Meeting Date	**02 December 2019**	**Agenda Item**	**2.2**
Report Title	**Operational Group Key Issues Report**		
Report Author	Laurie Higgs, Head of Health and Safety Jacqui Maunder Interim Head of Compliance, Corporate Governance Mark Parsons, Interim Assistant Director of Health & Safety		
Report Sponsor	Gareth Howells, Director of Nursing and Patient Experience		
Presented by	Mark Parsons, Interim Assistant Director of Health & Safety		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to update the Committee on the business discussions of the Health & Safety Operational group meeting 4th November 2019.		
Key Issues	• The Health and Safety Operational group meets on a bi-monthly basis and reports to the Health & Safety Committee. • A range of reviewed and updated policies and procedures were endorsed for ratification • Resources for a number of areas		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☒	☒	☐	☐
Recommendations	Members are asked to : • **NOTE** the report, • **ENDORSE** the policies and procedures, • **DISCUSS and NOTE** the Health and Safety Improvement Plan for 2019-2020.		

OPERATIONAL GROUP KEY ISSUES REPORT

1. INTRODUCTION

The purpose of this report is to update the Committee on the business discussions of the Health & Safety Operational group meeting 4th November 2019.

2. HEALTH & SAFETY OPERATIONAL GROUP MEETING 4 NOVEMBER 2019

2.1 Health & Safety Operational Group

Further to the review of the reporting structures for the group the new terms of reference reported on in the September Health & Safety committee meeting, all units were present at the H&S Operational Group on 4th November 2019 and confirmed the new health and safety governance structures have been implemented at unit level.

2.2 Unit Director Updates

Individual Unit Directors provided updates on health and safety issues within their respective areas. Health and Safety updates were also received from the Estates, Support Services, Security and HQ Corporate departments. Key elements are set out in the table below:

Item	Comments
Singleton Unit	• Cladding remains as one of the main risks to the Singleton Site. Work is currently being undertaken to remove the flank walls to reduce the risk, prior to a full removal of the front elevation. • Due to the amount of building works currently on the Singleton Site a number of environmental risks have been identified: Flooding, Noise, Asbestos and Service Disruption. Ongoing progress meetings are being held to minimise any risks to the above concerns. • A recent issue occurred whereby staff were entering a contractor's area following a contractor fall. In total 6 members of Health Board staff and 2 paramedics entered an asbestos controlled zone. This was allowed by the contractor's site manager who deemed it as safe as possible to provide medical treatment.
Lessons Learnt	• Minimise amount of staff to assess patient to reduce risk of exposure. Personal Protective Equipment (PPE) to always be worn when entering a controlled area. • Reinforce contract responsibility for controlled areas.
Morriston Unit	• Compliance with COSHH Regulations has been added to the unit risk register • Fire Planning – Morriston's current plan is out of date and needs revision in light of the Singleton incident – this coupled with a series of issues identified at ward/department level in relation to fire doors, wedges,

Lessons Learnt	training compliance etc. have been added to the risk register at Morriston. • Car Parking continues to be a prominent feature in patient feedback and features as a key location in incidents concerning negative patient behaviour and complaints. • Presentation by Morriston Delivery Unit regarding incident analysis and V&A incidents. Sharps Incidents appear to be on the increase on the Morriston site. A task & finish group has been relaunched to promote the safer sharps agenda.
Neath Port Talbot Unit	• A number of risks were identified, including: risk of harm to staff by violence and aggression from patients, which could result in physical harm to staff and poor patient experience, and actual and potential breaches concerning fire compartmentation; • Transportation of Liquid Nitrogen – Controls have been put in place to minimise the risks.
Primary Care and Community Car Unit **Lessons Learnt**	• New H&S risk identified 2154 (current risk score 12) – the Cimla Hospital Estate site is not secure. Action: CCTV cameras have been requested. The Primary Care Estates Manager has requested a copy of site risk assessment (RA) or who would be best placed to undertake a site RA. A buddy system is in place for staff. • Longstanding Primary Care Estate risks – discussion included the delay in estates attending Health Board owned buildings for repairs – Action: escalate to the Health & Safety Operational Group via the Unit Exception report. • Fire Risk Assessments for Health Board owned buildings; the need for the Unit to identify fire officers, and ensure they have appropriate training and clarity of responsibilities. Support will be provided by the Health & Safety Team. • Confirmation of lessons learned being shared with individual staff and across the unit via HOS reports to Quality & Safety Operational meeting groups, and the Unit Quality Safety and Patient Experience Group which are shared with Unit Board and HB Quality and Safety Forum.
Mental Health & Learning Disabilities Unit	• Risks include: 683 – Violence and Aggression – Offending History patients; 1389 – Child bearing staff members; 1432 – Fire on wards (different handler/manager for each locality); 1436 – Violence and Aggression towards staff from patients; 1440 – Staff health and morale. • 2062 – Caswell Clinic Security Issues – The alarm system requires updating as it is no longer meeting the security needs of staff.

Estates Management	• Currently, insufficient resources to cover the full range of Authorised Persons in areas such as electrical safety, low and high voltage electricity etc. An action plan to address the key issues is being developed • Resource issues throughout estates to meet the demands of workload to maintain compliances. • Challenges concerning the Cefn Coed site due to the closure plans for areas of the site and how to maintain compliance in the areas of no occupation. • Water management concerns – Schematics are either non-existent or out of date and require updating – Non compliant return temperatures • Age and condition of plant and equipment • It was highlighted that there are clinical waste concerns for collection and storage of waste, this is a national issue relating to the incineration of clinical waste for Wales. There are contingency plans in place to mitigate the risk.
Support Services	• Making good progress with Statutory and Mandatory training compliance, and good progress with the Health & Safety Executive (HSE) improvement notices. • A review of security at Singleton Hospital has shown low numbers of incidents but possible under reporting, so a further review to be undertaken in December 2019.
Health and Safety Alerts (MDA)	• General improvement in closure of Medical Device Alerts but further improvement required with some units
Policies with Health and Safety Implications	• Uniform policy does not form part of Operational Health and Safety group review.

2.3 Health and Safety Action Plan 2019-2020

The new Health and Safety action plan for 2019-2020 (**see Appendix 1**) was circulated with the minutes after the meeting, and a verbal update was provided during the meeting. The group were also given an update on the work progressing to address the Health & Safety Executive (HSE) improvement notices.

2.4 Policies

The group considered and approved the following policies:

- Health and Safety Policy – **see Appendix 2.**
- Low Voltage Systems Management & Operational Policy - **see Appendix 3.**
- Medical Gas Pipeline Systems Policy – **see Appendix 4**

Through this paper the Committee is asked to endorse the policies and procedures approved by the Health & Safety Operational Group. The minutes of the meeting will be circulated to the Committee.

The agenda from the Health & Safety Operational group meeting held in November 2019 is presented at **Appendix 5** for information.

The Equality Impact Assessments for both the Medical Gas Pipeline Inspection report and the Low Voltage Systems Management Policy are included as **Appendix 6** and **Appendix 7** respectively**.**

3. GOVERNANCE AND RISK ISSUES

Health and Safety governance is as important as any other aspect of governance. It is a fundamental part of an organisation's overall risk management function which is a key responsibility of directors. Failure to manage health and safety risk effectively has both human and business costs. The price of failure can be the damaged lives of workers, patients, their families and friends, as well as direct financial costs, damaged reputations and the risk of legal prosecution

4. FINANCIAL IMPLICATIONS

There are no direct financial implications arising from this report.

5. RECOMMENDATION

Members are asked to:

- **NOTE** the report,
- **ENDORSE** the policies and procedures,
  DISCUSS and **NOTE** the Health and Safety Improvement Plan for 2019-2020.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☐
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☐
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒
Quality, Safety and Patient Experience		
The effective communication of information and coordination of team activities is essential to providing safe patient care. The Health and Safety Operational group are		

responsible for managing and overseeing effective quality, safety and patient experience.	
Financial Implications	
There are no direct financial implications arising from this report.	
Legal Implications (including equality and diversity assessment)	
SBUHB is committed to providing and maintaining a safe and healthy work place and to provide suitable resources, information, training and supervision on health and safety to all members of staff, patients Contractors and visitors to comply with the legislative and regulatory framework on health and safety.	
Staffing Implications	
Staff will be briefed on health and safety developments through managerial meetings, staff meetings and health and safety alerts and bulletins.	
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)	
The Act requires the Health Board to think more about the long term, how we work better with people and communities and each other, look to prevent problems and take a more joined up approach with partners. There will be long term risks that will affect both the delivery of services, therefore, it is important that you use these five ways of working (Long Term Thinking, Prevention, Integration, Collaboration and Involvement) and the wellbeing goals identified in the Act in order to frame what risks the Health Board may be subject to in the short, medium and long term. This will enable The Health Board to take the necessary steps to ensure risks are well managed now and in the future.	
Report History	-
Appendices	Appendix 1 – Health & Safety Action Plan 2018/19 Appendix 2 – Health & Safety Policy Appendix 3 – Low Voltage Systems Management & Operational Policy Appendix 4 – Medical Gas Pipeline Systems Policy Appendix 5 – Health & Safety Operational Group – November 2019 Appendix 6 – Equality Impact Assessment for Medical Gas Pipeline Inspection report Appendix 7 - Equality Impact Assessment for the Low Voltage Systems Management Policy

Appendix 1

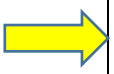
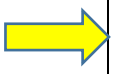
Swansea Bay University Health Board Health and Safety Plan 2019-20 (December 2019 review)

1	Target	To have Health and Safety owned and effectively managed at all levels of the Health Board

	Leadership and Accountability					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
1.1	**HSE Improvement Notices** Further to the HSE notices issued in February 2019 (9), May 2019 (1) and October 2019 (2) review develop and strengthen arrangements for the management of violence and aggression, manual handling and incident reporting	December 2019	Dir Nursing and Patient Experience	• Dedicated Health and Safety Improvement Group formed that has developed action plan and is monitoring progress towards compliance • Health Board working closely with HSE to have clarity on their expectations and to maintain good working relationships • 7 notices complied with but 5 outstanding	H&S 2	

1.2	**Health and Safety Policies** Review relevant health and safety policies so that they are fit for purpose, up to date and provide clear guidance for managers and staff to follow	March 2020	Dir Nursing and Patient Experience	• Policy or procedure reviews undertaken for Health and Safety Policy and other supporting policies including Violence and Aggression, lone working etc. • Estates Policies reviewed including Asbestos, Water Management and Low Voltage electricity • Small number of Board policies e.g. Fire Safety and Manual Handling to be reviewed.	H&S 1	
1.3	**Health and Safety Governance Structures** Review existing governance arrangements for Health and Safety to include TOR, attendance and function of Operational Health and Safety Group	July 2019	Dir Nursing and Patient Experience	• Review undertaken • Relevant documents agreed for use in Health Board	H&S11	☑

	Leadership and Accountability (continued)					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
1.4	**Health and Safety management In Service Delivery Units, Estates and Support Services** Develop effective governance arrangements and reporting to the Operational Health and Safety Group	March 2020	Unit Directors	• Governance procedure developed an agreed by Operational Health and Safety Group • Current roll out of system across Health Board • Active Health and Safety	H&S11	

				groups in all Units but need to develop consistent approach to governance • Skills and support for Units need to be reviewed as their governance agenda increases		
1.5	**Health and Safety Risk Register** Review the Health and Safety risk register and to develop revised risk register that more closely aligns with the new overarching risk register	March 2020	Dir Nursing and Patient Experience	• Risk register reviewed and updated • Unit registers that focus on their local risks are not regularly reviewed by their Health hand Safety groups with many risks long-standing on those registers	All	
1.6	**Estates Management** Review roles and responsibilities for the management of all sites and to identify key officers with responsibility for overall health and safety arrangements	March 2020	Dir Nursing and Patient Experience	• Report to Board Health and Safety Committee December 2019	H&S1	
1.7	**Security** Review existing security management arrangements for all sites and to identify key officers with responsibility for security including management of CCTV	March 2020	Dir Nursing and Patient Experience	• Improvement to security presence in Morriston Hospital • Reviews undertaken for Singleton and Neath Port Talbot Hospitals • All other sites have not been reviewed	H&S1	

	Leadership and Accountability (continued)					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**

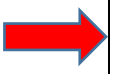
1.8	**Health and Safety Structure** Review corporate resources for the management of health, safety and fire to ensure that they are fit for purpose	March 2020	Dir Nursing and Patient Experience	• Initial review undertaken • Review of some roles in the department to expand their duties • Action to be taken to manage further reduction in resource due to retirements and staff leaving department	H&S2	

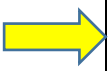
	Competent People					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
1.9	**Statutory and Mandatory Training (Core Skills Framework)** Develop a strategy and competency pathways for health and safety related topics In the NHS Wales Core Skills Framework on ESR	November 2019	Dir Nursing and Patient Experience	• Training needs analysis completed for violence and aggression and manual handling • Further work required to define pathways for fire safety competencies and the effectiveness of NHS Wales Core Skills Framework • Board level review currently being undertaken by Director Workforce and OD	H&S2	
1.10	**Health and Safety Role Related Training** Undertake a review key competencies for staff to be effective and safe in their tasks and roles	November 2019	Dir Nursing and Patient Experience	• Training needs analysis completed for violence and aggression and manual handling • Further review	H&S2	

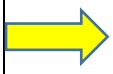
	and responsibilities			required in areas of fire, COSHH and management training		

	Compliance Assurance					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
1.11	**Health and Safety Governance** Review current arrangements for the delivery, recording and monitoring etc. of health and safety training and competencies	March 2020	Dir Nursing and Patient Experience	• Revised and included in the governance documents issued to units and Operational Health and Safety group	H&S2	
1.12	**Legislative and Regulatory Inspections** Ensure that all formal reports received from regulatory bodies relating to health and safety are correctly managed and relevant issues address as required to ensure compliance	March 2020	Dir Nursing and Patient Experience	• Health and Safety Committee, Operational Health and Safety Group and Unit Groups appraised of HSE Improvement notices • Further work required around management of fire notices	H&S2	
1.13	**Deep Dive – Key Risks** Develop a programme of deep dive sessions to review key health and safety risk topics with initial report to be received by the Operational Health and Safety Group	March 2020	Dir Nursing and Patient Experience	• Included within revised governance arrangements for Operational Health and Safety Group and Unit Health and Safety Groups • Some initial work undertaken in Units but full programme requires development	H&S2	
1.14	**Unit Health and Safety Improvement Plans** Further develop Unit Health and Safety Improvement Plans	Move to H&S Plan for 2020-2021	Dir Nursing and Patient Experience/ Units	• Included within revised governance arrangements for Operational Health and Safety Group and Unit Health and Safety Groups	H&S 11	

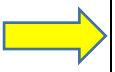
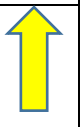
				• Limited number of formal plans in units		

	Compliance Assurance (continued)					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
1.15	**DSE Assessments** Ensure that a regular plan is in place for undertaking DSE risk assessment across the Health Board	March 2020	Dir Nursing and Patient Experience/ Units	• Limited Health and Safety resource available primarily focussed on high risk assessments	H&S2	

	Risk Management					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
1.16	**Health and Safety Risks Registers** Review the Health and Safety risk register and develop reviewed register that is more closely aligned to the overarching Board risk register Ensure that a regular plan is in place for undertaking DSE risk assessment across the Health Board	December 2019	Dir Nursing and Patient Experience/ Units	• Risk register reviewed and updated	H&S2	☑
1.17	**Unit Health and Safety Risk Registers** Review the risk registers used by Units and develop new arrangements to monitor those risks	November 2019	Dir Nursing and Patient Experience	• Unit registers that focus on their local risks are not regularly reviewed by their Health and Safety groups with many risks long-standing on those registers	H&S11	

