Bundle Health and Safety Committee 8 October 2019

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8 ITEMS FOR APPROVAL / RATIFICATION

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Martin Driscoll

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8.2 Contractor Control Policy

Geoff Walsh / Charles Dalton

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8.3.1 Operational Health and Safety Group - June 2019

Martin Driscoll

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9 ITEMS FOR NOTING AND INFORMATION

9.1 Health and Safety Priority Improvement Plan - in detail

Charles Dalton

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9.2 Environmental Health Report of Y Gegin, University Hospital of Wales on 20 June 2019

Geoff Walsh

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9.3 Environmental Health Report of Aroma Plaza Outlet, University Hospital Llandough 25 June 2019

Geoff Walsh

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9.4 Environmental Health Report of Aroma Coffee Outlet, Woodland House, on 9 August 2019

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10 ITEMS TO BRING TO THE ATTENTION OF THE BOARD / COMMITTEE

11 REVIEW OF THE MEETING

12 DATE AND TIME OF NEXT MEETING

Tuesday, 21 January 2020 at 9.00am
Woodland House, Ground Floor

HEALTH AND SAFETY COMMITTEE
To be held on 8 October 2019 at 9.00am

WOODLANDS HOUSE, GROUND FLOOR, COED Y NANT

AGENDA

	PRESENTATION – Health and Safety Training Compliance LED and Health and Safety	
1	Welcome & Introductions	Michael Imperato
2	Apologies for Absence	Michael Imperato
3	Declarations of Interest	Michael Imperato
4	Minutes of the Committee Meeting held on 9 July 2019	Michael Imperato
5	Action Log	Michael Imperato
6	Chairs Action taken since last meeting	Michael Imperato
7	**Items for Review and Assurance**	
7.1	Risk Register for Health and Safety	Martin Driscoll/Nicola Foreman
7.2	HSE Inspection of Violence and Aggression and Musculoskeletal Disorders in Healthcare 2018-19	Charles Dalton
7.3	Pedestrian Access Strategy – Update and Assurance	Geoff Walsh
7.4	Fire Safety Annual Report	Geoff Walsh
7.5	Enforcement Agencies Report	Charles Dalton
7.6	Fire Enforcement and Management Compliance Report	Geoff Walsh
7.7	Health and Safety Assurance Schedule and Priority Improvement Plan 2019/20	Charles Dalton
7.8	Lone Worker Devices Report	Charles Dalton
7.9	Updated Health and Safety Related Policies Schedule	Rachael Daniel
7.10	Environmental Health Report of Catering Department, Rookwood Hospital on 25th July 2019	Geoff Walsh
7.11	Environmental Health Report of Ward Based Catering, University Hospital of Wales on 13th August 2019	Geoff Walsh
8	**Items for Approval/Ratification**	
8.1	Health and Safety Policy	Martin Driscoll
8.2	Contractor Control Policy	Geoff Walsh / Charles Dalton
8.3	**Sub Committee Minutes:** i. Operational Health and Safety Group – June	Martin Driscoll
9	**Items for Noting and Information**	

9.1	Health and Safety Priority Improvement Plan – in detail	Charles Dalton
9.2	Environmental Health Report of Y Gegin, University Hospital of Wales on 20th June 2019	Geoff Walsh
9.3	Environmental Health Report of Aroma Plaza Outlet, University Hospital Llandough on 25th June 2019	Geoff Walsh
9.4	Environmental Health Report of Aroma Coffee Outlet, Woodlands House on 9th August 2019	Geoff Walsh
10	**Items to bring to the attention of the Board/Committee**	
11	**Review of the Meeting**	
12	**Date and time of next Meeting**	
	Tuesday 21st January 2020 at 9.00am Woodlands House, Ground Floor	

UNCONFIRMED MINUTES OF THE HEALTH AND SAFETY COMMITTEE HELD ON 9TH JULY NANT FAWR 2, GROUND FLOOR, WOODLANDS HOUSE, MAES-Y-COED

Present:		
Michael Imperato	MI	Independent Member – Legal (Chair)
Akmal Hanuk	AH	Independent Member – Community
Dawn Ward	DW	Independent Member – Trade Union
In attendance:		
Janice Aspinall	JA	Staff Safety Representative
Charles Dalton	CD	Head of Health and Safety
Martin Driscoll	MD	Director of Workforce and OD
Geoff Walsh	GW	Director of Capital, Estates and Facilities
Secretariat:		
Rachael Daniel	RD	Health and Safety Adviser
Apologies:		
Carol Evans	CE	Assistant Director of Patient Safety and Quality
Nicola Foreman	NF	Director of Corporate Governance
Fiona Kinghorn	FK	Director of Public Health
Observer:		
Laurie Higgs	LH	Swansea Bay University Health Board

HSC: 19/07/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting.	**ACTION**
HSC: 19/07/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
HSC: 19/07/003	**DECLARATIONS OF INTEREST** The Chair invited Committee Members to declare any interest in the proceedings included in the agenda. None were declared.	
HSC: 19/07/004	**MINUTES OF PREVIOUS MEETING** The minutes of the Health and Safety Committee held on the 9 April 2019 were reviewed. **The Committee resolved – that:** The Committee approved the minutes of the meeting held on 9 April 2019.	
HSC: 19/07/005	**COMMITTEE ACTION LOG** The Committee reviewed the action log from the meeting held on the 9th April 2019.	

	HSC: 19/036 – Enforcement Agencies Correspondence Report: The Head of Health and Safety advised the contractor fall legal case would be heard in Court on the 15th - 16th July 2019. **The Committee resolved – that:** The outcome of the case would be brought to the October meeting.	**CD**
HSC: 19/07/006	**PRESENTATION – STRUCTURE AND PROCESS FOR STAFF HEALTH AND SAFETY TRAINING** The Director of Workforce and OD informed the Committee the presentation would be deferred to the October meeting.	
HSC: 19/07/007	**HEALTH AND SAFETY ANNUAL REPORT** The Head of Health and Safety presented the Annual Report to the Committee and highlighted the following key issues: • A notable reduction in the number of lost time (RIDDOR) incidents, down from 118 to 99. • An 8% reduction in the number of all staff reported events. • Staff reported incidents show that violence and aggression accounts for 59% of all events and shows a small rise of 3% from 2018/19. • A positive trend in the reduction of manual handling incidents with the overall number for 2018/19 16% lower than the previous year. Equally data shows that the 5 year average for all manual handling incidents represent a significant improvement of being 38% lower than the previous 5 years and lost time events being 26% lower. • The reporting of sharps injuries is the lowest recorded to date at 255 being 8% lower than 2017/18. Furthermore since the introduction of the safer sharps initiative 5 years ago, data demonstrates an average reduction of 29% over the pre safer sharps period. • Mandatory training of health and safety has significantly improved with 4 clinical boards achieving the 85% target and a further 3 being above 80%. • Tutor led training compliance for both manual handling and violence and aggression is well below requirement and a review is being progressed with an aim to enhance competence. • The number of prosecutions for assaults on staff significantly increased during the year from 52 to 81. This effectively equates to a successful conviction every four and a half days of the year and the ten year average is still significantly greater than one successful conviction per year. • The lone worker devices continued to be highly valued by staff with average usage being at 70% and devices in great demand. • Control of Substances Hazardous to Health (COSHH) compliance increased from 62% in 2017/18 to 82%in 2018/19. • Corporate recruitment of an Adviser to enhance contractor control for non-estate activities.	

- High degree of contractor control maintained throughout 2018/19, reduction in the number of non-compliance issues identified with the new advisory category introduced.
- Notably consistently high Environmental Health star ratings of food preparation areas and restaurants was achieved during the period.

The Chair thanked Mr Dalton for his presentation.

The Committee resolved that:

The Annual Report be noted.

HSC: 19/07/008

PEDESTRAIN ACCESS STRATEGY

The Director of Capital, Estates and Facilities provided the Committee with an update following the last meeting. As previously reported there are three high risk areas and in order to prioritise these a Task and Finish Group was being established. The key aims of this group will be to identify the cause of the risk and develop tangible cost effective solutions to mitigate the risk to an agreed practical level. Mr Walsh also advised a programme of works had been developed for the group.

The Independent Member – Trade Union queried whether there would be any engagement with the public. Mr Walsh advised the aim is to move traffic off site but at present there is an abuse of parking by staff and students and a behavioural change is required. The Independent Member – Community queried whether there had been any campaigns to raise awareness with these groups. Mr Walsh stated the Chief Executive is very active in promoting the Park and Ride Facilities but their needs to be a change in staff attitudes to parking on site.

The Chair offered his congratulations to Mr Walsh and his team for moving this issue forward.

The Committee resolved that:

(a) the report be noted.
(b) an update of the Task and Finish Group Programme of Works be provided to the October meeting. **GW**

HSC: 19/07/009

PROACT AUDIT SURVEY PROGRESS

The Head of Health and Safety informed the Committee the Operational Health and Safety Group will review the status of the survey results and the action plan would then be brought to the Committee for assurance.

The Committee resolved that:

(a) the report be noted.
(b) the action plan be brought to a future meeting.

HSC: 19/07/010	**HSE INSPECTION OF VIOLENCE AND AGGRESSION AND MUSCULOSKELETAL DISORDERS IN HEALTHCARE 2018-19** The Head of Health and Safety informed the Committee as previously reported the inspection was anticipated during the third financial quarter. Mr Dalton also informed the Committee Hywel Da Health Board had also been inspected during the first week of July and the inspection had been undertaken by 4 Inspectors over 4 days, and had now been expanded to include Asbestos Management. A meeting was taking place with Hywel Da at the end of the month to learn from their experience. Mr Dalton stated he was concerned the Risk Management Policy and Procedure were currently out of date and this had been raised with the Director of Corporate Governance. He proposed that a Health and Safety Risk Assessment Procedure be developed and presented to the September meeting of the Operational Health and Safety Group for approval, this was endorsed by the Committee.	**CD**
	The Chair welcomed Mr Laurie Higgs, Head of Health and Safety for Swansea Bay University Health Board to the meeting and invited his observations from the inspection undertaken at Swansea Bay. Mr Higgs advised in addition to the general ward areas and accident and emergency they also visited the mortuary and operating theatres. He informed the Committee the Health Board had received 4 Improvement Notices relating to the management of manual handling risks to staff within the operating theatres, accident and emergency department and porters, 4 related to violence and aggression management in the accident and emergency department and porters and 1 related to inadequate arrangements to report and investigate incidents to ensure lessons learnt. The Independent Member – Community thanked Mr Higgs for attending as it was good to share experiences. Mr Imperato requested a progress report for the next meeting, Mr Dalton added a table top assessment against the knowns would also be undertaken.	**CD**
	The Committee resolved that: (a) the report be noted. (b) a progress report be presented to the October meeting. (c) a table top assessment be undertaken prior to the next meeting.	
HSC: 19/07/011	**ENFORCEMENT AGENCIES REPORT** The Head of Health and Safety informed the Committee of one new item in relation to a needle stick injury from a known BBV+ source which had been reported to the HSE under the Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) Regulations whereby the HSE had requested further information. This information had been provided to the HSE and based off this no further action was to be taken.	

Mr Dalton also advised the Committee the case in relation to the Contractor Fall would be heard in Court on the 14/15th July 2019.

The Committee resolved that:

(a) the report be noted.
(b) the outcome of the Contractor Fall case be brought to the October meeting.
(c) agreed that appropriate actions were being pursued to address the issues raised.

HSC: 19/07/012

FIRE ENFORCEMENT AND MANAGEMENT COMPLIANCE REPORT

The Director of Capital, Estates and Facilities informed the Committee unwanted fire alarms had reduced in University Hospital of Wales (UHW) by 22% and training compliance had increased to 70%.

Mr Walsh also highlighted the 2 significant fires which had occurred since the last meeting.

The first was at Lansdowne Hospital which had been a deliberate act. The second was on Ward C5 whereby a patient set themselves on fire lighting a match whilst on oxygen, this incident could have been a lot worse were it not for the actions of the staff on duty at the time and in particular the security staff, the staff have been commended for their actions on the day. A full debrief of this incident was being co-ordinated by Huw Williams, Emergency Preparedness Manager.

The Independent Member - Community advised there was increased assurances since the last meeting, he queried whether there would be an investigation in to the C5 incident. Mr Walsh advised there was an on-going criminal investigation and also as mentioned the internal debrief. The debrief included all staff who were involved in the incident on the day and the findings of the debrief would be presented to the Board, he also added there were some lessons to be learnt from the incident.

Mr Hanuk added he would like these types of incidents to be part of the training course.

Mr Walsh also raised his concerns in relation to the fire at Lansdowne Hospital as potentially the ducts in the building could have been accessed, as a result enhanced security was being put in place. He added Whitchurch Hospital was also a concern as there were too many access points, again the security had been enhanced with 3 dog handlers on a 24/7 basis at a cost of approximately £35k per month.

The Independent Member – Trade Union commended the Work undertaken by Mr Walsh with the Fire Service.

The Committee resolved that:

(a) the report be noted.

HSC: 19/07/013	**HEALTH AND SAFETY ASSURANCE SCHEDULE AND PRIORITY IMPROVEMENT PLAN 2019/20** The Head of Health and Safety informed the Committee a lot of the actions were operational in nature and would be monitored through the Operational Health and Safety Group. Mr Dalton brought one item to the attention of the Committee, he advised evacuation chair training was currently being reviewed and looking at whether a response team would be more appropriate as opposed to training a vast number of nursing and clinical staff. **The Committee resolved that:** (a) the report be noted. (b) agreed that appropriate actions are being taken to address the issues raised.
HSC: 19/07/014	**ENVIRONMENTAL HEALTH INSPECTION OF ALL AROMA COFFEE OUTLETS, UNIVERSITY HOSPITAL OF WALES (UHW) ON 25TH APRIL 2019** The Director of Capital, Estates and Facilities informed the Committee whilst a score of 3 is generally satisfactory as a Service Board the standard has been set at 4 and above. He was concerned at the type of mistakes identified in the inspection and he requires internal assurances. The inspections were becoming onerous and he was seeking to take on a qualified individual to manage food hygiene across the Health Board. On a positive note Mr Walsh advised that the outlets in UHL had scored 5 since the UHW inspection. The Committee resolved that: (a) the report be noted and the remedial actions taken.
HSC: 19/07/015	**UPDATED HEALTH AND SAFERTY RELATED POLICIES SCHEDULE** The Health and Safety Adviser informed the Committee the Department was looking to reduce the overall number of policies to have a small suite of policies with procedures feeding from these. The Independent Member – Trade Union requested staff representatives be involved in the process. **The Committee resolved that:** (a) the updated schedule be noted.
HSC: 19/07/016	**CONTRACTOR CONTROL POLICY** The Health and Safety Adviser informed the Committee the Policy approval was being deferred until after the outcome of the court case

	in July so that any actions could be incorporated into the Policy. The Policy would then be presented to the October meeting. The Director of Capital, Estates and Facilities informed the Committee Internal Audit would be undertaking a review of contractor control. **The Committee resolved that**: (a) the Policy would be deferred to the October meeting so that the outcome of the court case could be incorporated as appropriate.	**GW**
HSC: 19/07/017	**WORK PROGRAMME 2019/20** The Executive Director of Workforce and OD informed the Committee the Work plan had been updated. **The Committee resolved that:** (a) the Work Plan for 2019/20 be approved.	
HSC: 19/07/018	**OPERATIONAL HEALTH AND SAFETY GROUP** **The Committee resolved that**: (a) the minutes of the Operational Health and Safety Group held in February 2019 be RATIFIED.	
HSC: 19/07/019	**FIRE SAFETY GROUP** **The Committee resolved that:** (a) the minutes of the Fire Safety Group held in March 2019 be RATIFIED.	
HSC: 19/07/020	**HEALTH AND SAFETY PRIORTY IMPROVEMENT PLAN – DETAILED** **The Committee resolved that:** (a) the plan be NOTED.	
HSC: 19/07/021	**ENVIRONMENTAL HEALTH INSPECTION OF CENTRAL FOOD PRODUCTION UNIT, UNIVERSITY HOSPTITAL OF WALES ON 25TH MARCH 2019** **The Committee resolved that:** (a) the report be NOTED.	
HSC: 19/07/022	**DATE OF THE NEXT MEETING OF THE COMMITTEE** Tuesday 8th October at 9.00am, Woodlands House, Heath, Cardiff, CF14 4TT	

ACTION LOG
FOLLOWING HEALTH AND SAFETY COMMITTEE MEETING
9 JULY 2019

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Actions Completed					
HSC 19/07/005	Contractor Fall Case	Outcome to be brought to the October meeting.	C Dalton	08/10/19	**COMPLETED.** This is on the agenda
HSC 19/07/008	Pedestrian Access Safety Strategy	Committee to be kept up to date with progress against programme of works.	G Walsh	08/10/19	**COMPLETED.** This is on the agenda
HSC 19/07/010	HSE Inspection	Health and Safety Risk Assessment Procedure to be developed	C Dalton	04/09/19	**COMPLETED.** Procedure was approved by the Operational Health and Safety Group
HSC 19/07/010	HSE Inspection	Update to be provided to the October meeting.	C Dalton	08/10/19	**COMPLETED.** This is on the agenda
HSC:07/016	Contractor Control Policy	Policy to be brought to the October meeting	G Walsh	08/10/19	**COMPLETED.** This is on the agenda
Actions in Progress					
Actions referred to other Committees/Board					

Report Title:	**HSE Audit of Violence and Aggression and Musculoskeletal Disorders in Healthcare 2018/19 – Progress Update**								
Meeting:	Health and Safety Committee						**Meeting Date:**	08/10/2019	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		√
Lead Executive:	Director of Workforce & Organisational Development								
Report Author (Title):	Head of Health & Safety (02920 743751)								

SITUATION

The Health and Safety Committee was informed at the April and July meetings that the Health and Safety Executive (HSE) has initiated a program of auditing Health Boards on their compliance to violence and aggression, musculoskeletal disorders and asbestos controls.

It is understood that the HSE has indicated that it intends to progress these audits with Cardiff and Vale being inspected during the current year, most likely in the 3rd quarter of the fiscal period. The committee requested that it be kept updated on developments and knowledge of the process; although no confirmation of a visit has yet to be received.

BACKGROUND

Introduction

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

Cardiff and Vale University Health Board recognises its responsibility for the management of these statutory obligations and risks to its staff.

The HSE have undertaken one of these inspections at ABMU (now known as Swansea Bay Health Board) in late 2018 and had subsequently issued 9 improvement notices and has also now undertook a similar audit at Hywel Dda in July.

What will be covered at the inspection

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

- Each visit will be a joint visit with an occupational health inspector(s).
- Inspectors should obtain the care provider's local statistics initially to identify target areas.
- They should also contact local trade union representatives.
- They visit clinical areas where violence and aggression is a significant issue. Separately, choose other clinical areas with the highest MSD rates, as well as estate for Asbestos management.
- Accident and Emergency will be included automatically as our intelligence indicates that it is a problem area for both topics.
- A management inspection approach is envisaged following the Plan, Do, Check, Act principles.
- They will obtain the relevant policies, risk assessments, training records etc in advance of

the site visit.

- They will identify the relevant people to see and the areas to go to, aim for a hierarchical approach starting at a senior level.
- The Health Board will be asked to draw up a timetable in advance so that everyone who they wish to speak to is available and the site visit runs efficiently.
- The site visit should take approximately one week allowing time to speak to relevant members of staff and to view clinical areas where appropriate.
- The “Fees for intervention” any Notification of Contraventions (NoCs) and Notices will be applied.

The HSE has now added Asbestos compliance to the audit schedule

ASSESSMENT

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

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

The Adviser has initiated a number of meetings and actions to give greater assurance of our risk with knowledge status with particular emphasis on status of risk assessments, management controls and training compliance. The Adviser has also progressed a table top audit exercise of our anticipated related violence & aggression, musculoskeletal disorders and asbestos aspects.

Since the July Health and Safety Committee the Head of Health and Safety and the Project Adviser has continued to meet with their counterparts from Swansea Bay UHB and Hywel Dda to establish findings and approach. It is clear that the HSE will closely examine Health and Safety Committee Minutes and their correspondence with us and scrutinise performance.

They tend to give 4 weeks’ notice and request key data including committee papers, incident data, risk assessments and relevant policy documents.

We are pursuing a project to ensure that the accuracy of the ESR training compliance reflect competency against external standards and is maximised.

Suspected issues :

- From the Committee meeting - this is likely to include pedestrian safety towards having undertaken the urgent and deliverable aspects.

- Asbestos compliance – the estates department are updating their plans to meet the recently introduced guidance, it has continued to progress surveys of those small number of difficult to access non surveyed areas. It is understood this should be completed by the end of the fiscal year but will be well advance at the time of the audit.

- Manual Handling/MSD- HSE has consistently been critical of the Laundry transfer system – Health and Safety and the Laundry Manager are reviewing their risk assessments and procedures to examine appropriate control measures are in place.

The committee will also be aware that medical records handling has regularly been raised as both a fire and MSD issue; this is therefore continued to be pursued.

Review of training compliance on both patient and object handling show foundation training of good quality and reasonably well compliant. Refresher training is being reviewed as part of our mandatory training project.

The HSE Management Regulations and Approved Code of Practice states that competency will decline if skills are not used regularly (e.g. emergency procedures) these require refresher to be repeated periodically. We are therefore aiming to minimise manual handling refresher training by maximizing workplace positive evaluation, whilst working within the Passport Scheme.

Hoist contract has been renewed and reusable slings LOLER monitoring is being progressed.

The Manual Handling Advisers and Generalist Advisers are auditing risk assessments to add assurance that the appropriate risk management and control measures are in place.

Violence and Aggression - the personal safety case management team has consistently actively pursued best practice in both responding to and proactively implementing arrangements for violent & aggressive behavior; these include:-

- High level of prosecutions
- Violent Warning Marker to alert staff to potential danger
- Lone worker system

The HSE will look at our Security Arrangements at both our main Hospital Sites and Community Premises –

- Cardiff and Vale Security team has a significantly higher visual and actual presence than the previously audited Health Boards. It has a well-developed CCTV centralised control room and flexible response teams for smaller sites. The responding team are trained to higher level of intervention and we have local police presence at both UHL and UHW. Security Management are working with the Project Adviser to ensure all its protocols and training are compliant. It is understood the staff C+ training is at 70% and all will have completed the 3 day courses by April 2020.

- Mental Health Training level D – SIMA training is high with the Adviser reporting that all relevant staff have undertook the training and the current refresher frequency is approximately 14 months, against a 12 month internal standard. Hospital staff carry devices to both respond and call for assistance, community staff are issued with skyguard lone worker devices.

  Patient's rooms are regularly checked for weapons and patients are routinely screened with a metal detector wand.

  Visitor and non-mental health staff protocols are in place.

The Health and Safety Team are working with LED to ensure the correct staff receive the most relevant personal safety training particularly with regard to Level B De-escalation and Level C Breakaway.

Specific Clinical Board Arrangements

- A&E - the department has 24/7 security presence and has been designed to give good visibility. The Health and Safety Department is working with the A&E team to enhance training compliance and the quality of their risk assessment.
- It is likely that HSE will visit Medicine Service areas due to their high number of reported manual handling and violence & aggression events The Clinical Board has established a working group to maximise their compliance.

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

RECOMMENDATION

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

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

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

Prevention	√	Long term	√	Integration		Collaboration		Involvement	√

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

Report Title:	**PEDESTRIAN ACCESS STRATEGY – Progress Update**								
Meeting:	**Health and Safety Committee**						**Meeting Date:**	**8/10/19**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**√**
Lead Executive:	**Director of Planning**								
Report Author (Title):	**Director of Capital Estates and Facilities (02920 743761)**								

SITUATION

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

REPORT

BACKGROUND

Introduction

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

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

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

Traffic and Transport Management

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

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

Pedestrian Incident

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

Pedestrian Access Strategy

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

Recommendations

The final report provided a range of recommendations to be implemented at UHW which are summarised below:

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

Areas of Highest Risk

The areas of highest risk are:

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

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

ASSESSMENT

Traffic Management and Transport Strategy

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

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

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

Project Program

The project commenced in April 2019 and is scheduled for completion in December 2019/January 2020.

