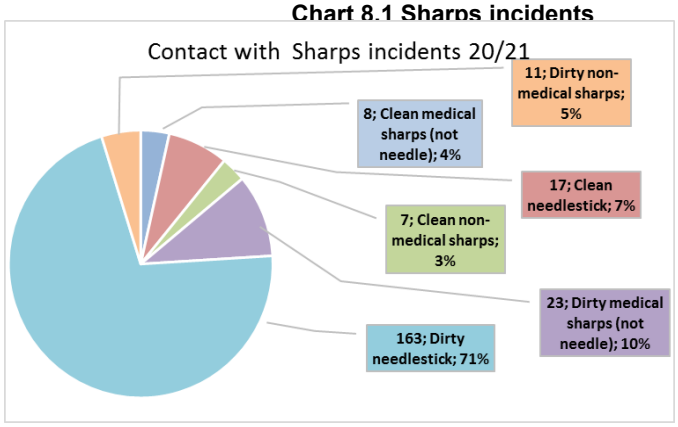
7. Estates

Food Hygiene, Waste Compliance, The Estates and Facilities Internal advances C&V team safety, Contractor management, Authorised persons (AP) sit within the Estates Management Team.

8. Sharps Safety

The reporting of sharps injuries is the lowest recorded to date at 229 showing a reduction of ~24% from the previous year, though this has been inflated due to a spike in the previous year's needle stick reports* from the surgical directorate. In comparison to 2018/19 which does not include this spike in reports there is a reduction of ~11%.

Chart 8.1 Sharps incidents



- Approximately 24% of sharp injuries reported were from clean sharps, presenting a lower risk of infection.
- The numbers of needle stick personal Injury claims remain low at only 4.5% of the All Wales NHS number of events whilst employing 16% of the workforce.

<u>3 year comparison of needle stick injuries by clinical board</u>

A 5 year comparison below of needle stick injuries shows most clinical boards with a stable number of injuries being experienced.

Table 8.1 Sharps injuries 5 Year Trend

	Estates & Facilities	Child &Women	C D & T	Exe & Corporat	Medicine	Mental Health	PCIC	Specialist	Surgical*	Other	Total
18/19	20	17	27	4	41	11	14	30	54	3	**255**
19/20	12	24	35	1	37	19	17	40	98	X	**286**
20/21	12	29	22	2	37	17	23	30	53	4	**229**

*Surgical board merged with dental service board in 2019-2020 this lead to an increase in sharps incidents, the subsequent reduction can be attributed to reduced surgical procedures over the COVID period.

ASSURANCE is provided by: Health and Safety aspects continue to be monitored and progressed as detailed within the report.

The Head of Health and Safety currently reports directly to the Chief Executive, and also works closely with the Executive Director of people and culture in order to successfully implement improvements.

RECOMMENDATION

The Health and Safety Committee is asked to:

- Note the contents of this report.

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Health & Safety Committee Effectiveness Review 2020-21 Results**								
Meeting:	Health and Safety Committee						**Meeting Date:**	27th July 2021	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**	**X**	
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Corporate Governance Officer**								

SITUATION

It is good practice and good governance for Committees of the Board to undertake a self-assessment of their effectiveness on an annual basis, in line with the requirement of Standing Orders. This is done for all Committees of the Board.

This is the first review undertaken by the Committee and the process will be completed annually going forward. The survey questions were selected based on their inclusion as key considerations in the Good Governance Handbook and Survey Monkey was used as a tool to gather the feedback.

ASSESSMENT

Attached are the results for the Health & Safety Committee Effectiveness review undertaken by Committee Members in addition to the Executive Director Lead for the Committee; where comments have been provided these are also included. In total four responses were received.

It is of note that there are a number of areas highlighted as “needs improvement” this year however the survey period covers the pandemic which added additional pressures/challenges to the running of Committees.

With the Committee now coming under the remit of the Corporate Governance Team, an improvement in next year’s responses should be seen.

RECOMMENDATION

The Committee is asked to:

- Note the results of the Committee’s self-assessment Effectiveness Review for 2020-21.

Shaping our Future Wellbeing Strategic Objectives *The UHB objectives relevant to this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care	

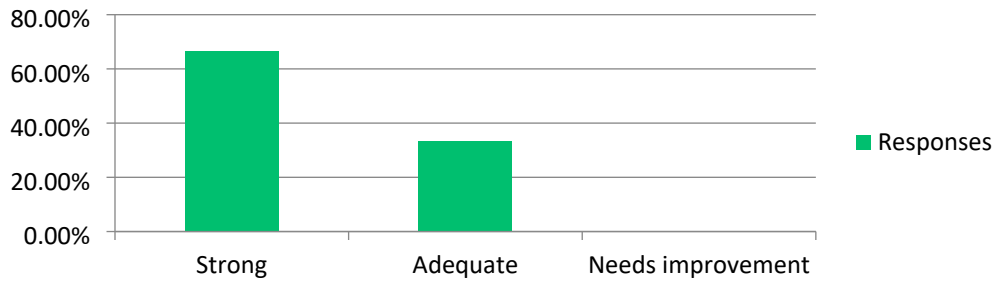
			sectors, making best use of our people and technology		
4.	Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us		
5.	Have an unplanned (emergency) care system that provides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

Five Ways of Working (Sustainable Development Principles) considered									
Prevention		Long term	x	Integration		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable								

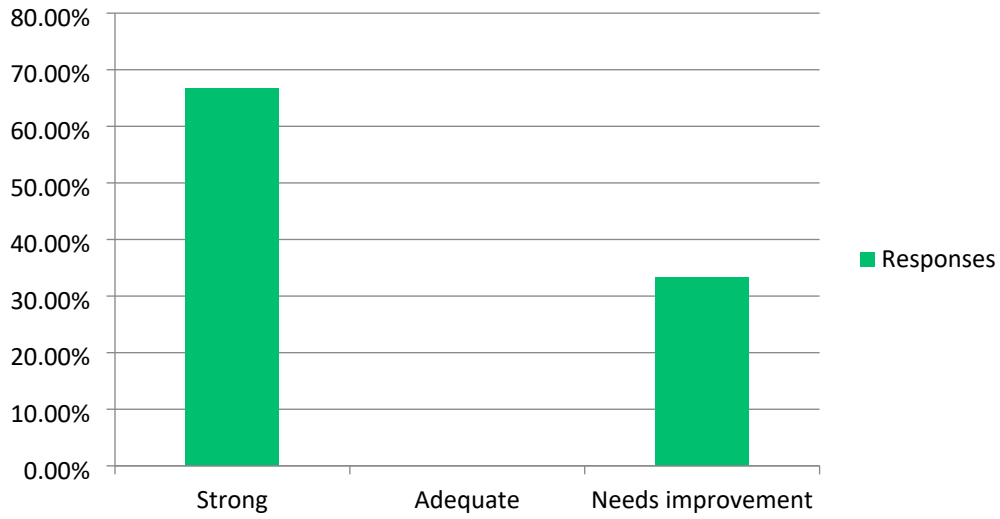
Health & Safety Committee Self Evaluation 2020-2021