	Learning from Events					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
1.18	**Incident Reporting policy** Review the Incident Reporting Policy and associated procedure and guidance to ensure that they are up to date and clearly define the roles of manager and staff	September 2019	Dir Nursing and Patient Experience/ Units	• Policy currently agreed but further review required following HSE comments and extension of specific improvement notice.	H&S2 H&S4	
1.19	**Incident Reporting Analysis** Undertake routine analysis of health and safety incidents and near misses	September 2019	Dir Nursing and Patient Experience/ Units	• Regular reports continue to be submitted to the Operational and Unit Health and Safety groups showing trends and hots spots etc.	H&S2 H&S4	☑
1.20	**Incident Reporting and Investigation** Sample quality of investigation of H&S incidents including learning lessons, action taken etc.	March 2020	Dir Nursing and Patient Experience/ Units	• RIDDOR reports produced for Operational Health and Safety group includes lessons learnt etc. and quality y of investigation • Key lesson learnt included in Unit reports • H&S resource strengthened to review incidents of violence and aggression	H&S2 H&S4	

1.21	**Lessons Learnt from Claims** Share lessons learnt form claims management experience	March 2020	Dir Nursing and Patient Experience/ Units	• Previously included in topic related audits sent to Operational Health and Safety group for review • Copy of Shared Services partnership claims management report made available to Operational Health and Safety Group	H&S2 H&S4	

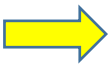
	Asset Management					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
1.22	**Electrical Equipment Asset Management** Undertake a review of electrical equipment management	Move to H&S Plan for 2020-2021	Units	• Ongoing review of safety with dynamic air mattresses • Updated procedure for PAT testing • No progress at Unit Health and Safety Groups	H&S2	
1.23	**Equipment Risk Assessments** Improve the use of risk assessments in the management of capital programmes	March 2020	All	• Manual Handling replacement programme completed in April 2019 but further work to identify potential placement of other equipment	H&S2	
1.24	**Electrical Safety Testing** Further review of dynamic air mattress systems to reduce the risk of electric shock	March 2020	Dir Nursing and Patient Experience	• Arrangements agreed with units and rollout of system ongoing	H&S2	

	Managing Contractors					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
1.25	**Contractor Management** Ensure contractors management is effective at all levels of the organisation	March 2020	Dir Nursing and Patient Experience/ Operations/ Strategy/ Units	• Contractor management policy agreed but yet to be published • Unit Health and Safety groups briefed	H&S2	☑

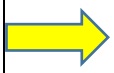
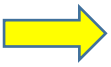
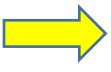
	Communications					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
1.26	**Health and Safety Operational Group** Review the governance framework for the Operational Health and Safety group	October 2019	Dir Nursing and Patient Experience	• Completed	H&S2	☑
1.27	**Health and Safety Intranet** Review the Health and Safety related content to ensure it is up to date, relevant an user friendly	Move to H&S plan 2020-21	Head of Health and Safety	• No progress and remaining member of staff with necessary sills has left the Health Board	H&S2	↓
1.28	**Health and Safety Newsletter** Introduce a quarterly newsletter to publicise key health and safety message	July 2019	Head of Health and Safety	• First newsletter published and second newsletter being developed for December 2019	H&S2	☑

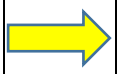
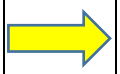
	Emergency Preparedness					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
1.22	**Health and Safety Emergency Procedures** Where necessary have in place appropriate emergency procedures e.g. fire, spillage	March 2020	Units	• Some reviews of site fire emergency procedures undertaken	H&S2	↑
1.23	**Review first aid provision**	March 2020	Dir Nursing and Patient Experience	• Reviewed 2019 an confirmed generally effective	H&S2	→

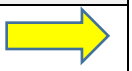
				arrangements but further review required for complexness		

	Measuring performance					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
1.22	**Key Performance Indicators** Identify, maintain and use key performance indicators (KPI) for Operational Health and Safety Group	March 2020	Dir Nursing and Patient Experience	• Review to be undertaken	H&S2	

2	**Target**	**To have Fire Safety owned and effectively managed at all levels of the Health Board**

	Leadership and Accountability					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
2.1	**Fire Safety Management Systems** Review fire safety management and necessary resources to effectively manage fire safety	March 2020	Dir Nursing and Patient Experience	• Confirmed fire resources inadequate but awaiting full review of Health and Safety structure and resources	H&S13	
2.2	**Fire Wardens** Ensure that there are sufficient and active fire wardens to assist in the management of fire safety	March 2020	Units	• Further review of Singleton recently undertaken • Unclear in other areas of scope and numbers of fire Wardens	H&S13	
2.3	**Health and Safety Operational Group** All management areas to demonstrate effective management of fire safety	March 2020	Dir Nursing and Patient Experience	• Forms part of revised governance arrangements but full implementation now required	H&S13	
2.4	**Health and Safety Unit Groups** Demonstrate key actions to demonstrate fire safety being managed	March 2020	Units	• Forms part of revised governance arrangements but full implementation now required	H&S13	

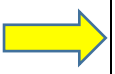
	Competent People					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
2.5	**Fire Safety Training : all Staff** Review arrangements to ensure a clear policy of fire training and maintenance of competencies	March 2020	Dir Nursing and Patient Experience	• Review not undertaken and competency pathways not developed	H&S13	
2.6	**Competencies of Managers** Review key skills for managers to effectively control fire safety and provide training and support as required	March 2020	Dir Nursing and Patient Experience	• Review not undertaken and competency pathways not developed	H&S13	

	Compliance Assurance					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
2.7	**Fire Risk Assessments** Improve the action taken following fire risk assessments	March 2020	Dir Nursing and Patient Experience / Units	• Limited progress due to lack of clerical resource in Health and Safety department • Reports to Units limited to progress with updating fire risk assessments	H&S13	

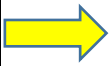
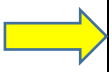
	Risk Management					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
2.8	**Fire Safety Risk Register** Maintain fire safety risk register and review as necessary	March 2020	Dir Nursing and Patient Experience	• Singleton cladding included in Corprote risk register • Other fire safety risk to firm part of the Operational Health and Safety/Fire Safety Group risk register	H&S5	

	Risk Management					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
2.9	**Fire Safety Incidents Lessons Learnt** Improve the reporting of fire safety incidents and lessons learnt etc.	March 2020	Dir Nursing and Patient Experience/ Fire Safety Group/ Units	• Generally fire safety incidents investigated by Fire Safety Advisers with limited involvement of Unit staff	H&S2 H&S4	

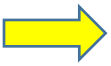
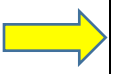
	Asset Management					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
2.10	**Fire Safety Capital Programme** Develop action plan for fire safety investment	March 2020	Dir. Strategy/ Fire Safety Group	• Approval given for part removal of Singleton cladding • Capital monies allocated for specific project work such as review of compartmentation	H&S 5	
2.11	**Fire Safety Compartmentation** Conduct rolling review of fire safety compartmentation across Health Board	March 2020	Dir. Operations/ Fire Safety Group	• Programme ongoing at Singleton and Neath Port Talbot hospitals		
2.12	**Fire Safety Cause and Affect** Conduct rolling review of fire safety cause and affect across the health board	March 2020	Dir. Operations/ Fire Safety Group	• Resources allocated and some work being undertaken		

	Emergency Preparedness					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
2.13	**Fire Safety Site Plans** Confirm all sites have management plan for site	March 2020	Units	• Forms part of governance structure for Units but limited number of reviews undertaken primarily on main sites •		

	Emergency Preparedness (continued)					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
2.14	**Fire Evacuation Plans** Confirm all wards and departments have a fire emergency plan	March 2020	Units	• Will form part of revised governance structure for Units but currently limited monitoring in place at Unit level • Reviewed as part of fire risk assessment system		
2.15	**Singleton Fire** Learn key messages from fire emergency in April 22019	September 2019	Dir. Operations/ Fire Safety Group	• Full review undertaken • Reported to Operational Health and Safety group and Unit Health and Safety Groups		☑

	Measuring Performance					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
2.16	**Fire Safety Key Performance indicators (KPI)** Develop capacity at corporate level to monitor fire safety performance	March 2020	Dir Nursing and Patient Experience	• Awaiting review of Health and Safety resources etc.	H&S 1	
2.17	**Local Fire Safety Audits** Incorporate enhanced monitoring of smaller properties into Fire Safety audit	Move to H&S Plan 2020-21	Dir Nursing and Patient Experience	• Current fire safety audit, due to resources, only focuses on larger properties and does not fully consider the full SWUHB estate. • Awaiting review of Health and Safety resources etc.	H&S 1	

3	Target	To have Manual Handling owned and effectively managed at all levels of the Health Board

	Leadership and Accountability					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
3.1	**Resources and Capacity** Review resources and capacity to ensure fit for purpose	March 2020	Dir Nursing and Patient Experience	• Review to be undertaken	H&S 1	
3.2	**Integration of Manual Handling Management** Embed the management of manual handling at all levels of the Health Board	March 2020	Units	• Revised governance structure will require regular review of manual handling • Regular incident reports provided to Units	H&S 1 H&S 2	

	Competent People					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
3.3	**Manual Handling Training** Full review of manual handling training and competency systems	September 2019	Dir Nursing and Patient Experience	• Retirement of staff will affect capacity to train from March 2019	H&S 1 H&S 2	

	Risk Management					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
3.4	**Manual Handling Risk Register** Maintain risk register and monitor by Unit, Operational Health and Safety Group	September 2019	Dir Nursing and Patient Experience	• Hoists already reviewed • To be included in governance work of relevant Health and Safety groups	H&S 1 H&S 14	

	Compliance Assurance					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
3.5	**Manual Handling performance** Review arrangements and resources to formally monitor key performance indicators	September 2019	Dir Nursing and Patient Experience	• Significant monitoring in place by Manual Handling Coaches • Monitoring at H&S group level largely limited to incident statistics • Limited corporate H&S resources to monitor wards and departments	H&S 1 H&S 2	

	Learning from Events					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
3.6	**Manual Handling Incidents** Maintain continuous review of incidents	September 2019	Dir Nursing and Patient Experience	• Regular reports provided to Operational and Unit H&S groups • RIDDOR reports scrutinised by Operational H&S group	H&S 2 H&S 4	☑
3.7	**Occupational Health** Maintain continuous review of incidents associated with musculoskeletal disorders	March 2020	Dir Nursing and Patient Experience	• Resources available to support investigations and risk assessments • Bespoke training systems in place to minimise key areas of MSDs	H&S 14	

	Asset Management					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
3.8	**Manual Handling Equipment** Complete annual review of equipment	March 2020	Dir Nursing and Patient Experience	• 2018-19 programme completed and implemented		

4	Target	To have Violence and Aggression owned and effectively managed at all levels of the Health Board

	Leadership and Accountability					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
4.1	**Policy** Review policy	September 2019	Dir Nursing and Patient Experience	• Policy reviewed	H&S 1	☑
4.2	**Integration of Violence and Aggression Management into Units** Embed the management of violence and aggression at all levels of the Health Board	March 2020	Units	• Revised governance structure will require regular review • Regular incident reports provided to Units	H&S 1 H&S 2	→

	Competent People					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
4.3	**Training** Full review of training and competency systems	March 2020	Dir Nursing and Patient Experience/ Units	• Current review being undertaken as part of HSE inspection and management of improvement notices	H&S 1 H&S 2	↑
4.4	**Restraint Training and Systems** Review restraint arrangements in Mental Health and learning Disability Unit	March 2020	Unit	• Review being undertaken	H&S 1 H&S 2	↑
4.5	**Training Needs Analysis** Review and agree with units	September 2019	Dir Nursing and Patient Experience/ Units	• Completed at Unit and ward/ departmental level for wards and key departments	H&S 1 H&S 2	☑

	Compliance Assurance					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
4.6	**Violence and Aggression Performance** Operational Health and Safety Group to maintain constant review	September 2019	Dir Nursing and Patient Experience	• Monitoring limited to incident statistics and lessons learnt	H&S 1 H&S 2	☑
4.7	**Violence and Aggression Unit Performance** Unit Health and Safety Groups to maintain constant review	September 2019	Units	• Monitoring limited to incident statistics and lessons learnt	H&S 1 H&S 2	☑
4.8	**Violence and Aggression internal Review** Develop internal reviews and Annual thematic Review to Operational Health and Safety Group	March 2020	Dir Nursing and Patient Experience	• Monitoring limited to incident statistics and lessons learnt	H&S 1 H&S 2	→

	Risk Management					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
4.9	**Risk Register** Understand risks and control measures for individual staff groups	March 2020	Dir Nursing and Patient Experience	• Training needs analysis completed at Unit and ward departmental level. Further rollout to other areas as necessary	H&S 1 H&S 2	↑

	Learning from Events					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
410	**Lessons learnt** Maintain regular review by Operational Health and Safety Group	November 2019	Dir Nursing and Patient Experience	• Regular reports provided to Operational and Unit H&S groups • RIDDOR reports scrutinised by Operational H&S group	H&S 2 H&S 4	☑
4.11	**Lessons learnt** Maintain regular review by Units	November 2019	Dir Nursing and Patient Experience	• Regular reports provided to units	H&S2	☑
4.12	**Case Management** Review resources for effective case management	March 2020	Dir Nursing and Patient Experience	• Temporary Case Manager appointed to cover retirement of existing staff	H&S2	→

	Emergency Preparedness					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
4.13	**Lone Worker Policy** Review policy/procedure	September 2019	Dir Nursing and Patient Experience	• Policy reviewed with additional guidance on risk assessment	H&S 1 H&S 2	☑
4.14	**Clinical information Systems** Review information systems	March 2020	Dir Nursing and Patient Experience	• NHS systems frequently incompatible • Potential role for Case Manager to support	H&S 1 H&S 2	→

5	Target	To have COSHH owned and effectively managed at all levels of the Health Board

	Leadership and Accountability					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
5.1	**Policy** Review policy	September 2019	Dir Nursing and Patient Experience	• COSHH procedure reviewed	H&S 1	☑

	Competent People					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
5.2	**Training** Full review of training and competency systems required	March 2020	Dir Nursing and Patient Experience/ Units	• No resources to take this work forward	H&S 1 H&S 2	↓

	Risk Management					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
5.3	**Risk Assessments** Undertake full range of COSHH assessments	March 2020	Dir Nursing and Patient Experience/ Units	• No resources to take this work forward	H&S 1 H&S 2	↓

	Learning from Events					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
5.4	**Lessons learnt** Review all relevant incidents	September 2019	Dir Nursing and Patient Experience/ Units	• Regular reports provided to Operational and Unit H&S groups • RIDDOR reports scrutinised by Operational H&S group	H&S 2 H&S 4	☑

6	Target	To have Display Screen Equipment (DES) owned and effectively managed at all levels of the Health Board

	Leadership and Accountability					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
6.1	**DSE Procedure** Review	March 2020	Dir Nursing and Patient Experience	• No progress	H&S 1	→

	Competent People					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
6.2	**Training** Managers to understand safety arrangements for equipment etc.	March 2020	Dir Nursing and Patient Experience/ Units	• No resources to take this work forward	H&S 1 H&S 2	

	Risk Management					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
6.3	**Risk Assessments** Undertake audit of range of DES assessments in Health board	March 2020	Dir Nursing and Patient Experience/ Units	• No resources to take this work forward	H&S 1 H&S 2	

	Learning from Events					
	Recommendation	**Timescale**	**Lead Executive**	**Current Position**	**Risk Reference**	**Status**
6.4	**Lessons learnt** Review all relevant incidents to be undertaken	March 2020	Dir Nursing and Patient Experience/ Units	• No incidents reported	H&S 2	

Appendix 2

Health and Safety Policy

Document Author:	Head of Health and Safety
Approved by:	Health & Safety Committee
Approval Date:	December 2019
Review Date:	December 2022
Document No:	HB117

This policy has been updated to reflect Health Board change of name, Director Responsibility and changes in management arrangements in the Health Board and to give greater detail on arrangements to monitor health and safety performance.