Pedestrian Access Recommendations

The original proposal was to address the higher risks identified in the original Pedestrian Access Study via the establishment of a Task and Finish Group. ADL however, have included this study in their program and drafted fresh Pedestrian Environment and Safety Audits at a number of sites including:

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

As these audits include pedestrian safety and include elements of the work to be undertaken by the Task and Finish group, the establishment of the group has been postponed as the audits will shape the objectives and function of the group.

The findings of the draft audits are currently being assessed and preliminary indications show that there are common issues to all sites:

- Condition/provision of footways.
- Obstructions and trip hazards on footways
- Condition of crossing points to be improved and additional crossing points required.
- Signage and road markings to be improved.
- Vehicle parking obscuring visibility or interfering with pedestrian access.

Once all the recommendations have been reviewed, risk rated, costed and agreed, a risk rated action plan will be prepared for implementation. The timescale for this action plan will be circa December 2019/January 2020.

ASSURANCE is provided by:

RECOMMENDATION

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

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

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

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

Report Title:	**Fire Safety Annual Report 2018/19**						
Meeting:	**Health and Safety Committee**				**Meeting Date:**	**08/10/2019**	
Status:	**For Discussion**		**For Assurance**		**For Approval** ✓		**For Information**
Lead Executive:	**Executive Director of Strategic Planning**						
Report Author (Title):	**Senior Fire Safety Officer**						

SITUATION

This paper has been prepared to provide assurance to the Committee that Cardiff and Vale University Health Board (C&V UHB) that identified fire safety risks have been suitably managed during 2018/19.

Fire Safety Management is a key statutory compliance duty for C&V UHB. Fire Safety management in Healthcare is a complex and challenging discipline as there is a wide range of risks that need to be identified, prioritised and mitigated.

This paper provides an update on C&V UHB progress and planned actions relating to fire safety issues by listing key priorities for 2018/19. (See essential supporting documentation Fire Safety Report Annual Appendix 1)

BACKGROUND

C&V UHB is committed to ensuring that all of its fire safety statutory and mandatory obligations are met. In order to meet these requirements, it is necessary to monitor fire safety performance.

NHS standards mandate the preparation of an annual report and an annual audit signed off by the Director responsible for fire safety and returned to NHS Wales Shared Services Partnership - Specialist Estates Services. This paper can therefore be utilised as an important document to demonstrate compliance within the internal and external audit processes.

ASSESSMENT

This report considers management processes and progress in 14 key areas i.e.

1. Welsh Assembly Government Annual Fire Safety Audits
2. Fire Risk Assessments
3. Enforcing Authority Audits and Notices
4. Unwanted Fire Signals
5. Fire Safety and Fire Warden Training
6. Emergency Evacuation Exercises
7. Compartmentation and fire Stopping
8. Fire Policy, Procedures and Permits
9. Appointment of Deputy Fire Safety Managers and Attendance at Meetings
10. Illicit Storage in Corridors and circulation spaces
11. Providing Complex Fire Safety Advice on all Capital Projects
12. Revenue Support to Continue Maintenance of Estate Fire Safety Services and Equipment
13. Capital Investment in Fire Safety precautions and systems
14. SWFRS Site Specific Risk Inspections (SSRI's)

The complete fire safety annual report can be found in essential supporting documentation attached as Appendix 1.

ASSURANCE is provided by:

- Issues identified in the fire risk assessments and the audits carried out by the Fire Authority and NHS Wales Shared Services Partnership - Specialist Estates Services are being appropriately managed.

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RECOMMENDATION

The Committee is asked to:

- Consider the contents of this report in terms of meeting C&V UHB Statutory duty to comply with current legislation and appropriate fire safety guidance.

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

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

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

APPENDIX 1

Fire Safety Annual Report 2018/19

Introduction

The effects of fire in any premises can be serious. However, in the case of healthcare premises, fires have a greater significance due to the presence of large numbers of mobility-impaired and vulnerable patients. Cardiff and Vale University Health Board (C&V UHB) is no exception.

Furthermore, it is widely acknowledged that the NHS, as a business sector, generates the largest proportion of false fire alarms i.e. unwanted fire signals (UwF'S) attended by the Local Authority Fire Service. This is very disruptive to staff and patients' and patient quality of care is also greatly affected. False fire alarm activations are also wasteful in terms of resources and inevitably involve the attendance of the Fire Service possibly causing them a delay in attending a life threatening incident at a different location.

It is also a statutory requirement under The Regulatory Reform (Fire) Safety Order 2005) for all public Organisations to take the necessary fire management precautions to ensure that their premises are safe, suitable and sufficient. Failure to provide adequate fire management can lead to prosecution by the Enforcing Authority post fire safety audit or post fire inspection following a fire incident. A range of enforcement notices can be served by the Enforcing Authority on the responsible persons should the inspecting officers determine there is an increased risk of fire likely to put lives at risk.

Therefore the primary aim of this paper is to provide information to allow informed decisions to be made in respect of fire safety measures that must be addressed. This paper can therefore be viewed to enable C&V UHB to demonstrate compliance thereby fulfilling its statutory obligations.

Fire Safety Management

Fire Safety Management is a key statutory compliance priority for Cardiff and Vale University Health Board (UHB). Fire Safety management in Healthcare is a complex and challenging discipline with risk areas being identified, prioritised and mitigated.

The UHB approach to Fire Safety considers 14 key elements:

1. **Welsh Assembly Government Annual Fire Safety Audits**
2. **Fire Risk Assessments**
3. **Enforcing Authority Audits and Notices**
4. **Unwanted Fire Signals**
5. **Fire Safety and Fire Warden Training**
6. **Emergency Evacuation Exercises**
7. **Compartmentation and fire Stopping**
8. **Fire Policy, Procedures and Permits**
9. **Appointment of Deputy Fire Safety Managers and Attendance at Meetings**
10. **Illicit Storage in Corridors and circulation spaces**
11. **Providing Complex Fire Safety Advice on all Capital Projects**
12. **Continue Maintenance of Estate Fire Safety Services and Equipment**
13. **Capital Investment in Fire Safety precautions and systems**
14. **SWFRS Site Specific Risk Inspections (SSRI's)**

1. Welsh Assembly Government Annual Fire Safety Audits

The annual fire audit for the Welsh Assembly Government has been completed and submitted In May 2019 using the on-line web based reporting system administered by NHS Wales Shared Services Partnership - Specialist Estates Services.

2. Fire Risk Assessments

The principle fire safety legislation applicable to all the Health Board's premises is the Regulatory Reform (Fire Safety) Order 2005 (FSO) enforced by the Local Fire Authority. To be compliant with this legislation a Fire Risk Assessment must be completed for every building or ward or department. Currently there are 442 risk assessment reports that are being repeatedly assessed and reviewed by members of the fire Safety team either annually, bi or tri-annually or they may be amended whenever materials alterations or significant changes in use take place in terms or service or staff.

The findings of the risk assessments are divided into three areas of responsibility: Management, Estates and Compliance, each sector has a data base, from which, progress is monitored.

A meeting of the Deputy Fire Safety Managers is held quarterly to monitor and progress all managerial actions.

Managerial Actions Summary – September 2018– August 2019

Total Number of Managerial Action Raised / Statistics supplied by the Health and Safety Department

Clinical/Service Board	DFSM	Number of Areas	Number of Actions
Women & Children	Cheryl Evans	2	4
Estates	Ian Fitsall	7	22
Mental Health	Ian Wile	14	75
CD&T	Mat Temby	7	26
Executive	Dir Corporate Gov	5	21
Dental	Rowena Griffiths	2	5
Specialist	Nick Godwin	3	6
Surgery	Tina Bayliss	11	41
PCIC	Lynne Topham/Sarah Congreve	2	4
Medicine	Awaiting new appointee	12	32
	Total	65	236

Risk Rating <5	Risk Rating 6-9	Risk Rating 10>	Total
41	168	27	236

The 4 most common management failings relate to training compliance, fire resisting doors being wedged open or propped open, illicit storage in corridors, and obstructions to fire escape routes.

3. Enforcing Authority Audits and Notices

Regular fire safety audits are carried out under current legislation by South Wales Fire and Rescue Service (SWFRS). During the preceding twelve months SWFRS has carried out 10 audits resulting in one Enforcement Notice being issued as a consequence of illicit smoking at Hafan-Y-Coed UHL. This matter was subsequently satisfactorily resolved within the timescale set by SWFRS and as a result the notice was lifted. In addition three Informal Notices were issued for minor fire safety deficiencies identified in Wards C5 and B5 at UHW and Anwen Ward at UHL with no timescale to resolve (See Schedule of Works issued by SWFRS in Appendix 1 of the Fire Enforcement Compliance and Management Report 2018/19). These reports are sent to local management, the appointed Deputy Fire Safety Manager, Estates and Compliance managers to enable those responsible to address the issues and update the Fire Safety Manager at quarterly Deputy Fire Safety Managers meetings.

C&V UHB has Fire advisors located PAN Estate supported by Fire Wardens who also interface with the Fire Safety Manager and Deputy Fire Safety Managers.

As a consequence of SWFRS undertaking regular audits of a representative sample of C&V UHB departments and buildings these visits will generally result in a clean bill of health or one of the following notices being issued:

- **INO1 or IN02 Informal Notice:** Remedial actions will be noted during the SWFS audit and will need to be addressed. Within 12 months the Fire Service will re-visit the area to ensure all actions are complete. Failure to complete all the high risk actions will result in an Enforcement notice.

- **Enforcement Notice:** Where remedial actions are noted during the visit which will result in the Fire risk exceeding a certain level, an Enforcement notice is served. This will require the UHB to complete the remedial actions within a specified timescale otherwise further action may follow.

4. Fires and Unwanted Fire Signals

Fire Incidents for the period – 01st September 2018 – 31st August 2019

No.	DATE	FIRE INCIDENTS LOCATION	CAUSE
1	01/09/2018	HYC – Beech Ward External Garden	Deliberate
2	16/09/2018	HYC – Cedar Ward Bedroom 5	Deliberate
3	30/09/2019	HYC – Alder Ward	Deliberate
4	30/10/2019	UHW – Pembroke House	Cooking
5	02/11/2018	Park Rd Houses	Cooking
6	23/01/2019	UHW – TB2 Blown Light Ballast Unit	Electrical
7	26/01/2019	St Davids – Deep fat fryer	Cooking
8	31/01/2019	UHW - Blown Light Ballast Unit	Electrical
9	05/03/2019	Ward C5 – Angle poised lamp in contact with bedding	Accidental
10	14/04/2019	Lansdowne Hospital	Arson
11	15/04/2019	Boiler house	Mechanical
12	09/05/2019	Ward C5 Room 15	Smoking
13	04/07/2019	Willow Ward - Hafan Y Coed	Arson
14	13/08/2019	Hafan y Coed	Deliberate

Unwanted signals (false alarms) 01st September 2018 – 31st August 2019

CAUSE	NUMBERS
Deliberate activations (malicious)	04
Good Intent	15
Accidental	46
Public	01
Cooking	37
Smoking	14
Insects	05
Other – Water Ingress / Steam leaks etc	54
System Faults	45
Contractors	24
Management	16
Unknown causes	59
Total Incidents	**320**

The occurrence of an unwanted fire signal's (UwF'S) is detrimental to the operation of any healthcare establishment. Such instances lead to disruption of service and patient care, increased costs and unnecessary risk to those required to respond to the alarm raised. Whilst it is impossible to eliminate all UwF'S these figures must be reduced.

The Welsh Government has tasked SWFRS with reducing false alarms, in turn SWFRS are concerned by the number of alarms we generate, in particular at UHW. They have already reduced the response to alarms between the hours of 08.00 and 18.00 from three fire engines to one fire engine for investigation purposes only, unless it is confirmed there is a fire. On receipt of this message SWFRS will mobilise the full pre-determined attendance (PDA) i.e. three fire engines

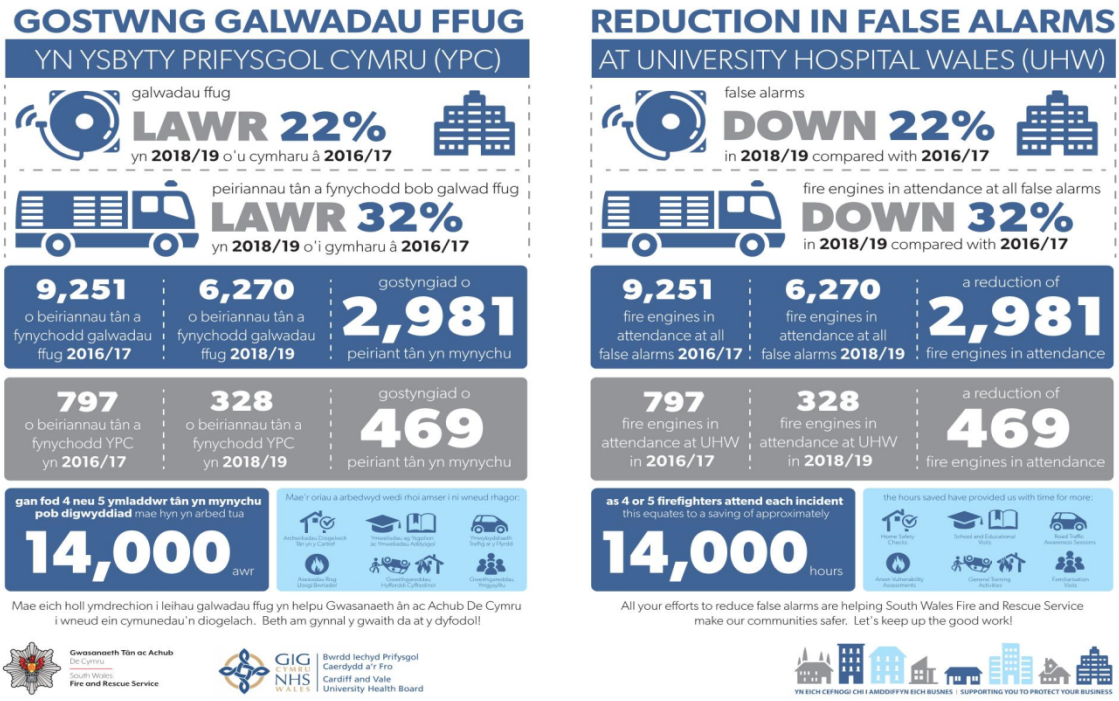
The Fire Safety Team investigates every false alarm in order to prevent similar occurrences being repeated. Documentary evidence indicates that 70% of the alarms are the result of human activity. It is widely recognised that false fire alarm activations are extremely challenging to prevent at UHW due to the size and complexity of the fire alarm and detection system and the sheer number of members of the public with a wide range of differing abilities entering this site every day. .

Comparison of fires and UwF'S by site between 01/09/2018 to 31/08/2019

Site	UwF'S	Fires
Barry Hospital	5	
Cardiff Royal Infirmary	7	
Hafan Y Coed	18	5
Llandough Hospital	66	
Rookwood Hospital	5	
St David's Hospital	4	1
University Hospital of Wales	237	6
Whitchurch Hospital	1	
Barry Hospital	5	
Lansdowne Hospital	0	1
5 - 11 Park Road, Whitchurch	0	1

On a positive note C&V UHB has seen a significant reduction in false alarms down 22% in 2018/19 compared with 2016/17.In addition this reduction has seen fire engines in attendance at all false alarms down 32% in 2018/19 compared with 2016/17. Figures supplied by SWFRS

Below is a copy of the recent poster produced by SWFRS and distributed PAN Estate



5. Fire Safety and Fire Warden Training

Data supplied by Workforce Information for 01st September 2018 – 31st August 2019

BOARD	ESTABLISHMENT	% ACHIEVED	% COMPLIANCE
All Wales Genomics Service	187	140	74.87%
All Wales Genomics Service Total	**187**	**140**	**74.87%**
Capital, Estates & Facilities Total	**1201**	**714**	**59.45%**
Children & Women Total	**2226**	**1692**	**76.01%**
Clinical Diagnostics & Therapeutics Total	**2313**	**1760**	**76.09%**
Corporate Executives Total	**806**	**590**	**73.20%**
Medicine Total	**1822**	**1175**	**64.49%**
Mental Health Total	**1440**	**965**	**67.01%**
Primary, Community Intermediate Care Total	**1080**	**786**	**72.78%**
Specialist Services Total	**1852**	**1248**	**67.39%**
Surgical Services Total	**2376**	**1526**	**64.23%**
Grand Total	**15303**	**10596**	**69.24%**

The compliance figures achieved relate to a rolling 12 month period, the fire safety e-learning package, classroom, locality based & Fire Warden training. All fire safety training records are recorded on the staff personal records Electronic Staff Records (ESR) database. LED collates all statistical information in relation to Fire Training and notifies workforce development. It can be seen that 69.24% of staff received fire training in the previous 12 month period ending 31st August 2019.

Mandatory fire training sessions at UHW & UHL conducted by members of the Fire Safety Team are organised by LED, with information in relation to venues, dates and times being available on the intranet. Whilst it is acknowledged that the current training figures above are the best C&V UHB have ever achieved to date further initiatives to try to increase this figure are being proposed.

Requests received by members of the Fire Safety Team from managers to carry out on-site training will be accommodated where possible and appropriate. It will be the responsibility of the organiser for the training to ensure that sufficient numbers of staff attend (normally minimum of 12) and that a suitable room to carry out the training is available and set up prior to arrival. It should also be understood that due to the fire safety team having numerous other fire safety duties, it will not always be possible to accommodate requests for on-site fire training. In these circumstances, staff will be referred to attend mandatory training drop in sessions arranged by LED either at UHW or UHL and facilitated by the fire safety team.

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

6. Emergency Evacuation Exercises

Fire evacuation exercises have been carried out in the following locations:

- Alas Treforest
- Global Link
- Ronald Macdonald House x 2
- Teddy Bear Nursery UHL X 2

It is intended to carry out more practical fire evacuation exercises to test procedures and there are a number planned for the remainder of 2019. It is recognised that it is extremely difficult to carry out this type of exercise due to staff shortages, suitable venues and possible disruption to patient services that could arise without very careful planning.

With this in mind the fire safety team is planning to carryout walk through talk through exercises in wards and departments over the coming 12 months.

Vertical Evacuation Proposal

The provision of equipment for implementing vertical evacuation of patients in the event of a fire emergency have been introduced in ward areas where there is a possibility of vertical evacuation down stairs. Equipment is provided & will greatly reduce the manual handling risks associated with vertical evacuation, and facilitate a more effective and speedy evacuation procedure.

Continuation training on the evacuation equipment has not been carried out and staff are not confident in using this equipment. The lack of training could cause a considerable delay if it was ever essential to evacuate vertically in the event of an emergency.

Therefore fire safety management has proposed that the function of using the fire evacuation chairs is removed from clinical staff and given to trained porters thus reducing the dual burden of cost and resources that are currently required to potentially train thousands of clinical staff per annum. Discussions are on-going

7. Compartmentation and fire Stopping

The fire strategy involves restricting a fire to a limited area by fire resisting construction so that patients can be safely moved progressively horizontally to a place of relative safety inside the building to enable care and treatment to continue. Over many years the structural fire compartmentation of our buildings has been compromised by the installation of a variety of services that include cables, pipes, ducting work etc through fire compartment walls, ceilings and floors and the subsequent omission of the required fire stopping installations to resist the passage of smoke and flame from a resultant fire.

As a consequence C&V UHB now have a rolling program of remedial work which is being carried out on a priority risk basis. Recently works have been completed at Barry Community Hospital, St David's Hospital and Woodland House. Currently the appointed 3rd part accredited fire stopping company is carrying out extensive intrusive works at UHW. It is estimated that this work will take at least two years to complete.

8. Fire Policy, Procedures and Permits

C&V UHB Fire Safety Policy and Procedures have been updated, approved in July 2018 and are available to view on the health Boards Intranet. It is worth noting that a number of fire safety permits to work have also been recently amended to reflect changes in work practices and to prevent any ambiguity by contractors as to their responsibility in respect of fire safety.

Fire safety permits that have been amended and are currently in draft awaiting approval are:

- Fire Safety Authorisation to Proceed
- Fire Compartmentation Integrity Assurance Permit

Other fire safety permits currently under review are:

- Hot Works Permit
- Fire Alarm System Isolation and Re-instatement Permit

9. Appointment of Deputy Fire Safety Managers and Attendance at Meetings

Each Service Board has nominated and appointed a Deputy Fire Safety Manager to be responsible for fire safety management issues within areas occupied by their staff.

In January 2019 NHS Wales Shared Services Partnership Audit & Assurance Services carried out a legislative and compliance audit and they noted in Finding 6 - Process in place to establish compliance is achieved (Operating effectiveness) that

"The management actions are monitored at the DFSM quarterly meetings. Copies of the DFSM meetings were obtained to ensure that the required people are attending each meeting and their frequency. Analysis of the attendance figures identified that the attendance levels are low and it is the same members of staff who are always present. Key areas that have the most management actions are not attending therefore we are unable to provide assurance that the management actions are being appropriately scrutinised".

The auditor recommended that

"Senior management should ensure that there is appropriate attendance at the DFSM meetings from each of the Service Board Fire Safety Managers".

10. Illicit Storage in Corridors and circulation spaces

It is recognised that storage facilities in healthcare premises are a premium. However it should be noted that the problem of illicit storage of a wide range of items that include beds, combustible items, bins, trolleys and discarded electrical equipment in main corridors is on the increase. This matter is not restricted to C&V UHB but is recognised as a Healthcare sector wide problem.

As this matter is a cause for concern C&V UHB Fire Risk Assessments and in SWFRS Audits record all such instances under management responsibilities.

It is therefore recommended that a collaborative approach to enable a reasonable way to reduce and eventually eliminate this matter should be adopted

11. Providing Complex Fire Safety Advice on all Capital Projects

During the preceding 12 months the fire safety team has completed technical reviews and reports for numerous major capitals and minor discretionary capital projects undertaken PAN Estate. These include the MRI Unit, Obstetrics and major ward refurbishments at UHW, Rookwood development, CAVOC and Cystic Fibrosis at UHL.

12. Maintenance of Estate Fire Safety Equipment and Systems

The equipment and systems listed below are required to be serviced and maintained annually. The list is not exhaustive but includes;

- Hand held Fire Fighting Equipment
- Fire Fighting Hose Reels
- Fire Resisting Doors
- Fire Fighting Mains
- Dry Rising Fire Mains
- Fire Suppression Systems
- Mechanical Smoke Extraction Systems
- Fire Fighting Lifts
- Bed Evacuation Lifts
- Fire Fighting Lobbies
- Fire Fighting Shafts
- Fire Alarm and Detection Systems
- Emergency Lighting Systems
- Fire and Smoke Dampers

13. Capital Investment in Fire Safety Precautions and Systems

The areas outlined below are current fire safety projects where considerable capital investment has been allocated for 2018/19 and work is ongoing:

- Fire stopping project PAN Estate
- Surveying, validation and swop out of mechanical fire dampers to be replaced by electronic fire and smoke dampers PAN Estate
- Fire alarm and detection system upgrade project at UHW
- Swop out end of life detectors and carryout a whole site cause and effect review at UHL
- Fire risk assessment rationalisation project upgrade using the IPR 3.5 MICAD system

14. SWFRS Site Specific Risk Inspections (SSRI's)

In the preceding twelve months SWFRS has carried out ten Site Specific Risk Inspections (SSRI) visits i.e. eight at UHW and two at UHL. These inspections are carried out under section 7.2d of the Fire Service Act 2004. The purpose of these inspections is to formalise their standard operating procedures (SOP's) in terms of Building layout, Building occupancies, risks and hazards in each building, location of fire hydrants, dry rising main inlet and outlet locations, fire suppression systems and isolation vale sets, mains gas and mains electric isolation switch locations, rendezvous positions, fire fighting staircases and lift locations. Also hazardous materials and flammable storage that is located either internally and externally. All this information is recorded and uploaded onto their on board computers to enable crews who attend incidents PAN Estate to retrieve relevant fire fighting information quickly allowing operational plans to be put in place beforehand and easily retrieved.