- 3 responses received

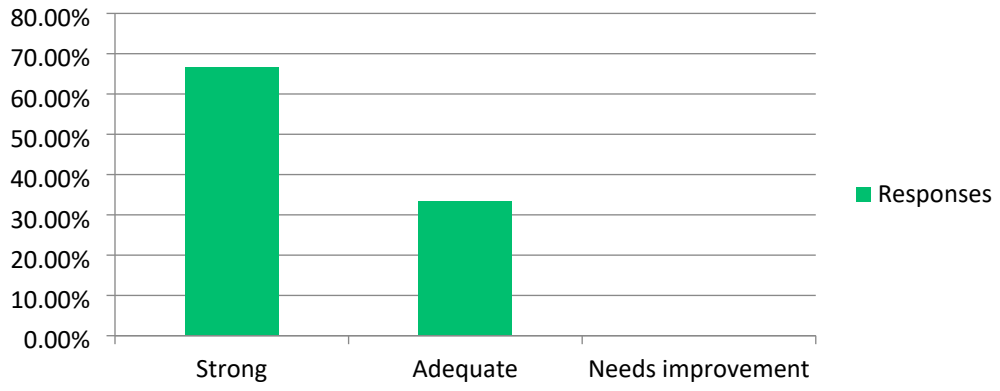
1.The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the committee and the full board.



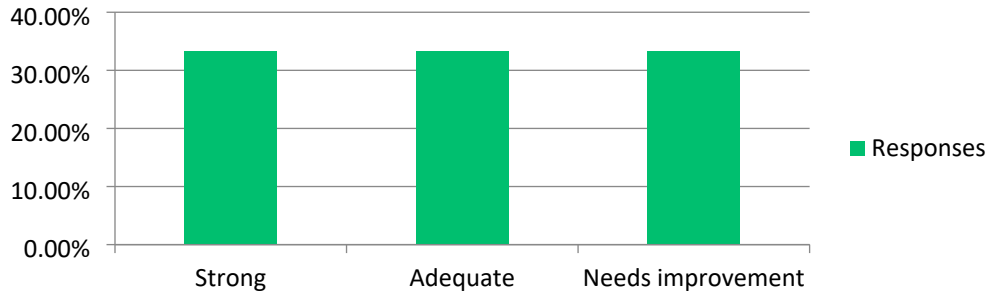
2.The board was active in its consideration of Committee composition.



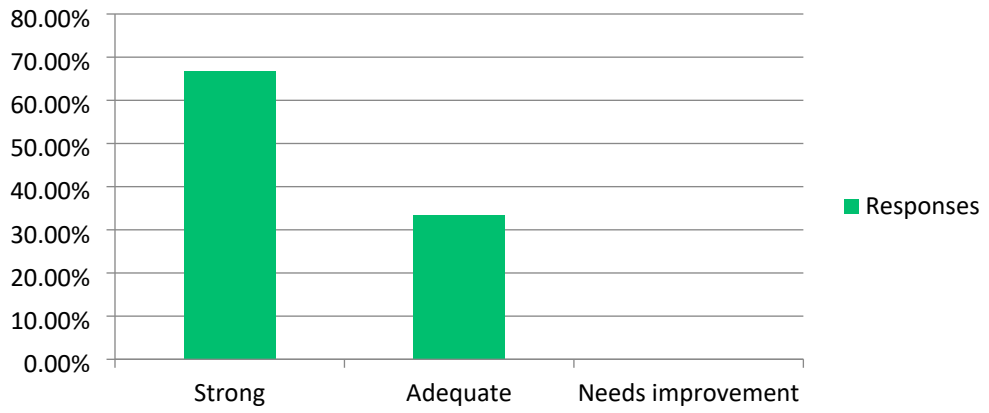
3.The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.



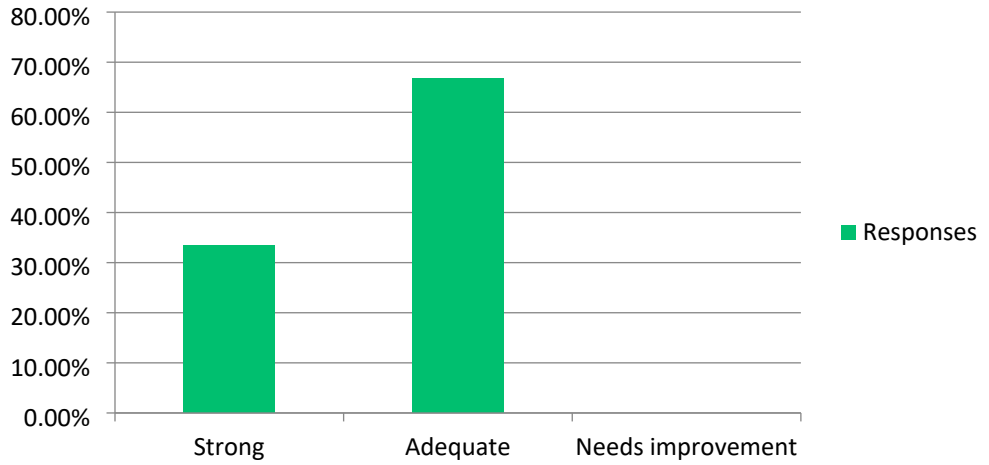
4.The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.



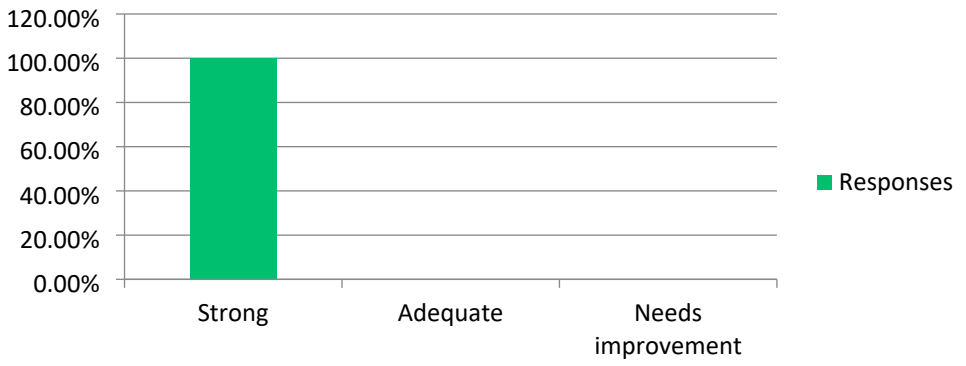
5.Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the committee's responsibilities.



