Health & Safety Committee Meeting

Tue 19 April 2022, 09:00 - 12:00

MS Teams

Agenda

1. Welcome & Introductions

Mike Jones

2. Apologies for Absence

Mike Jones

3. Declarations of Interest

Mike Jones

4. Minutes of the Committee Meeting held on 25 January 2022

Mike Jones

04 Draft HS Minutes - 25.1.22MD.NF.pdf (11 pages)

5. Action Log following the Meeting held on 25 January 2022

Mike Jones

05 Action Log - April 2022MD.NF.pdf (2 pages)

6. Chair's Action taken since last meeting

Mike Jones

7. Items for Review and Assurance

7.1. Health & Safety Overview (Verbal)

Rachel Gidman / Robert Warren

(to include Lone Worker Device statistics)

7.2. Fire Safety Report

Rachel Gidman / Robert Warren

7.2 Fire Safety Report Final.pdf (7 pages)

7.3. Environmental Health Food Hygiene Report

Rachel Gidman / Geoff Walsh

7.3 Environmental Health Food Hygiene Report.pdf (17 pages)

7.4. Enforcement Agencies Report

Rachel Gidman / Rachael Daniel

7.4 Enforcement Agencies Report.pdf (3 pages)

7.5. Regulatory and Review Body Tracking Report

Rachel Gidman / Robert Warren

7.5 Regulatory Review and Tracking Report.pdf (2 pages)
7.5a Regulatory Review and Tracking Report 21.pdf (2 pages)

7.6. Risk Register for Health and Safety

Rachel Gidman / Robert Warren

7.6 Health and Safety Risk Register Paper.pdf (2 pages)
7.6a H&S Risk Register.pdf (4 pages)

7.7. Standards for Health Services in Wales relevant to Health and Safety (Verbal)

Rachel Gidman / Robert Warren

7.8. Mental Health Update (Verbal)

Daniel Crossland

8. Items for Approval/Ratification

8.1. Latex Allergy Policy

Rachel Gidman / Rachael Daniel

8.1 Latex Allery Policy Cover Report.pdf (2 pages)
8.1a Latex Allergy Procedure.pdf (19 pages)
8.1b Latex Allergy Policy.pdf (18 pages)

9. Items for Noting and Information

9.1. Draft Health and Safety Culture Plan

Rachel Gidman / Robert Warren

9.1 H&S Culture Plan.pdf (3 pages)
9.1a Draft Health and Safety Culture Plan.pdf (35 pages)
9.1b Health and Safety Culture Plan.pdf (9 pages)

9.2. Sub Committee Minutes:

Robert Warren

i) Operational Health & Safety Group

9.2 Operational Health and Safety Group Minutes.pdf (8 pages)

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

Mike Jones

11. Review of the meeting

12. Date and time of next meeting

Tuesday 19 July 2022 at 09:00am

Draft Minutes of the Public Health and Safety Committee Minutes
Held On 25 January 2022 at 09.00am
Via MS Teams

Chair:		
Mike Jones	MJ	Independent Member – Trade Union / Committee Chair
Present:		
Akmal Hanuk	AH	Independent Member – Local Community
Michael Imperato	MI	Independent Member – Legal
Ceri Phillips	CP	UHB Vice Chair
In attendance:		
Nicola Foreman	NF	Director of Corporate Governance
Rachel Gidman	RG	Executive Director of People & Culture
Fiona Kinghorn	FK	Executive Director of Public Health
Robert Warren	RW	Head of Health and Safety
Geoff Walsh	GW	Director of Estates, Capital and Facilities
Janice Aspinall	JA	Safety Representative RCN
Rachael Daniel	RD	Health and Safety Advisor
Jonathan Strachan-Taylor	JS	Safety Representative GMB
Observers:		
Marcia Donovan	MD	Head of Corporate Governance
Secretariat		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		

Item No	Agenda Item	Action
HS 25/01/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
HS 25/01/002	**Apologies for Absence** Apologies for absence were noted.	
HS 25/01/003	**Declarations of Interest** No Declarations of Interest were noted.	
HS 25/01/004	**Minutes of the Meeting held on 12 October 2021** The minutes of the Committee Meeting held on 12 October 2021 were received.	

	The Committee resolved that: a) The minutes of the meeting held on 12 October 2021 were approved as a true and accurate record.	
HS 25/01/005	**Action Log following the Meeting held on 12 October 2021** The Action Log was received. **The Committee resolved that:** a) The Action Log was noted.	
HS 25/01/006	**Chair's Action taken since last meeting** No Chair's Actions were noted.	
	Items for Review and Assurance	
HS 25/01/007	**Health & Safety Overview** The Head of Health & Safety (HHS) presented the Health and Safety (H&S) Overview and highlighted the following: H&S department • It was noted that since the last meeting the Fire Safety team had been brought across to the Health and Safety department. They were working closely with the training department to organise training courses for staff. Health and Safety Culture Strategy • It was noted that a department workshop took place on 20 October 2021. The department formulated a 3-year Health and Safety Culture Strategy. Work had started on the actions and it would be brought to the next meeting. It had introduced forward thinking and provided a proactive approach to H&S. There were three main themes which included the following: - Achieving training and competence excellence. That would drive compliance and reduce the number of risks. - Achieving H&S risk and incident management excellence. - Achieving communication excellence.	RW

	It was noted that a stakeholder management system had been created. The H&S team planned to ensure that it was consistently applied throughout the Health Board. It was noted that H&S were currently not audited and that was something that would be completed. It was noted that achieving Fire Safety excellence was also a priority. Since the Fire Safety team had moved across to the H&S department, there was something that could be done to drive the improvement. Management system • It was noted that a management system would be introduced. The H&S department were already using the system. It would help the Clinical Boards manage their H&S. It would also be useful for identifying gaps. Environmental, waste management and change management folders were going to be added. H&S statistics • It was noted that the Health Board had plateaued. Time was lost with every Loss Time Incident (LTI). There were a high number of days also missed by staff due to incidents. December training compliance • It was noted that the face to face Fire Safety training rates had improved significantly and would be carried out into 2022. Compliance within training had been low and the H&S department were working with housekeeping. An improvement would be seen in training compliance which would lead to a decrease in incidents. There was also a project in place to verify trainer's competence within the H&S team. Current work. • The Health Board was organising the Obligatory Response to Violence (ORV) again. • The new Datix system would be coming into force on 1st March 2022. The H&S team were involved in implementing that. Staff COVID-19 RIDDOR reporting • It was noted that the department continued to investigate staff COVID transmissions. It was	

	likely that an outbreak in the RCN Representative office would be reported. The Independent Member - Local Community (IMLC) stated that he was pleased to hear the progress made. The IMLC queried what plans were in place to meet the KPIs and how could clear communication be implemented. The HHS responded that the dashboard was rolled out every month and was found to be very useful. They were also planning to the use the Intranet more efficiently. They were also planning to have monthly H&S drop in sessions. A H&S advisor was also assigned to each Clinical Board. That would be shared in the next meeting. The Independent Member Legal (IML) queried what was the holistic “buy in” of the stakeholders amongst the staff. The HHS responded that a H&S culture change was needed to protect colleagues. That could be done through a behavioural safety programme. That was not in the H&S Culture Strategy but it was at the forefront. The Safety Representative RCN (SR) stated that she was working hard with the HHI and wider team to change the H&S culture amongst staff. The Executive Director of People & Culture (EDPC) stated that actors would be brought in to do training and provide a different impact. That would be shared with the Committee and Clinical Board once finalised. **Lone worker report** The Lone Worker Report was received. It was noted that the report had been submitted. The current contract with Peoples Safe was due to expire in July 2022. It was noted that Procurement had been contacted. The HHS would like to continue working with People Safe, although he noted that the new contract would be subject to Procurement advice and/or procurement rules. There were 700 active devices and if the supplier was changed that could require more training hours and potential hidden costs. The UHB Vice Chair (VC) commented that he did a Patient Safety walk with the EDPC around one of the facilities. They came across a situation where a colleague was working in a flat above a retail outlet. The	

	access was one way and if someone went up to the flat the worker would need to escape using the same set of stairs as the intruder. Although the Device was useful, it may not be the only risk factor. The HHS responded that issue came down to individual risk assessment. It would mean having a discussion with managers and staff themselves. The Device was only one part of the risk assessment completed for the Lone Worker groups. The EDPC stated it would be useful to know who were the 700 people using the Lone Worker Device, and if alternatives were required for some people. The Health and Safety Advisor (HAS) stated that the Lone Worker Device was a last port of call. A risk assessment was completed first and then the Lone Worker Device was then added. The Device was meant for the high-risk community staff. **The Health & Safety Committee resolved that:** a) The Health and Safety Overview, which included the Lone Worker Device Report, was noted.	
HS 25/01/008	**Priority Improvement Plan Update (Verbal)** The HHS advised that the Priority Improvement Plan formed part of the H&S Culture Strategy. A more detailed review would be completed in the next few months. **The Health & Safety Committee resolved that:** a) The Priority Improvement Plan Verbal Update was noted.	RW
HS 25/01/009	**Fire Enforcement Report** The Fire Enforcement Report was received. The HHS stated that more information on the Fire Notices would be added to the report. The EDPC requested that the report was put against her name as the Lead Executive. **The Health & Safety Committee resolved that:** a) The on-going efforts to meet the requirements of the 3 key fire safety requirements were noted.	

HS 25/01/010	**Environmental Health Inspector Report (Verbal)** The Director of Estates, Capital and Facilities (DECF) stated there had been no Environmental Health Inspection visits by the relevant authorities since the last meeting.	
HS 25/01/011	**Fire Enforcement Notices** The Fire Enforcement Notices Paper was received. The HHS advised the Committee on the following – • On 21 April 2021 the Health Board had received a Fire Enforcement Notice. The Notice could not be satisfied and was raised with the compliance team. The Fire and Rescue Service (the Fire Service) sent a letter of caution against one of the Executives. The letter was responded to last Thursday and they had acknowledged receipt. The Health Board was awaiting their response. • There was a deliberate fire in Hafan Y Coed. Another Fire Enforcement Notice had been issued. The Enforcement Notice was closed down following the Fire Service visit to the facility. • On Sunday night there was another deliberate fire in Hafan Y Coed. The Fire Service visited yesterday but they did not issue a Fire Enforcement Notice. They were satisfied with the work being carried out. The H&S team were still reviewing it and working closely with Mental Health. It was highly likely that an ignitor was passed through the garden fence. The staff at Hafan Y Coed had staggered the smoking breaks to ensure that patients in adjacent garden wards could not speak to each other. There were also plans for garden fences to be boarded off. The IMC queried if there was a smoking policy in Hafan Y Coed and what areas could be improved upon. The HHS responded that there were designated areas for smoking. There were lighters in the gardens that did not require a flame, although they did get damaged. The protocol was that the nurses would go downstairs and help the patients light their cigarettes. There were also metal bins in place and regular sweeps in the garden. Overall there were protocols in place to allow patients to smoke in a safe place. The VC commented that some of the staff had put themselves in risk to prevent the incident from	

	escalating. The VC queried if there were any policies or recommendations on how staff should act in that type of situation. The HHS responded that would come out of the Fire Safety training. The HHS commended the staff and stated that they did act in the right manner. The EDPC stated that there was one action regarding the fences to be completed. The HHS stated that there was a Fire Safety visit on the 8 October 2021 to A4 in UHW. An Enforcement Notice was received regarding physical controls. A lot of the actions had been completed. A rolling ward improvement programme was put in place. The Fire Service was invited back on 8 February to discuss that and the Health Board was able to demonstrate that it was looking after the electrical gear switch. The DECF stated that his team were looking to take out the wards and address the issues in the quieter summer periods. The Fire Service had accepted that approach. **The Health & Safety Committee resolved that:** a) The content of the Fire Enforcement Notices Paper was noted.	
HS 25/01/012	**Enforcement Agencies Report** The Enforcement Agencies Report was received. The HSA advised the Committee on the following – • Since the last meeting, one new issue had been raised with the Health and Safety Executive (HSE). It concerned a TUG being used on the site and there were issues with a hard hat being placed over the mechanisms of the TUG. Once realised, it was taken out of service straight away. • Other concerns included vials of blood not disposed of correctly, loose wires were evident and that there was a lack of First Aid kit and eye wash station in the training area. • Despite the vague description from the HSE it was deduced that the other concerns were in relation to the waste area. • An explanation was provided regarding the TUG maintenance and inspection regime. The other concerns and issues were also addressed in the response which was satisfactorily closed out by the HSE on 1st December 2021.	

	• A Pre-Inquest Review into two staff COVID deaths, that was originally scheduled for early December, was adjourned and rescheduled for March 16th 2022. • An inquest into a staff COVID death was conducted on the 6th December and the verdict concluded that it was not a work-related transmission. That matched the Health Board's determination. **The Health & Safety Committee resolved that:** a) The content of the Enforcement Agencies Report was noted.	
HS 25/01/013	**Risk Register for Health and Safety (Verbal)** The HHS stated that the Risk Register would need to be updated. A meeting would take place with the Head of Risk and Regulation to drive that forward. The Director of Corporate Governance (DCG) commented that it would be useful to see it in the Committee meetings so that the Committee could view the Register. The HHS stated it would be brought to the next meeting. **The Health & Safety Committee resolved that:** a) The Risk Register for Health and Safety Update was noted.	RW
	Items for Approval/Ratification	
HS 25/01/014	**Pedestrian Safety Strategy** The DECF presented the Pedestrian Safety Strategy Paper and updated the Committee on the following - • Traffic for pedestrians across the Health Board sites had improved over the last few years. A review had been undertaken and a company had looked at access around the sites. They came up with a number of actions. • It was noted that there was still a lot of work to be done in terms of pedestrian safety. More people were being encouraged to cycle and take public transport such as "park and ride". The VC queried how changes to the Highway Code would affect the said Strategy.	

	The DECF responded that they were working with the Local Authority. There were discussions about bringing the safe cycle route onto sites. There was a need to reflect on changes made in the last couple of years and people's behaviours as they were not in the same place as when the Strategy was introduced. The IMC stated that relationships with Cardiff University should be looked into. A project could be engaged with the Town Planning department at Cardiff University. The DECF responded that a discussion would take place. The IML queried what the timelines of the report were. The DECF responded that the Strategy required funding along with many other obligations. The Discretionary Programme funding, out of which the Strategy was being funded, had been reduced by 25%. The Chair queried if concerns regarding finances could be raised in the Chair's Report to the Board. The DCG agreed that the Chair could escalate his concerns regarding funding via his Chair's Report to Board. The DECF stated that they were starting work on the first cycle hub in UHW. The hub included lockers and showers for cyclists. The hub was one of three such hubs that were in the pipeline. **The Health & Safety Committee resolved that:** a) The content of the Pedestrian Safety Strategy Report was noted.	DCG
HS 25/01/015	**Committee Annual Work Plan and Terms of Reference** The DCG stated that the Committee's Annual Work Plan and Terms of Reference required a review every 12 months and that the Board would approve the same in March. There were very few changes to be made and the changes made were highlighted in red. The Work Plan reflected the Terms of Reference to provide assurance to the Committee that it delivered against the Terms of Reference. **The Health & Safety Committee resolved that:** a) The changes to the Terms of Reference 2022-23 and associated Health and Safety Committee	

	Work Plan 2022-23 for the Health and Safety Committee, were ratified; and b) The changes be recommended to the Board for Approval.	
HS 25/01/016	**Committee Annual Report** The DCG commented that the report provided a backward look into the work of the Committee. It was not fully completed yet as it would need to include the details from today's meeting. The report would go to Board for approval at the end of March. **The Health & Safety Committee resolved that:** a) The draft Annual Report 2021/22 of the Health and Safety Committee was reviewed; and b) The Annual Report was recommended to the Board for approval.	
	Items for Noting and Information	
HS 25/01/017	**Sub Committee Minutes:** i. Operational Health and Safety Group – 14 September 2021 **The Health & Safety Committee resolved that:** a) The Operational Health and Safety Group minutes were noted.	
HS 25/01/018	**Items to bring to the attention of the Board/Committee** **The Health & Safety Committee resolved that:** a) There was nothing to bring to the attention of the Board.	
HS 25/01/019	**Review of the Meeting** The Chair stated that the past two meetings had finished by 11am. The Chair queried if the timing of the next Committee meeting could be reduced. The DCG responded that timings for individual agenda items could be considered which would help with the overall efficiency of the meeting. **The Health & Safety Committee resolved that:** a) Timings would be added to the agenda.	DCG

HS 25/01/020	**Any Other Business** Any Other Business was not discussed.	
	Date & time of next Meeting 19 April 2022 at 09:00am via MS Teams	

ACTION LOG
FOLLOWING HEALTH AND SAFETY COMMITTEE MEETING
25 January 2022
(Updated for the meeting 19 April 2022)

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Actions Completed					
HS 21/10/013	Risk Register for Health and Safety	an update to be provided at the next meeting in January 2022.	R Warren	25.01.21	**Completed.** Discussed at the Committee meeting on 25 January 2022. Note Action **HS 25/01/013**
HS 21/10/008	Priority Improvement Plan (PIP)	a Priority Improvement Plan (PIP) would be devised and brought to the Committee at the next meeting.	R Warren	25.01.21	**Completed.** Discussed at the Committee meeting on 25 January 2022. Note Action **HS 25/01/008.**
HS 25/01/007	Health & Safety Strategy	To bring the H&S Culture Strategy to the April meeting.	R Warren	19.04.22	**Completed.** On the agenda for April 2022 meeting – agenda item 9.1.
HS 25/01/013	Risk Register for Health and Safety	To bring the H&S risk register to the April meeting.	R Warren	19.04.22	**Completed.** Added as a standing item to the agenda April 2022 – agenda item 7.6
HSW 25/01/014	Pedestrian Safety Strategy	Committee's concerns regarding the reduction of the Discretionary Programme out of which this Strategy is funded, be raised in the Chair's Report to the Board.	N Foreman	31.03.22	**Completed** Matter highlighted to full Board via the Chair's report on 31 March 2022.
HS 25/01/019	Review of the meeting	Timings to be added to the April Agenda.	N Foreman	19.04.22	**Completed.**

					Timings for agenda items added to April's agenda.
Actions in Progress					
HS 25/01/008	Priority Improvement Plan	Matter discussed at January meeting and is to be brought back for a more detailed review in the next few months.	R Warren	19.07.22	To be brought to July's Committee meeting.
Actions referred to other Committees/Board					
HS 25/01/014	Pedestrian Safety Strategy	To raise concerns regarding financing the pedestrian safety strategy in the H&S chairs report to the board.	N Foreman	31.03.22	**Completed**. Chair's Report drafted, signed off by the Chair and presented to March Board.
HS 25/01/015	Committee Annual Work Plan and Terms of Reference	To go to Board for approval on 31 March 2022.	N Foreman	31.03.22	**Completed.** On the agenda for Board meeting on 31 March 2022
HS 25/01/016	Committee Annual Report	Draft Annual Report to go to Board in March for approval.	N Foreman	31.03.22	**Completed.** On the agenda for Board meeting on 31 March 2022.

Report Title:	Fire Safety Report				Agenda Item no.	7.2	
Meeting:	Health & Safety Committee		Public	✓	Meeting Date:	19/04/2022	
			Private				
Status *(please tick one only):*	Assurance	✓	Approval		Information		
Lead Executive:	Executive Director of People and Culture						
Report Author (Title):	Senior Fire Safety Officer						

Main Report
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 C&V 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 South Wales Fire and Rescue Authority (SWFRA) who 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 they are not satisfied they are empowered to issue a range of written notices detailing all fire safety contraventions and/or deficiencies identified during the physical audit procedure. The notice of contraventions and/or deficiencies will take the form of a Prohibition Notice (this notice prohibits the use of an area or premises), an Enforcement Notice (identifies serious fire safety contraventions and/or deficiencies), a time bound Informal Notice i.e. IN01 (fire safety contraventions and/or deficiencies that are deemed not to warrant enforcement action) or they may issue an alternative Informal Notice IN02 (advisory fire safety deficiencies - not time bound). An FSA04 notice is also an official notice that confirms the standard of fire safety at the time of audit appears to comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005, therefore no further action is required by the Local Fire and Rescue Authority at that time.

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

This paper provides an update on four key fire safety compliance and management obligations i.e.

1. **Significant Incidents**
2. **Unwanted Fire Signals (UwFS's) and False Fire Alarm Activations**
3. **Fire Risk Assessment**
4. **Fire Safety Training**

(See Appendix 1 Essential Supporting Documentation)

Recommendation:

The Committee is requested to:

a) consider and note the on-going efforts to meet the requirements of enforcement action and C&V UHB's statutory and mandatory fire safety obligations.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
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*									
Prevention	✓	Long term	✓	Integration		Collaboration		Involvement	✓

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/~~No~~
Risk of further enforcement action if current standards are not improved and/or maintained
Safety: Yes/~~No~~
Safety of staff will be compromised if training figures are not improved and maintained
Financial: Yes/~~No~~
Potential negative financial implications of not maintaining statutory and mandatory fire obligations.
Workforce: Yes/~~No~~
Potential negative safety work force implications of not maintaining statutory and mandatory fire obligations
Legal: Yes/~~No~~
Potential reputational damage is a real possibility if fire safety statutory and mandatory obligations are not met by C&V UHB
Reputational: Yes/~~No~~
Potential reputational damage is a real possibility if fire safety statutory and mandatory obligations are not met by C&V UHB
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: Yes/~~No~~
Architects and designers of all new major capital projects have to consider this matter. In order to reduce our carbon footprint and comply with this regulation they are already proposing to move away from using traditional fire-resisting/non-combustible structural elements such as steel, brick and

concrete to using combustible structural elements such as timber and laminates. The use of these construction materials will have a direct impact on the standard of fire resistance of building and consequently impact on the safety of all building occupants therefore the installation of life safety and property protection suppression systems will become an essential element of all new buildings.