November 2018: Further update shown in Appendix C linking this policy to list of other polices with potential health and safety implications.

This policy has been screened for relevance to equality. No potential negative impact has been identified so a full impact assessment is not required

This document may be made available in alternative formats and other languages, on request, as is reasonably practicable to do.

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SWANSEA BAY UNIVERSITY HEALTH BOARD

HEALTH AND SAFETY POLICY

STATEMENT OF POLICY

The Health Board is a large organisation that employs approximately 12,000 staff. It manages a large range of patient services with significant resources used to support effective patient care. We manage a large number of buildings, including hospitals, clinics and other premises and some of our staff are required to work in patient's homes or premises not directly controlled by the Health Board.

The Health Board is committed to ensuring the health, safety and welfare of all our employees. We extend this duty of care to our patients, visitors, volunteers, contractors, and all others who may be affected by our activities.

We do not consider that good health and safety management is a constraint to the effective running of the Health Board; it is a core value to which directors, managers and staff at all levels in the organisation have key roles to play. We also recognise the vital links to partners such as trade unions colleagues and primary care providers; by working closely with them this will support our vision of good standards of safety for all.

Identifying and the effectively managing health, safety and welfare risk are key features of this policy. We will promote a proactive approach to health, safety and welfare and make all practical efforts to safeguard everyone from hazards, injury and ill health.

Signed ..... Date .....
Chief Executive

DEFINITIONS

The following definitions and abbreviations are used throughout this policy: -

- “The Act” means the Health and Safety at Work etc. Act (HASAWA) 1974
- The “Health Board” means the Swansea Bay University Health Board
- “Management Units” includes Service Delivery Units and other Senior Management functions including Finance, Workforce and Organisational Development, Strategy etc.
- “Directors” includes Directors of Service Management Units and Directors of Management Units
- The “HSE” means the Health and Safety Executive
- “Service/Line/Departmental Manager” take responsibility for groups of staff, areas, functions, clinical lead etc. and includes Ward Manager, Departmental manager clinical lead etc.
- “Health and Safety’” includes where appropriate the consideration of welfare needs

SWANSEA BAY UNIVERSITY HEALTH BOARD HEALTH AND SAFETY POLICY

1. AIMS AND OBJECTIVES

The development of an effective Health and Safety policy is a key requirement of the Health and Safety at Work etc., Act 1974 (HASAWA).

This policy gives general guidance on how health and safety will be managed in the Health Board. Its aim is to promote and encourage high standards of health, safety and welfare at work and comprises 3 parts:-

- The General Policy statement setting out principal objectives to be achieved
- Scope of the policy and overall management arrangements
- General arrangements to implement health and safety in the Health Board

In addition appendices record relevant supporting information.

This policy will be supported by a range of other policies, procedures and arrangements necessary for the effective management of specific health, safety and welfare.

2. SCOPE OF THE POLICY

2.1 Staff

This policy applies to all ABMU staff whilst at work and includes working on or off ABMU premises and travelling between locations.

2.2 Patient Safety

Section 3 of HASAWA extends the duty of care to persons including patients, visitors, contractors, volunteers, temporary staff and others who may be affected by the Health Board's work activities.

For patients, HASAWA etc., may not directly apply to many clinical risk situations such as decisions on the method of treatment or choice of drugs. It can apply where there has been a system failure such as the failure to ensure the safety of equipment used in a clinical procedure. The Health Board is committed to the effective control of risk to patients and health and safety considerations form part of its overall approach.

2.3 Safety of Non-Employees

The general safety of visitors forms part of this policy including protection of their safety whilst on ABMU property

Temporary staff directly employed by ABMU will be treated as employees for the purpose of this policy. Other temporary staff such as agency and locum will be treated as contractor staff for the purpose of this policy and will require effective cooperation and coordination between the Health Board and that agency

For volunteers is acting on behalf of ABMU they will be treated as employees. Where the volunteer is provided by other agencies there will be effective cooperation and coordination between the Health Board and that agency.

Where contractors are employed there will a requirement for effective cooperation and coordination between ABMU and the Contractors to ensure that risks are effectively assessed and controlled.

3. DEVELOPMENT OF THE POLICY

3.1 Health Board Wide Policies

The policy will be supported by a number of other Health Board-wide policies (Appendix C) .These focus on specific areas of health and safety risk and detail how those risks should be effectively managed. This approach is consistent with the requirements of the Health and Safety at Work Act 1974 (HASAWA) that provides the overall legislative framework and is supported by a number of specific regulations relating to particular work activities such as manual handling.

3.2 Service Delivery Units, Management Units, Other Directors, Wards and Departments

Where necessary and to give greater focus on specific aspects of health and safety management not covered by an over-arching ABMU this policy also encourages the development of appropriate policies, procedures and systems. These policies and procedures must be consistent with the overall approach adopted by the Health Board

4. GENERAL STRATEGY

To ensure effective management of health, safety and welfare the Health Board will have:

- Arrangements to comply with the requirements of legislation, Welsh Government initiatives etc.
- Clarity on roles and responsibilities at all levels of the organisation. In general these arrangements will be consistent with the management arrangements in the Health Board
- Arrangements to identify risks and to implement the necessary action to remove or control them
- Procedures, protocols, safe systems of work etc. needed to control the risk
- Systems to ensure persons who may be at risk the necessary competencies, information, instruction, supervision etc. for them to work safely
- Effective arrangements for the design, maintenance etc. of equipment, buildings and associated engineering systems, working environments, public areas etc.
- Making available competent advice on relevant aspects of health and safety risk
- Systems to report and learn from accidents, ill health, dangerous occurrences whether or not actual injury, illness etc. took place
- Arrangements to consult with employees, safety representatives and others on matters of health and safety
- Systems to measure the health, safety and welfare performance of the Health Board

5. MANAGEMENT ARRANGEMENTS AND ROLES AND RESPONSIBILITIES

The Organisational chart for Health and Safety is shown in Appendix A

5.1 Health Board

The Health Board has ultimate responsibility for ensuring that it complies with the requirements of health and safety legislation including the provision of appropriate resources. It is responsible for approving this Policy: subsequent amendments may be actioned through the Health Board Health and Safety Committee. It may delegate responsibility for approving supporting Health and Safety Policies and Procedures to other appropriate Committees, Directors etc. in accordance with its Policy on Policies.

5.2 Chief Executive

The Chief Executive has responsibility for: -

- Ensuring that the Health and Safety Policy is implemented and reviewed as is necessary and advising the Board accordingly
- Identifying the Board's health and safety plans and performance requirements and ensuring the necessary resources to implement the Health and Safety policy effectively
- Appointing lead directors to take responsibility for the coordination of health and safety matters across the Health Board
- Ensuring that the Board is regularly informed regarding health and safety matters affecting employees, patients and others
- Monitoring health and safety performance against agreed targets.

5.3 Director of Nursing & Patient Experience

On behalf of the Chief Executive the Director of Nursing and Patient Experience takes executive responsibility for the implementation of health and safety within the Health Board. These responsibilities include: -

- Ensuring the health and safety policy is kept under is review and updated if changes in legislation, risk etc. makes this necessary
- Monitoring the implementation of the Health and Safety Policy
- Advising on the necessary resources for the effective management of health and safety risk
- Reporting to the Health Board on overall performance in health and safety matters and action being taken to improve health, safety and welfare within the Board
- Ensuring that any legal requirements due to changes in legislation are disseminated as necessary throughout the Board
- Chairing the Health Board Health and Safety Committee

5.4 Nominated Lead Directors

Board directors may be nominated by the Chief Executive to have lead roles for particular health and safety matters. Their general responsibilities are:-

- Developing Board-wide safety arrangements for the particular health and safety matters under their control
- Advising on the necessary resources for the effective management of health and safety risk
- Reporting to the Health Board on performance
- Monitoring the implementation of relevant policies
- Ensuring that any legal requirements due to changes in legislation are disseminated as necessary throughout the Board
- Reporting to the Chief Executive on the standards being achieved

5.5 Management Units (Service Delivery Units, Directors of Services etc.)

5.5.1 General

The size and complexity of the Health Board make it impractical to provide direct central management, policies etc. that cover all aspects of the management of health and safety. Responsibility for the management of health and safety is delegated from the Chief Executive to Service Delivery Units and Directors of Services.

5.5.2 Roles and Responsibilities

Management Units must:

- Demonstrate their commitment to high standards of health, safety and welfare
- Implement the Health Board Health and Safety Policy and associated policies and procedures as required in their areas of control in the Health Board.
- Ensure there are appropriate arrangements within their areas of the organisation for the effective management of health and safety with clearly defined roles and responsibilities
- Have adequate arrangements to identify and manage health and safety risks
- Where appropriate arrange to develop and implement policies, procedures and safe systems of work necessary for the safe management of their areas of responsibility
- Ensure the competency of staff (including new and temporary staff) by the provision of information, training, instruction and supervision as is necessary to control risk
- Have effective arrangements to consult with staff and safety representatives on matters of health and safety
- Maintain appropriate health and safety records
- Ensure the prompt reporting and investigation of all accidents and untoward occurrences
- Regularly monitor and audit health and safety performance

Directors of Management Units may delegate the management of health and safety to other staff within their areas of responsibility. Details of the individual responsibilities will be identified and appropriately recorded by the Service Delivery Unit or Director concerned. Staff undertaking these roles must be competent and given appropriate time and resources to undertake these duties.

5.6 Service Managers, Line/Departmental Managers etc.

These staff will directly manage staff and/or services and department(s).

Principal responsibilities include

- Demonstrating by personal example their commitment to high standards of health, safety and welfare
- Identifying health, safety and welfare risk present in their area(s) of control
- Putting into place appropriate arrangements to eliminate or control those risks.
- Apply Health Board policies and procedures to the work undertaken and risks present
- Apply appropriate Service Delivery Unit local policies, procedures and safe systems of work to the work undertaken and risks present
- Communicate with their staff on matters of health, safety and welfare
- Identify the training and information needs of staff ensuring that the training is received
- Investigate accidents and incidents ensuring that appropriate remedial action is taken

5.7 General Duties of Employees

All employees have a legal duty under HASAWA. They must take reasonable care for their own health and safety and that of others who may be affected by what they do (including their acts or omissions). In particular employees must:

- Co-operate by complying with health and safety policies and procedures
- Make use of equipment, procedures etc. necessary to control health and safety risks
- Report all untoward incidents and potential hazards even when no injury or property damage has resulted and co-operate in the investigation of such incidents

5.8 Competent Persons

5.8.1 General

The Management of Health and Safety at Work Regulations 1999 requires the Health Board to identify competent persons for key areas of health and safety risk. Details of the competent persons are shown in Appendix B.

5.8.2 Head of Health and Safety

The primary role of the Head of Health and Safety is to;-

- Act as the competent person to advise the Health Board of necessary actions and controls for the management of health and safety

- To support and advise the health and safety work of the Health Board and its management units and others as necessary on matters of legislation approved codes of practice, standards and guidance.
- To represent the Health Board during inspections etc. with the Health and Safety Executive and other enforcing bodies as appropriate.
- To direct and lead the Health and Safety Team (including manual handling, fire safety, personal safety) to ensure best practice is achieved throughout the Health Board
- Assist in the management of Health and Safety through the preparation of relevant SBUHB-wide policies and procedures
- Co-ordinating and undertaking a full range of internally developed and Nationally accredited training programmes to meet its mandatory requirements
- Ensuring that statistical information is available on health and safety performance throughout and interpret such information in order to evolve action plans in co-ordination with Directors and Managers to improve or maintain standards

6. ARRANGEMENTS

6.1 Risk Assessment

The Health Board has a comprehensive system for risk assessment that includes the assessment and control of health and safety risks. Health and safety risks are prioritised and managed using that system and this is recorded in a separate policy and associated procedures.

6.2 Policies, Procedures, Safe Systems of Work etc.

In addition to this policy other Health and Safety Policies and procedures will be developed including

- Health Board-wide policies and procedures to manage common risks or issues (e.g. violence and aggression).
- Health board-wide policies and procedures may need to be further developed by Service Delivery Unit to manage their local risks (e.g. manual handing in the community). Where Service Delivery Units develop their own local procedures etc. these must be consistent with Board-wide systems for the risk concerned.
- Safe systems of work, standard operating procedures, instructions, guideline etc. that may be specific to or include reference to health and safety matters.
- Procedures for emergency situations such as fire

6.3 Competent Staff

Competency can broadly be defined as a combination of training, knowledge, experience and personal attitude necessary to work safely. Staff may begin with no competency and ultimately progress to become very competent. For some risks such as fire or chemical spillage skills may not be routinely practiced. Therefore any training or other interventions need to reflect the relevant level of skills needed to be achieved and maintained.

The Health Board will adopt a flexible approach that will be determined by the risks present. This will include the use of formal training sessions, competency assessments, provision of the information, supervision, mentorship etc.

6.4 Health and Safety Information

Copies of relevant policies, procedures, safe systems of work will be conveniently available for employees and others to consult. Depending upon the need for the information they will include paper and electronic systems that may be held centrally, in wards and departments or at other locations as required.

Line managers must make the availability of information sources (e.g. policies) known to employees.

6.5 Support for Staff

Appropriate support will be made available to staff as part of their normal work activities and following an incident, ill health etc.

Initial support for staff will be provided by their manager or supervisor. Staff may also access the SBUHB Occupational Health Service and specialist advice from competent staff in the organisations. Trade Unions also have a key role in supporting staff and consulting with managers.

Details will be recorded in specific policies and procedures.

6.6 Working with Other Organisations

The range of work undertaken by the organisation means that our staff may work in premises owned by other organisations. In similar way employees of other organisations, volunteers etc. may work in our buildings. Risk assessments will be undertaken and control measures introduced as required to control identified risks.

6.7 Consultation

Section 2(6) of the Act, the 1977 Safety Representatives and Safety Committee Regulations and the Health and Safety (Consultation with Employees) Regulations 1996 requires employers to consult with employees on arrangements for health and safety.

Consultation will be undertaken with staff and safety representatives where there are changes in risk, prior to the introduction of new equipment or technology, changes in legislation etc.

Routes for consultation include

- Via the Board (or other correctly constituted) Health and Safety Committee and/or other committees that have health and safety issues as part of their remit
- Management Unit e.g. dedicated Health and Safety Committee
- Ward or departmental

Details of a committee's remit and membership must be recorded in their Constitution and Terms of Reference.

6.8 Safety Representatives

In order to promote active participation in health and safety at all levels within the organisation, the Board positively encourages staff to take on responsibilities as Health and Safety Representatives.

Safety Representatives can only be appointed by recognised Unions/staff organisations. Each organisation is required to notify the Human Resources department of appointed Health and Safety Representatives and of the group(s) of staff and workplace (s) that they represent.

Time off with pay is granted to representatives for the carrying out of their duties during working hours and to attend appropriate Health and Safety meetings etc.