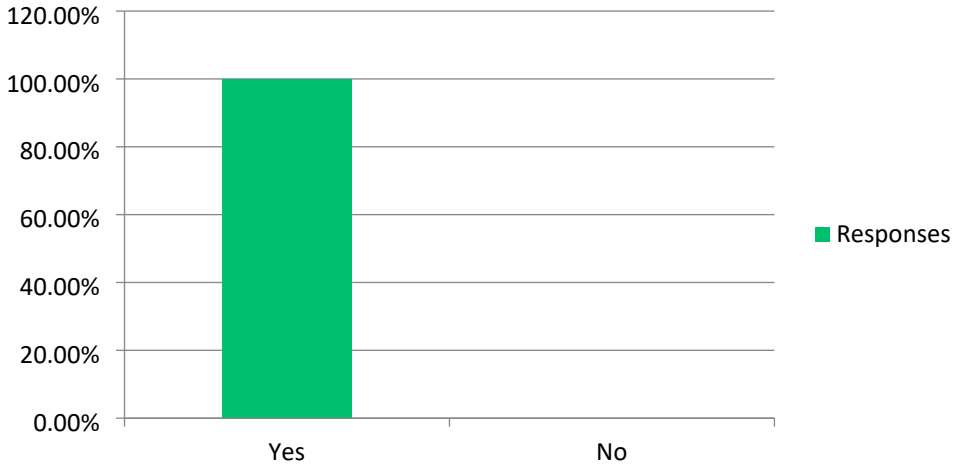
6.Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.

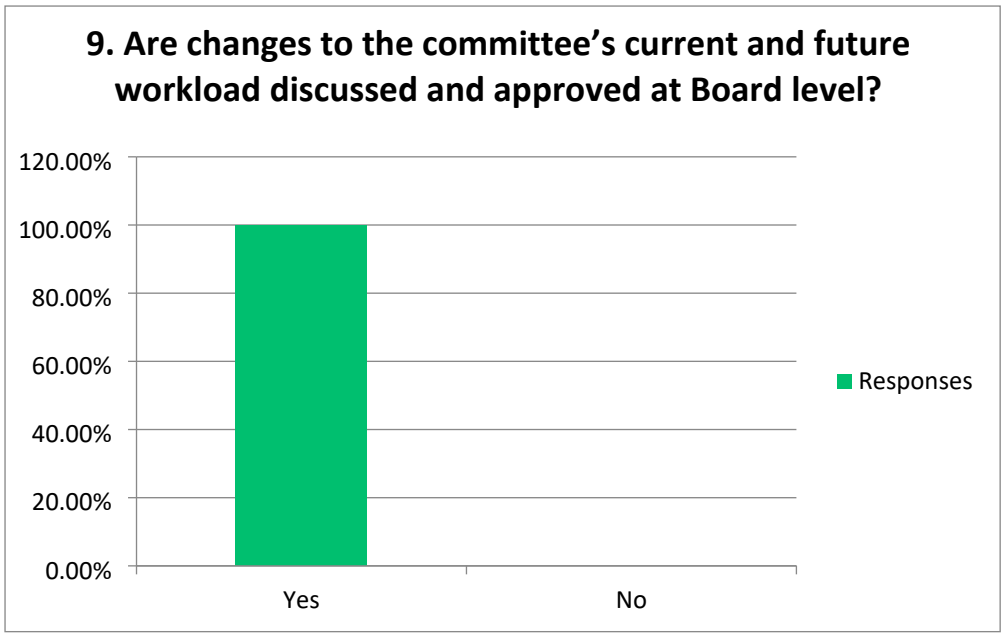


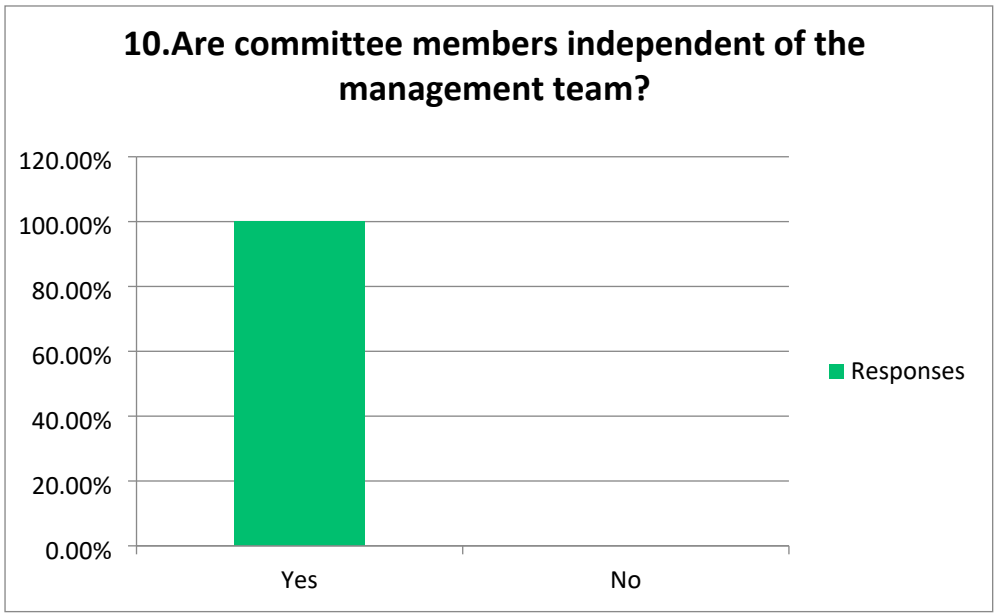
7.The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.