PROPOSED FIRE SAFETY MEASURES FOR 2019/20

- Improve attain and maintain attendance at basic fire training. Currently 70% of staff are compliant best practice requirement is 85% In order to attain and maintain this statutory requirement further planning and other ways of achieving an increase will have to be considered and agreed.

- Increase the number of trained Fire Wardens.

- Continue programmed of risk assessments reviews Pan Estate

- Develop bespoke emergency evacuation plans and install departmental 3 Dimensional emergency evacuation drawings. Undertake evacuation walk through exercises and carry out regular annual fire drills.

- Repair and replace all defective Fire Alarm and Detection System devices in areas that have been identified and outlined by survey.

- To continue fire stopping of compartment fire ceilings, floors and walls that have been breached or damaged due to the installation of a range of services.

- To design, deliver training and agree make up of first responder fire response team.

- Continue the projects outlined in item 13 of this paper.

Report Title:	Enforcement Agencies Report							
Meeting:	Health and Safety Committee					**Meeting Date:**	08/10/2019	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**	
Lead Executive:	Director of Workforce and Organisational Development							
Report Author (Title):	Head of Health and Safety							

SITUATION

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

During the period there were no new issues raised by the Health and Safety Executive (HSE), however the legal case for Contractor Control is included.

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

BACKGROUND

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

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

ASSESSMENT

Road Traffic Accident at UHW

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

The remedial actions and the pedestrian safety strategy have been progressed by the Director of Capital, Estates and Facilities, the outline plan was considered at the July Health and Safety Committee, both in terms of long term plan and immediate actions deliverable within the resources available.

This item is on the agenda for the October meeting.

Contractor Fall

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

Legal Action has been pursued by the HSE against both the Health Board and the Contractor. The case was heard in court on the 15th July 2019. The Health Board was fined £400K as being

medium culpability and the Contractor company was found to be of high culpability, the Managing Director was disqualified from being a Director of any company for 5 years and given a suspended custodial sentence.

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

RECOMMENDATIONS

The Committee is asked to:

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

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Fire Enforcement Compliance and Management Report 2018/19**						
Meeting:	**Health and Safety Committee**				**Meeting Date:**	**08/10/2019**	
Status:	**For Discussion**		**For Assurance**	✓	**For Approval**		**For Information**
Lead Executive:	**Executive Director of Strategic Planning**						
Report Author (Title):	**Senior Fire Safety Officer**						

SITUATION

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

Once SWFRS audits have been completed they are then empowered to issue either an Enforcement Notice (serious breaches in current legislation) or an Informal Notice (issues that are deemed not so serious to warrant enforcement).

BACKGROUND

South Wales Fire and Rescue Service (SWFRS) undertake a program of visits to mainly inpatient areas on Hospital Sites. These audits may result in SWFRS written reports being served on C&V UHB where they deem that the UHB has failed to comply with the FSO.

This report provides a current assessment on Notices served by SWFRS.

ASSESSMENT

During the preceding twelve months SWFRS has carried out 10 audits resulting in one Enforcement Notice being issued at Hafan-Y-Coed UHL as a consequence of their operational crew's attending a number of deliberate fires being set by patients. Following the audit carried out on the 12th October 2018 an Enforcement Notice was issued on the 31st October 2018.

The Enforcement Notice recorded four breeches of The Regulatory Form (Fire Safety) Order 2005 i.e.

- The University Health Boards smoking policy is not being adequately managed,
- The significant findings identified in the fire risk assessments have not been implemented,
- The fire detection system is inadequate for the type and use of the premises,
- Staff have not attended fire training sessions.

The Health Board was given 40 days to improve the situation after which SWFRS returned to confirm they were now satisfied the premises currently demonstrates suitable and sufficient measures to satisfy the requirements of the Fire Safety Order. Formal notification that the Enforcement Notice was lifted on the 27th December 2018

In addition three informal notices were issued for minor fire safety deficiencies identified in

Wards C5 and B5 at UHW and West 3 Anwen Ward at UHL with no timescale to resolve. (See Appendix 1 for the items identified and outlined within each Notice)

- **ASSURANCE** is provided by:

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

RECOMMENDATION

The Committee is asked to:

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

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

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

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

APPENDIX 1

South Wales Fire and Rescue Service
Informal Notices

THE REGULATORY REFORM (FIRE SAFETY) ORDER 2005 LETTERS OF FIRE SAFETY MATTERS:

WARDC5,UNIVERSITYHOSPITALWALES,HEATHPARK, CARDIFF,CF144XW

SCHEDULE OF WORKS REQUIRED

1 Article 8 – General fire precautions

1.1 Fire doors are being held open inappropriately.

1.1.1 During the inspection it was noted that fire doors to the sluice room and rooms along the ward corridor were being held open inappropriately as identified in the Fire Risk Assessment. However, it was also noted that constant access is required to these areas at peak times.

Consideration should be given to providing hold open devices to the fire doors which releases on the actuation of the fire alarm.

1.2 Isolation valves located inside ward do not comply with current standards.

1.2.1 Exposed medical gas pipe lines before the isolation valves should be enclosed in fire resisting construction as identified in the Fire Risk Assessment.

1.3 Smoking is not being effectively controlled on the premises.

1.3.1 Although there is a “no smoking” policy in place, following recent events a patient was badly burnt as a direct result of smoking in their bed. An effective system must be introduced and implemented by the responsible person to prevent smoking on the premises, particularly wards and bedrooms, where smoking is prohibited by the fire policy of the Health Board.

It is strongly recommended that procedures for monitoring/managing patients prone to smoking in bed be reviewed.

WARDB7,UNIVERSITYHOSPITALWALES,HEATHPARK, CARDIFF,CF144XW

SCHEDULE OF WORKS REQUIRED

1 Article 8 – General fire precautions

1.1 Fire doors are being held open inappropriately.

1.1.1 During the inspection it was noted that fire doors to the sluice room and rooms along the ward corridor were being held open inappropriately as identified in the Fire Risk Assessment. However, it was also noted that constant access is required to these areas at peak times.

Consideration should be given to providing hold open devices to the fire doors which releases on the actuation of the fire alarm.

1.2 Isolation valves located inside ward do not comply with current standards.

1.2.1 Exposed medical gas pipe lines before the isolation valves should be enclosed in fire resisting construction as identified in the Fire Risk Assessment.

2 Article 14 Emergency Exit Routes

2.1 Inappropriate storage/obstruction within escape route.

2.1.1 During the inspection it was noted that areas of the stem corridor contained items of storage and was partially obstructed by beds. Corridors and stairways that form part of escape route should be kept clear of obstructions and hazard free at all times. Items that may be a source of fuel or pose an ignition risk should never be located on any corridor or stairway that will be used as an escape route.

WARD WEST 3 ANWEN WARD, UNIVERSITY LLANDOUGH CFCF64 2XX

SCHEDULE OF WORKS REQUIRED

1 Article 8 – General fire precautions

1.1 During the inspection it was noted that the sluice room was provided with heat detection, it is recommended that this be replaced with smoke detection. Should there be a specific requirement to have heat detection in this area, then an appropriate rationale should be provided.

1.2 Fire resisting doors to the reception/waiting room area were missing hinge bracket screws and intumescent strips and cold smoke seals in parts. The fire resisting door to the treatment room was also missing intumescent strips and cold smoke seals in parts. Arrangements should be made to ensure that a suitable system of maintenance is put in place to ensure all fire resisting doors are in efficient working order and in good repair.

Report Title:	Health and Safety Assurance Schedule and Priority Improvement Plan 2019/20						
Meeting:	Health and Safety Committee				**Meeting Date:**	08/10/2019	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	Director of Workforce and Organisational Development						
Report Author (Title):	Head of Health and Safety						

SITUATION

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

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

BACKGROUND

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

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

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

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

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

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

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

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

Overarching Health Board Priority Improvement Plan

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

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

	Total no of Milestones	Green	Amber	Red	Total Actions	Green	Amber	Red	Overall Strategy Status
Health and Safety Policy Management and Organisational Arrangement	8	0	7	1	16	7	7	2	Reasonable assurance
Violence and Aggression (inc Lone worker)	3	2	1	0	10	8	2	0	Substantial assurance
Manual Handling	10	2	8	0	13	7	6	0	Reasonable assurance
Health Issues	8	1	5	2	16	10	5	1	Reasonable assurance
Patient and Environment Health and Safety	8	2	4	2	15	8	5	2	Limited assurance
Fire Safety Management	6	2	3	1	9	6	3	0	Reasonable assurance
Estate Health and Safety Management	9	3	5	1	17	11	5	1	Reasonable assurance
Sharp Safety	1	0	1	0	1	0	1	0	Reasonable assurance
Total	53	12	34	7	97	57	34	6	

The plan identifies 53 milestones within the 8 strategic areas and 97 actions for improvement. These have been progressed with 12 milestones and 57 actions being completed.

During the period a total of 13 actions were progressed sufficiently to enhance their status.

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

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

Ref	Subject	Progress
1.1	Health and Safety Policies	Project lead identified within the Health and Safety team to complete analysis
1.2	Project lead identified within the Health and Safety team to complete analysis	Violence & Aggression and Manual Handling generic risk assessments progressed.
1.5	Health and Safety meetings management structure met.	Health & Safety Adviser identified. To progress with individual heads. No Group formed as yet.
3.1	Working to Revised All Wales NHS Manual Handling Passport and Information Scheme	Joint Review with LED completed
4.2	Review of Health compliance	Review of programme and being reported to each Health &

		Safety Committee.
4.3	Work Place stressors	Funding has been secured from Health Lottery for additional wellbeing practitioners for a period of 2 years; these are currently being progressed.
4.4	Hand arm vibration	Programme of work has been initiated and is being progressed.
4. 5	DSEAR compliance development	DSEAR Guidance approved at the Fire Safety Group and Operational Health & Safety Group and being implemented through each clinical board as appropriate.
5.2	Mental Health Smoking Cessation	Review of smoking controls within Mental Health has been undertaken and met with Fire Service for approval – Re-installed electronic lighters at smoking stations.
		Monitored by Environmental Nurse for any significant breaches/ action being progressed by Mental Health.
5.4	Local Control of Water Safety	Reported improved attendance at Water Safety Group. Review of database initiated to improve flush monitoring.
6.4	Evacuation Mat/Chairs Training	Senior Fire Safety Officer and Fire Safety Manager has put forward to Fire Safety Group reviewed team approach to evacuation chairs. This is being further discussed at the next FSG.
7.2	Contractor Control	Confirmation backlog has been resolved.

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

RECOMMENDATION

The Committee is asked to:

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

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

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

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

Prevention	√	Long term	√	Integration	√	Collaboration	√	Involvement	√

Equality and Health Impact Assessment	Not Applicable

Completed:	

Report Title:	Lone Worker Report						
Meeting:	Health and Safety Committee					**Meeting Date:**	08/10/2019
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	Director Of Workforce and Organisational Development						
Report Author (Title):	Head of Health and Safety						

SITUATION

Lone Worker devices are issued to those staff in the community that are at risk unless management has confirmed that suitable alternative mechanisms have been introduced to support staff.

The Committee considered a report on the updated contract at the April meeting. This report updates the Committee on the progress made since.

BACKGROUND

The lone worker device is a system for calling for assistance; it is monitored 24/7 and recorded when justified.

The devices are issued to those staff in the community that are at risk, unless management has confirmed that suitable alternative mechanisms have been introduced to support staff.

The Health Board recognises there is a risk of injury to NHS staff working in the community from members of the public which are increased due to their remoteness. The Committee previously noted and supported that an important control measure in managing this risk is that relevant NHS staff are issued with a Lone Worker Alert System.

The HSE has pursued a number of prosecutions for failure to protect staff in lone worker incidents, including £100K to a Local Authority when a social worker was attacked and £900K to a utility company when a worker fell, the HSE was scathing about the company's lack of lone worker systems.

ASSESSMENT

The overall percentage compliance continues to shows high utilisation well in excess of the previous devices with an average usage of in excess of 70% month on month measured against device activity and movement.

This usage has been sustained over the last 3 years and justified the renewal of the contract in May 2019. This renewal included replacing the existing devices with newer models.

The establishment of a single framework agreement with the NHS has both assisted renewal and significantly reduced the cost of each device from £7.25 to £5.25 per month per unit based on a 3 year contract.

This reduction of cost allowed for both a budget saving and an expansion of the number of

devices from 655 to 700 devices in service. The expansion is mainly within new community services identified during the previous contract period. The allocation of devices had also been extended to victims of domestic abuse.

Managers will continue to receive monthly usage reports and progress is also monitored at the Anti Violence Group (previously Personal Safety and Security Strategy Group).

The Personal Safety Team and the company are working closely with each relevant clinical board to ensure that no user will be left without cover during the transition over to their new device. This change over will result in the user having both the old and new device active for a period, subsequently the usage reports will be erroneous and therefore the usage reports have been suspended during the transition periods. This transition is well underway and is expected to be completed by the end of October

The Operational Health and Safety Group continues to monitor usage and implementation of the new contract by Clinical Board and Sub Group.

ASSURANCE is provided by the continued high demand and usage of the devices and the monitoring undertaken at both local and corporate level.

RECOMMENDATION

The Health and Safety Committee is asked to:

- **NOTE** the report

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

UPDATED HEALTH AND SAFETY RELATED POLICIES SCHEDULE

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

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

POLICY	UHB REFERENCE NO	AUTHOR/LEAD RESPONSIBLE OFFICER	SUBMISSION TO HEALTH & SAFETY COMMITTEE	APPROVAL DATE	REVIEW DATE	COMMENTS
Closed Circuit Television (CCTV)	UHB 303	Director of Capital, Estates and Facilities	January 2019 (3rd review)	January 2019	January 2019	
Security Services	UHB 037	Director of Capital, Estates and Facilities	April 2019 (3rd review) **4th review****	April 2019	April 2022	

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

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

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

(1) LED Policy

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

Report Title:	**CATERING DEPT, ROOKWOOD HOSPITAL FOOD HYGIENE INSPECTION – 25th July, 2019**						
Meeting:	**Health & Safety Committee.**				**Meeting Date:**	**08/10/19**	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	**Director of Planning**						
Report Author (Title):	**Operational Services Manager**						

SITUATION

An inspection of Main Kitchen and Ward kitchens at Rookwood Hospital took place on 25th July, 2019, the outcome of which was confirmed in writing in a letter report dated 31st July,2019 from the Commercial Services Officer, Food and Port Health, Bridgend, Cardiff and Vale of Glamorgan Shared Regulatory Services.

In this report it was noted that the Kitchens at Rookwood Hospital were given an overall score of **3 (Generally Satisfactory)** in the National Food Hygiene Rating Scheme.

REPORT

BACKGROUND

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

ASSESSMENT

On receipt of the letter report, an action plan was developed by the Operational Services Manager to address the issues raised and is attached as an appendix 1 to this report**.** This will be monitored within the service by the Operational Services Manager.

ASSURANCE is provided by:

The maintenance of the Food Hygiene Rating score of **3 (Generally Satisfactory).**

RECOMMENDATION

The Committee is asked to:

- **NOTE** the Food Hygiene Rating and the remedial actions taken following the receipt of the Commercial Services Officer (Food & Port Health) report.
- A request for a re-inspection has been submitted following completion of works and measures implemented.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
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Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	√	Long term		Integration		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable								

Appendix 1

Action Plan

ID	Issue identified	Action	Lead	Catering Action	Estates Action	Target Completion Date
1	During the inspection, jugs were being stacked while still wet in ward 4/5 and wards 7. This will support microbiological growth. You must ensure all equipment is dried thoroughly before being stacked. *Regulation (EC) No. 852/2004, Annex II, Chapter IX, Para 3*	Housekeeping and Catering staff have being met with and issues discussed Notices placed in each kitchen. Supervisors to undertake ad hoc inspections.	KP			05/08/19
2	The blade of the heavy-duty can opener in the kitchen was encrusted with food, which would cause contamination of the food in the next tin opened. This part of the can opener must be cleaned and sanitised regularly. It was also noted that the base was becoming rusty and required repainting. *Regulation (EC) No 852/2004 Annex II Chapter V Para 1(a)*	Staff have been met with and the importance of the cleanliness of utensils been reiterated. Notice has been placed on the wall next to the tin opener instructing staff to clean tin opener after every use New tin opener has now been delivered and fitted to table.	KP			04/08/19 04/08/19 02/08/19
3	The hot water to the wash hand basin in the	Maintenance request placed for				6/08/19

	pot wash was too hot (the temperature fluctuated between 48.9˚C and 62.4˚C) this may result in staff failing to wash hands correctly. You must reduce the temperature to the hot water tap or provide a mixer tap to the wash hand basin. *Regulation (EC) No 852/2004 Annex II Chapter I Para 4*	Taps to be changed. Job number 745474 – Completed	GD			
4	The needle of a probe left on a trolley in the kitchen was engrained with food debris. You must ensure that all food debris is removed prior to sanitising the needle probe. *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*	Staff have been met with and the importance of the cleanliness of utensils/probes been reiterated Notice placed on Catering information board and in each ward kitchen	KP			05/08/19 01/08/19
5	The internal base of the walk in chiller door was becoming rusty. Thoroughly clean the internal surface and repaint or repair to provide a surface which is easy to clean. *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*	Surface cleaned on a regular basis. Maintenance request placed job number 745476 – Checker plate ordered – fitted	KP/GD			04/08/19 6/08/19

6	The skirting board tiles in the dry goods store were coming away from the walls in parts and there were some missing tiles. Replace any missing or damaged tiles. *Regulation (EC) No 852/2004 Annex II Chapter II Para. 1(b)*	All missing and broken tiles have been replaced	GD			12/08/19
7	The tap top inserts to the hot and cold taps to the left off the equipment sink in the main washing up area were missing. Replace the missing tops. *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*	Maintenance request placed job number 744887 – Completed	GD			6/08/19
8	The green colour coded board in the main kitchen was becoming scored and can no longer be thoroughly cleaned/disinfected. Replace the affected board. *Regulation (EC) No 852/2004 Annex II Chapter V Para 1(c)*	Chopping board replaced 2/8/19. Boards to be replaced on a 10 week cycle.	KP			02/08/19
9	There was pooling water noted in the dishwasher on ward 7 and a foul odour. Carry out such works to prevent water from pooling in the dishwasher. *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*	Dishwasher was emptied and dried on the day that dishwasher was reported Broken 07/07/19 Maintenance request placed on the 7/7/19	GD			27/07/19

		Repaired on the 27/7/19				
10	Food businesses must take all reasonable precautions to prevent food pests, namely rats, mice, cockroaches and flying insects gaining entry into food storage and preparation areas. This is to prevent the Contamination of foodstuffs. Any gaps and holes to external doors, windows, pipes, drains etc. must be filled or covered with a solid, durable material in order to minimise pest entry points into food preparation and storage areas. It was noted that there were numerous possible pest entry points, namely gaps under doors, holes to walls, doors being left open. As discussed, you must carry out a survey of any possible entry points (as a guide, if you can push a standard biro type pen through a gap then mice can access) once you have identified these entry points, carry out such works to fill or cover these points. *Regulation (EC) No 852/2004 Annex II Chapter IX para 4* *Regulation (EC) No 852/2004 Annex II Chapter I para 2 (c)*	Brushes have now been fitted on all kitchen doors New rear kitchen door & holding bay door to be manufactured. Due to be in place by 27th August, 2019.	GD/KP			16/08/19 27/08/19

11	Rat droppings had been found in the John Pathy Day Hospital kitchen on the 18th July and Rentokil attended on the 19th July. The rat droppings hadn't been cleared away when we visited on the 25th July. Whilst the kitchen had been locked and was not being used, you must clear away any old droppings in order to be able to see if any new droppings are left. *Regulation (EC) No 852/2004 Annex II Chapter I para 1*	It is the responsibility of Rentokil to attend site after putting bait down to check if there is rat droppings, they should clear any droppings whilst attending site. Concerns have been raised and discussed with Rentokil management. Pest control folder now placed in reception where supervisors will monitor on a daily basis. Any action points to be referred to management/admin team for follow up	KP			26/08/19
12	Audit of the current food safety policy document and monitoring records identified the following: □ Your HACCP specifies that Food Hygiene refresher training will be carried out annually. However, there was little evidence to demonstrate this was happening in practice. In some instances the last recorded Food Hygiene Training was in 2016 for Faisal Adams and Elizabeth Prichard and Sarah Sparks.	HACCP states that food hygiene refresher training is done on a regular basis not annually. Food hygiene recommendations state that refresher training should take place every 3 years	KP			

	It was also noted that there were no certificates available for Jackie Higham. Barbara Grigg, John Jones and Andrew Wood.	All staff apart from Jackie Higham currently compliant. Certificates will be kept on files..	KP			
	□ There were some occasions where a delivery temperature hadn't been recorded, but the temperature range had been circled. As staff are required to monitor and record the delivery temperature then a specific temperature needs to be recorded.	Member of the catering staff was met with on the 27/7/19 and correct procedure was clarified. Member of staff fully aware of the importance of recording correct temperatures	KP			27/07/19
	□ There were a number of occasions where milk delivery temperatures weren't being recorded;	Supervisors and Catering staff have been met with and correct procedure was clarified. All staff fully aware of the importance of recording correct temperatures. Catering staff being retrained on temperature recording and ensuring the appropriate corrective action is being undertaken.	KP			02/08/19
	□ Temperatures above your critical limit of 5°C (10°C) had been recorded on the 19th July at midday. However the corrective action recorded was fridge open. In this instance the corrective action should have been 'door open, so closed door and rechecked in 10 minutes and temperature was x°C;	Catering staff have been retrained on temperature recording and ensuring the appropriate corrective action is being undertaken.	KP			05/08/19
	□ Cross contamination needs to be considered as a hazard during delivery;	Team manager updating HACCP document with regards to Castell Howell deliveries	KP			07/08/19

	□ On the early morning check on the 18th July the walk in fridge temperature was recorded at 8.9°C, the corrective actions documented were that all perishable foods were moved to another fridge. As you have no way of knowing how long food had been held above 5°C the corrective action should have been to dispose all perishable foods;	Team manager discussed with Supervisor what corrective action should have been undertaken. Documentation is now in place.	KP			05/08/19
	□ Probe calibration checks were not always being completed monthly, the last probe calibration check was done on the 13th June and nothing had been completed for July. As discussed you should allocate a specific week when calibration must be undertaken;	Probe calibration now being undertaken on the first week of every month. Documentation now in place.	KP			05/08/19
	□ There were missing temperature checks and cleaning checks on Ward 6 for the 22nd July.	Supervisors and Catering staff have been met with regarding temperature's being recorded	KP			05/08/19
	□ There was staff food in the fridge on ward 6 which was unlabelled. All staff food stored in the same fridges as patient's food must be labelled. *Regulation (EC) No. 852/2004 Article 5* 13.	Discussed with ward manager regarding staff leaving items unlabelled in the fridge. Staff have their own fridge but was being de-frosted on the day. Ward manager will reiterate the importance of labelling food to her staff in case of	KP			29/07/19

		further need to use patient fridge.				
13	Rentokil had visited on the 19th July following rat droppings having been found in the John Pathy Day Hospital kitchen. Rentokill highlighted a collapsed drain outside the window to the kitchen as the possible access point. No works had been completed to remedy this issue. As discussed, any pest proofing works required, especially when there is an active pest issue must be remedied immediately. Any gaps and holes to external doors, windows, pipes, drains etc. must be filled or covered with a solid, durable material in order to minimise pest entry points into food preparation and storage areas. It was noted that there were numerous possible pest entry points, namely gaps under doors, holes to walls, doors being left open. As discussed, you must carry out a survey of any possible entry points (as a guide, if you can push a standard biro type pen through a gap then mice can access) once you have identified these entry points, carry out such works to fill or cover these points.	All works now completed. Any future works that need completing will now be sent to the Building Manager to progress. New rear kitchen door & holding bay door to be manufactured. Due to be in place by 27th August, 2019. Brushes have now been fitted on all kitchen doors	GD GD			2/08/19 27/08/19

	I was also concerned that there didn't appear to be a robust system in place to ensure that any pest issues or works highlighted by Rentokil would be communicated to the relevant person in a timely manner	Pest control folder now placed in reception where supervisors monitor on a daily basis. Any action points to be referred to management/admin team for follow up.	KP			
14	A strawberry trifle was left to thaw at room temperature in the kitchen. This practice encourages the growth of food poisoning bacteria. I recommend you thaw food in covered containers in the refrigerator.	All staff are fully aware with thawing procedures and been met with. Procedures reiterated with staff.	KP			02/08/19
15	The cold water tap to the left hand sink in the food wash area was dripping. I recommend you carry out works to prevent the tap from dripping.	Maintenance request placed Job number **744886 – Completed**	GD			6/08/19
16	I recommend that you keep the boiling water method for probe calibration in your HACCP as an alternative in case there are any issues with the probe calibration keys.	New probes been purchased for each ward kitchen and main kitchen. HACCP to show both probe calibration methods.	KP			05/08/19

Report Title:	**WARD BASED CATERING, UNIVERSITY HOSPITAL OF WALES (UHW) FOOD HYGIENE INSPECTION – 13th August, 2019**						
Meeting:	**Health & Safety Committee.**				**Meeting Date:**	**08/10/19**	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	**Director of Planning**						
Report Author (Title):	**Operational Services Manager**						

SITUATION

An inspection of several ward kitchens at the University Hospital of Wales took place on 13th August, 2019, the outcome of which was confirmed in writing in a letter report dated 16th August 2019 from the Commercial Services Officer, Food and Port Health, Bridgend, Cardiff and Vale of Glamorgan Shared Regulatory Services.

