HEALTH AND SAFETY COMMITTEE

9.30am on Tuesday 28 July 2015
Corporate Meeting Room, HQ, UHW
# Health and Safety Committee

**9.30am on 28th July 2015**  
Corporate Meeting Room, Headquarters, University Hospital of Wales  

**AGENDA**

## PART 1: ITEMS FOR ACTION

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<th>No.</th>
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<tr>
<td>1</td>
<td>Welcome and Introductions</td>
<td>Oral Chair</td>
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<td>Apologies for Absence</td>
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<td>Declarations of Interest</td>
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<td>Minutes of the Health and Safety Committee meeting held on 28th April 2015</td>
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<td>Action Log Review</td>
<td>Chair</td>
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### Deliver Outcomes that Matter to People

**Our Service Priorities**

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<td>Food Standards Agency Listeriosis Guidance</td>
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<td>12</td>
<td>Environmental Health Inspection of the Central Food Production Unit, University Hospital of Wales on 16th June 2015</td>
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<td>Environmental Health Inspection of Healthfields, Teddy Bear Trust and Wards on 30th June 2015</td>
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<td>Lone Worker Alert System Progress Report</td>
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<td>15</td>
<td>Dangerous Goods Safety Audit Report 2015</td>
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<td>Work Programme 2015/16</td>
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<td>Fire Safety Policy</td>
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<td>18</td>
<td>Mandatory Training Compliance and Lost Time Presentation</td>
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</tbody>
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**PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE**

Papers are available on the Health Board website

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<td>Corporate Risk Assurance Framework Exceptions Report</td>
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<td>Environmental Health Inspection of Whitchurch Hospital on 20th April 2015</td>
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<td>Environmental Health Inspection of Barry Hospital on 15th June 2015</td>
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<td>Environmental Health Inspection of University Hospital Llandough on 3rd July 2015</td>
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<td>Strategic Report on Health and Safety Management</td>
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<td>24</td>
<td>Health Board's statutory compliance to the reporting of Injuries, Diseases and Dangerous Occurrences Regulations Report</td>
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<td>26</td>
<td>Updated Health and Safety Related Policies Schedule</td>
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<td>27</td>
<td>Review of the Meeting</td>
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<tr>
<td>28</td>
<td>To note the date, time and venue of the next meeting: - 9.30am on Tuesday 6 October 2015 in the Corporate Meeting Room, Headquarters, University Hospital of Wales</td>
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To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. [Section 1(2) Public Bodies (Admission to Meetings) Act 1960]
UNCONFIRMED MINUTES OF THE HEALTH AND SAFETY COMMITTEE HELD AT 9.30am ON 28 APRIL 2015 IN THE CORPORATE MEETING ROOM, HQ, UNIVERSITY HOSPITAL OF WALES (UHW)

Present:
Martyn Waygood Independent Member – Legal (Chair)
Stuart Egan Independent Member – Trade Union

In attendance:
Steve Allen Community Health Council Representative
Claire Bateman-Jones Staff Representative
Claire Birchall Head of Operations and Delivery – Children and Women Clinical Board (until agenda item 15/030)
Charles Dalton Head of Health and Safety
Carol Evans Assistant Director of Patient Safety and Quality
Abigail Harris Director of Planning
Sharon Hopkins Director of Public Health
Geoff Walsh Assistant Director of Planning (Capital Estates and Operational Services)
Peter Welsh Board Secretary (from agenda item 15/031)

Apologies:
Andy Berry Director, OSHEU, Cardiff University
Steve Careless Staff Representative
Christopher Elmore Independent Member – Local Authority
Fiona Jenkins Director of Therapies and Health Sciences

Secretariat:
Rachael Daniel Health and Safety Adviser

PART 1

HSC: 15/024 WELCOME AND INTRODUCTIONS

The Chair welcomed all present to the meeting.

HSC: 15/025 DECLARATIONS OF INTEREST

The Chair invited Committee Members to declare any interest in the proceedings included in the agenda. None were declared.
The minutes of the Health and Safety Committee held on the 13 January 2015 were APPROVED and ACCEPTED as a true record.

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

- HSC: 15/007 – the Chair raised his concern that there was still not a nomination from the Surgery Clinical Board for the Deputy Fire Safety Manager, UHW. The Head of Health and Safety added that a nomination was also awaited from the Medicine Clinical Board, it was agreed that a letter would be sent on behalf of the Committee requesting these nominations urgently.

**ACTION - Mr C Dalton**

- HSC: 15/013 – the Head of Health and Safety informed the Committee this was being pursued with Procurement so that a central stock of fabric glide sheets could be purchased and discussions would then have to take place with Greenvale Laundry to ensure the glide sheets were returned to the Health Board following the laundering process.

Mrs Bateman-Jones, Trade Union Representative queried if other Health Boards had the same problem in having their stock returned to them, Mr Dalton believed this to be the case, however as a Health Board we would have the opportunity to identify the glide sheets via a tag prior to them being laundered. Mr Dalton also added a source of funding would need to be identified in order for them to be purchased. The Assistant Director of Planning (Capital Estates and Operational Services) queried the number of the glide sheets required, Mr Dalton stated he would need to review the paper presented at the last meeting. The Director of Planning advised these could be purchased through the operations budget but stressed the contract with Greenvale Laundry would need to be closely monitored to ensure the same quantity/quality was being returned, Mr Walsh stated that this would be undertaken by his team.

The Director of Public Health queried whether there were any actual incidents of harm relating to the use of the paper glide sheets and the Chair confirmed that there had been.

It was AGREED the glide sheets would be purchased from the operations budget and for Mr Dalton to liaise with Mr Neil Paul for the order to be placed.

**ACTION - Mr C Dalton**
COMMITTEE WORK PROGRAMME FOR 2015/16

The Health and Safety Adviser stated the Work Programme had been reviewed and updated to reflect the work of the Committee for the forthcoming year.

The Committee RECEIVED and SUPPORTED the 2015/16 Work Programme.

CHILDREN AND WOMEN CLINICAL BOARD ASSURANCE REPORT

The Head of Operations and Delivery for the Children and Women Clinical Board highlighted the key areas of the report to the Committee. Mrs Birchall advised of the problems in the Neo Natal Unit due to the increased demand and is frequently over capacity. The current environment has been identified as a contributory factor in the recent infection outbreak. It was noted that plans were being finalised to expand the department to address current environmental issues and prioritise the capacity needed to implement the South Wales Programme (SWP), but in the meantime a contingency plan had been agreed to mitigate the risks.

Mrs Birchall advised due to inadequate archiving capacity for medical records it has resulted in an increased risk of unsafe storage and injury to staff, however the Clinical Board was working very closely with the Medical Records Department to identify suitable storage facilities as well as a number of practical solutions.

Mrs Birchall informed the Committee the lifts in the Women’s Unit were often breaking down which was a significant risk to women who were in labour and the potential for them being trapped in the lifts. This has been escalated to the Assistant Director of Planning (Capital Estates and Operational Services) and a piece of work is being undertaken by the Clinical Board Estates Representative in relation to the number of breakdowns.

Mrs Birchall advised the level of compliance for mandatory training was poor within the Clinical Board and this was as a result of being unable to release the staff due to work pressures and the levels of vacancies and sickness/maternity leave. She informed the Committee this was being addressed by the Head of Workforce who was leading on developing an improvement plan, however she was assured that all staff involved in the recent transfer of the Childrens Hospital had received their fire training. The Head of Health and Safety observed there was not a high take-up of the revalidation options for manual handling training which would not require the staff to be released from the clinical area. Mrs Birchall advised the Clinical Board would consider this option.

ACTION – Mrs C Birchall

In relation to the lone worker devices Mrs Birchall stated there was poor compliance within the Clinical Board and the importance of the devices had been reiterated to staff and details of actual incidents have been shared with them. She is also aware that the contract is being reviewed with the option of a new supplier; Mr Dalton confirmed this was the case and would ensure the Clinical Board had a device to trial.
Mrs Birchall informed the Committee since the submission of the report a new risk had been added to their risk register in relation to evacuation plans and explained it was not easy to evacuate their client group so work was being undertaken with Angela Stephens, Civil Contingencies Manager to progress this and would be a key objective for them during the forthcoming year.

Finally, Mrs Birchall informed the Committee that every 3rd meeting of the Quality and Safety Meeting was dedicated to health and safety and the Clinical Board were currently reviewing their action plan. A nominated Board lead for health and safety had been identified.

The Chair thanked Mrs Birchall for her report and invited comments from the Committee.

Mrs Bateman-Jones, Staff Representative who works in the Neo Natal Unit stated staff were distressed by the outbreak and it was important that staff received support. Mrs Birchall stressed the outbreak was no reflection on the staff and the Infection Control Department was reassuring staff of this, she also advised of the increased presence of the Directorate/Clinical Board management team on the Unit to support staff.

Mr Allen, Community Health Council Representative expressed serious concerns in relation to the Unit. He stated the care provided by the staff was excellent but the environment was poor and queried whether the move could be expedited. The Assistant Director of Planning (Capital Estates and Operational Services) advised there was a solution but due to the amount of enabling works required the move could not be undertaken any quicker than planned and the Executive Team had agreed to these enabling works to support the Clinical Board. Mr Allen added the Unit had been on the Health Board’s risk register for many years and it was now at a critical stage. Mr Walsh stated there was nowhere for the Unit to decant to at present without the enabling works.

The Director of Public Health informed the Committee the Board had a very robust action plan in place and the role of this Committee would be to be assured that the milestones on the plan were being met.

Mr Waygood queried the timescales for completion, Mr Walsh advised that the 1st phase is planned to be completed in November 2015.

The Independent Member – Trade Union queried whether consideration had been given to limit the number of babies admitted into the Unit. Mrs Birchall advised as Welsh Government funding hasn’t yet been approved this was continually monitored but they could not refuse an emergency; Mrs Bateman-Jones concurred with this. Mrs Harris added the Board were well aware of the situation and work was being progressed to increase the staffing levels which was being led by the Director of Nursing. Mrs Hopkins assured the Committee they were looking at balancing all of the risks but it was not a simple problem to resolve. Mr Waygood stated the
Committee needs to understand the position and the requirement to monitor the action plan. Mrs Birchall advised she would attend a future meeting to provide the Committee with the reassurances it required and inform of progress against the action plan.

**ACTION – Mrs C Birchall**

Mr Allen advised the Community Health Council were reassured at the time of the closure of maternity services at Llandough Hospital that there would be a link between the Midwifery Led Unit and the Consultant Led Unit which was now being seriously affected by the breakdown of the lifts in the Women’s Unit. This was unacceptable as this was putting patients at risk. Mr Walsh explained the Health Board had a number of lifts which were in a poor condition and in need of replacement, and work was being undertaken to identify a replacement programme based off prioritisation. Mr Egan queried what systems were in place to release staff from these lifts in the event of a breakdown and whether patients were being escorted by the correct staff. Mr Walsh advised a number of staff were trained to deal with entrapment and Mrs Birchall stated that whilst there was a clear process for escorting patients there were a number of women in the final stages of labour who came in by themselves. Mr Walsh stressed that it was important to understand the risks and would work with the Clinical Board to assess this fully (including the number of times the lifts had failed).

Mrs Hopkins stated the Committee needs to have an awareness of where the refurbishment of lifts sits on the capital programme. Mr Walsh requested that he bring a report back to the next meeting with details of those lifts that carry patients and the number of breakdowns associated with them. This was **AGREED** by the Committee.

**ACTION – Mr G Walsh**

The Clinical Board Assurance Report was **RECEIVED** by the Committee.

**HSC: 15/030 HEALTH AND SAFETY EXECUTIVE PRIORTY ACTION PLAN**

The Head of Health and Safety highlighted the key issues of the report to the Committee:

Point 1.2 – E-Datix has now been implemented in the Specialist, Surgery, Dental and PCIC Clinical Boards with the remainder of the Clinical Boards on schedule for implementation by the end of the year. The Chair queried what feedback had been received from the users; the Assistant Director of Patient Safety and Quality advised the users were not reporting too many problems but the Managers responsible for processing the incidents were requiring a lot of training support. Mr Dalton added it was anticipated the number of reported incidents would reduce and this was being monitored by the Project Board. He added the positive aspect was that both Health and Safety and Patient Safety were being immediately notified of high level events and there should be benefits for RIDDOR reporting although this does still rely on the information being completed.
Point 3.6 – this is a new item added to the action plan, the Lifting Operations and Lifting Equipment Regulations (LOLER) requires the monitoring of lifting equipment and at present the Health Board does not have a complete survey of the number of hoists and slings. A joint survey will be undertaken with the hoist company to identify the numbers, age and condition of the hoists.

Point 5.3 – the legionella survey is continuing as this will be an on-going process.

Point 7.4 – this is a new item added to the action plan following an incident where a tree in a high risk area blew over and further work is being undertaken to monitor and implement the findings of the Tree Safety Survey.

The Chair thanked Mr Dalton for his report and invited comments from the Committee.

Mr Allen queried in relation to Point 2.6 the timeframe for violent warning markers to be retained on a patient’s record. Mr Dalton clarified a group regularly meets to ensure markers are not on records any longer than necessary and meets the requirements of data protection.

In respect of point 5.1 Mr Allen queried the position in relation to the window closures and Mr Walsh confirmed this had been completed.

The report was RECEIVED by the Committee.

HSC: 15/031  FIRE ENFORCEMENT REPORT

The Assistant Director of Planning (Capital Estates and Operational Services) informed the Committee of his concerns in respect of the fire enforcement notice for Theatres, Day Surgery and Anwen Ward at Llandough Hospital. He advised the estates work had been completed but the management issues still remain. A recent visit of the areas identified that although training had been progressed, doors were still being wedged open and inappropriate storage was evident despite the local managers being informed they would be held personally accountable as well as the organisation by the Fire Service. The Independent Member – Trade Union concurred it was the local managers’ responsibility however it has now been brought to the attention of the Committee and we have an obligation to assist in its resolution.

The Chair queried what else could be done to improve the situation, Mr Walsh stated Surgery was one of the Clinical Boards who had not identified a Deputy Fire Safety Manager and it was a key role as their attendance would be required at the Fire Safety Group. Mr Welsh added this had been raised at a recent HSMB meeting and the Clinical Boards gave assurances that they would nominate a representative to undertake this role. The Director of Planning stated formal escalation was now required and a letter would be sent on behalf of the Committee advising of their disappointment and concern that this action was still outstanding.

ACTION – Mr C Dalton/Mrs A Harris
Mr Walsh also informed the Committee that in addition to the enforcement notices the Health Board had also received 72 informal notices within the last 3 years and regular topics raised were fire door repairs, doors being wedged open, blocking emergency exits, changing the use of rooms, lack of training and no knowledge of local fire procedures. The Director of Public Health observed these were as a result of individual’s behaviour and suggested questions in relation to fire safety could be incorporated into the PADR and staff handovers. Mrs Hopkins also suggested that the profile of the Fire Officers could be raised in conjunction with the Chief Executive. The Head of Health and Safety agreed there needed to be a process where key messages could be communicated to staff and suggested the next Fire Safety Group Meeting was dedicated to how to raise the profile of fire safety and invite a representative from the Communications Team to the meeting. This was AGREED by the Committee.

**ACTION – Mr C Dalton**

Mrs Harris stated the Clinical Board Directors must receive copies of the audits from the Fire Brigade for their areas of responsibility and Mr Waygood added they could then also attend the Committee to explain the management failings if appropriate.

**ACTION – Mr G Walsh**

The report was RECEIVED by the Committee.

**HSC: 15/032 NEEDLE STICK REPORT**

The Health and Safety Adviser informed the Committee the 2013/14 annual report had identified a 14.3% reduction in the total number of needle stick incidents on the previous year and an overall trend decrease in the number of contacts with dirty sharps.

Miss Daniel reported an audit had been undertaken of all clinical areas and any stock of the non safety cannulas had been removed. She also informed the Committee of the trial that had been undertaken of Safety Butterfly Needles in the Phlebotomy Department with very positive results. Initial feedback was that these do not impact on clinical practices, the full implementation of these was now being progressed.

The Chair queried what action could be taken to reduce the number of needle stick incidents from insulin pens, Miss Daniel reported the majority of these incidents were as a result of patients who self administer and then leave them unattended, she suggested an education process with patients and wards would be required which she would take forward.

**ACTION – Miss R Daniel**

The report was RECEIVED by the Committee.
HSC: 15/033 UPDATE REPORT ON PARK VIEW HEALTH CENTRE

The Head of Health and Safety informed the Committee although the issue had not been fully resolved no new incidents had been reported since the last meeting and the long term solution was for the Clinical Board to identify the funding for the security presence to be retained.

Mr Allen, CHC Representative advised he had visited the Health Centre in January 2015 and the building was in a poor state of repair. The Assistant Director of Planning (Capital Estates and Operational Services) advised roofing and external fabric work was currently being carried out on the building, suitable materials to replace the windows was also being pursued as glass windows were being vandalised. Mr Walsh advised a longer term solution for providing the services to the community was also being discussed with the Local Authority and Police.

The Director of Planning stated feedback was required from the Clinical Board in respect of the funding issue, Mr Dalton agreed to pursue this and that it would also remain on the Priority Action Plan until resolved.

ACTION – Mr C Dalton

The report was RECEIVED by the Committee.

HSC: 15/034 HEALTH BOARD’S STATUTORY COMPLIANCE TO THE REPORTING OF INJURIES, DISEASES AND DANGEROUS OCCURRENCES REGULATIONS (RIDDOR) REPORT

The Head of Health and Safety noted it was disappointing that compliance for the period had reduced to 60% however the overall annual compliance was 86%. Mr Dalton informed the Committee the late reported incidents were pursued with the Clinical Boards and were discussed at their Health & Safety meetings.

The Director of Planning advised where patterns were occurring within the Clinical Boards these should also be reported via the performance dashboard and she would liaise with Caroline Bird, Head of Business Performance.

ACTION – Mrs Harris

The report was RECEIVED by the Committee.

HSC: 15/035 WASTE MANAGEMENT COMPLIANCE REPORT

The Assistant Director of Planning (Capital Estates and Operational Services) stated there had been a slight improvement on the previous period and any non compliances were low grade with overall performance being very good. Mr Walsh added the Waste Management Team will specifically work with areas that they have identified as not complying with the waste management regulations.

The Director of Public Health wanted the excellent work of the Waste Management Team during the time of the Ebola outbreak to be formally noted and that clinicians at
the time acknowledged the tremendous work undertaken by the team. The Chair added this was a prime example of why the Board walk rounds should not be confined to clinical areas only as had been discussed at the Quality, Safety and Experience Committee.

The report was RECEIVED by the Committee.

PART 2

HSC: 15/036 REPORT ON THE FEBRUARY 2015 ENVIRONMENTAL HEALTH INSPECTION OF LLANFAIR UNIT, LLANDOUGH HOSPITAL

The report was RECEIVED and NOTED for information by the Committee. The Chair stated a score of 5 out of 5 had been achieved but more importantly the report commented on the high standards being worked to and congratulation letters would be sent to the staff.

ACTION – Miss R Daniel

The Assistant Director of Planning (Capital Estates and Operational Services) informed the Committee that a 5 was also achieved in the inspection of Whitchurch Hospital during the previous week. Mr Waygood stated this was a reflection of the internal inspections that had been implemented within operational services. Mr Allen, CHC representative suggested this should be promoted as a good news story.

ACTION – Mr G Walsh

HSC: 15/037 STRATEGIC REPORT ON HEALTH AND SAFETY PATIENT AND ENVIRONMENT SAFETY

The report was RECEIVED and NOTED for information by the Committee. The Chair noted the Smoking Enforcement Officer was actively approaching smokers and advising them of the Health Board Policy on ‘no smoking’. The Director of Public Health added more work still needed to be done with staff who were not engaging with the policy particularly those who were smoking just outside of the Health Board boundary.

HSC: 15/038 HEALTH AND SAFETY RELATED POLICIES SCHEDULE

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

HSC: 15/039 FIRE SAFETY GROUP MEETING OF NOVEMBER 2014

The minutes were RECEIVED and NOTED for information by the Committee.
HSC: 15/040  REVIEW OF THE MEETING AND ITEMS TO BRING TO THE ATTENTION OF THE BOARD OR OTHER COMMITTEES

The Chair advised there were no issues from the meeting that needed to be brought to the attention of the Board or any other Committee.

HSC: 15/041  DATE AND TIME OF NEXT MEETING

The next meeting will be held at 9.30am on Tuesday 28 July 2015 in the Corporate Meeting Room, HQ, University Hospital of Wales.

Signed  ……………………………………

Date  ……………………………………
UP DATED ACTION LOG

NB: Following presentation to the Committee meeting in April 2015, those actions completed have been removed.

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<tr>
<td>HSC: 15/007</td>
<td>13/01/15 &amp; 28/04/15</td>
<td>Deputy Fire Safety Manager</td>
<td>Surgery &amp; Medicine Clinical Boards still to identify DFSM. Letter to be sent to Management Team requesting nomination as matter of urgency.</td>
<td>Mr Charles Dalton/Mrs Abigail Harris</td>
<td>COMPLETED Letter sent.</td>
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<tr>
<td>HSC: 15/013</td>
<td>13/01/15</td>
<td>Glide Sheet Provision</td>
<td>Review of SLA with Greenvale Laundry.</td>
<td>Mrs Abigail Harris/Mr Geoff Walsh</td>
<td>ACTION STILL UNDERWAY Review of SLA on-going</td>
</tr>
<tr>
<td>HSC: 15/013</td>
<td>13/01/15 &amp; 28/04/15</td>
<td>Glide Sheet Provision</td>
<td>Progress the purchase of fabric glide sheets with Procurement and Clinical Boards.</td>
<td>Mr Charles Dalton</td>
<td>ACTION STILL UNDERWAY Meetings have taken place with Procurement to progress tender.</td>
</tr>
<tr>
<td>HSC: 15/029</td>
<td>28/04/15</td>
<td>Manual Handling Training</td>
<td>Children &amp; Women to consider revalidation process for manual handling training.</td>
<td>Mrs Claire Birchall</td>
<td>ACTION STILL UNDERWAY Option being considered by Clinical Board.</td>
</tr>
<tr>
<td>HSC: 15/029</td>
<td>28/04/15</td>
<td>Lone Worker Device</td>
<td>Health Visiting to trial device being considered.</td>
<td>Mr Charles Dalton</td>
<td>COMPLETED</td>
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<td>HSC: 15/029</td>
<td>28/04/15</td>
<td>Neo Natal Action Plan</td>
<td>Committee to be kept updated in relation to compliance to action plan.</td>
<td>Mrs Claire Birchall</td>
<td>ACTION STILL UNDERWAY</td>
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<td>Progress against action plan to be reported to future meeting</td>
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<td>HSC: 15/029</td>
<td>28/04/15</td>
<td>Lift Compliance</td>
<td>Report to be brought to the July Committee meeting.</td>
<td>Mr Geoff Walsh</td>
<td>ACTION STILL UNDERWAY</td>
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<td>Deferred to October meeting.</td>
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<td>HSC: 15/031</td>
<td>28/04/15</td>
<td>Fire Safety</td>
<td>Raising the profile of fire safety management to be discussed at the next Fire Safety Group Meeting.</td>
<td>Mr Charles Dalton/Mr Geoff Walsh</td>
<td>COMPLETED</td>
</tr>
<tr>
<td>HSC: 15/031</td>
<td>28/04/15</td>
<td>Fire Safety</td>
<td>Clinical Boards to receive copies of Fire Service audits.</td>
<td>Mr Geoff Walsh</td>
<td>COMPLETED</td>
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<tr>
<td>HSC: 15/032</td>
<td>28/04/15</td>
<td>Needle stick Incidents</td>
<td>Needle stick incidents from patient’s insulin pens to be discussed at ward level.</td>
<td>Miss Rachael Daniel</td>
<td>ACTION STILL UNDERWAY</td>
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<td>Report and action plan on the agenda.</td>
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<td>HSC: 15/033</td>
<td>28/04/15</td>
<td>Security Arrangements at Park View Health Centre</td>
<td>Head of Health &amp; Safety to liaise with PCIC Clinical Board to identify funding for increased security.</td>
<td>Mr Charles Dalton</td>
<td>ACTION STILL UNDERWAY</td>
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<td>Funding to be identified.</td>
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<td>HSC: 15/034</td>
<td>28/04/15</td>
<td>RIDDOR Compliance</td>
<td>Late reporting of RIDDORs to be reported via the Performance Dashboard. To liaise with Head of Business Performance.</td>
<td>Mrs Abigail Harris</td>
<td>COMPLETED</td>
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<td>HSC: 15/036</td>
<td>28/04/15</td>
<td>Letter of Congratulations</td>
<td>Letters to be sent in the name of the chair on behalf of the Committee</td>
<td>Miss Rachael Daniel</td>
<td>COMPLETED</td>
</tr>
<tr>
<td>REPORTING COMMITTEE /GROUP</td>
<td>Medicine Clinical Board Quality Safety and Experience Group</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>---------------------------</td>
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</tr>
<tr>
<td>CHAIRED BY</td>
<td>Dr Richard Evans</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONTACT DETAILS</td>
<td><a href="mailto:Richard.evans9@wales.nhs.uk">Richard.evans9@wales.nhs.uk</a></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DATE OF LAST MEETING</td>
<td>2nd July 2015</td>
<td></td>
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</tbody>
</table>

**KEY AGENDA ITEMS/RISK TO NOTE**

**Clinical Environments** – The ward areas in UHW and UHL continue to provide challenges for the MCB both in terms of aging estate and inadequate storage facilities. This creates both challenges when delivering care, difficulty in ensuring appropriate cleaning standards are maintained and provides further challenges to delivering the required reductions in HCAI.

