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Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Date **10/09/2026**
Time **9:30 AM - 11:30 AM**
Location **Microsoft Teams Meeting**

Virtual Health & Safety Committee Meeting

HDD_Health and Safety Committee

NHS Wales

Agenda - 10 September 2026

1 GOVERNANCE

9:30 AM, 0 min

1.1 Welcome and Apologies

9:30 AM, 0 min

Ann Murphy (Hywel Dda UHB - RCN Trade Union Rep - Independent Board Member)

1.2 Declarations of Interest

9:30 AM, 0 min

All

1.3 Minutes of Previous Meeting

9:30 AM, 5 min

Ann Murphy (Hywel Dda UHB - RCN Trade Union Rep - Independent Board Member)

1.4 Matters Arising and Table of Actions from Previous Meeting

9:35 AM, 5 min

Ann Murphy (Hywel Dda UHB - RCN Trade Union Rep - Independent Board Member)

1.5 Assurance and Risk Report

9:40 AM, 10 min

James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science), Gareth Cottrell (Hywel Dda UHB - Deputy Chief Operating Officer)

2 HEALTH AND SAFETY UPDATES

9:50 AM, 0 min

2.1 Health and Safety Assurance Report

9:50 AM, 10 min

Adam Springthorpe (Hywel Dda UHB - Health & Safety Manager)

2.2 Regulation Assurance Report

10:00 AM, 10 min

Adam Springthorpe (Hywel Dda UHB - Health & Safety Manager)

2.3 Electrical Safety

10:10 AM, 10 min

Simon Day (Hywel Dda UHB - Head of Maintenance & Engineering)

2.4 Water Safety

10:20 AM, 10 min

Simon Day (Hywel Dda UHB - Head of Maintenance & Engineering)

2.5 Heatwave Response & Action Plan

10:30 AM, 15 min

Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health)

3 Clinical Care Group Updates

10:45 AM, 0 min

3.1 Planned and Specialist Services

10:45 AM, 10 min

Gareth Cottrell (Hywel Dda UHB - Deputy Chief Operating Officer), Tamara Bromley (Hywel Dda UHB - Assistant Director of Nursing)

3.2 Primary Care

10:55 AM, 10 min

Gareth Cottrell (Hywel Dda UHB - Deputy Chief Operating Officer), Rhian Bond (Hywel Dda UHB - Assistant Director of Primary Care)

4 FOR INFORMATION

11:05 AM, 0 min

4.1 HSC Workplan

11:05 AM, 0 min

Ann Murphy (Hywel Dda UHB - RCN Trade Union Rep - Independent Board Member)

5 ANY OTHER BUSINESS

11:05 AM, 5 min

All

6 MATTERS FOR ESCALATION TO BOARD

11:10 AM, 5 min

Ann Murphy (Hywel Dda UHB - RCN Trade Union Rep - Independent Board Member)

7

DATE AND TIME OF NEXT MEETING

11:15 AM, 0 min

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1 - GOVERNANCE

1.1

9:30 AM, 0 Mins

1.1 - Welcome and Apologies

*Ann Murphy (Hywel
Dda UHB - RCN
Trade Union Rep -
Independent Board
Member)*

1.2

9:30 AM, 0 Mins

1.2 - Declarations of Interest

All

[Board Member DOI Register](#)

1.3

9:30 AM, 5 Mins

1.3 - Minutes of Previous Meeting

***Ann Murphy (Hywel
Dda UHB - RCN
Trade Union Rep -
Independent Board
Member)***

| For approval

Attachments

[2026-07-07 - Virtual Health Safety Committee Meeting - Minutes.pdf](#)

MINUTES OF THE Health and Safety Committee MEETING

Date of Meeting: **9:30 AM, Tuesday 07 July 2026**

Venue: **Microsoft Teams Meeting**

Present: Ann Murphy, Independent Board Member (*Chair*)
Michael Imperato, Independent Board Member
Sarah Harraway, Independent Board Member
Iwan Thomas, Independent Board Member

In Attendance: James Severs, Executive Director of Allied Health Professions and Health Science
Joanne Wilson, Director of Corporate Governance/Board Secretary
Neil Wooding, Chair of Hywel Dda University Health Board
Gareth Cottrell, Deputy Chief Operating Officer
Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding (*deputising for Sharon Daniel, Executive Director of Nursing, Quality & Patient Experience*)
Sam Hussell, Head of Health Emergency Planning (*deputising for Ardiana Gjini, Executive Director of Public Health*)
Simon Chiffi, Head of Operations
Karen Ryan, Head of Occupational Health
Elin Brock, Head of Research, Innovation & Improvement
Adam Springthorpe, Health & Safety Manager
Anthony Dean, Staff Side Representative
Rebecca Temple-Purcell, Assistant Director of Nursing, Patient Safety, Quality and Experience (*part*)
Anna Chiffi, Assistant Director of Nursing, Patient Safety, Quality (*part*)
Ruth Poynting, Committee Services Officer (*Minutes*)

Apologies: Sharon Daniel, Executive Director of Nursing, Quality & Patient Experience
Heather Hinkin, Assistant Director People Management
Ardiana Gjini, Executive Director of Public Health

Minutes Ref.	Item	Action
HSC(26)040	Welcome and Apologies Ms Ann Murphy welcomed all to the meeting and apologies were noted as above.	
HSC(26)041	Declarations of Interest There were no declarations of interest.	

HSC(26)042

Minutes of Previous Meeting

The minutes of the previous meeting were approved.

Decision: The minutes of the previous meeting were APPROVED as an accurate record.

HSC(26)043

Matters Arising and Table of Actions from Previous Meeting

HSC(26)017: Mr James Severs reported that, following discussions with Ms Sharon Daniel and Ms Joanne Wilson, it has been agreed that a detailed review of the operational and corporate risks will be undertaken through the Health and Safety Compliance Group (HSCG).

Decision: The Committee NOTED the Table of Actions

HSC(26)044

Assurance and Risk Report

Ms Jo Wilson presented the operational risks update, noting that there were currently 54 reportable risks on the register. Since the previous report, eight new risks had been added, three risks had been closed, and one risk was no longer reportable. Eight of the total risks were rated as extreme. A significant proportion of the risks are related to the Estates and Facilities portfolio.

Mr James Severs observed that the risks spanned five different themes and emphasised the need to reduce duplication and ensure greater consistency in how risks were reported across groups. He noted that the same underlying risk could currently be described and scored differently in different forums. While some mitigations had been achieved, he expressed concern that ongoing management arrangements were not always in place and highlighted the need for appropriate oversight. He linked this to the proposed deep dive into operational and corporate risks, stressing that actions arising from the review needed to be impactful and demonstrably reduce risk.