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Essential Supporting Documentation

1.0 Significant Incidents

There has been one fire incident recorded during this reporting period.

On Sunday 23rd January 2022 at approximately 19.40 hrs a fire occurred in a lift car on the ground floor of Hafan-Y-Coed, University Hospital Llandough. The fire was caused as a result of malicious ignition set by a patient and is recorded by South Wales Fire and Rescue Service as a deliberate act of arson by persons known. A complete evacuation of the area was completed and the fire was extinguished by premises staff before the arrival of the fire service. No staff or patients were injured as a consequence of this incident.

2.0 Unwanted Fire Signals (UwFS's) and False Fire Alarm Activations (FFAA'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.

This reporting period saw 80 fire alarm activations PAN Estate, 20 activations were not attended by the fire service due to the speed of attendance by fire response personnel. Activations for the previous rolling 12 months were 326 giving a mean average of 27 per month. There were 250 unwanted fire signals attended by SWFRS giving a mean average of 20.8 per month. This figure remains a reflection of the size and age of our fire alarm and detection system and the complexity of our largest sites. This reporting period has seen a slight 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 tables 2 and 3 on page 5)

Table 1

Unwanted Fire Signals (UwFS's) between 01/01/2022 and 31/03/2022 attendance by fire service

Hospital	UwFS's only	Actuation devices	Grade
Cardiff Royal Infirmary	**1**	**2000**	**Performance level 1**
Hafan Y Coed	**1**	**1274**	**Performance level 1**
Llandough Hospital	**5**	**6500**	**Performance level 1**
University Hospital of Wales	**53**	**20000**	**Performance level 1**
Total	**60**	**29774**	

Performance level 1 – Performance should be maintained

Table 2

False Fire Alarm Activations (FFAA's) between 01/01/2022 and 31/03/2022 not attended by the fire service

Hospital	False alarms only	Actuation devices	Grade
Barry Hospital	0	562	no incidents
Cardiff Royal Infirmary	1	2000	A - performance should be maintained
Hafan Y Coed	2	1274	A - performance should be maintained
Llandough Hospital	4	6500	A - performance should be maintained
Rookwood Hospital	0	425	no incidents
St David's Hospital (Cardiff)	0	600	no incidents
University Hospital of Wales	13	20000	A - performance should be maintained
Whitchurch Hospital	0	2059	no incidents
Total	20	32420	

Table 3

Unwanted Fire Signals (UwFS's) and False Fire Alarm Activations (FFAA's) between 01/04/2021 and 31/03/2022

Hospital	UwFS's and False Alarms	Actuation devices	Grade
Barry Hospital	3	562	A - performance should be maintained
Cardiff Royal Infirmary	3	2000	A - performance should be maintained
Hafan Y Coed	22	1274	B - 10% reduction in UwFS's
Llandough Hospital	66	6500	B - 10% reduction in UwFS's
Rookwood Hospital	4	425	A - performance should be maintained
St David's Hospital (Cardiff)	2	600	A - performance should be maintained
University Hospital of Wales	226	20000	B - 10% reduction in UwFS's
Whitchurch Hospital	0	2059	no incidents
Total	326	32420	
Total UwFS's Attended by SWFRS	250		
Not attended by FRS	76		

3.0 Fire Risk Assessment

A fire risk assessment is an organised and methodical look at our premises, the activities carried on there and the likelihood that a fire could start and cause harm to those in and around the premises.

Good management of fire safety is essential to ensure that fires are unlikely to occur; that if they do occur they are likely to be controlled or contained quickly, effectively and safely; or that, if a fire does occur and grow, everyone in our premises is able to escape to a place of relative or ultimate safety easily and quickly.

The risk assessment process confirms that our fire safety procedures, fire prevention measures, and fire precautions (plans, systems and equipment) are all in place and working properly, the assessment should identify any issues that need attention.

The principle fire safety legislation applicable to all UHB 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 regularly assessed and reviewed by members of the fire safety management team either annually, bi or tri-annually or if there is a significant change to the assessable area in terms of physical alterations to the layout, a change of use, or a significant increase in occupant numbers that may affect the emergency evacuation strategy.

The findings of the risk assessments are divided into three areas of responsibility: Estates and Compliance findings are managed and resolved by managers of the Capital, Estates and Facilities Service Board. Management findings are monitored and predominantly resolved by the responsible person (RP), generally the most senior manager for the assessment area in which the assessment was carried out.

4.0 Fire Safety Training

Table 4

Data supplied by Workforce Information for 31st March 2021 – 31st March 2022

Clinical Board	Directorate	Assignment Count	Achieved	Compliance %
All Wales Genomics Service	AWG Directorate	290	238	82.07%
All Wales Genomics Service Total		**290**	**238**	**82.07%**
Capital, Estates & Facilities Total		**1284**	**918**	**71.50%**
Children & Women Total		**2305**	**1523**	**66.07%**
Clinical Diagnostics & Therapeutics Total		**2493**	**1785**	**71.60%**
Corporate Executives Total		**1005**	**639**	**63.58%**
Medicine Total		**1908**	**949**	**49.74%**
Mental Health Total		**1515**	**979**	**64.62%**
Primary, Community Intermediate Care Total		**1338**	**890**	**66.52%**
Specialist Services Total		**1979**	**1153**	**58.26%**
Surge Hospitals	Lakeside Wing	23	11	47.83%
Surge Hospitals Total		**23**	**11**	**47.83%**
Surgical Services Total		**2480**	**1390**	**56.05%**
Grand Total		**16620**	**10475**	**63.03%**

The compliance figures outlined in Table 4 on page 6 relates to a rolling 12-month period for the fire safety e-learning package, classroom, locality based & Fire Warden

training. Table 4 shows that 63% of staff received some form of fire safety training in the previous 12-month period ending 31st March 2022. A total of 295 individuals have received tutor led fire safety training during this reporting period.

N.B.

Due to recent organisational changes the fire safety team now sits within the health and safety team. As a consequence of this move the majority of tutor led fire safety training are now be accessed by staff using the ESR system to self-enroll on sessions.

Requests to carry out other on-site fire safety training will be accommodated by the fire safety management team where ever possible.

Report Title:	Environmental Health Food Hygiene Inspection Reports			Agenda Item no.	7.3
Meeting:	Health & Safety Committee	Public	x	Meeting Date:	19th April 2022
		Private			
Status *(please tick one only):*	Assurance ✓	Approval		Information	
Lead Executive:	Executive Director of People and Culture				
Report Author (Title):	Director of Capital, Estates & Facilities				

Main Report
Background and current situation:

It is a legal requirement that all food businesses / premises are registered as a food business with the Local Authority and are therefore subject to regular inspections by Environmental Health / Food Safety Officers.

During February 2022 both the ward-based catering service and Aroma Coffee units at University Hospital of Wales were inspected. Both achieved a food hygiene score of 5 and 4 respectively. This is an improved score since both food businesses were last inspected, most markedly ward-based catering whose food hygiene rating score increased from 3 (satisfactory) to 5 (very good). Details are outlined below:

Unit	Inspection Date	Previous Rating	New Rating	Description of Rating
UHW Ward Based Catering	17th February 2022	3	5	Very Good
Aroma Units - UHW	22nd February 2022	3	4	Good

On receipt of the respective Reports from the inspecting officer, action plans were developed to address any issues raised. The action plans are attached to this Report as Appendices 1 and 2.

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

The acknowledgement of the achievement of the food businesses in obtaining food hygiene ratings of 4 and 5 and the supporting action plans.

The works that have been instigated in a short period of time to implement the required close out of the action plans that address those issues / recommendations raised in each Report.

Recommendation:

The Committee is requested to**:**

a) **Note** the achievement of those food businesses with a 5 and 4 food hygiene rating and the associated action plans.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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*									
Prevention	✓	Long term		Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: **No**
Safety: **No**
Financial: **No**
Workforce: **No**
Legal: **No**
Reputational: **No**
Socio Economic: **No**
Equality and Health: **No**
Decarbonisation: **No**

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
04/13/2022 14:07:51

Appendix 1

Action Plan from Food Safety Inspection for Ward Based Catering UHW.
Undertaken on 17th February 2022 (Report dated 24th February 2022 received on 28th February 2022).

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 During the inspection, a few metal trays were stacked while still wet in the children's ward kitchen. This will support microbiological growth. You must ensure all equipment is dried thoroughly before being stacked. It was noted that generally across the wards seen that the stacking of equipment whilst wet was much improved on previous inspections. Regulation (EC) No. 852/2004, Annex II, Chapter IX, Para 3	All staff have been reminded and instructed regarding the importance of thoroughly drying any equipment before stacking.	Immediate	Catering Supervisors	Completed
2 There was a small amount of food debris evident on the blade of the heavy-duty can opener in the Children's ward kitchen, which would cause contamination of the food in the next tin opened. This part of the can opener must be cleaned and sanitised regularly, ideally after every use. Regulation (EC) No 852/2004 Annex II Chapter V Para 1(a)	Thoroughly clean. All staff have been reminded and instructed that it is their responsibility to ensure that the tin opener is cleaned and sanitised after every use.	Immediate	Catering Supervisors	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**
3 The ceiling mounted extractor fan in ward C1 was dusty. It must be thoroughly cleaned and maintained in a clean condition. Regulation (EC) No 852/2004 Annex II Chapter I Para 1	Maintenance Request to be submitted to remove fan cover for cleaning.	24 March 2022	Team Managers	MR No. 135093. Progressing
4 The floor in the women's unit kitchen was dirty under the dishwasher. Thoroughly clean the floor and maintain in a clean condition. Regulation (EC) No 852/2004 Annex II Chapter I Para 1	All staff have been reminded and instructed regarding their responsibility for completing the daily cleaning schedule. Supervisors to ensure checks undertaken.	Immediate	Catering Supervisors	Completed
5 The following pieces of kitchen equipment required cleaning: • A build up of limescale on the hot water urn taps on wards C1 and women's unit; • There was limescale build up on the tap tops to the wash hand basin in C1 kitchen; • The blade to the table mounted tin opener in the Children's ward;	Hot water urn taps to be thoroughly cleaned and limescale removed in C1 and women's unit. Limescale to be removed from the tap tops to the wash hand basin in C1 and thoroughly cleaned. Thoroughly clean. All staff have been reminded and instructed	Immediate Immediate Immediate	Catering Supervisors Catering Supervisors Catering Supervisors	Completed Completed Completed

• The rinser tap joints in Children's ward; Thoroughly clean these pieces of equipment and maintain in a clean condition. Regulation (EC) No 852/2004 Annex II Chapter V Para 1a Regulation (EC) No 852/2004 Annex II Chapter I Para 1	that it is their responsibility to ensure that the tin opener is cleaned and sanitised after every use. The rinser tap joints in the children's ward to be thoroughly cleaned and all staff have been reminded and instructed of their responsibility regarding daily cleaning tasks.	Immediate	Catering Supervisors	Completed
6 The following pieces of equipment were damaged and require repair or replacing; • There were scored and discoloured jugs in the children's hospital ward kitchen; • The seal to the freezer in C1 ward was beginning to split; Regulation (EC) No 852/2004 Annex II Chapter V Para 1(c)	All jugs that were scored and discoloured in the Children's Hospital Kitchen have been replaced. Maintenance Request to be submitted to replace seal.	Immediate 31 March 2022	Team Managers Team Managers	Completed MR 132812 Progressing .

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.				
7 Audit of the current food safety policy document and monitoring records identified the following: • The fridge and freezer monitoring sheets weren't being routinely signed off by a supervisor; • Probe calibration checks on the ad hoc freezer weren't always being carried out.	The supervisors have been reminded and re-instructed of their responsibility to ensure that all fridge and freezer monitoring sheets are being checked and signed off. Calibration blocks to be placed into all ad hoc freezers to record	Immediate Immediate	Team Manager / Catering Supervisors Team Managers / Catering Supervisors	Completed Completed

You must ensure that staff are properly trained and are aware of the controls they need to carry out. Staff must also be supervised and checked as necessary, so you are sure that all controls that are critical to food safety are being properly implemented and maintained. Regulation (EC) No. 852/2004 Article 5	the fridge and freezer temperature and monitoring sheets completed. All staff at management, supervisory and operational level to be re-instructed in ensuring that supervision and checks are undertaken and completed by all staff.	31 March 2022	Team Managers / Catering Supervisors	Progressing

Schedule B – Recommendations and Advice

Recommendations	Response / Action	Time Scale	Lead Responsibility	Update
8 You must ensure that blue roll and paper towels are fitted into their dispensers and not allowed to sit on work surfaces where they may become contaminated/wet. Cleaning materials must not be placed on surfaces likely to cause contamination. Had the blue rolls on the wards appeared dirty, wet or stained then this would have resulted in a contravention under hygiene and likely a risk score of '10' being awarded which would have resulted in a food hygiene rating of 4	Order placed via supplier for wall mounted dispensers. These will be fitted upon receipt. Maintenance Request will be submitted on receipt of the dispensers.	31 March 2022	Team Managers	Progressing

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

Appendix 2

Action Plan from Food Safety Inspection for Aroma outlets, UHW
Undertaken on 22nd February 2022 (Report dated 24th February 2022)

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**
<u>Aroma X-Ray</u> 1. At the time of the inspection, a pouch of D10 suma bac was found in the dispenser with an expiry date of April 2020. The expiry date is the date up until which the manufacturer guarantees the effectiveness of the cleaning chemical. Therefore, you must ensure the expiry dates are checked on all cleaning chemicals and only cleaning chemicals within their expiry date are used. Whilst I was told that this dispenser is no longer in use. You must	Dispenser has now been removed from the wall.	Immediately	Team Manager	Completed

ensure the out-of-date pouch is removed so that staff cannot accidentally use it. Regulation (EC) No. 852/2004, Annex II, Chapter IX, Para 3 **Express** 2. At the time of the inspection the sterile probe wipes used for cleaning the temperature probe were becoming dry. This makes the probe wipes less effective as the sterilisation effect results from the wipes being soaked in alcohol solution. You must ensure that probe wipes are kept away from sources of heat that may dry them out and are wet and within date to ensure they are capable of suitably disinfecting the probe. Regulation (EC) No 852/2004 Annex II Chapter IX paragraph 3 **Production Kitchen** 3. There was evidence of food debris on the blade of the heavy-duty can opener in the main kitchen (which is used by the production kitchen), this may cause contamination	Probe wipes removed from area and replaced with new. Removed and put through the dishwasher straight away.	Immediately Immediately	Supervisor Supervisor	Completed Completed

of the food in the next tin opened. This part of the can opener must be cleaned and sanitised regularly. Regulation (EC) No 852/2004 Annex II Chapter V Para 1(a)				

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**
Concourse 4. There was limescale build up to the tap tops to the hand wash basin in the shared kitchen. Thoroughly clean the taps and maintain in a clean condition. Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1	Taps were cleaned and is now on daily cleaning schedule	Immediately	Supervisor	Completed
X-Ray 5. There was food debris visible on the shelves of the black plastic trolley. Thoroughly clean the trolley and maintain in a clean condition. Regulation (EC) No 852/2004 Annex II Chapter I Para 1	All trolleys were cleaned and this is now on daily cleaning schedule	Immediately	Supervisor	Completed
Express 6. The external surface of the soup kettle was dirty thoroughly clean the surface and maintain in a clean condition. Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1	Removed and cleaned thoroughly	Immediately	Supervisor	Completed

7. The external surface of the probe wipe container required cleaning. Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1	Removed and cleaned thoroughly	Immediately	Supervisor	Completed
General				
8. A number of spray nozzles to the D10 bottles were becoming dirty and require thorough cleaning. It was also noted that the crevices and ridges on many of the bottles were becoming dirty. Ensure that all D10 bottles are maintained in a clean condition. Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1	Removed and cleaned thoroughly	Immediately	Supervisor	Completed
9. There was limescale building up around the nozzle from the hot water dispensers in a number of the units. Clean the nozzles and maintain in a clean condition. Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1	Nozzles were all checked and cleaned thoroughly	Immediately	Supervisor	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.		**Time Scale**	**Lead Responsibility**	**Update**
10. You have put in place a documented Food Safety Management Procedure based on HACCP principles. However, I would make the following observations.				
• Staffs were relying on the digital displays for monitoring the temperatures of the fridges and freezers. I suggest an independent thermometer is used to check the temperatures of the fridges and freezers on a weekly basis. This ideally would involve using the probe thermometer to test the temperature of a dummy food (such as a clearly labelled bottle of water) it should be clear on the monitoring sheets when independent testing has taken place	Bottles of water were placed in each fridge whilst we await the dummy Jel to replace.	Immediately	Manager	Completed
• Temperatures above your critical limit of 5°C had been recorded for a number of fridge and chiller units in many of the	Supervisors to rectify going forward and will be checked by manager on weekly basis.	Immediately	Manager / Supervisor	Completed

Aroma units. However, no corrective actions had been recorded. You must ensure that staff document any corrective actions carried out. • A bottle of D10 sanitiser in the Express Aroma had been given a made on date of 13/2 and use by 12/3, this appears to have been an error, staff must ensure they are applying the correct date labelling to ensure the D10 sanitiser is refreshed after a maximum period of 7 days. • Some of the temperature monitoring sheets I saw didn't have a week commencing date documented, ensure staff are completing the forms fully with relevant dates. • Supervisors were signing off monitoring sheets where corrective actions hadn't been recorded or the week commencing dates hadn't been completed, it would be useful to note what action has been taken on these occasions as currently it looks as though forms are being signed off without the issues noted being addressed. Points relating to not recording corrective actions have been raised previously Regulation (EC) 852/2004 Article 5 11. Ensure that your staffs are trained in effective disinfection methods .Staff must know when disinfection is essential and how to do it properly. It is therefore critical that all staff are trained and verified as competent in disinfection techniques before being asked to dilute and apply disinfectants, or to undertake hot water or steam disinfection.	Removed and replaced with new date Supervisors to check all book work with manager and ensure dates are correct weekly Supervisors to rectify going forward and will be checked by manager on weekly basis. COSHH training to be completed by all staff	Immediately Immediately Immediately 3 Months	Supervisor / Staff Manager / Supervisor Manager / Supervisor Manager / Supervisor	Completed Completed Completed Completed

The following issues were noted at the time of inspection. • Some staff were unclear on the 2 stage cleaning process, staff must ensure that food debris is removed with hot soapy water prior to disinfecting with the D10, some staff said they would use dry blue roll to wipe off debris.	Re-training of staff in all retail areas/	Immediately	Supervisor	Completed
• One bottle of D10 had been given a diluted on 13/2 sticker and use by12/3, this does appear to have been an error and was diluted on the day of inspection. Ensure staff are correctly labelling bottles to ensure they aren't used beyond 7 days of dilution. Regulation (EC) No 852/2004 Annex II Chapter V paragraph 1a	Removed and replaced with new date	Immediately	Supervisor	Completed
12. Ensure that food hygiene rating stickers are displayed at each of the Aroma units. At the time of my visit the only sticker being displayed was behind a parking eye stand at reception at the concourse. This wasn't clearly visible. Whilst it has been agreed that each individual ward doesn't need to display a rating due to the sheer number of stickers required. You have been provided with enough stickers to display at each of the units. Please note that failure to display conspicuously during future inspections will result on the service of a fixed penalty notice for non-display. Should you ever require additional stickers then please don't hesitate to contact me.	New stickers received and are visible in each unit as instructed	Immediately	Manager	Completed

Schedule B – Recommendations and Advice

Recommendations	Response / Action	Time Scale	Lead Responsibility	Update
13. Ensure the blades of tin openers are cleaned and disinfected between uses, this is to prevent allergens being transferred from food items being opened.	Staff have been informed by supervisors	Immediately	Supervisor	Completed
14. Ensure allergy information is readily available at all Aroma units. There was no allergen information being displayed at the Aroma unit on the concourse. It was also noted when checking the allergen matrix that the tuna melt option had gluten, eggs, fish, milk and mustard identified as allergens, however when checking the ingredients it wasn't clear where the mustard had come from. Ensure the matrices are reviewed on a regular basis to ensure they remain accurate and current.	Allergen info is now displayed on the wall.	Immediately	Supervisor	Completed
15. You must ensure that blue roll and paper towels are fitted into their dispensers and not allowed to sit on work surfaces where they may become contaminated/wet. Cleaning materials must not be placed on surfaces likely to cause contamination. Had the blue rolls in the Aroma units appeared dirty, wet or stained then this would have resulted in a contravention under hygiene and likely a risk score of '10' being awarded which would have resulted in a food hygiene rating of 3.	All blue rolls taken from work surfaces and more blue roll dispensers ordered to be fitted	Immediately	Supervisor	Completed

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

Report Title:	Enforcement Agencies				Agenda Item no.	7.4
Meeting:	H&S Committee		Public	x	Meeting Date:	19/04/2022
			Private			
Status *(please tick one only):*	Assurance	x	Approval		Information	
Lead Executive:	Executive Director of People and Culture					
Report Author (Title):	Head of Health and Safety					

Main Report
Background and current situation:

Background and Current Situation:

Health and Safety Executive (HSE)

T2 UHW Animal House Ventilation
Request for information from the HSE regarding maintenance and agreements between CAVUHB and Cardiff University in relation to the different types of local exhaust and extract ventilation systems associated with T2 animal house. Information forwarded, currently awaiting a reply.