**Bariatric Equipment** – There requirement for bariatric equipment continues to increase. Timely provision of equipment is required to deliver safe care for both patients and staff. Work continues to establish what is equipment is available and the extent to which patient needs can be currently met.

**Isolation rooms** – Capital Colleagues are currently developing rooms to meet the required specification for high risk infectious disease patients on ward A7. Whilst this is warmly welcomed it is posing challenges in maintain patient safety and flow. Remedial arrangements to mitigate risk have been put in place.

**Compliance with mandatory training** – Due to work pressures, levels of vacancies sickness and maternity leave there are difficulties in releasing staff to attend mandatory training. Improved compliance will a focus for work for the newly appointed Senior Nurses with the nursing workforce.

**ONGOING WORK/ACTIONS**

Whilst the risk register was updated in July 2015 it is recognised that further work is required and will be taken forward. The Risk Register was updated at the formal Clinical Board Meeting on 22nd June 2015.

It is acknowledged that there is more to do and this will be better supported in August when new Governance post is backfilled.
In particular we will review Directorates Risk Registers to ensure they are reflected appropriately within Medicine Clinical Board Risk Register. We shall also add any new risks as identified and consider current weightings.

A standalone Health and Safety meeting will be established for the MCB as current arrangements are encompassed within the Quality Safety and Experience meetings.

This meeting will be chaired by Head of Operations and Delivery, these new arrangements will provide sufficient assurance regarding robust health and safety issues and provide for escalation of issues and successes.

<table>
<thead>
<tr>
<th>ACTION PLAN SUBMITTED TO OPERATIONAL HEALTH AND SAFETY GROUP</th>
<th>Yes [ ] No [ No ]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This will be updated as part the revised meeting arrangements</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>DATE OF NEXT MEETING</th>
<th>TBA</th>
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</table>
HEALTH AND SAFETY EXECUTIVE - CONTRAVENTIONS OF THE HEALTH AND SAFETY (SHARP INSTRUMENTS IN HEALTH CARE) REGULATIONS 2013

Executive Lead: Director of Planning
Author: Head of Health and Safety
Caring for People, Keeping People Well: This report underpins the Health Board’s “Sustainability” and “Values” elements of the Health Board’s Strategy.
Financial impact: Fees for Intervention will apply. Costs for implementing safety sharp devices to be determined.
Quality, Safety, Patient Experience impact: This report is fundamental to the safety and quality of both staff and patients
Health and Care Standard Number: 2.1  CRAF Reference Number: 8.1.4
Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION
The Committee is asked to:

- NOTE the contraventions identified by the Health and Safety Executive and
- AGREE the implementation of the action plan.

SITUATION
The Health and Safety Committee has received regular progress reports on Needlestick Injuries and progress towards Safer Sharps. The Health and Safety Executive (HSE) on the 14th May 2015 came to the UHW Hospital site to audit the Health Board’s compliance of the Health and Safety (Sharp Instruments in Health Care) Regulations. The Inspectors met a number of key staff including Infection Control, Occupational Health, and Procurement and visited a number of Departments. The HSE concluded that the Health Board was in contravention of the 2013 regulations and that this contravention justified the issuing of a formal Improvement Notice against the Health Board, requiring remedial action and as such also incur Intervention Fees.

The HSE subsequently wrote to the Chief Executive on the 29th May 2015, issuing him with the Improvement Notice which requires resolution by the 27th August 2015. (Attachment 1)

The contraventions identified were:

- That the Health Board had failed to use Safer Sharps in place of standard sharps where there is a safer alternative on the market in all wards and departments with specific reference to the failure of Main Theatres to not use the introduced safety cannulas and that other...
areas of the Health Board had not implemented the use of syringes with shields or covers.
- The Health Board’s current Infection Control Protocol for Needlestick and Similar Sharps Injuries document was published and approved by the Quality and Safety Committee in 2010 and was due for review in August 2013, but was not actioned. This document predates the safer sharps legislation and as such needs to be reviewed and revised.
- There were a number of incidents where staff sustained sharps injuries from patients who were known to be carriers of blood borne viruses (BBV), which had not been reported to the HSE as required by regulation 7 of the RIDDOR regulations 2013.

BACKGROUND

The Health and Safety (Sharp Instruments in Healthcare) Regulations came into force in 2013. The Regulations require Health Care to undertake effective safe management of sharps and builds upon existing laws. Regulation 5 requires that organisations should avoid the unnecessary use of sharps where it is not reasonably practicable to avoid the use.

The regulations require:
- The use of safer sharps (incorporating protection mechanism)
- Preventing the re-capping of needles.
- Secure containers for disposal of medical sharps, close to the work area.
- To record and investigate incidents.
- To treat and follow up any sharp injuries.
- The review of procedures regularly.

In response to these Regulations the Health Board had undertaken a number of key interventions through the Health and Safety Committee including implementation of safety cannulas, safety lancets, and safe routes of disposal and had targeted areas of highest risk.

Furthermore, the RIDDOR regulations requires the Health and Safety Executive to be notified should any sharp injury occur to an employee, by a sharp known to be contaminated by a BBV such as Hep B or C or when the employee receives a sharp injury and a BBV occurred by this route sero converts.

ASSESSMENT

The HSE Inspector commended the work undertaken in the implementation of safety cannulas and the progress made with butterflies. Its visit to the Dental Hospital concluded that this Clinical Board had expanded the implementation to other key features to meet the requirements and had appropriate protocols in place. It also considered that safety cannulas had been implemented within the Medicine wards visited.
However on visiting Main Theatres they could find no evidence of any safety cannulas in use in the main operating theatre. It could not accept the explanation given by staff that safety cannulas were not used because in the opinion of the Anesthetists these compromised patient safety. The Inspector highlighted that:

- Safety cannulas are used throughout Theatres in other organisations and were indeed in use within SSSU.
- There was no effective risk assessment detailing the justification for non safety devices and additional protocols implemented.
- Whilst accepting that certain categories of patients may not be suited to safer sharps it is unlikely that all patients would be at risk.

They also considered that in the time scale more progress could have been made throughout the Health Board as a whole in the implementation of other safer sharps devices available on the market e.g. the range of syringes and needles now available with a shield cover.

The HSE met with Infection Control and reviewed its relevant documentation. It noted the “Infection Control Protocol for Needlestick and Similar Sharps Injuries” dealt only with post event actions, making no reference to avoidance or safer sharps. Concern was expressed that despite being two years out of date the draft was not completed. It was noted that the document was written prior to the regulations so failed to reflect the legislative requirements. It was explained that meetings had taken place to progress the reviewed protocol and it was planned that the reviewed protocol would be brought to the Infection Control Group in July for approval and publishing.

The Inspector met with Occupational Health and established that a number of needlestick injuries known to them to have come from a known BBV source had not been reported internally to the Health and Safety Department for progression through to the HSE under RIDDOR regulations. The Occupational Health Department explained that all staff are advised on treatment and to report the event to the Health and Safety Department.

The HSE further concluded that the protocol for safer sharps did not emphasise staff responsibility with regards to needlestick injuries and RIDDOR.

The Health Board is required to implement or appeal the Enforcement Notice by 27th August 2015. The attached action plan for implementation has been progressed that requires:

- Safety cannulas should be immediately re-implemented within main theatres and risk assessments should be completed for those patient types where these devices are not suitable.
- The Infection Control Protocol for Needlestick and Similar Sharps Injuries should be urgently revised and approved at the July Infection Control Group to include the requirements of safer sharps; this may
justify the consideration of a separate procedure/policy related to the requirements of the sharps regulations.

- Revised arrangements to be implemented to ensure that the Health and Safety Department are made aware of all needlestick injuries from known BBV sources and that assurance is given via regular reports to the Operational Health and Safety Group.
- Staff Health and Safety Induction and Mandatory training to be amended to reflect the requirements around reporting needlestick injuries from known BBV sources.
- A Task and Finish Group (made up of related clinical disciplines such as Procurement, Health and Safety, Occupational Health and Infection Control) reform to advance the implementation of further safer sharp devices.
Notification of Contravention

Date
27/5/15

Dear Sir

HEALTH AND SAFETY AT WORK ETC ACT 1974
HEALTH AND SAFETY (SHARPS INSTRUMENTS IN HEALTHCARE) REGULATIONS 2013

I am writing following my visit with Janet Hensey (Specialist Inspector Occupational Health), to the above address on 14th May 2015 where I met Ms Carol Evans (Assistant Director of Nursing), Mr Charles Dalton (Head of Health and Safety) and relevant employees. I visited to carry out an inspection to assess how your organisation is complying with the Health and Safety (Sharps Instruments in Healthcare) Regulations 2013.

Action Required

During my visit, I identified the contraventions of health and safety law listed in Appendix 1 of this letter. You must take action on these matters to comply with the law.

An Improvement Notice serial number JL260515A is also enclosed with this letter. The relevant law and the reasons for my opinion are given in the Notice. Contraventions numbered 1, 2 and 3 in Appendix 1 provides further details on this including the compliance date for the notice.

Whilst I looked at some of your activities to assess how you were complying with your legal responsibilities, I did not examine the whole of your business. There may be additional areas to those I identified which also require your attention. It is your responsibility to ensure the health and safety of your employees and other people, such as members of the public, who may be affected by the way you run your business.
HEALTH AND SAFETY AND NUCLEAR (FEES) REGULATIONS 2015 ('THE FEES REGULATIONS 2015') – FEE FOR INTERVENTION

I am notifying you that the contraventions numbered 1 and 2 in Appendix 1 are, in my opinion, material breaches for which a fee is payable by you to HSE under Fee for Intervention. My reasons for this are also given in Appendix 1. You should read “Information on Fee for Intervention” accompanying this letter for further information on this.

Advice

In Appendix 2, I give some additional recommendations for ensuring future compliance and improving your management of health and safety

Further Information

For further information about health and safety please visit HSE’s website at www.hse.gov.uk. You can view and download HSE guidance online and also order priced publications from the website. HSE priced publications are also available from bookshops.

Information for employees

Section 28(8) of the Health and Safety at Work etc. Act 1974 requires me to give information to your employees about matters affecting their health and safety. I have, therefore, sent a copy of this letter to Stephen Careless as a representative of your employees.

Please will you write to me confirming the action you have taken on the matters listed in Appendix 1 by 26/8/15. A return visit may be made to ensure the appropriate action has been taken if you require any further information or advice please contact me.

Yours faithfully

Jacqueline Leaker
HM Specialist Inspector (Occupational Health)

Enc: Appendixes 1, 2
Information on Fee for Intervention

cc: Stephen Careless
CONTRAVENTIONS OF HEALTH AND SAFETY LAW

I identified the following contraventions of health and safety law at my visit and these now require your attention. You must take action on them to comply with your legal duties. I have also given you the reasons for my opinion as to why you are contravening or have contravened health and safety law.

1) Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 – Regulation 5(1)(b)

The above regulation requires that you, where it is not reasonably practicable to avoid the use of medical sharps, use safer sharps (incorporating protection mechanisms). The term ‘safer sharp’ means medical sharps that incorporate features or mechanisms to prevent or minimise the risk of accidental injury.”

I identified the above contraventions of health and safety law at my visit and these now require your attention. You must take action on them to comply with your legal duties. I have also given you the reasons for my opinion as to why you are contravening or have contravened health and safety law.

You have failed to use safer sharps in place of standard sharps where there is a safer alternative on the market in all wards and departments at University Hospital of Wales. The term ‘safer sharp’ means medical sharps that incorporate features or mechanisms to prevent or minimise the risk of accidental injury. For example, a range of syringes and needles are now available with a shield or cover that slides or pivots to cover the needle after use. Safer cannulas have been introduced but these were not being used in the main theatre area. You as an employer must substitute traditional, unprotected medical sharps with a ‘safer sharp’ where it reasonably practicable to do so.

2) Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 – Regulation 5 (2)

The above regulation requires you as an employer to review at suitable intervals the policies and procedures in place to implement the following risk control measures so as to ensure that those policies and procedures remain up to date and effective.

   a) use of medical sharps at work is avoided so far as is reasonably practicable;
   b) when medical sharps are used at work, safer sharps are used so far as is reasonably practicable;
   c) needles that are medical sharps are not caged after use at work unless the risk of injury to employees is effectively controlled by use of a suitable appliance, tool or other equipment;
   d) in relation to the safe disposal of medical sharps that are not designed for re-use;
   e) written instructions are available for employees
   f) clearly marked and secure containers are located — close to areas where medical sharps are used at work.

Your current document, ‘Infection Control Protocol For Needlestick And Similar Sharps Injuries’ published 16th November 2010 was due to be reviewed 17/06/2013 but was not actioned. This current protocol predates the Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 and therefore needs to be reviewed and revised.

3) Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) Regulation 7

There have been a number of dangerous occurrences where a staff member sustained a sharps related injury with a contaminated sharp from a patient who was known to be a carrier of a blood borne virus. These incidents had not been reported to HSE as required by regulation 7 of RIDDOR. A system should be put into place to ensure that relevant incidents are reported to HSE as required by the Regulations.
Improvement Notice

You should read the Improvement Notice and the accompanying notes on the rear of the Notice carefully. Compliance will be measured against the content of the Notice and Schedule.

Failure to comply with the requirements of a Notice is a criminal offence which could result on summary conviction, to imprisonment for a term not exceeding 6 months in England and Wales and 12 months in Scotland, or to a fine, or both, or, on conviction on indictment for a term not exceeding 2 years, or a fine, or both.

You can appeal against this notice to an Employment Tribunal. Details of the method of making an appeal can be found on the GOV.UK website at https://www.gov.uk/employment-tribunals/make-a-claim. An appeal can either be submitted online at the above website address, or by downloading form ET1 and posting it to either the Employment Tribunal Central Office (England and Wales), PO Box 10218, Leicester, LE1 8EG; or Employment Tribunal Central Office (Scotland), PO Box 27105, Glasgow, G2 9JR.

If you do not have access to the internet, contact the person who issued this Notice and ask to be supplied with a hard copy of form ET1 and guidance T420: Making a claim to an Employment Tribunal.

Details on the time limit for an appeal can be found in the notes on the rear of the Notice.

It is HSE policy that information about formal enforcement action it takes should be brought to the public’s attention. The Notice will therefore be published on the HSE Public Register of Enforcement Notices at http://www.hse-databases.co.uk/notices/. Information on a Notice will not be entered onto the database until the period of appeal against the Notice has expired. Where a Notice is withdrawn or cancelled on appeal no entry will be made. Further details on this can be found on the website and in the notes on the rear of the Notice.

Extension to the time specified in an Improvement Notice+

If you have a good reason why you cannot comply with the Notice by the due date, then an extension to that date may be given. You should apply, in writing, before the Notice expires for this to be considered.
OTHER RECOMMENDATIONS AND ADVICE

Use of Safer Devices and Safe Systems of Work

Where safe devices are available but is may not be reasonably practicable to use them and it is necessary to provide an alternative standard device you should ensure that written instructions for the circumstances of use and the safe system of work should be drafted. Your risk assessment should specify the safe system of work to follow to prevent risk of injury where there is currently no safer device available. You should ensure that traditional devices are not stored alongside safer devices to avoid the wrong device being selected in error.
INFORMATION ON FEE FOR INTERVENTION

Under regulations 22 and 23 of the Health and Safety and Nuclear (Fees) Regulations 2015, HSE will recover its costs for the work it does in relation to certain contraventions of health and safety law. These contraventions are known as 'material breaches'. This cost recovery is called 'Fee for Intervention' or 'FFI'.

A material breach is when, in the opinion of the HSE Inspector, there is or has been a contravention of health and safety law that requires the inspector to issue notice in writing of that opinion to the dutyholder. This Notification of Contravention is written notice of my opinion. The reasons for my opinion are set out in Appendix 1.

HSE will recover from you the costs that it incurs in consequence of any contravention that is a material breach. The costs for the whole visit where a material breach is first identified are recoverable, along with other associated work.

HSE will send you an invoice for the costs incurred.

There are exemptions and disapplications, where HSE cannot recover its costs for carrying out its functions. These exemptions and disapplications are detailed in HSE 47 - Guidance on the Application of Fee for Intervention at http://www.hse.gov.uk/pubns/hse47.pdf.

Under regulation 24(5) of the Fees Regulations 2015 you have the right to dispute the invoice. You can find further information about Fee for Intervention and details of the terms on which you can dispute an invoice in the leaflet HSE 48 - Fee for Intervention: What you need to know at http://www.hse.gov.uk/pubns/hse48.pdf. More detailed information is given in HSE 47 - Guidance on the Application of Fee for Intervention at http://www.hse.gov.uk/pubns/hse47.pdf.
Improvement Notice

Name: Cardiff and Vale University Health Board

Address: Headquarters, University Hospital of Wales (UHW), Heath Park, Cardiff CF14 4XW

Trading as: 

I, (Inspector's full name) Jacqueline Leaker

one of Her Majesty's Inspectors of Health and Safety, being an Inspector appointed by an Instrument in writing made pursuant to section 19 of the said Act and entitled to issue this Notice

of 19 Ridgeway
9 Quinton Business Park, Quinton, Birmingham, B32 1AL

Telephone number: 

hereby give you notice that I am of the opinion that at

(Location of premises or place of activity) The above premises and other Health Board controlled premises

you, as an employer

have contravened in circumstances that make it likely that the contravention will continue or be repeated the following statutory provisions:

Health & Safety at Work etc. Act 1974, Section 2 (1) and the Health and Safety (Sharps Instruments in Healthcare) Regulations 2013, Regulation 5 (1) (b)

The reasons for my said opinion are:

That you have failed to ensure that where medical sharps are used, throughout the health board, that safer sharps are used as far as is reasonably practicable

and I hereby require you to remedy the said contraventions or, as the case may be, the matters occasioning them, by

27/8/15 (Date for compliance)

and I direct that the measures specified in the Schedule which forms part of this Notice shall be taken to remedy the said contraventions or matters

Signature

Date 27/5/15

This is not a relevant notice for the Environment and Safety Information Act 1988

Signature

Date 27/5/15
NOTES

1. Failure to comply with this Improvement Notice is an offence as provided by section 33(1)(g) of the Health and Safety at Work etc Act 1974 and section 33(2) and Schedule 3A of this Act renders the offender liable on summary conviction, to imprisonment for a term not exceeding 6 months in England and Wales and 12 months in Scotland, or to a fine, or both, or, on conviction on indictment, to imprisonment for a term not exceeding 2 years, or a fine, or both.

2. An Inspector has power to withdraw an Improvement Notice or extend the period specified in the notice, before the end of the period specified in it. If you wish this to be considered you should apply to the Inspector who issued the notice, but you must do so before the end of the period given in it. Such an application is not an appeal against this notice.

3. The issue of this notice does not relieve you of any legal liability for failing to comply with any statutory provision referred to in the notice or to perform any other statutory or common law duty resting on you.

4. You can appeal against this notice to an Employment Tribunal. Details of the method of making an appeal can be found on the GOV.UK website at https://www.gov.uk/employment-tribunals/make-a-claim. An appeal can either be submitted online at the above website address, or by downloading form ET1 and posting it to either the Employment Tribunal Central Office (England and Wales), PO Box 10218, Leicester, LE1 8EG; or Employment Tribunal Central Office (Scotland), PO Box 27106, Glasgow, G2 9JR.

If you do not have access to the Internet, contact the person who issued the Notice and ask to be supplied with a hard copy of form ET1 and guidance T420: Making a claim to an Employment Tribunal.

Time limit for appeal

A notice of appeal must be presented to the Employment Tribunal within 21 days from the date of service on the appellant of the Notice, or Notices, appealed against, or within such further period as the tribunal considers reasonable in a case where it is satisfied that it was not reasonably practicable for the notice of appeal to be presented within the period of 21 days.

The entering of an appeal suspends the Improvement Notice until the appeal has been determined or withdrawn, but does not automatically alter the date given in this notice by which the matters contained in it must be remedied.


Public availability of information on all enforcement notices

1. The Health and Safety Executive (HSE), for its own purposes, records and monitors trends in the enforcement action it takes, and in the convictions and penalties imposed by the Courts. It is HSE’s policy that this information should be brought to the public’s attention. HSE also has a statutory obligation under the Environment and Safety Information Act 1988 to maintain a public register of certain notices. Details from this notice will therefore be stored on an electronic database, which is available on HSE’s Website (www.hse.gov.uk).

2. Information on a notice will not be entered onto the database until after the right of appeal against the notice has expired. Where a notice is withdrawn or cancelled on appeal no entry will be made. Entries relating to notices served on individuals will be kept on the database for a period of 5 years from the date of issue. Notices served on individuals under the age of 18 will be removed sooner.

3. Information will be withheld where, in HSE’s belief, its disclosure would:
   • cause harm or prejudice; or
   • be in breach of the law.

4. Personal information is dealt with in accordance with the Data Protection Act 1998. Where disclosure of personal information would be incompatible with the Act it will not be included on the database.

5. If you are not satisfied with the information contained in the entry you have a further right to appeal to the HSE in the first instance.
Schedule

To Comply with this notice you should

EITHER

- Substitute traditional, unprotected medical sharps with a ‘safer sharp’ where it is reasonably practicable to do so.
- If a suitable safer sharp is not available to reduce the risk of injury, you should ensure that safe procedures for working with and disposal of the sharp are in place.