6.9 SBUHB Health and Safety Committee

SBUHB will maintain and develop a Health and Safety Committee. Its main duties are

- To ensure that effective partnership working arrangements are maintained between Management and Staff Health and Safety Representatives
- To review and monitor risks, incidents lessons learnt etc. as they affect general SBUHB matters
- To develop, use and maintain key performance indicators

- To develop, maintain and implement the Health and Safety Improvement plan
- To review SBUHB-wide polices
- To receive Health and Safety management reports from the relevant groups

6.10 Safe Equipment and Safe Premises

System will be developed and maintained to understand the risks associated with equipment and buildings and how they will be controlled. In particular when new or altered equipment or building are introduced they must be subject to an appropriate risk assessment.

Systems will be implemented to manage any risks including arrangement for maintenance, cleaning etc.

In determining risk should be sought from manufacturers, suppliers, competent SBUHB staff etc. Responsibility rests with the manager of the equipment, building, ward or department etc. involved and is determined by the scope of use of the equipment etc.

6.11 Occupational Health Service

The Occupational Health Service provides specialist services and advice to assist the Health Board in the management of health and safety risks. These include pre-employment assessment, health surveillance, elements of post incident management and assessment and treatment of staff with ongoing health problems.

Risk assessments will be used to determine the requirements for Health Surveillance that may be provided by the Occupational Health Service or externally as required.

6.12 Incident and Hazard Reporting

The Health Board has a comprehensive system for reporting of incidents and this is recorded in a separate policy and associated procedures.

6.13 Health and Safety Improvement Plan

The Health Board will annually develop and review a Health and Safety Improvement Plan. This will consider actions developed from risk assessments, lessons learnt, organisational change etc. that require effective planning and monitoring. This will form part of the work of the Health and Safety Committee.

Management Units will be required to interpret the plan, apply to areas under their control and monitor performance against that plan. They may also develop, based upon their risk profile etc., local Health and Safety

Improvement Plans.

6.14 Performance Monitoring

Performance monitoring for health and safety will include both internal and external systems.

Reports will be made to SBUHB Health and Safety Committee; Management Units etc. charged to review Health and Safety arrangements and performance in their areas of control or review.

Areas of performance monitoring include

- Progress against Health and Safety plans
- Progress in the control of health and safety risks identified by risk assessment, those included on risk profiles etc.
- Key performance indicators for relevant parts of the organisation
- Corporate audit programme
- Ward or departmental audits
- Competencies of staff
- Incident statistics, lessons learnt, claims etc.
- Compliance with Welsh Government Standards
- Reports from external bodies e.g. HSE

Key performance indicators (KPIs) will be developed to give focus on health and safety relevant to various levels of risk and management responsibility.

6.15 Publicity of the Policy

This policy will be made available for staff and others to consult in the Health Board document management system incorporated into its intranet. Where required and on request other formats will be made available.

6.16 Policy Review etc.

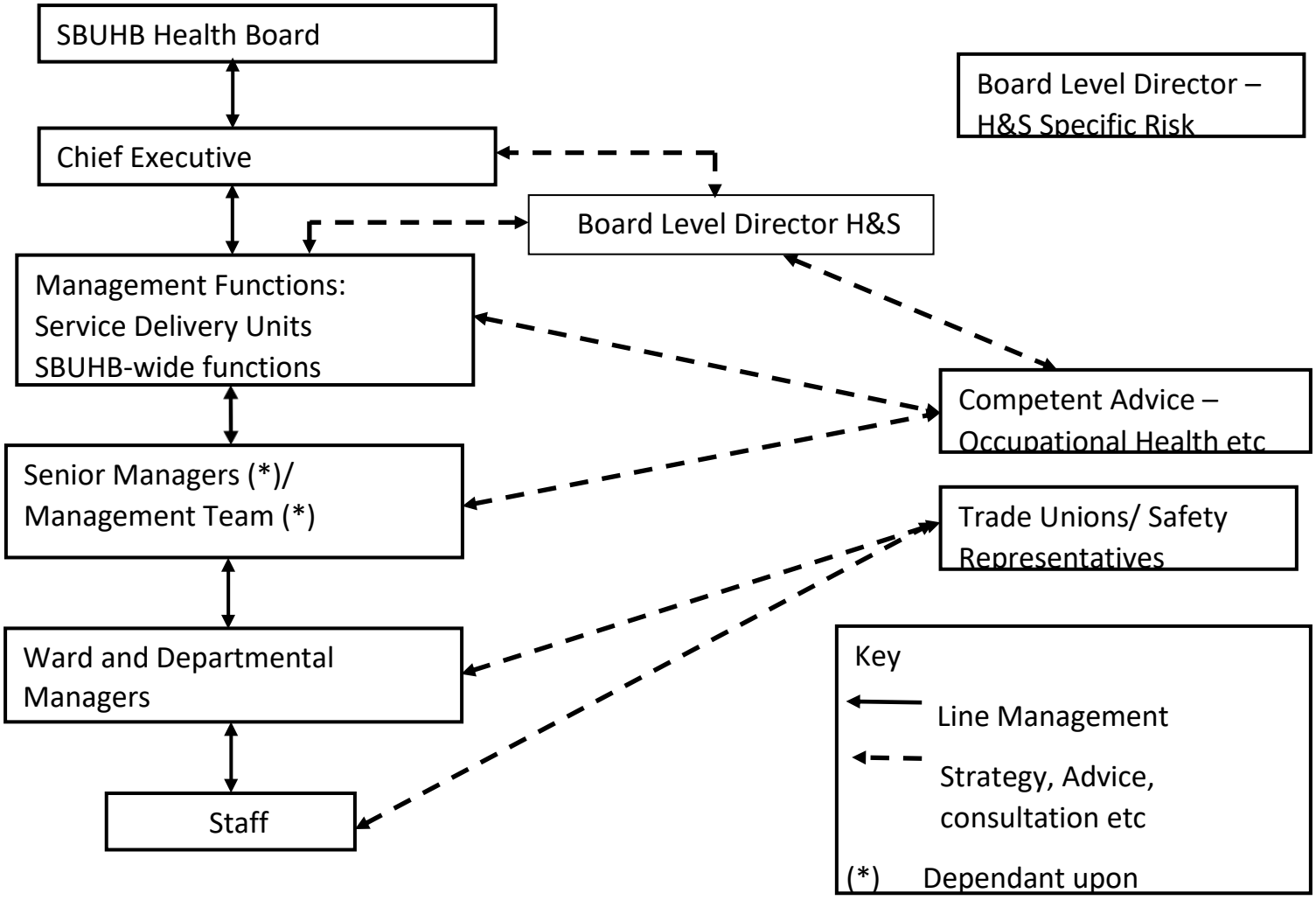
This policy will be reviewed often as is necessary to ensure continued compliance with health and safety legislation, changed or emerging health and safety risk or other relevant reasons.

It will be reviewed by the Health and Safety Committee on behalf of the Health Board. The Health Board must approve any significant amendments.

Policies, procedures, safe systems of work etc. that have not been developed corporately must be reviewed as often as necessary dependent upon the level of risk etc.

APPENDIX A

SBUHB Health and Safety Management Arrangements Chart



APPENDIX B

Competent Persons

This section records persons and departments within the Health Board able to give advice in particular areas of health, safety and welfare risk.

Topic Area	Advisory Service
Health and Safety	Health and Safety Department
Manual Handling	Manual Handling Adviser
Violence and Aggression	Health and Safety Department
Fire Safety	Health and Safety Department
Infection Control	Control of Infection Team
Occupational Health	Occupational Health Adviser
Health and Safety (Estates)	Health and Safety Adviser (Estates)
Risk Management	Patient Experience Manager
Waste Management	Estates Manager
Ionising Radiation	Radiation Protection Adviser
Non-Ionising Radiation	Radiation Protection Adviser
Medical Devices	Medical Devices Co-ordinator
Security	Estates Manager
Energy management	Estates Manager
Transport	Estates Manager
Asbestos	Estates Manager
Water Management	Estates Manager

APPENDIX C

REFERENCES

- Health and Safety at Work etc. Act 1974
- Management of Health and Safety at Work Regulations 1999
- Managing for Health and Safety (HSE 2013)
- Directors ' responsibilities for health and safety (HSE INDG 343)
- Health Inspectorate Wales Standard 22 – Managing Risk and Health and Safety
- NHS Wales Governance E-Manual
- All Wales NHS Manual Handling and Passport Training and Information Scheme
- All Wales NHS Violence and Aggression Passport Training and Information Scheme
- Health and Safety (Consultation with Employees) Regulations 1996
- Safety Representatives and Safety Committee Regulations 1977
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995

SBUHB HEALTH AND SAFETY POLICIES

ABMU Policies with a potential health and safety content (non-exhaustive list) may be found on the

- Corporate/Non-Clinical policy section of the SBUHB Intranet
- On the Health and Safety department website
  List of Health and Safety Related Policies

From: ABM Inquiries

Sent: 09 November 2018 11:18

To: Adel Davies (ABM ULHB - Surgical Specialties); Amanda Smith (ABM ULHB - Postgraduate Centre); Angela Hopkins (Cwm Taf LHB - Executive Directorate); Angela Kind (ABM ULHB - Estates); Anne Biffin (ABM ULHB - Medical Directors Department); Bellina Jenkins (ABM UHLB

- Children's Services); Cathy Dowling (ABM ULHB - Corporate Nursing); Ceri Matthews (ABM ULHB - Clinical support services); Christine Morrell (ABM ULHB - Therapies And Health Sciences); Darren Griffiths (ABM ULHB - Strategy); David Murphy (ABM ULHB - Health & Safety); David Roberts (ABM ULHB - Mental Health & Learning Disabilities); Debbie Bennion (ABM ULHB - Nursing Divison); Des Keighan (ABM ULHB - Estates); Dougie Russell (ABM ULHB - Musculo Skeletal); Eve Jeffery (ABM ULHB - Mental Health And Learning Disabilities); Fiona Reynolds (ABM ULHB - Singleton Hospital); Gareth Howells (ABM ULHB - Nursing); Gemma Otter (ABM ULHB - Acct); Helenna Jarvis-Jones (ABM ULHB - Medicine Directorate, Morriston Hospital); Hilary Dover (ABM ULHB - Primary and Community Services); Jamie Marchant (ABM ULHB - Service Directors Office); Jan Worthing (ABM ULHB - Singleton Hospital); Jonathan Goodfellow (ABM ULHB - Cardiology); Kathryn Jones (ABM ULHB - Workforce and OD); Kim Clee (ABM ULHB - Workforce); Lesley Jenkins (ABM ULHB - NPT Locality); Linda Bevan (ABM ULHB - Morriston Managed Unit); Lynne Hamilton (ABM ULHB - Finance); Malcolm Thomas (ABM ULHB - Corporate Services); Martin Bevan (ABM ULHB - Neath Port Talbot Locality); Matt John (ABM UHLB - Informatics Directorate); Mike James (ABM ULHB - Corporate Hospital Management); Neil Miles (ABM ULHB - Surgery); Nicola Williams (ABM ULHB - Morriston Unit); Pamela Wenger (ABM ULHB - Corporate Governance); Rebecca Carlton (ABM UHLB - Morriston Hospital); Rhian Thomas (ABM ULHB - Estates); Sandra Husbands (ABM UHLB - Public Health); Sian Harrop-Griffiths (ABM ULHB - Strategy); Silvana Gad (ABM ULHB - Primary & community Services Delivery Un); Susan Bailey (ABM ULHB - Communications); Susan Cooper (ABM ULHB - Bridgend Locality); Tracy Myhill (ABM ULHB - Corporate); Vicky Warner (ABM ULHB - Primary Care, Community Services); Victoria Gibbs (ABM ULHB - Trauma Orthopaedic & Spinal services); Wendy Penrhyn-Jones (ABM ULHB - Administration)

Cc: CatherineH Williams (ABM ULHB - CEO Office); Catrin Evans (ABM ULHB - Strategy); Claire Mulcahy (ABM ULHB - Corporate Services); Clare Dauncey (ABM ULHB - Human Resources); Ebony Smith (ABM ULHB - Corporate Services); Francesca Proietti (ABM ULHB - Informatics Directorate); Jeanie Stevens (ABM ULHB - Executive Medical Directors Department); Kirsty Joseph (ABM ULHB - Finance); Linda Smith (ABM ULHB - Nursing Divison); Lyn Westacott (ABM ULHB - Strategy); Paula Picton (ABM ULHB - Strategy)
Subject: Policies

Dear All

I write to advise that the following policies have been amended slightly and added to the Corporate Policies database:

- Health & Safety Policy
- Raising Concerns – Procedures for Staff

The policies are available to view via the corporate

policy database. Regards,

Llywodraethu Corfforaethol / Corporate Governance

Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg
University Health Board Pencadlys ABM / ABM
Headquarters

1 Talbot Gateway, Baglan, Port Talbot, SA12 7BR

Bwrdd Iechyd Prifysgol ABM yw enw gweithredu Bwrdd Iechyd Lleol
Prifysgol Abertawe Bro Morgannwg /

ABM Health Board is the operational name of Abertawe Bro Morgannwg
University Local Health Board

Appendix 3

Low Voltage Systems Management & Operational Policy

Document Owner:	Assistant Director of Operations (Estates)
Approved By:	
Approval Date:	
Review Date:	August 2021
Policy ID:	To be approved by the H& S Operational Management Group and ratified by the H& S committee

This policy has been screened for relevance to equality. No potential negative impact has been identified so a full equality impact assessment is not required.

Document Author:	Estates Officer		
Owning Committee/Group:	Health & Safety Sub Group – LV Systems		
Policy Classification Type:	Corporate		
Screened for Equality:	Yes	Outcome:	Approved
Circulated for Comments:	24/5/19	Actions:	Completed
Document Number:		Version No:	1

Reviews and Updates		
Version No:	Summary of Amendments:	Date Approved:
1		

Summary

Who this document is aimed at:
This document is aimed at all Estates staff, Managers, Executive Team, Contractors and anyone carrying out electrical work on Swansea Bay University Health Board premises.

Key issues:
To take all reasonable precautions to ensure low voltage systems and equipment are managed correctly for the safety of patients and staff.

Brief summary of document:
To introduce a structured procedure and reporting system for the management and control of low voltage systems and equipment in compliance with current legislation and other guidelines (Health Technical Memoranda (WHTM), Health Building Notes (HBN).

Policy Definition
A policy is a high-level overall guide, which sets the boundaries within which action will take place, and should reflect the philosophy of the organisation or department.

It provides a prescribed plan for staff to follow, which should not be deviated from.

Table of Contents

1. Aims and Objectives

1.1 Swansea Bay University Health Board recognises the importance of electrical safety. This Policy ensures that the statutory and legal requirements associated with low voltage (LV) systems are met, and in particular that the management of such systems complies with The Electricity at Work Regulations 1989 and the guidance in WHTM 06-01 & 02.

2. Policy Statement

2.1 Swansea Bay University Health Board is committed to ensuring that employees, self-employed persons and contractors working within its premises on LV systems, and other persons who may be affected by their work, are not exposed to danger. In particular, the organisation shall ensure that:

- LV supplies are designed, constructed, operated, maintained and tested in such a way as to prevent danger and in a manner that complies with relevant legislation and standards;
- LV systems are protected against hazardous environments;
- Only persons of adequate knowledge, skill and competence are allowed to carry out work on LV systems;
- All work on LV systems is carried out in accordance with safe systems of work;
- All work on LV systems is carried out with the conductors made dead, other than work carried out under a certificate of authorisation for live working or Live Functional Testing self-check safety precautions form (LW1);
- Limitation of Access - Danger areas associated with LV systems (e.g. switchrooms) are secured against unauthorised access;
- Full and accurate records of LV systems are maintained.