UHW Theatre Trolleys
The Health Board received a short notice request (3 Days) from the HSE to visit theatres at UHW to review the manual handling systems employed by this work group. Concerns of non-essential visits from the Director of Nursing for the Surgery Clinical Board was relayed back to the HSE and as a result the visit has been postponed however, information and documents have been forwarded to the HSE Inspector for review. Currently awaiting a reply.

South Wales Fire and Rescue Service (SWFRS) Enforcement

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

During the period there were no new notices raised and two remain open.

21st April 2021: EN03/21 issued against Hafan Y Coed in relation to failing to adequately control ignition sources. This is ongoing and has been raised to the South Wales Fire and Rescue Service (SWFRS) compliance team. SWFRS have now issued a letter under caution, a response to which was sent on 21st January 2022.

A meeting to discuss our current situation was held at SWFRS headquarters on 23rd March 31 2022 involving the CEO for CAVUHB, the Executive Director for People and Culture, the Head of Health and Safety, Chief Fire Officer SWFRS and several officers from his healthcare enforcement and compliance teams. No prosecution decision was made during the meeting however, there was a keen willingness for both parties to work closely together to resolve.

The three UHB members from the meeting personally fed back to senior managers within the mental health clinical board on 25th March 2022 reaffirming the actions that have been put in place to control ignition sources.
The head of Health and Safety is currently undertaking a benchmarking exercise against other similar UHB's in Wales and close working and support continues between H&S and Mental Health.

8th October 2021: EN59/21 issued against ward A4 at UHW in relation to physical fire controls such as fire dampers and fire and smoke resisting doors and also staff training requirements.

The Head of Health and Safety invited SWFRS to a meeting on 8th February 2022 to discuss the identified non-conformances in the notice. An explanation was provided as to the 'Reasonably Practicable' remedial work that has or would be completed by compliance date of 6th April 2022 however, other actions remained that would necessitate the removal of the ward from operational service. Work of this nature is covered in the UHB ward improvement programme and A4 was next due for a refit in financial year 2024/2025. The Capital, Estates and Facilities (CEF) Service Board have reviewed the ward improvement plan and have secured funding to bring ward A4 forward in the programme to 2022/2023. The Head of Health and Safety has written to SWFRS to formally request an extension to the compliance date from 6th April 2022 to 31st March 2023.

Outstanding work to complete

1.1 The standard of fire separation provided is not adequate.
1.1.1 The fire dampers in the HVAC system that pass-through compartment/sub-compartment walls are actuated by thermal link. These should be upgraded to fire dampers that are actuated by the automatic fire detection system in accordance with the HTM 05-02 Table 7.

All wards carry a similar known risk
Mitigation includes;
- Whilst not the latest technology, protection is afforded by fire dampers that operate using a fusible thermal link
- Properly maintained fire-fighting equipment
- Competent trained personnel in their use

1.2 Fire and smoke resisting doors.
1.2.1 The doors to the riser cupboards containing electrical services are not fire resisting and should be replaced with doors providing 30 minutes of fire and smoke resistance.
- The scope of this work goes beyond 'Normal Maintenance'
- In completing this work there is a high probability of disturbing asbestos
- Tied in with ward refurbishment plan

Mitigation:
- Electrical equipment regularly serviced and correctly maintained by competent third party
- Accredited service company
- Proactive maintenance regime in place
  - Thermography inspection
  - Insulation resistant testing
- No previous history of electrical ward failures

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

The UHB have reassured SWFRS that all reasonably practicable steps have and are being taken in resolving the identified non-conformances. Assurance is provided by the current mitigation in place on A4. CAVUHB are working closely with SWFRS on all other issues.

Recommendation:

The Health and Safety Committee is asked to:

a) Note the content of the report.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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	

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	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*									
Prevention	X	Long term	X	Integration		Collaboration	X	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
No
Safety: Yes/No
No
Financial: Yes/No
No
Workforce: Yes/No
No
Legal: Yes/No
No
Reputational: Yes/No
No
Socio Economic: Yes/No
No
Equality and Health: Yes/No
No
Decarbonisation: Yes/No
No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
H&S Committee	19/04/2022

Saunders.Nathan
04/13/2022 14:07:51

Report Title:	Regulatory Review and Tracking Report – 1st April 2021 – 31st March 2022			Agenda Item no.	7.5
Meeting:	Health and Safety Committee	Public	X	Meeting Date:	19th April 2022
		Private			
Status *(please tick one only):*	Assurance		Approval		Information X
Lead Executive:	Executive Director of People and Culture				
Report Author (Title):	Assistant Head of Health and Safety				

Main Report
Background and current situation:

This report is presented to the Committee to track that relevant Board Committees are receiving reports and information regarding inspections undertaken by various inspection/review bodies as a key source of assurance. The report provides information for the period 1st April 2021 – 31st March 2022 and includes:

(a) new inspections undertaken during the period as recorded in the post log or notified by Clinical/Service Boards;
(b) formal reports received during the period. Some reports are received a number of months after the actual inspection.

The statutory obligations of the University Health Board (UHB) are wide ranging and complex; the UHB must comply with general law as well as NHS specific legislation. The majority of regulatory visits monitored by the Health and Safety Committee fall into the following categories:

- Inspections/audits undertaken by the Health and Safety Executive;
- Fire Safety inspections undertaken by South Wales Fire and Rescue Service;
- Food hygiene inspections undertaken by the Local Authorities.

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

The attached report provides evidence that each category of review is assigned to the Health and Safety Committee. It contains a summary of five inspections, regulatory visits or correspondence which all took place during the period.

Recommendation:

The Health and Safety Committee is requested to:

- **NOTE** the content of the report

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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	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*									
Prevention	X	Long term	X	Integration		Collaboration	X	Involvement	X

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
NO
Safety: Yes/No
NO
Financial: Yes/No
NO
Workforce: Yes/No
NO
Legal: Yes/No
NO
Reputational: Yes/No
NO
Socio Economic: Yes/No
NO
Equality and Health: Yes/No
NO
Decarbonisation: Yes/No
NO

Approval/Scrutiny Route:	
Health and Safety Committee	19th April 2022

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Regulatory and Review Bodies Tracking Report - Reports Received and Inspections/Visits Undertaken - 1 April 2021 - 31 March 2022															
2																
3	Date of Report	Date of Visit/Review	Site/Location	Clinical Board/Directorate/ Specialty	Brief Description of reason for visit/Review	Summary of Findings/Recommendations	Management Response	Executive/Operational Lead	Due Date	Position as at 31 March 2022 (unless indicated otherwise by reference to receipt by Committees)	Status (Ongoing/Complete)	Assurance Committee & Chair	If reported to another group state here	Date Reported to Assurance Committee	Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)	Contained within CE Important Documents Log
4	**Health and Safety Executive**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 2: Safe Care *Standard 2.1 Managing Risk and Promoting Health and Safety*** **Theme 3: Effective Care *Standard 3.5 Record Keeping***							
5	24 May 2021	24th May 2021	Theatres, UHW	Capital, Estates and Facilities	Concern raised with them in relation to ventilation in Clinics and Theatres	Ventilation in theatres and clinics is by air con, pre covid these areas were packed and returning to normal will mean returning to the spread of aerosols and bacteria. An understanding that the air con is not maintained, e.g filters in the system not changed for 16 years	HSE were provided with: (1) Air Handling Units Quarterly and Yearly Inspections and Maintenance. (2) Annual Validation of Critical Air Plant. (3) Air Conditioning Bi Annual Inspections and Maintenance	Director of Capital, Estates and Facilities	9th June 2021	Completed and closed by the HSE	Completed	Health and Safety Committee - Mike Jones	N/A	27 July 2021	N/A	
6	2nd September 2021	2nd September 2021	Health Board Wide	Executive	Concern raised with them in relation to RIDDOR reporting of staff covid cases	Concern that Health Board had not reported any staff covid cases to the HSE under RIDDOR Regulations	HSE were provided with the processes in place to determine whether a likely occupational exposure or societal exposure.	Director of People and Culture	13th September 2021	Completed and closed by the HSE	Completed	Health and Safety Committee - Mike Jones	N/A	12 October 2021	N/A	
7	18th November 2021	18th November 2021	Waste Management, UHW	Capital, Estates and Facilities	Concern raised with them that a TUG onsite was faulty and had been repaired by hard hat bolted to the engine	The TUG in question was not an UHB asset but had been hired from a service provider. Once the hard hat repair had been found the tug was taken out of use and the service provider contacted.	HSE were provided with tug maintenance and inspection regime and also clarification in respect of a number of general issues raised.	Director of Capital, Estates and Facilities	25th November 2021	Completed and closed by the HSE	Completed	Health and Safety Committee - Mike Jones	N/A	25th January 2022	N/A	
8	27th January 2022	27th January 2022	T2 (Animal House), UHW	Capital, Estates and Facilities	Request for information in relation to local exhaust an extract ventilation systems.	Details of maintenance and agreements in place between UHB and Cardiff University.	Information forwarded to HSE, awaiting reply.	Director of Capital, Estates and Facilities	N/A	On-going	On-going	Health and Safety Committee - Mike Jones	N/A	25th January 2022	N/A	

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
3	Date of Report	Date of Visit/Review	Site/Location	Clinical Board/Directorate/ Specialty	Brief Description of reason for visit/Review	Summary of Findings/Recommendations	Management Response	Executive/Operational Lead	Due Date	Position as at 31 March 2022 (unless indicated otherwise by reference to receipt by Committees)	Status (Ongoing/Complete)	Assurance Committee & Chair	If reported to another group state here	Date Reported to Assurance Committee	Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)	Contained within CE Important Documents Log
9	21st March 2021	21st March 2021	Theatres, UHW	Surgery Clinical Board	Request to review Theatres to look at manual handling systems.	Concerns on non-essential visits relayed to HSE, visit postponed. Information and documentation sent.	Information forwarded to HSE, awaiting reply.	Director of Nursing, Surgery Clinical Board	N/A	On-going	On-going	Health and Safety Committee - Mike Jones	N/A	25th January 2022	N/A	
10																
11																
12																
13																
14	**South Wales Fire and Rescue**								**Health and Care Standards** **<u>Overarching Theme</u>: Governance, Leadership and Accountability** **<u>Theme 2</u>: Safe Care *Standard 2.1 Managing Risk and Promoting Health and Safety***							
15	21 April 2021	14 April 2021	Hafan y Coed	Mental Health Clinical Board	Scheduled inspections for high risk premises	Failure to comply with the Regulatory Reform (Fire Safety) 2005 1 x Management - Failed to comply with smoking policy		Executive Director of People and Culture	Enforcement Notice EN3/21 - Due to be completed by 19th May 2021	Report dated 27 December following visit on the 14th April 2021 Enforcement outstanding	On-going	Health and Safety Committee - Mike Jones		12 October 2021	19-May-21	Yes
16	21 April 2021	14 April 2021	Hafan y Coed	Mental Health Clinical Board	Scheduled inspections for high risk premises	Failure to comply with the Regulatory Reform (Fire Safety) 2005 1 x Management - Fire doors wedged open 1 x Compliance - Exit doors 1 x Estates - Maintenance of alarm system		Executive Director of People and Culture	Enforcement Notice EN4/21 - Due to be completed by 20th July 2021	Report dated 26 July following visit on the 21st July - Enforcement complied	Complete	Health and Safety Committee - Mike Jones		12 October 2021	20-Jul-21	Yes

Report Title:	Health and Safety Risk Register			Agenda Item no.	7.6
Meeting:	Health and Safety Committee	Public	x	Meeting Date:	19/04/2022
		Private			
Status *(please tick one only)*:	Assurance x	Approval		Information	
Lead Executive:	Executive Director People and Culture				
Report Author (Title):	Head of Health and Safety				

Main Report
Background and current situation:

Background
In line with section 3.5 of the Risk Management and Board Assurance Framework Strategy 2019-22 the Health and Safety department are required to compile and review a risk register which covers the management of identified strategic and operational risks that have the potential to impact upon the delivery of strategic objectives.

Situation
The existing risk register compiled by the previous Head of Health and Safety was noted by the new incumbent in 2021. A full review wasn't conducted at this point as it wasn't assessed be a departmental priority, additionally it was deemed prudent to include conclusions from the external 2021 RLB review and the findings of the new Head of Health and Safety in any update. Up to this point, reassurance has been provided verbally to the Health and Safety Committee.
The Health and Safety risk register has now undergone a comprehensive review by a team consisting of the Head and two Assistant Heads of Health and Safety and has confirmed that whilst new risks have been identified none of them are at the intolerable range of 20 or above.
The highest current risk ratings are 16, two of which are covered by the Health and Safety Culture plan and discussions are currently taking place to determine ownership of the third which relates to the management of bariatric patients.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:
The risk register was reviewed by the senior leadership team within the Health and Safety department. This approach utilised both long standing knowledge and experience within CAVUHB and a 'New pair of eyes' methodology. Assurance is provided by demonstrating progress through the 2022 Health and Safety Culture Plan which will be monitored at the Operational Health and Safety Group meeting and progress reported at each Health and Safety Committee meeting.

Recommendation:

The Committee is requested to:

a) **Note** the findings of the new identified risks and the actions in place to reduce the risk rating.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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	X

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
No
Safety: Yes/No
No
Financial: Yes/No
No
Workforce: Yes/No
No
Legal: Yes/No
No
Reputational: Yes/No
No
Socio Economic: Yes/No
No
Equality and Health: Yes/No
No
Decarbonisation: Yes/No
No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Health and Safety Committee	19/04/2022

Saunders,Nathan
04/13/2022 14:07:51

RISK REGISTER TEMPLATE: **Health & Safety Department**
CLINICAL BOARD:
DIRECTORATE:

Risk Ref.	Strategic Objective	Date risk added	Risk	Exec Lead	Initial Risk Rating			Controls	Assurances	Current Risk rating			Gaps in Control	Gaps in assurance	Actions	Who	When	Target Risk rating			Date of next review	Assurance Committee
					Consequence	Likelihood	Total			Consequence	Likelihood	Total						Consequence	Likelihood	Total		
1.1		29/03/2022	Failure of Management of H&S to ensure comprehensive range of Policies covering legislation.	Director of People & Culture	3	5	15	A competently staffed health and safety department. Access to legislation. Network of All Wales policies library. Project lead identified within the Health and Safety team to complete gap analysis of policies and procedures against UHB H&S management system in line with ISO 45001. Development of a register of safety legislation to provide gap analysis and ensure any changes or new legislation incorporated into policies and procedures.	Suite of policies approved and monitored by the H&S Committee. Key policies and procedures exist.	3	3	9	Management system is in its infancy. Gap analysis has identified some shortfalls. Time bound action in line with H&S culture plan to complete.	Gaps identified, some additional procedures required.	H&S department to maintain a register of policies and procedures. Status of register to be submitted at least annually to H&S Committee.	Dir of People and Culture	01-Apr-23	3	1	3		
1.2		29/03/2022	Failure to communicate relevant health and safety policies, procedures and information to all staff.	Director of People & Culture	4	5	20	All health and safety policies shared on the intranet. Policies are written by key, competent personnel and circulated for comment prior to approval. Managers health and safety course is offered. Mandatory training for key risks such as fire, manual handling and personal safety.	Compliance to training monitored at Operational Group level. H&S Dashboard published and circulated on a monthly basis which includes training compliance. All current health and safety policies and procedures are on health and safety web page.	4	2	8	Line managers failing to implement policies and bring to knowledge of staff at risk. No robust mechanism currently exists to cascade new and updated policies to employees.	Potential for employees not to have an understanding of the latest policies and procedures.	Introduce a new and updated policies dashboard for roll out alongside or in the current dashboard.	Head of Health and Safety	01-Apr-23	4	1	4		
1.3		29/03/2022	Failure of manager to maintain suitable and sufficient Risk Assessments .	Director of People & Culture	4	5	20	Risk management policy and risk assessment training. Risk quantification and escalation criteria established. Risk management and conrol is a key agenda item discussed in both Local and Operational H&S Groups. Risk management is part of the managers H&S training course.	Comprehensive Risk Assessment and Risk Register Procedure.	4	3	12	Lack of formal audit approach.	Unable to verify that suitable and sufficient risk assessments exist for all relevant processes.	Provide formal audit procedure and schedule managed by H&S department / advisers.	Head of Health and Safety		4	1	4		
1.4		29/03/2022	Managers failure to undertake their health and safety role.	Director of People & Culture	4	3	12	Local H&S Groups. Staff group inspection, H&S adviser link to each CB. Managers health and safety course is offered and following this course delegates are given the opportunity for one of the health & safety team to visit their area, undertake a gap analysis and provide on-going support.	Processes exist for the training of managers in their H&S responsibilities	4	2	8	Improved monitoring and support of health and safety management arrangements post Managers H&S training.	Managers health and safety training is not mandatory.	Promotion of Health and Safety managerial responsibilities through the H&S Culture plan	Head of Health and Safety		4	1	4		

1.5		29/03/2022	H&S Staff not meeting their mandatory training requirement.	Director of People & Culture	3	3	9	Mandatory training offered both e-learning and tutor led. Mandatory May & Nov.	Compliance monitored through line management and VBA's.	3	2	6	No recognised, specific KPI's in VBA's		Individual KPI's to be developed and discussed during staff VBA's	Head of Health and Safety	31/12/2023	3	1	3		
1.6		29/03/2022	Failure of clinical/service boards to consider H&S aspects in regular meeting format at local level.	Director of People & Culture	3	3	9	H&S advisers are aligned to each of the clinical and service boards and attend the board H&S meetings. All Clinical and Service Boards have established health and safety meetings that meet at least 4 times a year.	A competently staffed health and safety department provide advice and support. Evidence exists of some meetings containing a specific H&S line item, e.g. clinical shift safety briefings.	3	2	6	No current recognised guidance in place for clinical/service board meeting templates.	Uncertainty of current practices, meeting ToR's across the wider UHB	Establish a means of communication, e.g. via managing safely course/dashbaord/clinical service board meetings to ensure H&S is entered as a line item for all relevant meetings.	Head of Health and Safety	31/12/2023	3	1	3		
1.7		29/03/2022	Failure to implement a H&S management system 4.1.7. This is a UHB wide risk	Director of People & Culture	4	4	16	Competent H&S staff. Currently no commonly aligned system in place for the management of H&S	A process is currently in place for managing high level policies and procedures.	4	4	16	There is no systematic method or process in place to align all clinical/service boards with H&S	Unable to verify that all processes are suitable or sufficient	Establish a health board wide H&S management system	Head of Health and Safety	30/06/2022	4	1	4		
1.8		29/03/2022	Unclear understanding of roles, responsibilities and accountabilities with regards to H&S across the UHB. RLB Review 4.1.2, 4.1.5, 4.1.6, 4.2.2	Director of People & Culture	4	4	16	Current policies and procedures are in place and provide some guidance	Current policies and procedures provide some guidance around roles and responsibilites	4	3	12	No difinitive RACI Matrix in place	Unable to verify that all roles understand their responsibilities	Establish a Health Board wide H&S RACI matrix, update policy and roll out to the wider organisation.	Head of Health and Safety	31/12/2023	4	1	4		
1.9		29/03/2022	Lack of demonstratable independency between H&S and Operational maintenance	Chief Executive	4	5	20	Current policies and procedures provide some guidance	Change of structure and policy ownership. H&S roles within CEF have been changed to compliance. Key Health and safety policies such as contractor control and PTW being moved to H&S ownership.	4	2	8	Some policies are yet to be brought across. This will be identified and completed with the RACI (Line 16)	Both CEF and H&S management are working closely to eliminate any perceived lack of independency.	Complete RACI and formally transfer policy ownership.	Head of H&S and Heads of Compliance and Estates and Facilities	31/12/2022	4	1	4		
2		29/03/2022	Failure of a proactive approach to H&S. RLB Review 4.2.2. This is a UHB wide risk	Director of People & Culture	4	4	16	Some proactive initiatives are in place such as some audits and work inspections	Reviews conducted of the audits and inspections undertaken and improvements implemented as a result	4	3	12	The UHB lacks a SMART approach towards H&S	Lack of evidence of detailed specific audits in health and safety.	Implement and maintain a H&S strategy with clear objectives and KPI's. This is a specific action in the 2022 Health and Safety Culture Plan.	Head of Health and Safety	31/12/2022	4	1	4		