OR

- You should take any other equally effective measures to achieve compliance with the Notice.
<table>
<thead>
<tr>
<th>Item</th>
<th>Requirement</th>
<th>Action needed</th>
<th>Lead</th>
<th>Completion date</th>
<th>Comment</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>RIDDOR Compliance</td>
<td></td>
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</tr>
<tr>
<td>1.1</td>
<td>Staff are aware of need to report known Blood Bourne Virus (BBV) events</td>
<td>• Revise E Datix Form such that any report of sharps injury asks victim if BBV</td>
<td>R Sykes/ Patient Safety Manager</td>
<td>August 2015</td>
<td>Commitment given to add prior to 27/8/15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Revise Induction and Mandatory Training to reinforce RIDDOR requirement.</td>
<td>Head of H&amp;S/LED</td>
<td></td>
<td>Powerpoint presentation modified, E learning being progressed</td>
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<tr>
<td>1.2</td>
<td>All known BBV events reported to H&amp;S for submission to HSE.</td>
<td>• Severity grade on E-Datix form amended to automatically alert relevant Adviser of known BBV event.</td>
<td>R Sykes/ Patient Safety Manager</td>
<td>August 2015</td>
<td>Commitment given to give priority prior to 27/8.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Occ Health to copy H&amp;S into all reported BBV events.</td>
<td>Senior Nurse Occ Health</td>
<td>July 2015</td>
<td>Commitment confirmed – template completed</td>
</tr>
<tr>
<td>1.3</td>
<td>Assurance that RIDDOR compliance is monitored</td>
<td>• Operational H&amp;S Group agenda modified to include Needlestick report as standard agenda item.</td>
<td>Chair of Op H&amp;S Group</td>
<td>July 2015</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Occupational Health/H&amp;S to prepare separate reports.</td>
<td>Lead Nurse/ Head of H&amp;S</td>
<td>July 2015</td>
<td></td>
</tr>
</tbody>
</table>
1.4 **Sharps Injury Protocol** to be amended to reflect RIDDOR reporting requirements.

- Revision of sharps protocol to include RIDDOR requirements.
- IPC Clinical Director
- July 2015
- Protocol revised. Out for comments.

1.5 **Assurance to H&S Committee**

- H&S Committee to receive regular report confirming compliance status.
- Head of H&S
- July 2015

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<thead>
<tr>
<th>Item</th>
<th>Requirement</th>
<th>Action needed</th>
<th>Lead</th>
<th>Completion date</th>
<th>Comment</th>
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<tr>
<td>2.</td>
<td><strong>Safer Sharps Policy/Protocol</strong></td>
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<tr>
<td>2.1</td>
<td>Out of date Sharps Injuries Protocol to be revised and amended to reflect the Safer Sharps requirements.</td>
<td>• Infection Control Group to complete revision (circulate and approve)</td>
<td>IPC Clinical Director</td>
<td>July 2015</td>
<td>Amended Protocol circulated for comments, IPC to approve.</td>
</tr>
<tr>
<td>2.2</td>
<td>Overarching Safer Sharps Policy to be produced covering the requirements of the Safer Sharps regulations.</td>
<td>• Draft and circulate required Policy.</td>
<td>Head of H&amp;S/ IPC Clinical Director</td>
<td>July 2015</td>
<td>Document circulated.</td>
</tr>
<tr>
<td>2.3</td>
<td>Approve Policy and communicate.</td>
<td>• Agree on appropriate approving Committee i.e. QSE or H&amp;S Committee. • Approving Committee Chair to take Chair action to approve document.</td>
<td>Director of Planning/ Nursing Director Committe e Chair</td>
<td>July 2015</td>
<td>Clinical Director Infection Control/Head of H&amp;S met and concurred that there was direct links to waste management policy and as such H&amp;S Committee</td>
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<tr>
<td>Item</td>
<td>Requirement</td>
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<tr>
<td>3.</td>
<td><strong>Safer Sharps Devices Implementation</strong></td>
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<tr>
<td>3.1</td>
<td>Theatres to implement use of safety cannulas.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>- Memo sent to Theatres Management and clinicians requiring them to appropriately use safety cannulas and to prepare justification for when safety cannulas are unsuitable.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>- Non safety sharp justification</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td><strong>Action needed</strong></td>
<td></td>
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<tr>
<td></td>
<td><strong>Lead</strong></td>
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<tr>
<td></td>
<td><strong>Completion date</strong></td>
<td></td>
<td></td>
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<tr>
<td>3.2</td>
<td>Expand safer devices usage.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>- Extend use of Safety Butterflies to all relevant HB areas.</td>
<td></td>
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<tr>
<td></td>
<td>- Identify and implement safer Hypodermic Devices</td>
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<tr>
<td></td>
<td>- Identify and implement safer diabetic pen devices.</td>
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<tr>
<td></td>
<td>- Identify and implement other suitable devices.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Action needed</strong></td>
<td></td>
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<tr>
<td></td>
<td><strong>Lead</strong></td>
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<td></td>
<td><strong>Completion date</strong></td>
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<tr>
<td></td>
<td><strong>Comment</strong></td>
<td></td>
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</tr>
</tbody>
</table>

**Lead**

- Head of H&S
- Theatres Manager
- H&S Adviser/Procurement
- H&S Adviser/Procurement
- Task & Finish Group

**Completion date**

- June 2015
- July 2015
- July/August 2015
- June 2015

**Comment**

- Meetings have taken place with Suppliers and Procurement
- Audit completed
<table>
<thead>
<tr>
<th>Item</th>
<th>Requirement</th>
<th>Action needed</th>
<th>Lead</th>
<th>Completion date</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.3 Risk Assess use of non safety sharps.</td>
<td>• Undertake audit of safer sharps usage.</td>
<td>H&amp;S Dept</td>
<td>August 2015</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Prepare generic assessments.</td>
<td>H&amp;S Dept/ CB Leads</td>
<td>August 2015</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Audit areas of compliance.</td>
<td>H&amp;S Dept</td>
<td>July 2015</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Communication, Control, Competence and Cooperation.</td>
<td>• Briefing note for discussion at Operational H&amp;S Group and dissemination to Local areas.</td>
<td>Head of H&amp;S</td>
<td>August 2015</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.1 Communication</td>
<td>• Feedback to Infection Control on HSE findings of Audit.</td>
<td>Director of Planning</td>
<td>July/August 2015</td>
<td>Completed</td>
</tr>
<tr>
<td>4.2 Control</td>
<td>• Progress reports submitted to both Operational H&amp;S Group and H&amp;S Committee. Audit Findings to be directly communicated to CBs Clinical Leads</td>
<td>Head of H&amp;S/ H&amp;S Adviser</td>
<td>July/August 2015</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 4.3 Competency | • Supplying manufacturers to deliver direct staff training on the additional devices identified.  
• Short trials of additional products to be undertaken within required timescale prior to selection. | H&S Adviser  
Procurement | Ongoing |
| 4.4 Cooperation | • Joint progress and meeting with H&S /IPC.  
• Working group of H&S, Occupational Health and IPC and Clinical areas to be reformed.  
• Theatre Anesthetists to cooperate regarding safety cannulas | Head of H&S/ IPC Clinical Director  
H&S Dept  
Head of H&S/ Theatres | Ongoing |
HEALTH AND SAFETY EXECUTIVE CORRESPONDENCE

Executive Lead: Director of Planning
Author: Head of Health and Safety

Caring for People, Keeping People Well: This report underpins the Health Board’s “Sustainability” and “Values” elements of the Health Board’s Strategy.

Financial impact: Potential fiscal costs relating to breaches of statutory obligation.

Quality, Safety, Patient Experience impact: This report is fundamental to the safety and quality of both staff and patients.

Health and Care Standard Number: 2.1 CRAF Reference Number: 8.1.4

Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Committee is asked to:

- NOTE the content of this report and the actions taken to address the issues raised.

SITUATION

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

Since the April 2015 Health and Safety Committee four areas of concern have been raised by the Health and Safety Executive, these being:
1. HSE Audit on Sharps.
2. Passenger Lift Inspection Failing
3. Inspection of Category 3 Labs
4. Fire in Lecture Theatre, University Hospital of Wales (UHW)

BACKGROUND

The Health and Safety Executive has the responsibility to enforce the majority of the health and safety statutory requirements under the Health and Safety at Work Act and related Regulations as they apply to the Health Board.

The Inspectors have a number of powers including: prosecution of either the organisation or the individual, prohibition notice whereby they can require any process or machinery to be immediately stopped and improvement notices when they consider that the breach is not imminently dangerous but does require action over an agreed period of time.
In 2012 “Fees for Intervention” were introduced whereby the Inspector will charge for their time if they consider there is a material breach. These fees are currently £132 per hour.

**ASSESSMENT**

1. **HSE Sharps Audit**  
Two Inspectors visited the UHW site on the 14\(^{th}\) of May 2015 to audit the Health Board’s compliance to the Health and Safety (Sharp Instruments in Health Care) Regulations 2013. They met with a range of staff and visited a number of key areas.

They subsequently considered that there were areas necessary for further action and issued an Improvement Notice for resolution by 27 August 2015. This action will be subject to fee for intervention. An expanded briefing is included within the Committee agenda.

2. **Passenger Lift**  
On the 12\(^{th}\) of June 2015 the UHB received two letters from the HSE in relation to lifts inspected by our contracted engineers RSA, which had defects identified that were or could become a danger. Defects related to lift reference 22199 UHL – passenger lift, counterweight governor rope tension arm will not operate the stack rope and must be adjusted immediately and lift reference S-3387 UHL – electric hydraulic platform lift, the platform landing gate electrical interlocks are inoperative and must be repaired immediately. 2237G UHL – passenger lift, landing doors air cord contains broken strands and must be replaced immediately.

All three lifts were back in service within a few days of the notices being received.

The UHB confirmed to the HSE that as soon as we were notified of these defects, the relevant equipment was immediately taken out of use. We have also confirmed that we will be reviewing our preventative maintenance in light of the discovery of these defects so as to prevent future reoccurrence.

The Lifting Operations and Lifting Equipment Regulations 1998 require the UHB to have 6 monthly inspections for lifting equipment at our premises. RSA is our ‘competent person’ who currently perform these inspections. The competent person is legally required to notify us as soon as possible, following a thorough examination of any defects which are or could become dangerous. If the competent person identifies a defect which presents an ‘existing and imminent risk of serious personal injury’ they are also legally required to send a copy of the report to the Health and Safety Executive (HSE).

The UHB understands that since this correspondence, an additional 3 lifts have been taken out of service. As it is a new contract with RSA, the interim Estates Manager will be meeting with them and our maintenance contractors to carry out an in depth review.
3. HSE Inspection of Category 3 Laboratories
The HSE undertook and inspection of the category 3 Laboratories on the 14th May 2015 at UHW which is part of Cardiff University facilities but the Health Board have contracted responsibilities for some estate functions.

Subsequently the HSE requested the Health Board and the University to provide them with the following information in order to arrange suitable and proportionate enforcement to address the issues identified during inspection:

- The name and office address for the Chief Executive for the Health Board,
- The name and office address for the Director/Manager for the Health Board’s Estates Department and details of the special agreement between the University and the Health Board including details of the arrangements/agreement between the University and the Health Board for the demarcation of their respective responsibilities, they also required information on what systems and arrangements are in place between the two estates department to ensure that the two CL3 laboratories and their safety critical systems are fully maintained, serviced, repaired and safety checked satisfactorily and in a timely manner, and to also identify when they are not.
- The University and Health Board Estates Departments met to consider the inspection findings and subsequently responded to the HSE Inspector, since this response no further correspondence has been received.

4 Fire in the Lecture Theatre, UHW
Following the fire in the Lecture Theatre the HSE contacted the University Health and Safety Department enquiring why the fire had not been reported to them as a dangerous occurrence under RIDDOR, subsequently the University contacted the Health Board requesting we report the event. However we concluded that the requirement for reporting fires to the HSE is only when the plant or processes were stopped for more the 24 hours.

The area although on the UHW site was under the control of the University Estates Management and though there was some disruption during the fire there had been no ceasing of processes within the UHB, therefore any requirement to report was held with Cardiff University. This was accepted and no further approaches have been made.
### FIRE ENFORCEMENT STATUS REPORT

<table>
<thead>
<tr>
<th>Executive Lead</th>
<th>Director of Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Senior Fire Safety Adviser 02920 - 742292</td>
</tr>
</tbody>
</table>

**Caring for People, Keeping People Well:** This report underpins the Health Board’s “Sustainability” and “Values” elements of the Health Board’s Strategy.

**Financial Impact:** N/A

**Quality, Safety, Patient Experience impact:** Fire Safety is a statutory Health and Safety requirement and is therefore a high priority for the safety of the UHB’s patients, visitors and staff.

**Health and Care Standard Number:** 2.1  
**CRAF Reference Number:** 6.4.5

**Equality Impact Assessment Completed:** Not Applicable

### RECOMMENDATION

The Committee is asked to:

- NOTE the contents of the Fire Enforcement Report

### SITUATION

This report provides an overview of the current status of the Enforcement Actions issued by the South Wales Fire Authority (SWFS) against breaches in Fire Legislation.

Key issues highlighted in the report include:

- The Enforcement Notice in relation to Whitchurch Hospital Site.

- The three Enforcement Notices for the following areas in Llandough:
  - Theatres
  - Day Surgery
  - Anwen Ward.

- Progress in meeting the requirements of the notices within the required time scales.

### BACKGROUND

The South Wales Fire Service (SWFS) carry out regular audits on various areas within UHB sites. A number of the audits have resulted in Enforcement Notices being issued. The Notices set out remedial actions to be completed within a time scale to achieve a satisfactory level of fire safety.
The purpose of this report is to assure the Committee that the Enforcement Notices issued by South Wales Fire Service are being managed and monitored appropriately.

This report provides the current status of the Enforcement Notices in respect of progress.

**ASSESSMENT**

There are currently four Fire Enforcement Notices in force. The Notice for the Whitchurch site expired in January 2015 and South Wales Fire Service (SWFS) having carried out a further audit rescinded the Notice and issued a new Notice on the 27th January 2015 giving 24 months to comply with the expectation that the facilities will be transferred to Llandough.

SWFS accept Whitchurch Hospital does not comply with current standards structurally; however it is expected that fire safety management is of the highest standard to minimize any risk.

The Fire Adviser at Whitchurch continues to carry out fortnightly unannounced fire safety inspections to monitor compliance and the resulting reports are presented at a monthly meeting for discussion and action.

Three Notices are still in force for the following areas in Llandough; Theatres, Day Surgery and Anwen Ward. An action group has been formed to ensure that remedial actions are carried out by the 24th August 2015. The notices were issued in relation to defective fire doors, fire doors being propped open, defective compartmentation, lack of staff training, defective fire alarm and inappropriate storage of oxygen cylinders.

The one outstanding issue is fire compartmentation. A survey has been carried out and the remedial work has been tendered for.
HEALTH AND SAFETY PRIORITY ACTION PLAN 2015/16

<table>
<thead>
<tr>
<th>Executive Lead</th>
<th>Director of Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Head of Health and Safety 02920 743751</td>
</tr>
</tbody>
</table>

Caring for People, Keeping People Well: This report underpins the Health Board’s “Sustainability” and “Values” elements of the Health Board’s Strategy.

Financial impact: The report is strategic with direct cost being identified as required


Health and Care Standard Number: 2.1  Craf Reference Numbers: 8.1.4,6.4.7,6.4.5,6.4.4

Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Committee is asked to:

- CONSIDER the on-going work to meet the requirements of the Priority Action Plan and be ASSURED those areas of red and amber is being actively pursued.

SITUATION

The Health Board has initiated a Health and Safety Priority Action Plan to monitor its progress on key health and safety strategic areas. The 2015/16 plan builds upon the previously considered 2014/15 plan. The action plan is revised at each meeting; being updated to current status and adding any new priority items as they arise.

The Priority Action Plan is the Health Board’s strategic approach to tackling significant health and safety risks and has proved successful at reducing the risks and progressing on the basis of real risks and practical solutions. This can be demonstrated by both the number of completed actions areas (green) and the reduction in incidents as demonstrated in the Annual Report.

The Priority Action Plan has been amended to include an eighth strategic area of Sharps Safety. This is to reflect sharp injuries account for approximately 10% of all the staff incidents and the emphasis placed on sharps injuries by the Health and Safety Executive.

BACKGROUND

The Priority Action Plan is monitored at each Health and Safety Committee meeting and at the Operational Health and Safety Group meetings. It is also
considered that each Clinical Board has in turn produced its own Priority Action Plan based on the eight strategic areas.

The prioritised approach continues to identify the seven strategic areas, in addition to the eighth area of Sharps Safety. These being:
1. Structural and Health and Safety Management (including incident reporting)
2. Violence and Aggression Management
3. Manual Handling
4. Health Issues
5. Environment Safety and Health and Safety Patient Issues
6. Fire Safety Management
7. Health and Safety Estates Management
8. Sharps Safety

The Clinical Boards and Estates Management Risk Registers include identified risks within this Health and Safety Action Plan, whilst centrally managed risks are included within the Corporate Management Risk Register.

**ASSESSMENT**

<table>
<thead>
<tr>
<th>Below summarises the status of the plan by the strategic area</th>
<th>Total no of requirements</th>
<th>Green</th>
<th>Amber</th>
<th>Red</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety Policy Management and Organisational Arrangement</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Violence and Aggression (inc Lone worker)</td>
<td>11</td>
<td>5</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Manual Handling</td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Health Issues</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Patient and Environment Health and Safety</td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Fire Safety Management</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Estate Health and Safety Management</td>
<td>6</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Sharp Safety</td>
<td>6</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>49</td>
<td>17</td>
<td>27</td>
<td>5</td>
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</tbody>
</table>

The above demonstrates of the revised total of 49 requirements, 17 have been resolved and 5 remain as high priority and non compliant. A further 27 are identified as amber, thus meaning that the risk has been reduced as a result of action taken but further control measures are required.

**AREAS OF PROGRESS DURING PERIOD**

1.1 Risk Assessment programme – amended to reflect that a pilot is being initiated within the Dental Clinical Board. **Amber**

1.2 Amended to reflect progress in implementing E-Datix. **Amber**
1.3 Amended to reflect the benefits achieved through early knowledge of E-Datix. **Red to Amber**

2.3 Updated to reflect that following a meeting with EU and Security, agreement has been made for team training in response to violence, and a programme is being development. **Amber**

2.4 Updated to reflect Committee agenda item on Loneworker. **Amber**

2.8 Amended to reflect that a working group has been established on an All Wales basis to develop approaches around violence which are non gratuitous. **Red to Amber**

3.3 Updated to reflect the outcome of the April Health and Safety Committee, where material guide sheets are being progressed. **Amber**

3.6 Updated to reflect the work progressed on completing a Manual Handling equipment audit. **Amber**

4.1 & 4.2 Moved into strategic area 8.

4.4 Additional requirement added in regards to the safe use of Peracitic Acid. **Amber**

5.3 Moved into Estates function – item 7.6.

6.4 Amended to reflect evacuation procedures agreed for all in patient areas. **Amber to Green**

6.6 Amended to reflect a prioritised approach has been initiated for updating Fire plans, which is monitored through the Fire Safety Group. **Amber to Green**

7.1 – 7.3 Updated by Estates appropriately.

7.5 New requirement reflecting the current findings of inspections of passenger lifts and HSE correspondence. **Amber**
<table>
<thead>
<tr>
<th>Requirement</th>
<th>Status January 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>A comprehensive programme of risk assessments to be completed with identified control measures implemented</td>
</tr>
<tr>
<td>1.2</td>
<td>Incident Reporting - NHS Organisations are required to utilise E-Datix</td>
</tr>
<tr>
<td>1.3</td>
<td>Incident forms to be received by the Health and Safety Department within 48hrs of incident date.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Risk Assessment Procedure expanding the requirement so that assessments greater than 10 are validated and monitored</td>
</tr>
<tr>
<td>1.2</td>
<td>Project group formed to progress the corporate implementation of E-Datix</td>
</tr>
<tr>
<td>1.3</td>
<td>Recent analysis on Datix system identified significant delays, from date of event to date of entry. Clinical Board Leads alerted to delays relating to latent time between ward raising and posting to Health and Safety. Violent incident alerts</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete RA pilot and progress in other Clinical Boards subject to findings.</td>
</tr>
<tr>
<td>Implementation commenced with Specialist, Surgery, Dental &amp; PCIC CBs all now live on E-Datix, remaining CBs on plan for implementation before end of the year.</td>
</tr>
<tr>
<td>Implementation of Datix to the majority of Clinical Boards has resulted in direct notification of the incident on completion of the electronic form by the member of staff.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accountable Lead</th>
<th>Status</th>
<th>Priority</th>
<th>Time Scale for Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chairs of Clinical Boards Health and Safety Group</td>
<td>Red</td>
<td>High</td>
<td>September 2015</td>
</tr>
<tr>
<td>Director of Nursing</td>
<td>Amber</td>
<td>Mod</td>
<td>December 2015</td>
</tr>
<tr>
<td>Chairs of Clinical Boards Health and Safety Group/ Director of Nursing</td>
<td>Amber</td>
<td>High</td>
<td>December 2015</td>
</tr>
<tr>
<td>1.4</td>
<td>RIDDOR Incidents notified to HSE within 15 days.</td>
<td>Annual report identified significant shortfall.</td>
<td>Sustained progress being shown, report submitted to each Committee meeting.</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>1.5</td>
<td>Health and Safety Committee are kept informed of any relevant audit findings.</td>
<td>October 2013 meeting identified that an Internal Audit relating to Food Safety had not been considered at the Committee meeting.</td>
<td>The internal audit operational plan for 2015/16 has been presented to the Audit Committee. This has been noted and subsequently five audits relevant to health and safety have been added to the Committee Work Programme, these being: (i) Risk Management and Assurance, (ii) Concerns/complaints/e-datix, (iii) Risk Management Arrangements, (iv) Statutory and Mandatory Training/PADRs, (v) Backlog Maintenance.</td>
</tr>
<tr>
<td>1.6</td>
<td>All Health and Safety Training to be recorded through the ESR system.</td>
<td>Internal audit recommendation and findings identified Mental Health Violence and Aggression training was being maintained on a separate database.</td>
<td>Mental Health has confirmed training is being submitted into ESR</td>
</tr>
</tbody>
</table>
### 2 Violence and Aggression