Ms Sarah Harraway raised concerns regarding Risk 2354 (*risk of interruption to patient, staff and visitor meals due to increasing age related faults in the main dishwasher*), noting that the site had not been identified within the report. Members clarified that this related to Bronglais Hospital (BGH). Concerns were also expressed regarding Risk 2353 (*insufficient air conditioning*), with members questioning how such an issue had arisen within a new-build facility.

The Committee noted the volume and severity of estate-related risks, particularly those relating to public and staff safety. Consideration was given to whether the nature of the risks warranted escalation through a Board Alert.

Mr Michael Imperato queried Risk 1263 (*Risk to patient safety due to ongoing Issues with vermin (Pigeons)*), noting that the target completion date of 2030 appeared a considerable distance away.

Mr Iwan Thomas observed that no principal risks had been identified and queried whether the collective estate-related risks should be regarded as a principal risk due to their potential impact on patients, staff and the organisation.

Mr Severs observed that there appeared to be a substantial level of corporate risk associated with the estate which may not be fully reflected within current reporting arrangements. He highlighted the continued vacancies in key leadership posts, including the Director of Estates, Facilities and Capital and Head of Health and Safety, and commented that, whilst significant work was being undertaken to manage estate-related risks, achieving a meaningful reduction in the overall risk profile would be challenging until these posts were filled.

Ms Cathie Steele emphasised that estate risks had a direct impact on patient flow and patient experience. She requested that patient experience considerations be incorporated into the proposed deep dive review and offered her support in this work.

The Committee requested that Risk 2353 (insufficient air conditioning) be considered by the Ventilation Sub-Group, with an update to be provided outside of the Committee. SC

Ms Wilson advised that particular challenges existed at Glangwili Hospital (GGH) and Withybush Hospital (WGH) due to the ageing estate. She noted that reporting was limited to risks recorded within Datix and confirmed that work would continue with operational colleagues to ensure risks were appropriately reflected.

Dr Neil Wooding acknowledged that risk registers can appear inherently concerning and that not all identified risks ultimately materialise. However, he emphasised the importance that the organisation's focus should be on ensuring that all reasonable actions are being taken to mitigate risks, rather than simply tolerating it.

Mr Severs agreed that the volume of risks presented a challenge and observed that organisations could become overwhelmed by maintaining and updating risk registers, creating a risk that focus shifts towards the process of risk management rather than the management of the risks themselves. Whilst there were examples of good assurance and effective management, he noted a lack of consistency across some areas.

Mr Simon Chiffi advised that the discussion aligned with later agenda items relating to fire risk assessments and noted that assurance could be provided regarding the controls and

mitigations in place, even where full assurance could not be achieved. He explained that the Health Board currently faced an estimated £250m estate backlog maintenance liability, with this figure expected to increase significantly as a result of the Reinforced Autoclaved Aerated Concrete (RAAC) position at WGH. Despite these challenges, a range of mitigation measures were in place, including day-to-day operational controls, the Targeted Estates Funding (TEF) programme, discretionary capital programmes and wider infrastructure investment schemes. He acknowledged that greater emphasis was needed on communicating the assurances provided by these controls.

Dr Wooding noted that the backlog maintenance figure would not materialise as a single issue and cautioned against becoming overwhelmed by the scale of the figures. He stressed the importance of distinguishing between risks and issues, understanding the mitigations in place and maintaining a realistic risk appetite.

The Committee considered whether a Board Alert was required; however, following discussion, agreed that the matter should not be escalated at this stage and should remain advisory to the Board pending the planned deep dive review of operational and corporate estate risks.

Decision: The Committee RECEIVED PARTIAL ASSURANCE that there are processes in place to oversee operational risks to ensure these are being managed effectively and agreed a Deep Dive into Operational and Corporate Risks is needed to provide full assurance.

HSC(26)045

Health and Safety Assurance Report

The Committee received the Health and Safety Assurance Report and noted improvements in training compliance across the organisation. Members were advised that areas with lower levels of compliance had recovery plans in place, providing some assurance that mitigating actions were being taken. However, concern was raised regarding the sustainability of training provision in Ceredigion, with Mr Adam Springthorpe advising that the current training venue would shortly cease to be available. Work is underway with Estates, Property and Learning & Development colleagues to secure dedicated training accommodation in Aberystwyth.

The Committee also noted improvements in mandatory training compliance, with greater visibility of compliance data across Clinical Care Groups (CCG) and Corporate Functions and recovery plans in place where compliance levels remained below target.

Ms Harraway welcomed the successful recruitment of the new Head of Health and Safety, due to take up post in October 2026, and discussed opportunities to strengthen future reporting. It was

suggested that trend lines be incorporated into charts to better demonstrate direction of travel and reduce the impact of month-on-month variation.

Members sought assurance regarding the causes of training non-attendance and were advised that, whilst operational pressures remained the principal factor, additional work was underway to review training profile allocations within Electronic Staff Record (ESR) and ensure training requirements were appropriately assigned. Mr Springthorpe advised that staff formally withdrawing from training was preferable to non-attendance, as places could then be reallocated, noting that recent figures showed a roughly equal split between withdrawals and staff failing to attend.

Mr Severs reflected on the evolving governance arrangements and suggested that much of the operational detail contained within the report would be more appropriately scrutinised through the Health and Safety Compliance Group, with the Committee receiving a more strategic assurance-focused report.

Mr Severs further advised that discussions had taken place with Lisa Gostling, Executive Director of Workforce & OD/Deputy CEO and Executive Lead for the People, Organisational Development and Culture Committee (PODCC) regarding a Task and Finish Group to review face-to-face training capacity and venue availability across the organisation.

Mr Imperato highlighted the reported temporary increase in manual handling incidents. In response, Mr Springthorpe advised that the increase related primarily to minor staff injuries. He noted that investigations were ongoing to determine whether any of the incidents met the criteria for Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reporting, recognising the complexity of establishing a direct link where a period of time had elapsed between the incident occurring and the subsequent sickness absence of affected staff members.

Mr Severs acknowledged concerns around the clarity of the assurance ratings in the report and agreed that future reports should place greater emphasis on improvement plans, mitigating actions and organisational controls. Ms Wilson suggested that officers work with Ms Cathie Steele who presents a similar report to the Quality and Safety Committee (QSEC) to ensure a more consistent assurance-based approach across committees.

ASp

Mr Gareth Cottrell highlighted that training capacity was a finite resource and emphasised the importance of aligning training provision with staff availability as effectively as possible. Whilst acknowledging that the report demonstrated areas of good training compliance, he stressed the need to ensure staff were released in a timely manner to attend training, thereby improving compliance and reducing organisational risk.

Dr Wooding noted that the Committee's primary interest was in receiving assurance that staff were being appropriately trained to reduce risks across the organisation. While he welcomed the report's analytical approach and useful data presentation, he questioned whether enough consideration had been given to technology-enabled learning solutions to support training delivery and address the challenges of releasing staff from operational duties.