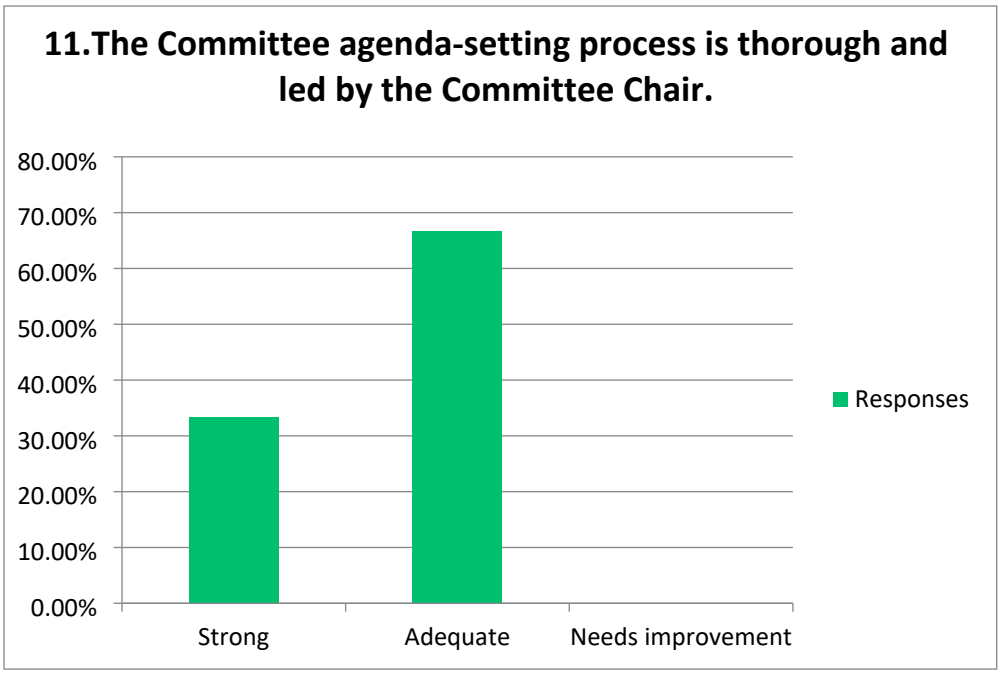


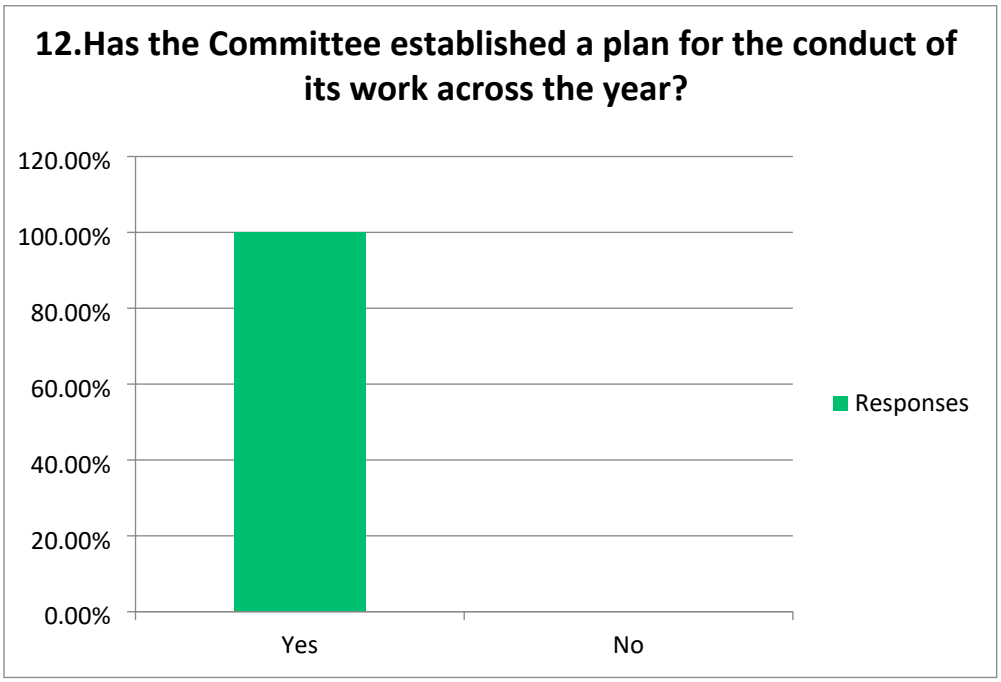
8.Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?

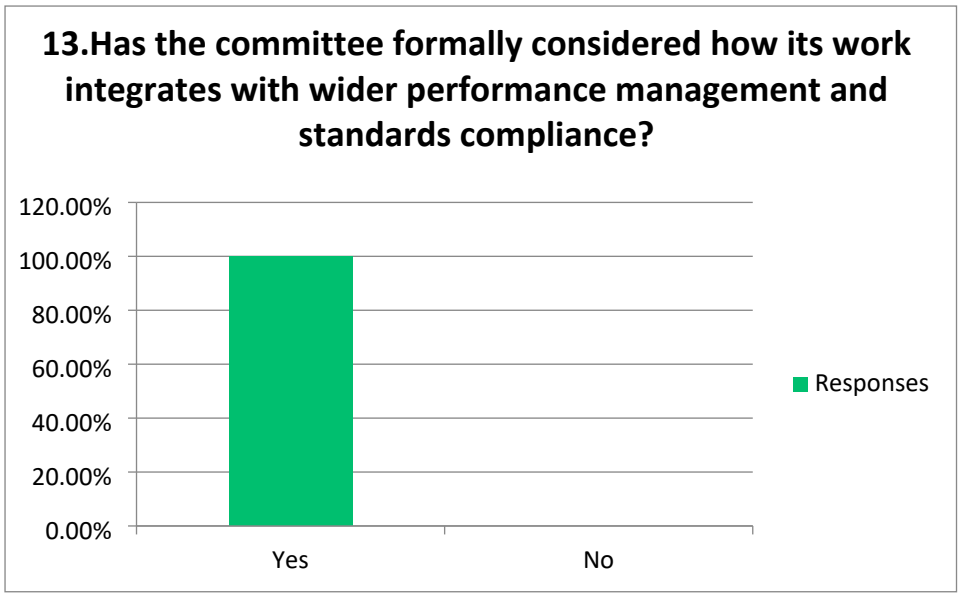






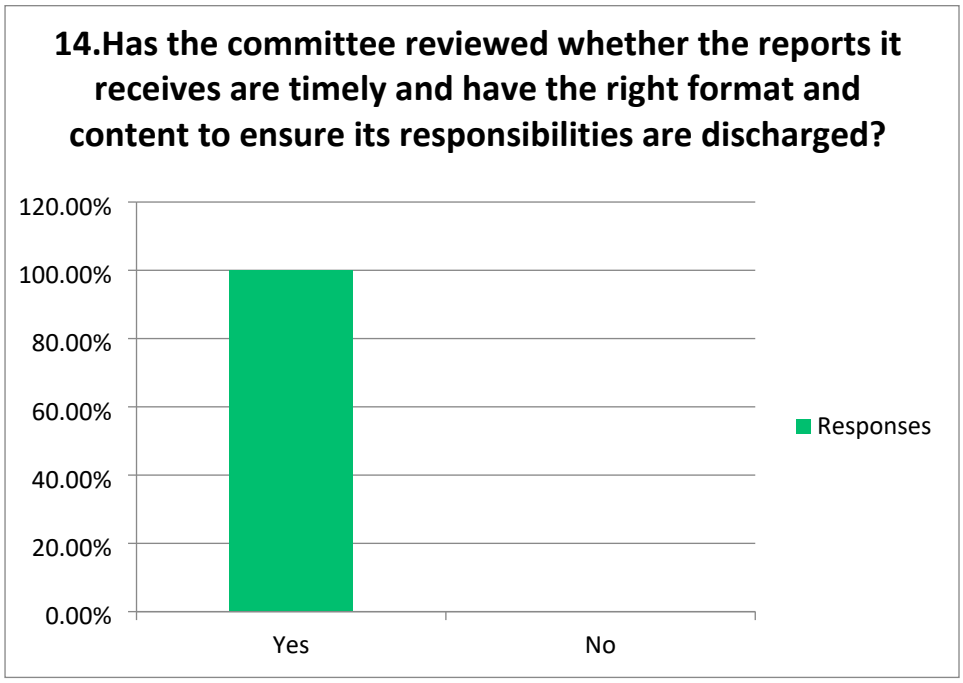




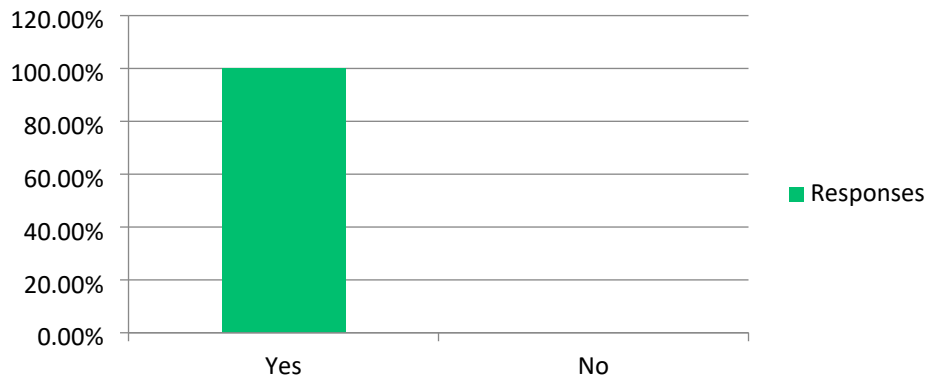


Comments received:

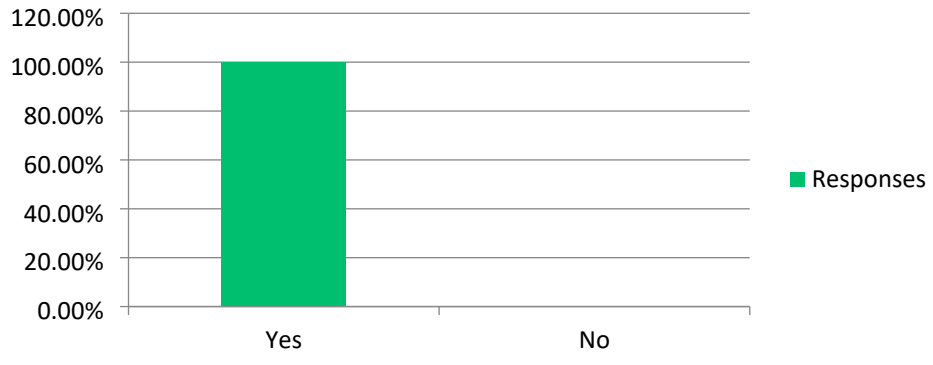
- *Report to Audit Committee on interrelationships between Committees*

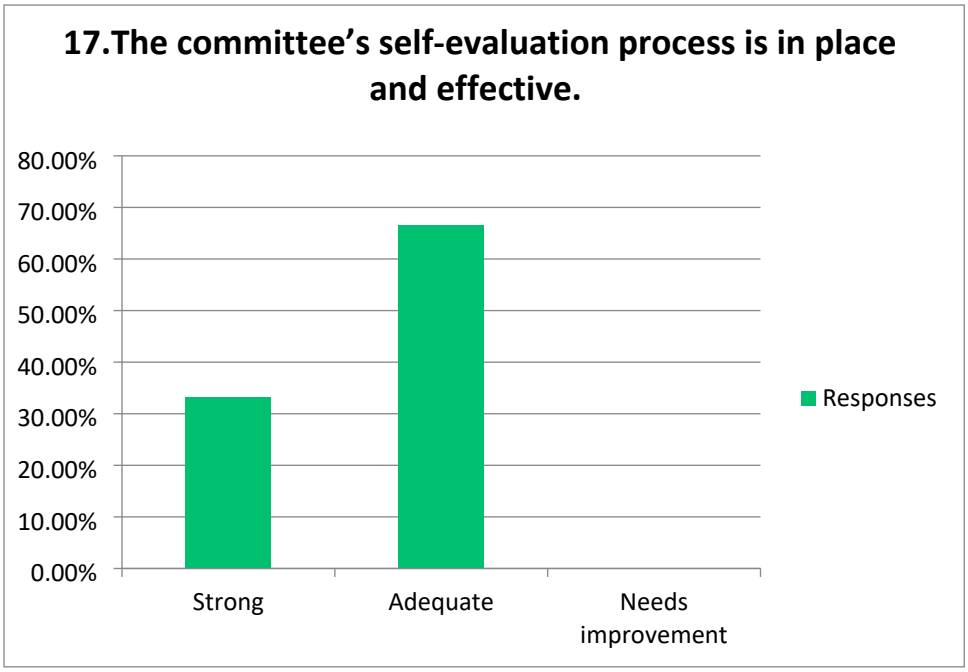


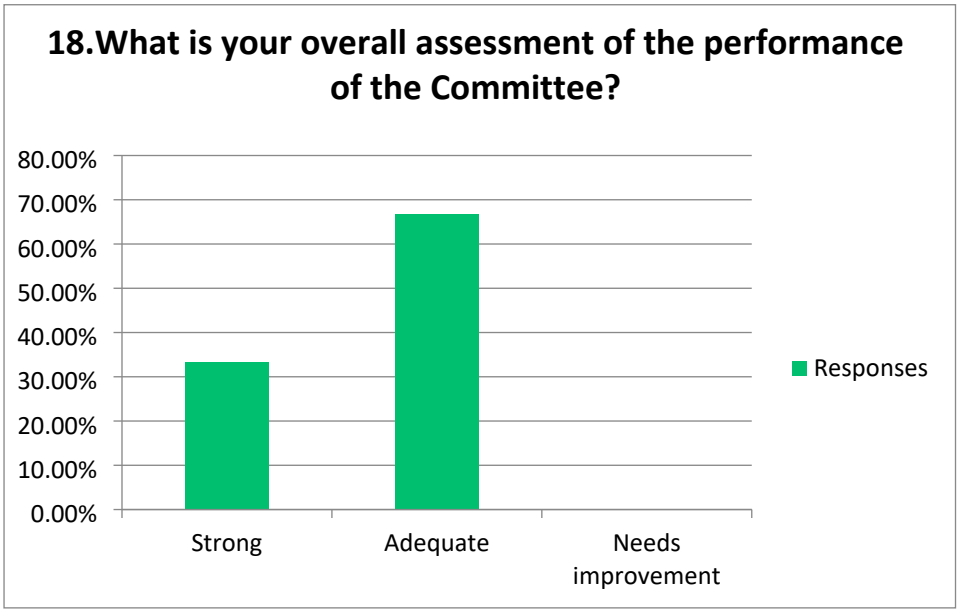
15.Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters?NHS Handbook status: 2 - should do



16.Is the committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?







Additional comments received:

- *Committee needs reinvigorating which hopefully will coincide with appointment of new Head of H&S but also needs more buy in at Executive level*

H&S Dept
1st Floor Woodland House,
Cardiff, CF14 4TT
Tel: 029218 36560

MEETING MINUTES
OPERATIONAL HEALTH AND SAFETY GROUP
9:30AM on WEDNESDAY 10TH MARCH 2021 via MS TEAMS

Attendance

Present:

Robert Warren	Head of Health and Safety
Nicola Bevan	Head of Employee Health and Wellbeing
Rowena Griffiths	Dental Directorate - Governance and Quality
Stephen Gardiner	Head of Estates and Facilities
Jonathan Davies	Health and Safety Advisor
Caroline Murch	Health and Safety Advisor
Rachael Sykes	Health and Safety Advisor
Stuart Egan	Lead Trade Union Representative
Mal Perrett	Discretionary Capital (10:45)
Jon McGarrigle	Head of Energy and Performance

Clinical/Service Board Representatives

Maxine Gronow	PCIC
Ian Wile	Mental Health
Sue Bailey	CD&T
Lucy Coates	Specialist Services