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Status January 2015</th>
<th>Progress</th>
<th>Further Action required</th>
<th>Accountable Lead</th>
<th>Status</th>
<th>Priority</th>
<th>Time Scale for Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Have in place an action plan to ensure full and ongoing compliance with requirements of the All Wales Violence and Aggression Passport Scheme.</td>
<td>Lack of ability to release staff for training has also reduced compliance. A number of specialist programmes for training have been initiated. It has subsequently reviewed its prioritisation of training.</td>
<td>National review of passport scheme completed. ERS compliance reported through PPP. Evidence shows approx 50% compliance.</td>
<td>Head of Health and Safety Chairs of Clinical Boards Health and Safety Group</td>
<td>Amber</td>
<td>High</td>
<td>December 2015</td>
</tr>
<tr>
<td>2.2</td>
<td>CCTV coverage is able to monitor and record all areas of risk to staff from violence within limits of agreed dignity protocols</td>
<td>CCTV coverage within Hospital sites is incomplete and of insufficient standard to allow for effective detection and prosecution. Business Case has been prepared and implemented by Security Manager to replace faulty and upgrade cameras</td>
<td>Business case prepared for enhanced CCTV coverage for external areas.</td>
<td>Director of Planning</td>
<td>Green</td>
<td>High</td>
<td>September 2014 - Completed</td>
</tr>
<tr>
<td>2.3</td>
<td>Sufficient Trained Staff to respond to personal attacks and safely restrain</td>
<td>Security Team not trained to required standard. Security team required to be of suitable size and deployed to respond to events.</td>
<td>Meeting between EU and Security and trainers has agreed a programme of developing a combined response team, with a two day training course on module D. Validation of suitability of Mental Health training completed. Courses to commence Nov 15</td>
<td>Head of Security Services</td>
<td>Amber</td>
<td>High</td>
<td>December 2015</td>
</tr>
<tr>
<td>Lone Worker</td>
<td>The analysis of data of the Lone Worker Alert devices illustrates that staff have a poor utilisation rate</td>
<td>Trial of alternative lone worker device proved successful, much preferred by users. Specification sent to procurement for review of contract. New system to ensure transfer within current financial restraints.</td>
<td>Review of contract and initiate programme of supplying new devices.</td>
<td>V&amp;A Group/Chairs of Clinical Boards Health and Safety Group</td>
<td>Amber</td>
<td>Mod</td>
<td>October 2015</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>2.4 Lone Worker Alert System Contract review due in June 2015. Investigation into suitable alternatives to enhance usage</td>
<td>National Lone Worker Group formed to evaluate performance</td>
<td>Meetings between suitable suppliers and HB have been undertaken. Review of allocation based off usage and Committee recommendations implemented.</td>
<td>Renew contact with suitable supplier.</td>
<td>Director of Planning</td>
<td>Green</td>
<td>Mod</td>
<td>September 2015</td>
</tr>
<tr>
<td>2.5 Implement requirements of the Patient Warning Marker Procedure.</td>
<td>Protocol required to ensure staff are given knowledge of risk and patient's markers are timely reviewed</td>
<td>Procedure implemented and warning markers are now being placed on the PARIS system.</td>
<td>Health Board’s Violence and Aggression incident form put on PARIS.</td>
<td>Head of Health and Safety/Personal Safety Adviser</td>
<td>Green</td>
<td>Mod</td>
<td>April 2014 - completed</td>
</tr>
<tr>
<td>2.6 Ensure suitable protocol/procedure for restraint of patients with capacity.</td>
<td>The HB has protocols for the restraint of mental health patients, similar procedures are required for patients with capacity</td>
<td>Training course for paediatrics established. Preparation of procedure based off MH document being initiated. National project in calming the storm covering this feature.</td>
<td>Submit procedure for ratification to Security Strategy group.</td>
<td>Head of Health and Safety/Personal Safety Adviser</td>
<td>Amber</td>
<td>High</td>
<td>October 2015</td>
</tr>
<tr>
<td>2.7 Establish forum for violence associated with caring for Mental Health patients in an acute or non acute setting (non mental health environment).</td>
<td>Annual report identified risk of violence related to caring for mental health patients on an acute ward</td>
<td>Forum established on an all Wales basis to consider this issue. With findings being progressed through Wales Riskpool.</td>
<td>Finding of forum to be considered at Security Strategy group.</td>
<td>Head of Health and Safety/Personal Safety Adviser</td>
<td>Amber</td>
<td>High</td>
<td>October 2015</td>
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</tbody>
</table>
2.9 Develop joint response mechanism with Clinical and Police involvement.  
Risk of inappropriate response to violent patients with an ongoing care need identified  
Joint meeting with Police, EU, Security and Personal Safety has met. To develop team approach.  
Head of Health and Safety/Personal Safety Adviser  
Green Mod  
September 2014 - completed

2.10 Treatment of known violent patients  
Safe Haven facilities available however there is a lack of facilities to treat high risk patients outside of Safe Haven requirements.  
Issue raised and discussed at the Personal Safety and Security Strategy Group. Need for an additional area identified. Security available by arrangement. Meeting with LCM regarding better communication.  
Review of Safe Haven arrangements at CRI  
PCIC Amber Mod October 2015

2.11 Park View Health Centre  
Lack of adequate security cover. Reports received of personal safety and vandalism.  
Improved violence and aggression training. Security presence implemented; no further incidents reported.  
Monitoring to be continued through Personal Safety and Security Strategy Group.  
Head of Security  
Green Mod January 2015

### 3 Manual Handling

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<th>Requirement</th>
<th>Status January 2015</th>
<th>Progress</th>
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<th>Accountable Lead</th>
<th>Status</th>
<th>Priorit y</th>
<th>Time Scale for Completion</th>
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</table>
| 3.1 All staff involved in manual handling tasks require training to required standard and refreshed at the agreed intervals | Training Working Group formed led by Assistant Director of OD  
Training frequency assessment (TFA) commenced | Working with LED and directs visits to hotspot areas. | Further development of ward based training.  
Assistant Director of OD  
Head of Health and Safety |  
Green | High | December 2015 |
| 3.2 Addressing the NHS National Patient Safety Agency Report "Essential care after an inpatient fall" | Hover Jacks purchased, additional equipment identified | The change of protocol for staff not to use a hoist to move a patient with suspected lower limb fracture, spinal/head injury after a fall. Training was given by the manual handling department to  
Director of Therapies and Health Sciences | |  
Green | High | January 2013 - completed |
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<td><strong>3.</strong></td>
<td><strong>3</strong></td>
<td>The lack of flat glide sheets which are essential Manual Handling equipment</td>
<td>Special Sheets were purchased but stock has diminished. Risks identified in the use of single use glide sheet Paper was considered at January 2015 Committee meeting. Following Committee discussion specification made and agreed with procurement for establishing a central resource of Glide sheets funding from within planning. Unique colour and tagging of glide sheets agreed to reduce likelihood of loss.</td>
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<td><strong>3.</strong></td>
<td><strong>4</strong></td>
<td>Delivering manual handling advice to carers in the community</td>
<td>Expansion of care in the community has resulted in the Manual Handling Advisers visiting patient’s homes, training carers and advising on devices. Some of these visits are directly linked to patient discharge</td>
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<td><strong>3.</strong></td>
<td><strong>5</strong></td>
<td>Disposable Glide Sheets tearing under strain, whilst turning patients.</td>
<td>Report received of paper glide sheets whilst being used as per instruction tearing on turning a heavy patient resulting in a RIDDOR event.</td>
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<tr>
<td><strong>3.</strong></td>
<td><strong>6</strong></td>
<td>LOLER compliance (Lifting operations, Lifting equipment regulations)</td>
<td>LOLER regulations require the inspection and maintenance of all lifting equipment including hoists and meeting has taken place between estates, manual handling and lifting company Arjo to identify our stock and status. Survey of stock and status. Survey of stock and status.</td>
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slings. Slings have previously been internally inspected, however HSE has indicated recently that this must be an independent assessment.

all lifting equipment including slings being initiated and to include concerns raised by infection control regarding health risks.

4 Health Issues -

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<tr>
<td>4. 1</td>
<td>Moved to 8.5 Sharps</td>
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<td>4. 2</td>
<td>Moved to 8.6 Sharps</td>
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<td>4. 3</td>
<td>Food Hygiene Control</td>
<td>Following findings of EHO Inspections the need for internal monitoring of kitchen safety identified.</td>
<td>Internal audit report presented to January Health and Safety Committee meeting. Independent audit ongoing.</td>
<td>Independent Audit findings included in July committee agenda.</td>
<td>Head of Operational Services</td>
<td>Green</td>
<td>High</td>
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<tr>
<td>4. 4</td>
<td>Safe use of peracetic acid in sterilisation of medical instruments.</td>
<td>The use of peracetic acid is being introduced into four areas to sterilise instruments, this chemical is subject to COSHH being of higher hazard.</td>
<td>Specialist Adviser working with Clinical Boards to undertake monitoring and ensure controls are in place.</td>
<td>Based findings of monitoring, implement appropriate controls including spill response.</td>
<td>Chair of Surgery H&amp;S group</td>
<td>Amber</td>
<td>High</td>
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5. Health & Safety Patient and Environment Safety

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<th>Priority</th>
<th>Time Scale for Completion</th>
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<tbody>
<tr>
<td>5.1 Window Closures</td>
<td>Not all windows above the ground floor are fitted with 100mm restrictors. A programme of work</td>
<td>Survey and risk assessment of all windows above the ground floor has been completed. Action has been taken to rectify those</td>
<td>Further Work on anti tamper screws to be initiated to meet hazard alert guidance.</td>
<td>Assistant Director of Planning (Capital, Estates and</td>
<td>Amber</td>
<td>Mod</td>
<td>October 2015</td>
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<tr>
<td>Section</td>
<td>Description</td>
<td>Details</td>
<td>Responsible Party</td>
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<td>5.2</td>
<td>Legionella – Legionella Policy and Water Safety Group</td>
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<td></td>
<td>Low use water outlets are flushed at agreed intervals.</td>
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<td></td>
<td>Lack of confirmation that requirements are implemented.</td>
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<td></td>
<td>Water Safety Group chaired by IPC established. Membership, TOR prepared. Representation from Clinical Boards and other departments identified. Paper has been produced and submitted to the Health and Safety Committee.</td>
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<td></td>
<td>Paper submitted to Operational Health and Safety Group.</td>
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<td></td>
<td></td>
<td>Implement findings of report.</td>
<td>Clinical Boards</td>
<td></td>
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<tr>
<td>5.3</td>
<td>Asbestos compliance</td>
<td>Policy and AMP requires only controlled breach of Asbestos</td>
<td>All Amber High October 2015</td>
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<td></td>
<td>Enhanced Contractor control introduced. Briefing paper issued to Operational Group in September 2014.</td>
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<td></td>
<td>Each Clinical Board to ensure implementation requirements of Contractors Control Procedure.</td>
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<td>5.4</td>
<td>Record Storage - The organisation has the requirement to safely store its mandated records for the agreed periods.</td>
<td>There is insufficient suitable storage for all records particularly in relation to archived records in the community.</td>
<td>Policy to be finalised</td>
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<td></td>
<td>Policy for greater use of Electronic storage being considered to alleviate problem. Improved storage and fire protection have been</td>
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<td>Director of Planning Amber Mod October 2015</td>
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<td>Requirement</td>
<td>Status January 2015</td>
<td>Progress</td>
<td>Further Action required</td>
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<td>Priority</td>
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<td>5.5</td>
<td>Utilisation of appropriate waste route.</td>
<td>Audit of compliance to Environmental Permitting Regulations show some shortfalls with regards to sharps boxes.</td>
<td>Paper of compliance status considered at Operational Health and Safety Group meeting and Health and Safety Committee. Action plan to improve compliance prepared.</td>
<td>Implement Action Plan. Update report presented to April 2014 and 2015 Health and Safety Committee Meeting.</td>
<td>Chief Operating Officer</td>
<td>Green</td>
<td>High</td>
</tr>
<tr>
<td>5.6</td>
<td>Implementation of the Health Board No Smoking &amp; Smoke Free Environment Policy</td>
<td>Policy approved, steering group formed and actions implemented.</td>
<td>Recruitment of Officer. Contract for Enforcement Officer expanded to 1 year contract.</td>
<td></td>
<td>Director of Public Health</td>
<td>Green</td>
<td>High</td>
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### 6 Fire Safety Management

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<tr>
<th>Requirement</th>
<th>Status January 2015</th>
<th>Progress</th>
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<th>Accountable Lead</th>
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<th>Priority</th>
<th>Time Scale for Completion</th>
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<tbody>
<tr>
<td>6.1 Firecode</td>
<td>All staff within the organisation are required to be provided with Fire Safety Training. The incumbent organisation is at approximately 50% compliance.</td>
<td>Fire Policy submitted for approval. Training improvements being pursued through PPP.</td>
<td>Planned “toolbox” talks to wards by Fire Advisers to enhance local knowledge. Each Clinical Board to monitor local compliance. Fire Policy to be reviewed.</td>
<td>Director of Planning</td>
<td>Red</td>
<td>High</td>
<td>October 2015</td>
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<tr>
<td>6.2 Each geographic location is required to have a Deputy Fire Manager who is responsible for monitoring fire arrangements.</td>
<td>The new Organisation’s management structures will identify Deputy FSM for each site.</td>
<td>DFSM’s appointment still awaited for Surgery, Medicine. Letter sent to Clinical Board Leads.</td>
<td>DFSM appointments for UHW to be completed</td>
<td>Director of Planning/Fire Safety Manager</td>
<td>Amber</td>
<td>High</td>
<td>October 2015</td>
</tr>
<tr>
<td>6.3 Fire Compartmentation</td>
<td>Programme of improved fire compartmentation</td>
<td>Fire Annual Report presented to January 2014 Health and Safety</td>
<td>Health and Safety Committee to review and consider risks associated</td>
<td>Assistant Director of Planning</td>
<td>Amber</td>
<td>High</td>
<td>October 2015</td>
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</table>
initiated Committee. Follow up report for April 2014 meeting with fire dampers/compartmenention. 2015 Fire Annual Report presented to January 2015 meeting.  

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<thead>
<tr>
<th></th>
<th></th>
<th>Committee. Follow up report for April 2014 meeting with fire dampers/compartmenention. 2015 Fire Annual Report presented to January 2015 meeting.</th>
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<td></td>
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<td>(Capital, Estates and Operational Services)</td>
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6. 4 Fire Evacuation Procedures  
Review of Fire Evacuation Procedures required and its co-ordination with Major Incident Plan for all in-patient care areas. 
Evacuation procedures agreed for all in patient areas. 
Health Centres/Clinics and CRI to be agreed.  

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<th>Assistant Director of Planning (Capital, Estates and Operational Services) and Fire Safety Manager</th>
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<td>Green Mod October 2015</td>
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6. 5 Major Incident Evacuation Procedure  
Current Major Incident Plans do not contain guidance for evacuation procedures and require being co-ordinated with current fire procedures. 
Major Incident Plan was submitted at Board in September 2013. It includes patient evacuation processes from fire procedures.  

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<th>Civil Contingencies Manager</th>
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<td>Green High April 2014 - completed</td>
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6. 6 Fire plans out of date  
Fire Safety Group has recognised that the fire plans are out of date and in some instances inaccurate. 
Assistant Director of Planning has identified resource requirement to progress updating the plans. Plans being progressed on a prioritised basis.  

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<th>Assistant Director of Planning (Capital, Estates and Operational Services) and Fire Safety Manager</th>
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<td>Green Med October 2015</td>
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7 Estates H&S Management  

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<th>Priority</th>
<th>Time Scale for Completion</th>
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</thead>
<tbody>
<tr>
<td>Asbestos</td>
<td>Implement Asbestos Management Plan</td>
<td>The Asbestos Management Plan has been reviewed, updated and implemented. The Asbestos Management Group has formed and</td>
<td>Re-inspection program is ongoing with completion anticipated at the end July.</td>
<td>Assistant Director of Planning (Capital, Estates and Operational Services)</td>
<td>Amber</td>
<td>High</td>
<td>October 2015</td>
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<td>7.2</td>
<td>Back log maintenance of the UHB Estate</td>
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<td><strong>Impact:</strong> Resources available to estates in line with an increasing burden of ageing physical infrastructure, bringing increased maintenance costs and increased refurbishment costs.</td>
<td>A programme of estate rationalisation and modernisation in place across the UHB estate. Wherever possible capital projects are linked to improvement and eradication of backlog maintenance to maximise impact of investment. Major refurbishment programme being developed but will require significant WG investment. Maintenance funds are subject to a rigorous risk assessment procedure to</td>
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<td>Regular reviews of estate condition via Estate Property Appraisals. Health and Safety Committee informed at October 2013 meeting that backlog maintenance items include equipment that has passed it replacement date but was still functional</td>
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<td>Report to be prepared to identify that there is an appropriate system for prioritising and monitoring failed equipment with Health and Safety implications.</td>
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<td></td>
<td>Results of the property appraisal presented to October 2014 Health and Safety Committee.</td>
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<td>Committee updated on scale of problem, priorities reflected in the IMTP.</td>
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<td>New identified ACM’s require remediation and/or implementation of appropriate management controls.</td>
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<td>Audit processes has been reviewed and enhanced.</td>
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<td></td>
<td>Draft Asbestos Permit to Work has been circulated.</td>
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<td>Additional audit forms are completed by the independent analyst for most asbestos removal projects undertaken.</td>
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<td>Assistant Director of Planning (Capital, Estates and Operational Services)/Director of Therapies and Health Sciences (for medical equipment)</td>
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<td>Director of Planning</td>
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<td>7.3 Pressure Vessels Autoclaves</td>
<td>Following HSE Audit of Public Health Wales Laboratories – Autoclaves are not being examined, maintained and validated (EMV) to statutory requirements.</td>
<td>Independent Contractor approved to complete inspection plan and contract is now established</td>
<td>Contract Implemented</td>
<td>Assistant Director of Planning (Capital, Estates and Operational Services)</td>
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<td>Mod</td>
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<td>7.4 Tree Safety</td>
<td>HB has requirement to undertake tree survey against risk of hazard at appropriate intervals</td>
<td>Following a tree which fell investigation identified that the survey was out of date and identified actions were not progressed</td>
<td>Estates Compliance have resurveyed and tagged all trees at UHW and orders were placed for all priority 1 &amp; 2 work. This work has been completed.</td>
<td>Assistant Director of Planning</td>
<td>Amber</td>
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<td>7.5 Passenger lift safety</td>
<td>The Health Board operates a system of maintaining its responsibilities to inspect and maintain lifts through a planned inspection and maintenance programme. Recent inspections identified defects that require these to be taken out of service.</td>
<td>HSE wrote requiring confirmation of suitable plans and has been responded to and progress is planned with regards to coordinating the findings of the inspection with the maintenance company.</td>
<td>Joint meeting to be progressed.</td>
<td>Assistant Director of Planning</td>
<td>Amber</td>
<td>High</td>
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<td></td>
<td>7.6 Legionella Survey and Risk Assessment</td>
<td>Survey initiated has identified a number of remedial actions are required.</td>
<td>Implement recommendations</td>
<td>Director of Planning</td>
<td>Red</td>
<td>High</td>
<td>October 2015</td>
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### 8 Sharps Safety

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<tr>
<td><strong>8.1</strong> Health and Safety (Sharps Instruments in Health Care) Regs 2013 requires a policy in place covering a) avoidance of medical sharps, b) use of safer sharps afarp, c) needles not capped after use, d) safe disposal, e) written instructions available for employees, f) clearly marked secure container located close to where sharps are used.</td>
<td>Current documentation - Infection Control for Needlestick and Similar Sharps Injuries, was due for review in August 2013. Protocol pre dates regulations and requires revision. Produce overarching Sharps Policy covering the requirements of the sharps in health care regulations. Circulate document for comments and submit through QSE Committee.</td>
<td>Revised protocol prepared taken to IPC and circulated for comments prior to submission to QSE Committee in July.</td>
<td>Complete review of protocol within IPC. Submit protocol to QSE Committee for approval.</td>
<td>Director of Infection Prevention Control</td>
<td>Amber</td>
<td>High</td>
<td>August 2015</td>
</tr>
<tr>
<td><strong>8.2</strong> Sharps injuries sustained from patients known to be a carrier of BBV e.g Hepc, hep b and HIV, are reportable to the HSE as required by regulation 7 of RIDDOR</td>
<td>Known BBV’s are reported under RIDDOR. However, evidence of some known BBV events have not been informed to the H&amp;S department for RIDDOR reporting.</td>
<td>A) Request made for E-Datix to be modified to reflect sharps RIDDOR requirements. B) Induction and Mandatory training package has been amended to inform staff of requirement. C) Protocol established with Occ Health for all known BBV events reported to</td>
<td>A) E-datix incident form to be modified to include asking staff if the source of injury is from known BBV. B) Meeting with LED and Infection Control to modify the E-package. C) Protocol to be submitted to Operational H&amp;S Group.</td>
<td>Asst Director of Nursing/Head of Patient Safety. Head of H&amp;S/LED Manager - Skills/Senior Nurse IPC Senior Nurse Occ Health/Health and Safety</td>
<td>Amber</td>
<td>High</td>
<td>August 2015</td>
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<td>8.3</td>
<td>The Sharps in Health Care Regs requires that where it is not reasonably practical to avoid the use of medical sharps, use of safer sharps (incorporating safety mechanisms) to prevent or minimise the risk of injury/ use of safety cannulas</td>
<td>Health Board has implemented the use of safety cannulas throughout Clinical areas. However HSE audit identified that these were not in use at all within Main Theatres. Whilst accepting that safety cannulas may not be suitable for all patients, these are designed and fit for most patients and requires use.</td>
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<td>Correspondence sent to Senior Management Team identifying that safety cannulas should be in use in Main Theatres as they are in SSSU and that an appropriate assessment must be in place for those occasions where safety cannulas are not suitable.</td>
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<td>Meeting with Clinical Director of Anaesthetics to support implementation of safety cannulas.</td>
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<td>Implement monitoring mechanisms with procurement to observe frequency of non safety sharp devices use.</td>
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<td>Briefing with Theatre Sister and staff regarding regulatory requirements.</td>
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<td></td>
<td></td>
<td>Head of Health &amp; Safety</td>
<td>Amber</td>
<td>High</td>
<td>August 2015</td>
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<tr>
<td>8.4</td>
<td>The Sharps in Health Care Regs requires that where it is not reasonably practical to avoid the use of medical sharps, use of safer sharps (incorporating safety mechanisms) to prevent or minimise the risk of injury.</td>
<td>Localised implementation of the requirements is varied throughout Clinical Boards. Audit concluded that dental most advanced. Phlebotomy using safety butterflies for blood collection</td>
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<td>Completed audits received from Clinical Boards.</td>
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<td>Meeting arranged with Safety Sharps Supplier and Procurement to implement a range of safety sharps throughout the Health Board.</td>
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<tr>
<td></td>
<td></td>
<td>Implementation of a range of safety sharps</td>
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<tr>
<td></td>
<td></td>
<td>Head of Health and Safety/Health and Safety Adviser – Sharps Lead</td>
<td>Red</td>
<td>High</td>
<td>August 2015</td>
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<tr>
<td>8.6</td>
<td>Implementation of Safety Cannula</td>
<td>Safety Cannula implemented</td>
<td>Audits have been undertaken across HB since implementation. Concerns raised by Anaesthetics that use impacts on patient comfort.</td>
<td>Anaesthetics concerns have been addressed. Old stock of non safety cannulas have been removed from clinical areas.</td>
<td>Head of Health and Safety</td>
<td>Green</td>
<td>Low</td>
</tr>
</tbody>
</table>
FOOD STANDARDS AGENCY LISTERIOSIS GUIDANCE

Executive Lead: Director of Planning
Author: Head of Operational Services ext 46593

Caring for People, Keeping People Well: This report underpins the Health Board’s “Sustainability” element of the Health Board’s Strategy

Financial Impact: N/A

Quality, Safety, Patient Experience Impact: Adherence to the Food Standards Agency Guidance on reducing the risk of contracting Listeriosis via the consumption of food will provide a safer patient and staff experience

Health and Care Standard Number: 1.1/2.1/2.4/2.5
CRAF Reference Number: 5.1.5
Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Committee is asked to:

- AGREE the proposed actions

SITUATION

The Food Standards Agency (FSA) has issued new guidance for hospitals on Listeriosis. This is to help reduce the risk of vulnerable groups contracting Listeriosis through the consumption of food, in particular ready to eat meals (RTE) such as sandwiches and pre packed salads; and to enable those responsible for food safety to identify and implement appropriate steps to reduce the risk of *Listeria monocytogenes* in foodstuffs. The European Food Safety Authority has reported an increase in Listeriosis cases of 8.6% since 2012. In 2014 The FSA conducted an online survey and only 44% of respondents confirmed that their organisations food safety management system (FSMS) had specific reference to *L. monocytogenes* and its control.