Ms Murphy suggested that consideration be given to organising dedicated training days, enabling multiple mandatory face-to-face training requirements to be delivered on the same day and making more effective use of staff time.

The Committee was assured, while recognising that further work was needed to strengthen the report's robustness and the level of assurance provided.

Decision: The Committee RECEIVED ASSURANCE that appropriate processes and governance arrangements are in place to support effective health and safety management, noting the continued strong performance in incident reporting and associated oversight arrangements, and that targeted improvement actions are being implemented to address identified risks, including improving mandatory training compliance, strengthening manual handling arrangements, and effectively managing behaviour-related risks.

HSC(26)046

Health & Safety Training Overview

Mr Springthorpe presented the Health and Safety Training Compliance Report and discussed the factors contributing to non-attendance at mandatory training. Ms Harraway queried whether the organisation sufficiently understood the root causes of staff failing to attend training, noting that whilst operational pressures were frequently cited, this represented a broad explanation and further analysis may be beneficial. She also welcomed the Workplace Assessors model, commenting that it appeared to be a positive development.

Ms Elin Brock advised that the report had been discussed in detail by the HSCG, where constructive discussions had focused on making it easier for staff to attend training. This included consideration of behavioural nudges, improvements to roster planning and closer collaborative working between operational services and training teams. She further explained that reporting arrangements and oversight mechanisms for health and safety training packages were being reviewed to ensure appropriate governance and would be reported through the Strategic People Planning and Education Group (SPPEG).

Mr Imperato sought clarification regarding the proportion of non-compliance attributable to refresher training compared with first-

time attendance, observing that refresher training can often present greater engagement challenges. He also welcomed the emphasis on senior manager accountability and suggested that future reports could provide greater detail on this aspect.

Mr Severs highlighted ongoing discussions within SPPEG and stressed the importance of clearly distinguishing between statutory and mandatory training requirements, alongside understanding both the training provision available and staff uptake. Whilst supportive of the Workplace Assessors model, he noted that it shifted responsibility from corporate teams to operational services and that this needed to be recognised. He also observed that there were areas of overlap between HSC and PODCC, including work relating to resuscitation training.

In response, Mr Springthorpe advised that foundation training continued to be prioritised due to the higher level of risk associated with non-completion and noted that compliance levels for foundation training were significantly higher. He confirmed that the majority of non-compliance related to refresher training requirements rather than first-time training attendance.

The Committee was assured that appropriate arrangements were in place to monitor and improve training compliance and noted the ongoing work to strengthen oversight, accountability and accessibility of training provision.

Decision: The Committee NOTED current compliance levels and associated risks outlined in the Health and Safety Training Overview Report and RECEIVED ASSURANCE that improvement plans are in place to improve compliance.

HSC(26)046

Regulation Assurance Report

Mr Springthorpe noted that the majority of the amber-rated areas in the report are related to ageing infrastructure, the resolution of which would require significant investment. He emphasised, however, that assurance could still be provided where appropriate controls and oversight arrangements were in place. As an example, where modern ventilation systems were not available, the Ventilation Group maintained oversight of the associated risks.

Ms Harraway acknowledged that while some issues could be addressed quickly, it was more challenging to mitigate risks associated with the estate. She highlighted the principle of ensuring compliance "so far as is reasonably practicable".

Mr Imparato observed that there had been a move away from strict liability for defective equipment, noting as an example that it would not be realistic to redesign an entire hospital environment to eliminate an isolated tripping hazard.

Mr Severs advised that the report sought to reflect the legislation underpinning the Committee's work and acknowledged that the process for obtaining assurance regarding the completion and quality of risk assessments remained under development. He advised that the HSCG had recently considered how assurance information could be fed back from operational and corporate directorates. He stressed the importance of strengthening feedback mechanisms and ensuring that information and learning were effectively shared with operational colleagues. Members were also advised that the prioritisation of this work needed to be reviewed.

Dr Wooding considered the report to be balanced and welcomed the focus on risk assessments. He stressed that all staff should take ownership of risk management responsibilities, noting that failure to do so could result in claims and financial consequences for the organisation. He suggested that health and safety responsibilities should be embedded within performance management arrangements and that a culture of personal accountability should be promoted.

Mr Cottrell advised that new ways of working were being introduced, with clearer accountability arrangements and stronger reinforcement of responsibilities. He recognised the challenges associated with demonstrating assurance given the volume of risk assessments undertaken daily across operational services, cautioning against creating an overly bureaucratic system for cataloguing them.

Mr Springthorpe advised that approximately 25 template risk assessments had been developed and partially completed by subject matter experts, enabling staff to complete them more easily without requiring specialist knowledge. He noted the additional complexity created by the size and scale of the organisation.

Mr Severs emphasised the need for clarity regarding roles and responsibilities, advising that operational colleagues were responsible for demonstrating compliance against required standards. He described this as a significant organisational change and reiterated the need for a mechanism to provide assurance that risk assessments were being completed to an appropriate standard.

Ms Brock highlighted improvements in operational health and safety governance arrangements, including the development of new performance metrics. She acknowledged that further work was required to strengthen the triangulation of information and to clarify the issues that should be escalated from the HSCG to the Health and Safety Committee.

The Committee was assured by the report and the progress made in strengthening health and safety governance arrangements.

However, Members agreed that further work was required to clarify ownership and accountability for risk assessments and to strengthen the mechanisms through which assurance regarding their completion and quality is reported to the Committee.

Decision: The Committee RECEIVED ASSURANCE that the Health Board is operating in compliance with the following regulations as far as reasonably practicable, whilst acknowledging the challenges presented by an aging estate:

- Management of Health and Safety at Work Regulations 1999;
- Workplace (Health, Safety and Welfare) Regulations 1992;
- Health and Safety (Safety Signs and Signals) Regulations 1996.

HSC(26)047

Fire Safety Risk Assessment Assurance Update (BORIS)

Mr Chiffi outlined a series of system enhancements and governance changes that had been implemented to strengthen accountability, improve visibility of outstanding actions and support the more timely closure of identified risks. These included enhanced dashboard reporting, monthly Executive scrutiny through CCG Delivery Review meetings, clearer allocation of responsibility to named individuals, and the introduction of automated reminders to action owners.

Data from the BORIS Fire Risk Assessment System demonstrated a continuing downward trend in the number of outstanding fire safety actions across the Health Board, with no extreme-risk actions currently overdue. Enhanced reporting functionality now enabled visibility of actions by CCG and allowed data to be exported for local analysis. In addition, escalation arrangements had been developed to support timely intervention where actions remained outstanding.

Mr Chiffi explained that accountability had been strengthened through the allocation of actions to named individuals rather than generic postholders, with responsibility for completion resting with the action owner. Automated email reminders were also being developed to prompt regular review and updating of actions. While a substantial backlog remained, he advised that governance and management oversight arrangements had significantly improved.