2.1		29/03/2022	**Failure of H&S department to provide an adequate system to protect lone workers.**	Director of People & Culture	4	4	16	Local management assisted by Personal Safety specialists to establish appropriate risk assessment for justification of allocating devices. Circumstances may permit device sharing. Procedures to monitor lone-working are promoted including - periodically visiting and observing people working alone, determining which jobs and locations require working in pairs and pre-agreed intervals of regular contact.	Regular lone worker device user compliance reports submitted to Health and Safety Committee. Devices are monitored for consistent use which is highlighted on the monthly H&S dashboard. Low number of recorded lone worker incidents.	4	2	8	Neccesity to renew contract ~3 yearly has the potential to leave gaps in lone worker device usage.	Programme managed by case management team. Contract renewal commences six months from the end of previous contract. Potential for gaps in local procedures for assessing the allocation of lone worker devices.	Continued review of device usage to identify gaps in clinical board management.	Case Manager Personal Safety Advisor	01/08/2022	4	2	8	Jul-22	
2.2		29/03/2022	Failure to maintain and demonstrate competence of H&S trainers.	Director of People & Culture	3	3	9	Staff have previously attended train the trainer courses along with external accredition for the course provided.	All training team are experienced training professionals and internal verifictation is conducted by training manager.	3	3	9	No external acreditation currently valid.	Unable to demonstrate trainers competence to an external organisaiton or regulator	Trainers to attend externally accredited courses for all courses currently offered.	Head of Health and Safety	01/10/2022	3	2	6		
2.3			Failure to have adequate systems in place to safely handle bariatric patients.		4	4	16	Bariatric equipment is available for use.	Manual Handling Adviser worked with Medicine Clinical Board to assess best practice.	4	4	16	Work on this had commenced prior to COVID and was being led by medecine. Ownership of this process is currently unclear. Further work	Ownership of this process is unclear. Further work	Determine ownership of the bariatric patient pathway and provide support as appropriate	Head of Health and Safety	31/12/2022	4	1	4		
2.4		29/03/2022	Failure to ensure DSEAR compliance to regulations which requires areas of potential explosives to be assessed and appropriate control measures are put in place.		4	4	16	Specific DSEAR compliance and risk assessment training was undertaken by H&S adviser. A DSEAR guidance document and 2-part risk assessment has been compiled and circulated. Key areas have been identified and some DSEAR risk assessments carried out.		4	3	12	Identification of further areas requiring DSEAR assessments needs to be extracted from the fire risk assessment information.	Unable to fully verify through current audit programme	Establish a multi disciplined approach with H&S and Fire Safety jointly taking the lead to support area/process owners.	Head of Health and Safety	31/12/2024	4	1	4		
2.5		29/03/2022	H&S department risk of incorrect use of DSE and/or poorly designed workstations or work environments leading to musculoskeletal disorders.	Director of People & Culture	3	3	9	Display Screen Equipment (DSE) and Eye Test Procedure. DSE risk assessment form and guidance documentation. The completion of the risk assessment is a management responsibility with DSE users required to assist with the assessment. E-learning training package through ESR. DSE is part of the managers H&S training course.	Identification process implemented for DSE users and specialist advice available.	3	2	6	No robust process in place to ensure compliance with standard in ensuring assessments are completed.	Potential gaps exist for home working.	Add requirement to conduct assessments to VBA's	Head of Health and Safety	31/06/2022	3	1	3		
2.6		29/03/2022	Failure to establish mechanism for delivery of training and refresher training in the use of evacuation chairs and mats.	Director of People & Culture	4	4	16	ALBAC Mat training provided to Heli-pad porters in 2021 and response agreement in place.	ALBAC Mat training provided to Heli-pad porters in 2021 and response agreement in place.	4	3	12	Gaps currently exist for the training in the use of EVAC chairs	No agreement currently in place	Review the training provision and benchmark across Wales.	Head of Health and Safety	31/12/2023	4	1	4		

2.7		29/03/2022	Failure to implement a system for the control of high risk maintenance work outside of CEF.	Director of People & Culture	4	4	16	All work of this nature is performed by contractors outside of CEF. Permit system in place for contractor work of specified high risk areas. Permit system communicated through contractor control policy, procedures and induction process. Contractor monitoring system is in place.	Low number of recorded incidents.	4	2	8	No system in place to audit clinical boards on contractor and permit to work aspect of management system.	Unable to verify clinical board compliance with standard.	Implement a structured departmental audit programme in line with the H&S management system		30/06/2023	4	1	4		
2.8		29/03/2022	Failure to ensure contractor control within the remit of non estates has effective mechanisms for monitoring and reacting to safety breaches.	Director of People & Culture	4	4	16	Contractors are pre-vetted for health and safety competence and a supervising officer is allocated. All contractors are required to provide Risk Assessments and Method Statements (RAMS) and attend a site induction. High risk work is identified beforehand and a Job Registration Form (JRF) completed. Relevant safety information is exchanged and the contractors performance is monitored. H&S exeptions, breaches and/or incidents are recorded and investigated appropriately. Contractor monitoring process has been intensified and the Contractor Control Working Group established.	Key UHB procedures documentation and the Control of Contractors Policy have been further developed. A dedicated H&S Adviser has been allocated to assist with non-estates contractor control throughout the UHB. Contractor control is an element of the managers H&S training course. Contractor management requirements are deciminated through the various clinical boards H&S meetings.	4	3	12	Enhance non-estates to same standard as estates contractor control. Contractors are still brought in by individuals/parties who may not be familiar with the requirements of the UHB Control of Contractors Policy. Contractor H&S vetting needs to be fully established as part of the procurement process.	Unable to verify all risks are identified	Implement a structured departmental audit programme in line with the H&S management system	Head of Health and Safety	30/06/2023	4	1	4		
2.9		29/03/2022	Failure to implement a change management process	Director of People & Culture	4	4	16	Some policies and procedures in place that would be pertinent for assessing potential risks for any planned changes.	No change management issues have been identified as failings with regards to incident investigations	4	4	16	No recognised change management system in place however, all key H&S policies exist to cover work activities.	Unable to verify all risks are identified when implementing change	Determine the requirements and necessity of implementing a structured change management process	Head of Health and Safety	31/03/2025	4	1	4		

Report Title:	Latex Allergy Policy			Agenda Item no.	8.1
Meeting:	Health and Safety Committee	Public	X	Meeting Date:	19th April 2022
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Executive Director of People and Culture				
Report Author (Title):	Assistant Head of Health and Safety				

Main Report
Background and current situation:

The Health Board must ensure that it has arrangements in place for assessing and managing the risks that latex may present in the clinical environment. The Health Board also has a duty to assess the risk from latex in accordance with the Control of Substances Hazardous to Health Regulations 2002.

The policy is revision UHB 4 and was previously reviewed in January 2019.

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

Whilst overall responsibility to provide and maintain safe and healthy working conditions, equipment and safe systems of work rests at the highest level of management, every individual has a responsibility to ensure its implementation, so far as reasonably practicable.

THE AIM OF THE LATEX ALLERGY POLICY

The policy aims to:-

- To prevent the development of latex allergy;
- To prevent symptoms of latex allergy in both staff and patients;
- To minimise the risk from exposure to latex;
- Where latex allergy in patients and staff is suspected or known, control measures will be identified to allow healthcare to be provided and continued employment where possible;
- To ensure the Health Board complies with the Control of Substances Hazardous to Health Regulations 2002

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

Recommendation:

The Health and Safety Committee are requested to:

- **APPROVE** the Latex Allergy Policy

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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	
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*									
Prevention	X	Long term		Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
No
Safety: Yes/No
No
Financial: Yes/No
No
Workforce: Yes/No
No
Legal: Yes/No
No
Reputational: Yes/No
No
Socio Economic: Yes/No
No
Equality and Health: Yes/No
No
Decarbonisation: Yes/No
No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Reference Number: *TBA unless document for review* **Version Number:** 2	**Date of Next Review:** April 2025 **Previous Trust/LHB Reference Number:**

Latex Allergy Procedure

Introduction and Aim

The aim of this Procedure is to support the Latex Allergy Policy in its duty to assess the risk from latex in accordance with the Control of Substances Hazardous to Health Regulations 2002.

Objectives

The Objectives of the procedure are to:-

- Prevent the development of latex allergy
- Prevent symptoms due to latex allergy in both staff and patients
- Provide an environment where the UHB seeks to minimise the risk from exposure to latex
- Manage - where latex allergy in patients and staff is suspected or known, control measures will be identified to allow healthcare to be provided and continued employment where possible
- To ensure the UHB complies with the Control of Substances Hazardous to Health Regulations 2002.

Scope

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

Equality Health Impact Assessment	*An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be no impact.*
Documents to read alongside this Procedure	Health and Safety Policy Control of Substances Hazardous to Health (COSHH) Procedure Occupational Health Policy Managing Attendance at Work Policy All Wales Incident, Hazard and Near Miss Reporting Policy
Approved by	Operational Health and Safety Group/Health and Safety Committee
Accountable Executive or Clinical Board Director	Executive Director of People and Culture
Author(s)	Assistant Head of Health and Safety

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1		*TBA*	New Procedure in line with new UHB Policy arrangements
2			3 yearly review

1 WHAT IS LATEX?

Latex is the protective fluid contained in tissue beneath the bark of the rubber tree, *Hevea brasiliensis.*

Natural rubber latex (NRL) is a cloudy white liquid, similar in appearance to cows' milk, collected by cutting a thin strip of bark from the tree and allowing the latex to exude into a collecting vessel.

The latex collected from the rubber tree is composed of rubber particles, protein, water and other substances.

Processing of the latex (eg centrifugation and leaching) can affect the level of protein in the finished product. Some glove manufacturers wash the gloves in a chlorinated solution to reduce the tackiness of the latex to avoid having to powder the glove. Chlorination followed by prolonged leaching reduces the protein levels, producing a glove low in protein.

2. ROUTES OF EXPOSURE

The potential routes of exposure to latex allergens are:

- Cutaneous – via gloves, tapes, masks, urine drainage bags;
- Mucous membranes – via products used in dentistry, anaesthesia and rectal examinations, eye droppers;
- Inhalation – via aerosolisation of glove powder;
- Internal tissue – via latex products used in surgery;
- Intravascular – via latex products used in intravascular devices (e.g. IV cannulae) or devices used to deliver IV fluids and injectables (syringes and IV administration sets) or in the vial stopper or needle sheath of some injectable medicines;
- Gynaecological examinations.

3. TYPES OF REACTION

3.1 Irritant Contact Dermatitis

This is a common form of dermatitis, one example is "Housewives Hand Dermatitis". In most cases it is caused by damage to the skin from repeated exposure over a long period of time to water, soap and other detergents (such as surgical scrub). It is not due to an allergy to latex.

3.1.1 Symptoms

It usually presents as a dry, itchy red rash on the back of the hands and fingers. There may be episodes of blistering and weeping of affected skin which may swell. After prolonged involvement, the skin may become dry, thickened and scaly. Symptoms may appear to be aggravated by latex gloves, largely through the effect of occlusion, friction or the powder.

3.1.2 Diagnosis

Diagnosis is based primarily on history and examination.

Patch tests which test for type IV delayed hypersensivity allergy to various common contact allergens are negative in irritant contact dermatitis.

3.1.3 Treatment

Treatment is with non-irritating soap substitute, emollient creams and topical steroids. Sufferers must reduce their irritant exposure. Paradoxically this usually involves recommending greater use of non-powdered latex gloves for protection during wet work.

3.2 Allergic Contact Dermatitis (Type IV Delayed Hypersensitivity)

This is less common than irritant contact dermatitis, it is caused by an allergy to the residues of the rubber chemical agents used in latex glove manufacture.

3.2.1 Symptoms

The symptoms and signs are usually indistinguishable from irritant contact dermatitis as above, frequently the two conditions coexist. There may be dermatitis at other sites exposed to latex, such as under the waist-band or on the soles of the feet. Secondary spread of dermatitis to non-exposed skin can occur.

3.2.2 Diagnosis

Diagnosis is confirmed by demonstrating positive patch tests to one or more of the rubber accelerators. Once

established, this form of allergic response lasts for many years.

3.2.3 Treatment

Effective management requires the stringent avoidance of the responsible agent along with topical treatment as above. Although prolonged contact must be avoided, transient contact may not be a problem.

3.3 Immediate Hypersensitivity (Type 1)

This is much rarer than the above forms of contact dermatitis. However, it is very important as it can cause severe and even fatal reactions.

3.3.1 The Role of Protein

Type 1 (immediate) hypersensitivity is due to an Immunoglobulin E (IgE) response to natural latex protein which happens in two stages. Stage one is when the body first becomes sensitised to allergen and the immune system makes antibodies called (IgE) against it. Stage two occurs if the person is exposed to the same allergen again, these antibodies then trigger an immune response to fight them off causing the symptoms of an allergic reaction. It should be noted that latex protein may adhere to particles of starch powder inside gloves, and the powder aerosol may thus also induce symptoms through inhalation.

3.3.2 Symptoms

Symptoms usually develop within 5 – 40 minutes of exposure and diminish rapidly once contact with the latex material has ceased. It may present with immediate itching and swelling of the fingers or hand when a latex glove is worn. This is more likely to occur at sites where the skin is broken or affected by dermatitis.

Immediate hypersensitivity may manifest as rhinitis, conjunctivitis or asthma.

More serious but uncommon are symptoms of anaphylaxis. These are more likely to occur when there has been latex contact with the mucous membranes or

body cavities (as in surgery). Anaphylaxis may present with any or all of the following:

- Local or generalised itching, urticaria and/or angio-oedema
- Rhinitis and/or conjunctivitis
- Asthma
- Extreme anxiety
- Nausea, vomiting and abdominal pain
- Tachycardia with or without hypertension
- Faintness or loss of consciousness
- Cardio-respiratory arrest

If anaphylaxis is suspected immediate medical assistance should be summoned.

4. DIAGNOSING THOSE AT RISK

4.1 Staff

4.1.1 Diagnosis

Employees who think they may have latex allergy, after discussion with their Line Manager should be seen by the Occupational Health Service. Managers who are concerned that an employee may have latex allergy must refer them to the Occupational Health Service for clinical investigation.

4.1.2. Management of Affected Employees

Advice regarding latex avoidance will be given and the Occupational Health Service will review latex allergic employees after avoidance advice has been given to ensure symptom control.

The condition of latex allergy may require reporting as an Occupational Disease under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013. Further advice on this matter is available from the Occupational Health Service and the Health, Safety and Environment Unit.

4.2 New Employees

The pre-employment health questionnaire asks about known allergies, including latex. If latex allergy is identified and confirmed in a prospective employee the Occupational Health Service will advise the management and the employee of any adjustments needed to the working practices or workplace to accommodate the employee. The Health Board will make any reasonable adjustments necessary to comply with this advice. The Occupational Health Service will review latex allergic employees after avoidance advice has been given to ensure symptom control.

4.3 Locums and Agency Staff

All locum and agency staff should be screened by their own agencies before commencing work within the Health Board however they would be expected to comply with the Health Board's policy/procedure whilst in post. If presenting with symptoms of a Latex Allergy, they should seek advice or clinical investigations from their own agency.

4.4 Patients

Certain conditions, occupations or those with a previous history of immediate reaction to skin-rubber exposure during various contact activities should alert the clinician to the possibility of latex allergy. For example:

- Atopy
- Spina Bifida
- Food allergy – avocado, banana, chestnut and kiwi represent the biggest risk of cross allergencity.
- Being a Healthcare Worker
- An allergy to rubber balloons, condoms and rubber gloves
- Multiple Surgical procedures

If latex allergy is suspected, further investigation may be requested from the Dermatology Department.

4.4.1 Management of Latex Sensitive Patient Admitted to Hospital

Effective communication between staff from all departments involved in the case of the patient is essential in maintaining patient safety.

- On admission, the named nurse will ensure that the patient is asked about any allergies.

- Patients notes must be labelled 'Latex Allergy', this is to be included in all relevant documentation i.e. nursing notes, medication chart, medical notes, on procedure request forms to other departments e.g. X-ray etc

- Notify all departments who are involved in treatment, investigation or care for the patient to ensure all necessary precautions are maintained e.g Theatres, X-ray etc.

- Do not use any product that contains latex for nursing, surgical, medical or any other procedure.

- Most equipment today is latex free, however check all labels and packaging before use to ensure they do not contain latex. If in doubt do not use the item until it has been determined that it is latex free. **(In the event of a resuscitation attempt this may not be possible).**

- Remove latex products from the patient's room to reduce the risk of inadvertent use of these products.

- Educate the patient about latex allergy and the possibility of obtaining a Medic-Alert bracelet or locket.

- Where Type I allergy is confirmed and surgery or other medical procedures are imminent, patients should be scheduled first on the theatre list to minimise risk of contamination with latex.

- For patients requiring emergency surgery, every effort will be made to schedule with the latex

allergy first on the emergency operating list. However, when this is not possible due to clinical demand, all latex items will be removed from theatre prior to sending for the patient to prevent contact with the patient and to allow necessary air changes to occur.

- Obstetric patients who have known or have possible latex allergies should be noted at booking clinic, and all appropriate departments notified at this time i.e ward, theatres etc.

4.4.2 Management of Patients in the Community

- Do not use any product that contains latex for nursing, surgical, medical or any other procedure.

- Check all labels and packaging before use to ensure they do not contain latex. If in doubt do not use the item until it has been determined that it is latex free.

- Ensure non-latex gloves are used when attending to patients with latex allergy.

- Remember to check other items such as urinary catheters, syringes, IV giving sets and dressings or bandages.

- Educate the patient about latex allergy and the possibility of obtaining a Medic-Alert bracelet or locket.

- Ensure all documentation is labelled 'Latex Allergy', to ensure continuity of care. Update the patient's notes.

5. PREVENTION

5.1 Use of Low Protein Devices

Sensitisation can be prevented by the use of devices low in protein. Currently, the accepted method for assaying protein in latex devices is the Modified Lowry Assay.

The Surgical Materials Testing Laboratory carries out testing of medical devices for the All Wales Contracts. Part of this work includes assaying protein levels in medical devices. Reports are available from SMTL on request and on their Internet site http://www.smtl.co.uk, which documents protein levels in various medical devices including gloves and urinary catheters. More information can also be found at HSE - Skin at work: Latex allergies

5.2 Use of Non-Latex Devices

The use of non-latex devices is recommended in situations where staff or patients have a known latex allergy, and contact with the device is unavoidable. Appendix 1 lists products known to contain latex. As far as is reasonably practicable, all clinical areas should have latex-free items available in case of an emergency. This would include items such as latex-free gloves and all items on resuscitation trolleys.

5.3 General Measures

Good housekeeping practices should be followed to remove latex containing dust from the workplace. Areas potentially contaminated from latex devices should be identified for frequent cleaning.

Ventilation filters and vacuum bags should be changed frequently in these identified areas.

6. RESPONSIBILITIES

6.1 Chief Executive

The Chief Executive has overall responsibility for ensuring arrangements are in place for the implementation of the Latex Allergy Policy/Procedure.

6.2 Executive Director of People and Culture

The Executive Director of People and Culture has delegated responsibility for ensuring arrangements are in place for the implementation of the Latex Allergy Policy/Procedure.

6.3 Clinical Board Managers/Nurses will:

Ensure through their Directorate/Locality/Department Managers that Departments have Local Procedures for managing latex allergy in their areas.

6.4 Directorate/Locality/Departmental Managers will:

Ensure that this procedure and appropriate arrangements are implemented into their areas of responsibility. This includes making staff aware of this procedure and providing adequate information to staff.

6.5 Lead Clinicians will:

- Ensure that the allergy history, including latex of any patient being considered for elective surgery is established and recorded in advance of admission. All conscious non-elective patients will be asked on admission to the Emergency Department if they have any known allergies. If the patient has a skin problem for which the diagnosis is not clear but in which a latex allergy is a possibility, the patient should be referred for a dermatological opinion.

- Ensure that if it is known that the patient has a latex allergy that this information is recorded and communicated to all parties who will be involved in the treatment and care of the patient.

6.6 Ward/Departmental Managers/Community Leads will:

- Ensure staff are made aware of the risks of latex allergy.

- Ensure that COSHH Assessments for latex are undertaken.

- Ensure only non-latex gloves (powder free, low protein latex gloves) are available for all employees and effectively manage provision through the risk assessment process and appropriate control measures.

- Ensure that where it has been identified that non-latex gloves must be used due to a specific clinical procedure, a risk assessment has been carried out and that these

risk assessments are reviewed and updated as necessary.

- Ensure non-latex products are available for employees who may be sensitised to latex.
- Ensure non-latex gloves and latex gloves are stored separately, if it has been risk assessed that latex gloves are required.
- Make use of a health surveillance programme including pre-employment screening to establish if a prospective employee has a history of latex allergy.
- Raise awareness of latex allergy by inclusion of the topic in the induction process for new starters.
- Ensure every reasonable precaution is taken to protect a latex sensitive member of staff.
- Manage exposure to latex through health surveillance and the annual appraisal system where appropriate. A Latex questionnaire is to be completed with the employee as part of their appraisal (Refer to Appendix 2). Positive results are to be referred to the Occupational Health Service.
- Ensure a latex free environment as far as reasonably practicable, if he/she is notified that there is a latex sensitive patient on ward/department.
- Ensure that every patient is asked if they have any allergies and is recorded on the patient notes.
- Ensure that all staff are made aware if a latex sensitive patient is on the ward/department and that this is clearly marked in the patient notes.
- Complete an E-Datix Incident Report Form if a patient suffers an adverse reaction as a result of being in contact with latex.

6.7 Occupational Health Service will:

- Refer to the process developed to deal with the assessment of latex allergy in staff before and during employment.

- Advise employees and their managers on restrictions necessary to safeguard their health.

- Ensure that staff with known Type 1 latex sensitivity receives health surveillance at appropriate intervals.

- Ensure that there is a follow up for staff that are diagnosed with latex allergy/sensitivity.

  Advise the Health and Safety Department of any employees who have been diagnosed with contact dermatitis as the condition of latex allergy may require reporting as an Occupational Disease under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013.

- Advise the Health Board management through the Operational Health and Safety Group of significant issues as they arise.

6.8 Health and Safety Department will:

- Provide advice and support in the completion of the COSHH Assessments.

- Provide advice and information with regard to potential hazards in the workplace.

- Advise on methods of risk assessment.

6.9 Procurement Department will:

- Provide advice to Managers on the purchase of gloves and other equipment.

- Ensure only non-latex gloves (powder free, low protein latex) are available for all employees and effectively manage provision through the risk assessment process and appropriate control measures.