2.2 This Policy is intended to complement WHTM 06-02 Electrical Safety Guidance for low voltage (LV) systems

3. Principles

3.1 Swansea Bay University Health Board, through its Chief Executive, will ensure that its duties and responsibilities for the safe management of LV systems are fully met. All work on LV systems will be carried out with the conductors made dead, other than work carried out under a certificate of authorisation for live working or Live Functional Testing self-check safety precautions form (LW1)

4. Scope of Policy

4.1 The general policy for management and operation of LV systems in the NHS Estate is contained in WHTM 06-02, Electrical safety guidance for low voltage systems, but differences between each site/region will require a dedicated Health Board Operational Procedures Manual for those LV Systems.

4.2 This Policy should be read in conjunction with WHTM 06-02. Note that duplication of information from the WHTM to the Policy has been avoided where possible.

4.3 This Operational Policy will apply to the LV systems owned and maintained by Swansea Bay University Health Board. It is designed to ensure safe operation and maintenance of the LV systems.

5. Legislative and NHS Requirements

5.1 The Electricity at Work Regulations 1989 came into force on 1st April 1990. Practical guidance is given in Electricity at Work Regulations HS(R)25, WHTM 06-01 was published in 2017 and WHTM 06-02 was published in 2006.

6. Managerial Responsibilities

6.1 Duty Holder

6.1.1 The Chief Executive of Swansea Bay Health Board who has overall responsibility for ensuring that the premises comply with all statutory requirements, also has an overriding duty of care as the Duty Holder under the Health and Safety at Work etc. Act 1974.

6.2 Designated Person (Chief Operating Officer)

6.2.1 The Designated Person shall be appointed by the Chief Executive to have management responsibility for the implementation of this Policy within the organisation. The Designated Person Shall:

- Appoint in writing an Authorising Engineer (LV) for all systems and installations for which management has responsibility.
- Review the authorising Engineers (LV)'s Appointment annually to ensure their duties have been carried out in accordance with the WHTM 06-02
- Agree any local variations from WHTM 06-02

6.3 Authorising Engineer (AE) (LV)

6.3.1 The Authorising Engineer (LV) shall be Chartered/Incorporated Engineer with required knowledge, training, experience and possess the necessary degree of independence from local management. The Authorising Engineer shall:

- Assess and recommend in writing sufficient Authorised Persons (LV) to provide the necessary cover for all the electrical systems for which management has responsibility.
- Define the extent of the systems for which each Authorised Person/s is responsible.
- Suspend or cancel the appointment of an Authorised Person/s, if deemed necessary.
- Maintain a register of all Authorised Person/s.
- Ensure that Authorised Person/s have the necessary qualifications, training, experience and knowledge of the systems and equipment to carry out the role.

6.4 Authorised Person(s) (AP) (LV)

6.4.1 Swansea Bay University Health Board shall appoint one or more AP's (LV) on the recommendation of the AE (LV), to take responsibility for the site-specific day-to-day operation of LV systems. They must ensure that this Policy is fully complied with by all persons carrying out work on or near LV systems who might be exposed to danger. The Authorised Person Shall:

- Be responsible for the practical implementation of the electrical safety policy.
- Be responsible for the preparation of inspection, maintenance and safety programmes.
- Be responsible for maintaining and updating all relevant system records.
- Have responsibility for the appointment of Competent Person.
- Have responsibility for establishing procedures for switching operations where inherent risks exist for patients, employees and other workers.
- Have responsibility for ensuring that test equipment is maintained in safe working order.
- Have responsibility for the issue and cancellation of safety documents.
- Co-operate with the authorising engineer on safety policy matters.
- Report any dangerous or unusual occurrences to the Designated Person.

6.5 **Competent Persons (CP) (LV)**

6.5.1 The AP (LV) shall appoint one or more CP (LV) with site-specific knowledge to carry out work on its LV systems. Competent Person/s shall:

- Be responsible for undertaking tasks on electrical systems, which have been clearly defined, by agreement in the Authorised Person/s instructions.
- Ensure that all safety measures are taken to avoid injury and prevent danger during the course of any work on the systems.

6.5.2 The AP (LV) (site specific) shall appoint all Contractors staff working on the Electrical LV system. They should be assessed and be of a standard equivalent to what is required by WHTM 06-02, Section 4.45.

6.6 **Accompanying Safety Person (ASP) (LV)**

6.6.1 The AP (LV) shall nominate an ASP (LV) if considered necessary under certain circumstances detailed in WHTM 06-02 Section 4.3, the ASP is to have received training in emergency first aid.

6.7 **Department Managers**

6.7.1 Local management in user departments shall be responsible for the day-to-day safety of portable and transportable electrical equipment, including flexible power cords, extension leads etc.

7. Demarcation

7.1 Whenever there is a division of responsibilities between management and others, the Duty Authorised Person (LV) appointed should issue instructions to other parties, as necessary, to prevent danger.

7.2 Where a specialist contractor has been appointed under contract or other arrangement by management they should be required to comply with:

- Swansea Bay University Health Board Electrical Safety Policy for low voltage.
- The requirements of WHTM 06-02 Electrical safety guidance for low voltage systems.
- Any instructions issued by the appointed Authorised Person (LV).

8. Procedures

8.1 All work on LV systems shall be carried out in accordance with the procedures contained in WHTM 06-02 Electrical Safety Guidance.

8.2 Any work not covered in the LV Policy will have a site specific "Safe System" developed by the relevant authorised person (AP) (LV).

8.3 Switchrooms

8.3.1 All access doors to switch rooms must be kept securely locked when unattended.

8.3.2 Suitable access locks shall be fitted to enable access to be gained to any switch room over which the Authorised Person (LV) has control.

8.3.3 No Person other than an Authorised Person (LV) or competent person (LV) may enter a switch room unless they are accompanied by an Authorised Person (LV) or have receipt of a safety document issued by an Authorised Person (LV)

8.4 Dead Working

8.4.1 All work on LV electrical equipment including conductors should be carried out dead and isolated from all sources of supply and after being proved dead at the point of work.

8.4.2 If electrical equipment and conductors cannot be isolated and proved dead at the point of work, the 'Live Working' guidance should be followed in WHTM 06-02 Section 8.

8.5 Isolation

8.5.1 In achieving Isolation, the following steps should be carried out where reasonably practicable:

- The application of a safety system to prevent the circuit breaker or switch being closed or fuse replaced. Use of special locking devices to allow the use of safety locks is recommended.
- A visible break in air should be obtained (whenever possible)
- A caution sign should be fixed

8.6 Work on or near Live equipment

8.6.1 Work or testing on or near live equipment which involve a Competent Person (LV) includes:

- All forms of testing, fault finding or adjustment where practicalities dictate live working is essential

- The removal and replacement of fuse carriers in final circuits
- The removal and replacement of plug in components
- Basic battery maintenance
- Work on battery systems more than 25V and or 10AH

8.6.2 When work of the type referred in 8.6.1 is carried out:

- The extent of the work should be kept to a minimum
- Approved test equipment to the GS38 standard should be used.
- If equipment is not to IP2X or IPXXB standard Self-Check live working form (LW1) should be completed.
- Removal of components from connections or terminals is not allowed.

8.7 Unsafe Conditions

8.7.1 It is the Health Board's policy that if any person working on LV systems believes that because of an unsafe condition they (or other persons) are exposed to danger, they shall suspend what they are doing, make safe and seek the advice of the Duty AP (LV).

8.8 Service Shutdown Requests

8.8.1 The service shutdown request form should be submitted to the relevant estates department 10 working DAYS prior to the actual date required for the shutdown. The service request shutdown request form is in Appendix C.

8.9 Safety Documents

8.9.1 Permit to Work (Electrical LV)

8.9.1.1 The Authorised Person (LV) shall issue a Permit to Work to Competent Person (LV) as laid out in WHTM 06-02, defining the scope of work, what equipment is dead, isolated and safe to work on. A permit to work should be issued for work:

- On a complex circuit.
- On a main or sub main LV switch board.
- On a cable external to a building.
- On standby generators.
- Whenever the Authorised Person (LV) deems it necessary to ensure a safe system of work.

8.9.2 Certificate of Authorisation for Live Working

8.9.2.1 Under certain circumstances a Certificate of authorisation for Live Working may need to be issued by the AP (LV). Compliance with regulation 14 of the Electricity at Work Regulations is essential in these

cases. Consultation with the Authorising Engineer should take place (except for work on batteries). The safety precautions and procedures in WHTM 06-02 Section 8 outlines the correct safety procedures. The LW1 form shall be completed by a competent person (CP) (LV) prior to such work as live functional testing where no fixed components are to be removed or replaced.

8.9.3 **Limitation of Access**

8.9.3.1 The AP (LV) shall issue a Limitation-of-Access safety document to a person in charge of work to be carried out in an area or location which is under the control of an Authorised Person (LV) and for which a permit-to-work (LV) is not appropriate.

9. Operational Records

9.1 For each site for which an Authorised person (LV) have been appointed records are to be kept. These records should be accurate and up-to-date

9.2 **LV Logbook**

9.2.1 The book is to be clearly and indelibly marked with the name of the site, the location, and the system or installation to which it refers, and is to be kept in the lockable document cabinet when not in use.

9.2.2 Entries are to be made in chronological order, each entry being ruled off with a horizontal line across the page. Entries are to show:

- The acceptance and relinquishing of responsibility between Authorised Persons (LV).
- The removal, return and transfer of the Authorised Person (LV)'s key from the Authorised Person (LV)'s key box.
- The issue and return of any switchroom key.
- The issue, cancellation, loss or withdrawal of a safety document.
- The receipt, termination and remedial action associated with an operational restriction.
- The issue of a safety guidance handbook.
- The annual inspection of protective equipment, test equipment and the six-monthly inspection of portable earthing equipment.

9.2.3 Completely filled logbooks are to be retained for a period of 3 years after the date of the last entry.

9.3 **Operational Procedure Manual**

9.3.1 For each site for which AP (LV)'s have been appointed, a ring binder file entitled "Operational Procedure Manual" is to be maintained.

9.3.2 The binder is to be clearly and indelibly marked with the name of the site, location, systems or installations to which it refers, and is to be kept in the lockable document cabinet when not in use.

9.3.3 The manual is to contain, in separate sections, a copy of each of the following:

- Certificate of appointments issued to AP (LV), CP (LV), contractors CP (LV) – a register of AP (LV) and CP (LV), including details and dates of training, issue dates and review dates of certificates.
- Any operational restrictions received.
- Inspection report and details of any remedial work undertaken in connection with an operational restriction.
- Cancelled operational restrictions.
- Demarcation agreement with other organisations.
- Demarcation agreement with contractors.
- Any operational agreements with the distribution network operator.
- The original copy of completed safety programmes together with isolation and earthing diagrams, including any completed and subsequently not used.
- Details of protective equipment, test equipment and portable earthing equipment kept within the establishment, including specifications, operators or users instructions, maintenance instructions and where appropriate calibration records.
- A copy of audits carried out in accordance with WHTM 06-02.

9.3.4 Documents in the manual are to be retained for a period of three years after the date of their cancellation or termination.

9.4 Operating and Maintenance manuals

9.4.1 For each geographical area for which Authorised Persons (LV) have been appointed, one or more ring-binder files entitled "Operating and Maintenance manual" is to be prepared and/or provided by Capital Planning as part of a Capital Scheme.

9.4.2 The ring-binder is to contain:

- Manufacturers' maintenance and operating instructions for each type of low voltage distribution switchgear installed in the system or installation, with test certificates and relevant records.
- A copy of any current operational restriction applicable to any equipment installed in the system or installation.
- A copy of the current "as-installed" drawings of the system(s).

9.4.3 The manuals shall be revised to take account of any modifications to the system.

9.4.4 Accurate schematic circuit diagrams shall be maintained of the entire low voltage distribution systems.

9.5 Maintenance, testing and records

9.5.1 Fixed Electrical Testing and surveys shall be carried out for all health boards Premises not less than once every five years in line with the Electricity at Work Regulations and BS7671 Requirements for Electrical Installations.

9.5.2 Appropriate remedial action shall be taken to correct any faults discovered.

9.5.3 Inspection and test records shall be retained for a period of ten years.

10. Training

10.1 Training is an essential element of safe work practices and all staff must be appropriate trained, prior to being appointed or instructed to undertake duties under the safety procedures.

10.2 The training of an individual, which can be by formal education and by on-the-job tuition, as appropriate, is to be assessed for suitability by the person responsible for the appointment of the individual to a particular duty.

10.3 Examination of each person's training record is to be included in the procedures review process and where necessary, periodic retraining is to be arranged to cover the technical aspects, electrical safety and first aid matters as appropriate for each individual's duties.

10.4 Records of all training activities are to be held in the operational procedures manual for each particular system. This will include the records of each individual who has received the necessary training appropriate to the duties to be undertaken.

11. Contractors

11.1 Swansea Bay University Health Board shall use only approved, technically vetted contractors for work involving LV systems; this will be part of the tendering procedure for awarding contracts to contractors.

11.2 The Authorised Person (LV) should be given confirmation that checks have been made to determine the satisfactory technical and safety

competence of the Contractor by taking into account. such considerations as:-

- Company safety policy.
- Company accident record.
- Qualifications and training of employees.
- Adequate insurance.
- Adequate physical resources (tools, safety equipment etc.).
- Quality assurance checks during the progress of work on site.

11.3 Swansea Bay University Health Board shall be provided with a risk assessment and method statement prior to any work involving contractors and ensure that risks are either eliminated or reduced to the lowest level reasonably practicable by suitable control measures.

11.4 There shall be a requirement in every contract that contractors comply with the Swansea Bay University Health Board's LV policy, WHTM 06-02 and that they obey any instruction from the relevant AP (LV) relating to LV work.

11.5 All Contractors staff working on the health boards electrical systems shall be assessed competent by the relevant AP(LV), (WHTM 06-02 Section 4.45-4.50)

11.6 Contractors shall be monitored whilst on site by the Swansea Bay University Health Board's Capital Departments Project Manager or the Estates Departments Operational Supervising AP (LV)

11.7 **No installation shall be accepted from a contractor by the site AP (LV) until satisfactory test certificates, as-installed drawings, schematic drawings and other relevant information have been received.**

12. Review, Monitoring and Audit Arrangements

12.1 The appointed Authorising Engineer (AE) (LV) shall be required to conduct a formal audit of the LV System Management Policy and operational procedures annually.

12.2 Any deviations from procedures and rules discovered during audit shall be documented and appropriate corrective action taken. Compliance with the Policy will be subject to continual monitoring.

13. Retention or Archiving

13.1 In line with Swansea Bay University Health Board's policy on records, all engineering/building drawings and permits will be kept for the

lifetime of the premises. PPM's relating to the premises will be kept for 3 years. All other records will be retained in line with the relevant department requirements, if not dictated by the Swansea Bay University Health Board's Policy.

14. Equality Impact Assessment Statement

14.1 This Policy has been subject to a full equality assessment and no impact has been identified.

15. References

Electricity at Work Regulations 1989;
Electricity Safety, Quality and Continuity Regulations 2002;
Low Voltage Electricity Equipment (Safety) Regulations 1988;
BS 7671 Requirement for Electrical Installations;
WHTM 06-01 Electrical Services Supply and Distribution
WHTM 06-02 Electrical Safety Guidance for low voltage systems;

APPENDIX A - Definitions

The following definitions apply throughout this document and Appendices:

Designated Person
The Designated Person is an individual appointed by a healthcare 0rganisation (a board member or a person with responsibilities to the board) who has overall authority and responsibility for the low voltage electricity system within the premises and who has a duty under the Health and Safety at Work etc. Act 1974 to prepare and issue a general policy statement on health and safety at work, including the organisation and arrangements for carrying out that policy. This person should not be the Authorising Engineer (LV).