Ms Harraway welcomed the report and the improvements made to the control and visibility of outstanding actions. She sought assurance that the enhanced oversight arrangements would translate into action completion and asked what good performance would look like in this area. In response, Mr Chiffi advised that many of the outstanding actions related to major capital projects and fire safety matters. He anticipated that completion of significant capital schemes over the next 12 months would result in approximately two-thirds of the current actions being resolved. However, he noted that fire risk assessments were dynamic by nature and therefore it would not be realistic to expect the number of actions to reduce to zero.

Mr Severs welcomed the clarity provided regarding the anticipated timeline for reducing the backlog of actions.

Dr Wooding confirmed that he was assured by the report, noting that the issue had been a concern for some time. He considered the report well balanced and welcomed the evidence of increasing ownership and accountability within the system.

Mr Severs reflected on the wider organisational learning arising from this work and the potential for similar approaches to be applied elsewhere within the Health Board.

Mr Chiffi advised that work was ongoing with CCG colleagues to improve communication and engagement and reported that these strengthened communication arrangements were already contributing to significant improvements.

Decision: The Committee RECEIVED ASSURANCE from the actions being implemented to strengthen governance, oversight and ownership of Fire Risk Assessment actions, whilst recognising that further evidence of sustained improvement is required.

HSC(26)048

Compliance with Environmental Ligature Anchor Point Assessments and Adoption of the All-Wales Procedure

Mr Springthorpe advised that the report had previously been considered by the HSCG and that the Health Board was in a strong position due to the significant amount of work already undertaken in relation to ligature risk management. He explained that the All-Wales policy and procedure applied specifically to inpatient services and that the Health Board had already implemented ligature assessments across mental health inpatient facilities, outpatient facilities and mental health triage rooms within Emergency Departments. As a result, the organisation was ahead of the requirements set out within the All-Wales guidance.

Only one inspection remained outstanding within the current inspection cycle. This had been placed on hold pending significant estates work at the relevant property and would be prioritised once those works had been completed. Mr Springthorpe further advised that existing audit assessments were being transferred into the new All-Wales format to enable comparison between the two approaches. The outcome of this work would be presented to Mental Health colleagues to support the transition of remaining assessments to the new format.

Ms Murphy sought assurance that future refurbishment schemes across hospital sites, as well as mental health facilities, would take account of ligature risks. Mr Springthorpe confirmed that ligature considerations were embedded within design processes and

project teams, although he noted that this remained an evolving area requiring ongoing review.

Ms Brock highlighted that the All-Wales guidance promotes a collaborative approach and advised that the HSCG had agreed to establish a task and finish group, including an anti-ligature subgroup, to support implementation and oversight.

Ms Rebecca Temple-Purcell added that the work extended beyond Mental Health and Learning Disabilities services. She advised that broader representation would be sought to ensure a more holistic approach to identifying and managing potential ligature risks across all relevant service areas.

Dr Wooding sought assurance that patients receiving care in other Health Board settings would receive the same level of protection and risk management as those in specialist mental health environments. In response, Mr Springthorpe advised that one of the aims of the All-Wales Procedure was to provide a consistent approach across healthcare settings, noting that Swansea Bay University Health Board had already implemented similar arrangements. Mr Temple-Purcell added that the guidance was also being shared and cascaded to independent healthcare providers across Wales and aligned closely with similar work being undertaken elsewhere in the UK.

Decision: The Committee RECEIVED ASSURANCE that HDdUHB has effective and evidenced arrangements in place to identify, assess and manage environmental ligature anchor point risks and, that a structured implementation is in place to transition to the All-Wales Ligature Anchor Point Procedures during 2026, further enhancing organisational consistency, oversight, and assurance.

HSC(26)049

Health & Safety Individual Regulations Written Control Documents Status Report

Mr Springthorpe advised that all Health and Safety-related Written Control Documents were currently in date. He reported that two documents were scheduled for consideration and approval by the HSCG at its next meeting. The Violent Patient Warning Marker Procedure has undergone a significant review and revision and is currently out for consultation across the organisation prior to final approval.

Decision: The Committee RECEIVED ASSURANCE on the current status of Health and Safety related Written Control Documentation.

Clinical Care Group Updates

HSC(26)050

Mental Health and Learning Disabilities

Ms Temple-Purcell advised that the report represented the early stages of a developing assurance process and reflected significant work undertaken by Health and Safety and Corporate colleagues to establish metrics and a dashboard approach. She noted that the new arrangements were helping to bridge gaps between operational services and corporate oversight and were supporting a shift in ownership of the health and safety agenda within CCGs. Improved access to health and safety data was strengthening accountability and enabling services to take greater ownership of their responsibilities while working collaboratively with Health and Safety colleagues.

It was confirmed that responsibility for Health and Safety inspection actions had been transferred to operational teams, including Heads of Service and that this process had now been completed. While no significant risks had been identified, work remained ongoing to review outstanding actions and provide assurance regarding their completion. A formal review process had been established, with the aim of concluding this work by the end of September 2026.

In relation to manual handling training discussions had taken place with the Moving and Handling Training Lead to develop a more holistic understanding of compliance and training needs. Ms Temple-Purcell explained that the issue extended beyond attendance at training sessions and included consideration of how information was communicated, how training requirements were assessed and how these were reflected within ESR reporting arrangements.

With regard to restrictive practice training compliance, a unannounced inspection of Enlli Ward, Aberystwyth, had prompted immediate assurance activity. Ms Temple-Purcell reported that improvement actions were already underway prior to the inspection and that subsequent actions measures were expected to bring the ward into full compliance with the required training standards.

Mr Severs welcomed the report as a strong first step in developing CCG assurance reporting. He noted the importance of including timescales and trajectories within future reports to strengthen the level of assurance available to the Committee. He also advised that further work would be undertaken through the HSCG over the next four to six weeks, ensuring that assurance gaps were identified and addressed appropriately.

Ms Harraway welcomed the report, commenting that it provided assurance from both operational and corporate perspectives. She praised the collaborative approach between the CCG and the Health and Safety Team and noted that the reporting helped address a previously missing element of assurance.

Mr Imperato queried the reported inability to reliably identify work-related stress absences and sought clarification on whether this was specific to the CCG or represented a wider organisational issue. In response, Mr Severs confirmed that work was ongoing with Lisa Gostling to develop reporting arrangements relating to stress-related absence. He noted the challenges associated with distinguishing between stress that was directly attributable to work and stress arising from other personal or external factors.

Ms Temple-Purcell added that, particularly in relation to violence and aggression incidents, the CCG believed there was an opportunity to take a more proactive approach. She advised that existing incident management processes could be used to better understand the impact of such incidents on staff wellbeing and identify opportunities for further support and intervention.

Decision: The Committee RECEIVED ASSURANCE on the Mental Health and Learning Disabilities Clinical Care Group Health & Safety Assurance position, including strong compliance with statutory reporting requirements, strengthened governance arrangements, improving incident trends, progress in training compliance across key areas, structured management of historical inspection actions, and the response to HIW immediate assurance requirements.