In this report it was noted that the Ward Kitchens at UHW were given an overall score of **3 (Generally Satisfactory)** in the National Food Hygiene Rating Scheme.

REPORT

BACKGROUND

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

ASSESSMENT

On receipt of the letter report, an action plan was developed by the Operational Services Manager to address the issues raised and is attached as an appendix 1 to this report**.** This will be monitored within the service by the Operational Services Manager.

ASSURANCE is provided by:

The maintenance of the Food Hygiene Rating score of **3 (Generally Satisfactory).**

RECOMMENDATION

The Committee is asked to:

- **NOTE** the Food Hygiene Rating and the remedial actions taken following the receipt of the Commercial Services Officer (Food & Port Health) report.

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

Appendix 1

DRAFT

Action Plan from Food Safety Inspection on 13th August 2019 (Report dated 9th September 2019)

Schedule A – Legal Requirements

Food Hygiene and Safety Procedures Some non-compliance with statutory obligations and industry codes of recommended practice* that are not considered significant in terms of risk (but may become significant if not addressed). Standards are being maintained or improved.	**Response / Action**	**Time Scale**	**Update**
• During the inspection, plastic jugs and cups were being stacked while still wet on many of the wards. This will support microbiological growth. You must ensure all equipment is dried thoroughly before being stacked *Regulation (EC) No. 852/2004, Annex II, Chapter IX, Para 3*	Catering staff have being met with and issues discussed. Notices placed in each kitchen. Scheduled checks to be put in place to ensure compliance continues. Dedicated team lead by Band 5 team manager to undertake training with all Caterers	Immediate	Completed
• The blade of the heavy-duty can opener on C1 Ward was encrusted with food, which would cause contamination of the food in the next tin opened. This part of the can opener must be cleaned and sanitised regularly. It was also noted that the base was becoming rusty and required repainting. *Regulation (EC) No 852/2004 Annex II Chapter V Para 1(a)*	Staff have been met with and the importance of the cleanliness of utensils been discussed and potential severity of outcome explained to them. New tin opener has been installed. Scheduled checks to be put in place to ensure compliance continues. Dedicated team lead by Band 5 team manager is undertaking training sessions with all Caterers	Immediate	Completed Training Ongoing

• Bowls and scoops were being stored inside cereal and custard powder containers on a number of wards. This creates a risk of contamination. You must ensure that any scoops used for decanting are kept separate to food and washed and sanitised after use. *Regulation (EC) No 852/2004 Annex II Chapter IX para 3*	Staff have been met with and the importance of the cleanliness of utensils been discussed and potential severity of outcome explained to them. Notice has been placed on the wall instructing staff to clean utensils after every use and store in correct area. Scheduled checks to be put in place to ensure compliance continues. Dedicated team lead by Band 5 team manager is undertaking training sessions with all Caterers	Immediate	Completed Training Ongoing

Structural / Cleaning Issues Some non-compliance with statutory obligations and industry codes of recommended practice* that are not considered significant in terms of risk (but may become significant if not addressed). Standards are being maintained or improved. *(*Where a relevant code / industry guide has been published.)*	Response / Action	Time Scale	Update
• The ceiling mounted extractor fan in ward B2 was dusty, it must be thoroughly cleaned and maintained in a clean condition. *Regulation (EC) No 852/2004 Annex ll Chapter I Para 1*	Estates maintenance request has been placed.	Immediate	To be cleaned by 20/09/19
• There was food debris noted at floor/wall junctions (under the toaster area and sink) in ward A2. Thoroughly clean the floor and maintain in a clean condition. *Regulation (EC) No 852/2004 Annex ll Chapter I Para 1*	A cleaning regime has been implemented with a sign off list in each kitchen to ensure all items are cleaned on a daily basis. Notices placed in each kitchen. Supervisors to undertake daily inspections.	Immediate	Cleaning scheduled has been put in place
• The following pieces of kitchen equipment required cleaning: ➢ The shelf edge below the window in ward Cl ➢ A build-up of lime scale on the hot water urn taps on wards C3, A2 and B2 vascular; ➢ The equipment sink taps on wards B2 vascular and A2 ➢ The rinser tap joints in Children's ward. ➢ Under handle of the dishwasher in the sterile feeds kitchen. ➢ The seals to fridge A in ward A2. ➢ There was mould growth on the base of freezer C in ward A2.	A cleaning regime has been implemented with a sign off list in each kitchen to ensure all items are cleaned on a daily basis. Notices placed in each kitchen. Supervisors to undertake daily inspections. Chemical being sourced to remove Lime scale	Immediate	Cleaning scheduled has been put in place

➢ The D10 bottle on ward C3. ➢ The cord to the probe thermometer on ward C3. 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*	New D10 bottles ordered Staff have been met with and the importance of the cleanliness of utensils been discussed and potential severity of outcome explained to them.	Immediate Immediate	Completed Completed
• The following pieces of equipment were damaged and require repair or replacing; ➢ The handles to the microwave on ward A2 was peeling; ➢ There was a cracked white tray storing utensils in ward C3 ➢ There were scored and discoloured jugs on ward B2 colorectal; *Regulation (EC) No 852/2004 Annex II Chapter V Para 1(c)*	Microwave has been replaced. Tray destroyed and replaced. Ward manager been informed to purchase new jugs, current Jugs been thrown out and replaced by Facilities.	Immediate Immediate Immediate	Completed Completed Completed
• There was a loose filter on the base of the rational oven in ward C1. Re-affix the filter. *Regulation (EC) No 852/2004 Annex II Chapter I Para 1*	This has been replaced on the day	Immediate	Completed
• There was a hole to the wall behind the drinks making area in ward C3. Renew or repair the wall covering and leave in a sound easy to clean condition. *Regulation (EC) No 852/2004 Annex II Chapter II Para. 1(b)*	MR placed on system, estates undertaking maintenance inspections with facilities management on a weekly basis to ensure works are completed in a timely manner.	Immediate	Will be completed by 20/09/19

Confidence in Management / Control Procedures	Response / Action	Time Scale	Update
Satisfactory record of compliance. Access to relevant food safety advice source and/or guides to good practice or assurance scheme commensurate with type of business. Understanding of significant hazards and control measures in place. Has implemented satisfactory food safety management procedures or is making satisfactory progress towards documented food safety management procedures, commensurate with type of food business. Making satisfactory progress towards documented food safety management procedures commensurate with type of business. A score of 10 can be awarded for more than one intervention cycle if: • the previous non-compliances have been addressed but different non-compliances have arisen; and, • the overall risk has not increased.			
Audit of the current food safety policy document and monitoring records identified the following: • When reviewing your HACCP you must have regards to the Listeria Guidance issued for Healthcare settings. A copy of this guidance was emailed to Joanne Ellis	HACCP being amended but Listeria is already in section of HACCP	Sept 19	Completed
• Probe calibration checks on the fridges and freezers weren't always being carried out. Fridge A & B ward C1 not calibrated w/c 19.7.19. Freezer A & B ward C1 not calibrated w/c 26.7.19. Fridge A calibration check C3 for this current week not recorded.	Dedicated team lead by Band 5 team manager is undertaking training sessions with all Caterers	Immediate	
• Probe calibration checks of the freezers in the Children's Hospital 1Oth & 11th August were recorded at -14.6'C and -17.5'C but there were no corrective actions recorded; .	Dedicated team lead by Band 5 team manager is undertaking training sessions with all Caterers	Immediate	
• There were numerous occasions where freezer temperatures on ward C1, B7 and B2 were being recorded at warmer temperatures than your critical limit of -18'C but no corrective actions were being recorded.	Dedicated team lead by Band 5 team manager is undertaking training sessions with all Caterers	Immediate	

• There were gaps on the daily cleaning checklist on C1 (27/7), C3 (28/7 all items missed,30/7 walls missed)	A cleaning regime has been implemented with a sign off list in each kitchen to ensure all items are cleaned on a daily basis. Notices placed in each kitchen. Supervisors to undertake daily inspections.	Immediate	Completed
• Sandwiches on all wards other than in the Children Hospital previously had sandwiches delivered from the fridge directly to the patient. You have recently changed the practice so sandwiches are taken out in an insulated container with ice packs where an infra-red thermometer is used to check the temperature of packs on return and if these are below 5'C the items are placed back in the fridge for future use. As discussed you must either carry out destructive probe testing of food items being returned or use a clearly labelled dummy food (such as a bottle of water) to check the return temperatures. I would also make clear on the form if no Sandwiches are returned. Your HACCP must reflect this.	HACCP to be amended and water bottle will be placed in cooler box for checking on return to kitchen. All staff to be retrained in respect of completion of monitoring forms.	Immediate	Completed
• The freezer on ward A2 wasn't working and hasn't been for the past 2 weeks. The big blue ice pack for the insulated box was left inside the broken freezer. The insulated container checks had been completed up until the 12/8 but with no means of freezing the ice pack;	All broken Freezers are being replaced on the 11th September 2019. Estates undertaking maintenance inspections with facilities management on a weekly basis to ensure works are completed in a timely manner.	Immediate	Completed
• As discussed, I suggest you include a procedure for temporary loss of hot water within your HACCP document. As you have for fridge and freezer breakdowns	HACCP document to be updated and adjustment to be made relating to guidance that has been received from EHO regarding temporary loss of hot water.	Immediate	Completed
• Fridge A on ward B7 was on a defrost cycle on PM 20/7 and PM 24/7 so no temperatures were recorded. As discussed, if the fridges or freezers are on a defrost cycle then staff must re-check after a short time to ensure they are operating below your critical limit of 5"C or -18"C;	Review monitoring form to ensure it is clear to ALL staff to retake temperatures especially if on defrost cycle and in addition, ensure all corrective action is recorded. Dedicated team lead by Band 5 team	Immediate	Ongoing

	manager is undertaking training sessions with all Caterers		
• Your procedure for sanitising the needle probe in your current HACCP refers to cleaning the probe then using a paper towel and alcohol gel or boiling water. In practice staff are removing food debris then using the designated probe wipes to sanitise the needle probe.	HACCP document to be amended to show current amended practice	Immediate	Completed
• Staff must ensure they use the minus sign when recording freezer temperatures. Failure to use the minus sign indicates ambient temperatures are being recorded.	Dedicated team lead by Band 5 team manager is undertaking training sessions with all Caterers	Immediate	Ongoing
• A number of freezers had broken on the wards, consequently frozen foils were being stored in the fridge for a number of hours prior to cooking. The packaging on the foils state that they are not to be thawed.	All broken Freezers have been replaced on the 11th September 2019. All staff have been met with and informed that no foils should be thawed	Immediate	Completed
• There was staff food in the fridge on ward B2 which whilst labelled with a name there was no date to indicate when the food was placed in the fridge. All staff food stored in the same fridges as patient's food must be labelled with a name and date.	Lead nurses, Senior nurses and Ward managers to be sent e-mail regarding staff food in our fridges. Ward managers to be met with.	Immediate	Sept 30th
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*	Supervisors will be undertaking checks on a daily basis and signing off sheets. Dedicated team lead by Band 5 team manager is undertaking training with all Caterers and supervisors. Review if disciplinary action to be taken.	Immediate	Ongoing

Rentokil had visited the cardiac unit on a number of occasions recently following evidence of gnawing in the ceiling tiles. I was concerned that there didn't appear to be a robust system in place to ensure that any pest issues or works highlighted by Rentokil would be communicated to the relevant person in a timely manner, especially if any pest issues highlighted near kitchens would be picked up on.	The Pest control folder which is held in the admin office will be monitored on a daily basis by the admin team. Any action points will be referred to management or estates dept for follow up. All reports of pest infestation will be communicated to kitchen staff in that area. Concerns have been raised and discussed with Rentokil staff who will now highlight any issues with the management team on each visit.	Immediate	Completed

Schedule B – Recommendations and Advice

Recommendations	Response / Action	Time Scale	Update
These recommendations provide advice on good practice:- • I recommend that you keep the boiling water method for probe calibration in your HACCP as an alternative in case there are any issues with the probe calibration keys.	HACCP document has now been amended.	Immediate	Completed

• As discussed during the visit it is recommended that fly screens are provided to those external windows of the kitchen which are used for ventilation at times when high risk open food is handled. If fly screens are provided they should be easily removable for cleaning. It was noted that there was no fly screen in ward C3.	All kitchens now have fly screens in place.	Immediate	Completed
• The bulbs to the Eazyzap EFK in ward B2 colorectal appeared very dim. I recommend these bulbs are replaced.	Eazyzap contacted by estates and they confirmed that the colour of the bulb was correct.	Immediate	Completed

HEALTH AND SAFETY POLICY	
Name of Meeting : Health and safety Committee	**Date of Meeting:** 8/10/2019

Executive Lead : Director of Workforce and Organisational Development
Author : Head of Health & Safety– 02920 743751
Caring for People, Keeping People Well: Health and Safety is fundamental to the core objective of the UHB in relation its employees, patients and visitors by providing a safe and secure environment. This policy underpins the Health Board Sustainability and Values Elements of the Health Board Strategy through the delivery of effective Health and Safety management.
Financial impact : The report has no direct financial consequences
Quality, Safety, Patient Experience impact: The protection of patients, staff and visitors will enable the continuation of our core activity, that is the treatment and care of our patients to be conducted in a safe environment. Additionally, the protection of assets, either corporate or personal will enable resources to be focused into patient care.
Health and Care Standard Number 2.1
CRAF Reference Number: 8.1
Equality and Health Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Committee is asked to:

RATIFY the policy for submission to the Health Board, who are the designated body to **APPROVE**

SITUATION

The previous Health and Safety Policy is due for review. This policy reflects changes within the organisation.

As the overarching policy for health and safety it is required to be approved by the Health Board.

The purpose of this paper is to seek approval of the Health and Safety Committee for submission on to the Health Board.

BACKGROUND

The Health Board has a statutory obligation under the Health and Safety at Work Act 1974 to prepare and review its Health and Safety Policy. The document has been reviewed to reflect the current management arrangements and diversity of the Organisation.

The Health and safety at work act 1974 section 2.3, sets out the requirement of the policy that must include a policy statement, organisation and arrangements for carrying out the policy. For this reason the document is more detailed than the current general policy requirements.

The Health and Safety Policy is an overarching document that enables the Organisation to implement all health and safety responsibilities. It covers employers, staff, establishment, patients and members of the public and is therefore of the broadest scope.

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

The Cardiff and Vale University Local Health Board's health and safety objective is to minimise the number of occupational accidents and incidents of ill health and ultimately to achieve an accident-free workplace.

The Policy aims are to:

- Outline the management of health and safety arrangements within the Health Board through the statement of intent, the organisation and structures;

- To minimise the health and safety risks within the Health Board to all staff, patients and others;

- Recognise the obligation imposed under the Health and Safety at Work Act 1974, Section 2(3), to prepare an appropriate policy.

ASSESSMENT

Minor amendments made relate mainly to:

- Changes in management structure mainly the Chief Executive creating the Director of Workforce and Organisational Development as Executive Lead.
- Amendments to reflect changes in antiviolence guidance.
- Revision to reflect closure of Whitchurch and West Wing Hospitals and Iorwerth Jones Centre.

Reference Number: UHB 02 **Version Number: 5**	**Date of Next Review:** **Previous Trust/LHB Reference Number:** *Any reference number this document has been previously known as*

HEALTH AND SAFETY POLICY

Policy Statement

On behalf of Cardiff and Vale University Local Health Board, the Chief Executive is committed to the health, safety and welfare of all employees and of those who may be affected by work related activities.

The Health Board believes that an excellent organisation is by definition, a safe and secure organisation. It therefore follows that caring for all personnel and minimising risks is inseparable from all other Health Board objectives. It recognises that it is essential that there is a safe patient care environment and that all staff are competent, healthy and safe at work. All employees will be provided with equipment, information, training and supervision as is necessary to implement the Policy and achieve the stated objective.

Policy Commitment

The Chief Executive regards health and safety management to be fundamental to the delivery of its mission of caring for people and keeping people well. It is also essential to delivering our strategy and sustainability of avoiding waste, harm and variation, empowering people and delivering outcomes that matter to them.

Supporting Procedures and Written Control Documents

The Health and Safety Committee maintains a schedule of all supporting policies and documents. These include:-

- Personal Safety Policy
- Minimal Manual Handling Policy
- Fire Safety Policy
- Risk Management Policy and Strategic Framework
- Incident, Hazard and Near Miss Reporting Policy
- Risk Assessment and Risk Register Procedure

Other supporting documents are:

<u>References</u>

Health and Safety at Work etc Act 1974

HSC Management of Health and Safety at Work Regulations 1999 Approved Code of Practice L21

Safety Representatives & Safety Committees Regulations 1977

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995

HSE (1994), *Management of Health and Safety in the Health Service*, Health Service

Advisory Committee, Health and Safety Executive. HSE – Managing Contractors –A Guide for Employers HSG 159 HSE – Successful Management of Health and Safety HSG 65 Cardiff and Vale - Aims and Value	
Scope This policy applies to all of our staff in all locations including those with honorary contracts	
Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be 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 Workforce and Organisational Development
Disclaimer **If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.**	

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	June 2010	December 2010	Updated and reviewed in line with the UHB.
2	July 2012	September 2012	Updated and reviewed in line with the UHB.
3	July 2014	October 2014	Updated and reviewed in line with the UHB
4	October 2016	October 2016	Updated and reviewed in line with the UHB
5		September 2019	

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Health and Safety Policy of: -

Cardiff and Vale University Health Board
Woodland House
Maesycoed Road
Cardiff
CF14 4HH

Comprising: -

- Barry Hospital
- Cardiff Royal Infirmary
- Childrens Hospital for Wales
- Community Premises/Health Centres and Clinics
- Rookwood Hospital
- St Davids Hospital
- University Dental Hospital
- University Hospital Llandough
- University Hospital of Wales

1.0 INTRODUCTION

The Health and Safety at Work etc Act 1974 provides the legislative framework to promote, stimulate and encourage high standards of health and safety at work. It places a duty upon the employer to safeguard so far as is reasonably practicable, the health, safety and welfare of all employees, including the provision and maintenance of safe plant and systems of work. In addition, a number of other related laws have relevance within the Health Board. These are also designed to ensure that work is conducted in as safe and healthy manner and environment as possible.

It therefore, makes a comprehensive and integrated system of law to deal with the health and safety of virtually all people at work, whilst protecting the public where they may be affected by the activities of people at work.

The Act requires all employers to prepare a written statement of their safety policy and to bring that policy to the attention of all employees. As legislation is continuously under review, so too must the Health and Safety Policy be continually reviewed. It should be active not static and relies on the co-operation of each and every member of the organisation, for which it is intended.

Compliance with the Health and Safety at Work Act is a legal requirement. As such, an offence, committed under the Act would constitute a criminal offence and could lead to prosecution, resulting in a fine and/or a term of imprisonment**.**

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.

Employees have a duty under the Act, to take reasonable care to avoid injury to themselves and others and to co-operate with employers and others in meeting statutory requirements. The Act also requires employees not to interfere with or misuse any assistance provided to protect their health, safety and welfare in compliance with the Act.

In addition to its legal obligations the Health Board has a moral and economic reason for managing health and safety. In short good health and safety is good management.

Under section 2.3 of the Health and Safety at Work Act, the Health Board has a duty to prepare and review a written statement of a general health and safety policy; this should include the organisation and arrangements, as well as written statement of intent.

2.0 STATEMENT OF INTENT

On behalf of Cardiff and Vale University Local Health Board, the Chief Executive is committed to the health, safety and welfare of all employees and of those who may be affected by work related activities.

The Health Board believes that an excellent organisation is by definition, a safe and secure organisation. It therefore follows that caring for all personnel and minimising risks is inseparable from all other Health Board objectives. It recognises that it is essential that there is a safe patient care environment and that all staff are competent, healthy and safe at work. All employees will be provided with equipment, information, training and supervision as is necessary to implement the Policy and achieve the stated objective.

The Chief Executive regards health and safety management to be fundamental to the delivery of its mission of caring for people and keeping people well. It is also essential to delivering our strategy and sustainability of avoiding waste, harm and variation, empowering people and delivering outcomes that matter to them.

The role, therefore, accepts ultimate responsibility for health and safety issues. The management of health and safety for the Health Board has been delegated to the respective Executive Directors and Service and Clinical Board Managers; however, to ensure that all hospitals, properties and departments of the Health Board comply, many of the duties arising from the responsibility have been further delegated to line managers.

To further maintain and promote the implementation of the Policy and enable employees to function efficiently with regard to health and safety; information, instruction, training and supervision will be provided in accordance with identified needs. It is recognised that health and safety is a key responsibility for Managers and is included in all job descriptions. Effective health and safety management is based on a good understanding of the risks and how to control them. This is achieved through good quality risk management and a programme of training based on a Training Needs Analysis.

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

It is accepted that staff are our most important asset and the preservation of human and physical resources is an important means of minimising costs. Therefore, total safety is the ongoing integration of safety into all activities with the objective of attaining leadership in health care provision in safety performance. Since we are committed to excellence and the provision of quality health care, it follows that minimising risk to staff, patients, students

and other people visiting the site, plant and property, is fundamental to healthcare.

The Cardiff and Vale University Local Health Board's Health and Safety objective is to minimise the number of occupational accidents and incidents of ill health and ultimately to achieve an accident-free workplace.

SIGNED:

Chief Executive

DATE: _____

3.0 Aims

The Policy aims are to:

- Outline the management of health and safety arrangements within the Health Board through the statement of intent, the organisation and structures.

- To minimise the Health and Safety risks within the Health Board to all staff, patients and others.

- Recognise the obligation imposed under the Health and Safety at Work Act 1974, Section 2(3), to prepare an appropriate policy.

4.0 Objectives

- To secure the health, safety and welfare of people at work.