BACKGROUND

Listeriosis is a rare but potentially life-threatening illness caused by the bacterium *Listeria monocytogenes*. There are two forms of Listeriosis, invasive and non-invasive. Invasive is the most serious as it enters the bloodstream and can be life threatening with a high mortality rate in vulnerable groups. It is the main cause of death associated with food-borne pathogens in the UK. Those at increased risk include patients who have weakened immunity due to illness, disease, medication/treatment, as well as pregnant women and people of advanced age with a weakened immune system. The illness is most commonly associated with chilled ready-to-eat foods and controls are therefore needed to minimise the risk from this source. Although
it is relatively rare, it can be serious for these most vulnerable groups, with a mortality rate of 50% from invasive Listeriosis. Research into hospital related outbreaks between 2003 and 2014 (10 outbreaks) found pre-packed sandwiches were implicated in most cases. A workshop has been delivered to a mixed audience including members of the catering department by a company called STS on behalf of the FSA, and the purpose of the workshop was:

- To provide an awareness of *L. monocytogenes* and Listeriosis, including distinguishing features, symptoms, higher risk foods and vulnerable groups
- To identify how growth of *L. monocytogenes* could arise in a hospital setting and outline effective controls to reduce the risk
- To identify how contamination from *L. monocytogenes* could arise in a hospital setting and outline effective controls to reduce the risks
- To identify that appropriate food safety management controls are in place to reduce *L. monocytogenes* risks

**ASSESSMENT**

The rate of growth of *L. monocytogenes* increases significantly above 5˚C and can double at 8˚C compared to 5˚C. Therefore fridges used for food storage should be of commercial grade, and be maintained at <5˚C, with temperatures checked regularly to ensure units maintain correct temperature. Chilled RTE foods should not be stored outside of fridges for consumption at a later time, they must be consumed by the use-by-date, and uneaten served food should be thrown away.

Contamination can occur via a number of sources including drains and drainage gulley, water and condensation from air cooling units, dirty premises and equipment, as well as raw food and food handlers. Moisture plays a key role in the survival and growth of *L. monocytogenes*. Kitchens with damaged and poor floor drainage, damaged flooring and areas where water can pool are often a reservoir for *L. monocytogenes* biofilms. Risks can be minimised if structures and equipment, specifically those used for food production, are maintained in a good condition and designed to be easy to clean. Ventilation and extraction systems should also be sited to avoid contamination in high risk food preparation areas. Risks will also be minimised by adherence to thorough cleaning and disinfection practices, and food contact equipment and utensils should be cleaned in a dishwasher in line with manufacturer’s instructions.

All on-site food caterers, including 3rd party retailers, should have adequate food safety standards and appropriate systems in place. This would comprise of robust procurement procedures, appropriately trained staff and a comprehensive documented Food Safety Management System based on HACCP principles. *L. monocytogenes* specific training/instruction should be provided to all staff involved with Listeria control to vulnerable groups across all food pathways including permanent and temporary staff, maintenance staff that work on air handling units and condensers, agency, voluntary, students.
and casual staff. Training must be meaningful to food handlers and delivered in a manner that transforms existing attitudes and behaviours. The training should be evaluated and assessed to ascertain if training meets the learners’ needs, skills and knowledge. In order to provide assurance the following actions will be taken:

- The Operational Services Manager (South) will prepare and deliver a training presentation to all staff involved with Listeria control to vulnerable groups across all food pathways.
- Comprehensive monitoring of all systems throughout the food chain must be in place. This includes internal and external audits by a competent person, review and monitoring of EHO reports and any serious/recurring complaints and review of sampling results, where applicable. Systems should be verified to ensure they are achieving the intended effect i.e. food safety hazards are under control. The above assurance will be provided via the PFI Contract/Compliance Manager within Operational Services.
- Fridge failures should be responded to as a priority
Caring for People, Keeping People Well: This report underpins the Health Board’s “Sustainability” element of the Health Board’s Strategy.

Quality, Safety, Patient Experience impact: Consistent implementation of the documented Food Safety Management System will ensure compliance with the Food Safety Regulations and provide a safer patient and staff experience. A UHB food safety document has been finalised and is being used throughout patient catering services.

Health and Care Standard Number: 2.5 CRAF Reference Number: 5.1.8

Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Committee is asked to:

- NOTE the food hygiene rating and the remedial actions taken following the receipt of the Environmental Health Officer Inspection Report.

SITUATION

City of Cardiff Council undertook a Food Hygiene Inspection visit to the Central Food Production Unit at UHW on 16th December 2014 and again on the 16th June 2015. Following the December visit the unit was given a food hygiene rating of 3 and the recommendations at the time were addressed. This was the first time that the Central Food Production Unit (CPU) had been scored by the Council. Unfortunately following the latest inspection the CPU was awarded a food hygiene rating of 2. All food hygiene scores less than 3 are automatically reported to the Health Minister.

BACKGROUND

It is a legal requirement that each Hospital is registered as a food premises with the Local Council and is therefore subject to an inspection by the Environmental Health Department. The CPU was built over 20 years ago and provides inpatient meals to all hospitals within the UHB. There has been little or no investment in the fabric or equipment in the unit since it opened. However, the Capital Estates and Operational Services Board are considering a number of options regarding the future provision and or location of the CPU.
As the CPU is food production facility it is subject to 6 monthly food hygiene inspections.

**ASSESSMENT**

The letter notifying the UHB of the food hygiene rating contained a number of failings that the UHB has to put right. The failings are split into two schedules, Schedule A which details the work required to comply with the law whilst Schedule B lists those items which although are not legally required are considered to be good working practice. The Health Board has a 21 day period in which to submit a right of reply and an appeal against the score both has been submitted. After the 21 day period and depending on the outcome of the appeal the food hygiene sticker must be displayed and the score becomes available in the public domain. Once all of the items in Schedule A have been addressed the UHB can apply for a re-rating visit and on completion of the Schedule A items a re-rating visit will be applied for,

An action plan has been developed to address the failings identified and is attached as an appendix to this report. This will be monitored within Operational Services by the PFI/Compliance Manager on behalf of the Head of Operational Services.
### Schedule A - Legal Requirements

<table>
<thead>
<tr>
<th>Action</th>
<th>Time Scale</th>
<th>Comment</th>
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</thead>
<tbody>
<tr>
<td><strong>Food Hygiene and Safety Procedures</strong></td>
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</tr>
<tr>
<td>1. There was confusion over which sanitizer was being used to disinfect work surfaces. This may result in incorrect dilution rates and inadequate disinfection.</td>
<td>July 1st</td>
<td>Completed - All chemicals now ordered from one supplier, consistent training provided.</td>
</tr>
<tr>
<td>2. Must ensure that raw egg shells are kept separate from ready to eat foods on the trolleys towards</td>
<td>July 1st</td>
<td>Completed</td>
</tr>
<tr>
<td>3. The current practice of decanting raw meat from the yellow bins into the pans or boilers poses a risk of contamination to staff uniforms</td>
<td>July 1st</td>
<td>Staff instructed to roll up sleeves, however this is not new and has never been raised previously by EHO</td>
</tr>
<tr>
<td>4. The following were dirty and required cleaning: Taps to wash hand basins. Bowls to wash hand basins. Outer casing of probe thermometers. Drain cover in the meat room.</td>
<td>July 1st</td>
<td>Cleaning undertaken, monitoring now on supervisors check list</td>
</tr>
<tr>
<td>5. Floor covering in the walk in chiller within the low risk area was beginning to rise at floor/wall junctions.</td>
<td>Mid July</td>
<td>Unit to be taken out of use for 24hrs to allow temperatures to normalise to allow adhesive to set</td>
</tr>
<tr>
<td>Ensure that staff are trained in effective disinfection methods</td>
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<tr>
<td>Eggs to be delivered in separate boxes to ready to eat items</td>
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<tr>
<td>Staff must ensure sleeves are rolled above the elbows when handling raw meat</td>
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<tr>
<td>Wash hand basins and taps to be cleaned</td>
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<tr>
<td>Drain cover to be painted</td>
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<tr>
<td>Renew or repair the affected seals and leave in a sound and easy to clean condition.</td>
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</tbody>
</table>
6. There were no paper towels at the wash hand basin in the portioning room and no soap at the wash hand basin in the desserts area.

7. There was a quantity of disused equipment in the old baby feeds area.

8. There were 2 ceiling tiles missing from their position due to a water leak in the high risk production area. Whilst the leak was not directly above a food preparation area, the water may be contaminated and could cause contamination to food.

9. The use of the taped up plastic sheets to cordon off an area whilst works are being carried out to replace blast chillers isn’t sufficient to allow staff to carry out food preparation hygienically.

10. The use of tape on freezer handles, broom handles, and one of the mixers must be discouraged.

11. The condition of the metal trolley used for cooked joints of meat has deteriorated and can no longer be thoroughly cleaned.

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<tr>
<th></th>
<th>Ensure that there is always a supply of soap and paper towels to all hand wash basins.</th>
<th>The equipment must be removed to allow access for cleaning.</th>
<th>Fix the leak as a matter of urgency and replace the missing tiles and leave in a sound clean condition.</th>
<th>All building works must be planned so that they are not being carried out at the same time as staff are preparing foods or a more substantial screen put in place.</th>
<th>Any damaged equipment must be repaired or disposed of.</th>
<th>Do not use the trolley and remove from the premises</th>
<th>July 1st</th>
<th>Paper towels replenished and new soap dispenser fitted. Monitoring now on supervisors check list</th>
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<td>July 1st</td>
<td>July 1st</td>
<td>July 1st</td>
<td>July 1st</td>
<td>July 1st</td>
<td>July 1st</td>
<td>Paper towels replenished and new soap dispenser fitted. Monitoring now on supervisors check list</td>
<td>Completed</td>
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</table>
12. There was water leaking onto the floor into the area that was previously used for the preparation of sterile baby feeds

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<tr>
<th>Action</th>
<th>Time Scale</th>
<th>Comment</th>
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<tbody>
<tr>
<td>Investigate the source of the leak and repair</td>
<td>July 1st</td>
<td>Complete</td>
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Confidence in Management/Control Procedures

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<thead>
<tr>
<th>Confidence in Management/Control Procedures</th>
<th>Action</th>
<th>Time Scale</th>
<th>Comment</th>
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<tbody>
<tr>
<td>13. There is a Food Safety Management System in place based on HAACP principles. The following weaknesses were identified in the documented system</td>
<td>Given the presence of <em>Listeria monocytogenes</em> within the production room periodic samples of ready to eat food such as angel delight should be sent for testing. Amend HAACP</td>
<td>July 1st</td>
<td>Supervisors will ensure that a sample of Angel Delight is sent for testing Completed</td>
</tr>
<tr>
<td>HAACP states that Public Health Labs call through negative results you should change this to unsatisfactory results</td>
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<td>A number of old food labels were stored in the old baby food prep area</td>
<td>These labels must be stored securely to avoid food fraud or destroyed. You must ensure that the food safety management system covers all activities and considers all significant food safety hazards.</td>
<td>July 1st</td>
<td>Completed – labels removed</td>
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<tr>
<td>14. At the time of the visit it was noted that some controls and monitoring procedures were not being implemented as required by your documented food management system</td>
<td>Ensure that staff are properly trained and aware of the controls and monitoring they need to carry out. Staff must also be supervised and checked as necessary.</td>
<td>July 1st</td>
<td>Completed – staff met with and reminded of the importance of complying with the food management control systems.</td>
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</tbody>
</table>
15. All staff should receive food hygiene refresher training even those who have intermediate food hygiene certificates.

Rolling re-training programme to be delivered.

July 8th

Rolling re-training programme to be delivered. Intermediate food hygiene qualification is a life time qualification.

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<tr>
<th>Schedule B - Recommendations</th>
<th>Action</th>
<th>Time Scale</th>
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<tbody>
<tr>
<td>16 Please provide details of the most recent food hygiene training completed by all staff working in the CPU</td>
<td>Provide training records</td>
<td>July 1st</td>
<td>Completed</td>
</tr>
<tr>
<td>17 Guidance in how to comply with the allergen labelling requirements</td>
<td>Provide allergen information</td>
<td>July 1st</td>
<td>Completed</td>
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</tbody>
</table>
Caring for People, Keeping People Well:  This report underpins the Health Board’s "Sustainability" element of the Health Board's Strategy.

Financial Impact: N/A

Quality, Safety, Patient Experience impact: Consistent implementation of the documented Food Safety Management System will ensure compliance with the Food Safety Regulations and provide a safer patient and staff experience. A UHB food safety document has been finalised and is being used throughout patient catering services.

Health and Care Standard Number: 2.5  CRAF Reference Number: 5.1.8

Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Committee is asked to:

- NOTE the food hygiene rating and the remedial actions taken following the receipt of the Environmental Health Officer Inspection Report.

SITUATION

An inspection of Heathfields Restaurant, the catering outlet in Theatres, Ward Based Catering, Aroma unit in Children’s Hospital and the Teddy Bear Trust was undertaken on 30th June 2015 and the outcome of which was confirmed in writing in a letter report from the Senior Environmental Health Officer, Cardiff City Council.

In this report it was noted that these areas were given a score of 2 (Improvement necessary) in the National Food Hygiene Rating Scheme. All food hygiene scores less than 3 are reported to the Health Minister.

BACKGROUND

It is a legal requirement that each Hospital is registered as a food premises with the Local Council and is therefore subject to an annual inspection by the Environmental Health department. This is the first inspection where all catering outlets within the Operational Services remit on the UHW site have been combined as one rating.
ASSESSMENT

The letter notifying the UHB food hygiene rating contained a number of failings which the UHB has to put right. The failings are split into two schedules, Schedule A which details work required to comply with law whilst schedule B those items that are not required by law but would be considered as good working practice. The UHB has a 21 day period in which to submit a right to reply and appeal against score and these are being prepared. After the 21 day period and depending on the outcome of the appeal the food hygiene sticker must be displayed and the score becomes available in the public domain.

On receipt of the letter from the Senior Environmental Health Officer, an action plan was developed by the Operational Services Manager to address the issues raised and is attached as an appendix to this report. This will be monitored within Operational Services by the PFI/Compliance Manager on behalf of the Head of Operational Services.

Once all Schedule A failings have been addressed and the appeal period has passed the UHB can apply for a re-rating.

A number of corrective actions are being put in place immediately including:

- Introducing a rolling weekly audit programme of all ward kitchens and outlets
- Providing refresher food hygiene training for catering staff
- A dedicated role for a Food Safety Advisor responsible for interacting with Environment Health Officers, and carrying out food safety audits as well as checking practice against HACCP documentation. An individual has been identified to take on this role as part of their current duties.
- In the medium term provide additional support to the catering manager responsible for Heathfields and Aroma.
## Schedule A - Legal Requirements.

<table>
<thead>
<tr>
<th>Food Hygiene and Safety Procedures</th>
<th>Action</th>
<th>Time Scale</th>
<th>Comment</th>
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</thead>
<tbody>
<tr>
<td>Ensure that an area is provided for the handling and storage of raw foods. This is an area within the food establishment that is specifically managed to ensure that harmful bacteria, including E.coli O157, is kept separate from areas where ready to eat foods are handled.</td>
<td>Raw Prep Area to be re located Purchase 2 colour coded (red) trolleys for raw food prep only.</td>
<td>July 7th</td>
<td>Area has been relocated Trolleys on order</td>
</tr>
<tr>
<td>Mushrooms with visible dirt and boxed raw shell eggs were being stored above and next to yogurt, milk and salad this could lead to possible contamination. Dirty vegetables and raw shell eggs must be kept separate from ready to eat foods.</td>
<td>Mushrooms to be stored at the bottom of the fridge. Eggs to be stored in the raw area of the fridge bottom shelf</td>
<td>July 7th</td>
<td>Purchasing frozen mushrooms instead.</td>
</tr>
<tr>
<td>Ensure that staff are trained in effective disinfection methods. Staff must know when disinfection is essential and how to do it properly. It is therefore critical that all staff are trained and verified as competent in disinfection techniques before being asked to dilute and apply disinfectants, or to undertake hot water or steam disinfection.</td>
<td>D10 dispenser to be fitted in theatre kitchen. HACCP refresher training for all staff to be arranged.</td>
<td>July 25th</td>
<td>Training slides updated and sessions booked</td>
</tr>
<tr>
<td>The air temperature of the display chiller in the theatre kitchen was too high at 9°C. Foods stored in this fridge are high-risk and will support the growth of food poisoning bacteria and/or their toxins. Your fridge must operate at a temperature that will keep high-risk foods at or below 8°C. You must either adjust or service the</td>
<td>Fridge to be serviced Air conditioning unit to be repaired</td>
<td>July 31st 2015</td>
<td>Working with Estates for a solution. Refrigeration company has serviced all equipment 8th July 2015. However the ambient temperature in Restaurant</td>
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</table>
refrigerator. If the refrigerator is not able to hold high-risk foods at or below 8°C, it must be replaced.

Pre packed sandwiches are required to be stored below 5°C. As such destructive testing of food items in the display chillers is undertaken, however, staff weren’t always testing the temperatures of sandwiches.

It was noted at the time of the visit that the salad bar was not capable of holding foods below 5°C some products were probed at 14.1°C. After 4 hours, the food must be refrigerated until it is sold, served or thrown away. The food must not be displayed again at room temperature.

Air temperature of patient’s refrigerator on B1 was too high. The food must be operated at a temperature that will keep high risk foods at a temperature of below 8°C. Sandwiches from the Good Food Company stored in this fridge must be stored at below 5°C.

A packet of sliced turkey was past its use by date. Stock must be checked daily and any out of date food disposed of.

Dirty root vegetables such as potatoes and carrots can be a source of E. coli. These must be handled in such a way to avoid cross contamination.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action Description</th>
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<tbody>
<tr>
<td>July 7th</td>
<td>Temperatures to be checked and recorded daily, corrective action to be recorded in detail along with wastage of products. During hot weather only small amounts of sandwiches to be displayed.</td>
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<tr>
<td>July 20th</td>
<td>Salad bar not to be filled until 11.45 am Smaller amounts displayed with back up prepared any items that are left must be discarded and noted on the waste sheet.</td>
</tr>
<tr>
<td>July 14th</td>
<td>EHO advice is not to leave sandwiches in these fridge’s, alternative is that food not required to be stored at below 5°C will be left out overnight for patients.</td>
</tr>
<tr>
<td>Immediately</td>
<td>Staff instructed to check dates daily and dispose of out of date food. Will be covered by HACCP refresher training.</td>
</tr>
<tr>
<td>Immediately</td>
<td>Vegetables will be stored separately.</td>
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<tr>
<td></td>
<td>Sandwiches will be stored in industrial fridge.</td>
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<td></td>
<td>Completed. HACCP training includes how EHO wish to proceed with handling cold meats.</td>
</tr>
</tbody>
</table>
### Structural/Cleaning Issues

<table>
<thead>
<tr>
<th>Action</th>
<th>Time Scale</th>
<th>Comment</th>
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</thead>
<tbody>
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<td>Holes to be filled and repaired</td>
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<td>Taps and hand basin to be cleaned</td>
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There were a number of drill holes to the wall covering in the Heathfields kitchen. Fill Repair the wall covering and leave in a sound easy to clean condition.

The window mounted fan in the Heathfields wash up area was dusty.

Taps to the wash hand basin in the kitchen on Ward C1 needed cleaning as there was a build up of lime scale around the taps and on the tap head.

### Confidence in Management/Control Procedures

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<td>HACCP documentation to be amended to reflect the recommendations in the report. Discussion will be had with EHO as HACCP previously amended based on their guidance.</td>
<td>July 25th</td>
<td>The HACCP document is being revised and request has been put forward to EHO to further discuss the document.</td>
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</table>
Caring for People, Keeping People Well: This report underpins the Health Board’s “Sustainability” and “Culture” elements of the Health Board’s Strategy.

Financial impact: The current budget for the lone worker system is £80,000 approximate.

Quality, Safety, Patient Experience impact: This report is fundamental to the safety and quality of both staff and patients.

Health and Care Standard Number: 2.1  CRAF Reference Number: 9.2

Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Committee is asked to:

• NOTE the report and SUPPORT the proposed actions

SITUATION

The lone worker alert system is a discreet one-way communication device. When a ‘red alert’ is activated a channel is opened to the Reliance Alarm Receiving Centre (ARC). Trained operatives listen to the call and determine the appropriate action to take, including the deployment of emergency services if needed. In addition to this, audio evidence can be secured and used in cases that are progressed through the criminal justice system.

Progress reports were submitted to the Health and Safety Committee in November 2010, January 2012 and July 2013. The Health and Safety Operational Group also received an updated report in November 2014.

This report updates the Committee on status, plans to review the contract and improve usage.

The report underpins the Health Board’s Sustainability and Culture elements of the Health Board’s Strategy.

BACKGROUND

The implementation of lone worker devices to staff at risk in the community was a Welsh Government led initiative as part of its approach to minimise the number of incidents and effect of violence to NHS Staff in Wales.
Following subsequent reports on usage to the Health and Safety Committee devices have been rationalised to those people who regularly use them or are in specific high risk areas. The affect of this rationalisation reduced the number of devices allocated from 1394 at the commencement of the contract down to 714 at present.

The current contract with Reliance Services was signed in June 2010 for a 3 year period and was extended to date on a rolling programme. However this contract was based on the use of the purchased lone worker devices which are now over 5 years old and as such require replacement as they are obsolete with a very limited battery life. The cost of ongoing usage is budgeted within the health and safety finance plan.

The risk associated with lone working of injury without recourse to assistance could result in major or catastrophic events related to significant violence or hostage situations. It is necessary for Cardiff and Vale Health Board (UHB) to have suitable control measures in place to manage these low frequency high risk events as it is to protect against the frequent violent events experienced by our staff. Due to Cardiff and Vales migrant population and city based service these risks are enhanced with the UHB reporting the most significant proportion of violent events within Wales. The lone worker system has a proven track record of alerting the Emergency Services and supporting staff during such events.

**ASSESSMENT**

A lone worker device with access to a 24hr staffed Alarm Receiving Centre (ARC) with direct line access to the Emergency Services offers a level of lone worker protection that cannot be delivered in house.

Analysis of device usage shows that over a 2 year period there has been a total of 7 genuine red alerts raised by users (one of which was escalated to the Emergency Services), 1947 false alarms and approximately 42,000 amber alerts. Recent activity reports show that 25% of lone workers are regularly using their device. The level of usage demonstrates a continued need to control the risk of violent attacks and have an effective lone worker system in place.

The Health and Safety Department has worked with Clinical Board Management and device users to improve the system within the financial restraints of the budget. It concluded the following:

- A mobile phone, notebook device or paper based system could not offer the same level of protection offered by a lone worker device.
- Whilst failure to use the device could diminish the likelihood of a civil negligence claim to the UHB, the UHB has a statutory obligation to manage the risk of lone working in the community.
- The feedback received highlighted that the ARC had demonstrated confidence that when needed help would be provided. However the current device was subject to frequent false alarms due to the design, a
short battery life and maintaining and updating the administration of the system was time intensive.

- It further considered that the GPS tracking currently available to only 10% of devices would be beneficial on all devices.
- Lease hire of devices would be the preferred option as it requires no initial financial outlay and places the responsibility on the supplier to replace obsolete and broken devices.

A trial of existing and alternative products was undertaken by the users to develop a specification for a replacement device. This identified that the preferred device would have key features including a minimum of 100 hours battery life (currently 12 hours), GPS with tracker on all devices, two way audio communication and flexibility in user transfer. The trial considered that the above features would significantly increase usage.

Meetings between Procurement and suppliers have identified that these devices can be supplied within the current lone worker budget. A contract specification has been submitted to Procurement to undergo the tendering process. It is considered the new system will be available during the late autumn. Plans have been formulated to ensure that any transition is carried out with minimum disruption and without putting staff at risk. It will be based on an ongoing commitment of staff to use their device.

Monitoring and compliance will be undertaken through the Operational Health and Safety Group and Personal Safety and Security Strategy Group and will be reported to the Health and Safety Committee at agreed intervals.
DANGEROUS GOODS SAFETY AUDIT REPORT

Executive Lead: Director of Planning
Author: Head of Transport & Sustainable Travel x46388

Caring for People, Keeping People Well: This report underpins the Health Board’s “Sustainability” and “Values” elements of the Health Board’s Strategy.

Financial Impact: N/A
Quality, Safety, Patient Experience impact: Manages the risks associated with the legal duties on the Board as a consignor and carrier of substances classed as dangerous goods on public roads and highways.