- Assist in finding alternative products for staff and patients who are allergic to latex products.

- Provide information to managers from manufacturers.

6.10 Staff will:

- Report any skin allergy problems to their Line Manager and Occupational Health.
- Assume responsibility to read and understand the relevant sections of this procedure.
- Complete a Datix Incident Report Form if any skin allergy problems occur.

6.11 What Staff Can Do To Protect Themselves

The assessment of risk under COSHH and this Procedure should eliminate the use of latex gloves and restrict the use of other latex products with a high leachable protein content, as far as is reasonably practical. In practice, measures likely to be identified by a suitable and sufficient risk assessment will include having a procedure, which includes:

- not wearing gloves unnecessarily
- ensuring that powdered latex gloves **are not** used
- following good hygiene practices, such as washing hands after removing gloves.
- all staff must use reasonable measures to ensure their skin remains healthy and intact. Barrier creams can affect glove integrity and should not be applied to hands immediately before wearing gloves.
- reporting any skin allergy problems to their Manager and the Occupational Health Service as soon as possible.

12. REVIEWING THE PROCEDURE

The Procedure will be reviewed within three years of implementation or as the Health Board changes and/or when legislation, codes of practice and official guidance dictate.

REFERENCES

Control of Substances Hazardous to Health Regulations 2002
Management of Health and Safety at Work Regulations 1999

Royal College of Physicians and NHS Plus – Latex Allergy, Occupational Aspects of Management 2008

Medical Device Alert (1996) Latex Sensitisation in the Healthcare Setting 1996/01

National Patient Safety Agency (NPSA) Protecting People with Allergy Associated with Latex 2005/08

APPENDIX 1

COMMON MEDICAL DEVICES CONTAINING LATEX

Adhesive tape
Ambu bags
Band-Aids and similar
Bulb syringes
Colostomy pouch
Condom urinary collection devices
Dental cofferdams
Elastic bandages
Electrode pads
Enema tubing kits
Fluid warming blankets
Gloves - examination and sterile
Haemodialysis equipment
Mattresses on stretchers
Neonatal incubator
PCA syringes
Protective sheets
Rubber gloves
Rubber pads
Stethoscope tubing
Stomach and GI tubes
Tourniquets
Urinary catheters
Vial stoppers
Wound drains

<u>Anaesthesia and Operating Room Equipment</u>

Blood pressure cuffs (bladder and tubing)
Bile bags
Chest drainage units
Drapes
Electrode pads
Endotracheal tubes
Epidural catheter injection adapters
Eye shields
Head straps
Injection ports on iv bags
Laparoscopy insufflation hoses
Linear/Burr hole drapes
Latex cuffs on plastic tracheal tubes
Latex injection ports on iv tubing

Multidose vial stoppers
Needle counting systems
Naso-pharyngeal airways

Oral-pharyngeal airways
Porous tape
Penrose tubing
Rubber suction catheters
Rubber breathing circuits
Rubber ventilation bellows
Rubber masks
Rubber tourniquets
Surgical masks
Teeth protectors & Bite blocks
Vented basic solution sets

Miscellaneous Products Containing Latex

Adhesive tape
Balloons
Condom
Camera eyepiece
Diaphragm
Dummies
Household work gloves
Paint
Raincoats
Shower cap
Swimming fins
Tennis/squash shoes
Underwear

Reference source:
http://www.jr2.ox.ac.uk/bandolier/bandopubs/NHSSlatex.html

APPENDIX 2

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

Latex Questionnaire for the Personal Development Appraisal Review

Name……..... Dept……..…..

DOB……... Location…….

Job title……... Date started in post……

Have you had any reactions to gloves you have used at work? Including the following:	**Yes**	**No**	**Details**
Runny nose or sore itchy eyes			
Eczema, rash or dermatitis on hands			
Eczema on any other part of body			
Red, sore skin on hands			
Wheezing or breathlessness at work			
Have you had any reactions to the gloves you use at work?			

Signature of employee……..

Name and post of person administering this questionnaire……..

Signature……

Name of manager…….

Refer any positive responses to the Occupational Health Department

Action: NO FURTHER ACTION REQUIRED AT THIS TIME/YES - REFER TO OH

Date of next due questionnaire…….

Saunders,Nathan 04/13/2022 14:07:51

Reference Number: UHB 127 **Version Number:** 3	**Date of Next Review:** April 2025 **Previous Trust/LHB Reference Number:** 32

LATEX ALLERGY POLICY

Policy Statement

The UHB recognises its responsibility to implement safe working practices, in keeping with the principle Health and Safety legislation and therefore will, where reasonably practicable, undertake to reduce the risk of exposure to latex by staff and patients.

Policy Commitment

The introduction in 1987 of Universal Blood and Body Fluid Precautions aimed to reduce the risk of transmission between patients and staff of various pathogens, especially viruses. There has subsequently been a great increase in the use of latex gloves by health care workers.

As the frequency and duration of the use of latex products has increased, the emergence of various forms of latex sensitivity has been identified as a problem for both staff and patients. This sensitivity can vary from mild contact dermatitis to a severe reaction resulting anaphylactic shock. The Cardiff and Vale University Health Board (the UHB) must ensure that it has arrangements in place for assessing and managing the risks that latex may present in the clinical environment.

The UHB has a duty to assess the risk from latex in accordance with the Control of Substances Hazardous to Health Regulations 2002.

Supporting Procedures and Written Control Documents

This Policy describes the following with regard to Latex Allergy

- Prevention of the development of latex allergy
- Prevention of symptoms due to latex allergy in both staff and patients
- Provision of an environment where the UHB seeks to minimise the risk from exposure to latex
- Management - Where latex allergy in patients and staff is suspected or known, control measures will be identified to allow healthcare to be provided and continued employment where possible
- To ensure that the UHB complies with the Control of Substances Hazardous to Health Regulations 2002.

Other supporting documents are:

- Health and Safety Policy
- Control of Substances Hazardous to Health (COSHH) Procedure

- Occupational Health Policy
- Managing Attendance at Work Policy All Wales
- Incident, Hazard and Near Miss Reporting Policy

Scope

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

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be a no impact.
Policy Approved by	Health and Safety Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Operational Health and Safety Group
Accountable Executive or Clinical Board Director	Executive Director of People and Culture

Disclaimer

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

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
2	July 2017		Reviewed and updated in line with departmental and reporting structure changes
3	January 2019		3 yearly review period
4	April 2022		3 yearly review period

Equality & Health Impact Assessment for

LATEX ALLERGY POLICY

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	N/A
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Executive Director of People and Culture
3.	Objectives of strategy/ policy/ plan/ procedure/ service	
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings	Considered all staff groups and patients that could come into contact with latex – clinical and non-clinical staff. The UHB's usual arrangement with regard to consultation was followed.

	• research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	All UHB Staff and those with honorary contracts, patients

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

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	There does not appear to be any impact	N/A	N/A
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term	The UHB is aware from its demographic information that it employs staff who have disabilities as defined within the Act. As such, the policy would be made accessible to staff and service users in alternative formats on request or via usual good management practice.	N/A	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
medical conditions such as diabetes			
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	There appears not to be any impact on staff or service users regarding gender.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.4 People who are married or who have a civil partner.	There appears not to be any impact		
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	There appears not to be any impact.		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers,	There appears not to be any impact on staff regarding race, nationality, colour, culture or ethnic origin.	Whilst there doesn't appear to be any impact, if a member of staff or service user was known to have difficulties with the	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
gypsies/travellers, migrant workers		written word, good management would dictate that alternative arrangements be made, such as individual meetings. Translators would be used where necessary to communicate with service users.	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	There appears not to be any impact.		
6.8 People who are attracted to other people of: • the opposite sex (heterosexual);	There appears not to be any impact		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
• the same sex (lesbian or gay); • both sexes (bisexual)			
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language			
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless,	There appears not to be any impact		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
people who are unable to work due to ill-health			
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	There appears not to be any impact		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	There are no other groups or risk factors to take into account with regard to this Policy.		

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	**N/A**	N/A	
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or	N/A	N/A	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels,	N/A	N/A	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
job security, working conditions Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality	N/A	N/A	

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
and safety of play areas and open spaces Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	**N/A**	N/A	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	**N/A**	N/A	

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

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Overall, there appears to be very limited impact on the protected characteristics and health inequalities, however, it is suggested that implementation of the policy will have a positive impact on the safety and wellbeing of UHB staff, Patients and Visitors.

Action Plan for Mitigation / Improvement and Implementation

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

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

Report Title:	Draft Health and Safety Culture Plan			Agenda Item no.	9.1
Meeting:	Health and Safety Committee	Public	x	Meeting Date:	19/04/2022
		Private			
Status *(please tick one only):*	Assurance		Approval		Information x
Lead Executive:	Executive Director People and Culture				
Report Author (Title):	Head of Health and Safety				

Main Report
Background and current situation:

Background
The Health and Safety Culture Plan 2022-2025 has been developed to provide a structured, prioritised approach to underpin Cardiff and Vale University Health Board's H&S aims and objectives. It has been established from the findings of the independent external review conducted in 2021 and a full department workshop session conducted in October 2021.

Situation

The Health and Safety Culture Plan sets out the actions we will take over the next three years, with a clear focus on improving the H&S culture within the organisation. It is built around 6 themes each with a competent departmental lead:

1. **Achieving Training and Competence Excellence** – to develop H&S education which inspires and empowers people to work safely within their capabilities. To create a workforce that is competent in everything they do.
2. **Achieving Health and Safety Risk & Incident Management Excellence** – to embed a process for identifying and mitigating risk at all levels. To develop a suite of lagging and leading performance indicators. To introduce a robust system for investigating incidents at a proportional level with a feedback mechanism to review and share the relevant findings.
3. **Achieving Communication Excellence** – to create an environment to enable collaboration and open discussion ensuring clear, consistent communications utilising a range of channels to reach all stakeholders both internal and external.
4. **Measuring Performance** – to create a stakeholder adopted management system and ensure it is consistently applied throughout the UHB
5. **Audit & Review** – to create a leading audit process by which we identify non-conformances, rectify in an appropriate time bound fashion, and share these improvements with Clinical and Service Boards
6. **Achieving Fire Safety Excellence** – to develop leading fire safety preventative and protective measures that provide a robust, compliant, and resilient approach to fire safety management

Within each theme are a number of SMART objectives and agreed actions, with identified owners.

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

The plan commits the Health Board to continually improve the health and safety of its staff and other persons affected by its activities and will evidence a step change in H&S culture at CAVUHB. Assurance is provided by demonstrating progress through the 2022 Health and Safety Culture Plan which will be monitored at the Operational Health and Safety Group meeting and progress reported at each Health and Safety Committee meeting.

Recommendation:

The Committee is requested to:

a) Note the findings of the plan and the objectives identified to improve H&S; and
b) Note that the H&S Committee will receive regular progress updates.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
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	X

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
No
Safety: Yes/No
No
Financial: Yes/No
No
Workforce: Yes/No
No
Legal: Yes/No
No
Reputational: Yes/No
No
Socio Economic: Yes/No
No
Equality and Health: Yes/No
No
Decarbonisation: Yes/No
No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Health and Safety Committee	19/04/2022

Health and Safety Culture Plan 2022-2025

Llunio ein Gweithlu i'r Dyfodol

Shaping Our Future Workforce

Title for plan???

Welcome

From the Executive Director of People and Culture

To be provided by Rachel Pressley

Insert the pictorial poster from the away day

Introduction

At Cardiff and Vale University Health Board (UHB) we pride ourselves on being a safe place to learn, work and live, with inclusion, wellbeing, and development at the heart of everything we do.

An independent external review of H&S arrangements within the UHB was conducted in May 2021. The Health and Safety Culture Plan 2022-2025 has been developed in line with this review to provide a structured, prioritised approach to underpin the UHBs H&S aims and objectives. It commits the Health Board to continually improve the health and safety of its staff and other persons affected by its activities.

As stipulated by the Health and Safety Executive (HSE), the Board should set the direction for effective H&S management. This starts with the H&S policy which should be an integral part of the organisations culture, values and performance standards. The Health and Safety Culture Plan builds on this policy foundation, existing systems and the strong Health and Safety departmental competence. It strengthens what we already do and introduces new key systems and processes that are fundamental to managing H&S. It introduces forward thinking, providing a proactive approach which will further embed H&S into the operations of the UHB, leading to an improved culture from top to bottom.

The HSE lay out a four-part approach for the management of H&S based on a Plan, Do, Check, Act principle –this helps us achieve a balance between the systems and behavioural aspects of management. It also treats H&S management as an integral part of good management, rather than as a stand-alone system. This principle has been incorporated into the plan and is covered within the proposed management system which incorporates all the departmental elements of Health and Safety, Personal Safety/Case Management, Manual Handling, Fire Safety and Health and Safety Training.

At its most effective, full involvement of our workforce creates a culture where relationships are based on collaboration, trust and joint problem solving. All UHB staff should be involved in assessing workplace risks and the development and review of workplace H&S policies in partnership working.

"I find it hard to imagine how one could ever put in place an effective workplace health and safety system that did not include real participation and engagement of the workforce."

Judith Hackitt, Chair of the HSE

During the Covid-19 pandemic, we have seen our workforce adapt quickly to the challenges they faced. New surge hospitals were built at the Dragon's Heart Hospital and Lakeside Wing; new working patterns and new ways of working were adopted; our people were redeployed to priority areas; and there was rapid onboarding of new recruits; all while we ensured a safe working environment and protected the safety of our staff.

About This Plan

The Health and Safety Culture Plan sets out the actions we will take over the next three years, with a clear focus on improving the H&S culture within the organisation. The Health and Safety Culture Plan is built around 6 themes:

Achieving Training and Competence Excellence – to develop H&S education which inspires and empowers people to work safely within their capabilities. To create a workforce that is competent in everything they do.

Achieving Health and Safety Risk & Incident Management Excellence – to embed a process for identifying and mitigating risk at all levels. To develop a suite of lagging and leading performance indicators. To introduce a robust system for investigating incidents at a proportional level with a feedback mechanism to review and share the relevant findings.

Achieving Communication Excellence – to create an environment to enable collaboration and open discussion ensuring clear, consistent communications utilising a range of channels to reach all stakeholders both internal and external.

Measuring Performance – to create a stakeholder adopted management system and ensure it is consistently applied throughout the UHB

Audit & Review – to create a leading audit process by which we identify non-conformances, rectify in an appropriate time bound fashion, and share these improvements with Clinical and Service Boards

Achieving Fire Safety Excellence – to develop leading fire safety preventative and protective measures that provide a robust, compliant, and resilient approach to fire safety management

Within each theme are a number of objectives and agreed actions, with identified leads and this plan describes these.

The Health and Safety Culture Plan can only be delivered through engagement and partnership working with our staff

Theme 1: Achieving Training and Competence Excellence

The Health and Safety Department aim to have a workforce that are informed, suitably trained and competent to improve the H&S culture across the UHB.

The overall aim of this theme is to ensure we provide a programme of H&S courses and interventions to improve the H&S for all staff working within the UHB and that this training is accessible, relevant and appropriate.

Achieving this aim will provide assurance that the UHB is fulfilling its legal responsibilities in relation to H&S Legislation, ensuring that there is a skilled workforce, resulting in a reduction of H&S incidents across the UHB.

The challenges we face under this theme include:

- A number of the actions require joint working with other stakeholders across the UHB
- Staffing numbers in wards/departments allowing staff time to be released to complete mandatory training requirements
- Training team establishment – having adequate resource to be able to deliver to Training Needs Analysis (TNA)
- Training venues – limitation on numbers due to number and size of training venues under control of the Health and Safety department
- Staff not having allocated time to meet their training needs
- Developing effective, inclusive and accessible ways of enabling employees to meet their training needs

How we will overcome these challenges:

- Create a training strategy and action plan that has measurable outcomes
- Review and enhance the booking process to ensure access to training is easier for staff
- Explore alternative avenues for staff to meet their training needs, to include wider use of Workplace Assessors, expand online and face to face training provisions and explore more flexible ways of delivery
- Explore 'protected time' for staff to be able to meet their H&S mandatory training needs
- Identify those staff most 'at risk' and offer training in a timely manner to address this risk
- Continue to support our employees to improve their own H&S, ensuring that they have access to the right information, services and activities
- Provide departments with up-to-date training compliance data for monitoring and improvement purposes

Character image to show training link

Improve accessibility of courses and training through ESR

The current ESR system is not easy for staff to navigate when booking onto training courses. This objective hopes to address this issue by ensuring the process is as clear and easy as possible. To achieve this, work is ongoing with LED to ensure that there are clear links and access to the ESR system for all UHB staff. Monthly meetings are in place to address concerns raised and progress issues. The objective should lead to an increase in training compliance and a general reduction in errors with staff booking on inappropriate training courses.

Action plan to influence UHB wide mandatory training is up to date and completed as planned

LED lead on the UHB's mandatory training action plan. A number of the training courses included within this action plan are owned by the Health and Safety department. The purpose of this objective is to influence and contribute to the corporate action plan by enabling departments to monitor their training compliance via the monthly H&S training dashboards and by providing reports on request. This will highlight areas that are failing to meet their mandatory training targets and allow managers within the Clinical and Service Boards to take more ownership/responsibility to improve the situation.

In addition to managers having more responsibility for ensuring their staff are compliant there is an aim to have mandatory training requirements reintroduced to the standard Values Based Appraisals (VBA) template to ensure that everyone within the UHB has an identified responsibility to attend identified training and that this training is linked to their KPIs.

Whilst each member of staff has an identified number of mandatory training requirements that are linked to their role and recorded on ESR, there is currently no 'protected time' to enable this to be completed. The H&S Team aim to explore the possibility of each staff member being allocated (pro rata) specific protected time to achieve compliance .

Review of statutory and mandatory requirements to ensure requisite competencies identified, delivered and maintained to include all aspects i.e. manual handling, V&A and fire

Currently, the way in which mandatory training requirements are allocated may result in some staff undertaking training that is not relevant/needed and others not completing training that is. This objective aims to rectify this, to try to ensure staff have training that is identified by individual roles to ensure training is relevant.

A review of training requirements at point of recruitment/application will be undertaken and consideration for specific courses for new starters will explored to ensure all relevant mandatory training is undertaken as soon after appointment as possible, with protected/allocated time to do so.

A review of all existing H&S training will be undertaken to identify any gaps and training requirements.

Increase the utilisation of digital technology for training purposes

At present the majority of training materials/resources used for H&S training are paper based. Digital technology will be explored to reduce training paperwork. This will ensure training records are more accurate, less likely to be misplaced, and able to be held for longer periods of time as evidence of training for potential personal injury claims against the UHB (? Include this last bit).

Having a more digital approach will modernise the way training is delivered/managed and enable delegates to have a digital record of evidence for training rather than paper copies which often get lost. This will enable staff to provide evidence more easily when changing roles in the future.

Full implementation of Manual Handling Workplace Competency Assessment course

The Health and Safety department reintroduced a training programme for manual handling workplace competency assessors (MHWCA) in September 2021 for patient handling staff. This was a pilot scheme for 6 months which has now been rolled out across the UHB. The aim of the MHWCA is to reduce the frequency of classroom manual handling training by undertaking a workplace competency assessment at specified intervals. The MHWCA can carry out competency assessments at any time during the working day/night thus affording much more flexibility for staff to achieve their competence for manual handling without needing to be released from the clinical area for a whole shift at a time. The assessments take approx. 40 mins thus each assessment is saving precious time away from the workplace. The goal is to expand the number of patient handling MHWCA across the UHB and a similar programme for inanimate handling staff will be implemented across the UHB.

The project will be constantly monitored to ensure standardised assessments are completed and submitted. There is a quality assurance process in place for the MHWCA to resolve concerns raised by the MHWCAs

Integrate training requirements on the use of the H&S management system

The Health and Safety department are implementing a H&S management system to be rolled out across the organisation. A comprehensive training programme will be developed to support Clinical and Service boards for this project.

Review H&S induction training and mandatory training

At present a number of H&S topics are included in the induction and mandatory training programmes.

A review will be undertaken to identify any gaps in delivered information. This review will ensure relevant H&S subjects are included and to determine if this is the most appropriate way to cascade this training

Review of technology-based training delivery

H&S E-learning mandatory training programmes are available for all staff to complete on ESR. A review of the content will be undertaken to ensure relevance and accuracy.

Measures of success for this theme include:

- Improvement in training compliance
- A reduction in reported H&S incidents
- Improved organisational H&S culture
- Positive impact on patient experience
- Provide compliance with H&S legislation for the UHB

Theme 2: Achieving Health and Safety Risk & Incident Management Excellence

To embed a process for identifying and mitigating risk at all levels. To develop a suite of lagging and leading performance indicators. To introduce a robust system for investigating incidents at a proportional level with a feedback mechanism to review and share the relevant findings.

This theme contains two key elements – incident management and risk management. These components will be addressed separately.

Incident Management

The challenges we face for incident management under this theme include:

- Implementation of Datix Cymru
- Maintaining a good reporting culture
- Competence in undertaking an appropriate and thorough investigation
- Monitoring and follow up of investigation findings and recommendations
- Support from management and workforce towards behavioural safety

The UHB is committed to the health, safety and welfare of our staff, patients, visitors and all users of our premises and services, and our impact on the environment by being proactive in our approach to reduce the number of untoward incidents.