- To protect patients and people other than those at work against risks to their health and safety arising out of work activities.

- To minimise the number of occupational accidents and incidents of ill health and ultimately to achieve an accident-free workplace.

- To establish a culture of co-operation, communication, competency and control for health and safety.

5.0. ORGANISATION FOR HEALTH AND SAFETY

5.1. Health Board Profile

The management structure of the Health Board places ultimate managerial responsibilities on its Chief Executive and the Board.

The Board has established an Independent Member Champion and has established a Health and Safety Committee which has policy making powers on its behalf.

The Chief Executive has nominated the Executive Director of Workforce and Organisational Development as the Senior Responsible Officer for Health and Safety, and is responsible throughout the Health Board for the implementation of the Health Board's Health and Safety Policy and for presenting Health and Safety issues to the Health Board.

Operational management for Health and Safety within the Health Board has been devolved to the Clinical Boards and Executive Directorates; they are

supported in the management of health and safety by the Directorates. The duty of implementing these requirements has, however, been delegated to:-

- Each Directorate Manager/Head of Department or equivalent level of manager, who is responsible within their own area.

The Health and Safety Committee which, in order to ensure good and effective communication within the Health Board includes board members, management, safety specialists and trade union/staff representatives. The Committee is chaired by an Independent Member.

The Health Board has duties as controller of premises and provides care at a number of sites including Barry Hospital, Cardiff Royal Infirmary West Wing, and Childrens Hospital for Wales, University Hospital Llandough, Rookwood Hospital, St Davids Hospital, University Dental Hospital, University Hospital of Wales and Community Premises. In addition, the Health Board has administration offices and support facilities at a number of other locations. The Health Board also shares its sites with Cardiff University and other external organisations.

Each site shall have arrangements to ensure that those health, safety and welfare risks relating to the site in general are appropriately managed, with an identified senior person to whom concerns can be raised.

5.2. Responsibilities

5.2.1. Chairman

The Chairman has responsibility for:

- Identifying an Independent Member to champion Health and Safety within the Health Board.

- Identifying an Independent Member to champion Violence and Aggression within the Health Board.

5.2.2. Independent Member

The Independent Member will make arrangements to:

- chair the Health and Safety Committee.

- champion health and safety at Board level.

- ensure effective assurance and monitoring arrangements are in place.

5.2.3. **Chief Executive**

The Chief Executive has overall responsibility for making sure that arrangements are in place for:

- ensuring that there are Executive leads appointed for health and safety, fire, violence and aggression and wellbeing.
- ensuring that the Health Board's Health and Safety Policy is implemented.
- ensuring that the Health Board's Health and Safety Policy is reviewed annually.
- there are sufficient resources for the implementation of this Policy.
- ensuring that the Board is informed as required on health and safety matters affecting employees and/or the public.
- supporting quality initiatives aimed at continuous improvement.

The Chief Executive will be supported in progressing these responsibilities by a Senior Management Team.

5.2.4 **Lead Executive Director for Health and Safety.**

The Executive Director of Workforce and Organisational Development has the responsibility at Executive Board level for the managing of health and safety and is responsible for ensuring;

- regular update reports are presented to the Board.
- supporting training and development of staff – safe staff are our most important asset.
- monitoring health and safety performance against agreed targets.
- including within the Annual Report a section on the Health Board's Health and Safety plans and performance.
- ensuring that health and safety is adequately resourced within the Health Board.
- ensuring that health and safety information is effectively communicated throughout the organisation.

- ensuring appropriate financial provision to deliver health and safety responsibilities.

- that this Policy is appropriately disseminated throughout the UHB.

- the approach to health and safety is both systematic and appropriate.

- there are sufficient competent advisers and trainers to support the Policy.

- ensuring that the Health and Safety Department is appropriately resourced.

- ensuring that fire safety is appropriately managed.

- submitting regular reports on fire to the Health and Safety Committee.

- ensuring that there are appropriate arrangements in place to respond to major incidents and emergencies.

- ensuring that there are appropriate business continuity arrangements in place.

- Ensuring that arrangements are in place to implement and monitor the Asbestos Management Plan and other estates based statutory health and safety responsibilities.

- Responsible lead for violence and aggression.

The Executive Director of Workforce and Organisational Development also has other responsibilities under section 5.2.7 of this Policy.

5.2.5 **Director of Nursing**

The Director of Nursing will be responsible for:

- ensuring that the health and safety aspects of patient safety are integrated throughout the Health Board.

- providing advice with regard to patient safety.

5.2.6 **Chief Operating Officer**

The Chief Operating Officer will make arrangements to:

- ensure appropriate arrangements for health and safety are in place within each of the Clinical Boards.

- ensure that they provide appropriate support to Clinical Board Directors where matters arise that require their intervention.

- ensure they advise the Chief Executive of any issues which require his attention which cannot be resolved or is of an organisation wide significance.

- monitor health and safety performance against agreed targets within the Clinical Boards.

- ensure that there are nominated leads at each site so as to provide a focus for each site outside of the management accountability structure that will provide staff with an identified senior person to whom concerns can be raised.

- establish arrangements for each site to support the site nominated lead function.

5.2.7 **Director of Workforce and Organisational Development**

The Director of Workforce and Organisational Development will be responsible for:

- ensuring an effective Mandatory and Induction Training Health and Safety programme is appropriately monitored and recorded.

- ensuring that the Occupational Health Stress and Mental Health Wellbeing (identification and prevention) are appropriately resourced.

- submitting regular reports on Stress and Mental Health Wellbeing to the Health and Safety Committee.

5.2.9 **Clinical/Service Boards**

Clinical/Service Board Directors and Directors of Corporate Functions have overall responsibility for making sure that arrangements are in place for:

- establishing a Clinical/Service Board Health and Safety Group which is chaired by the Head of Operations and Delivery Senior Nurse, with representatives from all relevant Directorates/Departments and Staff Health and Safety Representatives. Executive Directors should establish similar arrangements, however due to the level and similarity of risks involved they may by agreement form a Joint Group, in which

case each Clinical Board will ensure suitable representation and an appropriate chair.

- the active involvement of the Health and Safety Adviser in supporting the Management Team.

- preparing and implementing the organisational structure and allocating responsibility for health and safety, and that the identified personnel (e.g. Clinical Board Manager) are aware of their responsibilities.

- the monitoring of health and safety performance within their Clinical Boards and Directorates.

- ensuring that risk assessments have been undertaken in accordance with the Health Board's Risk Assessment Procedure or more specific procedure (e.g. manual handling).

- ensuring that health and safety risk assessments where appropriate have been passed to the relevant Health and Safety Adviser and been entered on their Risk Register.

- preparation and submission of an annual schedule of workplace inspections to the Operational Health and Safety Group, ensuring all areas are inspected annually.
-
- developing a health and safety action plan and performance indicators which will be regularly monitored, a copy of the plan and performance indicators will be submitted to the Health and Safety Operational Group.

- for notifying the Chief Operating Officer and if necessary the Chief Executive, where matters arise outside the Clinical Board Director's remit or control.

5.2.10 **Directorates/Departments**

Directorate Managers and/or Heads of Department have overall responsibility for making sure that arrangements are in place:

- to have access to specialist advice by liaising with the relevant Health and Safety or Specialist Adviser.

- to ensure individuals are aware of their responsibilities for health and safety.

- for the development and effective implementation of the Health Board and Clinical Board Health and Safety Policy within their Directorate/Department.

- identifying hazards and carrying out risk assessments in line with current legislation and the Health Board's Risk Assessment Procedure.

- preparing and implementing the organisational structure and allocating responsibility for health and safety within their Directorate/Department to specific people, and that the identified personnel within the structure are aware of their responsibility and are competent to perform these functions.

- to consult and involve staff and safety representatives effectively and in a timely manner.

- for staff to have sufficient information about the risks they face and the preventive measures that are in place to minimise those risks.

- for the right level of expertise and people to be properly trained on recruitment and when exposed to new or increased risks, changes in responsibility, the environment or the introduction or change of technology. Training must be repeated periodically where appropriate.

- to prepare and implement as necessary effective safe systems of work.

- to action Medical Device Alerts and other safety related alerts as relevant.

- to monitor health and safety performance.

- to ensure that risk assessments are carried out for all activities within the Directorate/Department.

- to ensure that there is adequate resource to co-ordinate and monitor health and safety**.**

- to ensure that incidents are appropriately investigated and incident forms are readily available.

- to ensure that where matters arise outside the Directorate Manager/Head of Department's remit or control, this should be notified to the Clinical Board Manager and the Health and Safety Adviser.

- to facilitate the provision of such information, instruction, training and supervision as is necessary to ensure, so far as is reasonably

practicable, the health, safety and welfare at work of staff within the Directorate/Department.

- to organise the distribution of Health Board instructions and guidance to staff within the Directorate/Department.

- to assemble information on health and safety initiatives and issues including maintaining a Risk Profile and Register ensuring that significant health and safety risks are included in this process within the Directorate/Department.

5.2.11 **Head of Health and Safety**

The Head of Health and Safety and will be responsible for:

- ensuring specialist advice in relation to Health and Safety, Manual Handling, Personal Safety, Environmental and Biological hazards is available. To enhance communication each Clinical Board has been allocated a designated competent Health and Safety Adviser.

- assisting the management of health and safety through the preparation of relevant policies and procedures.

- monitoring of health and safety performance.

- co-ordinating and undertaking a full range of internally developed and nationally accredited training programmes to meet its mandatory requirements.

- facilitating the implementation of the Incident, Hazard and Near Miss Reporting Policy.

- formulating and developing policies and procedures that identify key health and safety objectives, provides direction as to how these objectives will be met and review progress towards their achievement.

- planning, measuring, reviewing and auditing health and safety activities so that legal requirements are satisfied and all risks are minimised.

- ensuring that statistical information is available on health and safety performance throughout the Health Board and interpret such information in order to evolve action plans in co-ordination with Executive Directors and Clinical/Service Boards to improve or maintain standards.

- preparing an Annual Report for submission to the Board on progress and standards being achieved.

- ensuring a systematic approach to the identification of risks and appropriate control measures.

5.2.12 **Individual Employees**

- All employees have a statutory duty of care, both for their own personal safety and that of others who may be affected by their acts or omissions.

- All employees (for the purpose of this Policy this includes volunteers, bank, agency and locum staff) are required to co-operate with their Manager/Supervisor to enable the Health Board to meet its own legal duties.

- All employees are expected, in the course of their employment, to report to their Manager/Supervisor any hazardous situations or defective equipment and to use the incident forms provided as necessary.

5.3 **Contractor Control**

Contractors include those who deliver services on behalf of the Health Board and therefore include Primary Providers such as GPs, Dentists etc. A Contractor can be defined as anyone who carries out work, on behalf of the Health Board but excluding an employee. This is not limited to maintenance type work, but includes those services contracted out by the Health Board and the Procurement Department where persons may be put at risk, or put Health Board staff, patients or visitors at risk by their activities, such contractors are subject to the same controls where relevant. Appropriate arrangements are prepared and implemented to manage these risks, and all contractors are included in health and safety procedures and communication between all parties is promoted. To support this, a Contractor Control Policy has been implemented.

5.4 **Health and Safety Strategy**

The Health and Safety Strategy will be consistent, proportionate and targeted and shall aim:

- to encourage strong leadership in championing importance of a common sense approach that will motivate focus on core aims to distinguish between real and trivial issues.

- to increase competence and reinforce promotion of worker involvement.

- to undertake a base line assessment and set realistic targets and priorities on key health issues.

- to investigate accidents and ill health and take action to prevent harm.

5.5 **Safe Systems of Work**

- Each Directorate/Department is required to have health and safety arrangements and procedures specific to that area.

- The Directorate/Department Manager is responsible for ensuring that Policies/Safe Systems of Work/Standard Operating Procedures are operational for all procedures undertaken within the Department. These must be strictly observed.

- All Policies/Safe Systems of Work must be monitored and regularly reviewed for their effectiveness with a maximum period of 3 years.

- Following the risk assessments, the Directorate Managers/Heads of Department are responsible for devising, documenting and implementing any safe systems of work/safe operating procedures necessary in areas under their control, to eliminate hazards or minimise any risk to the health and safety of employers (and others).

5.6. **Incident Reporting and Investigation**

To ensure that there is a culture in which incidents are investigated appropriately and to make certain that lessons can be learnt from adverse incidents and near misses a specific policy has been developed and approved, and is accessible on the Health Board Intranet site entitled “Incident, Hazard and Near Miss Reporting Policy”.

It is not possible to identify accurately the full extent of the Health Board's risk issues, without the full notification, recording, analysis and feedback of information, in relation to all adverse incidents. The information produced by effective reporting systems will enable the Health Board to correct specific faults and to identify, track and monitor trends of incidents and accidents. The term 'adverse incident' must be interpreted in its widest context to include concerns, accidents and near misses, relating to patients, staff and visitors.

Effective monitoring of these events depends on the willingness of staff to report organisational process failures as well as their own errors and thus every effort must be made to avoid cover ups of adverse

incidents, mistakes or near misses. The overall approach within the Health Board will be one of help and support to each other, rather than recrimination and blame and to this end staff should be encouraged to use incident forms when appropriate. Every adverse incident that is reported presents a chance to learn in order to improve the services in the future. The Health Board is committed to this approach.

5.7. Health and Safety Training

The identification of health and safety training needs is the responsibility of the Directorate Manager/Head of Department. The Health Board's Health, Safety and Environment Department will be available to assist managers in identifying training needs in all aspects of health and safety.

- All levels of staff, including senior managers, junior doctors to consultants and new entrants MUST be included in the training programme.

- Risk situations specific to the Directorate/Department should be assessed for training requirements.

- The frequency of health and safety related training will be agreed by the Health and Safety Committee.

- Health and safety and fire training is mandatory for ALL staff.

- Training in accordance with identified needs must be allocated to appropriately trained staff.

- A condition of employment for all employees is that they are required to complete the on-line E-Learning Mandatory/Corporate Induction training programme on appointment.

- In-house training courses available to staff include: manual handling, personal safety, working safely, managing safety, directing safely, 1st Aid and specialised training.

- Records of training should be kept by both the Directorate and Training Department.

- It is the Health Board’s intention to actively encourage and promote all aspects of health & safety training throughout its employees.

5.8 **Discipline**

Disciplinary action under the terms of the Health Board's Disciplinary Policy will be taken against any employee, regardless of status, who shows wilful disregard for the safe working practices. No disciplinary action will be taken against an employee until the case has been appropriately investigation. Where the total disregard for Safe Working Practices seriously affects the health and safety of themselves or that of any other employees, the employee may be summarily dismissed. Also the employer and their employees may be subject to prosecution under the Health and Safety at Work Act etc 1974 and Corporate Manslaughter legislation.

5.9 **Emergency Situations**

Due to the wide variety of work undertaken within the Health Board, it is not possible to produce valid and detailed instructions to cover every emergency situation which may arise. Therefore, each Directorate/Department needs to ensure that it has adequate plans in place to deal with foreseeable emergencies, incidents and failures in systems.

The Major Incident Plan supports mechanisms for perceived significant health and safety events such as fire which is supported by the Civil Contingency Department.

6.0 **Audit Monitoring Arrangements for Health and Safety**

Senior Managers, supported by staff health and safety representatives, will carry out monitoring of this policy at specified intervals following implementation.

6.1 A number of mechanisms will exist to measure the success of the policy. These will include:

6.1.1 **Internal Monitoring**

Internal monitoring of health and safety within the Health Board is the responsibility of the Clinical Boards who through their Health and Safety Adviser will carry out an Annual Audit. The findings will be sent to the Chair of the Clinical Board Health and Safety Group and discussed at the Group. The results will then be collated by the Health, Safety and Environment Department as a Health Board wide audit and discussed at the Operational Health and Safety Group.

Internal monitoring is achieved by the following means:

- ensuring that the Directorate/Department has a Safety Group.

- ensuring completion of all incidents/accidents on the appropriate Incident Report Form (HS/IDO/07***)*** is passed to the line manager who should then send it within 48 hours to the Health, Safety and Environment Department at UHW.

- ensuring that all incidents/accidents are investigated and actions are fed back to the reporting individual.

- undertaking regular checks of accident statistics with particular note of type and location of accidents.

- undertaking regular checks of sickness and absence statistics, to identify those absences, that are as a result of work related injuries/ill health.

- compiling records and statistics of staff health and safety training.
- using a checklist for inspections to identify positive and negative findings.
- checking performance against policies, procedures, and safe systems of work to ensure that safe working conditions and practices exist.

- undertaking 'spot' health and safety checks, these can be arranged in partnership with the staff representative.

- appropriate involvement of Safety Representatives in line with National Codes of Practice.

- undertaking an annual review of health and safety.

- Preparing an action plan of identified problems with proposed solutions, target date for dealing with problems and estimated costs, which should be submitted to the Directorate Manager/Head of Department, Clinical Board Manager and Director.

Health and Safety Representatives have a function which includes monitoring health and safety in the workplace.

Employees also have a duty to monitor health and safety and to ensure that unsafe conditions and practices are brought to the attention of Representatives and Managers. Problems emanating from the audit must be referred to the appropriate Manager for actioning. If the Manager is unable to take the appropriate action for financial or any other reason it should be

referred to the Clinical Board Director who will ensure the Executive Lead and Chief Executive is aware of any issues which cannot be resolved.

6.1.2 **Health and Safety External Monitoring**

External monitoring of Health and Safety within National Health Service premises is vested in the Health and Safety Executive, Government Buildings, Ty Glas Road, Llanishen, Cardiff.

Health and Safety Inspectors have the right of entry to property or premises at any time and are empowered to obtain information and take possession of any article or substance. However in practice they will normally inform the Health, Safety and Environment Department who will ensure the visit is communicated and co-ordinated with the appropriate staff.

The Health Board will look to external agencies to monitor performance as appropriate.

6.1.3 **External Monitoring**

Aspects of health and safety will be monitored by other external agencies. These Include;

- Environmental Health Department
- Fire and Rescue Authority

7. RESOURCES

7.1 With respect of resource implications identified within this policy, the policy reflects current arrangements and as such identifies no additional resource need.

7.2 In respect of resources, the Health Board will identify designated budgets for health and safety across the organisation. If any additional resources are required, this will be considered as part of the risk management and profiling arrangements within the Health Board.

7.3 Any additional cost needs identified as a result of new or specific policy needs will be brought to the Health Board for justification as separate items.

8. TRAINING

8.1 The Health Board's Health and Safety Policy and enactment arrangement will be brought to the attention of all new staff at local induction.

8.2 Additionally training shall be given on the requirements of the policy to all staff on intervals not exceeding 3years during their employment using the following mechanisms:

- Mandatory Training Programme
- Mandatory Training Evaluation Form
- Mandatory Training E Learning

9. COMMUNICATIONS AND IMPLEMENTATION

9.1 A copy of the Health Board Health and Safety Policy and related publications, are held at the Health, Safety and Environment Department, Denbigh House and the Health and Safety Offices at Llandough.

9.2 A copy of the Health Board Health and Safety Policy is also available on the Health Board's Intranet site. For those staff without access to the intranet, it will be the responsibility of the local manager to post a hard copy of the Policy in a prominent location.

A register of all current Health Board Health and Safety Policies and Procedures will be maintained by the Health, Safety and Environment Department, and will ensure that all Policies and Procedures are maintained on the Health Board's Intranet.

9.3 Local Procedures and Protocols will be approved at the relevant Clinical Board Health and Safety Group, and a controlled copy of which will be submitted to the Health, Safety and Environment Department.

9.4 All employees should assume responsibility to read and understand the relevant sections.

9.5 The policy statement will be included in the Staff Handbook.

10. EQUALITY & DIVERSITY STATEMENT

Cardiff and Vale University Local Health Board is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate, harass or victimise individuals or groups. These principles run throughout our work and are reflected in our core values, our staff employment policies, our service standards and our Strategic Equality Plan & Equality Objectives. The responsibility for implementing the scheme falls to all employees and UHB Board members, volunteers, agents or contractors delivering services or undertaking work on behalf of the UHB.

We have undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. We wanted to know of any possible or actual impact that this policy may have on groups in respect of gender, maternity and pregnancy, carer status, marriage or civil partnership issues, race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment found that there was no impact to the equality groups mentioned.

Arrangements

11. Committee's and Sub Groups

The Health Board has established a Health and Safety Committee as a Committee of its Board, Chaired by an appointed Independent Member.

The Sub Groups reporting to the Health and Safety Committee are:-

- Operational Health and Safety Group, Chaired by the Executive Lead.
- Anti-Violence Group (Personal Safety Strategy Group) Chaired by an appointed Senior Manager
- Fire Safety Group, Chaired by the Executive Lead for Fire with the Director of Capital Estates and Facilities as Deputy, under the fire policy.
- The Water Safety Group, Chaired by a Senior Manager.
- Each Clinical/Service board has established a local health and safety group, which reports to the Operational Health and Safety Group.

12. REVIEWING THE POLICY

The Policy will be reviewed within two years of implementation or as the Health Board changes and/or when legislation, codes of practice and official guidance dictate, by the Head of Health and Safety in collaboration with the Chief Executive.

Review of the Health Board Health and Safety Policy will be taken to the Health and Safety Committee for approval and will be submitted to the Health Board for ratification in line with Health Board procedures.

CONTROL OF CONTRACTORS POLICY	
Name of Meeting : Health and Safety Committee	**Date of Meeting:** 8/10/2019

Executive Lead : Director of Planning
Author : Health and Safety and Asbestos Manager
Caring for People, Keeping People Well: Health and Safety is fundamental to the core objective of the UHB in relation its employees, patients and visitors by providing a safe and secure environment. This policy underpins the Health Board Sustainability and Values Elements of the Health Board Strategy through the delivery of effective Health and Safety management.
Financial impact : The report has no direct financial consequences
Quality, Safety, Patient Experience impact: The protection of patients, staff and visitors will enable the continuation of our core activity, that is the treatment and care of our patients to be conducted in a safe environment. Additionally, the protection of assets, either corporate or personal will enable resources to be focused into patient care.
Health and Care Standard Number 2.1
CRAF Reference Number: 8.1
Equality and Health Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Committee is asked to:

- **APPROVE** the policy
- **APPROVE** the full publication of the Contractor Control Policy in accordance with the UHB Publication Scheme

SITUATION

The Health Board has a duty under the Health and Safety at Work etc. Act 1974 (section 2.3) and regulation 12 of the management of health and safety at work regulations 1999 to ensure the Health, Safety and Welfare of those not in their employment but effected by their undertakings. This policy is a review of the existing Control of Contractors Policy with some minor amendments that better reflect the current management of contractors. The previous review of this Policy was in July 2016

BACKGROUND

Cardiff and Vale University Health Board (UHB) is committed to ensuring that the health, safety and welfare of employees, patients and visitors and any other person who may be affected by their undertaking is not compromised by contractor's activities. Contractors are present on many UHB sites daily

carrying out a variety of activities, by careful management and control any disruption and risk to others can be minimized to ensure the smooth running of the core business is not compromised.
This policy aims to provide managers and supervisors with responsibility for contractors the systems to safely manage contracts from inception through to completion of the contract work.

The Policy aims are to:

- To control contractor activities at all UHB sites
- To reduce the likelihood of disruption to the core business as result of contractor work
- To reduce the risk from contractor activities for staff, patients and visitors
- To manage contractors throughout the contract period
- To ensure the health board complies with section 3 of the Health and Safety at Work etc. Act 1974 and associated regulations made under the Act

ASSESSMENT

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

- The document was added to the Policy Consultation pages on the intranet between 08 of August 2019 and the 09 of September 2019.
- The documents was shared with the Operational Health and Safety Group
- Comments were invited via individual e-mails from the Operational Health and Safety Group

Where appropriate comments received have been incorporated within this document

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

Reference Number: UHB 163 **Version Number:** 3	**Date of Next Review:** 19/07/2022 **Previous Trust/LHB Reference Number:**

Control of Contractors Policy

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will undertake to plan, monitor and control site contract work to minimise risks to all personnel on the premises.