HSC(26)051

Community and Integrated Medicine

Presenting the report, Ms Anna Chiffi advised that while a number of indicators were included, some metrics were not yet capable of being fully quantified, including certain overdue Datix actions and compliance with some risk assessments. She advised that further work was underway to strengthen the reporting framework and provide more robust data in future reports.

Ms Chiffi highlighted a number of key areas of assurance. She reported a positive trend in the incident reporting culture, with reporting rates per 100 staff increasing month on month. Whilst this reflected the ongoing operational risks experienced by services, it also provided assurance that staff were becoming more confident in reporting incidents, thereby improving organisational visibility of risks and learning opportunities.

Areas of concern included increasing trends in violence and aggression incidents, needlestick injuries and restrictive practice incidents. Ms Chiffi advised that these represented direct workforce safety risks and would continue to be monitored and escalated through Datix and established governance processes. She added that the CCG was adopting a more thematic learning approach, focusing on identifying and addressing recurring themes and trends rather than considering incidents solely on an individual case basis.

The Committee noted a number of areas of improvement. Manual handling incidents had reduced following a previous increase,

while slips, trips and falls had also shown a downward trend. RIDDOR reporting timescale compliance had improved despite static numbers of reportable incidents, providing assurance that regulatory responsiveness and oversight arrangements were strengthening.

Overall compliance remained above interim targets, although a declining trend had been identified and was being reviewed by the CCG. Manual handling training compliance remained below target for both Level 1 and Level 2 training, whilst violence and aggression training compliance remained high and display screen equipment compliance remained stable and above target.

Mr Severs welcomed the report as a positive first and advised that further work would be undertaken to refine future reporting and ensure consistency across CCGs. Ms Harraway welcomed the inclusion of narrative analysis and suggested that future reports combine this with quantitative performance data to provide a more balanced assurance framework. Mr Cottrell agreed and confirmed that the intention was to develop a consistent reporting template incorporating both narrative commentary and numerical metrics.

Mr Imperato highlighted the importance of developing health and safety-related sickness absence and manager induction compliance metrics as key indicators of assurance. Ms Chiffi advised that, while the data existed within corporate systems, further work was required to extract and present it effectively, and Mr Severs noted the ongoing challenges in accurately reporting work-related stress.

Decision: The Committee RECEIVED ASSURANCE from the current position with the Community and Integrated Medicine Clinical Care Groups Health & Safety Assurance Report, noting the improvements in reporting and compliance arrangements, while recognising that risks remain in relation to increasing incident trends, backlogs within incident management processes, and existing limitations in reporting capability.

HSC(26)052

Major Incident Plan

Ms Hussell advised that the Major Incident Plan was a long-established and well-tested document that was regularly communicated across the Health Board. She highlighted the significant investment made in training and exercising teams to ensure preparedness for major incident response.

The revised plan includes three key updates. Firstly, significant enhancements have been made to scene management and the pre-hospital response arrangements, with strengthening alignment between Welsh Ambulance Services University NHS Trust (WAST) pre-hospital response arrangements and the Health Board's Emergency Department response processes. Secondly, the role of the CCG has been further embedded within incident

management arrangements, strengthening the connection between major incident and mass casualty response planning and supported a more consistent approach across Health Boards in Wales.

Ms Harraway sought assurance regarding how the effectiveness of the plan was evaluated and whether formal debriefing arrangements were undertaken following exercises. In response, Ms Hussell advised that Health Boards were required to undertake major incident exercises every three years. She outlined the most recent large-scale exercise, Exercise Tendley, which tested activation and notification processes, Emergency Department response arrangements, the Hospital Coordination Centre, and subsequent mortuary and Disaster Victim Identification (DVI) procedures in partnership with the Police service. Following the exercise, a formal report and action plan had been produced, with recommendations subsequently incorporated into revisions of the Major Incident Plan and supporting action cards. This process provided assurance that lessons identified were translated into improvements.

Ms Hussell further advised that the recent Kidwelly bus crash major incident was currently progressing through the debrief process. An immediate Emergency Department debrief had already taken place, with a wider multi-agency responders' debrief underway and due to conclude later that week. Learning from the incident would be incorporated into future revisions of the Plan.

Decision: The Committee APPROVED the Major Incident Plan for onward ratification by the Board on 30 July 2026.

HSC(26)053

HSC Workplan

No comments were made on the workplan.

HSC(26)054

ANY OTHER BUSINESS

Mr Imperato highlighted the recent heatwave experienced across the UK and sought assurance regarding whether extreme heat represented a risk to the Health Board.

In response, Ms Hussell advised that heatwave response arrangements were managed through existing incident response structures, with heat-related risks routinely discussed through daily operational calls. She outlined a range of proactive measures undertaken ahead of periods of extreme heat, including communication with staff and services and the provision of cooling units to protect critical digital infrastructure and server rooms. While the recent heatwave had presented challenges due to hot and humid conditions and limited air-cooling systems across parts of the estate, a number of mitigation measures had been implemented.

Ms Hussell further reported that a virtual debrief process was underway, with over 270 responses received to date. Feedback

would be reviewed to identify short, medium and longer-term improvement actions.

Mr Severs emphasised the need to consider the impact of extreme heat on the quality, safety and experience of patients, visitors and staff. He advised that discussions were taking place with Trade Union colleagues and that the findings would be considered through the Health Board Partnership Forum before being reported to the Executive Team.

HSC(26)055

MATTERS FOR ESCALATION TO BOARD

HSC wish to advise the Board of the following:

- Concerns raised in the Assurance and Risk Report regarding the volume of operational risks, particularly those relating to Estates and Facilities, the consistency of risk reporting and management arrangements, and the extent to which mitigating actions and controls were clearly articulated with up-to-date timescales within the report.

DATE AND TIME OF NEXT MEETING

Thursday 10 September 2026, 9.30am-11.30am

1.4

9:35 AM, 5 Mins

1.4 - Matters Arising and Table of Actions from Previous Meeting

***Ann Murphy (Hywel
Dda UHB - RCN
Trade Union Rep -
Independent Board
Member)***

| For discussion

Attachments

[HSC Table of Actions 10.09.26.pdf](#)

HEALTH AND SAFETY COMMITTEE (HSC)/ PWYLLGOR IECHYD A DIOGELWCH
07/07/2026

TABLE OF ACTIONS/TABL GWEITHREDOEDD

Key: ASp-Adam Springthorpe; SC-Simon Chiffi

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
07/07/2026	HSC(26)044	Assurance and Risk Report • For Risk 2353 (insufficient air conditioning) be considered by the Ventilation Sub-Group, with an update to be provided outside of the Committee.	SC	03/11/2026	In progress Inserted as agenda point within Ventilation Sub group. HB has HVAC systems rather than air conditioning due to age and nature of estate. Further discussion required at September and October groups.
07/07/2026	HSC(26)045	Health and Safety Assurance Report • To review the format of future assurance reports to ensure a consistent assurance-based approach, with greater emphasis on improvement plans, mitigating actions and organisational controls.	ASp	10/08/2026	Complete Feedback has been considered and the report format has been revised to strengthen the assurance-based approach.