Health and Care Standard Number: 2.1, 2.4, 2.6, 2.8, 2.9
CRAF Reference Number: 5.1.6
Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Committee is asked to:

• APPROVE/AGREE the proposed way forward

SITUATION

Between July 2014 and April 2015, the University Hospital of Wales (UHW) was audited to examine its dangerous goods practices in order to determine current levels of compliance with statutory requirements and relevant sector guidance, and to make recommendations to correct any non-compliance. The final Dangerous Goods Safety Audit (DGSA) Report was received in June 2015. A specific DGSA Report has been presented separately to the UHW Nuclear Medicine Department.

This in part fulfils the Board’s legal duty, under the below mentioned Regulations, to monitor and report annually on the Board’s activities which fall into scope of the Regulations. This report should be kept for five years and be produced at the request of the enforcement authorities.

The lead enforcement authorities concerned are the Health and Safety Executive (HSE) and The Office for Nuclear Regulation (ONR) with powers also held by the Police and the Driver and Vehicle Standards Agency (DVSA).

The audit identified a number of non-compliances which have been compiled into a RAG assessed Action Plan. Action to be undertaken to redress non-compliance supports the Board’s strategy in terms of Sustainability (avoiding harm, waste and variation) and Values.
BACKGROUND

The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009 place legal duties on the Board as a ‘consignor’ and a ‘carrier’ of substances/articles classed as dangerous goods for the purposes of carriage on public roads and highways. This includes hazardous wastes that are generated by the Board, for example, clinical waste.

The Board accesses specialist advice, in this regard, via its Service Level Agreement with the Health Courier Service (HCS - now part of NHS Wales Shared Services Partnership). HCS was formerly part of Welsh Ambulance Services NHS Trust (WAST) and provides the Board with a non-patient transport service for bloods, specimens, mail, etc. Such DGSA advice has been lacking in recent years since the internal WAST DGSA retired. Consequently, this is the first audit undertaken for a number of years and there have been a number of non-compliances identified.

ASSESSMENT

Upon receipt of the audit, a meeting with HCS was undertaken to compile the Action Plan. This has recently been circulated to relevant managers for consideration/action and will be progressed as a matter of urgency during the summer.

The audit identified 58 non compliances; 15 being red, 32 amber and 11 green and were in relation to:

- Clinical Waste
- Consignment and Transport of Contaminated Medical Instruments
- Laboratory Medical Services Department
- Pharmacy
- Gas Installation and Cylinder Storage
- Chemical Waste
- Transport
- Security of Dangerous Goods
- Dangerous Goods Safety Adviser
- Medical Physics

A Task and Finish Group will be established to ensure relevant actions are undertaken and report back on progress and any implications to the Committee at its October 2015 meeting. Progress against the action plan will be monitored within Capital Planning Estates and Facilities.
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FIRE SAFETY POLICY

Executive Lead: Director of Planning

Author: Head of Health and Safety – 02920 743751

Caring for People, Keeping People Well: This policy underpins the HB strategy in avoiding harm whilst delivering outcomes that matter to them.

Financial impact: The implementation of this Policy will be undertaken within the resources of the UHB and any identified additional resource requirement will be brought to the Committee for approval.

Quality, Safety, Patient Experience impact: The policy requirements, impacts on all services of the Health Board and directly relates to both pts and staff care and safety.

Health and Care Standard Number 2.1  CRAF Reference Number 8.1

Equality Impact Assessment Completed: Yes

RECOMMENDATION

The Committee is asked to:

- APPROVE the Policy
- APPROVE the full publication of the Fire Safety Policy in accordance with the UHB Publication Scheme or

SITUATION

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

The policy is revision UHB 2 and was previously reviewed in April 2013. The South Wales Fire Service considers the Fire Policy as the core key Fire Safety document to implement appropriate fire arrangements.

BACKGROUND

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

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

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

- Minimises the incidents of fire and all unwanted fire signals throughout all properties used by Cardiff & Vale University Health Board.
- Minimises the impact from fire on life, safety, delivery of service, the environment and property.

Achieving these aims will ensure the UHB acts within the legislative and regulatory framework, complies with: The Regulatory Reform (Fire Safety) Order 2005 and where applicable the following legislation:

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

ASSESSMENT

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

- The document was added to the Policy Consultation pages on the intranet between 11th June 2015 and 9th July 2015;
- The document was shared with the Fire Safety Group and the Operational Health and Safety Group.
- Comments were invited via individual e-mails from the Fire Safety Group and Operational Health and Safety Group.

Where appropriate comments were taken on board and incorporated within the draft document.
The primary source for dissemination of this Fire Safety Policy within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

Amendments made relate mainly to:

1. Organisational structural changes. The appointment of the Director of Planning as being the Executive Lead.
2. A review of the arrangements with regards to Deputy Fire Safety Managers for an identified need of a representation for each Clinical Board based at UHW.
3. It also reflects site closures and amendments, including CRI West Wing.
4. The document continues to reflect the requirements imposed by the Fire Service in relation to Whitchurch Hospital site.
FIRE SAFETY POLICY

Policy Statement

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

Policy Commitment

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

Supporting Procedures and Written Control Documents

- CRI Fire Procedure
- Acute Hospital Fire Procedure
- Community Hospital Fire Procedure
- Health Centres and Clinics Fire Procedure
- St David’s Hospital Fire Procedure

Other supporting documents are:

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

Scope

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

Equality Impact Assessment

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

Health Impact Assessment

A Health Impact Assessment is/ is not required for this policy.

Policy Approved by

Health and Safety Committee
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**Disclaimer**

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

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1.0 INTRODUCTION

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

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

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

A brief précis of the Regulations is listed in Appendix I. However, a full copy can be obtained by using the following web link:

www.cabinetoffice.gov.uk/regulation/documents/regulatory
reform/pdf/firerrofinalscrut.pdf

2.0 POLICY STATEMENT

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

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

3.0 AIMS

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

The principle objectives of this policy are to:

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

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

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

4.3 All premises used or occupied by Cardiff & Vale University Health Board fall within the scope of this policy.

4.4 The Health Board is committed to comply with all statutory fire safety standards.

4.5 When commissioning new buildings, leasing new buildings or occupying buildings under a PPP/PFI contract, the Health Board must be satisfied that such buildings comply with legislation relating to fire safety.

4.6 Appropriate advice and guidance through the Firecode suite of guidance documents issued by the Welsh Assembly’s Department of Health and Social Services will be used for all matters related to fire safety.

4.7 All contracts for health services placed by commissioners must contain clauses to ensure that premises comply with, and will continue to comply with, all statutory fire safety provisions and where appropriate, Firecode.

5.0 RESPONSIBILITIES/IMPLEMENTATION

5.1 The Chief Executive

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

5.1.1 The Health Board has an effective Fire Safety Management system.
5.1.2 Fire safety will be a standing agenda item at the Health Boards Executive Board meetings.

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

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

5.2 Executive Director

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

5.2.1 Ensure appropriate arrangements for Fire are in place within each of the Divisions.

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

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

5.3 Fire Safety Manager


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

The Fire Safety Manager will be responsible to work within the defined role with in the Firecode Guidance including the structure of the Management of Fire within the Health Board and the role of the Deputy Fire Safety Managers, previously referred to as Nominated Officers (Fire). These include:

- Ensuring that programmes are in place to provide fire safety training for all staff appropriate to their duties and place of work.
- Ensuring that procedures are in place to undertake fire risk assessments and monitor them to make sure they remain relevant.

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

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

5.4 Deputy Fire Safety Manager (DFSM)

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

UHW –
  Each Clinical Board with Services at UHW will appoint a Deputy Fire Safety Manager for their areas on Site.

UHL -
  The General Manager of the Hospital is appointed as the DFSM

Other In-patient Sites -
  The Clinical Board with the major presence will be responsible for nominating a DFSM for each in-patient hospital sites

Community including CRI -
  The Clinical Board with the major presence will be responsible for nominating a DFSM for each Community premises.

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

5.4.1 Monitor the effectiveness of the day-to-day upkeep of the established Fire Safety Policy. As the Deputy Fire Safety Manager may not be “onsite” on a day-to-day basis, this responsibility will be delegated to the relevant Line Managers/Heads of Department to monitor day-to-day upkeep of the established Fire Safety Policy for their areas.

5.4.2 Ensure that for all areas within their control, emergency evacuation procedures are in place.
5.4.3 Verify that for all patient areas, appropriate fire response teams are established, this is detailed in the relevant site fire procedure.

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

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

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

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

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

5.4.9 Appointed Nominated Officers of Fire will receive appropriate training on their role requirements.

5.5 **Senior and Fire Safety Advisers**

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

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

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

5.5.3 Advising management of their initial and continuing responsibilities in respect of Health Board premises falling within the scope of The Regulatory Reform (Fire Safety) Order 2005.
5.5.4 Assisting Capital and Asset Management and Facilities Management staff and others in fire risk assessments, audit and the preparation of reports to management.

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

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

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

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

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

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

5.6 Fire Wardens

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

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

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

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

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

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

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

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

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

5.7.7 Ensure that actions identified via Fire Risk Assessment are acted upon without delay or escalated to Fire Safety Manager where necessary.

5.7.8 Ensure all Fire Service Notices and Enforcement Actions are acted upon without delay and communicated with the Fire Safety Manager and relevant Fire Adviser.

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

5.8 Responsibility of all Staff

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

5.9 **Responsibility of Other Authorised Users, Students, Contractors etc.**

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

5.10 **Contractors**

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

5.11 **Health Board Fire Safety Group**

The Health Board Fire Safety Policy Group will determine the standards of fire prevention/protection throughout the Health Board and will oversee the implementation of the Fire Safety Policy on the various sites.

The meeting reports as a sub group of the Health and Safety Sub-Committee.

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

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

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

- Assistant Director of Planning (Deputy Chair)
- Fire Safety Manager
5.12 **Health and Safety Committees**

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

### 6.0 RESOURCES

It is likely that issues will arise as a result of implementation of the policy, which may require resources to monitor effective standards of fire safety. This resource needs will be considered at the Fire Safety Group and taken to the Executive Director of Planning for resolution or progression, on to the relevant Board Committee.

### 7.0 TRAINING

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

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

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

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

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

7.3 Compliance to fire training will be monitored at the Fire Safety Group, Operational Health & Safety Group and other relevant Divisional/Departmental meetings.

7.4 Assurance of compliances will be given to the Board via regular reports to the Health & Safety Sub-Committee and Workforce Committee.

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

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

8.0 FURTHER INFORMATION

The relevant evidence base for the document is listed below:

- The Regulatory Reform (Fire Safety) Order 2005;
  - Firecode Suite of Documents;
  - Building Act 1984;
  - Building Regulations 2000;
  - Health and Safety at Work etc. Act 1974;
  - The National Health Service & Community Care Act 1990;
  - The Management of House in Multiple Occupation (Wales) Regulations 2006;
  - Furniture and Furnishings Fire Safety Regulations 1988;
The Health & Safety (Safety Signs and Signals) Regulations 1996;

The Disability Discrimination Act (2005);

The Construction (Design and Management) Regulations 2007;

The Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR);

The Management of Health and Safety at Work Regulation 1999.

9.0 FIRE SAFETY PROCEDURES

9.1 Reporting of Fire Incidents

- All fires no matter how small, even if extinguished, must be reported to the Fire Safety Adviser for investigation and action.

- Details of all outbreaks of fire to which the fire service is called must be reported promptly to NHS Wales Shared Services Partnership – Specialist Estates Service.

- A fire report which is now available via the Fire and Unwanted Fire Signal (UwFS) Information Reporting System on the NHS Wales Shared Services Partnership – Specialist Estates Services intranet site is to be completed by the Fire Safety Adviser and the Senior Fire Safety Adviser informed.

- The Senior Fire Safety Adviser will review the report via the web site and forward a copy electronically to NHS Wales Shared Services Partnership – Specialist Estates Services. The report is to reach NHS Wales Shared Services Partnership – Specialist Estates Services within 48 hours of the incident.

- A copy of the report will be forwarded to the respective Deputy Fire Safety Officer who will forward a copy through the Executive Director to the Chief Executive. In addition, a copy of the report will be sent to the Cardiff University Vice Chancellor if University property or personnel are involved.

- In the event of a serious fire incident developing where disruption to services and patient care are likely, the senior person present should consider whether to initiate the “Health Board Major Incident Plan”.

- In addition, fires involving multiple deaths, multiple injuries or damage on a very large scale are to be notified immediately to
the Director of the NHS in Wales, National Assembly for Wales, Health Service and Management Division, Cathay's Park, Cardiff, CF1 3NQ by the Health Board Chief Executive Officer or Executive Director on call, depending on availability. The Health and Safety Executive must also be advised in the nearest regional office.

- Details of all false alarm calls to which the fire service is called must also be reported to NHS Wales Shared Services Partnership – Specialist Estates Services. The False Alarm Report which is now available via the Fire and UwFS Information Reporting System on the NHS Wales Shared Services Partnership – Specialist Estates Services intranet site, is to be completed by the respective Fire Safety Adviser for each call and forwarded electronically to NHS Wales Shared Services Partnership – Specialist Estates Services

- Switchboard operators will complete a Fire Call Report Form (Appendix II) for every fire call (including false alarms) received.

These will be forwarded to the appropriate Fire Safety Adviser and the Senior Fire Safety Adviser.

- In the event of a serious fire involving property or life, senior management and Health Board members will be informed in accordance with the site fire procedures. The Vice Chancellor will be informed of serious fires involving CU personnel or property.

- Other users of Health Board premises such as National Public Health Service for Wales (NPHS), Concourse Units etc. will be informed of fires in their areas of responsibility.

- The Senior Fire Safety Adviser will maintain the fire statistics for the Health Board and submit quarterly reports to the Health and Safety Committee.

9.2 Maintaining Adequate Levels of Physical Fire Precautions

- The Health Board needs to ensure it has an extensive programme for installing and satisfactorily maintaining an adequate level of physical fire precautions designed to prevent the occurrence, ensure the detection, and stop the spread of fires. If required further specialist advice in the preparation of this programme will be obtained from the Senior Fire Safety Adviser.

- The Chief Executive is responsible for the strategic organisation of fire safety arrangements. The Senior Fire Safety Adviser is to
be informed of any proposals that could affect such arrangements.

- The Senior Fire Safety Adviser must be consulted prior to any changes to the structure, use/function, layout, furniture, fittings or decoration, or to procedures and staffing levels to determine if such changes will have a bearing on fire safety.

- The Senior Fire Safety Adviser will arrange for systematic inspections, at prescribed intervals, to be undertaken by the Fire Safety Advisers of all areas of the Health Board.

- Site Fire Plans are to be kept by the Head of Capital & Asset Management showing the following:
  
  - Fire resisting construction.
  - Periods of fire resistance.
  - Location of fire fighting equipment.
  - Location of fire alarm call points, detectors, sounders and panels.
  - Fire locks.
  - Location of fire action notices.
  - Arrangements for means of escape.
  - Location of exit signs.
  - Emergency lighting points.

9.3 **Maintenance and Testing of Fire Appliances, Alarms etc.**

The maintenance of all fire appliances such as alarms, fire doors, emergency lighting and mechanical ventilation etc. is a legal requirement under the Regulatory Reform (Fire Safety) Order 2005. It is the responsibility of the Assistant Director of Planning (Capital & Estates) and is implemented by designated trained engineers. These defined policies, procedures and programmes of work; maintenance and training are essential, irrespective of any designation of hospitals or other premises under the Regulatory Reform (Fire Safety) Order 2005. All such policies, procedures and programmes should be reviewed annually and brought up to date. Equipment is to be maintained and tested by the staff of Facilities Management in accordance with the following standards:
Portable fire extinguishers  BS 5306 Part 3
Fire blankets  BSEN 1869
Hydrants, dry risers and hose reels  BS 5999
Fire alarms  BS 5839 Part 1
Emergency lighting  BS 5266 Part 1
Sprinkler systems  BSEN 12845
Lightning protection systems  BS 6651:
Mechanical ventilation systems and Fire Dampers  BS 9999:
Fire doors  BS 8214
Smoke control systems  BS 7346-2

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

9.4 Project Design/Building Works

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

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

During building works:

- The site of the activities should be strictly supervised and controlled, even during small works and sporadic maintenance visits.

- Capital & Asset Management and Estate Maintenance staff must ensure that all necessary precautions against fire are taken.
- The Fire Safety Adviser should give guidance and keep in regular contact with such activities to check compliance with fire safety policy.

- The 'permit to work' and 'hot work permits' policy issued by the Estates Department is to be used for removal/covering of fire detectors, and use of flame producing equipment for cutting, welding and grinding.

- The use of open waste skips is not permitted unless authorised by the Fire Safety Adviser. Enclosed lockable skips will be used and positioned in safe areas away from buildings and boundaries.

- The Loss Prevention Council booklet ‘Fire Prevention on Construction Site’ is a useful checklist of fire precautions, which contractors should observe and must be included as part of the contract documents.

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

9.5 Escape Routes

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

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

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

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

9.5.5 A visual inspection at the start of the working day or shift should be made by staff working in a given area and any obstruction or defect found must be dealt with immediately.
9.5.6 A further check should be made at the end of the working period to ensure that appropriate doors are shut, locked or secured as appropriate and the site cleared.

9.6 Fire Safety Signs

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

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

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

9.7 Fire Service Access

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

9.8 Restricted Smoking Policy/ Sources of Ignition

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

9.8.1 MENTAL HEALTH AREAS
Areas for smoking for certain mental health patients have been agreed and are set aside and designated as smoking rooms.

Where provided, ward managers should ensure smoking rooms are checked regularly throughout the day, to ensure smoking materials are extinguished and no accumulation of waste smoking materials occurs.

Litterbins for general refuse must not be provided in designated smoking rooms. Ashtrays must not be emptied into the general waste containers.

Further specific procedural requirements have been developed relating to the control of smoking and sources of ignition within Mental Health premises (Appendix VIII); these include

- Regular monitoring of high risk areas such as bedrooms
- The right to remove ignition sources from patients where there is a perceived risk of injury to themselves or others
- Strict control of prohibiting smoking in non-designated areas
- Removal of smoking materials and combustible material in rooms and from behind radiator covers
- Training and Auditing of Wards Managers responsibilities

9.8.2 NON MENTAL HEALTH AREAS

Smoke free regulations apply at all times.

9.9 Furniture and Textiles

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

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

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

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

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

9.10 Staffing Levels

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

9.11 Communications

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

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

9.12 Arson

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

9.12.2 Security systems and procedures are already in place to keep unauthorised persons out of vulnerable areas e.g. lower ground floor at UHW. These systems must not be abused by personnel taking or allowing unauthorised persons into restricted areas without the necessary authority.
9.12.3 Identification badges must be worn at all times, including contractors and servicing personnel.

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

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

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

9.13 Car Parking

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

9.14 Waste Management

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

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

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

10 EQUALITY

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

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

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

12 DISTRIBUTION

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

To access the document:

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


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

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

Article 4. General Fire Precautions means:

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

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

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

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

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

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

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

and

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

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

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

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

PART 2. FIRE SAFETY DUTIES

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

Article 9. A written fire risk assessment must be carried out in each work area if 5 or more are employed.
Article 10. Duty to prevent fires.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CARDIFF AND VALE UNIVERSITY HEALTH BOARD
BWRDD IECHYD
PRIFYSYGOL CAERDYDD A’R FRO
& CARDIFF UNIVERSITY
PRIFYSYGOL CAERDYDD

FIRE CALL REPORT FORM

1. DATE: _____________  DAY: _____________  TIME: ________ am/pm

2. HOSPITAL/CLINIC: ____________________________________________

3. AREA INVOLVED: ____________________________________________

4. ALARM RECEIVED BY: AFA: ___  TELEPHONE: ________OTHER: ______

5. FULL NOTIFICATION PROCEDURE INITIATED? YES/NO ___  TIME: _____

6. FIRE SAFETY ADVISOR INFORMED? YES/NO ___  TIME: _____

7. RECEPTION NOTIFIED BY DIALLING ‘3333’? YES/NO/NA ___  TIME: _____

8. DID FIRE SERVICE ATTEND? YES/NO ___  TIME: _____

9. CAUSE OF ALARM: ____________________________________________

10. TIME FIRE ALARM RESET: _____________________________________

11. ADDITIONAL COMMENTS: _______________________________________

_______________________________________________________________

SWITCHBOARD OPERATOR (PLEASE PRINT NAME)

PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE AND SEND
COMPLETED FORM TO:

1. THE SITE FIRE SAFETY ADVISOR;

2. THE SENIOR FIRE SAFETY ADVISOR, PLANNING & ASSET MANAGEMENT
   DEPARTMENT, UHW.

AS SOON AS POSSIBLE AFTER THE INCIDENT
FIRE REPORTING PROCEDURE

FACC Completes Fire Call Form

FALSE ALARM
- Fire Safety Adviser Completes False Alarm Report electronically
- Reviewed by Senior Fire Safety Adviser and Electronic copy sent to Welsh Health Estates

FIRE
- Fire Safety Adviser Completes Fire Incident Report electronically
- Reviewed by Senior Fire Safety Adviser and Electronic copy sent to Welsh Health Estates
- Copy to NOF Executive Director Chief Executive/CU
FIRE SAFETY ORGANISATION

Chief Executive

Executive Director
With special responsibility for fire

Fire Safety Manager

Health Board
Fire Safety Advisers

Deputy Fire Safety Managers
(Nominated officers (Fire))

Line Managers
All Staff

Health and Safety Committee

Appendix IV
PROJECT DESIGN PROTOCOL FOR FIRE SAFETY

Appendix V

Are there FIRE SAFETY implications involved with the project scheme?

NO

This protocol therefore not applicable.

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

NO

Consult with the Senior/Fire Safety Adviser (SFSA/FSA)

Has the Fire Plan been consulted?

NO

Fire Plan to be consulted.

Have Fire Risk Assessments been consulted for fire safety elements?

NO

Fire Risk Assessments to be consulted for fire safety elements

Develop drawings detailing all fire protection features of scheme

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

NO

SFSA/FSA to check

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

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

Notify start date and contract particulars to the SFSA

Notify SFSA/FSA of completion of project/scheme

Carry out handover inspection – SFSA/FSA and Project Manager

Compile ‘snagging list’ of any remedial works required.

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

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

Fire drawings to be suitable amended
Fire Safety Management Structure

Health Board

Executive Lead for Fire
Exe Director of Planning
Abigail Harris

Fire Safety Manager
C Dalton

Ast Director of Capital & Planning
G Walsh

Estates Compliance Manager
T Ward

Senior Fire Advisor
F Barrett

Deputy FSM
UHL
P Welsh

Deputy FSM
Barry
C Darling

Deputy FSM
radio
R Thomas

Deputy FSM
UHW
D Cox

Dental - R Griffith
CAB - C Evans
Medicine - Vacant
Surgery - Vacant
CD&T - M Temby
Specialist-p - TBC

Deputy FSM
Rookwood
A Richards

Deputy FSM/NOF
Whitchurch & I Jones
I Wle

Deputy FSM/NOF
St Davids
L Topham

Fire Safety Advisor UHL
K Harrington

Fire Safety Advisor UHW
D Cox

Fire Safety Advisor Whitchurch & Community
T Edger

ST Davids PFI
Supported by
K Harrington

Health and Safety Committee
124 of 166
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Protocol for the Management of Smoking
In the Adult In-Patient setting

Appendix VIII

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

Introduction

The incidence of smoking amongst service users in Mental Health is very high and in some areas is as much as 100%. Whilst smoking is perceived as important to many service users, the laws on smoking have changed and apply to mental health service users equally in public places. There is strong support to move mental health services to be as smoke free and safe as possible for both service users and staff.