Policy Commitment

Cardiff & Vale UHB believes that an excellent organisation is, by definition, a safe and secure organisation. It follows therefore that minimising risk are inseparable from all other UHB objectives. In keeping with this principle, the UHB will undertake to plan, monitor and control site contract work to minimise risks to all personnel on the premises

Supporting Procedures and Written Control Documents

- Health and Safety Policy
- Asbestos Management Policy

Other supporting documents are:

- Asbestos Management plan
- Capital contract vetting financial control procedure

Contractors General Code of Safe practice *and associated operational procedures for Capital planning & estates*

Scope

This policy applies to all of our staff in all locations including those with honorary contracts The majority of contractors are employed directly by the Capital planning and Estates department which follow local contractor control procedures. This policy also applies to works contracted by other Health Board departments or other parties who may bring contractors on to UHB sites e.g. Cardiff University, Public health Wales etc.

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has been completed and this found there to be no impact
Health Impact Assessment	A Health Impact Assessment (HIA) is not required for this Policy.
Policy Approved by	Health and safety Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Operational Health and Safety Group
Accountable Executive or Clinical Board Director	Director of Planning

Document title: Control of contractors policy	3 of	Approval date	dd mm yyyy
Reference number:		Next review date.	dd mm yyyy
Version Number:	3	Date of publication.	dd mm yyyy
Approved by:			

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
2	19/07/2016	23/08/2016	Organisational changes
3			Job registration forms required for all high risk contractor activities as defined in appendix 1 (previous appendices had only stipulated this requirement for Capital planning, facilities and estates)
3			Inclusion of ATP form for fire risk where the fabric of the building is likely to be breached during construction work

Contents

1. Introduction

As a corporate body, the Cardiff and Vale University Health Board (UHB) is responsible for the effective management and control of contractors employed to work on sites owned or used by the UHB.

The UHB has specific duties under the Health and Safety at Work Act 1974 and The Construction (Design & Management) Regulations 2015 and other related regulations on all sites where contracted work is carried out to ensure that all relevant legislation is adhered to. The Contractors general Code of Safe practice appendix 7) sets out the framework for these duties on all parties.

The UHB also has a duty where construction or maintenance falls within the scope of the Construction (Design and Management) Regulations 2015 to ensure, where applicable, notification of the work to be undertaken (form F10) is sent to the enforcing authority (HSE). The Capital Planning and Estates department directly employ the majority of contractors and as such, have developed local procedures to comply with relevant legislation. This policy is to ensure other Clinical boards in the UHB or other parties that may bring contractors onto UHB sites also comply with legislative and UHB requirements.

2. Policy statement

Cardiff & Vale UHB believes that an excellent organisation is, by definition, a safe and secure organisation. It follows therefore that minimising risk are inseparable from all other UHB objectives. In keeping with this principle, the UHB will undertake to plan, monitor and control site contract work to minimise risks to all personnel on the premises.

3. Scope

The majority of contractors are employed directly by the Capital planning and Estates department which follow local contractor control procedures. This policy also applies to works contracted by other Health Board departments or other parties who may bring contractors on to UHB sites e.g. Cardiff University, Public Health Wales etc.

This policy applies to all sites and premises within the UHB at which new work, maintenance or refurbishment work is undertaken. It applies to all contractors' staff, UHB employees, patients and other persons affected by our safety arrangements. It also applies to Cardiff University where their works cross over onto the directly managed UHB estate. For the purpose of this policy it excludes contractors who provide a service such as medical professional or ambulance service staff or similar.

4. Aims and objectives

- To minimise incidents and control contracted activities within the UHB.

- To improve the health, safety and welfare of contractors and UHB employees affected by construction work and contracted activities.

- To ensure the co-ordination between UHB employees and contractors and self-employed persons who carry out work and activities on our premises so that risks associated with those activities are minimised so far as reasonably practicable.

- To provide a structured approach to Health, Safety and Welfare duties on all sites and in all activities which are undertaken on our premises.

- To ensure that before contracts are finalised the competence of contractors is assessed in relation to health and safety matters.

- To ensure that adequate information is provided to all contractors engaged to work on UHB premises.

- To ensure that all hazards that could affect contractors' personnel are clearly defined and controlled.

- To ensure that the interests of staff, patients, clients and visitors are protected before and during any contract work.

5. Management responsibilities

5.1 The Chief Executive has ultimate responsibility for all aspects of health and safety. Specific responsibilities are delegated through the Board of Directors to ensure that the health and safety requirements of the UHB are met at all levels.

5.2 The Executive Director of Planning has the specific responsibility to ensure that all health and safety requirements relevant to their areas of operation are fully met.

5.3 Clinical Board Managers are responsible for ensuring arrangements are in place to implement this policy.

5.4 Supervising Officers are responsible for:

- Appointing a competent contractor following appropriate procedures.
- Completing Checklist (Appendix 1) or JRF form for CEF controlled projects with the contractor to identify any higher risk works and then informing / involving relevant departments.
- If works include interfering with the fabric of the building (building pre 2000) asbestos may be present and therefore authorisation must be sought from the Asbestos management team by submitting an authorisation to proceed form' as per UHB Asbestos Management Plan. (Appendix 8)

▪ Depending on the type and scale of the contract a pre contract meeting may be convened to exchange relevant health and safety information including risk assessments and method statements.
▪ Ensure when the contractor is on site, they sign in and out and wear appropriate Identification.
▪ Ensure the contractor is aware of site rules e.g. no smoking policy and that the contractor undertakes any necessary induction training
▪ Ensure the contractor has the necessary permits to work for higher risk work.
▪ Monitor contactors performance and report any breaches to the health and safety team the first breach should result in a verbal advisory, the second a yellow card and the third may result in removing contractor from site until breach can be resolved or alternative contractor employed. A major breach which could result in imminent risk of serious injury will result in a red card and work being halted immediately and investigation and rectification before work able to resume.

5.5.1 Capital Planning and Estates Department.

Will provide support to Clinical Boards in implementing this policy including:

- Asbestos Management team issuing authorisation to proceed when works includes interfering with the fabric of the building (building pre 2000).
- Issuing permits to work for higher risk operations.
- Fire team issuing authorisation to proceed for work that involves breaches to the fabric of the building.

5.5 Risk Management

The UHB Health and Safety Department will advise on appropriate measures to meet legal and organisational requirements when requested to do so by Directors or requested to do so by Directors or Directorate / Clinical board Managers

6. Definitions

6.1 'Contractor' means a Contracting Company or self-employed person engaged directly by Cardiff & Vale UHB for installation work, building or maintenance of plant and / or equipment. For the purpose of this policy it excludes contractors who provide a service such as medical professional or ambulance service staff or similar.

6.2 'Sub-Contractor' means a Contracting Company or self-employed person engaged by the 'Contractor' to undertake work in relation to the 'Contractors' work programme with Cardiff & Vale UHB.

6.3 'Competent Person' means a person who has sufficient training and experience or knowledge and other qualities to undertake and advise on the measures to be taken to comply with statutory safety legislation.

6.4 Supervising Officer' is the person responsible for the works being undertaken.

7. Resources

Any additional resource requirements will be identified through the implementation plan.

8. Training

The Executive Director of Planning will ensure that the necessary training or education needs and methods required to implement the policy are identified and resourced or built into the delivery planning process. This may include the identification of external training providers or development of an internal training process.

9. Implementation

Each Clinical board is responsible for their implementation of this policy.

10. Control strategy

10.1 Lower risk work

The Supervising Officer determines if higher risk work involved by ensuring themselves and the contractor jointly complete checklist Appendix 1 or The JRF for CEF controlled works BEFORE the start of the contracted work. For low risk work, follow Appendix 2 flow chart, the main requirements of which are summarised below:-

- Ensure a competent contractor is appointed.
- Exchange relevant Health and safety information including risk assessments and
- method statements
- Provide contractor with a summary of site safety rules for contractors (see Appendix 6).
- Ensure the contractors are signed in and out and wear appropriate ID.
- Ensure work is appropriately supervised and monitored.
- Ensure any incidents or health and safety concerns are acted upon and reported via the UHB incident reporting procedure.

10.2 Higher risk work

Supervising Officer determines if higher risk work involved by ensuring themselves and the contractor jointly complete checklist in Appendix 1 or a JRF for CEF controlled work BEFORE the start of the contracted work. For higher risk work, follow Appendix 3 flow chart the main requirements of which are summarised below.

Higher risk work includes the following where the UHB imposes specific requirements controlled by permit to work systems:-

- Work interfering with structural fabric of the building (if building pre 2000 - it could contain asbestos and therefore asbestos management plan requirements must be followed).

- Interrupting or disturbing a service e.g. electrical, piped medical gas, steam, air, hydraulics.
- Carrying out hot work e.g. welding or other flame / spark producing tools.
- Working in confined spaces.
- Working at heights e.g. roof work or scaffolding.
- Excavation or ground works.
- Working with ionising radiation.

10.2.1 Identification of suitable contractors

In addition to the works specification, the UHB's Health and Safety standards must be conveyed to all contractors invited to tender. It is essential to pass on information that may be required to safeguard the interests of UHB staff, patients and visitors who need to be protected before and during contract work.

This information will typically include:

- Significant health and safety risks relevant to the work or site condition which may require control.

- The standards required to control those risks.

- An information sheet identifying common health and safety problems and specific hazards (Appendix 5).

10.2.2 Specification / Tender Stage

The Supervising Officer will ensure that at the tender stage the contractor is registered with safety schemes in procurement (SSIP) and is issued with appropriate internal pre-qualification health and safety questionnaires (Appendix 4 - Contractors Competence Pre- Qualification Questionnaire). If using our internal form (Appendix 4), the completed questionnaires will be returned to the Health and Safety Team for evaluation. Any concerns regarding the questionnaire should be conveyed to the Supervising Officer / Project Manager on successful completion of the questionnaire the Health and Safety team will add the contractor to the UHBs approved list of contractors and retained for future information.

It should be noted that the assessment into the competence of a contractor should be proportionate to the risk and scale of proposed work. In essence what is needed is to check that the contractor has sufficient knowledge and understanding of:

- The type of work to be carried out.

- The management of health and safety and control of risks associated with the proposed work.

- The capacity to apply this knowledge and experience to the work in question.

10.2.3 Monitoring of Tender/Quotation

When considering returned tender / quotation, in addition to the arithmetical, pricing and financial checks, the following will be taken into account:

- Is the tender price unexpectedly low?
- Has adequate provision been made for health and safety?
- How does the contractor propose to manage health and safety on site, especially any high-risk operations?
- Does the contractor have the infrastructure to manage health & safety effectively?

10.2.4 Awarding the Contract

Dependent upon the type and scale of the contract, a pre-contract meeting may be convened. The purpose of the meeting is to discuss contract details and to exchange all relevant health and safety information (Appendix 5) which will include detailed risk assessments, method statements and contractors' on-site procedures.

The Supervising Officer must also provide regular contractors with the contractors General Code of Safe Practice (Appendix 7).

Where the possibility of sub-contracting work exists this can only be done with the agreement of the Supervising Officer. Where such an agreement is reached it is the responsibility of the main contractor to carry out the same checks to the same standards and ensure that all sub-contractors observe these requirements.

Prior to commencement of works the Supervising Officer and the contractor must jointly complete the checklist for contractors Appendix 1 or the JRF for CEF controlled work. The supervising officer must then inform and involve the appropriate departments outlined in the checklist/JRF (i.e. Asbestos team, Estates or Radiation Protection Supervisor)

10.2.5 Management of Contractors on Site

On arrival at site the contractor must report to the relevant department. If undertaking higher risk work, the contractor and all associated staff will undergo a full health & safety induction at a pre-arranged time on their first day on site. On completion of induction, they will be issued with the following:

- Keys or swipe cards required to enable access to specific areas Which must be signed and authorised by the Supervising Officer

- Contractors' identification badge which must be worn on display whilst on the UHB premises.

Note: contractors not issued with a UHB identification badge must display a Company ID badge or be clearly identifiable to which company they work for (e.g. high visibility vest with company name on it).

- Summary of Cardiff & Vale UHB Mandatory Code of Conduct for Contractors (Site rules see appendix 6).

- Permit(s) to work, if applicable.

10.2.6 Contract Monitoring

The Supervising Officer is responsible for monitoring the contractors' progress to ensure work is being carried out in accordance with the terms of the contract and in full compliance with both the contractors and UHB's safety procedures.

Any health and safety exceptions/breaches are acted upon and Reported to the Health and Safety Team and recorded on Datix incident reporting system where relevant

A persistent failure to comply with these requirements may result in termination of the contract and may possibly jeopardise the company from obtaining any future business.

10.2.7 Contract Completion / Performance Review

On completion of the contract, the contractor must ensure that the work site is left in a clean and tidy condition, removing all waste, materials, tools or equipment. The Supervising Officer responsible for monitoring the contract will check the area for compliance.

11. Equality statement

Cardiff and Vale UHB is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff, patients and others reflects their individual needs and does not discriminate, harass or victimise individuals or groups. These principles run throughout our work and are reflected in our core values, our staff employment policies, our service standards and our Strategic Equality Plan & Equality Objectives. The responsibility for implementing the scheme falls to all employees and UHB Board members, volunteers, agents or contractors delivering services or undertaking work on behalf of the UHB. We have undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. We wanted to know of any possible or actual impact that this policy may have on any groups in respect of gender, maternity and pregnancy, carer status, marriage or civil partnership issues, race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment found that there was no impact to the equality groups mentioned.

12. Audit

This policy will be audited quarterly initially and annually thereafter.
Key performance indicators include the following.

-Evidence of contractor complying with pre tender selection process:
-Valid Health & Safety Policy
-Incidents being reported
-Risk assessments
-Method statements.
-Evidence of contractors being provided with health & safety information.
-Evidence of pre site checklist being completed (Appendix 1/JRF).

13. Review

This policy will be reviewed every 3 years or sooner if appropriate.

Appendix 1	Checklist for Contractors for higher risk work (non CEF work)U:\H&S & Asbestos Files\contractor control policy\control of contractors policy review 19\Appendix 1 Checklist before the start of contract work.doc
Appendix 2	Flow chart for lower risk work by UHB departments other than Capital Planning & Estates U:\H&S & Asbestos Files\contractor control policy\control of contractors policy review 19\Appendix 2 Lower risk work flow chart.doc
Appendix 3	Flow chart for higher risk work by UHB departments other than Capital Planning & Estates U:\H&S & Asbestos Files\contractor control policy\control of contractors policy review 19\Appendix 3 Higher risk work flow chart.docx
Appendix 4	Contractor Competence Pre-Qualification Questionnaire U:\H&S & Asbestos Files\contractor control policy\control of contractors policy

review 19\Appendix 4 Contractor competence pre qualification questionnaire.pdf

Appendix 5 Contractors Information sheet U:\H&S & Asbestos Files\contractor control policy\control of contractors policy review 19\Appendix 5 contractors information sheet.doc

Appendix 6 Summary of site rules for Contractors U:\H&S & Asbestos Files\contractor control policy\control of contractors policy review 19\Control of Contractors Policy Appendix 6.docx

Appendix 7 Contractor General Code of Safe Practice U:\H&S & Asbestos Files\contractor control policy\control of contractors policy review 19\Appendix 7 - Contractors General Code of Safe Practice sept 19.doc

Appendix 8 Asbestos Authorisation to Proceed Form U:\H&S & Asbestos Files\contractor control policy\control of contractors policy review 19\appendix 8 ATP - Amended V3.docx

Appendix 9 Control of Contractors quick guide for capital planning, facilities and estates and flow chart U:\H&S & Asbestos Files\contractor control policy\control of contractors policy review 19\Appendix 9 - Control of contractors quick guide.docx

Appendix 10 Job registration form U:\H&S & Asbestos Files\contractor control policy\control of contractors policy review 19\appendix 10 -Job Registration Form.docx

Appendix 11 Fire Authorisation to Proceed Form U:\H&S & Asbestos Files\contractor control policy\control of contractors policy review 19\appendix 11 Fire safety authorisation to proceed.doc

Equality & Health Impact Assessment for

Control of Contractors 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	Chair of Operational Health and Safety Group
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 who may be impacted by this policy including temporary staff The UHB's usual arrangement with regard to consultation was followed (ie. 28 days on the intranet).

	• 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 who are likely to engage contractors as part of their roles All staff who may be affected by contractor activities All patients who may be affected by contractor activities All visitors who may be affected by contactor activities

[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	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.	Any signage will be in pictogram format where ever practical to overcome any languages issues for staff and or service users.	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
gypsies/travellers, migrant workers			
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	There appears not to be any impact.		
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	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
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	Signage will be required to comply with the Welsh Language act		
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	There appears not to be any impact		
6.11 People according to where they live: Consider	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 living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities			
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 non-prescribed drugs plus access to services that support disease prevention (e.g. immunisation and	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
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, job security, working conditions Well-being Goal – A prosperous Wales	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
7.4 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 and safety of play areas and open spaces Well-being Goal – A resilient Wales	During any construction work appropriate care will be taken to effectively barrier off the work area from staff and the general public to protect the working environment. Noisy activities will be controlled as far as reasonably practical or will be arranged out of hours if necessary.	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
7.5 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	
7.6 People in terms of macro-economic, environmental and	**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
sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales			

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. Well managed contracts and contactors will have a beneficial effect on the UHB as they will be improving the estate and or services

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:
  ○ continues unchanged as there are no significant negative impacts
  ○ adjusts to account for the negative impacts
  ○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so)
  ○ 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.			

MINUTES OF THE OPERATIONAL HEALTH AND SAFETY GROUP HELD AT 9AM on THURSDAY 3rd JUNE 2019 – CORPORATE MEETING ROOM, HQ UHW

Present:

Martin Driscoll	Executive Director of Workforce and O D
Charles Dalton	Head of Health and Safety
Caroline Murch	Environmental Health and Safety Adviser
Jonathan Davies	Health and Safety Adviser
Linda Jones	Claims Department
Mal Perrett	Senior Fire Adviser
Nicky Bevan	Occupational Health
Rachael Sykes	Health and Safety Adviser
Stuart Egan	Staff Representative
Clinical/Service Board Representatives	
Alicia Williams	Women and Children
Hattie Cox	Specialist Services
Rowena Griffiths	Dental Services

Apologies:

Clare Wade	Surgery
Ian Wile	Mental Health
Janice Aspinall	Staff Representative
Jon McGarrigle	Estates Services
Karen Lewis	Claims Manager
Matthew Price	Specialist
Peter Welsh	General Manager
Rachael Daniel	Health and Safety Adviser
Rhys Davies	Primary, Community and Intermediate Care
Sue Bailey	CD&T

In Attendance:

Zoe Brooks	Health and Safety
Mark Pinder	Arjo

OHSG: 17/19 Minutes of the Meeting held May 2018

The minutes of the meeting held on the 28th February 2019 were accepted as a true record, with the exception of one amendment to page 2 OHSG: 03/19 Portable Heaters. The minute read 'temperatures should meet the national guidance of 23oC' this should read guidance of between 21-23oC.

OHSG: 18/19 Feedback from Health and Safety Committee

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

The Head of Health and Safety gave an overview of the reports, highlighting that the main topic of discussion was around Pedestrian Safety; which was also on the

agenda for this Group. It was also noted that the Security Services Policy where approved.

OHSG: 19/19 Health and Safety RIDDOR's

A report was noted by the Group.

The Head of Health and Safety reported 8 RIDDOR's during the period. It was noted that the report contained details of these incidents and highlighted that the majority of these related to slip, trips and falls as well as lifting/Manual handling.

The Group were informed that all of the incidents had been closed out with the exception of one relating to a trip on a raised pavement.

In addition to the RIDDOR's during the period, the Group were informed of the number of incidents during the year (April 2018 – March 2019); these being 99, demonstrating a reduction of the previous year which was a total of 118.

OHSG: 20/19 Enforcement Agencies Correspondence Report

The Health and Safety Adviser – Ms R Sykes informed the Group of 5 additional issues raised during the period, where the Health and Safety Executive (HSE) had contacted the Health Board with concerns or information.

Ms R Sykes gave an overview of these items, confirming that a number had been resolved. It was also noted that full detail can be found within the report.

It was highlighted that one of the items relates to an upcoming planned HSE audit on Violence and Aggression and also Musculoskeletal Disorders in Healthcare. It was noted that the HSE are expected around October 2019 and had already carried out a similar audit within ABMU and issues 9 improvement notices.

The Health and Safety Department had obtained details of the ABMU findings for review and comparison against Cardiff and Vale practice and an action plan was being prepared.

OHSG: 21/19 Fire Safety Management and Enforcement Report

The report was received and noted by the Group.

The Group were informed that during the period, the Senior Fire Adviser – Mr F Barrett had retired and replaced by the Fire Adviser Mr M Perrett. It was also noted that interviews had taken place to recruit two Fire Advisers, in which one position had been successfully filled.

The Head of Health and Safety reported that regular meetings were taking place with the Fire Service to tackle concerns around the number of Unwanted Fire Signals the Health Board was generating. It was highlighted that since the introduction of these meetings the number of unwanted fire signals had reduced significantly.

The Senior Fire Adviser raised awareness of the incident on C5 on May 9th 2019, where a patient used a source of ignition whilst on oxygen; this resulted in an explosion and the area being evacuated. It was reported that two Fire appliances attended and the incident was safely managed.

The Senior Fire Adviser praised the staff on the ward as well as members of the Security team and highlighted that lessons could be learnt from this incident; this incident was the subject of a cold de-brief arranged by the Emergency Preparedness Manager to take place on June 18th.

In addition to the above incident, the Group were also made aware of a fire incident at Lansdowne Hospital site. It was noted that this was a major incident caused by a deliberate fire.

It was highlighted that training compliance remains around 66%.

Representative for Women and Children – Ms A Williams queried if the figures could be broken down by Directorate. The Senior Fire Adviser reported a breakdown of all training compliance is available through the Learning, Education and Development Department.

The Chair felt that the training compliance figures, although slightly improved, had been around the same number for years. He asked that the Senior Fire Adviser look at ways to improve compliance over the next coming months. **Action: MP**

OHSG: 22/19 Health and Safety Priority Improvement Plan

The report was noted and accepted by the Group.

The Head of Health and Safety reported that a number of meetings had taken place with the Assistant Director of Governance to look at the priority action plan system and the Risk register.

It was noted that whilst a review is underway, the Priority Improvement Plan continues to be updated with the majority of key actions receiving a status of green, highlighting that these items have either been closed out or reached the desired progress.
The Head of Health and Safety gave an overview of the progressed areas reporting that during the period a total of 7 milestones and 22 actions were progressed sufficiently. It was also noted that an additional item was added to the Manual Handling section of the plan relating to concerns around the status of LOLER inspection of hoist slings, item 3.7. Full details can be found in the full report.

The Group were informed of an assurance schedule within the report; the Head of Health and Safety advised that each Clinical Board will in turn present their local action plan to this Group. It was noted that both Mental Health Clinical Board and Women and Children will be asked to bring theirs to the September meeting; he advised that the Health and Safety Adviser's would be advising local Health and Safety Groups and would be available if any assistance was needed.

OHSG: 23/19 Legal and Risk Personal Injury Report

Legal and Risk submitted a trends analysis and graph of personal injury claims settled over the last six month period, up until 1st April.

The data was correlated against other Health Boards, referencing Cardiff and Vale employees accounting for approximately 16% of the workforce.

The Chair queried the mechanism for payment.

It was explained that the Health Board pays up to 25k and after this it is funded by the Wales risk pool, to which the Health Board pays an annual contribution.

OHSG: 24/19 Managers Safety Course

The Health and safety Adviser – Mr J Davies reported that a two day managing safely course had been established and a course had run during the period for the staff side representatives.

He highlighted that the course was well received and additional dates for 2019 was available.