1.5

9:40 AM, 10 Mins

1.5 - Assurance and Risk Report

**James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science),
Gareth Cottrell (Hywel Dda UHB - Deputy Chief Operating Officer)**

| For assurance

Attachments

[HSC Public Governance Arrangements September 2026 v2.pdf](#)

[Appendix 1 - Health Safety Corporate Risk Register - 17Aug26.pdf](#)

[Appendix 2 - Health Safety Committee Overdue Audit Inspection Recommend~.pdf](#)



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Assurance and Risk Report

Health and Safety Committee – 10 September 2026

This report provides the Health and Safety Committee (HSC) with the status of the corporate risks and audit and inspection recommendations within its remit.

The Committee is asked to seek assurance from the Lead Executive Directors that the corporate risks are being managed effectively and that recommendations from audits and inspections are being implemented by the Health Board.

Principal risks, operational risks and Welsh Health Circulars are reported at alternate meetings, and due to be presented to the Health and Safety Committee (HSC) at its next meeting in November 2026.

Corporate Risks:

6

Audit and Inspection
Reports

25

Ministerial Directions

0

Risk Management - Overview



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Effective risk management requires a 'monitoring and review' structure to be in place to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place.

The Health Board's risk management process is recorded via the Datix Risk Register module, and enables risks to be recorded at either principal, corporate or operational level. An escalation process is in place to ensure that risks which require escalation or de-escalation are done via appropriate approval processes and governance arrangements.

The Health Board operates within the widely accepted "Three Lines of Defence" model to ensure the appropriate responsibility is allocated for the management, reporting and escalation of risk.

Risks are aligned to an appropriate Clinical Care Group or Executive Function (hereto referred to as "Functions"), and each has a designated risk lead responsible for reviewing in a timely and comprehensive manner.

The Board's Committees are responsible for the monitoring and scrutiny of corporate and operational risks within their remit and providing assurance to the Board that risks are being managed effectively and report areas of significant concern (eg where the [risk appetite](#) is exceeded, or there is a lack of action).

Committees are also responsible for reviewing risks over tolerance and where appropriate, recommend the 'acceptance' of risks that cannot be brought within risk appetite.



Corporate Risks Assigned to HSC



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Hywel Dda Risk Heat Map

	LIKELIHOOD →				
IMPACT ↓	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5			2381 (NEW) 1745 (→) 813 (→)		
Major 4			2349 (→) 1433 (→)		
Moderate 3					1860 (→)
Minor 2					
Negligible 1					

Each risk on the Corporate Risk Register (CRR) has been mapped to a Board level Committee to ensure that risks on the CRR are being managed appropriately, taking into account gaps in controls, planned actions and agreed tolerances, and to provide assurance to the Board through their update report on the management of these risks.

Corporate risks have been aligned to the most appropriate Board level Committee. These risks have been identified by individual Directors via a top down and bottom-up approach and are either:-

- Associated with the delivery of the Health Board objectives; or
- Significant escalated operational risks that are of significant concern and require corporate oversight and management.

There are 6 corporate risks currently aligned to HSC (out of the 25 that are on the CRR at 13 August 2026).

Since the previous report, Risk 1861 (reported via In-Committee) has been closed and superseded by Risk 2381 relating to Martyn's Law following agreement at Formal Executive Team on 17 June 2026. Due to its sensitive nature, Risk 2381 is being reported in detail to the In-Committee to support discussion and provide assurance.

The following slides provide a summary of the reportable corporate risks aligned to HSC. The Risk Register attached at **Appendix 1**, provides full detail of the reportable risks, including control measures in place, a risk action plan to further manage and mitigate the risk, an expected date to achieve the noted Target Risk Score, and sources of assurance.

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Corporate Risks Assigned to HSC



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Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Previous Risk Score	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
1860 - Risk of serious harm to staff due to violence & aggression within healthcare settings	Estates & Facilities	Executive Director of Allied Health Professions and Health Sciences	15	15 ➔ (Reviewed 14/08/26)	12* ↑ (Previous TRS of 9, amended June 2026)	01/04/27	No

Rationale for Current Risk Score

The high frequency of violence and aggression incidents contributes greatly to the current risk score, with over 1,400 incidents recorded during 2025. More recent figures show that this trend is continuing in 2026 (April 107, May 120, June 99). The likelihood remains at 5 as these incidents occur numerous times daily.

Due to the number of patients with complex needs (e.g. cognitive impairment, medical confusion or substance misuse) it is unlikely that the likelihood score will reduce greatly. The lack of adequate and suitably qualified security staff to deal with these incidences means the consequences and impact of any incidents can be catastrophic, resulting in physical injury to staff, psychological harm, reduced well-being and service disruption.

Inconsistent compliance with violence & aggression (V&A) risk assessments and training and a lack of process surrounding the management of lone working safety measures are also contributory factors.

Rationale for Target Risk Score

The likelihood of the risk occurring is high, and revised in June 2026 from 3 to 4 ensuring consistency with the CRS. In order to achieve the TRS, the impact of the risk can be reduced by employing suitably qualified security staff at acute sites.

Corporate Risks Assigned to HSC

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Previous Risk Score	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
1745 – Risk of not being able to safely deliver services due to ageing estate and infrastructure across the Health Board	Estates & Facilities	Executive Director of Allied Health Professions and Health Sciences	15	15 ➔ (Reviewed 14/08/26)	10	31/08/32	No – however included in Planning Goal 8
Rationale for Current Risk Score							
The current risk score is based upon the level of detailed information the Estates department has for its buildings, plant and infrastructure, including external reports, risk information and Estates and Facilities Performance Management System (EFPMS) data submitted to Welsh Government (WG), clearly articulating the scale of backlog and deficiencies across the Health Board. The Programme Business Case (PBC) has been under development with WG since 2018/19. The risk score also reflects insufficient capital support (noting this project dates back to 2018), the Health Board has therefore changed the approach entirely and has worked since October 2024 in a partnership arrangement with NHS Wales Shared Services Partnership – Specialist Estates Services (NWSSP-SES) to jointly develop an estates priority and risk consequence paper. This document provides clarity as to the potential implication if a specific infrastructure item was to fail. The Health Board undertook workshops directly with NWSSP-SES in August 2025 to determine the preferred options, accounting for risk mitigation, technical implications, deliverability and cost. The Health Board are engaging with WG directly to secure the resources to progress these works via the appropriate business process. On a positive note, this project is one of the supported priority projects by WG for investment in Health Board estate.							
Rationale for Target Risk Score							
Backlog figures and risks are being reviewed regularly to inform the target risk score, and to determine any future risk reductions. The currently predicted expected date to achieve improved compliance is 2032. The achievement is directly linked to the amount of funding the Health Board will receive to address the current issues faced across the organisation, and our ability to successfully deliver these improvements to reduce risk over time. This will be reviewed regularly as schemes progress.							