Apologies:

Rachael Daniel	Health and Safety Advisor
Philip Mackie	Discretionary Capital – H&S and Asbestos
Emma Stone	Dental Nursing
Matthew Price	Specialist Services
Janice Aspinall	Staff Side Representative
Sian Jones	CD&T
Hayley Dixon	Dental Clinical Board
Lisa Dunford	PCIC
Rhodri John	Children & Women

In Attendance:

Thomas Bott	PA to Head of Health and Safety

H&S Dept
1st Floor Woodland House,
Cardiff, CF14 4TT
Tel: 029218 36560

Minutes

Item 1	**Welcome and introductions** **Robert Warren** opened the meeting and **Robert Warren** introduced himself to the Operational Group, explaining that he has taken over as Head of Health and safety and explaining his experience in the organisation and his previous H&S experience. Explaining that it his first time chairing this meeting. **Robert Warren** praised the teams he has interacted with for their ability to look at improvement within their teams. And emphasised the importance of the OHSG meeting in facilitating this. -(After Apologies)- **The members of the meeting** introduced themselves to **Robert Warren**
Item 2	**Apologies for absence** **Thomas Bott** introduced himself and then gave the apologies. The meeting received apologies from **Rachael Daniel**, **Philip Mackie**, **Emma Stone**, **Matthew Price**, **Janice Aspinall**, **Sian Jones**, **Hayley Dixon**, **Lisa Dunford**, **Rhodri John**
Item 3	**Minutes from previous meeting** **Robert Warren -** opened up the meeting and passed it to **Rachael Sykes** **Rachael Sykes** raised an issue with previous minutes related to training, the previous minutes were inaccurate. Explaining that the minutes were inaccurate and that emergency covid manual handling had still been present. That foundation courses were still being provided and substantive posts would need to complete this. That in the previous meeting she did not state staff had been asked to withdraw from courses. **Rachael Sykes** also advised that mental health/violence and aggression practical training had stopped so only the theory part is online. She didn't say that and doesn't know if that was true in December as she believes they had reinstated it by then! **Ian Wile** confirmed that mental health training was back up and running. **Robert Warren** asked for agreement with the above changes. (A yes was taken in absence of any disagreement) **Sue Bailey** requested a small amendment required to page 2 item 7, Sue Bailey was in attendance, with no RIDDOR incidents to report on. **Technical issues delayed meeting** **Rachael Sykes** suggested cameras be turned off,

H&S Dept
1st Floor Woodland House,
Cardiff, CF14 4TT
Tel: 029218 36560

	Action – Thomas Bott to amend previous minutes
Item 4	**Action Log from previous meeting** **Robert Warren and Thomas Bott** clarified that no action minutes were available from the previous meeting Actions were taken from the minute notes of the previous meeting **Robert Warren** Expressed a desire to have a separate action log going forward. **Stuart Egan** explained a previous action for Rachael Daniel to update him on the HSE reporting around staff contracting COVID and that this action is still outstanding. **Action – Rachael Daniel to update Stuart Egan on HSE reporting for staff COVID infections.** **Robert Warren** reinforced the desire to reinstate an action log as separate document **Action – Thomas Bott** to produce action log going forward.
Item 5	**External Independent Review of Health and Safety** **Robert Warren** raised point 5, external review of H&S. Explaining that this was brought in by the board prior to his employment and he had taken over the process on commencement his employment. An external organisation was appointed the day prior to the meeting and the review will begin imminently. This will assist in seeing how the H&S department and the health board is standing to close gaps and drive forward H&S in the health board. Robert Warren was asked to lead and he feels that this review will support the organisation in developing robust processes. Robert Warren suggested this would be positive and asked that anyone asked to contribute would do so openly. Opening floor to question. **Nicola Bevan** Queried about other departments asking if other departments have been notified about their involvement as of yet? **Robert Warren** expressed that other departments had not been directly contacted yet except in some small cases such as estates but noted that Occupational health unlikely to be part of review, but will be informed if they are included. **Stephen Gardiner** asked why only estates was being included at this time. **Robert Warren** explained that at the moment key policies and standards sit with estate which are directly related to the health and safety of the health board. **Stephen Gardiner** expressed that could also relate to many other departments. **Robert Warren** acknowledged this and explained the scope of the review was a movable thing depending on situation. **Stephen Gardiner** asked if there was current a scope document set out that could be viewed. **Robert Warren** stated there was no document currently as the scope was still under review. **Stephen Gardiner** asked if there had been an initial scope during tender process. **Robert Warren** explained the tender process had involved an open scope to be discussed and confirmed post tender.

	Mal Perrett returned to this after joining the meeting. **Mal Perrett** asked if fire safety was to be included in the scope of the review. **Robert Warren** explained that Fire safety was to be included. **Mal Perrett** asked if the review would cover certain service boards or be more general. **Stephen Gardiner** explained that this had been discussed and the scope was not fully defined, with estates being looked at as a contributor at the moment. **Robert Warren** confirmed fire is being included, and explained he was more than happy to have a meeting with **Stephen Gardiner** to discuss estates involvement **Stephen** was happy to discuss in a later the meeting **Action – Meeting between Robert Warren and Stephen Gardiner to Discuss Review of H&S and estates.** - **Thomas Bott to arrange meeting** - **Meeting to discuss.**
Item 6	**Feedback from Health and Safety Committee** **No feedback from recent committee**
Item 7	**Enforcement Agencies Correspondence** **Robert Warren** Opened item and passed to Caroline Murch. **Caroline Murch –** Explained that previous report raised issue with boiler in UHL . She explained repair of boiler in UHL had occurred, the assessment had been revised and annual checks are to be carried out by engineering services. This was then Closed. She explained the HSE has concluded investigation into a staff member who died from COVID, concluding that this was not work related. The issue of fit testing in a nursing home discussed last meeting, **Jonathan Davies** worked with this and the fit testing report was reviewed, the training package reviewed, **Jonathan Davies** and **Rachael Sykes** are putting an audit schedule in place to go to clinic boards to review practise, this is closed with HSE who are happy with the response. **Robert Warren** asked **Jonathan Davies** is it timely to mention Face fitting accreditation **Jonathan Davies** explained the H&S team has had external verification regarding Face fitting leading to accreditation of face fitting practice to support the review of best practice with internal face fitters within clinical boards.
Item 8	**RIDDOR Incidents** **Robert Warren** Opened the item and passed to **Rachael Sykes** and **Clinical board representatives** for RIDDOR incidents **Rachael Sykes** *Displayed the riddor incident report in meeting.* Rachael asked about who was leading for areas and explained we were looking to get feedback from clinical boards on RIDDOR reports in their board. **Ian Wile** explained the clinical meeting in which RIDDOR was discussed in Mental Health(MH) has been delayed. **Rachael Sykes** Picked up meeting RIDDOR incidents for Mental Health.