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

Aims

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

Procedure

1. All service users will be asked to hand in their lighters / matches etc. upon admission. These items will be stored securely in the ward office and returned when the service user has leave / is discharged from the ward or, where service user has carers / relatives visiting, they will be asked to take the items away.
2. A poster will be displayed advising both service users and visitors that lighters / matches etc. are not permitted on the ward to maintain the safety and security of those on the ward.
3. The ward smoke room will be fitted with an electronic ignition source so that other ignition sources are not required.
4. Service users will be asked upon return to the ward to hand in any ignition sources.
5. Service users found smoking in any area other than a designated smoking area, may be liable to prosecution.
6. Service users who are known to smoke, but who decline to hand in an ignition source may be searched as per the Search of Patient – Persons and Belongings Policy and Procedure. (Procedural Guidance attached as Appendix 1).
7. The ward smoke room will operate restricted opening times. These will be:
   - 06:00 – 08:00
   - 20:00 – 00:00

The smoke room will remain locked at all other times unless there is exceptionally inclement weather, a service user poses a significant risk of absconding (for those areas without a secure garden), or for frail and physically unwell individuals.
8. Each clinical area will have a smoking shelter for use by the service users and staff will organise regular breaks off the ward (e.g. hourly for 15 minutes). Staff will accompany service users as required according to individual risk assessments.

9. Information leaflets for service users will be provided regarding smoking cessation.

10. An information sheet for Nicotine Replacement Therapy options is provided by the UHB Smoking cessation service.

**Procedural guidance for:**

**Search of Patient – Person and belongings**

**Search Procedures**

**Alternative Interventions**

- Alternative approaches must be used to give the patient the opportunity to hand over any items of concern. This is due to the serious nature of undertaking a search and the potential harm to the therapeutic relationship.

- Alternative approaches include:
  - Negotiation
  - Nursing separately
  - Accompanied by staff allowing time for individual to hand over the item
  - Giving time for the individual to express their concern
  - Contacting police – would be essential if there were any potential risk to the safety of staff or others.

**Principles of Undertaking a Search**

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

If staff suspect an informal patient of possession of a harmful object the individual may be asked whether this is the case, and if they confirm this they can be asked to hand it over for safe keeping. The legal justification for such an action is to prevent a breach of the peace. Consideration should be given to involving the Police if the patient refuses to hand over the object.

If a client is being assessed under Section 136 of the Mental Health act the police have powers to search a patient if they are suspected of possession of a harmful object.

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

**13.1 Searching Patients without consent**

Consideration should always be given to The Mental capacity Act 2005 when assessing a patient’s capacity to consent to a search (see section 6).

If a patient does not consent to a search, the most senior staff member on duty must make one of the following decisions (based on the principle of necessity (Gunn 1992)): -
• a) To search the patient against their will on the grounds that there was immediate risk of serious harm to self or others that necessitated immediate action. Necessity does not limit the action of search to emergency situations only, but extends to action taken in order to prevent serious harm to self or others. An example of this would in removing an article such as a knife from a patient's pocket or illicit drugs / alcohol
• b) To delay the search and seek advice of the patient's consultant and / or the clinical manager or deputy
• c) To involve the police

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

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

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

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

. Communication

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

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

13.2 Any search of a personal nature must be undertaken by persons of the same gender as the patient, wherever possible, unless necessity dictates otherwise.
13.3 The patient must not be unaccompanied at any stage of the search procedure.
13.4 Staff should be aware of the potential implications and outcomes of a search and should use clinical judgement in deciding immediate future management following a search.

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

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

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

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

13.9 Types of Search

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

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

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

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

d) **Personal Search:**

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

Within the context of personal search, the following stages may be identified.

i) Looking for objects attached to skin, or concealed in the mouth or ears

ii) The patient may be asked to remove superficial clothing that can be removed without impacting on their dignity, (e.g. coat, jacket, shoes)

iii) Touching the patient to look for objects. Wherever possible the patient should assist staff, thus reducing the need to touch the patient. An example of this is by asking the patient to run their fingers through their hair or to lift folds of skin

iv) Intimate search - including body orifices (excluding mouth or ears). More intimate searches are deemed to be beyond the capabilities of the mental health team and liaison with other agencies / parts of the organisation may be necessary.

### 13.10 Record Keeping

Details of all searches are to be recorded in the patients clinical notes and incident form completed. This should include:

a) The reasons of risk which informed the decision to ask for permission to search.

b) Reasons why any decisions to enforce a search are made.

c) The outcome of the search, including items/substances removed and their disposal. Also any damage caused to patient’s belongings during the process of search.

d) Physical and psychological effects which are observed in relation to the patient and the care of that person managed accordingly (incident forms should be completed as necessary).

e) The incident should be reviewed by all concerned including the patient involved. This will ensure that effective evaluation and best practice is promoted.

f) Identifying times of searches, staff involved names of Police Officers attending.

There should be support for patients and staff who are affected by the process of searching involving physical intervention.
**Section A: Assessment**

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<th>Fire Safety Policy</th>
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<td>Charles Dalton – Head of Health and Safety 02920 743751</td>
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## 1. The Policy

### Is this a new or existing policy?

Existing – this is version UHB 2 of the policy.

### What is the purpose of the policy?

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

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

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

Achieving these aims will ensure that the UHB acts within the legislative and regulatory framework, complies with: The Regulatory Reform (Fire Safety) Order 2005 and applicable legislation.

### How do the aims of the policy fit in with corporate priorities? i.e. Corporate Plan

This Policy is linked with the following documents:

- Health and Safety Policy
- Risk Management Policy and Strategic Framework
- Equal Opportunities Policy
- Incident, Hazard and Near Miss Reporting Policy
- Civil Contingencies Strategic Framework
- Major Incident Plan Immediate Response and Recovery
- No Smoking and Smoke Free Environment Policy
- Contractor Control Policy
### Waste Management Policy

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<td>The Policy aims to protect Staff, Patients and all users of Health Board premises.</td>
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<th>What outcomes are wanted from this policy?</th>
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<td>Contributory factors include: adequate fire evacuation equipment and plans, fire segregation, audible and visual signage, adequate mandatory training, adequate and relevant risk assessments, safe systems of work, competent advice from advisors, staff actively reporting incidents, adequate staffing levels, positive peer pressure.</td>
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The outcome of the Policy can be affected detrimentally by any of the above not being in place.

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<td>The Policy is highly related to the competency of staff in assisting in reducing the risk of fire and responding to the needs of others during an evacuation. Therefore training is a key element as is cooperation.</td>
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### 2. Data Collection

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<td>Data was collected relating to the ethnicity of our staff.</td>
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<th>What quantitative data do you have on the different groups (e.g. findings from discussion groups, information from comparator authorities)?</th>
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Reference was made to the Equality Impact Assessment undertaken for the Recruitment and Selection Policy which had gathered data from the workforce profile of the Cardiff and Vale UHB and information was obtained from NHS Jobs.

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<table>
<thead>
<tr>
<th>3. Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please answer the following</td>
</tr>
</tbody>
</table>

Consider the information gathered in section 2 above of this assessment form, comparing monitoring information with census data as appropriate (see www.ons.gov.uk Office National Statistics website) and considering any other earlier research or consultation. You should also look at the guidance in Appendix 1 with regard to the protected characteristics stating the impact and giving the key reasons for your decision.

<table>
<thead>
<tr>
<th>Do you think that the policy impacts on people because of their age?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(This includes children and young people up to 18 and older people)</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you think that the policy impacts on people because of their caring responsibilities?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No - however caring staff have further responsibilities within the procedures.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you think that the policy impacts on people because of their disability?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(This includes Visual impairment, hearing impairment, physically disabled, Learning disability, some mental health issues, HIV positive, multiple sclerosis, cancer, diabetes and epilepsy.)</td>
</tr>
</tbody>
</table>

Staff/patients with sensory disabilities may need a fire incident bringing to their attention. However in key risk areas a combination of visual and auditable alarms are employed.

Some physically disabled staff/patients may need assistance in the event of an evacuation. It is the responsibility of all staff to ensure that this group is assisted at all times if affected by a fire incident within the Health Board. Specialised evacuation equipment is available and some healthcare practices are restricted where the potential of emergency evacuation may be detrimental to the patient.

Managers of staff with physical disabilities are required undertake assessments and take advice on the staff needs and arrangements for evacuation.

The evacuation of very heavy patients from upper floors is also relevant to patient mobility – the lateral evacuation techniques together with support from the Fire Service is utilised.
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you think that the policy impacts on people because of Gender reassignment? (This includes Trans transgender and transvestites)</td>
<td>No</td>
</tr>
<tr>
<td>Do you think that the policy impacts on people because of their being married or in a civil partnership?</td>
<td>No</td>
</tr>
<tr>
<td>Do you think that the policy impacts on people because of their being pregnant or just having had a baby?</td>
<td>No</td>
</tr>
<tr>
<td>Do you think that the policy impacts on people because of their race? (This includes colour, nationality and citizenship or ethnic or national origin such as Gypsy and Traveller Communities.)</td>
<td>No</td>
</tr>
<tr>
<td>Do you think that the policy impacts on people because of their religion, belief or non-belief? (Religious groups cover a wide range of groupings the most of which are Buddhist, Christians, Hindus, Jews, Muslims, and Sikhs. Consider these categories individually and collectively when considering impacts)</td>
<td>No</td>
</tr>
<tr>
<td>Do you think that the policy impacts on men and woman in different ways?</td>
<td>No</td>
</tr>
<tr>
<td>Do you think that the policy impacts on people because of their sexual orientation? (This includes Gay men, heterosexuals, lesbians and bisexuals)</td>
<td>No relevance</td>
</tr>
<tr>
<td>Do you think that the policy impacts on people because of their Welsh language?</td>
<td>Fire Signage are governed by statutory requirements and are pictographic in nature to take into account the language barriers</td>
</tr>
</tbody>
</table>

4. Summary.

The Fire Safety Policy has the potential to affect staff and patients with sensory and physical disabilities. However processes and procedures are in place to take into account the needs of these persons which results in the Policy being **Neutral**.

Impact expected to be **neutral**. The supporting procedure seeks to address any issues regarding language and disability.
5. Report, publication and Review
Please record details of the report or file note which records the outcome of the EQIA together with any actions / recommendations being pursued (date, type of report etc)

<table>
<thead>
<tr>
<th>Please record details of where and when EQIA results will be published</th>
</tr>
</thead>
<tbody>
<tr>
<td>On UHB intranet and internet site</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Please record below when the EQIA will be subject to review.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 years after approval of policy, or earlier if required by changes to legislation or best practice</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of person completing</th>
<th>Charles Dalton</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signed</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>28 July 2015</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Responsible Executive/Clinical Board Director Authorising Assessment and Action Plan for publication</th>
<th>Abigail Harris Director of Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signed</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>
CAREING FOR PEOPLE, KEEPING PEOPLE WELL

This report underpins the Health Board’s “Sustainability” and “Values” elements of the Health Board’s Strategy.

**Financial impact:** Not applicable – where a risk has a financial impact this should be known by the Executive Lead and/or Risk Owner.

**Quality, Safety, Patient Experience impact:** The Corporate Risk and Assurance Framework includes a number of risks that impact on quality, safety or patient experience.

**Health and Care Standard Number:** 2.1

**CRAF Reference Number:** Not applicable

**Equality Impact Assessment Completed:** Not applicable

**RECOMMENDATION**

The Committee is asked to:

- **NOTE** the Health and Safety Committee Corporate Risk and Assurance (CRAF) Update Report.

**SITUATION AND BACKGROUND**

The CRAF aligns principal risks, key controls and assurances alongside each of the previously identified objectives of the Health Board. Gaps are identified where key controls and assurances are considered insufficient to mitigate the risk of non-delivery of an objective. It enables the Board and Committees to identify where additional assurances might be required and to direct additional measures to mitigate unacceptable risk. In March 2014 the Board agreed to merge the Corporate Risk Register and the Board Assurance Framework. The Health Board is therefore operating with a combined Corporate Risk and Assurance Framework (the CRAF).

The CRAF supports all domains of the Health Boards Strategy, but in particular it allows the Health Board:-

- to consider whether services are sustainable and
- to consider whether or not the values of the organisation are taken account of when determining how risks should be managed.
ASSESSMENT

Committee members have previously been informed that an Audit Committee sponsored Board Development Session was planned early in 2015. It has been necessary to postpone this on more than one occasion. The revised date is the 4 August 2015.

In preparation for the Development Session the CRAF has undergone an interim review. This has involved cross referencing it, where possible, with the Integrated Medium Term Plan (IMTP) 2015/16 – 2017/18 and any updates received from Clinical Boards/Corporate Departments. Cross referencing to the new Health and Care Standards is still to be completed. The interim review can be found here and via the following link:


The risks assigned to the Health and Safety Committee are detailed in the attached appendix.

At a recent Academi Wales event – Governance in Health attended by the Chair and Board Secretary, the importance of fully utilising the CRAF to influence the business of the Board was emphasised. The Board Development Session will provide an opportunity for the full Board to consider this further and to ensure that the CRAF adequately reflects the risks facing the Health Board. At the session Executive Directors and Independent Members, using their detailed knowledge, will review the adequacy of control measures in place, their risk appetite with regard to the risks and whether or not the Board should continue to Tolerate, Treat, Transfer or Terminate the risks. This will also provide an opportunity to advise if there any risks that require adding to the risk register. The Committee informed of any changes which impact on risks assigned to it at the next meeting.
WHITCHURCH HOSPITAL FOOD HYGIENE INSPECTION

<table>
<thead>
<tr>
<th>Executive Lead</th>
<th>Director of Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Operational Services Manager ext 26747</td>
</tr>
<tr>
<td>Caring for People, Keeping People Well</td>
<td>This report underpins the Health Board’s “Sustainability” element of the Health Board’s Strategy.</td>
</tr>
<tr>
<td>Financial impact</td>
<td>N/A</td>
</tr>
<tr>
<td>Quality, Safety, Patient Experience impact</td>
<td>Consistent implementation of the documented Food Safety Management System will ensure compliance with the Food Safety Regulations and provide a safer patient and staff experience. A UHB food safety document has been finalised and is being used throughout patient catering services.</td>
</tr>
<tr>
<td>Health and Care Standard Number</td>
<td>2.5</td>
</tr>
<tr>
<td>CRAF Reference Number</td>
<td>5.1.8</td>
</tr>
<tr>
<td>Equality Impact Assessment Completed</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

RECOMMENDATION

The Committee is asked to:

- NOTE the food hygiene rating and the remedial actions taken following the receipt of the Environmental Health Officer Inspection Report.

SITUATION

An inspection of Whitchurch Hospital took place on 20th April 2015 the outcome of which was notified in writing by the Senior Environmental Health Officer, Cardiff City Council.

In this report it was noted that the Whitchurch Hospital was given a score of 5 (very good) in the National Food Hygiene Rating Scheme.

BACKGROUND

It is a legal requirement that each Hospital is registered as a food premises with the Local Council and is therefore subject to an annual inspection by the Environmental Health department.

ASSESSMENT

On receipt of the letter an action plan was developed by the Operational Services Manager to address the issues raised and is attached as an appendix to this report. This will be monitored within Operational Services by the PFI/Compliance Manager on behalf of the Head of Operational Services.
**Action Plan**

**Whitchurch Hospital, Food Hygiene Inspection for Main Kitchen, Restaurant, Wards West 4a and East 5a**  
Undertaken Monday 20 April 2015 by EHO, Cardiff City Council

### SCHEDULE A

<table>
<thead>
<tr>
<th>Food Hygiene &amp; Safety Procedures</th>
<th>Management Response / Action</th>
<th>Time Scale / Update</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>The pre packed sandwiches you receive are required to be stored below 5°C. The temperatures recorded on East 5A indicated fridge temperatures above this on numerous occasions. You must ensure that any fridges used to store pre packed sandwiches are capable of maintaining food temperatures of 5°C or colder.</td>
<td>• New fridge in situ and temperature control gauge adjusted. Monitoring to continue and where above 5°C escalated to Ward Manager / Operational Services for corrective action.</td>
<td>Immediate – Completed</td>
<td>OSM</td>
</tr>
</tbody>
</table>

**Food Hygiene (Wales) Regulations 2006 Schedule 4 para 2 (1)**

<table>
<thead>
<tr>
<th>Structural / Cleaning Issues</th>
<th>Management Response / Action</th>
<th>Time Scale / Update</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>No contraventions noted.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Confidence in Management / Control Procedures</th>
<th>Management Response / Action</th>
<th>Time Scale / Update</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff were relying on the LCD displays for monitoring fridge temperatures in Ward East 5a kitchen and Ward West 4a kitchen. You should periodically check fridges using a probe thermometer rather than just relying on LCD displays. It should be clear on the monitoring</td>
<td>• New fridges in situ and temperature control gauge adjusted to meet required temperature. Monitoring to continue including use of probe thermometer by Ward Manager /</td>
<td>Immediate – Completed</td>
<td>OSM</td>
</tr>
</tbody>
</table>
sheets when this is happening.

*Regulation (EC) 852/2004 Article 5*

Operational Services. Monitoring sheet to indicate when undertaken.

<table>
<thead>
<tr>
<th><strong>SCHEDULE B - RECOMMENDATIONS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Guidance in relation to how to comply with the allergen labelling requirements can be found at <a href="https://www.food.gov.uk/business-industry/allergy-guide">https://www.food.gov.uk/business-industry/allergy-guide</a></td>
</tr>
<tr>
<td>An interactive food allergy training tool can be found at <a href="https://food.gov.uk/allergy-training">food.gov.uk/allergy-training</a></td>
</tr>
<tr>
<td>• Following successfully completion of Leading Improvement in Patients Safety (LIPS) course by Operational Services Management, allergen information in situ linked to project team outcomes.</td>
</tr>
<tr>
<td>• Reference made to information as required.</td>
</tr>
<tr>
<td>Immediate - Completed</td>
</tr>
<tr>
<td>Immediate – Completed</td>
</tr>
</tbody>
</table>

**Key**

**OSM** – Operational Services Manager (South)
BARRY HOSPITAL FOOD HYGIENE INSPECTION

Executive Lead: Director of Planning
Author: Operational Services Manager ext 26747

Caring for People, Keeping People Well: This report underpins the Health Board’s “Sustainability” element of the Health Board’s Strategy.

Financial impact: N/A

Quality, Safety, Patient Experience impact: Consistent implementation of the documented Food Safety Management System will ensure compliance with the Food Safety Regulations and provide a safer patient and staff experience. A UHB food safety document has been finalised and is being used throughout patient catering services.

Health and Care Standard Number: 2.5 Craf Reference Number: 5.1.8

Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Committee is asked to:

- NOTE the food hygiene rating and the remedial actions taken following the receipt of the Environmental Health Officer Inspection Report.

SITUATION

An inspection of Barry Hospital took place on 15th June 2015 the outcome of which was confirmed in writing in a letter report from the Environmental Health Officer, Vale of Glamorgan Council.

In this report it was noted that the Barry Hospital was given a score of 5 (very good) in the National Food Hygiene Rating Scheme.

BACKGROUND

It is a legal requirement that each Hospital is registered as a food premises with the Local Council and is therefore subject to an annual inspection by the Environmental Health department.

ASSESSMENT

On receipt of the letter report from the Environmental Health Officer, an action plan was developed by the Operational Services Manager to address the issues raised and is attached as an appendix to this report. This will be monitored within Operational Services by the PFI/Compliance Manager on behalf of the Head of Operational Services.
### SCHEDULE A

<table>
<thead>
<tr>
<th>Food Hygiene &amp; Safety Procedures</th>
<th>Management Response / Action</th>
<th>Time Scale / Update</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>No contraventions noted at the time of inspection.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Structural / Cleaning Issues</th>
<th>Management Response / Action</th>
<th>Time Scale / Update</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>The area under the ventilation in the walk in chiller was dirty. This must be thoroughly cleaned and maintained in a clean condition. (Annex II Chapter V Para 1(a))</td>
<td>• Remove grill guard and clean thoroughly.</td>
<td>Immediate - Completed</td>
<td>OSM</td>
</tr>
<tr>
<td>The handle of Freezer 3 was broken, repair or replace the Handle.</td>
<td>• Submit maintenance request to repair / replace handle.</td>
<td>30 June 2015 - Completed</td>
<td>OSM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Confidence in Management / Control Procedures</th>
<th>Management Response / Action</th>
<th>Time Scale / Update</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>At the time of inspection I was shown HACCP document. As discussed with Senior Supervisor minor deficiencies were noted with regard to:</td>
<td>• Reword and amend paragraph 7.1.</td>
<td>Immediate – Completed</td>
<td>OSM</td>
</tr>
<tr>
<td>• Paragraph 7.1 regarding cleaning requires re wording.</td>
<td>• Amend and replace monitoring form to ensure temperatures taken</td>
<td>Immediate – Completed</td>
<td>OSM</td>
</tr>
<tr>
<td>• Page 19 of the HACCP table stated to record temperatures of fridges and</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Once your Food Safety Management Procedure is in place, it is important for you to regularly review your control measures and take any necessary steps to take account of future changes in your operations. To maintain your score of 5 in Confidence in Management these must be addressed prior to the next inspection.

*(Regulation (EC) 852/2004 Article 5 paras 2 & 4)*

<table>
<thead>
<tr>
<th>SCHEDULE B - RECOMMENDATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>No further recommendations</td>
</tr>
</tbody>
</table>

**Key**

**OSM** – Operational Services Manager (South)
UNIVERSITY HOSPITAL LLANDOUGH FOOD HYGIENE INSPECTION

Executive Lead: Director of Planning
Author: Operational Services Manager ext 26747

Caring for People, Keeping People Well: This report underpins the Health Board’s “Sustainability” element of the Health Board’s Strategy.

Financial Impact: N/A

Quality, Safety, Patient Experience impact: Consistent implementation of the documented Food Safety Management System will ensure compliance with the Food Safety Regulations and provide a safer patient and staff experience. A UHB food safety document has been finalised and is being used throughout patient catering services.

Health and Care Standard Number: 2.5 CRAF Reference Number: 5.1.8

Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Committee is asked to:

- NOTE the food hygiene rating and the remedial actions taken following the receipt of the Environmental Health Officer Inspection Report.

SITUATION

An inspection of University Hospital Llandough took place on 3rd July 2015 the outcome of which was confirmed in writing in a letter report dated 13th July 2015 from the Environmental Health Officer, Vale of Glamorgan Council.

In this report it was noted that the University Hospital Llandough was given a score of 5 (very good) in the National Food Hygiene Rating Scheme.

BACKGROUND

It is a legal requirement that each Hospital is registered as a food premises with the Local Council and is therefore subject to an annual inspection by the Environmental Health department.