Corporate Risks Assigned to HSC

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Previous Risk Score	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
813 – Risk of non-compliance with the Regulatory Reform (Fire Safety) Order 2005 due to ageing infrastructure	Estates & Facilities	Executive Director of Allied Health Professions and Health Sciences	15	15 ➔ (Reviewed 14/08/26)	5	31/08/29	No – however included in Planning Goal 8

Rationale for Current Risk Score
Phased fire safety improvement works are ongoing across our sites, with significant investments being made to address the recommendations in the Mid and West Wales Fire & Rescue Service (MWWFRS) letters and Enforcement Notices (EN). All programme dates have been agreed with the Health Board, Welsh Government and MWWFRS senior inspecting officers. The progress of completed actions is regularly reviewed to determine the risk score as these works are progressed. Extensions for delivery, particularly for EN schemes, have been fully agreed by MWWFRS. A reduced scope of works has been agreed for Withybush General Hospital (WGH) and Glangwili General Hospital (GGH) Phase 2 on achievement of the following: - Fire alarm systems to L1 standard (achieved). - Health Board to achieve and maintain an 85% target for combined Fire Safety Training - MWWFRS have mandated that this must be achieved by 31/03/26, however the Health Board has not met this requirement. It has been escalated to the HB to address. - Night fire wardens are in place (WGH and GGH). Night fire wardens at Bronglais General Hospital (BGH) will also be in post by 1 September 2026. The BORIS software system has been implemented, and all fire risk assessments have been transferred across. Papers are submitted to the estates CCG meetings providing a high-level summary of the Estates and Hospital Management Risks. Currently, the risk is felt to still be extreme until further progress is made on the above fire safety improvement works.

Corporate Risks Assigned to HSC



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Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Previous Risk Score	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
813 – Risk of non-compliance with the Regulatory Reform (Fire Safety) Order 2005 due to ageing infrastructure	Estates & Facilities	Executive Director of Allied Health Professions and Health Sciences	15	15 ➔ (Reviewed 14/08/26)	5	31/08/29	No – however included in Planning Goal 8

Rationale for Target Risk Score

It is anticipated that when training attendance levels have reached >85% target (and are sustained at this level) coupled with the completion of all major fire enforcement schemes, reduction of risk score will be considered. The current predicted expected date to achieve compliance across all areas is August 2029. This will be reviewed regularly in line with progress made to our infrastructure and obtaining appropriate levels of assurances that clearly evidences that the HB has effective fire safety management arrangements in place.

Corporate Risks Assigned to HSC



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Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Previous Risk Score	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
1433 – Risk to the ability to maintain routine and emergency services in the event of a severe pandemic	Public Health	Executive Director of Public Health	12	12 ➔ (Reviewed 21/07/26)	8	31/12/2026 31/03/2027	No Included within Operational Delivery Plan for 2026/27

Rationale for Current Risk Score

The national security and risk assessment was reviewed and re-published in November 2025; this remains unaltered.

The previous pandemic influenza risk has been changed into three new risks; one generic pandemic event (1433) and two emerging infectious diseases reflected on the operational risk register (1879 re: measles and 2093 re: tuberculosis).

Current likelihood of the risk has been scored as a 3 to reflect the risk of the Health Board being unable to respond to the scale and severity of the pandemic - not the likelihood of the pandemic actually occurring.

Rationale for Target Risk Score

Following 'Exercise Pegasus', the UK Government Exercise Report is due Winter 2026 which will identify recommendations at both government and local levels. This will be followed by the publication of the UK Government Respiratory Pandemic Plan/Guidance which our regional and Health Board plans will need to dovetail with. Following review of our Pandemic Response Framework in April 2026 a follow up table-top exercise is planned for the Autumn which will further inform our own pandemic preparedness. The Target Risk Score has been amended to reflect these timescales and provide time to analyse and incorporate recommendations.

Corporate Risks Assigned to HSC



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Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Previous Risk Score	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
2349 - Risk of disruption to services and increased financial pressure arising from fuel supply constraints and rising cost	Public Health	Executive Director of Public Health	12	12 → (Reviewed 21/07/26)	6	31/08/26	No new risk added in FY2026/27

Rationale for Current Risk Score

The likelihood of adverse impact from fuel supply constraints and rising fuel costs has reduced from inherent levels due to active national fuel market monitoring, existing national and regional contingency arrangements, business continuity planning, and cost monitoring measures already in place. However, the impact remains high because the Health Board continues to rely heavily on fuel (vehicle and heating) to operate a geographically dispersed estate, maintain patient transport, and support staff travel and community-based services. Sustained fuel price volatility therefore still presents a significant financial and operational risk, justifying a current risk score of 12.

Rationale for Target Risk Score

With continued implementation of mitigating actions such as nationally strengthened fuel supply resilience, optimisation of fuel (heating and vehicle) procurement, review of fleet usage, increased use of hybrid and low emission vehicles, enhanced digital and remote service delivery where appropriate, enhanced business continuity planning and longer-term investment in decarbonisation the potential impact of fuel disruption can be substantially reduced. While external market volatility means the likelihood cannot be reduced further in the short to medium term, these measures are expected to limit operational disruption and financial exposure, reducing the impact to a tolerable level and achieving the target risk score of 6 by the end of August 2026.

Audits and Inspections - Overview



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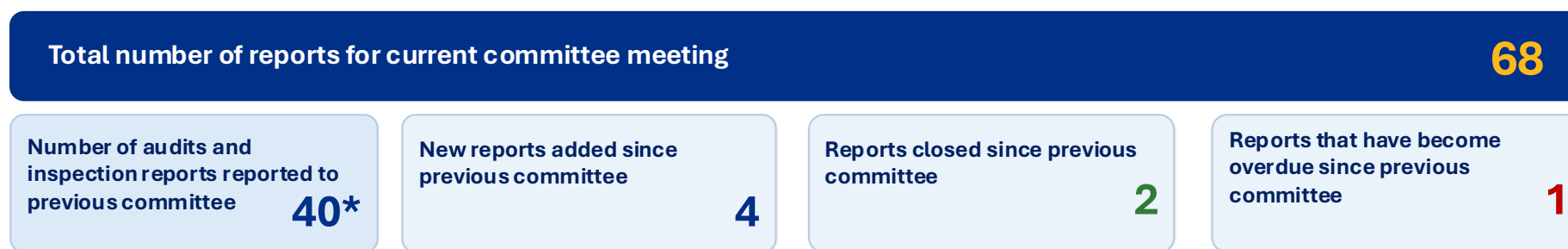
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The Health Board remains in Level 4 status with Welsh Government (WG) as a result of challenges relating to financial sustainability, strategy and planning, service delivery and organisational performance. The Health Board must meet the following criteria within the NHS Wales oversight and escalation framework:

- Evidence that all recommendations from the Royal Colleges / Health Inspectorate Wales (HIW) and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the Health Board's longer-term improvement plan;
- Support the implementation and realisation of Getting it Right First Time (GIRFT) and the national programme reviews opportunities;
- Support the implementation and realisation of the three Ps policy, GIRFT, theatre optimisation, CIN optimisation programmes and related national improvement recommendations; and
- Develop a prompt response to any HIW unannounced inspections, Audit Wales and Royal College recommendation, developing and completing action plans that demonstrate sustainable evidence.