Duty Holder
The Duty Holder is a person on whom the Electricity at Work Regulations 1989 impose a duty in connection with safety.

Management
Management is defined as the owner, occupier, employer, general manager, chief executive or other person in a healthcare organisation, or their appointed responsible contractor, who is accountable for the premises and who is responsible for issuing or implementing a general policy statement under the Health and Safety at Work etc. Act 1974.

Authorising Engineer (LV)
An Authorising Engineer (LV) is appointed in writing by the Designated Person to take responsibility for the effective management of the safety guidance (LV). The person appointed should possess the necessary degree of independence from local management to take action within the guidance of WHTM 06-02.

Co-ordinating Authorised Person (AP) (LV): An individual possessing significant technical knowledge and having received appropriate training, appointed in writing by the AE (LV) to be responsible for overseeing the practical implementation and operation of management's safety policy and procedures on defined electrical systems.

Authorised Person (LV)
An Authorised Person (LV) is appointed in writing by the management on the recommendation of the Authorising Engineer (LV) in accordance with WHTM 06-02 the Electrical safety guidance (LV) and is responsible for the implementation and operation of WHTM 06-02 with regard to work on, or the testing of, defined electrical equipment.

Competent Person (LV)
A Competent Person (LV) is approved and appointed in writing by an Authorised Person (LV) for defined work, possessing the necessary technical

knowledge, skill and experience relevant to the nature of the work to be undertaken, who is able to prevent danger or, where appropriate, injury, and who is able to accept a permit-to-work from an Authorised Person (LV).

Accompanying Safety Person (LV)
An Accompanying Safety Person is a person not involved in the work or test who has received training in emergency first-aid for electric shock and who has adequate knowledge, experience and the ability to avoid danger, keep watch, prevent interruption, apply first-aid and summon help.
The person is to be familiar with the system or installation being worked on or tested, and is to have been instructed on the action to be taken to safely rescue a person in the event of an accident.

Employer: Any person or body whom:
(a) Employs one or more individual under a contract of employment or apprenticeship;

(b) Provides training under the schemes to which the Health and Safety (Training for Employment) Regulations 1988 (Statutory Instrument No. 1988/1222) apply.

Northern Ireland: Health and Safety (Training for Employment) Regulations 1990, Statutory Instrument No. 1990/1380.

General

Charged: When the electrical equipment has acquired a charge either because it is "live" or has retained/regained a charge even though it may be disconnected from the rest of the system.

Complex circuit: a circuit which is normally operated at low voltage and which requires more than one point-of isolation from known voltage sources to ensure safety at the point-of-work

Conductor: A conductor of electrical energy.

Circuit Conductor: Any conductor in a system, which is intended to carry electrical current in normal conditions, but does not include a conductor provided solely to perform a protective function by connection to earth or other reference point.

Connected Equipment: Equipment connected into the low voltage system utilising electrical power to perform its dedicated function.

Danger: A risk of injury or death.

Dangerous Condition: A condition that is likely to lead to a dangerous occurrence.

Dangerous Occurrence: an incident involving a source of electrical energy which may be dangerous to any person, whether or not an accident has occurred.

Dead: a conductor that is neither "live" nor "charged".

Department: An abbreviation of the generic term "UK Health Departments" (Department of Health, The Scottish Office, The Welsh Office and The Department of Health and Social Services Northern Ireland).

Earthed: connected to the general mass of earth in such a manner as will ensure at all times an immediate discharge of electrical energy without danger.

Electrical Equipment: Includes anything used, intended to be used for installed for use to generate, provide, transmit, transform, conduct, distribute, control measure or use electrical energy.

Equipment: Abbreviation of "electrical equipment".

Injury: death or personal injury from electric shock, electric burn, electrical explosion or arcing, or from fire or explosion initiated by electrical energy, where any such death or injury is associated with the generation, provision, transmission, transformation, rectification, conversion, conduction, distribution, control, measurement or use of electrical energy.

Isolate: disconnect and separate electrical equipment from every source of electrical energy in such a way that this disconnection and separation is secure.

Isolating Device: This is a purpose-designed item of equipment. This equipment provides a secure method of disconnecting and separating electrical equipment and/or circuit conductors from every source of electrical energy.

Live: implies connection to a source of electricity.

Live functional testing: the testing of electrical equipment while live which does not involve live working.

Live working: the connection/disconnection of electrical equipment while live.

LV logbook: a book in which all matters relating to the electrical system should be recorded.

Operational procedure manual: a ring-binder containing information relating to the control and operation of the low voltage system.

Operational restriction: a written safety instruction, issued via the Authorising Engineer (LV), modifying or prohibiting the normal operating procedures associated with a particular make and type of equipment.

Safety signs

Caution sign
This is a temporary, non-metallic sign bearing the words "caution – persons working on equipment" and "do not touch" which is to be used at a point of-isolation.

Danger sign
This sign is a temporary, non-metallic sign bearing the words "danger live equipment" and "do not touch" which is to be used where there is adjacent live equipment at the place of work.

Switchroom sign
This is a permanent, non-metallic sign bearing the words "electrical switchroom" "no unauthorised access".

Safety Documents: One of the following:

Limitation-of-access
This is a safety document, which is a form of declaration, signed and issued by an Authorised Person (LV) to a person in charge of work to be carried out in an area or location which is under the control of an Authorised Person (LV) and for which a permit-to-work (LV) is not appropriate.

Permit-to-work (electrical LV)
This is a safety document, which is a form of declaration, signed and issued by an Authorised Person (LV) to a Competent Person (LV) in charge of work to be carried out. It defines the scope of the work to be undertaken and makes known exactly what equipment is dead, isolated from all live circuit conductors and safe to work **(Also see flow charts 1 and 2 in Appendix D)**

Certificate of authorisation for live working
This is a safety document, which is a form of declaration, signed and issued by an Authorised Person (LV) to the Competent Person (LV) in charge of the work to be carried out live. It makes known to that person exactly what equipment should be worked on, with details of the work to be undertaken live, what safety equipment is to be used, and the safety precautions to be taken.

Supervision -

(a) **Immediate Supervision**: Supervision by a person (having adequate technical knowledge, experience and competence) who is continuously available at the location where work or testing is in progress and who attends the work area as is necessary for the safe performance of the work or testing;

(b) **Personal Supervision**: Supervision by a person (having adequate technical knowledge, experience and competence) such that they are at all

times, during the course of the work or testing, in the presence of the person being supervised.

Switchroom: a room or enclosure designated by an Authorised Person (LV) which contains low voltage distribution switchgear that can be operated without the use of a tool or key.

System: an electrical system in which all the equipment is, or may be, connected to a common source of electrical energy, including the source and its associated equipment.

Voltage range
The ranges of voltage are defined as follows:

extra low voltage: a potential not exceeding 50 V ac or 120 V ripple-free dc whether between conductors or to earth;

low voltage (LV): a potential not exceeding 1000 V ac or 1500 V dc between conductors, or 600 V ac or 900 V dc between a conductor and earth;

high voltage (HV): a potential normally exceeding low voltage.

Definition of "shall"
Where "shall" is used in these rules with no qualification, this indicates a mandatory requirement with no discretion permitted and no judgement to be made.

Definition of "reasonably practicable"
Where a statement is qualified by the words "reasonably practicable" a slightly less strict standard is imposed. It means that an assessment must be made considering, on the one hand, the magnitude of the risks of a particular work activity or environment, and on the other hand the cost in terms of the physical difficulty, time, trouble and expense which would be involved in taking steps to eliminate or minimise those risks. The greater the degree of risk, the less weight that can be given to the cost of measures needed to prevent that risk.

APPENDIX B - Further Guidance

Further guidance may be found in the following publications:

REF	TITLE	BODY
A	Health Technical Memorandum 06-02 Electrical Safety Guidance for low voltage systems	NHS Estates
B	Health Technical Memorandum 06-01 Electrical services supply and distribution	NHS Estates
C	Health Building Note 00-07 Resilience Strategy for Health Care Estate	NHS Estates
D	Code of Practice for the Inspection and Testing of Portable equipment	Institute of Engineering and Technology
E	18th Wiring Regulations BS 7671 2018	Institute of Engineering and Technology
F	A Guide to Electricity at Work Regulations	Health & Safety Executive
G	Electricity at Work Regulations	Health & Safety Executive

APPENDIX C - Form LW1

All sections must be read and completed before proceeding, in conjunction with **flow chart 4 in Appendix D**.

Live Functional testing – Self check safety precautions

Note: This is not a certificate of authorisation for live working. No fixed components are to be removed or replaced.

Department: _____ Location: _____

Task: _____

		Tick	Delete as appropriate
1.	Is live working necessary? Reason (please tick): Disruption of services Fault diagnosis not practical dead Contradiction of other statutory regulations Other (please state)		YES / NO ❑ ❑ ❑ ❑
2.	Have unnecessary personnel been removed from work area?		YES / NO /NA
3.	Are you a competent person who is authorised for LIVE LV WORKING?		YES / NO
4.	Can you control the work area to achieve safe working?		YES / NO
5.	Do you have all the information required to do the work?		YES / NO
6.	Are you using the correct equipment? (please tick) Rubber gloves / eye protection Insulated tools Rubber mats Test gear / probes (fused) Screens / barriers Suitable clothing to wrist		YES / NO ❑ ❑ ❑ ❑ ❑ ❑
7.	Is the above equipment legal, dated, certified, calibrated as appropriate?		YES / NO
	Note: if you have answered NO to any of the above questions, **LIVE WORKING CANNOT TAKE PLACE**		
8.	Are assistants required for the following: (if YES, tick appropriate reason) Isolation purposes only? Assisting actual work? Controlling work areas? Monitoring remote area?		YES / NO ❑ ❑ ❑ ❑
9.	Are assistants aware of points of isolation?		YES / NO
10.	Are your assistants competent / trained in First Aid?		YES / NO

I have carried out the above checks and am satisfied that it is safe to proceed

Signed _____ **Date** _____ **Time** _____

Note: If your tests indicate that a component needs to be removed or replaced, this may only be done live following the issue of a CERTIFICATE OF AUTHORISATION FOR LIVE WORKING by an authorised person. The management policy is that such work will normally be done with equipment etc. DEAD and ISOLATED.

APPENDIX D - Service Shutdown Request Form

PLEASE RETURN COMPLETED FORMS TO YOUR SUPERVISOR

SWANSEA BAY UNIVERSITY HEALTH BOARD

ESTATES DEPARTMENT

Service Shutdown Request

Date: / /20 **Request No:**

This form is to be submitted to the Estates Operational Services where a shutdown of services is required. Notice is required **10 working days** before the time of the requested shutdown.

Part A – Contractor to complete.

Site Address:	
Description of Works:	**Job No:**
Contractor:	
Description of Service Shutdown Required:	
Requirement Date: **Isolation for Contract Works Period 6 weeks**	**Start Time:** **Finish Time:**
Contractors Representative Making Request – Signed:	**Date: / /20**

Part B - Estates Officer – Technical to complete

Date request received:		
Description of arrangements made to meet the request:		
Request: APPROVED / NOT APPROVED		
Additional requirements / restrictions:		
Signed:	**Dated: / /20**	**Date Returned to Contractor:**

Part C – Reinstatement

Systems tested □ Safety devices removed □ Warning notices removed □ (✓on completion)
I certify that the above system has been tested and brought back into service: **Work Carried Out By:** **Position within Health Board:** **Signed:** **Date: / /20**

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Medical Gas Pipeline System (MGPS) Management Policy

DRAFT – APRIL 2019

Document Owner:	Assistant Director of Operations (Estates)
Approved By:	Health & Safety Operational Group
Approval Date:	
Review Date:	3 years from date of approval
Policy ID:	

This policy has been screened for relevance to equality. No potential negative impact has been identified so a full equality impact assessment is not required.

Document Author:	Estates Department		
Owning Committee / Group:	Health & Safety Sub Group - MGPS		
Policy Classification Type:	Corporate		
Screened for Equality:	Yes	Outcome:	No issues
Circulated for Comments:	Yes	Actions:	Completed
Document Number:		Version No:	V4

Reviews and Updates		
Version No:	Summary of Amendments:	Date Approved:
1		

Contents

1.0 Policy Statement

Bwrdd Iechyd Prifysgol Bae Abertawe/Swansea Bay University Health Board, recognises its responsibility to implement in full, the safe management of the medical gases in accordance with the statutory requirements, the Health and Safety at Work etc. Act 1974, supporting legislation and all Welsh Health Technical Memoranda and relevant NHS guidance relating to the Management of Medical Gas Pipeline Systems (MGPS).

This policy addresses the provision of a Medical Gas Pipeline Systems (MGPS) at Bwrdd Iechyd Prifysgol Bae Abertawe/Swansea Bay University Health Board properties.

The Medical Gas Pipeline System (MGPS) provides a safe, convenient and cost-effective supply of medical gases to points where these gases can be used by clinical and nursing staff for patient care.

Bwrdd Iechyd Prifysgol Bae Abertawe/Swansea Bay University Health Board recognises its commitment to maintaining the MGPS to required standards and the training of all personnel associated with its operation.

It is the Health Board's policy that before work on the MGPS can commence, a Permit to Work form, signed by an Authorised Person (MGPS) MUST be completed.

2.0 Scope of Policy

This Policy is intended for use by all staff involved with Medical Gas Pipeline Systems (MGPS) at Bwrdd Iechyd Prifysgol Bae Abertawe/Swansea Bay University Health Board, herein after referred to as SBUHB.

This Policy applies throughout the SBUHB, to all fixed Medical Gas Pipeline Systems (MGPS) and to the use and management of cylinders associated with the MGPS only, and related equipment as defined in Welsh Health Technical Memorandum WHTM 02-01. It does not apply to the use of small portable cylinders used, for example, during the transportation of patients.

Any compressed gas and vacuum supplies to general engineering workshops are separate from the general MGPS and are NOT included in this policy, although the general principles of safety in this document should be applied to all compressed gas and vacuum systems.

Cylinder gases and their management are excluded from the policy.

MGPS terminal units define the limits of Estates' responsibility in this policy.

General cylinder management is the responsibility of the Facilities department – please refer to document
'Policy for the Supply, Storage and Security of Medical Gases'

Equipment connected to the terminal units is NOT covered by this policy, other than where its mode of use may affect system operation or safety.

Medical equipment is the responsibility of the Medical Equipment Management Services Department (MEMS) (Previously known as EBME).

Medical gases should not be used for non-medical purposes, other than as a test gas for medical equipment.

The operational management responsibility for the MGPS on Health Board sites resides with the Estates department, each Estates department shall have an Estates Authorised Person(s) with responsibility for the site, specific information detailed in a separate procedure document that supplements this policy.

3.0 The importance of a Managed Approach to Medical Gases

This policy is compliant with Health Technical Memorandum (HTM 02-01) and looks at the issues of operational management. The policy covers such issues as statutory requirements, functional responsibilities, operational procedures, training and communication, general safety, maintenance and risk assessment. This policy is intended for use by all staff, including Operational Managers, Engineers, Quality Controllers, and External Contractor staff involved in the day to day running of a Medical Gas Pipeline system (MGPS).