ASSESSMENT

On receipt of the letter report from the Environmental Health Officer, an action plan was developed by the Operational Services Manager to address the issues raised and is attached as an appendix to this report. This will be monitored within Operational Services by the PFI/Compliance Manager on behalf of the Head of Operational Services.
# Action Plan

University Hospital Llandough, Food Hygiene Inspection  
Undertaken on Friday 3 July 2015 by EHO, Vale of Glamorgan Council

<table>
<thead>
<tr>
<th>SCHEDULE A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Food Hygiene &amp; Safety Procedures</strong></td>
</tr>
<tr>
<td>No contraventions noted at the time of inspection.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Structural / Cleaning Issues</th>
<th><strong>Management Response / Action</strong></th>
<th><strong>Time Scale / Update</strong></th>
<th><strong>Lead</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The floor covering in the kitchen was dirty below one of the Rational ovens. Thoroughly clean the floor and maintain in a clean condition. <em>(Annex II Chapter I Para 1)</em></td>
<td>• Floor to be thoroughly cleaned including removal of stain from water filter system.</td>
<td>Immediate - Completed</td>
<td>OSM</td>
</tr>
</tbody>
</table>
| The floor covering in the kitchen leading to the pot wash area was split in a very small area. Renew or repair the floor covering and leave in a sound easy to clean condition. *(Annex II Chapter II Para 1(a))* *(I am aware that this has already been completed as Mr Simon Williams has sent me a photograph)* | • Repair floor leading to pot wash area. | 4 July 2015  
Completed (as scheduled prior to EHO visit) | OSM |
<p>| The brush strip to one of the double doors in the kitchen (to the side of the meat slicer) has come loose. Reattach the strip. <em>(Annex II Chapter IX)</em> | • Repair to be undertaken to door including fitting of new brush strips. | 31 July 2015 | OSM |</p>
<table>
<thead>
<tr>
<th>Confidence in Management / Control Procedures</th>
<th>Management Response / Action</th>
<th>Time Scale / Update</th>
<th>Lead</th>
</tr>
</thead>
</table>
| At the time of inspection I was shown a new HACCP which is to be implemented. As discussed with staff, minor deficiencies were noted in the sections of the HACCP documentation that I read on site, and paragraph 7 was in the process of being re-written. | • Reword and amend paragraph 7  
• Undertake full document review and amend as necessary. | Immediate – Completed | OSM |
| The HACCP document was in the process of being reviewed and amended. Once your Food Safety Management Procedure is in place, it is important for you to regularly review your control measures and take any necessary steps to take account of future changes in your operations. To maintain your score of 5 in Confidence in Management these must be addressed prior to the next inspection. (Regulation (EC) 852/2004 Article 5 paras 2 & 4) | | 31 August 2015 | OSM |
| **Food Standards** | The new Food Information Regulations introduce a requirement that food businesses must provide information about the allergenic ingredients used in any food they sell or provide. There are 14 major allergens which need to be mentioned (either on a label or through provided information such as menus) when they are used as ingredients in a food. An ingredient list should be | | |
available for each menu item against an allergen checklist (please see Food Standards Agency website for further details) so any customer can immediately check if their menu choice contains allergens. The 14 allergens are given below:

- Cereals containing gluten: wheat, rye, barley, oats, spelt, kamut and their hybridised strains.
- Crustaceans.
- Eggs.
- Fish.
- Peanuts.
- Soya
- Milk.
- Nuts including almonds, hazelnuts, walnuts, cashews, pecans, Brazil nuts, pistachios, macadamias, and Queensland nuts.
- Celery.
- Mustard.
- Sesame seeds.
- Lupin
- Molluscs
- Sulphur dioxide and sulphites at concentrations of more than 10mg/kg or 10mg/litre expressed as SO₂.

*(The Food Information Regulations 2014)*

- Undertake full document review and amend as necessary with inclusion of allergens information.

| 31 August 2015 | OSM |
These recommendations provide advice on good practice.

I recommend that the broken plastic strip to the walk in chiller (in the kitchen) is repaired or replaced.

At the time of inspection 5kg containers of Beef Madras (for use in the Restaurant) had been frozen, I recommend that these foods are used as soon as possible after defrosting in accordance with any period recommended by the manufacturer.

As the trust has decided to no longer use D2 as a detergent, I recommend that the Food Safety Management system or HACCP clearly defines that there is a detergent in use for the two stage cleaning process. I am aware that the D10 is still in use as a sanitiser.

<table>
<thead>
<tr>
<th>SCHEDULE B - RECOMMENDATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>These recommendations provide advice on good practice.</td>
</tr>
<tr>
<td>I recommend that the broken plastic strip to the walk in chiller (in the kitchen) is repaired or replaced.</td>
</tr>
<tr>
<td>At the time of inspection 5kg containers of Beef Madras (for use in the Restaurant) had been frozen, I recommend that these foods are used as soon as possible after defrosting in accordance with any period recommended by the manufacturer.</td>
</tr>
<tr>
<td>As the trust has decided to no longer use D2 as a detergent, I recommend that the Food Safety Management system or HACCP clearly defines that there is a detergent in use for the two stage cleaning process. I am aware that the D10 is still in use as a sanitiser.</td>
</tr>
<tr>
<td>Plastic strip to be repaired / replaced.</td>
</tr>
<tr>
<td>Food items to be used as soon as possible or discarded.</td>
</tr>
<tr>
<td>Safe system document to be amended as part of review to ensure clarity in using two stage cleaning process.</td>
</tr>
<tr>
<td>31 July 2015</td>
</tr>
<tr>
<td>Immediate - Completed</td>
</tr>
<tr>
<td>OSM</td>
</tr>
<tr>
<td>31 August 2015</td>
</tr>
<tr>
<td>OSM</td>
</tr>
</tbody>
</table>

**Key**

**OSM** – Operational Services Manager (South)
Executive Lead: Director of Planning
Author: Head of Health and Safety 02920 743751

Caring for People, Keeping People Well: This report underpins the Health Board’s “Sustainability” and “Values” elements of the Health Board’s Strategy

Financial Impact: Potential fiscal costs relating to breaches of statutory obligation.

Quality, Safety, Patient Experience Impact: This report is fundamental to the safety and quality of both staff and patients.

Health and Care Standard Number: 2.1 CRAFT Reference Numbers: 8.1.4,6.4.7,6.4.5,6.4.4

Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Committee is asked to:

- to be ASSURED that health and safety management is being appropriately managed

SITUATION

The Health and Safety Committee’s work programme has identified the need for the submission of a strategic report on the management aspects of health and safety. The Health and Safety Committee previously considered management aspects in its July 2013 Committee meeting, which included the findings of the NHS Wales Audit and Assurance Services. These findings identified that the Health Board had ‘Reasonable Assurance’ and since this time the Committee has received updated reports of the Priority Action Plan on progress made.

The NHS Audit Service returned to review our progress and concluded that good progress had been made, however the main action required was implementation of E-datix.

Health and Safety Management is one of our eight strategic areas covered within the Priority Action Plan.

BACKGROUND

The Health and Safety Management Strategy is identified as dealing with real risks and practical solutions. The purpose of the strategic report is to ensure there are appropriate systems in place for the Management of Health and Safety, based off the HSG 65 guidance. The guidance is aimed at taking the
HSE approach of (POPMR) these being; policy, organising, planning and implementation, measuring performance and reviewing.

ASSESSMENT

Policy
The Health and Safety Committee maintains a comprehensive suite of policies which are considered at each meeting. The schedule of policies also includes those policies which are not within the remit of the Health and Safety Committee but has strong health and safety links.

The Committee and the Priority Action Plan identifies as a result of new legislations and/or new practices the need for new policies or procedures; these are affectively communicated throughout the organisation through the Intranet and the local health and safety group structure. During the period of April to April all policies within the Health and Safety Committees remit were reviewed on a timely basis.

Organising
The Health and Safety Committee continues to have a health and safety structure in place to deliver its policy. It has met at the agreed intervals and continues to be chaired by an Independent Member, which demonstrates linkage with the Board. The Governance Structure demonstrates ongoing accountability for health and safety via the terms of reference of the Committee and its relevant sub groups. Each Committee that has met has been deemed to be quorate during the period. Its membership includes, three Independent Members including the Chair and a number of Executive Directors.

Sub Groups of the Committee are the Operational Health and Safety Group, Fire Safety Group and Security and Personal Safety Strategy Group.

(i) Operational Health and Safety Group
This meeting is chaired by the Board Secretary and due to changes in the senior management positions meetings were postponed. However these have now recommenced under the Chair of the Board Secretary.

(ii) Clinical Board Heath and Safety Groups
Each Clinical Board is required to have a Senior Management Health and Safety Lead and a meeting structure arrangement to monitor and review health and safety performance.

(iii) Fire Safety Group
This Group continues to meet on a bi-monthly basis. The Chair of this Group is identified by the Director of Planning, who has delegated the responsibility to the Assistant Director of Planning.

(iv) Security and Personal Safety Strategy Group
This Group has continued to meet on a regular basis and is chaired by the Head of Health and Safety and Security.
The Health and Safety Committee receives minutes from each of the above Sub Group Meetings.

Planning and implementation
The Health and Safety Committee has a work programme which includes an Assurance Report from each Clinical Board. It also reports at each meeting against its Priority Action Plan and monitors progress. It receives and considers an Annual Report on performance at its October Health and Safety meeting.

Measuring Performance
Since the previous report the Health Board has embarked on the implementation of E-datix which is aimed at maximising its opportunities of improvement through the incident reporting system. The Committee also looks at compliance to RIDDOR and currently shows compliance between eighty and a hundred percent.

Training
Since the audit a training needs analysis has been completed for health and safety training and training records have been centralised through ESR. Compliance to health and safety training is reported within the Annual Report and through the PPP Committee. Current training shows that the Health Board does not achieve total compliance or meets its target of 85%. Appendix 1, graph shows a direct coloration between training and incidents rate for manual handling, justifying the need for continued emphasis on this facet.

Performance Review
This is considered through the Priority Action Plan and the Annual Report. The HSE audited compliance to sharps legislation and issued an Improvement Notice, the first the Health Board has received since 2001.

Food Hygiene
Food hygiene has been audited both externally and internally during the period and the outcomes brought to the Health and Safety Committee meetings.

Fire
An Annual Audit is completed and sent to NHS Wales Shared Services Partnership each year. The Fire Service undertakes regular inspection visits; the findings are consistent with the Fire Risk Assessments. During the period there has been six enforcement notices. The Health Board has continued to make progress since its audit in 2013 and has implemented the short falls identified. However, there have been areas of regression with regards to meeting structure and the issuing of enforcement action.
Caring for People, Keeping People Well: This report underpins the Health Board’s “Sustainability” and “Values” elements of the Health Board’s Strategy.

Financial impact: HSE intervention costs at £150 an hour maybe incurred if breaches occur.

Quality, Safety, Patient Experience impact: RIDDOR requirements relates to both patients and staff.

Health and Care Standard Number: 2.1 CRAF Reference Number 8.1.4

Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Committee is asked to:

- CONSIDER the report and AGREE that appropriate assurance regarding Health and Safety Committee concerns has been provided.

SITUATION

This paper details Cardiff and Vale University Health Board’s (UHB) status relating to health and safety and statutory obligations under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) and also includes recommendations which have been formulated.

The Annual Report for 2013/14 identified that the Health Board had mechanisms in place to ensure the appropriate reporting of RIDDOR events, however there were some instances of injuries being reported outside of the required timescale.

The Committee considered it was essential that the Health Board had mechanisms in place to monitor and address any reporting delays which resulted in a breach of the RIDDOR requirements and a report be prepared for each meeting of any failings.

BACKGROUND

The reportable events are all of significant severity and impact on the organisation and require appropriate investigation to put in place remedial action, delays in reporting hinders this process and facilitates further reoccurrences of the incident. Late reporting also results in inaccurate trend
and statistical data being provided to both internal and external stakeholders which undermines the confidence in other aspects of health and safety and performance.

The requirement to notify the HSE is defined as from date of knowledge not from date of event. Hence if the employee fails to inform their manager of the industrial injury the 15 day timing commences from the date they informed the Health Board which may not always be the incident date.

**ASSESSMENT**

Subsequent to the concerns expressed at the Health and Safety Committee meeting the following actions were initiated:

- All Chairs of the Health and Safety meetings are monitoring and investigating any RIDDOR reporting delay.
- The Health Board is progressing implementation of Electronic Incident Reporting, which will assist with meeting the legal obligations.

### RIDDOR Reported During the Period

<table>
<thead>
<tr>
<th>Reference No.</th>
<th>Date of Incident</th>
<th>Date Reported to HSE</th>
<th>Clinical Board</th>
<th>Total Number of days</th>
<th>Outside 15 day requirement</th>
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<tbody>
<tr>
<td>IN2928</td>
<td>02/04/2015</td>
<td>20/04/2015</td>
<td>Specialist</td>
<td>18</td>
<td>No Staff reported on 19/4/2015</td>
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<td>15101148</td>
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<td>20/04/2015</td>
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<td>8</td>
<td>No</td>
</tr>
<tr>
<td>505153</td>
<td>28/03/2015</td>
<td>21/04/2015</td>
<td>Mental Health</td>
<td>24(21)</td>
<td>Yes reported on 31/3/2015</td>
</tr>
<tr>
<td>505277</td>
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<td>22/04/2015</td>
<td>Medicine</td>
<td>27 (18)</td>
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<tr>
<td>505169</td>
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<td>47</td>
<td>No (Not informed until return)</td>
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<tr>
<td>505915</td>
<td>28/04/2015</td>
<td>19/05/2015</td>
<td>Exec Ops</td>
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<tr>
<td>505913</td>
<td>08/05/2015</td>
<td>19/05/2015</td>
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<td>IN4567</td>
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<td>505583</td>
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<td>18/06/2015</td>
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<td>02/03/2015</td>
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<td>24/06/2015</td>
<td>Children &amp; Women</td>
<td>12</td>
<td>No</td>
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<tr>
<td>506834</td>
<td>19/06/2015</td>
<td>26/06/2015</td>
<td>Exec Ops</td>
<td>7</td>
<td>No</td>
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- The data shows that of the 17 reported incidents 7 were not brought to the manager’s attention at the time of the event that the lost time was related to the injury.
- The above table shows that the level of compliance is currently 88%.
• There were 2 incidents reported outside of the Regulatory requirement of 15 days from the date of knowledge, both these events were from Clinical Boards who at the time of the incident were using the paper based form.

• Investigation indicates that the delays were related to the transfer of paperwork through the organisation.
Fire Safety Group

Minutes of the Meeting held at 9:30am at Meeting Room 1, 2nd Floor, Lakeside Offices on 20 January 2015

Present: Charles Dalton  Head of Health and Safety
Cheryl Evans  Service Manager - Obstetrics and Gynaecology
Ceri Butler  Learning, Education & Development (LED)
David Lozano  South Wales Fire Service
Frank Barrett  Senior Fire Safety Officer
Rachel Thomas  Locality Manager (From item 6)
Steve Careless  Staff Health and Safety Adviser
Tony Ward  Projects Officer Mechanical

Apologies: Geoff Walsh  Assistant Director of Planning
Ian Wile  Head of Operations and Delivery–Mental Health
Angela Stephenson  Strategic Partnership and Planning Manager
Chris Darling  Assistant Locality Manager
Eleri Crudgington  Assistant Locality Manager
Lynne Topham  Locality Manager
Peter Welsh  Hospital General Manager Llandough
Richard Steed  Cardiff University - OSHEU
Sue Paul  Assistant Locality Manager

In Attendance: Zoe Brooks  Health and Safety Administrator

15/01 Minutes of the Meeting

The minutes of the meeting held on the 6th November 2014 were accepted as a true account.

15/02 13/53 Fire Drawings

It was reported that a new CAV employee, (to progress fire drawings), has been appointment; areas at UHW are currently being prioritised with six areas already completed.

14/29 Compartmentation

Mr Barrett highlighted that surveys have been carried out at the University Hospital of Wales site and have gone out to tender; a contractor will be appointed within the next two weeks.
15/03  **NWSSP-FS Audit 2015-16**

Mr Dalton informed the group that 2015/16 audit is due in May and that last years audit reports will be sent out to the Deputy Fire Safety Managers shortly for updating and comment.

15/04  **Enforcement Notice Status**

Mr Lozano updated the group on the recent audit that was carried out in November 2014 at Whitchurch Hospital. He reported that the enforcement notice (issued in 2013) for Whitchurch Hospital was due to expire and as a result of the recent audit a new enforcement notice will be issued sometime this month, with an end date of two years.

He advised that some items were removed as a result of improvements carried out, however; some additional findings have been added to the new enforcement notice.

Mr Dalton stated that the monthly Whitchurch Hospital Fire Safety Management meeting was still taking place with many positive actions implemented.

He reported that the No Smoking Enforcement Officer will be visiting Whitchurch Hospital site shortly. The group were informed that the Enforcement Officer submits a report to the No Smoking Group which details the number of people found smoking and whether they are Staff, Patient or visitor; it also highlights areas where people are found smoking.

It was reported that three enforcements have been issued to Llandough Hospital. Mr Barrett informed the group that a meeting has taken place with the Managers of those areas and actions are in hand.

15/05  **Unannounced Fire Service Inspections**

Mr Dalton informed the Group that a recent inspection of the Medical Records Department, Llandough Hospital, highlighted Fire Safety Concerns. He stated that the Health Board was working closely with South Wales Fire Service to improve on the findings before any enforcement notice is issued.

15/06  **Planned Evacuations**

Mr Barrett informed the Group that a table top exercise was carried out recently at Llandough Hospital for Ward Managers, and reported that the feedback was good.
15/07 Fire Policy & Procedures

Mrs Brooks informed the group that amendments had been made to the Community Fire Procedures, to reflect the closing of West Wing and also the removal of Cardiff Royal Infirmary (CRI will now be a stand alone document) as agreed in the previous meeting.

The group were informed that further discussion needed to take place between the Fire Safety Manager and Fire Safety Advisers in relation to Health Centres and Clinics. The document will be circulated once amendments completed.

15/08 Training

Mrs Butler circulated a report to the group, listing all Fire wardens trained in the past few years.

A long discussion endured around the lack of Fire Wardens and low compliance for Fire Safety Training. The group were informed that December’s compliance report showed a compliance rate of 44%.

It was highlighted that despite efforts to hold Fire lectures and Mandatory May sessions as well as other means of delivering the training, the compliance rate remains under 50%.

15/09 DFSM/ Local Fire Safety Group Feedback

St David’s Hospital

It was reported that NWSSP-FS undertook an audit at St David’s Hospital in January 2015; The report has not yet been received.

Barry Hospital

Mrs Thomas queried whether progress is being made to fix a fire shutter at Morgannwg Ward Barry Hospital; she informed the group that a defect report had been raised and was awaiting a part.

Mr Barrett stated that he would discuss this issue with Fire Safety Adviser to progress.

CRI

Mrs Thomas highlighted that all Fire Risk Assessments for Cardiff Royal Infirmary were being sent to her and informed the group that she did not have managerial responsibility for all areas at CRI.
Mr Dalton stated that there needed to be clarity of the Deputy Fire Safety Managers role and responsibility for areas of non-occupancy.

Mr Ward circulated a summary report of Risk Assessment Actions during the period.

**UHW DFSM**

Item raised at the Health and Safety Committee to be progressed; Executive leads to nominate a representative for their Clinical Board.

**Other**

Mr Barrett highlighted that Bariatric Patients (item 14/36.3 of the Action Log) had been removed although not progressed and reiterated the need for a policy in relation to evacuation be produced.

Mrs Brooks to include this in March’s action Log for discussion.

**15/10**

**Date and Time of Next Meeting**

19th March at 14:00 Corporate HQ meeting room, UHW
SEcurity and personal Safety Strategy Group Meeting
Minutes of the Meeting held at 9.30am on Wednesday 21st January 2015 at the Health and Safety Training Room, Ground Floor, Denbigh House, UHW

Present:
- Charles Dalton - Head of Security
- Emma Foley - Case Management Officer
- Steve Careless - Staff Health and Safety Adviser
- PS J Madoc-Smart - South Wales Police
- Sue Paul - Assistant Locality Manager

Apologies:
- Abigail Harris - Director of Planning
- Carl Ball - Case Management/Personal Safety Manager
- Chris Darling - Assistant Locality Manager
- Ceri Pell - Case Management Officer
- Steve Pellatt - Security Manager

15/01 ACTION LOG

13/15.3 Security Intervention Training
A meeting was held between the Senior Health and Safety Trainer, Security and Trainer for Mental Health; it was agreed that the Security Officers would attend training carried out by the Mental Health Team.

14/21 Police Partnership – Information Sharing
Case Manager for the ambulance service has recently retired; new Case Manager will be in post by the end of May.

15/02 Other Matters Arising – Information Sharing with Primary Care
The group were informed that a meeting had taken place during the period with LMC for Primary Care, and Mr Dalton agreed to enhance mechanisms for information sharing in relation to patients who have been issued with a Violent Warning Marker (VWM) or a patient within the primary care sector who may pose a risk to secondary care.

PS J Madoc-Smart queried whether this information could also be shared with the police.

Action: PS J Madoc-Smart to progress this with Mr C Ball.
**15/03 Priority Action Plan / Risk Register**

Mr Dalton gave an overview of the risk register highlighting a number of areas of concern.

2.2 CCTV coverage

It was reported that 32 cameras had been installed in tunnels and externally at UHW. Also a further 12 Cameras installed at the new Childrens Hospital Phase 2.

**15/04 Park View Health Centre**

Mr Dalton informed the group of recent issues of vandalism and anti social behaviour at Park View Health Centre. It was reported that Security presence had been increased on overtime basis, however due to annual leave these shifts were becoming difficult to cover.

Action: Clinical Board to investigate permanent funding.

**15/05 Shoulder Cameras**

It was reported that there has been positive feedback in the use of shoulder cams, the committee recognised the positive publicity that has been received and also recognised the benefit in terms of both prosecution and diminishing events.

Mr Dalton informed the group that additional cameras are to be purchased for Llandough; Welsh Government has agreed to fund this. It was also noted that Cardiff and Vale are the first Health Board to use shoulder cams.

**15/06 CCTV Update and Security Access Control**

Mr Dalton reported that cameras and TDSI in the Childrens Hospital phase two have been made live, together with external cameras along Heath Park Way. The group were informed that an extended programme of TDSI badges issue was being implemented within the Childrens Hospital staff.

The meeting raised concerns in relation to the size of the control room, which is limiting the ability to monitor the expanded camera compliment.

**15/07 Lone Worker**

It was noted that the Lone Worker Procedure was approved at the Operational Health and Safety group in November. Mr Dalton informed the group that amendments were made to the procedure to reflect data protection requirements and ensuring that recorded information was only kept for a minimum period required.
Mrs Foley reported that rationalization for those devices which have not been active for some time was ongoing and reported that processes were also being pursued with regards to contract renewal.

15/08

**Attendance**

Concerns were expressed regarding the attendance.

Action: Mr Dalton to review membership and attendance.

**Date and Time of Next Meeting**

22\textsuperscript{nd} April 2015 – Manual Handling Unit, Denbigh House at 13:30pm
## UPDATED HEALTH AND SAFETY RELATED POLICIES SCHEDULE

<table>
<thead>
<tr>
<th>POLICY</th>
<th>UHB REFERENCE NO</th>
<th>AUTHOR/LEAD RESPONSIBLE OFFICER</th>
<th>SUBMISSION TO HEALTH &amp; SAFETY COMMITTEE</th>
<th>APPROVAL DATE</th>
<th>REVIEW DATE</th>
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</thead>
<tbody>
<tr>
<td>Fire Safety</td>
<td>UHB 022</td>
<td>Director of Planning</td>
<td>April 2012</td>
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<td>April 2015</td>
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<td>Environmental</td>
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<td>Contractor Control</td>
<td>UHB 163</td>
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<td>January 2013 (2&lt;sup&gt;nd&lt;/sup&gt; review)</td>
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<td>January 2016</td>
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<tr>
<td>Safe Working with Electricity</td>
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<td>Director of Planning</td>
<td>October 2013 (2&lt;sup&gt;nd&lt;/sup&gt; review)</td>
<td>October 2013</td>
<td>October 2016</td>
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<td>Management of Violence &amp; Aggression</td>
<td>UHB 035</td>
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<td>Lone Worker</td>
<td>UHB 034</td>
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<td>January 2014 (2nd review)</td>
<td>April 2014</td>
<td>April 2017</td>
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<td>POLICY</td>
<td>UHB REFERENCE NO</td>
<td>AUTHOR/LEAD RESPONSIBLE OFFICER</td>
<td>SUBMISSION TO HEALTH &amp; SAFETY COMMITTEE</td>
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<td>Waste Management</td>
<td>UHB 038</td>
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<td>Employee Wellbeing</td>
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