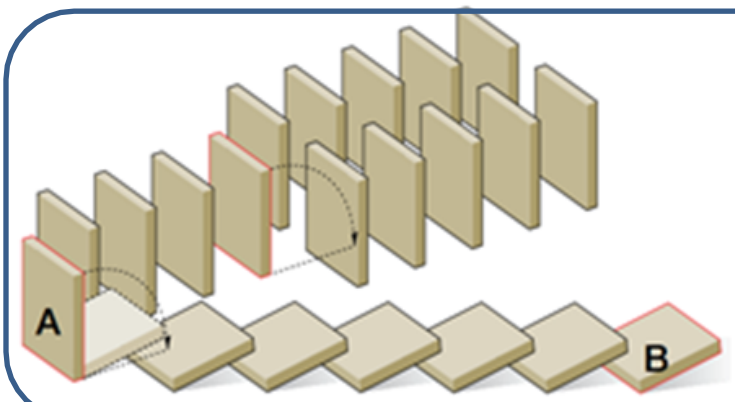
An Adverse Incident is defined as

"Any unplanned event that resulted in, or had the potential to result in, an injury or the ill health of any person, or the loss of, or damage to, property"

Every year staff are injured at work. In our UHB, between 1st April 2021 and 31st January 2022 there were 11,155 working days lost due to work related incidents reported during this period. Adverse events have many causes and what may appear to be bad luck (being in the wrong place at the wrong time) can, on analysis, be seen as a chain of failures and errors that lead inevitably to the adverse event -this is often known as the Domino effect. Clearly, there are good financial reasons for reducing accidents and ill health but the safety of our staff must be at the heart of everything that we do.

How the challenges will be overcome

- Close working with the Patient Safety Team to provide support and guidance for staff in the use of Datix Cymru
- Implementation of incident investigation tools
- Incident investigation training including appropriate levels of investigation
- Arrangements to ensure action plans are implemented and progress monitored
- A structure to share lessons learned
- Implementation of a behavioural safety programme
- Review incident investigation process
  - Incident investigation flowcharts and templates will be developed and rolled out across the organisation. Training programmes will be enhanced to provide managers with the necessary skills.
  - Identification of clear roles and responsibilities for incident management will be established.
  - A process will be developed and implemented to review and monitor actions from RIDDORs and incident investigations. This will be rolled out across the Clinical and Service Boards to ensure a consistent and clear approach. Monthly meetings will be established with senior managers to review the status of serious incident investigations and monitor outstanding agreed actions.



Each domino represents a failing or error which can combine with other failings and errors to cause an adverse event. Dealing with the immediate cause (B) will only prevent this sequence. Dealing with all causes especially root causes (A) can prevent a whole series of events.

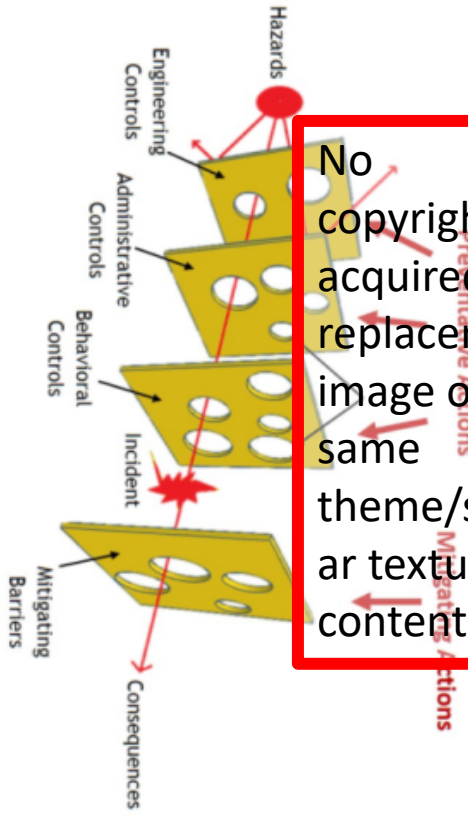
There are hazards in all workplaces; risk control measures are put in place to reduce the risks to an acceptable level to prevent accidents and cases of ill health. To prevent adverse incidents, we need to provide effective risk control measures which address the immediate, underlying and root causes. The fact that an adverse incident has occurred suggests that the existing risk control measures were inadequate. Learning lessons from near misses can prevent costly accidents and improve employee morale and attitude towards H&S.

It is essential that all incidents, near misses and hazards are reported so that appropriate action can be taken to try to prevent their reoccurrence, improve the environment, patient experience and services where appropriate. The Health Board utilises an electronic reporting system, Datix, and encourages a fair and open culture where there is willingness to report so that lessons can be learned, and risks reduced as far as is reasonably practicable. The E-Datix system was replaced with a new reporting system from 1st March 2022 – Datix Cymru.

DatixCymru

Adverse incidents should be investigated to ensure that corrective action is taken, learning is shared, and any necessary improvements are put in place. The objective is to establish not only how the adverse event happened, but more importantly, what allowed it to happen. An investigation is not an end, but the first step in preventing future adverse incidents and establishing a deeper understanding of the risks associated with work activities. Investigations will help us to:

- identify why existing control measures failed and what improvements or additional measures are needed
- plan to prevent the incident from happening again
- point to areas where risk assessment needs reviewing
- improve risk control in our workplace in the future



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Improve Datix Utilisation

The implementation of Datix Cymru is being led by the Patient Safety Team with close working and support from the Health and Safety Team. Advice and guidance will be provided to staff where required and selective audits will be undertaken to ensure the system is being used effectively

Proactive interventions will be explored where there has been an identified trends in losses

Incident data will be reviewed to formulate specific stretching KPIs for individual Clinical and Service Boards and channels of communication will be explored to ensure lessons learned from incidents are shared across the UHB where appropriate.

Streamline Reporting Mechanisms for Unsafe Conditions

Behavioural safety is a key part of the UHBs journey to ensuring excellence in workplace safety and health. Behavioural safety programmes can help to prevent work related accidents and diseases and is about identifying bad habits that could cause accidents or lead to ill health and reinforcing good habits. Over the next 3 years the Health and Safety Department will implement a behavioural safety programme and this will be communicated across the organisation with support and training available.

Measures of success

- Reduction in incident rates
- Reduction in days lost because of adverse incidents at work
- A systematic approach to effective incident investigation with a methodical, structured approach to information gathering, collation and analysis.
- Evidence of near miss reporting.
- Proactive approach towards an interdependent H&S culture
- Shared learning from incidents and mitigating actions implemented
- Clear guidance for determining the level of investigation which is appropriate for the adverse incident

Risk Management

H&S risk management is a process where we do what we can to minimise the risks associated with health and safety hazards within our workplace. The aim is to ensure that no one is injured or hurt by a hazard at work.

The challenges we face for Risk management under this theme include:

- Different versions of risk assessment forms in circulation
- Competence in undertaking suitable and sufficient risk assessments
- Monitoring and follow up of actions
- Support from management and workforce towards behavioural safety

To address these challenges, we will:

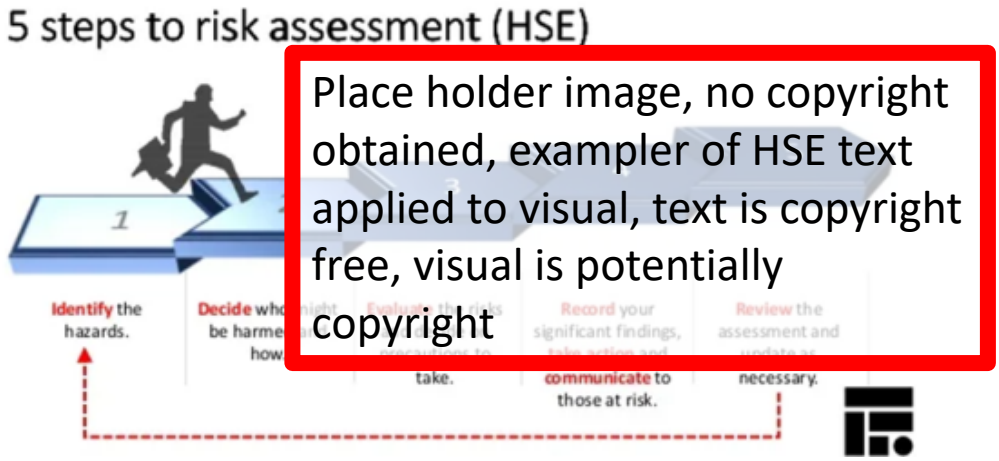
- Provide a suite of risk assessment forms
- Provide appropriate training and support in completing risk assessments
- Arrangements to ensure action plans are implemented and progress monitored
- Implementation of a behavioural safety programme

Objectives of risk assessment

Risk assessments are conducted across the organisation to facilitate the identification and management of risk. In simple terms, the objectives of a risk assessment are:

- Identify the hazards associated with an activity.
- Assess the risks posed by those hazards.
- Eliminate the hazards (design out), or manage the hazards (incorporate safety systems, control measures etc) to reduce the risk to an acceptable level; and
- Monitor the risks to ensure controls are working and feedback lessons to ensure continual risk reduction.

Risk management is a systematic process that involves the following five steps:



There are many instances when a risk assessment should be undertaken. These being, when:

- a new hazard has been introduced
- an incident (including a near miss) has occurred
- when a new activity involving significant risk is planned.

We are required to make a 'suitable and sufficient' assessment of risks to our employees and others not in our employment that are created out of our work. Risk assessments are led by competent persons who have appropriate skills, knowledge, and experience with input from individuals with practical knowledge of the work activities being assessed. They include both activities undertaken at our own premises and risks associated with offsite activities such as work at the premises of others, travel, and driving.

Assessing risk is just one part of the overall process used to control risks in our workplace. Risks can often change and be unpredictable and therefore it is essential that we can demonstrate flexibility in our responses and processes to manage our risks.

Risk Scoring = Consequence x Likelihood (C x L)

Consequence Score	Likelihood Score				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 - Catastrophic	5	10	15	20	25
4 - Major	4	8	12	16	20
3 - Moderate	3	6	9	12	15
2 - Minor	2	4	6	8	10
1 - Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3 = Low Risk	**Quick, easy measures implemented immediately, and further action planned for when resources permit**
4 -10 = Moderate Risk	**Actions implemented as soon as possible but no later than a year**
12 -16 = High Risk	**Actions implemented as soon as possible but no later than six months**
20 - 25 = Extreme Risk	**Requires urgent action. The UHB Board is made aware, and it implements immediate corrective action**

Embedding new Health and Safety policy statement

H&S must be embedded in the culture of the organisation. The UHB's Statement of Intent has been signed by the Chief Executive and displayed at key points throughout the organisation - this demonstrates visible leadership across the UHB.

The Statement of Intent is the Board's commitment to provide a safe and healthy workplace for all and is the responsibility of the Clinical and Service Boards to ensure it is widely communicated within their areas.

Relaunch Risk Register and Priority Improvement Plan System

The H&S Risk Register and Priority Improvement Plan (PIP) are key documents for recording risks, controls, mitigation and actions. These are live documents which require regular review - the Clinical and Service Boards will be supported to produce their PIP.

The Health and Safety Department will work closely with the Corporate Governance Department to ensure the consistency of advice and information to the Clinical and Service Boards.

The general risk assessment and task specific templates will be reviewed so that they are aligned with the risk register scoring process. The templates will be incorporated to all relevant H&S training.

Management of High-Risk Work

The UHB has policies and procedures in place for the safe management and control of high-risk work to minimise risks to all personnel on the premises. This applies to staff, contractors, and partners.

There will be a review of all associated H&S policies and procedures to ensure correct ownership

There will be a review of the contractor management process to ensure a standardised and uniform approach with key stakeholders.

Review departmental risk management activities to ensure risks are identified, recorded, and tracked

The Priority Improvement Plan will be reviewed and updated and actions from the previous PIP will be transferred and will include fire safety. The PIP will also be cross referenced with the departmental risk register to ensure all is captured and progressed.

Measures of success for this theme include:

- Signed copy of Statement of Intent widely on display throughout the UHB
- New Priority Improvement Plan (PIP) created and signed off
- Updated Risk Register and PIP for Clinical and Service Boards & Directorates/Departments
- Updated templates in use and incorporated into the managing safely and working safely courses
- Reduction in incident rates

Theme 3: Achieving Communication Excellence

Communication is a critical component of successful leadership. Whether you're the manager of a small team or leading a large network of workers, vital information will be ignored or misunderstood if you don't have the correct skills and tools to effectively communicate.

This is especially true when promoting workplace H&S, as methods of communication can be 'make or break' in terms of safety. An incorrect strategy can lead to disengaged and uninformed employees.

Communication should be two-way and not only take place with internal stakeholders, but will also need to consider external parties - these could include third party sectors, voluntary sectors or enforcing authorities.

Effective communication supports the development of positive relationships and can influence attitudes and behaviours in relation to H&S.

The challenges we face under this theme include:

- Integrity of information.
- Stakeholder engagement and collaboration
- Behaviours and attitudes
- Developing effective and inclusive ways of enabling employee involvement

How the challenges will be overcome

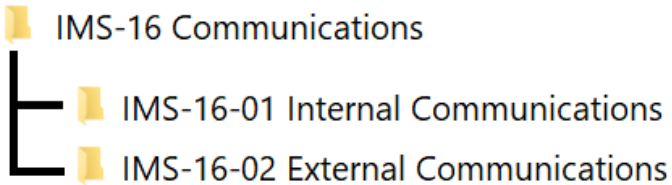
- Competent H&S advice based on legislation and guidance
- Clear procedures and guidance on key H&S processes e.g. incident investigation
- Implementation of a behavioural safety programme
- Communication platforms to be maintained to ensure a steady flow of relevant, factual and timely information to key stakeholders
- Implementation of the H&S management system will allow a review and feedback mechanism

The fundamental goal of good communication is to provide meaningful, relevant and accurate information, in clear, concise and understandable terms. This in turn can:

- Promote awareness and understanding of the management of H&S as well as specific risk issues
- Promote consistency and transparency in arriving at and implementing H&S risk management decisions
- Provide a sound basis for understanding the management of H&S within the organisation
- Improve the overall effectiveness and efficiency of the implementation of the management system
- Contribute to the development and delivery of effective information, instruction and learning opportunities
- Strengthen the working relationships and mutual respect among all participants in H&S
- Exchange information on the knowledge, attitudes, values, practices and perceptions concerning H&S.
- Enhance two-way communication as an effective feedback mechanism to the Health and Safety Team

Develop a Communication H&S Plan

Communication is a key element of the H&S Information Management System (IMS) and is a specific component of the hierarchy. IMS-16 will detail the specific processes and procedures necessary for the consistent storage and management of communications, both internal and external.



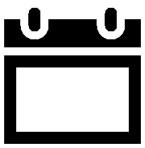
We will review and improve existing communication platforms including the H&S intranet pages, Terms of References and dashboard.

Review and Redefine Terms of Reference for Current H&S Meetings at all levels

The structure of the UHB Operational H&S meeting will be reviewed to ensure it is fit for purpose and provides the UHB with the necessary assurance that H&S is effectively managed at all levels. The relevant findings from this review will be used to inform and improve the Clinical and Service Board H&S meetings to ensure a consistent approach across the UHB.

Temporary image
Colleagues sat around a table,
For a meeting

Develop H&S Calendar of Subjects



Potential image spot
Calendar wearing a hard hat? Or HiVis?

An annual programme of regular themed H&S topics will be developed and implemented to provide advice, information and reassurance across the UHB. This could be achieved in a variety of formats including dial in/drop-in sessions and website content.

Measures of success for this theme include:

Regular relevant and up to date information posted throughout the UHB utilising various platforms
Implementation of standardised Terms of Reference for Clinical and Service Board H&S meetings
Developed and implemented annual programme of themed H&S topics
Intuitive departmental intranet webpages in line with the H&S management system

Theme 4: Measuring Performance

To create a stakeholder adopted management system and ensure it is consistently applied throughout the UHB.

The primary purpose of measuring H&S performance is to provide information on the progress and status of the strategies, processes and activities used by the UHB to control risks to H&S. Measurement information sustains the operation and development of the H&S management system by:

Potential location for image
Suggestion:
Upward trending
charting maybe?

- providing information on how the system operates in practice.
- identifying areas where remedial action is required.
- providing a basis for continual improvement.
- providing feedback and motivation.

The challenges we face under this theme include:

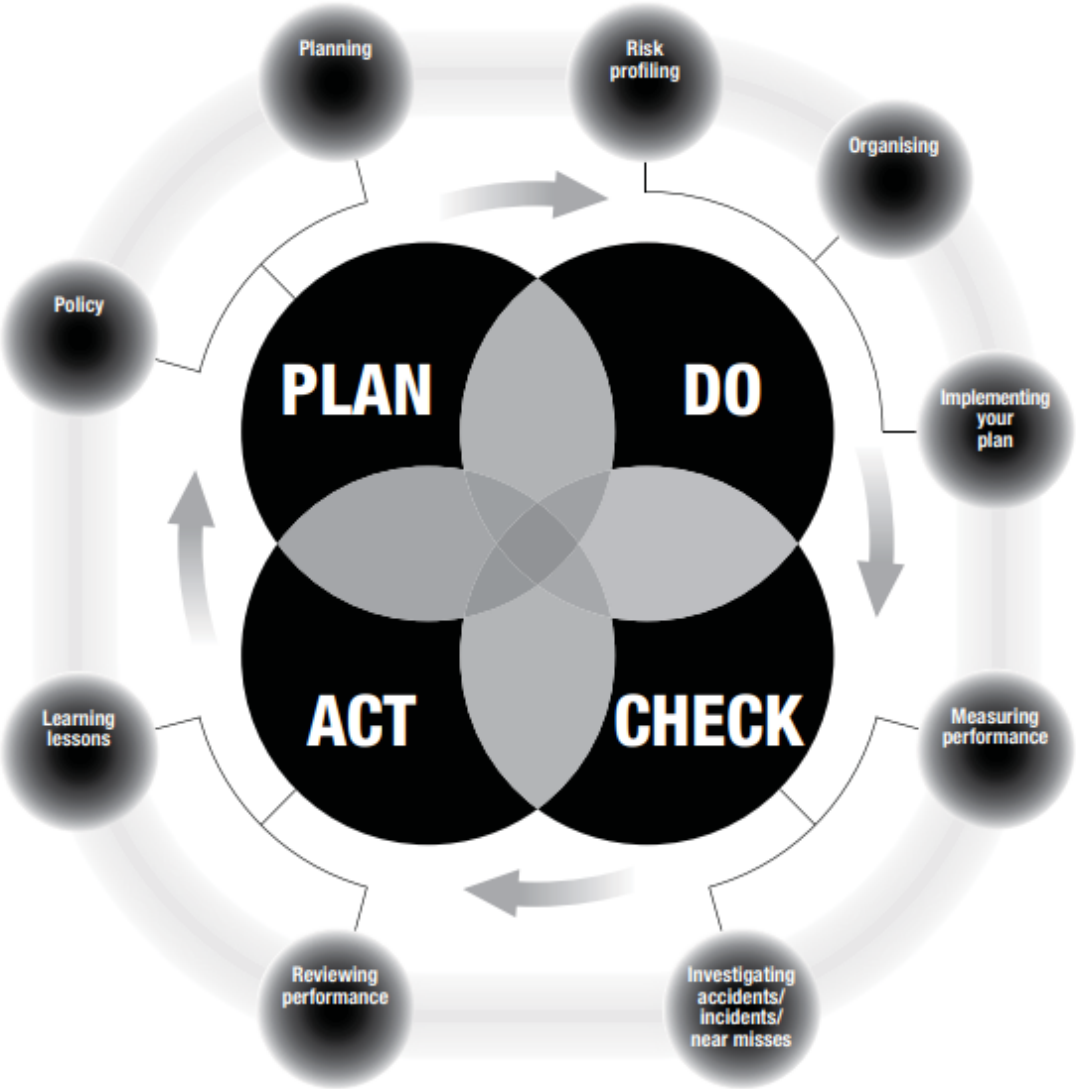
- Embedding the culture into every day working practices
- Encouraging managers to embrace new ways of working
- Developing effective and inclusive ways of enabling employee involvement
- Lack of engagement and collaboration
- Providing information at all levels in relation to roles and responsibilities

To address these challenges, we will:

- Implement an organisational wide H&S Management System that will influence a positive safety culture.
- Support managers and provide information, instruction, and training
- Roles and responsibilities will be clearly identified and communicated

Measurement is a key step in any management process and forms the basis of continual improvement. If measurement is not carried out correctly, the effectiveness of the H&S management system is undermined and there is no reliable information to inform managers how well the H&S risks are controlled.

Measurement is an accepted part of the 'plan-do-check-act' management process.