The primary objective of this policy is to ensure the provision of safe and reliable MGPS and their efficient operations and use. The objective will only be achieved if the Medical and Nursing users and Estates staff participate in the introduction of this policy designed to minimise the hazards likely to arise from misuse of the system

According to HTM 02-01 and ISO 9170-1:2017 'Terminal units for use with compressed medical gases and vacuum', all hospitals should at least have:
Effective system designs covering the capacity and capability of piped medical gases, including alarm systems and the siting of back-up systems.

Defined functional responsibilities requiring the nomination of an Authorised Person; Competent Person, Quality Controller and Designated Medical / Nursing Officer.

A hospital wide medical gases operational policy based on comprehensive risk assessment and training carried out for clinical and non-clinical staff.

4.0 Aim

The aim of this Policy is to ensure a structured procedure and reporting process, for the management and control of the SBUHB's Medical Gas infrastructure, in order to satisfy current legislation and guidance, such as Health Technical Memorandum HTM 02-01 Medical Gas Pipeline Systems – Operational Management and other relevant Health Building Notes (HBN's). This will involve the continued implementation and communication of a multi-disciplinary group to be known as the Health and Safety Sub Group - MGPS and all relevant participating stakeholders.

To achieve the aim of this Policy and as required by HTM 02-01, SBUHB will undertake to:

- Ensure appropriate management protocols and arrangements in place
- Make appointments for responsibility such as Authorised Persons (AP's) and Competent Persons (CP's).
- Identify and assess sources of risk through effective management arrangements.
- Remove sources of risk whenever possible and only manage risk appropriately if it becomes the only option.
- Prepare appropriate written maintenance documentation for managing the medical infrastructure for minimising risk.
- Train staff to understand the risks and how to fulfil their roles and responsibilities as appropriate.
- Only use service providers that can demonstrate capability and competence.
- Maintain records in accordance with guidance of all; maintenance, training, policies, associated procedures, risk assessments and monitoring and testing.
- Regularly review performance and provide information to promote continued diligence on compliance.
- To ensure the provision of safe systems of work for patients, staff and public by defining training requirements and operating to a standardised Permit to Work system.
- To ensure that all SBUHB employees understand their specific roles and responsibilities with regard to medical gases.

- To ensure best practice is observed in the provision of medical gas services to the patient.

5.0 Objectives

The objectives of this Policy are to implement appropriate arrangements and management protocols, in order to ensure that SBUHB's medical gas pipeline system infrastructure remains safe and fully functioning for the use of patient services.

6.0 Legislation

It is the Health Board's policy to fully comply with statutory requirements with respect to Health and Safety. Although this is not intended to cover all relevant legislation and codes of practice, the following elements should be considered as a minimum when dealing with MGPS:

6.1 Statutory Requirements – Medical Gas Pipeline Systems

- Health and Safety at Work Act 1974
- Management of Health and Safety at Work Regulations
- Work Place (Health, Safety and Welfare) Regulations
- Provision of Use of Work Equipment Regulations
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
- Control of Substances Hazardous to Health (COSHH) Regulations
- Pressure Equipment Regulations
- Pressure Systems Safety regulations
- Highly Flammable Liquid and Liquid Petroleum Gas Regulations
- Medicines Act, 1968
- Human Medicines Regulations 2012
- Manual Handling Operation Regulations
- Personal Protective Equipment at Work Regulations
- Electromagnetic Compatibility Regulations
- Electricity at Work regulations

6.2 Specific Guidance Relevant to Medical Gas Pipeline Systems

- Health Technical Memorandum (HTM) 02-01 "Medical Gas Pipeline Systems"
  Part A, Design, Installation, Validation and Verification
  Part B, Operational Management

- Health Technical Memorandum (HTM) 2022
  Supplement 1 "Dental Compressed Air and Vacuum Systems" 2003

- European Pharmacopoeia Standards for medical gases, including medical compressed air

- ISO 9170-1:2017

7.0 Relationship with Other Policies

This Policy should not be considered in isolation. The following Policies should also be taken into account, together with adherence to local procedures:

- Health and Safety
- Asbestos Policy
- Fire Safety Policy
- Infection Control
- Manual Handling
- Policy for the Supply, Storage and Security of Medical Gases
- Prescription and Administration of Emergency Oxygen in Adults

8.0 Responsibilities

Responsibility for the effective implementation of this Policy principally resides with a number of staff as referred to in the management hierarchy diagram within this Policy.

The responsibilities detailed by job title or role in this section are to be made specific to each site by the Authorised Person(s) for that site. This will be detailed in the site specific procedural document that supplements this policy.

8.1 Chief Executive

The CEO has ultimate management responsibility for MGPS rests with the Health Board's Chief Executive.

The Health Board's Chief Executive is responsible for ensuring that an Authorising Engineer (AE) is appointed for MGPS. This will be fulfilled by NHS Wales Shared Services Partnership – Specialist Estate Services (NWSSP-SES).

Authority to execute this function and any subsequent appointments detailed in this Policy as a Chief Executive function, has been delegated, in writing, to the Chief Operating Officer.

8.2 Chief Operating Officer – Designated Person (DP)

A Board level director responsible for Estates and Facilities Services (Chief Operating Officer) is assigned as the Designated Person (DP) with responsibilities for Medical Gas as defined under HTM 02-01 Part B, and is therefore responsible for ensuring that an appropriate Estates structure has been formulated to professionally support and deliver the requirements of this Policy. Furthermore, is required to communicate all relevant issues to the Board that may impact on the delivery and effectiveness of this Policy.

The appointed deputy, Chief Operating Officer (COO), will appoint in writing all AP's (MGPS) after recommendation by the AE. The Chief Operating Officer will also appoint

in writing, one or more Quality Controllers (QC) (MGPS) on the recommendation of the Pharmacy Acute Site Manager.

The COO has delegated specific responsibilities as follows:

- The AP's at each acute site are responsible for the day to day management of the MGPS and implementation of this Policy.
- The Pharmacy Acute Site Manager has responsibility for the pharmaceutical quality control management

8.3 Authorising Engineer (AE)

The duties and responsibilities of the Authorising Engineer are:

9.3.1 To recommend to the DP those persons who, through individual assessment, are suitable to be Authorised Persons (MGPS);

9.3.2. To ensure that all Authorised Persons (MGPS) have satisfactorily completed an appropriate training course;

9.3.3 To ensure that all Authorised Persons (MGPS) are re-assessed every three years and have attended a refresher or other training course prior to such re-assessment;

9.3.4 To review the management systems of the MGPS, including the Permit to Work System;

9.3.5 To monitor the implementation of the management policy and operational procedures.

9.3.6 Provide independent advice to the Health Board, with regards to the MGPS

8.4 Authorised Person (AP) (MGPS)

The Authorised Person(s) (AP) (MGPS) are identified within the specific site procedure document. The Authorised Persons (MGPS) assume effective responsibility for the day-to-day management and maintenance of the MGPS.

The duties and responsibilities of Authorised Persons (MGPS) are:

8.4.1 To ensure that the MGPS is operated safely and efficiently in accordance with the statutory requirements and guidelines.

8.4.2 To manage the Permit to Work System, including the issuing of Permits to Competent Persons (MGPS) for all servicing, repair, alteration and extension work carried out on the existing MGPS;

8.4.3 To supervise the work carried out by Competent Persons (MGPS) and for the standard of that work. A Register of Competent persons (MGPS) is held within the site specific procedure that supplements this policy.

8.4.4 To ensure that the Health Board MGPS maintenance specification, schedule of equipment (including all plant, manifolds, pipe work, valves, terminal units and alarm systems) and associated paperwork are kept up to date;

8.4.5 To liaise closely with Designated Nursing / Medical Officers, the Quality Controller (MGPS) and others, who need to be informed of any interruption, alteration and testing of the MGPS.

8.4.6 To provide technical advice to those responsible for the purchase of any medical equipment which will be connected to the MGPS, in order to avoid insufficient capacity and inadequate flow rates;

8.4.7 To provide advice on the provision and or replacement of MGPS central plant and associated systems. The Estates department will hold overall responsibility for the provision and maintenance of MGPS services within the Health Board;

8.4.8 To organise such training of Estates staff and / or transfer of MGPS information, as is needed for the efficient and safe operation of the MGPS;

8.4.9 To advise the Health Board on any other training requirements, outside the Estates department.

8.4.10 Assess & appoint CP's.

8.4.11 Manage and amend drawings as necessary.

8.5 Competent Persons (MGPS)

Competent Persons (MGPS) directly employed or contracted by SBUHB and are listed in the site specific procedure that supplements this policy.

All Competent Persons (MGPS) shall be registered to BS EN ISO 9001 / BS EN ISO 13485, with clearly defined registration criteria.

The Duties and Responsibilities of Competent Persons (MGPS) are:

8.5.1 To carry out work on the MGPS in accordance with the Health Board maintenance specification;

8.5.2 To carry out repair, alteration or extension work, as directed by an Authorised Person (MGPS) in accordance with the Permit to Work System and HTM 02-01 (2006);

8.5.3 To perform engineering tests appropriate to all work carried out and inform the Authorised Person (MGPS) of all test results.

8.5.4 To carry out system integrity tests under direct supervision of the Authorised Person.

8.5.5 To carry out all work in accordance with the SBUHB Health & Safety Policy.

8.6 Pharmacy Acute Site Manager

The Pharmacy department will be responsible for the following:

8.6.1 To organise MGPS training of Pharmacy staff who may deputise for the QC (MGPS);

8.6.2 Receive delivery notes for compressed gas cylinders, check against invoices received and pass invoices for payment;

8.6.3 Order and supply cylinders of medical gases and special gas mixtures for the hospital;

8.6.4 Maintain a record of cylinder rental charges and pass rental invoices for payment;

8.6.5 Ensure that cylinders comply with Ph Eur requirements;

8.6.6 Ensure that other gases and gas mixtures comply with manufacturers' product licences.

8.7 Quality Controller (MGPS)

It is the responsibility of the Chief Executive or the designated Executive Director to appoint, in writing, on the recommendation of the Chief Pharmacist, a Quality Control Pharmacist with the MGPS responsibilities who will also be appointed to the Quality Controller (QC) (MGPS) register.

The Authorised Person (MGPS) will be responsible for liaising with the QC (MGPS) to ensure effective communication on all relevant matters.

The Duties and Responsibilities of the QC (MGPS) are:

8.7.1 To assume responsibility for the quality control of the medical gases at the terminal units, i.e. the wall or pendant medical gas outlets;

8.7.2 To liaise with the Authorised Person (MGPS) in carrying out specific quality and identity tests on the MGPS in accordance with the Permit to Work System and relevant Pharmacopoeia Standards;

8.7.3 They should have received training on the verification and validation of MGPS and be familiar with the requirements of this MGPS Management Policy;

8.7.4 The Quality Controller (MGPS) will accept the professional responsibility for the last independent check of an MGPS that, if faulty, could cause clinical consequences to patients.

8.7.5 Quarterly testing of SA/MA plants

8.8 Designated Medical / Nursing Officer (DMO)

The Designated Medical / Nursing Officer in charge, is the person, on each site, with whom the Authorised Person (MGPS) liaises on any matters, affecting the MGPS and who should give permission for a planned interruption to supply. These persons must have received training on MGPS relevant to their departments and on the action to be taken in the event of an emergency.

The Duties and Responsibilities of the Designated Medical / Nursing Officer (DMO) are:

8.8.1 To give permission for any interruption to the MGPS and should sign the appropriate part of the permit. However, in certain circumstances such permission may be given by the senior clinician in charge;

8.8.2 To ensure that all relevant staff are aware of the interruption to the MGPS and which terminal units cannot be used

8.8.3 For the purposes of MGPS work at ward level, have jurisdiction over all MGPS work, in their area of responsibility. This will include all planned and emergency local work.

8.8.4 In the event of a planned interruption involving more than one department, e.g. for a major shutdown, formal approval of the DNO/DMO is required after making necessary consultation.

8.8.5 A DMO or DNO (MGPS) will, outside normal working hours, sign emergency Permits-to-Work for local work only.

8.8.6 Isolation of piped medical gas at emergency valves in the event of serious and imminent danger, such as fire.

8.8.7 Training of the DMO or DNO (MGPS) in operational safety aspects of the MGPS should take place on a regular basis (as detailed in the HTM). This training should be organised by the Medical Device Training Department and may involve liaison with the Authorised Person (MGPS) and the head of Medical Equipment Management Services (MEMS).

8.10 The Estates Manager

The Estates Manager is responsible for the interrogating and collating the reports and audits from the AE and others, ensuring the site based APs address any actions / recommendations in a timely manner, and will coordinate a response on behalf of the Health and Safety Sub Group – MGPS.

8.11 Appointed Contractors

Contractors employed to work on the MGPS for SBUHB must be registered to BS ISO 9001 / BS ISO 13485, with the scope of registration defined as design, installation, commissioning and maintenance of the MGPS.

All contracted staff must comply with the requirements of HTM 02-01.

It is essential to ensure that individuals employed are suitably qualified to undertake work on the MGPS, these check should be undertaken as part of the procurement of contractor's process.

8.12 Assistant Director of Strategy (Capital)

The Assistant Director of Strategy (Capital) must ensure that appointed designers and installers of MGPS utilise only approved materials in accordance with published British Standards (BS) as described in HTM 02-01

Collectively, they must consult with the appointed AE as well as the AP (MGPS) on all schemes where alterations are made to the MGPS infrastructure.
The appointed AE will provide input and advice to the design process in respect to the construction phase and for the subsequent operational service thereafter.

- Ensure an effective handover process is in place
- Provide the Estates Maintenance department with O & M manuals
- Ensure that liaison with the AP (MGPS) before, during and at handover stages of all schemes.
- Amend drawings as necessary

8.13 Health and Safety Sub Group - MGPS

The Health and Safety Sub Group – MGPS shall report any medical gas pipeline system compliance discrepancies to the Operational Health and Safety Management Group and / or the Health and Safety Committee to ensure effective communication is maintained, the Health and Safety Sub Group – MGPS should meet quarterly or as required by circumstance and include the following individuals:

- Assistant Director of Operations (Estates) – (Chair)
- Estate Managers
- Quality Controller (QC MGPS)
- The nominated AP's (MGPS)
- Head of Nursing or nominated representative
- Assistant Director of Planning (Capital) or nominated representative
- Head of Support Services
- Health and Safety Manager
- Appointed Authorising Engineer
- Head of MEMS

Other signatories or advisors to this document shall also be invited to join the group when appropriate.

The purposed of this group shall be to determine, communicate and monitor the MGPS Policy to enable the effective management of MGPS activities. This will include but not be limited to:

Strategy

- Operational procedure development, distribution and review
- Medical gas safety reports
- Review of systems compliance
- Risk register, arising from compliance
- Medical Gas Training Programme
- MGPS upgrade projects (to comply with strategy)
- Audit – progress against recommendations

Operational

- Planned shutdowns
- Equipment selection
- Emergency actions
- Audit – progress against recommendations
- DATIX – Incidents
- Alerts (Patient Safety or estates and Facilities)
- Integrity of Storage Facilities

8.13 MGPS Management Hierarchy.

Please refer to Appendix B

9.0 MGPS Record Drawings and Documentation

The Authorised Person (AP) (MGPS) will maintain copies, for each site of responsibility, of the following:

- Up to date and accurate 'as fitted' record drawings (including valve / key numbers / TU identification) for all MGPS;
- Any necessary MGPS insurance / statutory documentation;
- MGPS safety valve replacement schedule as per Manufacturers' recommendations;
- New and completed Permit to Work books for work on the systems (for 10 years);
- Plant history / maintenance records;
- Manufacturer's technical data sheets / manuals for all MGPS components;
- Welsh Health Technical Memorandum 02-01, any associated supplements, all latest editions;
- MGPS Contractors' service contracts and ISO 9001 (or equivalent) certificates, staff training records, equipment calibration certificates (copies);

- A list of all personnel associated with the MGPS, especially the Permit to Work System;
- Emergency and other useful telephone numbers;
- MGPS staff training records;
- Calibration certificates of the hospital test equipment;
- The MGPS Management Policy

10.0 Medical Gas Pipeline System Training

It is essential for the safety of patients that NO PERSON should operate, or work on, any part of an MGPS unless adequately trained or supervised.