OHSG: 25/19 Arjo Audit Presentation

The Group received a presentation from Arjo, in relation to its findings of the Audit carried out in July 2018. The presentation identified that an improvement on the number of items that where beyond manufacturer's life expectancy to only 3%.

However, it was noted that the findings did recognise that there were impending numbers of hoists, which would shortly be beyond recommended used by date.

The representative from Arjo also highlighted that the audit identified a need to review the arrangements for re-usable slings and associated sling inspections.

The Chair suggested that a bid be submitted to capital, for the impending need.

OHSG: 26/19 Items raise by Staff Side

Concerns were raised in relation to beds being dumped on the UHW site in tunnels and on wards.

The Head of Health and Safety advised that this should be raised with the Bed Management Group.

The Staff side Representative highlighted that there was a new stress procedure and felt that managers should be trained to know the symptoms of stress. He suggested that stress was underreported and felt that managers should be made aware of this procedure and receive the relevant training.

Concerns were raised around the general thermal comfort within the hospitals and community buildings. It was reported that it is either too hot or too cold and is having effect on productivity and general health.

The Chair highlighted that the Estates Department were working hard to resolve these issues and putting measures in place to deal with concerned areas.

It was reported that restaurant at both UHW and Llandough had signs stating 'Only food bought in this restraint can be eaten here' suggesting that members of staff could not take their own lunch and sit in these areas. The Staff Side representative raised concerns with the lack of facilities for staff to eat their lunch and was shocked at the cost of food within Health Board restaurants, highlighting that a portion of lasagne and a drink is around £8; he felt this was too expensive for staff.

The Chair agreed that this price was and was not aware of staff not able to eat food brought in, in restaurants.

The Head of Health and Safety agreed to check this with Director of Estates and Facilities.

OHSG: 27/19 Items raised by Clinical/Service Boards

No items raised however the Head of Health and Safety asked if there should be a representative from procurement on this Group.

The Chair suggested that membership is reviewed, to ensure there is the right people attending.

OHSG: 28/19 Policies and Procedures

No procedures brought to this meeting for consultation or approval.

OHSG: 29/19 DATE AND TIME OF NEXT MEETING:-
4th September 2019 - Cefn Mably, Woodlands House – 9:00am

Health and Safety Priority Improvement Plan

Health & Safety Management

Change	REF	Area of Improvement	Milestone	M/stone Status	Actions Requirement	Progress/Assurance	Action Status	Lead	Date Due
	1.1	**Health and Safety Policies**	Comprehensive range of Health and Safety Policies covering all legislative requirements	Amber	Gap analysis of policies by reviewing policies and procedures of other health boards	Project lead identified within the Health and Safety team to complete analysis.	Green	Head of Health and Safety	Apr 19
					Develop register of safety legislation to provide gap analysis and ensure any changes or new legislation incorporated into policies and procedures	Register of legislation utilised, project lead reviewing findings using Barbour information system ensuring any changes or new legislation incorporated into policies and procedures	Amber	Head of Health and Safety	Jan 20
			Health and Safety Policies are appropriately reviewed and communicated to all relevant staff	Amber	Ensure link to all current health and safety policies and procedures are on health and safety web page	Departmental review of health and safety polices undertaken. Reviewed at each Health and Safety Committee and approved policies add to web	Green	Director of Corporate Governance	Apr 19
					Status of related Health and Safety Policies approved by other committees requires progress through relevant committees	Director of Corporate Governance has circulated shortfalls for review.	Amber	Director of Corporate Governance	Jan 20
	1.2		Health and Safety Risk Assessments are included within the Board Assurance Framework (BAF) register	Amber	Implement new BAF format	BAF pilot project of Dental and Capital Planning & Estates progressed. Rollout of revised risk register approach being progressed	Amber	Director of Corporate Governance/ Head of Risk Governance	Jan 20
					Review health and safety items on clinical/service board's risk register and ensure high risk health and safety items included on priority improvement plan	Benchmarking exercises being progressed as part of Clinical Boards shortcomings.	Amber	Head of Health and Safety	Jan 20
			Managers maintain suitable and sufficient Risk Assessments	Red	Utilise E Datix System to monitor progress of controls identified within risk assessments	Plans to develop E Datix agreed – progress subject to patient safety resource.	Red	Director of Corporate Governance/ Head of Risk Governance	Jan 20
					Identify some common high risk activities and produce some generic risk assessment pro-forma for local use	Violence & Aggression and Manual Handling generic risk assessments progressed.	Green	Head of Health and Safety	Jun 19

	1.3	**Managers Safety Course**	Managers competency in their health and safety role is enhanced	Amber	Allocate health and safety resource to develop training package	Role identified in newly appointed Health and Safety Adviser. Course devised.	Green	Head of Health and Safety	Jan 19
					Offering of course to all mangers	As above	Green	Head of Health and Safety	Jan 19
					Accompanying training materials to support course and attendees in their role.	As above	Green	Head of Health and Safety	Jan 19
					Monitoring and support of health and safety management improvements post course.	As above	Red	Head of Health and Safety	Jan 20
	1.4	**Mandatory Training Compliance**	Review of mandatory training to maximise effectiveness	Amber	Review of mandatory training to maximise effectiveness through appropriate frequency review and assessment of training needs.	Project initiated. Item agenda for Health and Safety Committee.	Amber	Director of WOD	Jan 20
			Mandatory training compliance - Health Board target 85%		Monitoring of mandatory training compliance - Health Board target 85%	Annual report showed successful improvement in mandatory training compliance. Corresponding to the above.	Amber	Director of WOD	Jan 20
	1.5	**Health and Safety meetings management structure met.**	All Clinical and Service Boards have established health and safety meetings that meet at least 4 times a year	Amber	Annual report identified shortfall within some Clinical Boards	Shortfall has now been rectified including Medline Clinical Board establishing a Group and will be monitored at Operational Health and Safety Group	Green	All	Oct 18
					Establish Health and Safety Group for corporate functions	Health & Safety Adviser identified. To progress with individual heads. No Group formed as yet.	Amber 	Director of Corporate Governance	Jan 20

2. Violence and Aggression

CRAF	REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
	2.1	**Working within the scope of the Memorandum of Understanding for violence and aggression**	Review of the MOU to meet service needs and support guidance based off NHS Chief Executive's launch together with police and the prosecution service.	Green	Review current practice against revised approach	Health Board taking lead with partnerships, new document being appropriately progressed following Cardiff and Vale practice. Launch planned November 2018	Green	Director of WOD	Nov 18
					Monitor CPS and Police outcomes for comparison of criminal sanctions, community resolutions and police actions	Annual report identified suitable sub divisions, national group progressing comparative standards across Health Boards	Green	Director of WOD	Apr 19
					Pursue non-criminal sanctions and monitor, including violent warning	Personal Safety section reviewing its monitoring to demonstrate efforts made within non-criminal sanctions.	Green	Head of Health and Safety	Jan 19

					markers, victim interviews and perpetrator internal sanctions				
	2.2	**Lone Worker Devices**	Ensure those at risk within the community have systems in place for device or suitable assessment	Green	Monitor for consistent use, demonstrating effective management of device allocation	Regular reports submitted to Health and Safety Committee	Green	Head of Health and Safety	Oct 18
					Review of contract due in 2019 to reflect current demands	Meeting with Procurement to establish specification in readiness for contract renewal in April 2019	Green	Head of Procurement	Apr 19
					Local Management to establish appropriate risk assessment for justification	Local Management approaching for additional devices are being supported by Advisory team and advice that items can be progressed by local funding	Green	Head of Health and Safety	Oct 18
					Current devices with battery fault to be resolved by both identification and remedial action	Three devices of the 650 in operation found to have faulty batteries associated with their age. Investigation initiated. Replacement of whole batch been agreed by supplier and completed	Green	Head of Health and Safety	Jan 18
	2.3	**Violence & Aggression response competence**	Ensure sufficient trained staff to respond to violence & aggression events	Amber	Review of training to ensure sufficient trained staff to respond.	Internal review with specialist trainers of violence & aggression to ensure response and capabilities.	Amber	All	Jan 20
					Mechanism to monitor training against Training Needs Analysis (TNA)	Health and Safety department advising Clinical Boards of compliance status	Green	Head of Health and Safety	Apr 19
					Monitoring and support to local areas to give assurance on effectiveness of training	Clinical Board meetings to include training status	Amber	Head of Health and Safety	Jan 20

3. Manual Handling

CRAF	REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
	3.1	**Working to Revised All Wales NHS Manual Handling Passport and Information Scheme**	Implementation of the Revised All Wales NHS Manual Handling Passport and Information Scheme	Amber	Review of manual handling passport delivery to meet Agored Cymru standards.	Action plan initiated to meet required standards by December. Progress being monitored by LED, Agored Cymru and Health and Safety. Review Complete	Green	Head of Health and Safety/Head of LED	Dec 18
			Ensure manual handling training is based on need by risk assessment	Amber	Review training against TNA	Joint review with LED completed	Green 	Head of Health and Safety	Apr 19
					Monitor compliance against TNA requirements	Health and Safety department advising Clinical Boards of compliance status	Green	Head of Health and Safety	Apr 19

	3.2	**Pro-Act Audit**	Audit compliance of hoisting and hygiene equipment against patient requirements.	Green	Proact re-audit during winter demands	Re-audit progressed and agreed with proact to commence in November 2018, with report coming to April Health and Safety Committee	Green	Head of Health and Safety	Apr 19
					Review of audit findings and action shortfalls.	Review has been completed. Work to enhance sling inspections.	Amber	Head of Health and Safety	Jan 20
					Review of slings against suitability of current slings used	Within Proact audit	Amber	Head of Health and Safety	Jan 20
	3.3	**Bariatric patient compliance**	Assessment of bariatric patient compliance against manual handling aspects.	Amber	Undertake an assessment of bariatric patient compliance against manual handling aspects	Manual Handling Adviser working with Medicine Clinical Board to assess best practice including proact audit	Amber	Head of Health and Safety	Jan 20
	3.4	**Lifting Operations Lifting Equipment Regulations (LOLER)**	Meet LOLER inspection requirements	Green	Audit of mechanisms to meet LOLER inspection requirements. Previous reports identified shortfall in LOLER inspection regime	Action taken by Director of Planning to rectify LOLER inspection programme. All equipment re-examined.	Green	Director of Planning	Oct 18
	3.5	**Management of Hoverjacks**	Suitable quantities of equipment to respond to fallen patients' needs	Amber	Validation of suitable Hoverjack quantities to respond to fallen patients' needs	New Hoverjacks purchased via Capital Funds.	Green	Assistant Director of Nursing	Jan19
			Hoverjacks considered and maintained as a lifting compliance under LOLER		Hoverjacks considered and maintained as a lifting compliance under LOLER	As above	Green	Assistant Director of Nursing	Jan 19
			Ownership of existing stock is established		Ownership of existing stock is established.	As above	Amber	Assistant Director of Nursing	Jan 20
	3.6	**Suitable Glide/Slide Sheets**	Enhanced stock of material glide sheets to replace wear and tear	Amber	Savings made from non-use of paper glide sheets are converted into enhanced stock of material glide sheets to replace wear and tear	A paper is being prepared for the Operational Health and Safety Group in December 2019 by the Manual Handling Adviser	Amber	Head of procurement	Jan 20
	3.7	**Sling inspections to meet LOLER**	Proact audit identified a higher than needed number of reusable slings and that a more robust mechanism was needed to demonstrate LOLER inspections were being carried out		Rationalise slings to greater use of disposable and review of ward based sling inspections	All reusable slings have been tagged to be uniquely identified. Costs related to external inspections pursued. Discussion of best means of monitoring initiated	Amber		Jan 20

4. Health Issues

CRAF	REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
	4.1	**Review of Health compliance**	Review of all health related risks to ensure appropriate controls are in place	Red	Initiate a review of all health related risks to ensure appropriate controls are in place	Health and Safety Adviser co-ordinating a review to reflect concerns raised about all health initiatives	Amber	Head of Health and Safety	Jan 20
					Identify status of Stress, Musculoskeletal Disorder , Display Screen Equipment, Workplace Environmental, Menopausal Effects	Review of programme and being reported to each Health and Safety Committee.	Amber 	Head of Health and Safety	Jan 20
	4.2	**Control of Substances Hazardous to Health (COSHH)**	Suitable and Sufficient Risk Assessments in Place	Amber	All areas has designated COSHH coordinators	Shortfall status tabled at each Clinical Board Health and Safety Group for resolution improvement in compliance to above 80%	Green	Director of WOD	Apr 19
					Risk Assessments are valid	As above	Green	Director of WOD	Apr 19
					Monitoring that ensures high risk areas have complete compliance.	Personal Monitoring Plan established for high risk areas to ensure compliance with workplace exposure limits.	Amber	Head of Health and Safety	Jan 20
			Identified Control Measures are implemented	Amber	Mechanism for minimising the effects of hazardous substances.	Action plans are being developed for high risk areas following monitoring to determine any gaps in control measures	Amber	Head of Health and Safety	Jan 20
					Safe use of peracetic acid in sterilisation of medical instruments	Health and Safety Adviser working with Clinical Board to establish best practice	Green	Head of Health and Safety	Oct 19
	4.3	**Work Place stressors**	The Health Board to have in place suitable response mechanism to staff experiencing stress and demands.	Amber	Review Policy and access to Employee Wellbeing Service. Policy has now been reviewed as a procedure.	Procedure has been agreed.	Green	Director of WOD/Head of Occupational Health	Jan 19
			The Health Board has proactive approaches to identify areas of hotspot and diminish stressors prior to the acute event.	Red	Proactive approaches to identify areas of hotspot and diminish stressors prior to the acute event initiated	Wellbeing Working Group has ceased, health and safety working towards identifying criteria with specialist partners on mechanism for identifying potential events.	Red	Head of Occupational Health /Head of Health and Safety	Jan 20
					Specialised group to monitor and develop proactive actions	Funding has been secured from Health Lottery for additional wellbeing practitioners for a period of 2 years; these are currently being progressed.	Amber 	Head of Occupational Health /Head of Health and Safety	Jan 20

	4.4	**Hand arm vibration**	Activities which use devices at risk of hand arm vibration are assessed	Amber	Review of activities which use devices at risk of hand arm vibration	HAVs identified within Dental and Estates Areas. Full survey initiated in Dental, identification mechanisms developed in Estates, other areas to be progressed	Green	Head of Health and Safety	Apr 19
					Assessment of those areas requiring direct monitoring	Progressed as a rolling programme based on risk priority	Green	Head of Health and Safety	Jan 19
					Complete monitoring to these areas	Programme of work has been initiated and is being progressed.	Green 	Head of Health and Safety	Apr 19
	4.5	**Dangerous Substances & Explosive Atmosphere Reg (DSEAR) compliance to regulations**	DSEAR compliance to regulations requires areas of potential explosives to be assessed and control measures in place	Amber	Assessment of DSEAR requirements against simple demand areas through localised assessments and remedial actions	Risk assessment approach adopted based on industry standard	Green	Head of Health and Safety	Apr 19
					Identification and full DSEAR assessment for complex areas	DSEAR Guidance approved at the Fire Safety Group and Operational Health & Safety Group and being implemented through each clinical board as appropriate.	Green 	Clinical Board Leads	Apr 19
	4.6	**Muscular Skeletal Risks**	Meet DSE Requirements	Green	Maintain assessment of display screen equipment database and complete assessment for those defined users	Revised Database implemented	Green	Head of Health and Safety	Oct 18

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

CRAF	REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
	5.1	**Ligature Risk in Mental Health**	Complete comprehensive ligature assessment for areas where patients are at risk of self harm	Green	Complete audit and support installation within Mental Health	Adviser completed audit and supported installation within Mental Health	Green	Head of Health and Safety	Oct 18
					Implement findings to minimise self harm risk	Meeting established with health and safety and estates to verify status of remedial work Review completed	Green	Mental Health Lead	Jan 19
	5.2	**Mental Health Smoking Cessation**	Implementation of an absolute smoking cessation approach with mental health establishment	Green	Smoking cessation implemented	Smoking cessation implemented however increased reports of fire and violence and aggression events	Green	Mental Health Lead	Jan 19
					Review of increased reports of fire and violence and aggression events		Green	Mental Health Lead	Jan 19

			Suitable support mechanisms for patients and access to safe electronic smoking and other devices	Amber	Project plan required non charging e-cigarettes E-cigarette chargers if used must be in suitable flame proof areas	Monitored by Environmental Nurse for any significant breaches/action being progressed by Mental Health.	Amber	Mental Health Lead	Jan 20
					Monitor smoking cessation compliance and report on enhanced staff risk related to fire and violence and aggression	Review of smoking controls within Mental Health has been undertaken and met with Fire Service for approval – Re-installed electronic lighters at smoking stations.	Green	Mental Health Lead	Jan 19
	5.3	**Window Closures**	All windows at a height which may be a self harm or fall risk is fitted with suitable window restrictors.	Amber	Survey of windows undertaken and restrictors fitted	Survey of windows undertaken and restrictors fitted.	Green	Director of Planning	Oct 18
					Anti tamper devices fitted to all restrictors	Review of restrictors in self harm areas to fit anti tamper screws	Red	Director of Planning	Jan 20
	5.4	**Local Control of Water Safety**	Low use water outlets are flushed at agreed intervals	Red	Audit and monitoring of flushing mechanisms	Reported improved attendance at Water Safety Group. Review of database initiated to improve flush monitoring.	Amber	Local Health Board Leads	Jan 20
	5.5	**Management of Bariatric Patients**	Suitable mechanisms in place to care for bariatric patients with dignity and without enhanced risk to staff	Amber	Assessment of patient need	Assessment of patient needs undertaken, further work required to diminish fire, staff and dignity issues	Amber	Assistant Director of Nursing	Jan 20
					Specialised beds, hoisting and other support equipment are available as needed	Bariatric care package in place with access to a range of equipment	Green	Assistant Director of Nursing	Oct 18
					Mechanisms of implementing care with dignity for bariatric patients that go beyond our standard profile	Project to improve care being progressed between Manual Handling and Medicine Clinical Board	Amber	Assistant Director of Nursing	Jan 20
	5.6	**Record Storage**	There is agreed policy for retaining paper records	Amber	Progress Policy	The organisation has the requirement to safely store its mandated records for the agreed periods. Policy approved	Green	Director of Corporate Governance	Oct 18
					There are suitable controls implemented within record storage areas to ensure that manual handling and fire risks are not breached	Work undertaken to improve condition of storage in short term	Amber	Head of Medical Records	Jan 20
			Progress an enhanced programme to electronically store, where possible medical record	Red	Progress an enhanced programme to electronically store, where possible medical records	Project under review	Red	Head of Medical Records	Jan 20

6. Fire Safety Management

CRAF	REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
	6.1	**Fire Compartmentation**	Review and maintain compartmentation system	Amber	Implement a prioritised programme for reviewing and maintaining its compartmentation system	Priority plan being progressed	Amber	Director of Planning	Jan 20
	6.2	**Unwanted False Signals (UFS)**	UFS's are minimised, investigated and monitored	Green	Work jointly with SWFRS and Specialist Services to reduce UFS	Joint working group results show 30% improvement	Green	Director of Planning	Apr 19
					Those UFS associated with aged automatic alarm systems are progressed through a prioritised approach	Enhanced programme of replacement agreed	Green	Director of Planning	Apr 19
					UFS associated with inappropriate contractor work is diminished through enhanced job allocation form	Fire Adviser working with Estates to enhance dust and hot work controls	Green	Director of Planning	Apr 19
					Mechanism to notify the fire service to stand down if known false alarm	Fire Service progressing direct line number for speedier contact. Training includes message relating to informing switchboard	Green	Director of Planning	Apr 19
	6.3	**Fire Incidents within Mental Health**	Fire incidents in mental health associated with the smoking cessation campaign is minimised through effective controls	Amber	Fire incidents in mental health associated with the smoking cessation campaign is minimised through effective controls: a) removal of ignition sources, b) meeting health care guidance on use of charging devices and c) local monitoring of internal areas	New Lead and improved compliance	Green	HOD Mental Health /Director of Planning	Jan 19
	6.4	**Evacuation Mat/Chairs Training**	Establish mechanism for training and refresher training in the use of evacuation chairs and mats	Red	Cascade training given several years ago, further demand identified	Senior Fire Safety Officer and Fire Safety Manager has put forward to Fire Safety Group reviewed team approach to evacuation chairs. This is being further discussed at the next FSG.	Amber 	Senior Fire Adviser/Fire Safety Manager	Jan 20
	6.5	**Evacuation Fire drills**	Enhanced commitment to evacuation drills	Amber	Fire Safety Group to devise an agreed programme of evacuation drills and local areas to co-operate in participation		Amber	Director of Planning	Jan 20
	6.5	**Fire Audit - Annual Submission**	Annual submission of fire audit is submitted within a timely manner	Green	Submit Annual Audit	2018 audit submitted	Green	Director of Planning	Oct 18

7.1 Health and Safety Estates Management.

CRAF	REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
	7.1	**Water Safety/Legionella**	Water Safety Plan Implemented with increased assurance of compliance against flushing need	Amber	Legionella Survey and Risk Assessment audit package under development for completion by all area managers identifying all outlets and usage or flushing regime	Package developed on MICAD System for dissemination to local areas	Green	Director of Planning	Oct 18
					Water Safety Group has effective representation from all related areas	Current Clinical Board representation is improved but not total	Amber	Clinical Board Leads	Jan 20
					Compliance against water safety plan and policy is reported to the Health and Safety Committee	Included within work programme	Green	Director of Public Health	Oct 18
	7.2	**Contractor Control**	Contractor control within remit of **estates** has effective mechanisms for monitoring and reacting to safety breaches	Amber	Reported at Operational Health and Safety Group	Reported at Operational Health and Safety Group	Green	Director of Planning	Oct 18
			Permit system in place for contractor work of specified high risk areas			Enhanced permit system under development	Amber	Director of Planning	Jan 20
			Contractor control within remit of **non estates** has effective mechanisms for monitoring and reacting to safety breaches	Amber	Enhance non estates to same standard as estates contractor control. Health and Safety Adviser appointed to progress same standard of work. Has actively progressed backlog since appointment	Confirmation Backlog has been resolved.	Green 	Head of Health and Safety	Jan 19
	7.3	**Asbestos**	Asbestos database to ensure that Asbestos Register has evaluated asbestos status for all areas	Green	Review of asbestos database to ensure that asbestos register has evaluated asbestos status for all areas	External review undertaken	Green	Director of Planning	Oct 18
					Effective asbestos management for all intrusive work within asbestos identified areas	As above	Green	Director of Planning	Oct 18
					Action plan for resolving those areas not surveyed as part of the asbestos register	Report 94 of the 8000+ areas surveyed Work on non surveyed areas halted until resurvey undertaken, report to progress "Black Areas " being prepared	Amber	Director of Planning	Jan 20
	7.4	**Back Log Maintenance**	Backlog maintenance to evaluate those areas which potentially affect their safety compliance.	Red	Review of backlog maintenance to evaluate those areas which potentially affect their safety compliance	Resources available to estates in line with an increasing burden of ageing physical infrastructure, bringing increased maintenance costs and increased refurbishment costs	Red	Director of Planning	Jan 20

	7.5	**Pedestrian and Tunnel Safety**	Enhanced pedestrian and tunnel safety.	Amber	Undertake complete survey and specialist advice on enhancing pedestrian and tunnel safety	Survey undertaken	Green	Director of Planning	Apr 19
					Implement phased approach to zoning tunnel areas and minimising usage	Definitive plan for zone 1 access control system initiated for October 2019.	Amber	Director of Planning	Jan 20
					Implement pedestrian safety within identified key high risk areas	Within cost restriction being progressed	Amber	Director of Planning	Jan 20
	7.6	**Estates Compliance to Lifting Operations Lifting Equipment Regs (LOLER) Requirements.**	Estates compliance to LOLER requirements are maintained for lifting equipment.	Green	Planned transfer of LOLER responsibilities to Clinical Engineering	Gold contract established with Arjo	Green	Director of Planning/ Director of Therapies and Health Sciences	Apr 19
					Comprehensive maintenance and inspection schedule maintained	Gold contract established with Arjo	Green	Director of Planning	Apr 19
	7.7	**Category 3 Laboratories compliance**	Appropriate mechanisms are implemented to ensure risks presented to the Health Board from these areas is controlled	Green	Appropriate mechanisms are implemented to ensure risks presented to the Health Board from these areas is controlled by effective maintenance of their internal pressurised containment	Regular meeting established	Green	Director of Planning	Oct 18
					Formal mechanisms of communications between the relevant parties are formalised and recorded	Regular meeting established	Green	Head of Health and Safety	Oct 18

8. Sharps Safety

CRAF	REF	Area of Improvement	Milestone	M/Stone Status	Actions Requirement	Progress/Assurance	Status	Lead	Date Due
	8.1	**Safety Needles**	Requirement of Safety Sharps legislation are maintained	Amber	Re-engage staff in enhanced safe needles controls and appropriate disposal	Health and Safety Advisers are pursuing through Clinical Boards Health and Safety Groups	Amber	Clinical Board Leads	Jan 20

Report Title:	**Y GEGIN RESTAURANT, UNIVERSITY HOSPITAL OF WALES (UHW) FOOD HYGIENE INSPECTION – 20th June 2019**						
Meeting:	**Health & Safety Committee.**				**Meeting Date:**	**8th October 2019**	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	**Director of Planning**						
Report Author (Title):	**Commerial Services Manager**						

SITUATION

An inspection of the Y Gegin Restaurant at the University Hospital of Wales (UHW) took place on 20th June 2019, the outcome of which was confirmed in writing in a letter report dated 25th June 2019 from the Commercial Services Officer, Food and Port Health, Bridgend, Cardiff and Vale of Glamorgan Shared Regulatory Services.