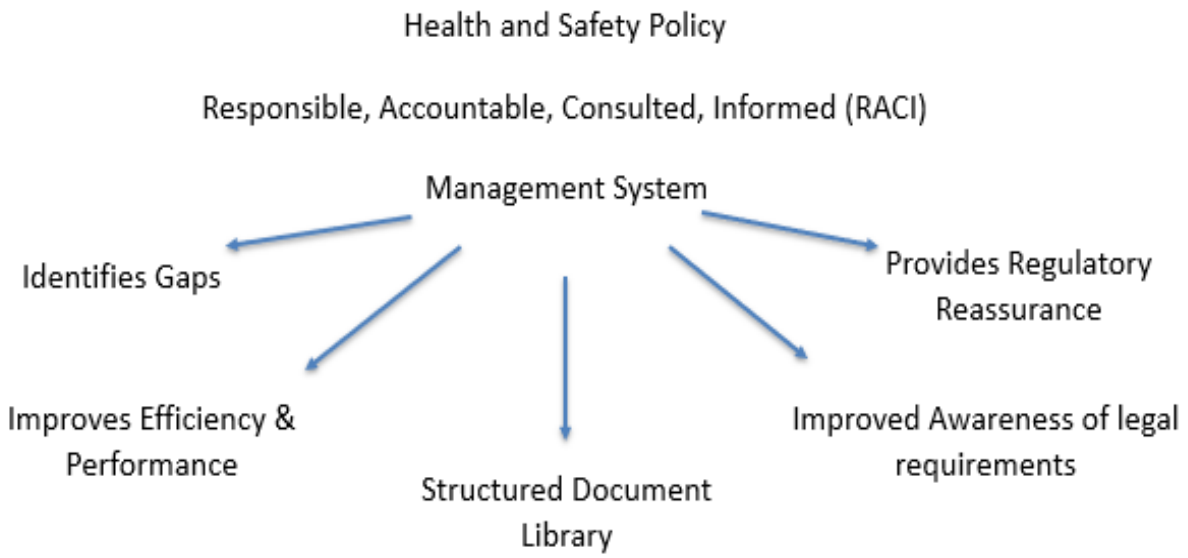
A key aspect in the management of H&S is to perform regular management reviews to assess the suitability, adequacy and effectiveness of the information management system for H&S to meet the present and anticipated future needs of the organisation. Input to the review could include:

- Operations, engineering and organisational changes since the last review.
- Review of actions from previous review minutes
- Common trends and themes from incident analysis data
- Results of internal and external audits or assessments

Outputs from the reviews should include:

- Decisions and actions (if appropriate) regarding improving the effectiveness of the H&S information management system and its processes.
- Resource requirements for future continual improvements of the H&S IMS
- Actions to improve staff health, safety and wellbeing.

Implement Health and Safety Management System



Key Health and Safety Policies

Under section 2.3 of the Health and Safety at Work Act the UHB has a duty to prepare and review a written statement of a general H&S policy; this includes the organisation and arrangements, as well as a written statement of intent. The Act requires all employers to prepare a written statement of their H&S policy and to bring that policy to the attention of all employees. As legislation is continuously under review, so too must the H&S Policy be continually reviewed. The UHB's Statement of Intent has been signed by the Chief Executive and displayed at key points throughout the organisation.

Insert image of signed statement of intent#

Although the main responsibility for compliance with the Act rests with the employer, every employee also has a responsibility to ensure that no one is harmed as a result of their acts or omissions during the course of their work.

In addition to its legal obligations the UHB has a moral, economic and reputational reasons for managing H&S.

- H&S Policy **approval** and **commitment to its full implementation**.
- **H&S Policy review** every three years.
- Should demonstrate the importance of the H&S Policy by ensuring that their own behaviours actively promote and **serve as a role-model for the desired H&S values and principles**.
- Must **ensure that their employees and contractors understand the requirements** of the H&S Policy.
- Must ensure that **they understand the policy and its implications** for them.
- Must **ensure that the H&S Policy is communicated to our organisational partners** and that they actively cooperate with us to achieve compliance with the policy.

The H&S Policy is the overarching document with a number of key H&S polices emanating from this, including:

- Minimal Manual Handling
- Management of Violence and Aggression
- Incident, Hazard, and Near Miss Reporting
- Fire Safety
- Contractor Control

RACI Matrix

Fundamental to H&S management is a delegated authority structure that clearly defines the responsibility of individual roles for H&S within the organisation. Failure to do this can lead to a perceived lack of accountability and leadership in addressing H&S issues and can lead to misalignment between departments and personnel.

The accepted way of best achieving this is through a grid of organisational roles set against objectives, commonly known as a RACI Matrix.

Responsible - Does the work (Knowledgeable/Competent)

Accountable - Ensures work is done (Line / Duty Holder)

Consulted - Technical or expert support or authorisation

Informed - An interested party

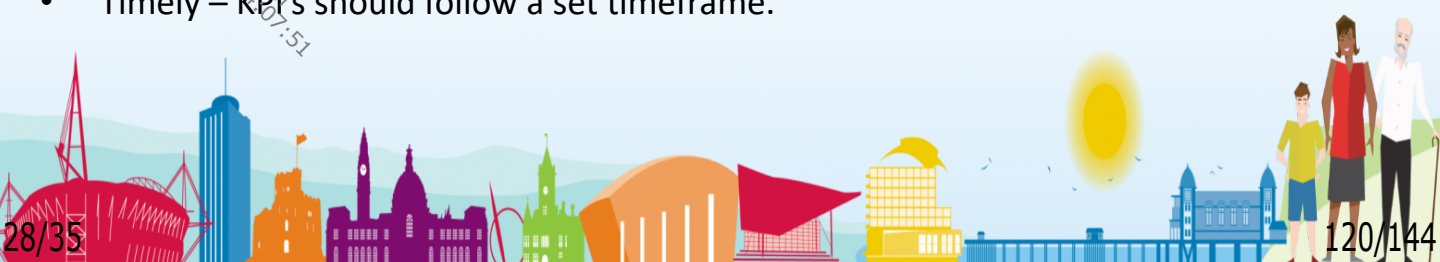
Formulating a comprehensive RACI informs the organisation of;

- **Gaps -** ensures each specific area/task/ policy has an accountable role assigned to it
- **Removal of Ambiguity -** defines clear unambiguous accountability and responsibilities for H&S within an organisation.
- **Employee Workload -** It clearly shows which functional roles are assigned to each person and can help determine whether one individual has a responsibility level that could be detrimental to their overall performance.
- **Increases productivity - r**emoves all doubt as to whom to speak to. You can have the right conversation with the right person quickly.

Health and Safety Key Performance Indicators

KPI's are a valuable way of monitoring lagging or leading performance. A good performance indicator is part of the 'SMART' tool and to make sure goals are clear and reachable, each one should be:

- Specific – it should be clear what is being measured
- Measurable – it should be measurable against set standards
- Achievable – target a realistic/achievable goal
- Relevant – it should offer insight into overall safety performance
- Timely – KPI's should follow a set timeframe.



H&S KPI's will be set by the Health and Safety department for implementation across the UHB aimed at driving continued improvement. These will be aimed at embedding H&S and giving equal priority and prominence to the safety, health, and wellbeing of staff to the that of clinical and patient safety. KPI's will be reported on at the Clinical and Service Board H&S meetings and exception reports taken to the UHB Operational H&S Group. To continually improve the H&S of our staff, our aim is to incorporate individual KPI's into Values Based Appraisals.

Executive Board Engagement with H&S

Protecting the H&S of employees or members of the public who may be affected by our activities is an essential part of risk management and must be led by the board. The board sets the direction for effective H&S management. A H&S policy has been established and signed off by the board and this is an integral part of our organisation's culture, values, and performance standards. Good H&S will result in a healthier, happier, and better motivated workforce.

It is important for the UHB that staff H&S has the same acceptance as patient safety throughout the organisation. This is led by the Executive Director for People and Culture who champions H&S at Board level.

Measures of success for this theme include:

- H&S management system implemented across the organisation.
- Management review system in place
- SMART Objectives in place, tracked and reviewed
- Individual VBAs include an element of H&S
- H&S policies and procedures reviewed and in date

Theme 5: Audit & Review

The primary purpose of measuring H&S performance is to provide information on the progress and current status of the strategies, processes and activities used by an organisation to control risks to H&S. It is an accepted part of the 'plan-do-check-act' management process and is as much part of a H&S management system as financial or service delivery management.

Image of a bow tie chart, Details can be finalised

The challenges we face under this theme include:

- There is a perception that the UHB H&S resource is disproportionately utilised in a reactive manner.
- Implementation of a proactive H&S management programme.
- Competence of wider UHB staff to undertake H&S safety audits.
- Communication and engagement

To address these challenges:

- Engagement and communication programme to be developed and implemented.
- Development and establishment of a competent H&S audit team
- Appropriate audit tools and question sets to be established.
- Implementation of an effective and meaningful audit schedule.

Create Sustainable Audit System

A structured audit programme, based on the H&S Management System, will be implemented that is achievable and not onerous for the Clinical and Service Boards. This will be in collaboration with NWSSP (internal audit department) to prevent duplication and will be scored and prioritised based on risk. Information from audit actions will be reviewed and fed back and can be used as an indicator of the maturity of the organisation towards H&S. A timebound approach will be applied to rectify non-conformances and mitigation implemented.

Investigate and where needed address the specific actions and clarity of information in policy and procedure documents in response to feedback from review.

The implementation of the management system will identify gaps due to the nature of the structured document library. In addition to this, the RACI matrix will identify those with responsibility and accountability for policy and procedural ownership. Policies and procedures identified in the external review will be updated as part of this process.

Measures of success for this theme include:

- An Audit Schedule in place capturing all groups
- Audits developed and conducted
- Audit follow up is documented and recommended actions are planned/completed
- Trained competent auditor teams are available
- Feedback provided to Clinical and Service boards
- Data sets established and utilised to set KPI's.
- Reduction in incidents, injuries and ill-health

Theme 6: Achieving Fire Safety Excellence

Fire Safety must be embedded in the safety culture of any organisation and in order to achieve and maintain the highest standards of assurance it should be fully integrated with the H&S management system. This theme details how fire safety will be driven in line with the overarching fire safety policy.

Fire is a major workplace hazard that can lead to injury and in some cases death. Similarly to the management of H&S there are sound reasons for maintaining good standards of fire safety:

- Moral: Fires result in a great deal of suffering for those affected, the loss of personal items and the shock.
- Legal: It is a legal requirement to prevent fire and protect employees and other relevant persons from the effects of fire.
- Financial: The associated costs of a fire are substantial, especially when the consequential losses such as interruption to business and the physical and or uninsured losses are taken into account.

Challenges faced under this theme:
Many of the challenges for fire safety overlap with other themes and are covered there.

- Embedding a safety culture into every day working practices
- Undefined roles and responsibilities with regards to fire safety
- Inadequate management system tools
- Lack of engagement and collaboration
- A number of the actions require joint working with other stakeholders across the UHB

To address these challenges we will:

- Integration of fire safety in the organisational wide H&S Management System
- Support managers and provide information, instruction and training
- Roles and responsibilities will be clearly identified and communicated
- Developing effective and inclusive ways of enabling employee involvement
- Fire Safety Policy and procedures reviewed and updated

All fires have a root cause and as such can be deemed as being preventable. The UHB has responsibility for workplaces and other buildings to which the public have access. Fires can be avoided by individuals taking responsibility in adopting the right behaviours and procedures.

The promotion of fire safety throughout the UHB is a priority and can be achieved by implementing a concise plan to develop, embed, maintain and achieve the highest Fire Safety standards. In doing this we will ensure no harm comes as a result of our actions to people, the environment or the communities in which we operate.

Review and update the current Fire Safety Procedures

All UHB fire procedures will be reviewed and a gap analysis conducted to identify shortcomings

A comprehensive suite of fire procedures to be communicated and made readily available for premises across the UHB.

Implement a Fire Safety Management System

Fire management system will be fully integrated into the H&S management system and audits created in line with the wider audit and review theme to provide a holistic approach to evaluating the management of H&S

Review current Fire Safety Management Organisational Structure

The fire safety team sit within the Health and Safety department. Roles, responsibility and accountabilities for the wider UHB will be established in the wider management system RACI

Review the requirement for a recognised Fire Safety Audit System

To implement a system in line with the national healthcare recognised standard PAS7.

The system will assist the UHB in implementing a clear, formally documented system to reduce fire risk. This can help to safeguard employees, contractors, patients and the general public as well as property, and assets. It can also minimise the impact of fire on business continuity.

Major Capital Planning Project System

Fire safety is incorporated into all major capital plans and refurbishments - processes and arrangements will be reviewed, gaps identified, and any necessary enhancements implemented. Close working relationships with the Capital Estates and Facilities department will continue and will be underpinned with the RACI matrix.

Introduce a Call Delay Procedure at UHW and UHL

The UHB are duty bound to reduce the number of unwanted fire signals that occur annually, this subsequently results in a number of unnecessary attendance events by South Wales Fire and Rescue Service (SWFRS). The UHB are working closely with SWFRS to explore effective ways in which this can be achieved.

Emergency evacuation equipment training

A review of the procedures for emergency evacuation will be conducted to ensure that clear instruction, competence and responsibilities are established.

Review the UHBs Major Incident Plan

Stakeholder engagement and partnership working will be maintained with strategic planning and security to formulate and adopt a common robust plan in line with UHB requirements.
Regular desktop and live exercises will continue to be run, a review will be conducted in line with management system requirements and any necessary improvements implemented and cascaded to all relevant interested parties.

Review the requirement for an alternative recognised Fire Risk Assessment Audit System

The fire safety team will work closely with NWSSP to review the process of recording fire risk assessments, including tracking, monitoring and review of completed inspections and the compilation of reports.

Review use of disposable/one use (p50) fire extinguishers with remote sites

The UHB are continually investigating cost reduction opportunities and in line with this a review is to be conducted on the types of extinguisher in place across the wider organisation. Technological advances have been made in recent years and these will be explored to ensure the best use of resource is being utilised in terms of cost and time.

Review implementation of bespoke evacuation exercise/procedures to localised areas

As part of the wider management system and emergency planning review, a series of bespoke evacuation exercise/procedures to localised areas will be considered. The aim would be the promotion and engagement of all staff to be confident in implementing their local emergency evacuation plans.

Measures of success for this theme include:

- Clear fire safety policies and procedures established and implemented across the UHB
- Fire safety culture embedded into the behaviours and values of all UHB staff
- Clearly defined roles, responsibility and accountability for all staff across the organisation with regards to fire safety
- An integrated fire safety management system within the UHB H&S management system
- A concise plan implemented that is monitored and reviewed on a regular basis with a audit trail to maintain standards and achieve improvements
- A reduction in unwanted fire signals and fire incidents.
- Implementation of clear and meaningful KPI's for Clinical and Service boards
- Recognised programme of live training exercises established

Theme Lead:	Samantha Skelton	Theme 1 – Achieving Training and Competence Excellence

Objective	Specific Actions	How will we know the objective has been achieved?	Who will lead this objective?	predicted completion date
Improve accessibility of courses and training through ESR	Review with LED the administration of ESR -Links and access to ESR systems -Removal of dead links -Access for external health boards to ensure they are able to enrol on suitable courses	Reduction in staff booking on incorrect courses. Reduction in monthly issues entries for ESR Training compliance improvement Conduct general questionnaire on ease of using ESR as a booking tool. Review of results to determine positive outcome	Catherine Salter	Q3 2022
	Use of Monthly ESR meeting with LED to progress issues	Meetings in place and time bound actions being completed	Catherine Salter	Ongoing
Action plan to influence UHB wide mandatory training is up to date and completed as planned	H&S contribution to LED mandatory training action plan	Improvement in training compliance Reduction in incidents	Rebecca Corbin (LED) Catherine Salter (H&S)	Ongoing – This is owned by LED with H&S contribution
	Provide provision for departments, directorates and clinical boards to review their overall H&S training compliance easily -Dashboard -Report by request	Clinical board / Directorate feedback. Improved training compliance Reduction in incidents	Robert Warren	Ongoing
	Add mandatory training requirement to the standard PADR template and instigation of training KPI's both individual and departmentally	Improved compliance with KPIs	Robert Warren	Q3 2023
	Consider the requirement for protected study time by role to enable staff to fulfil mandatory training requirements	Improved training compliance. Reduction in incidents	Robert Warren / Sam Skelton	Q4 2023
Review of statutory and mandatory requirements to ensure requisite competencies identified, delivered and maintained to include all aspects i.e. manual handling, V&A and fire	Alongside workforce develop training criteria for new position numbers	Improvement in training compliance. Improvement in competency Reduction in incidents	Catherine salter	Q4 2022
	Promotion of TNAs for specific job roles -Linked in with LED -Develop line management process to get managers to assess training needs and update LED.	Improvement in training compliance Reduction in incidents	Catherine Salter	Q3 2023

	Initiate specific recruitment spaces, and pre-booking for new colleagues during recruitment process	Improvement in training compliance Reduction in incidents	Elinor Thorne	Q4 2022
	Review the requirement for protected time for new starters to undertake training	Improvement in training compliance Reduction in incidents	Sam Skelton	Q4 2022
	Alongside LED implement enhanced mandatory training requirement -Managing safely or similar training	Improved organisational culture Reduction in incidents Increased UHB H&S risk assurance	Jonathan Davies	Q3 2024
Increase the utilisation of digital technology for training processes	Review feasibility, cost, and requirements for reduced training paperwork Review the merits with -LED -IT Security	Reduced usage and storage of physical media	Robert Warren	Q2 2023
Full implementation of Manual Handling Workplace Competency Assessment course	Review and roll out MHWCA system	Fully integrated course	Samantha Skelton	Q4 2021
	Audit and expand MHWCA system	Reviewed findings fed back into course content. Consistent high-quality assessor reports submitted	Samantha Skelton	Q2 2022
Integrate training requirements on the use of the H&S management system	Construction of self-explanatory slide pack on the use of the management system and filing process for specific documents.	Roll out of training package Improved organisational culture	Caroline Murch	Q2 2022
Review of H&S Induction Training and Mandatory Training	Review process of new starter induction training to improve quality. Review content of 3 yearly mandatory H&S training packages – Online and face to face Seek support from LED	Improved induction process	Robert Warren	Q1 2023
Review of technology-based fire training delivery for all staff	Review approaches to training,	Improved compliance records for fire safety	M Perrett	Q4 2024
	To include consideration of digital fire safety training and response systems e.g. Teams			
	Appropriate delivery			

Theme Lead:	Risk – Rachael Daniel Incident – Rachael Sykes	Theme 2 -Achieving H&S Risk & Incident Management Excellence

Objective	Specific Actions	How will we know the objective has been achieved?	Who will lead this objective?	predicted completion date
Embedding new H&S policy statement	Influencing management executives - Link to fire safety policy	Management executive commitment. Signed copy of Statement of Intent widely on display throughout UHB Commitment to achieve KPIs agreed	Robert Warren	Q2 2022
Relaunch Risk Register and Priority Improvement Plan system	Clear definitions of Risk Register and PIP -collaborate with corporate governance team	Updated Risk Register and PIP for Clinical Boards and Directorates	Rachael Daniel	Q3 2023
	Communication pack with support available to clinical boards and directorates	Updated Risk Register and PIP for Clinical Boards and Directorates	Rachael Daniel	Q3 2023
	Identify the accountability path to confirm Risk Register and PIP is complete	Updated Risk Register and PIP for Clinical Boards and Directorates	Robert Warren	Q3 2023
	Update general risk assessment and task specific templates aligning with risk register scoring process	Updated templates in use and training incorporated into the managing safely and working safely courses Reduction in incident rates	Rachael Daniel	Q3 2023
Management of High-Risk Work	Contractor Management Policy: Review of Contractor Management arrangements	-Policy brought across to H&S ownership	Jonathan Davies	Q3 2022
	Ensure communication and implementation of policies more widely	-Gaps closed on Risk Registers -Contractor management to be implemented as a line on clinical board risk registers	Jonathan Davies	Q4 2022
	Extend contractor monitoring -improve procurement H&S process -ongoing monitoring of established contractors -extend contractor inductions to all contractors	Implement H&S element into a procurement process Report into operational H&S meeting.	Jonathan Davies	Q4 2022
	Permit to Work Policy (PTW). Review of Safe systems of Work including Permit to Work arrangements and fire authorisation to proceed permit.	-Policy brought across to H&S ownership	Jonathan Davies	Q3 2022
		-Gaps closed on Risk Registers	Jonathan Davies	Q4 2022

Review departmental risk management activities to ensure risks are identified, recorded and tracked	Review and update/transfer actions from previous priority improvement plan to include fire safety element	New PIP created and signed off	Robert Warren	Q3 2022
Review incident investigation process	Review the monitoring of follow-up actions from RIDDOR incidents -Monthly Senior line management meetings	RIDDOR incident actions closed in timely manner Learnings shared and mitigating actions implemented	Clinical Board Advisors	Q4 2022
	Create and distribute investigation templates	Updated forms in use	Rachael Sykes	Q2 2022
Improve Datix Utilisation	Assisting in the implementation and training of Datix Cymru system. Patient Safety Department lead on this and are the UHB administrators	Sampling of incident forms as selective audit. System embedded and in wide use across the UHB	Rachael Sykes	Q4 2022
Identify trends in losses to inform proactive interventions	Review for UHB and clinical board meetings	Reports presented at operational meetings	Rachael Sykes	Q4 2022
Streamline reporting mechanisms for unsafe conditions	Implementation of behavioural safety programme. Identify type of behavioural safety programme required. Include elements in existing training programmes	Evidence of Near miss reporting. Proactive culture towards H&S move towards an interdependent culture	Carl Ball	Q4 2024