First incident staff member injured by object during psychiatric incident, impacted by door. Colleague received full hand over, full training, the patient was on intermittent observations, medication was used, no trigger was identified, care plans and risk assessments were complete and up to date; incident appeared to be an accident.
Second incident was assault on MH older persons ward, awaiting investigation, patient lacked capacity, an injury to member of staff did occur; investigation results awaited.
Third incident with MH older persons services, patient getting up in middle of night, staff providing assistance, patient became agitated, sat at nurses station and was receiving support. Patient assaulted member of staff speaking with him, awaiting the report.

Ian Wile explained incidents were happening on dementia ward so patients were lacking capacity more often than not. He explained there was a variety of techniques and approaches include getting to know patients and triggers for aggression as well as physical methods. Training involves interaction and some elements of safe holds are required. Despite how good training has become, and training is high quality, there continues to be high levels of assaultive behaviour which reflects the patients being supported by MH, including personality disorders and substance misuse. Care plans being created is key. In some cases unfortunately patients are often contained to the ward limiting ways to approach behaviour management removing controls such as a patient being asked to attend an alternative service.
Rachael Sykes explained there is work going on around safer wards and ward design, and psychologists working with staff on safer management.
Ian Wile supported including use of care plans, and management methods with staff. Picking up on difficult behaviour. He expressed the positivity around the various things being done but there is a worry about assaults remaining high.

Rachael Sykes asked if anyone was present to address capital and estates incidents
Caroline Murch asked if **Stephen Gardiner** happy for Caroline to lead on these incidents in support of Stephen.
Stephen Gardiner agreed.
Caroline Murch addressing the incidents:
First, a house keeper pushing mop-it trolley twisted her back, outcome was manual handling training needs to be refreshed.
Second was a physical assault on E7, case management team have offered support but the investigation is currently outstanding.
Third incident was collision with door frame in the kitchen in UHL, this is awaiting investigation.
Fourth incident was a house keeper pushing a trolley through tunnels in lakeside who subsequently injured their back, this activity is now being undertaken by stores using a powered trolley.

Rachael Sykes asked if anyone was present to address Specialist services incidents
Lucy Coates explained that unfortunately she had not been able to review incidents to provide feedback
Jonathan Davies explained that there was no new feedback on incidents other than the updated incident document shown in meeting.
Rachael Sykes suggested this be picked up outside meeting with Specialist services team.

Rachael Sykes explained that no one was present to discuss the incidents for Medicine and that the document shown in meeting would showed the state of medicine incidents.

	Rachael Sykes took the incidents for Children's and women's service, The first incident was an unforeseen accident, a maternity care assistant running to theatre, as staff was running and grabbing equipment include PPE, the staff member dropped an apron, slipped on the dropped item and was injured. The investigation showed no more suitable area to store PPE and no changes were made. **Robert Warren** thanked **Rachael Sykes**, **Caroline Murch**, and **Ian Wile** for taking the meeting through the incidents. **Robert Warren** explained that he had taken a brief look at January and February, out of 12 RIDDORs, only 1 was due to a specified injury with 11 reportable for absence from work over the 7 day threshold. Suggesting that the health board could reflect on where RIDDORs were coming from with a view to supporting staff.
Item 9	**Health and Safety Training Update** **Robert Warren** opened item and handed over to **Rachael Sykes** **Rachael Sykes** *displayed the training compliance report in meeting.* Rachael explained there had been no changes in relation to training being offered. Foundation and update Manual Handling and Violence & Aggression training was being provided. First aid at work training being run. Risk Assessment working safely has been re-started. Managing safely has not been reinstated due to resources within the department. The compliance of training has been very low as shown on document in meeting, difficulties around this include release of staff and limited training spaces due to social distancing; the switch to direct booking via ESR may also have had an impact. She asked if clinical board representatives could look at taking improving training attendance and compliance back to the clinical boards. **Sue Bailey** explained that regarding module C violence and aggression, some staff have ESR module C required when they do not which is impacting on compliance levels.. **Rachael Sykes** noted that **Catherine Salter** was looking at ESR competencies with the ESR team; managers are advised to let LED know if un-needed competencies are on staff records then these can be removed. This can sometimes be harder to determine with Violence & Aggression, compared to Manual Handling, as this needs to be reviewed on a local risk assessment basis, which can then be communicated to LED. **Robert Warren** added, as the face fitting requirement tails off, the H&S department are looking to increase the number of courses on offer. **Rachael Sykes** added that as the health board response to COVID and social distancing requirements change with the changing pandemic we will be able to increase places available on each course as guidance changes.
Item 10	**Fire Safety Report** **Robert Warren – postponed for Mal to attend** **Mal Perrett attended meeting and this section was returned to** **Mal Perrett** *Displayed fire safety report in meeting*. Mal explained that one fire incident in the recent months, the current situation has reduced fires dramatically from an average of 12 a year due to a combinations of factors.

	The one incident was a staff members personal IT charging unit being the cause, staff were advised with regards to safe purchasing of equipment and personal items. False alarms, we have 67 false alarms in the 3 month reporting period. We are doing well in comparison with other boards, and we have been reducing false alarms year on year. Recent numbers have been reduced due to a combination of factors and these false alarms might rise again at the end of COVID. Risk assessments, currently there are around 450 fire risk assessments across the site, some are out of date due to sickness and leave. These should be addressed by the next reporting period. Some assessments have been put back due to COVID, and are being pushed forward where possible. Training provision and compliance has gone down due to COVID, there has been a drop in attendance. Work force and development have done a comparison of a period of years. Figures are not as good in relation to face to face training as desire, this will be challenging to address during the pandemic, though online training has seen a small reduction in compliance as well. Face to face training has been delivered over the last months, with social distancing in mind, figures show 516 for a roughly 7 month period which is down significantly. Normally fire safety training face to face would be expecting 500 attendances a month, this is down due to the current issues affecting the health board and training in general. *Report was used to show a best practice matrix*. The best practice matrix can be helpful going forward to improve the service. **Robert Warren** thanked **Mal Perrett** for the report, and addressed that training compliance is something we all have a part to play in as the changes to services due to the pandemic are changed and adjusted to respond to the changing situation. He emphasised that the health board should address getting courses in place and clinical boards being in a position to release staff for attendance. He acknowledged that challenges in patient facing roles will need to come first but hoped we could see an easier time for staff to attend training in the coming period. **Mal Perret** agreed that attendance and release of staff is a massive challenge going forward. **Robert Warren** Any issues or questions (nothing raised)
Item 11	**Personal Protective Equipment Cell Update** **Robert Warren** explained that the Health and Safety team were looking to do a structured withdrawal from some of the PPE roles we had taken on and **Jonathan Davies** will be best placed to give an update. **Jonathan Davies** explained that at the moment continuity of supply for RPE shows to be in a stable position, the requirement for central face fitting has reduced somewhat. There have been a number of issues regarding continuity of supply in relation to powered units but this is being addressed at the moment. The health board seems to be in a strong position in relation to PPE supply. **Robert Warren** asked if there were any questions (nothing raised)
Item 12	**Clinical Boards Health and Safety Group Feedback**

Robert Warren asked if this was a section for everyone, and suggested that **Rachael Sykes** could lead.