In this report it was noted that the Y Gegin Restaurant at UHW was given an overall score of **4 (Good)** in the National Food Hygiene Rating Scheme.

REPORT

BACKGROUND

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

ASSESSMENT

On receipt of the letter report, an action plan was developed by the Catering Services Manager to address the issues raised and is attached as an appendix 1 to this report**.** This will be monitored within the service by the Commercial Services Manager.

ASSURANCE is provided by:

The maintenance of the Food Hygiene Rating score of 4 (Good) and corrective actions taken immediately.

RECOMMENDATION

The Committee is asked to:

- **NOTE** the Food Hygiene Rating and the remedial actions taken following the receipt of the Commercial Services Officer (Food & Port Health) report.

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

Appendix 1

Action Plan from Food Safety Inspection on 20th June 2019 (Report dated 25th June 2019)

Schedule A – Legal Requirements

Food Hygiene and Safety Procedures High standard of compliance with statutory obligations, and industry codes of recommended practice, with only minor contraventions.	**Response / Action**	**Time Scale**	**Update**
1. There was food debris noted on the blade of the heavy-duty can opener, which would cause contamination of the food in the next tin opened. This part of the can opener must be cleaned and sanitised regularly *Regulation (EC) No 852/2004 Annex II Chapter V Para 1(a)*	Thoroughly clean blade of can opener. Ensure completed on daily basis.	Immediate	Completed
2. During the inspection, utensils and metal containers were being stacked while still wet. This will support microbiological growth. You must ensure all equipment is dried thoroughly before being stacked. *Regulation (EC) No. 852/2004, Annex II, Chapter IX, Para 3*	Ensure all small equipment items are both clean and dried prior to storage. Staff to be re-instructed to undertake.	Immediate	Completed
3. The use of gloves in your premises was unhygienic and likely to give rise to a risk of cross contamination. Ensure that hands are always washed thoroughly before putting gloves on and after taking them off. Gloves must be disposable and must always be changed between the handling of raw and ready-to-eat foods. Gloves must also be changed before handling ready-to-eat food if they have come into contact with any surface or objects not designated as clean (e.g. money), and also at every break and when gloves become damaged. Whilst observing staff practices, gloves were routinely being changed, however, there was no hand washing to accompany this. *Regulation (EC) No 852/2004 Annex II Chapter IX paragraph 3*	Staff to be re-instructed and encouraged to wash hands between any tasks whether wearing gloves or not. (The use of disposable gloves to be reviewed for service area and other service areas across the UHB).	Immediate	Completed

Structural / Cleaning Issues High standard of compliance with statutory obligations, and industry codes of recommended practice, with only minor contraventions.	Response / Action	Time Scale	Update
4. The wash hand basin in the kitchen was obstructed by the raw meat trolley and there were spray bottles of D10 hanging from the bowl. The basin must be emptied, kept clean and available for use at all times for washing hands. *Regulation (EC) No 852/2004 Annex II Chapter I Para 4*	Raw meat trolley to be located and stored (whether in use or not) away from in front of wash hand basin. D10 bottles not to be stored on WHB. The WHB to be emptied and cleaned.	Immediate	Completed
5. There was a missing ceiling tile above the sink in the pot wash area (sink closest to the doors out to the serving area) Repair or renew the ceiling to leave a surface that will prevent the accumulation of dirt. *Regulation (EC) No 852/2004 Annex II Chapter II Para. 1(c)*	Ceiling tile to be replaced.	Immediate	Completed
6. There was some food debris noted on the floor under the cooking range and along the walls. Thoroughly clean the floor and maintain in a clean condition. *Regulation (EC) No 852/2004 Annex II Chapter I Para 1*	Floor to be thoroughly cleaned in kitchen production area.	Immediate	Completed
7. Some of your chopping boards were badly scored and can no longer be thoroughly cleaned / disinfected. Replace the scored boards. *Regulation (EC) No 852/2004 Annex II Chapter V Para 1(c)*	New chopping boards to be ordered.	Immediate	Completed
8. The rinser taps at the equipment sinks in the pot wash were dirty around the joins and handle areas. The tap to the sink closest to the server was also dusty with cobwebs visible. Thoroughly clean the rinser taps and maintain in a clean condition. *Regulation (EC) No. 852/2004, Annex II, Chapter I, Para 1*	Taps to be thoroughly cleaned and maintained in clean condition.	Immediate	Completed

Confidence in Management / Control Procedures	Response / Action	Time Scale	Update
Satisfactory record of compliance. Access to relevant food safety advice source and/or guides to good practice or assurance scheme commensurate with type of business. Understanding of significant hazards and control measures in place. Has implemented satisfactory food safety management procedures or is making satisfactory progress towards documented food safety management procedures, commensurate with type of food business. Making satisfactory progress towards documented food safety management procedures commensurate with type of business. A score of 10 can be awarded for more than one intervention cycle if: • the previous non-compliances have been addressed but different non-compliances have arisen; and, • the overall risk has not increased.			
9. You have put in place a documented Food Safety Management Procedure based on HACCP principles, I would make the following observations:			
• There were a number of occasions when the fridges behind the serving area were on a defrost cycle so no temperatures were recorded. As discussed, if the fridges or freezers are on a defrost cycle then staff must re-check after a short time to ensure they are operating below your critical limit of 5°C, this check must then be recorded in the corrective actions box;	Review monitoring form to ensure it is clear to ALL staff to retake temperatures especially if on defrost cycle and in addition, ensure all corrective action is recorded.	31/7/19	Completed
• Temperatures above your critical limit of 5°C had been recorded on a few occasions to your fridges. However no corrective actions had been recorded. You must ensure that staff document any corrective actions carried out;	All staff to be reinstructed in respect of completion of monitoring forms including ANY corrective action if temperatures above critical limit.	31/7/19	Completed
• Whilst your HACCP has a critical limit of 5°C for chilled storage, your monitoring forms stated 0 - 8°C. As discussed, your monitoring forms must be amended to be in line with your HACCP document;	Monitoring form to be amended to reflect critical limit of 5°C.	31/7/19	Completed
• I was pleased to see you had updated your probe calibration method to your master HACCP document on the computer. You must ensure this section is printed and placed in your HACCP file;	Revised probe calibration methodology sheet to be inserted into printed HACCP document.	31/7/19	Completed

• There were no fridge temperatures recorded for 18/6 column B and C, 19/6 B column was blank, no checks for the walk in fridge and freezer had been completed for the morning of inspection, staff must ensure they monitor and record these temperatures prior to preparing any food;	Manager and supervisory team to ensure checks are undertaken as per HACCP document and monitoring requirements. Staff to be re-instructed.	31/7/19	Completed
• Staff were observed preparing bulbs of garlic on the green colour coded boards. The green chopping board is for wash salad and fruit. Ensure staff preparing garlic that is to be cooked use the brown chopping board. If garlic is to be used raw then the garlic must be peeled on the brown board, washed, then chopped on the green board;	Staff to be re-instructed and reminded in use of correctly coloured chopping board for food preparation and raw items e.g. garlic.	31/7/19	Completed
• Pork stock was noted in the freezer with a frozen on date of 3rd April 2019. Your HACCP states that when freezing food made on site a 1 month shelf life is applied;	All staff to ensure and be reminded of correct timescales to be adhered to for items that are frozen.	31/7/19	Completed
• There were occasions where the disposed time for the ambient rolls had gone beyond 4 hours. There were also times when no times were recorded for disposal of rolls despite products having been documented as being wasted. Whilst the Listeria Guidance discourages this practice in health care settings, if you are to continue with this practice you need to ensure that after 4 hours the food is removed from sale;	Rolls not to be used after 4 hours and recorded as waste with time of disposal. Filled rolls to be displayed in chilled counters only.	31/7/19	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 monitoring maintained. *Regulation (EC) 852/2004 Article 5*	All staff to be written to individually to endorse safe / good working practices including temperature monitoring, food prep/storage, completion of monitoring forms, personal hygiene, cleaning and disinfection, etc.	31/7/19	Completed
10. There were a number of fresh turkey butterfly in the freezer with a use by date of 6th June 2019. Minced lamb with a use by date of 31st January 2019, minced beef with a use by date of 3rd March 2019. The use-by date is the date until which the manufacturer of the food guarantees it is safe to eat. Food sold beyond its use-by date may be of poor quality or unfit. It is an offence to sell or expose for sale food with an expired use by date. You must check your stock daily and dispose of any out of date food.	All staff to be re-instructed to check use by dates on foods daily, dispose of any out of date foods and to check with management / supervisory team on freezing of products.	31/7/19	Completed

There was no labelling to indicate the date on which the products had been frozen and there was no information on the label to indicate that the product was suitable for freezing. I suggest you contact the manufacturer to find out in the product is suitable for freezing and if so what the frozen shelf life is. If you wish to freeze food then you must ensure that it is frozen with plenty of shelf life remaining and that it is clearly labelled with a frozen on date. *Article 14(1) of (EC) 178/2002*	All staff to be re-instructed to ensure all foods are labelled and dated accordingly. Managers to check with manufacturers on whether some food items are suitable for freezing.	31/7/19 31/7/19	Completed Completed

Schedule B – Recommendations and Advice

Recommendations	Response / Action	Time Scale	Update
These recommendations provide advice on good practice:-			
1. As you now have a new D10 self diluting dispenser, I suggest pouches in any standalone units are removed to avoid them being used and the pouches becoming out of date.	. D10 pouches to be removed from standalone units as required.	Immediate	Completed
2. I recommend you install dispensers for the blue roll used in the kitchen.	Dispensers to be fitted for blue rolls.	31/7/19	Completed
3. I was pleased to note that the mixer is no longer used to mix raw meat for burgers and this is now done by hand.	Fresh burgers to continue to be made manually using burger mould to shape.	Immediate	Completed
4. There were a small number of fruit flies noted on the window sills in the restaurant. Ensure the windowsills are kept clean. It was also noted that a small window was left open, this window was not fitted with a fly screen. I recommend that any windows opened for ventilation are fitted with fly screens.	Window sills to be cleaned in the restaurant. Windows to be kept closed. Windows to be opened to be identified and screens fitted if / as required.	Immediate	Completed
5. The temperature monitoring files were becoming greasy. As discussed, I recommend these are periodically sprayed and cleaned with the D10 spray.	Files to be cleaned.	Immediate	Completed

Version 1 – Draft ref. SD/CS/AF (1/7/19)
Version 2 – Draft Update ref. SW/CS/AF (17/7/19)
Version 3 – Final Update ref. SW/CS/AF (31/7/19)

Report Title:	**AROMA PLAZA OUTLET, UNIVERSITY HOSPITAL LLANDOUGH (UHL) FOOD HYGIENE INSPECTION – 25th June 2019**						
Meeting:	**Health & Safety Committee.**				**Meeting Date:**	**8th October 2019**	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	**Director of Planning**						
Report Author (Title):	**Commerial Services Manager**						

SITUATION

An inspection of the Aroma Plaza Outlet at the University Hospital Llandough (UHL) took place on 25th June 2019, the outcome of which was confirmed in writing in a letter report dated 5th July 2019 from the Commercial Services Officer, Food and Port Health, Bridgend, Cardiff and Vale of Glamorgan Shared Regulatory Services.

In this report it was noted that the Aroma Plaza Outlet UHL was given an overall score of **5 (Very Good)** in the National Food Hygiene Rating Scheme.

REPORT

BACKGROUND

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

ASSESSMENT

On receipt of the letter report, an action plan was developed by the Restaurant and Retail Manager to address the issues raised and is attached as an appendix 1 to this report**.** This will be monitored within the service by the Commercial Services Manager.

ASSURANCE is provided by:

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

RECOMMENDATION

The Committee is asked to:

- **NOTE** the Food Hygiene Rating and the remedial actions taken following the receipt of the Commercial Services Officer (Food & Port Health) report.

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

Appendix 1

Action Plan from Food Safety Inspection on 25th June 2019 (Report dated 5th July 2019)

SCHEDULE A – LEGAL REQUIREMENTS

Food Hygiene and Safety Procedures High standard of compliance with statutory obligations, and industry codes of recommended practice, with only minor contraventions.	**Response / Action**	**Time Scale**	**Update**
1. At the time of inspection the spiralizer in the main kitchen which will be in direct contact with food was not completely clean although it had been washed, this can result in cross contamination. You should ensure the spiralizer is completely clean before use. *Regulation (EC) No 852/2004 Annex II Chapter IX para 3*	New spiralizer to be purchased utilised immediately.	Immediate	Completed
2. The upright foster fridge was operating at a slightly elevated temperature of 7.1°C (and was therefore above the 5°C upper limit that needs to be in place to comply with the Food Standard Agencies guidance on the Control of Listeria and Cardiff and Vale UHB's Food Safety Management Document. I appreciate that my inspection was conducted during a busy service period and so have taken this into account. However I did note that the temperature did reach 4.8°C once the refrigerator was left closed. This should be investigated and any appropriate remedial works carried out to enable the unit to refrigerate its contents effectively. *EC Regulation 852/2004, Article 5 and Annex II, Chapter V, paragraph 1*	During inspection this fridge was being stocked up. Staff are aware to ensure the door remains closed as much as possible during this operation and have been re-instructed to follow this standard.	Immediate	Completed

Structural / Cleaning Issues High standard of compliance with statutory obligations, and industry codes of recommended practice, with only minor contraventions.	**Response / Action**	**Time Scale**	**Update**
3. The Foster milk fridge in the Servery had some milk stains. This must be thoroughly cleaned and maintained in a clean condition. *Regulation (EC) No 852/2004 Annex II Chapter V Para 1(a)*	Fridge immediately cleaned and monitored via cleaning schedules.	Immediate	Completed
4. The small extractor vent in the Aroma Kitchen ceiling was in a little dusty condition. It must be thoroughly cleaned and maintained in a clean condition *Regulation (EC) No 852/2004 Annex II Chapter I Para 1*	MR submitted prior to inspection to action cleaning of vent.	Immediate	Completed

Confidence in Management / Control Procedures	Response / Action	Time Scale	Update
Good record of compliance. Food safety advice available in-house or access to, and use of, technical advice from a Primary or Home Authority, trade associations and/or from Guides to Good Practice or assurance scheme commensurate with type of business. Effective management control of Hazards. Having effective self-checks with satisfactory documented food safety management procedures commensurate with type of business. Audit by Food Authority confirms general compliance with procedures with minor non-conformities not identified as critical to food safety. .			
5. At the time of Inspection I looked at the Food Safety Management Document, pre requisites and monitoring records, the following were noted: • On the 20/05/19 and 27/05/19 the records had not been signed off by the supervisor, these must be completed as required. • On the 03/06/19 the temperature of one of the fridges was recorded as 6°C with no corrective actions completed. (Your food safety management document specifies storage temperatures for chilled products of 5°C and below). • The air temperature of the Foster refrigerator was 7.1°C. Consideration must be given to listeria and UHB's requirements, therefore your fridges must operate at a temperature that will keep high-risk foods at or below 5°C. Ensure the records and corrective actions are completed as required. *Regulation (EC) 852/2004 Article 5*	Supervisor to check and sign all monitoring forms. Staff aware of corrective actions as per HACCP document and re-instructed to adhere to. Refrigerator rechecked and correct temps recorded including any corrective actions.	Immediate Immediate Immediate	Completed Completed Completed

SCHEDULE B and C – FOOD STANDARDS INSPECTION REPORT / RECOMMENDATIONS AND ADVICE

Legal Requirements	Response / Action	Time Scale	Update
1. Although the hospital has allergens documentation in place as discussed an allergens matrix or similar allergens information can be downloaded at https://www.food.gov.uk/sites/default/files/media/document/allergen-chart.pdf Food Information Regulations 2014	Allergen information in situ. Information accessed via link as provided.	Immediate	Completed
2. Guidance in relation to how to comply with the allergen labelling requirements can be found at https://www.food.gov.uk/business-industry/allergy-guide. An interactive food allergy training tool can be found at food.gov.uk/allergy training.	Guidance accessed via link to ensure allergen information utilised. Staff receiving allergen training which is certificated.	Immediate	Completed
Recommendations	**Response / Action**	**Time Scale**	**Update**
1. I recommend you provide a thermometer or use a probe to check the temperature of all chilled and frozen storage units and regularly check the temperatures remain at or below 5°C for chilled foods and around -18°C for frozen foods. Do not rely on the digital display as this will only record the air temperature in specific areas.	Provided and implemented.	Immediate	Completed

Report Title:	**AROMA COFFEE OUTLET, WOODLAND HOUSE FOOD HYGIENE INSPECTION - 9th August 2019**						
Meeting:	**Health & Safety Committee.**				**Meeting Date:**	**8th October 2019**	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	**Director of Planning**						
Report Author (Title):	**Commercial Services Manager**						

SITUATION

An inspection of the Aroma Coffee Outlet at Woodland House took place on the 9th August 2019 the outcome of which was confirmed in writing in a letter report dated the same day 9th August 2019 from the Commercial Services Officer, Food and Port Health, Bridgend, Cardiff and Vale of Glamorgan Shared Regulatory Services.

In this report it was noted that the Aroma Coffee Outlet, Woodland House was given a score of **5 (Very Good)** in the National Food Hygiene Rating Scheme.

REPORT

BACKGROUND

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

ASSESSMENT

On receipt of the letter report, an action plan was developed by the Assistant Retail Manager and reviewed by Catering Services Manager to address the issues raised and is attached as appendix 1 to this report**.** This will be monitored within the service by the Commercial Services Manager.

ASSURANCE is provided by:

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

RECOMMENDATION

The Committee is asked to:

- **NOTE** the Food Hygiene Rating and the remedial actions taken following the receipt of the Commercial Services Officer (Food & Port Health) report.

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

Appendix 1

Action Plan from Food Safety Inspection at Woodland House Aroma on 9th August 2019 (Report Dated 9th August 2019)

Schedule A – Legal Requirements

Food Hygiene and Safety Procedures High standard of compliance with statutory obligations, and industry codes of recommended practice, with only minor contraventions.	**Response / Action**	**Time Scale**	**Update**
1. The blade of the heavy-duty can opener in the kitchen was encrusted with food, which would cause contamination of the food in the next tin opened. This part of the can opener must be cleaned and sanitised regularly *Regulation (EC) No 852/2004 Annex II Chapter V Para 1(a)*	Ensure can opener is cleaned and sanitised before and after use. Monitor via completed cleaning schedules.	Immediate	Completed

Structural / Cleaning Issues High standard of compliance with statutory obligations, and industry codes of recommended practice, with only minor contraventions.	**Response / Action**	**Time Scale**	**Update**
2. There were a number of raw plugs noted in the tiled wall in the pot wash. Remove any raw plugs and suitably fill the holes to leave a surface in a sound easy to clean condition. *Regulation (EC) No 852/2004 Annex II Chapter II Para. 1(b)*	Noted 4 x small raw plug holes under dishwasher tabling. Ensure any remaining raw plugs from wall removed and holes suitably filled. Estates department to undertake via submitted MR.	2 weeks	Completed

3. The hot water to the hand wash basins was at 31.2°C which was just lukewarm. You must ensure there is a supply of hot and cold, or appropriately mixed, running water to the wash hand basins at all times. I was pleased to note that this was rectified within a short period while on site and had been down to works being carried out on the boiler. If you continue to have issues with the boiler not being able to provide the level of hot water required, then I would suggest electric water heaters are fitted to each hand wash basin. *Regulation (EC) No 852/2004 Annex II Chapter I Para 4*	Estates maintenance aware of issue on day of inspection and matter rectified when EHO still present. As part of HACCP review, a procedure for temporary loss of hot water to be included.	Immediate	Completed
Confidence in Management / Control Procedures Good record of compliance. Food safety advice available in-house or access to, and use of, technical advice from a Primary or Home Authority, trade associations and/or from Guides to Good Practice or assurance scheme commensurate with type of business. Effective management control of Hazards. Having effective self-checks with satisfactory documented food safety management procedures commensurate with type of business. Audit by Food Authority confirms general compliance with procedures with minor non-conformities not identified as critical to food safety.	**Response / Action**	**Time Scale**	**Update**
4. 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;	A dummy bottle of water placed into all fridges, a monitoring form has been introduced to record an independent thermometer probing of a dummy food on a weekly basis for all fridges.	Immediate	Completed

• The breakfast cooking sheet for Friday 9th August hadn't been completed with the date; • Bacon and sausage is cooled at the unit ready for use the following day, however there was no specific sheets available for staffs to document the cooling process; • You need to identify cross contamination as a hazard during storage. You have excellent controls in place in practice such as a designated raw meat fridge. This needs to be documented; • As discussed, I suggest you include a procedure for temporary loss of hot water within your HACCP document. As you have for fridge and freezer breakdowns. 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) 852/2004 Article 5*	All staff to be reinstructed in respect of completion of monitoring forms. As part of HACCP review, produce or use existing monitoring form to record the cooling process following the 90 minute limit Control measure rechecked and in HACCP document. As part of HACCP review, a procedure for temporary loss of hot water has been introduced. All staff trained to adhere to the procedure when required	Immediate 2 weeks 2 weeks 2 weeks	Completed Completed Completed Completed

Schedule B – Recommendations and Advice

Recommendations	Response / Action	Time Scale	Update
5. There were no records available to demonstrate that staff had completed suitable food hygiene training as records were held at UHW. As discussed, can you forward me details of training completed by staff working at the Woodlands site.	E-mail sent to EHO with certificates attached for all staff working at Aroma Woodland House.	Immediate	Completed
6. One member of staff was noted wearing stud type earrings and another member of staff a ring with stones in. I recommend that food handlers do not wear jewellery	All staff met with and individual spoken to. All staff have been retrained regarding	Immediate / 1 week	Completed

other than plain wedding rings and sleeper earrings. 7. I recommend that the fillings for jacket potatoes are probed mid way through the 3 hour service period to ensure they are stored below 5°C. This is because the leftover fillings maybe refrigerated and used again the following day.	uniform requirements. Food monitoring forms have been reviewed and amended to include hot and cold temperatures records.	2 weeks	Completed