Theme Lead:	Carl Ball	Theme 3 -Achieving Communication Excellence

Objective	Specific Actions	How will we know the objective has been achieved?	Who will lead this objective?	predicted completion date
Develop H&S communications strategy (in line with management system)	Further dashboard roll out - Management executives down to all levels -Consider adding to CEO staff connect	Feedback from Senior management Discussion in Clinical Board Meetings	Robert Warren	Q2 2022
	Communication of H&S Management system -mentioned in induction / Mandatory training	Management system in wide use throughout the HB Audit compliance	Robert Warren	Q1 2023
	Improve intranet web-site design/navigation	Tracked page listings.	Robert Warren	Q3 2022
	Create COMPT (Communication Order – Members, Purpose, Times) plan for communications outward.	Plan in place and being worked through	Caroline Murch	Q4 2022
Develop a Service level style agreement with clinical boards	Develop in line with RACI requirements	Services Agreed with Clinical Boards in a formal format	Robert Warren	Q3 2023
Review and redefine Terms of Reference for Current H&S meetings at all levels	H&S committee structure review	TORs comply with minimum template standards	Robert Warren	Q3 2022
	Sub Committee Structure/TOR review	TORs comply with minimum template standards	Rachael Daniel	Q3 2022
Develop H&S Calendar of Subjects and drop in advice sessions on all H&S issues	Look at creation of calendar and how to implement interactions	Calendar implemented and in circulation.	Rachael Daniel	Q2 2023
	Review resourcing needs and potential usage/process -Via teams/face-to-face/phone call -Subject specific	Advice process in operation.	Rachael Daniel	Q1 2023
	Run pilot sessions	Pilot being run	Rachael Daniel	Q1 2023
	Consider guidance documents, and content	Review conducted	Rachael Daniel	Q1 2023

Theme Lead:	Caroline Murch	Theme 4 – Measuring Performance

Objective	Specific Actions	How will we know the objective has been achieved?	Who will lead this objective?	predicted completion date
Implement H&S Management System	Create Project plan to implement H&S management system (guiding documents) *HSMS*	Document review Clinical boards implement management system	Caroline Murch	Q3 2022
	Create H&S Information Management System (IMS) structure and roll out to wider organisation	S-drive system to be in place locally S-drive system in place UHB wide	Caroline Murch	Q2 2022
	Include process for outputs from HSMS to be reviewed by Senior management teams.	Management review process in place.	Caroline Murch / Robert Warren	Q4 2022
	SMART H&S objectives to cascade out to health board.	Objectives in place, tracked and reviewed	Caroline Murch	Q3 2022
Key H&S Policies (management system)	Review Policy management and review schedule	Policy management process reviewed and any necessary improvements implemented.	Caroline Murch	Q3 2022
	Conduct Policy and Procedures Gap Analysis	Gaps identified and time bound action plan in place to address any short falls.	Caroline Murch	Q4 2022
RACI Matrix	Identify those individuals with Responsibility, Accountability, Consulted and Informed duties across the UHB in terms of H&S.	Roles and responsibilities clearly identified and communicated	Robert Warren	Q3 2022
	Get confirmed commitment from delegated responsible persons	Through Operational H&S meeting, agreement	Robert Warren	Q4 2022
Include personal H&S deliverables in KPIs and PADRs	Discuss with HR including H&S deliverables in KPIs/PADRs (linked to training)	PADR update includes a H&S element.	Robert Warren	Q1 2023
Include Clinical Board/Directorate KPI's	Identify Key H&S KPI's for implementation to Clinical Boards/Directorates	Specific targets implemented, worked to and achieved.	Caroline Murch	Q3 2022
Drive exec board engagement with H&S topics	Executive management H&S training around responsibilities	Exec board compliance to training, course completed	Robert Warren	Q4 2022
	Staff stories/focussed H&S initiative taken to H&S committee level meetings	Evidenced in meeting minutes	Robert Warren	Q3 2022

Theme Lead:	Jonathan Davies	Theme 5 – Audit & Review

Objective	Specific Actions	How will we know the objective has been achieved?	Who will lead this objective?	predicted completion date
Create Sustainable Audit System	Audit against H&S Management System -create audit question sets -collaborate with NWSSP to prevent duplication and resource	Audits developed and conducted Audit follow up documented	Robert Warren	Q4 2024
	Create schedule for full audit suite Including: Statutory compliance Compliance with internal policies and procedures Best practice	Audit Schedule in place capturing all groups	Robert Warren	Q4 2024
	Creation of competent departmental lead auditors	Trained competent auditors available.	Jonathan Davies	Q2 2023
	Define Audit procedure. Consistent scoring system	UHB wide auditing process implemented	Jonathan Davies	Q4 2024
	Capture and analysis of audit action completion status	Feedback to clinical boards/directorates. Data used to set KPI's.	Jonathan Davies	Q4 2024
Investigate and where needed address the specific actions and clarity of information in policy and procedure documents in response to feedback from review	-Updated/Review and distribute managers handbook	Updated handbook in place	Jonathan Davies	Q4 2022

Theme Lead:	Mal Perret	Theme 6 - Fire Safety

Objective	Specific Actions	How will we know the objective has been achieved?	Who will lead this objective?	predicted completion date
Review and update the current Fire Safety Procedures	Conduct a procedures gap analysis Provide a list of unambiguous fire safety procedures applicable to the UHB	Gap analysis conducted and procedures in place.	Mal Perrett/Caroline Murch	Q4 2022
Integrate a Fire Safety Management System (FSMS) into the H&S Management System	Formulate and implement a FSMS to best ensure a holistic approach for fire risk reduction for the UHB	When the following operational management procedures are fully embedded including • Fire Safety Protocols • Bespoke Emergency Action Plans • Fire Safety Training • Fire Safety Audits • Bespoke exercises and drills	Caroline Murch / Mal Perrett	Q3 2023
Review current Fire Safety Management Organisational Structure (FSMST)	Roles and responsibilities *-link to RACI* Direct accountability for fire safety *-link to RACI*	When review complete and any necessary actions implemented.	Robert Warren	Q3 2022
Review the requirement for a recognised Fire Safety Audit System	Recognised healthcare specific audit system is PAS7	If deemed necessary audit system in place. Following the first successful 3rd party audit	Robert Warren / Mal Perrett	Q4 2023
Major Capital Planning Project System	Draft a Fire Safety Project process service level agreement/RACI Present to CEF Management Agree approval	When process is operational with improved service delivery	Mal Perrett/T Ward	Q3 2023
Introduce a Call Delay Procedure at UHW and UHL	Conduct a procedure gap analysis Review Fire stopping programme Create and implement enhanced Fire response team training Smart objective – implementation of segregated programme I.E non-sleeping patient areas	When there is significant measurable reduction in SWFRS emergency response attendance	Mal Perrett	Q4 2023
Emergency evacuation equipment training	Conduct a procedure gap analysis Engage porter Management Agree a workable procedure for deployment	Post training and establishment of a robust procedure is implemented	M Perrett / Catherine salter	Q3 2022

Review the Health Boards Major Incident Plan and How Fire Safety Contributes to Robust Arrangements.	Work in conjunction with strategic planning and security to adopt a robust plan in line with health board requirements. Maintain and Improve the plan, extend information to external emergency services to run regular desktop and practical exercises to improve our incident handling procedures.	We have a better understanding of specific key contacts within our health board and external emergency services to build better relationships and remove barriers. More robust emergency incident arrangements	Robert Warren / Mal Perrett / A Stephenson	Q3 2022.
Review the requirement for an alternative recognised Fire Risk Assessment Audit System	Influence and promote within shared services a more robust easier system for recording and reviewing risk assessment action and response.	When the system is purchased and fully adopted by Shared Services, Compliance and Estates and The Board	Mal Perrett	Q3 2024
	Conduct a system gap analysis			
	Research alternative methods and systems			
	Benchmark systems and cost analysis			
	Produce a business case for change and approval			
Review use of disposable/one use (p50) fire extinguishers with remote sites	Look into current legal standards of P50s in healthcare properties and shared services rules.	Understanding of legal standards established	Mal Perrett	Q2 2022
	Roll out process		Mal Perrett	Q1 2023

Health and Safety Department
1st Floor Woodland House,
Cardiff, CF14 4TT
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MINUTES OF THE OPERATIONAL HEALTH AND SAFETY GROUP 09:30 on the 7th of December 2021 via MS TEAMS

Attendance

Present:

Robert Warren	Head of Health and Safety (Chair)
Rachel Gidman	Director of People and Culture
Nicola Bevan	Head of Employee Health and Wellbeing
Daniel Crossland	Head of Operations - Mental Health Clinical Board
Stuart Egan	Lead Staff Safety Representative
Stephen Gardiner	Head of Estates and Facilities
Philip Mackie	Interim Head of Assurance, Safety & Compliance – CEF Service Board
Caroline Murch	Environmental Adviser
Mal Perrett	Senior Fire Safety Adviser
Rachael Sykes	Health and Safety Adviser
Rachel Thomas	Assistant Director of Operations – Planning and Delivery - PCIC Clinical Board
Sue Bailey	Clinical Board Director for Quality, Safety & Patient Experience - CD&T Clinical Board
Janice Aspinall	Staff Safety Representative
Rachael Daniel	Health and Safety Adviser
Jonathan Davies	Health and Safety Adviser
Claire Main	Director of Nursing - Specialist Services Clinical Board
Melanie Wilson	General Manager, Dental Hospital
Clare Wade	Director of Nursing - Surgery Clinical Board
Andy Jones	Interim Director of Nursing - Children & Women Clinical Board
Ian Fitsall	Interim Head of Estates and Waste
Rhodri John	Directorate Manager - Obstetrics

Apologies:

Lisa Dunford	Head of Operations - PCIC Clinical Board
Rowena Griffiths	Governance and Quality Manager – Dental
Jon McGarrigle	Head of Energy and Performance

In Attendance:

Thomas Bott	PA to Head of Health and Safety

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OHSG/07/12/21/001	**Welcome and Introductions** The Head of Health and Safety welcomed all to the meeting and apologies for absence were received and noted.
OHSG/07/12/21/002	**Minutes from Previous Meeting** The minutes of the meeting held on the 14th September 2021 were received and accepted as a true record.
OHSG/07/12/21/003	**Action Log** The action log was presented to the group and the following issues were discussed: **MG-SG-01:** This was still outstanding and the Assistant Director of Operations, PCIC CB and the Head of Estates and Facilities would discuss outside of the meeting. **OSHG/09/06-04:** The Head of Health and Safety advised this was not for health and safety to lead but would be involved. He would request for the Manual Handling Adviser to liaise with Judith Hill who had led on this issue pre covid. **OHSG/09/06-07:** The Head of Health and Safety requested clinical boards revisit their covid risk assessments and update as appropriate. The Director of Nursing, Surgery CB advised it had been discussed at the Directors of Nursing meeting whether risk assessments needed to be amended to reflect vaccination status. Mr Warren suggested there needed to be careful consideration as to how much mitigation was attributed to the vaccine. The Director of People and Culture advised an all wales approach had been discussed and avoided using vaccination as mitigation, she will raise again at the Workforce Directors meeting next week which included a representative from Welsh Government. **Action – Mrs R Gidman** **OHSG/09/06-11:** The Environmental Adviser advised not all clinical boards had responded to the request for information in respect of operating procedures and risk assessments for reusable respirators and would send out a reminder. **Action – Mrs C Murch** **OHSG/09/06-12**: Clinical boards raised issues around staff traveling between sites during the day and parking between shifts, including the risk of patient appointments and surgeries being cancelled if traveling consultants could not park in a timely fashion. Parking difficulties also resulted in staff becoming stressed and patients becoming aggrieved. The Head of Estates and Facilities advised there were shuttle buses operating between sites but acknowledged there were on going

	challenges around parking. As a result of feedback received the timings of the park and ride busses around peak times and the 20 minute service was being reviewed. He added issues were being taken on board but this was a long term fix with high numbers of essential parking permits being in existence which required review with the assistance of requesting managers. The Director of Nursing, Surgery CB raised this was a risk to patients as clinicians may not be able to attend surgery if they could not park, whilst the Director of Nursing, Specialist Services CB added it was also a risk for staff due to reduced staffing if parking was unavailable including during emergency situations. The Head of Health and Safety also acknowledged an additional risk around violence and aggression from agitated patients. The Director of People and Culture agreed to take this to the Health and Wellbeing Strategic Group. **Action – Mrs R Gidman** **OHSG/14/09-11:** The Environmental Adviser informed the group the duraflow powered hood had been discontinued and were being replaced by the versaflow powered hood, SOPs and toolbox talks were available. She also added clinical boards would now need to order their hoods directly through a non-catalogue purchase order.
OHSG/07/12/ 21/004	**Health and Safety Update** The Head of Health and Safety provided an update to the Group. He advised the Fire Safety Team had now transferred to the Health and Safety Department, he stressed there were no changes to their role. He informed the group a Health and Safety Strategy had been developed which focussed on six themes; these being: • Achieving Training and Competence Excellence • Achieving Health & Safety Risk and Incident Management Excellence • Achieving Communication Excellence • Measuring Performance • Audit and Review • Achieving Fire Safety Excellence Mr Warren advised the department had implemented an Information Management System which he hoped to roll out across the Health Board so that a standardised approach could be adopted. The incident data was discussed and Mr Warren stated the aim was to proactively reduce the number of incidents and requested Clinical Boards

	to look at improving their training compliance and reduce the number of DNAs on health and safety courses. Mr Warren also informed the group of a recent fire in Hafan-y-Coed and commended the staff's response to the incident. The Director of People and Culture commended the work being undertaken by the Department and added the health and safety strategy would look to reframe health and safety and increase its profile across the UHB. It was anticipated the strategy would be launched in early 2022.
OHSG/07/12/21/005	**Feedback from Health and Safety Committee** It was noted the next meeting of the Health and Safety Committee was on the 25th January 2022.
OHSG/07/12/21/006	**Enforcement Agency Report** The Head of Health and Safety presented the report to the group. The Health Board received communication from the HSE on the 2nd September 2021 in relation to a concern that was raised with them. The details of the concern were as follows: • *Issue over not reporting Covid based employees under RIDDOR, this has been ongoing for a number of months* • *Linked to over 370+ with Lab Confirmed cases of Covid - that employer has failed to report since last year onwards* • *Several staff have passed away and as a result and local coroner involved in a number of these case-* • *Finds it hard to believe that all these staff didn't contract Covid within the workplace* A response was provided to the HSE on 10th September 2021 outlining the Board's approach to assessing the "reasonable evidence" criteria and the system we have in place for determining RIDDOR reportability or otherwise for Covid-19 (fatal and non-fatal) in our staff. The HSE replied on the 16th September, concluding that they were satisfied that the Health Board does have a system for gathering information and assessing if there was reasonable evidence to support COVID cases in workforce due to occupational exposure. It was noted there must be reasonable evidence that illness or death was more likely than not caused by exposure due to specific work activities and an identified breach and not just societal transmission. A concern was raised with the HSE that a TUG onsite at Cardiff and Vale University Health Board was faulty and had been repaired using a hard hat bolted to the engine. Other concerns included vials of blood not

	disposed of correctly, loose wires were evident and that there was a lack of first aid kit and eye wash station in the training area. A response was required by 25th November. The response was sent to the HSE on 25th November explaining that the tug in question was not a UHB asset but had been hired from the UHB service provider. Once the hard hat repair had been found, the tug in question was taken out of use and the service provider contacted. An explanation was provided regarding the tug maintenance and inspection regime and the concern was satisfactorily closed out by the HSE on 1st December 2021. Mr Warren updated the group in relation to the Fire Enforcement Notices: 21st April 2021: EN03/21 issued against Hafan Y Coed in relation to failing to adequately control ignition sources. This is ongoing and has been raised to South Wales Fire and Rescue Service (SWFRS) compliance team. 6th October 2021: EN56/21 issued against Hafan Y Coed in relation to failing to adequately control ignition sources. This was as a consequence of a deliberate fire started by a patient in his room. SWFRS revisited HYC on 10th November and met with H&S, Mental Health and fire safety. Reassurance provided to SWFRS and the enforcement notice withdrawn. 8th October 2021: EN59/21 issued against ward A4 at UHW in relation to physical fire controls such as fire dampers and fire and smoke resisting doors and also staff training requirements. All key stakeholders are involved and an action plan is in place to address. Compliance is due 6th April 2022. The Director of Nursing, Specialist Services Clinical Board queried whether the notice for A4 related to the whole ward or just the north or south side, it was clarified it was in relation to the whole ward despite recent refurbishments. The Director of People and Culture observed there needed to be closer working and support to the Clinical Boards to ensure they were fully aware of all the issue, Mr Warren agreed and advised he would liaise with Mrs Main outside of the meeting.
OHSG/07/12/21/007	**RIDDOR Incidents** The Health and Safety Adviser (RS) presented the report and advised there had been 23 reportable incidents since the last meeting. Clinical Board Representatives provided updates to their incidents and investigation findings. Mrs Sykes raised there were a number of outstanding investigations which maybe due to the fact that Datix had not been updated however some of these were well overdue. The Director of People and Culture requested these be closed out by 1st January 2022. **Action – Clinical Board Leads**

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OHSG/07/12/21/008	**Fire Safety Report** The Senior Fire Safety Adviser presented the report to the group. Mr Perrett advised there had been no fire incidents since the last meeting. There had been 103 false alarms but the downward trend was continuing. Mr Perret noted there were inconsistencies in the fire training compliance figures and this was being addressed with LED. There was also an issue in relation to face-to-face training not being captured correctly on ESR.
OHSG/07/12/21/009	**Health and Safety Training Update** The Health and Safety Adviser (RS) presented the report to the group. Mrs Sykes highlighted that following a review the frequency of manual handling and violence and aggression refresher/update training had been extended from 2 years to 3 years - these changes however do not apply to the SIMA training delivered by the Mental Health Clinical Board.
OHSG/07/12/21/010	**PPE Cell Update** The Health and Safety Adviser (JD) provided the group with an update in relation to PPE. Mr Davies stated that whilst the Health and Safety Department have been widely undertaking fit testing during the pandemic, Clinical Boards now need to be in a position where they can undertake fit testing within their own clinical areas and fit tester training was available to enable this. The central fit testing service should now predominately be for those staff that had failed fit testing at a local level and required an enhanced level of fit testing. **Action – Clinical Board Leads** With regards to PPE stock the UHB are in a strong position and there are no current stock issues. Mr Davies reminded the group that valve respirators should not be used in certain sterile fields and procedures.
OHSG/07/12/21/011	**Clinical Boards Health and Safety Group Feedback** Mrs Bailey, CD&T Clinical Board thanked Mr Mackie for his assistance in relation to safe pedestrian walkways and the case management team who had supported staff with police involvement. Mr Crossland, Mental Health Clinical Board raised a concern in relation to ligature points and windows, this had been added to their risk register whilst a resolve was being sought.

	Mr Crossland also thanked the health and safety team and Mr Perrett for their support in relation to the recent fire in Hafan-y-Coed. The Health and Safety Adviser (RD) advised both Medicine and Surgery Clinical Board health and safety meetings were being held the following week.
OHSG/07/12/21/012	**Staff Covid Cases and Issues** This had been discussed under agenda item **OHSG/07/12/21/006.**
OHSG/07/12/21/013	**Health Issues** The Head of Employee Health and Wellbeing informed the group the number of referrals to Occupational Health had significantly increased. They were looking to provide immediate advice to managers as a mechanism of support as waiting times were approximately 10 weeks. Mrs Bevan advised pre-employment checks were now down to the usual turn around times which should improve the flow of new colleagues and help contribute to reducing staffing issues. She also advised the funding for additional employed staff ceases in February 2022 and this will have an imminent impact on waiting times. She is looking at alternative funding sources and is currently putting a bid into the health charity to resource additional temporary funding.
OHSG/07/12/21/014	**Staff Side Issues** The Lead Staff Safety Representative advised of an issue in CAVOC outpatients, they have a procedure in place whereby two members of staff are positioned at the main entrance and have been requesting a screen be erected for a number of months, which was still outstanding. The Head of Estates and Facilities noted that whilst this was not a function of estates maintenance consideration would need to be given to the siting of the screen to ensure that it did not impede flow and an assessment of the area would be required. The Health and Safety Adviser (RD) was not aware of the issue but would follow up with the Clinical Board. **<u>Action – Miss R Daniel</u>** The Staff Safety Representative (JA) highlighted that following a workplace inspection of SSSU, it found staff and contractors were in the Bin area and was raised by Managers as an ongoing issue. The Head of Health and Safety advised this was a line management responsibility, Mrs Aspinall agreed with this but advised the issue was more problematic with contractors who when challenged stated they didn't have time to leave site. The Senior Fire Safety Adviser stated on induction contractors were told we are a no smoking site and failure to comply can result in contracts being withdrawn. The Interim Head of Assurance, Safety and

	Compliance, CEF reinforced this was addressed in induction and monitored via contractor checks, and contractors could be issued yellow cards if found to be smoking on site. Mrs Aspinall added there is photographic evidence and the Manager of the area had escalated the issue, Mr Gardiner requested copies of the images to aid in following up with the Contractors, this was agreed by Mrs Aspinall. **Action – Mrs J Aspinal/Mr S Gardiner** It was noted that this was Mr Egan's last meeting and both Mrs Gidman and Mr Warren expressed they're thanks to Mr Egan for his commitment to staff health, safety and wellbeing and recognised that he would be a loss to the Health Board. The Group wished Mr Egan well for the future.
OHSG/07/12/21/015	**Policy and Procedures** The Head of Health Safety informed the Group the following policies were approved by the Health and Committee at it's meeting on the 12th October 2021: • Health and Safety Policy • Violence and Aggression Policy and Procedure • Minimal Manual Handling Policy and Procedure
OHSG/07/12/21/016	**Any Other Business** The Interim Head of Assurance, Safety and Compliance, CEF informed the group of a recent event involving chemical drain cleaners onsite, whereby a pipe had been found to be filled with caustic soda. Mr Mackie reiterated that acidic and caustic drain cleaners had been prohibited from use on site outside of the permitted work by estates. It was agreed this should be distributed to all staff using the staff safety alert system. **Action – Mr P Mackie**
OHSG/07/12/21/017	**Date and Time of Next Meeting** The next meeting will be held at 9.30am on Tuesday 1st March 2022 via Teams