It is essential that staff at all levels have a sound general knowledge of the general principles, design and functions of the MGPS, and that all staff will be trained in relation to their responsibilities.

MGPS training records for Estates personnel is held in the relevant Estates department.

It is the duty of departmental managers to ensure that all staff using MGPS are appropriately trained and records kept.

The Authorised Person (MGPS) may request training records of contractors' staff.

Individuals training records will be reviewed as part of the Medical Gas Committee to ensure training requirements are up to date and compliant.

10.1 Training on MGPS will be provided as follows:

Position	Safe use and application of medical gases	Emergency procedures and Permit to Work System	Management of the MGPS	Installation and maintenance of MGPS	Medical gas quality control and testing
Authorised Person	3 yearly	3 yearly	3 yearly	3 yearly	-
Competent Person	3 yearly	3 yearly	-	3 yearly	-
Designated Medical/Nursing Officer	3 yearly	3 yearly	-	**-**	-
Nursing staff, medical staff	Annually	-	-	-	-
Designated Porter	Annually	-	-	-	-
Quality Controller (MGPS)	5 yearly	5 yearly	5 yearly	5 yearly	5 yearly

10.2 Training Content

The training requirements outlined above should cover all, nut not be limited to the topics as detailed and comply with the course content and training outcomes as detailed in WHTM 02-01

The Safe Use and Application of Medical Gases

- Properties and hazards of medical gases
- Safe use of equipment
- Cylinder safety, handling and management

Emergency Procedures and Permit to Work System

- Emergency supply provision
- Actions in the event of an emergency
- Responsibilities and application of the permit to work system

Management of the MGPS

- Design and application of the MGPS
- Installation practice
- Validation and verification of MGPS
- Maintenance requirements of components

Medical Gas Quality Control and Testing

- Requirements of medical gas testing
- Test equipment and protocols of use
- Statutory requirements for medicines management

Note: No persons should operate or work on any part of an MGPS unless adequately trained or supervised.

11.0 Communications

11.1 Routine Planned Work

A minimum of 2 weeks' notice in writing shall be given prior to all routine work on the MGPS, which could result in an interruption of supply, with copies to all affected stakeholders.

11.2 Connection of New and Demonstration Equipment

The Relevant AP (MGPS) shall be notified prior to any new or demonstration equipment being connected to the MGPS.

11.3 Permit to Work System

A Permit to Work system is primarily to ensure the safety of patients and is designed to safeguard the integrity of the medical gas system.

Before any work can be undertaken on any area of the organisation's MGPS, consideration must be given to other areas that might be affected or interrupted by the work, the time to be taken, the level of risks and the back-up systems required. The issue of a Permit to Work System and the way in which the work is carried out must follow the directions of the HTM 02-01, and the site specific MGPS operational procedure.

12.0 Compliance and Risk Assessments

There is a requirement within WHTM 02-01 for compliance reports to be undertaken detailing the whole system, and an action plan to address any items required in order to ensure the systems is of standard.

This should be undertaken 5 yearly and regularly reported as part of the Medical Gas Committee.

13.0 Audit and Review

13.1 Audit

Audit will be a function of the Authorised Engineer (NWSSP-SES) who will issue a subsequent report to the Assistant Director of Operations (Estates).

13.2 Review

The MGPS Management Policy should be reviewed annually. The Assistant Director of Operations (Estates) as Chair of the Medical Gas (Pipeline Systems) Committee is responsible for writing and distributing the minutes of the meeting. The Medical Gas Committee shall report to the Health and Safety Operational Sub Group, which in turn reports to the Health Board's Health and Safety Committee.

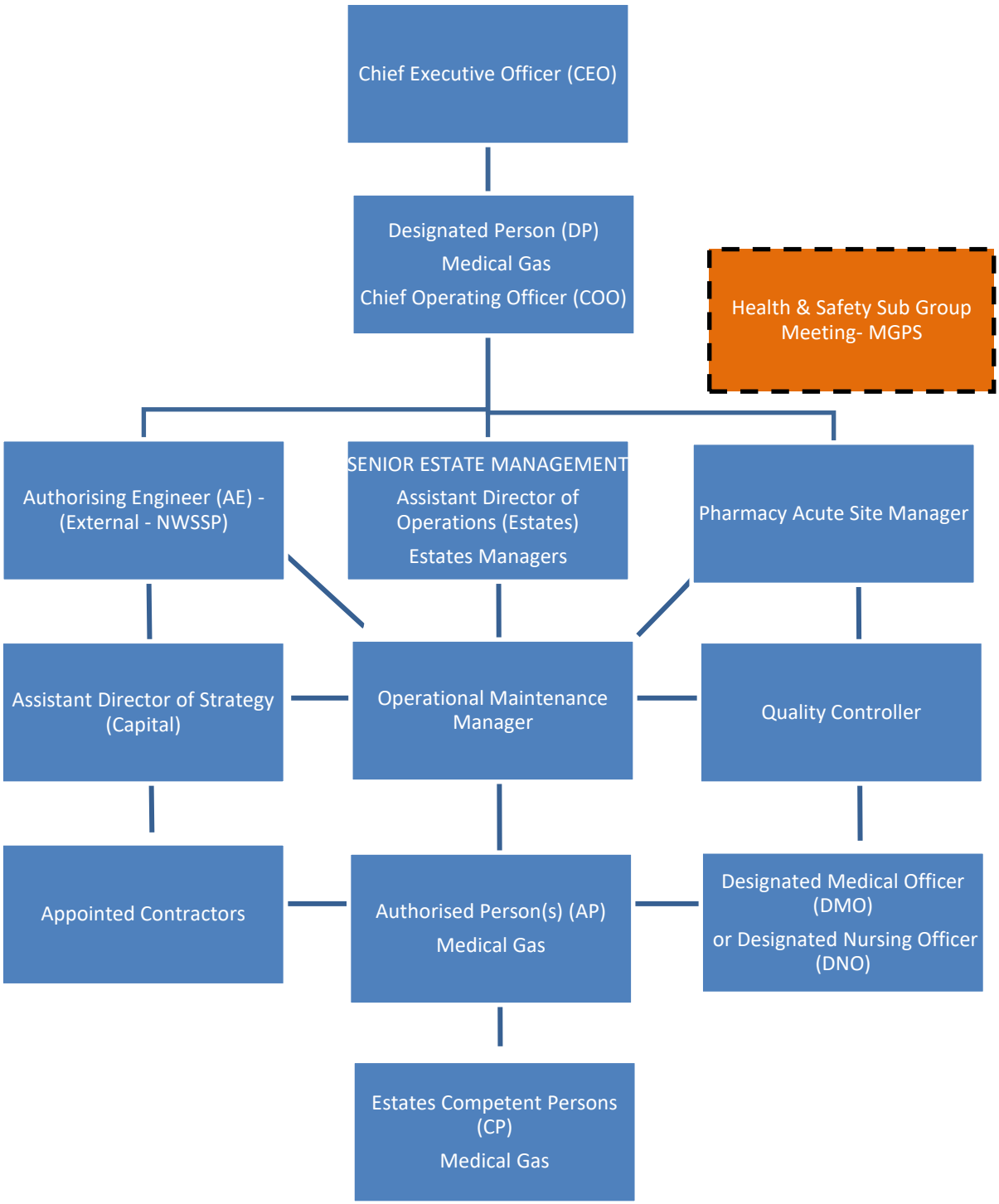
The Site specific operational procedure documents that supplement this policy shall be reviewed formally annually, but shall be kept under constant review to check they reflect the current arrangements and contact numbers, together with any changes to staff personnel.

14.0 Incident Reporting

Any incident involving or related to Medical Gases must be reported on the Health Board's DATIX incident reporting system.

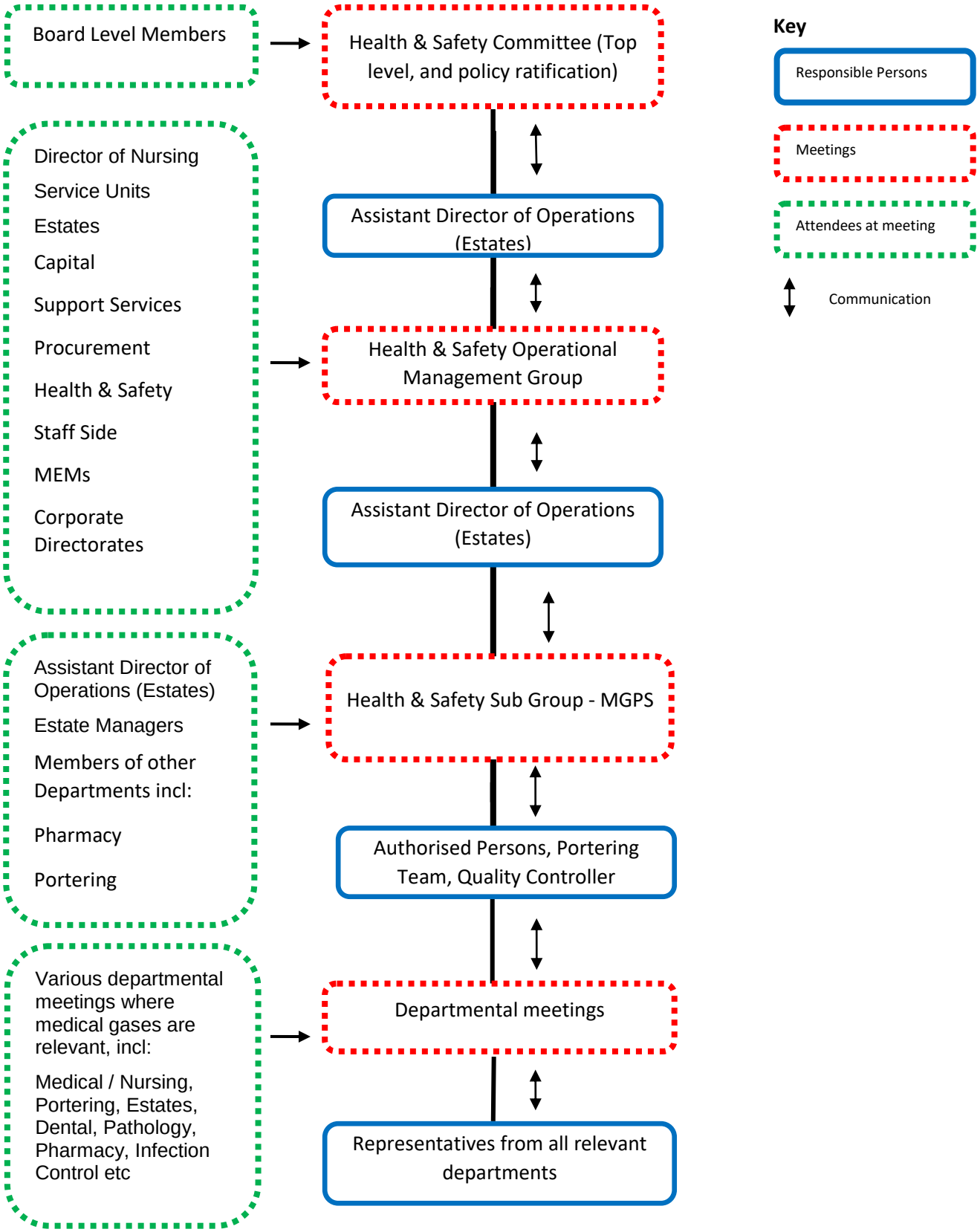
Appendix A

Medical Gas Pipeline Systems Management Hierarchy



Appendix B –

Reporting Structure for Medical Gases Responsibility



Appendix 5

AGENDA

HEALTH & SAFETY OPERATIONAL GROUP
MONDAY 4 NOVEMBER 1.30pm-4pm
ATTENBOROUGH MEETING ROOM, FIRST FLOOR, HQ BAGLAN

No.	Agenda	Purpose	Lead	Attached/ Verbal
PRELIMINARY MATTERS				
1.	Welcome & Introductions	Noting	Chair	Verbal
2.	Apologies for Absence	Noting	Chair	Verbal
3.	Declarations of Interest	Noting	Chair	Verbal
4.	Minutes from Meeting Held 5 August 2019	Approval	Chair	
5.	Matters Arising	Noting	Chair	Verbal
HEALTH & SAFETY REPORTS/EXCEPTIONS				
6.	Unit Director Health and Safety Report – Singleton Hospital (*Key areas/hot spots/risks*)	Noting	Matthew Fisher	Report

7.	Unit Director Health and Safety Report – Morriston Hospital (*Key areas/hot spots/risks*)	Noting	Suzanne Holloway	Report
8.	Unit Director Health and Safety Report – Neath & Port Talbot Hospital (*Key areas/hot spots/risks*)	Noting	Susan Jones	Report
9.	Unit Director Health and Safety Report – Primary & Community Care (*Key areas/hot spots/risks*)	Noting	Debra Rees	Report
10.	Unit Director Health and Safety Report – Mental Health & Learning Disabilities (*Key areas/hot spots/risks*)	Noting	Ricky Morgan	Report
11.	Estates, Health and Safety report (includes confirmation on the alerts received Fire etc.) (*Key areas/hot spots/risks*)	Noting	Des Keighan	Report
12.	Support Services, Security and HQ Corporate Health & Safety update (*Key areas/hot spots/risks*) What is planned?	Noting	Joanne Jones	Report
13.	Health and Safety Action Plan 2019-2020	Information	Laurie Higgs	Report
14.	Health and Safety Alerts	Information	Laurie Higgs	Report
PERFORMANCE DASHBOARD				
15.	Incident Reporting • Contractor incidents – how reported? • Guidance on v&a evidence gathering	Assurance	Laurie Higgs	Report
16.	Training Compliance & Training Needs Analysis (TNA)	Assurance	Laurie Higgs	Report
17.	Investigations – Lesson Learned	Assurance	Laurie Higgs	Report
GOVERNANCE, RISK AND ASSURANCE				
18.	Health and Safety Risk Register	Noting	Laurie Higgs	Report
19.	Update from Estates Sub Groups • Fire • Water • Asbestos @Singleton	Assurance	Des Keighan	Verbal

	• Electricity • Security • Gas • Clinical Waste - incineration			
20.	Update from Health and Safety Committee 2 September 2019	Noting	Chair	Verbal
21.	HSE visits / Improvement Notice Update	Information	Mark Parsons	Verbal
22.	Audit/Inspection Reports	Assurance	Chair	Verbal
23.	Policies & Procedure review and development schedule update	Information	Mark Parsons/ Laurie Higgs	Report
24.	Policies & Procedure reviewed/developed for consultation/for approval: **For Consultation:** - Low Voltage Policy - Medical Gas Pipelines System Management - Health & Safety Policy (Only organisation name and director responsibility has changed)	Approval	Mark Parsons/ Laurie Higgs/ Des Keighan/ Mark Parsons	
25.	Health and Safety Newsletter	Information	Laurie Higgs / Mark Parsons	Verbal
Any Other Business				
26.	AOB	Assurance	Chair	
Date and Time of Next Meeting				
27.	The next scheduled meetings are: 4 February 2020 5 May 2020 4 August 2020			