Rachael Sykes asked if any clinical boards have anything they wish to raise to the meeting,

Maxine Gronow Had been asked to raise that several sites in the community group had issues with CCTV not operational, including the Cardiff Royal Infirmary, South East Office and Riverside. Appropriate paperwork has been complete and given to capital, the issues are unfortunately outstanding and **Maxine Gronow** wondered if this could be pushed. **Stephen Gardiner** suggested he could look into this if **Maxine Gronow** sent him a separate email.

Action – Maxine Gronow to email Stephen Gardiner to chase CCTV repairs.

Sue Bailey explained that she did report an incident with ionizing radiation to HSE, a needlestick with radiopharmaceutical. HSE was happy with the investigation performed and that it was an accident; and with actions taken. The staff member affected is fine.
In terms of clinical board Health & Safety action plan, the element in red is work related stress. Actions going on includes training around wellbeing for staff and managers.
The team is grateful for staff haven however colleagues working in satellite sites are asking about staff havens for satellite sites.

Nicola Bevan covered that Llandough and Jubilee garden (UHW) sites were opening soon. Teams looking to open small areas and break rooms can look to the health charity for funding as well as estates for works to make the rooms comfortable. **Nicola Bevan** Will take the Cardiff Royal Infirmary site haven room to the health and well being group.

Action - Nicola Bevan to raise the Cardiff Royal Infirmary Haven room at the Health and Well Being Group.

Sue Bailey explained that staff in the mortuary would like to contribute to bariatric action plan, but they are currently unsure who to contact with.
Rachael Sykes suggested that she can contact **Sam Skelton**, to confirm it is sitting with **David Pitchforth**

Action – Rachael Sykes to check if bariatric action plan is sitting with David Pitchforth and feedback to Sue Bailey.

Sue Bailey thanked **Rachael Sykes**

Robert Warren expressed he is keen on the sharing of information and that **Sue Bailey** had mentioned current systems to address work related stress, is this something that could be shared.

Sue Bailey explained that her board are working with the company AfterThought that provides roleplay and video training, and they would be delighted to share the video as a UHB wide resource. Working with company to confirm content.

Nicola Bevan asked if this could be shared with the employee wellbeing service.

Sue Bailey agreed.

	Action – Sue Bailey to contact Health & Safety and the Well Being Service once the After Thought videos are produced. **Rachael Sykes** expressed that there is a lot of working going around work related stress, and asked **Nicola Bevan** to take over this topic. **Nicola Bevan** explained there was a lot of work going on both pre and during COVID, including training available for managers and staff, that the stress risk assessment has been revamped. Training was is available virtually and there is a YouTube resource available. **Nicola Bevan** raised a query regarding Denbigh house. Staff have raised an issue with the access to Denbigh house. Door has been broken for several months, with Security having to come and open and close building daily, this is a security issue especially out of hours. This has been raised alongside an issue with the elevator in Denbigh house not functioning. **Jon McGarrigle** explained his team are aware of the lift issue, and a part is being ordered. Unfortunately this is the first time time he has heard about the doors, but will review this after the meeting. **Action – Jon McGarrigle to investigate the issues around access to Denbigh House.** **Ian Wile** mentioned for **Robert Warrens** benefit, the introduction of the smoking ban changing to law on hospital sites. Because patients need to go to specific locations there could be an increase in levels of frustration among patients who do not understand the implications, which could include patients of the Mental Health service. The hospital sites are possibly only 18 months from a complete ban of smoking without exception of Mental Health patients, which going forward might need to be considered. With relation to Violence & Aggression in Mental Health the environmental elements seem to be good for supporting staff in central sites but other community sites are in poor condition and regular requiring H&S support to maintain. On work related stress, the Mental Health services are looking around Wales for areas of good practice and Betsi Cadwaladr Health Board have got promising numbers for staff sickness and they are looking at getting that information. **Action – Ian Wile to approach contemporary at Betsi Cadwaladr to ask about their stress support programme.** **Ian Wile** continued explaining that The Recovery College has been opened which is run by peer support workers and includes mental health awareness courses being run by people with lived experience available for both staff and patients, early courses have been successful and are looking to expand that service.
Item 13	**Health Issues** **Robert Warren** opened this item and passed this to **Nicola Bevan** **Nicola Bevan** explained recently she has been out in the wards a lot; staff are tired both physically and emotionally. Nicola Bevan is encouraging services not to come back into

	full service levels, to allow time for staff to pause and reflect, where possible, to support exhausted staff. In regards to Occupational Health and Employ Wellbeing, this is the time as the last wave starts to dip down when the tsunami of staff Wellbeing issues will hit with staff able to take a moment to begin processing what has occurred during the pandemic. Waiting times in the Employee Wellbeing Service are still low. Staff are also being signposted to Health Professional's Wales which provides a similar service to EWS. EWS are running twice weekly virtual drop in sessions for support or talk about wellbeing. Uptake in this is quite poor. Q&A session for managers are being run, and any managers needing support can be signposted to this. Stress risk assessment, compassion and self-care sessions are being run for training. The service is developing training on moral injury, to support staff with the impact of decisions and choices made that may have affected their wellbeing. Wellbeing champion training is being done and hopefully the service can encourage 10% of all staff to become wellbeing champions to support colleagues in the workplace and in accessing other support. Collaborative work has been done with multiple areas including The Recovery College and the chaplaincy. Havens have been developed and are still being worked on and the request for Cardiff Royal Infirmary will be carried forward. Occupational Health is showing an increase on long COVID referrals coming in along with a high amount of stress and anxiety referrals, some stress referrals are COVID related and some not. Occupational Health has developed a fast access pathway for dermatology for PPE related skin issues, this will remain available for a while going forward. Funding has been received from the health charity allowing investment in a team to look at preventative wellbeing services, to support in pushing preventative initiatives. This team will link in with clinical boards and be engaging with them to look at good practice already in place. **Sue Bailey** to pick up on fatigue management. This is something that has been worrying for a while, the impact of fatigue on clinical incidents. It would be good if there was support provided around this including sleep support. **Nicola Bevan** agreed and explained sessions are being done on sleep going forward with the Wellbeing Service specialising on a different topic at a time with sleep already being addressed. **Robert Warren** suggested that clearly a lot of good work was being done, especially to pre-empt a surge in wellbeing issues, the challenge seems to be promoting these services that are on offer for employees. **Robert Warren** also strongly praised the approach to preventative measures. **Nicola Bevan** explained the Occupational Health and Employee Wellbeing Service work closely with the COMMS team, but unfortunately staff don't seem to have had the time and space to consider what they have been going through. Part of the reason for wellbeing champions could help to share and distribute information.
Item 14	**To note the date and time and view of the next meeting 2pm on Wednesday the 9th of June 2021**

H&S Dept
1st Floor Woodland House,
Cardiff, CF14 4TT
Tel: 029218 36560

Other Business	**Any Other Business** **Robert Warren** asked if there was any other business or everything has been covered during the meeting? **Stephen Gardiner** confirmed he was looking for a chat post meeting with **Robert Warren** **Robert Warren** agreed to a meeting and asked for any further issues, and then offered to bring meeting to a close. **Rachael Sykes** explained next meeting date. **The Meeting Expressed their Good Byes and the meeting closed.**