All reports from audits, inspections and reviews undertaken across the Health Board are logged and tracked on AMaT (Audit Management and Tracking), with progress updated by relevant service leads against each recommendation, with evidence required to be uploaded to demonstrating progress and implementation, and any barriers to completion clearly noted.

AMaT enables services to directly update progress against all recommendations via one central system, promoting a consistent approach with regards to processes and reporting, improvement in transparency and accountability, supporting services with their governance arrangements, and improvement in information flow. Progress is monitored via the utilisation of a traffic light system based on performance against original completion dates, outlined on the next slide.



*To provide greater assurance and transparency to the Committee, the reporting format for this section has been enhanced to include reports classified as *Complete Pending Approval* and *Complete Approved*. These categories were not reported separately in May and account for the difference in reported numbers.

Audits and Inspections – Overview at Report Level



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The following reports have been assigned to the Health and Safety Committee to enable them to undertake the following responsibility set out in their Terms of Reference:

3.1.19 Seek assurances on the requirements arising from the Health Board's regulators, Welsh Government and professional bodies

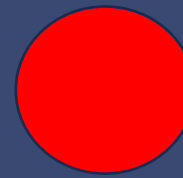
Status Category	Definition	Number of Reports – September 26	Number of Recommendations – May 26	Number of Recommendations – September 26
Overdue	Report / recommendation is behind schedule to the timescale provided by the Lead officer, or a plan / management response (with date for implementation) is not yet in place.	22	48	72
Unable to Complete	Report / recommendation cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	1	3	3
Pending Decision	Report / recommendation is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the report is overdue or not whilst decision pending.	0	0	0
In Progress	Report / recommendation is currently in progress, and within the agreed original timeframe for implementation.	19	66	58
Reliant on External Factors	Report / recommendation considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	1	4	3
Complete Pending Formal Approval	The CCG / Function have completed the report / recommendation and are currently awaiting formal approval to close.	23	47	165
Complete	Report / recommendation has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.	2	174	157

The September 2026 data shows an increase in the number of total recommendations, with a stronger position in relation to recommendations either completed or completed pending approval. There is a notable increase in overdue recommendations, however this is a reflection of the approval process where recommendations previously assessed by the service as completed have been challenged and rejected on AMAT with the request that additional evidence is uploaded to support their closure.

Detail of recommendations that are overdue are included in **Appendix 2**.

Audits and Inspection Reports

- Overdue



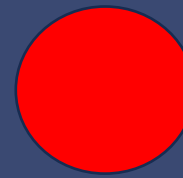
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Date of report	Report Issued By	Report Title	Clinical Care Group / Executive Function	Lead Director	Original Completion Date of the report	Revised Completion Date of the report	Number of recommendations in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	Mar-26 May-26 Sep-26	13	2	0	11	0	0	0	0	A number of barriers to completion within timeframe including incorrect sized doors received from manufacturer and lack of access to inpatient areas due to admissions and clinical priorities.
Sep-23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 1, (X-Ray & External Plant Room) Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Jun-24	Jun-24 Oct-25 Dec-25 N/K	6	1	0	5	0	0	0	0	Recommendation awaiting evidence of implementation to be uploaded to AMAT. Revised completion date sought.
May-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Central Core, GF Block 6, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Sep-24	Sep-24 Sep-26	9	2	0	7	0	0	0	0	Recommendation awaiting evidence of implementation to be uploaded to AMAT. On track for completion by revised date.
Jun-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cwm Seren PICU Ward, Hafan Derwen, Jobs Well Road, Carmarthen SA31 3HB	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Feb-26	Feb-26 May-26 Sep-26	9	5	0	3	1	0	0	0	Delays due to incorrect doors received from manufacturer/inability to access inpatient areas due to clinical priorities.
Aug-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Health Care Centre, Doctors Surgery, Maes Yr Eglwys, Solva, Pembrokeshire, SA62 6TW	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Dec-24	Dec-24 Dec-25 Sep-26	10	1	0	9	0	0	0	0	Recommendation awaiting evidence of implementation to be uploaded to AMAT. On track for completion by revised date.

Audits and Inspection Reports

- Overdue



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Date of report	Report Issued By	Report Title	Clinical Care Group / Executive Function	Lead Director	Original Completion Date of the report	Revised Completion Date of the report	Number of recommendations in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Sep-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Llandovery Hospital, Llanfair Road, Llandovery SA20 0LA	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Sep-24	Sep-24 Aug-25 Sep-26	10	10	0	0	0	0	0	0	Recommendations awaiting evidence of implementation to be uploaded to AMAT. On track for completion by revised date.
Oct-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Withybush General Hospital, Fishguard Road, Haverfordwest, SA61 2PZ, Block 24 (A+E)	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Jan-25	Jan-25 Mar-26 N/K	3	1	0	2	0	0	0	0	Recommendation awaiting evidence of implementation to be uploaded to AMAT. Revised completion date sought.
Dec-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 5 Cysgod Y Cwm Ward, Amman Valley Hospital, Folland Road, Glanamau, Ammanford SA18 2BQ	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Jun-25	Jun-25 Mar-26 N/K	3	1	0	1	0	0	1	0	1 recommendation os awaiting evidence of implementation to be uploaded to AMAT. 1 recommendation reliant on outcome of capital bid.
Jan-25	Local Authority	Food Safety & Hygiene Report Amman Valley Hospital	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Apr-26	Apr-26 Sep-26	5	3	0	2	0	0	0	0	On track for completion by revised completion date.
Jan-25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Hafan Derwen, Jobs Well Road, Carmarthen SA31 3BB	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Jul-25	Jul-25 Oct-25 Sep-26	11	10	0	1	0	0	0	0	Recommendations awaiting evidence of implementation to be uploaded to AMAT. On track for completion by revised date.

Audits and Inspection Reports

- Overdue



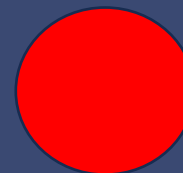
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Date of report	Report Issued By	Report Title	Clinical Care Group / Executive Function	Lead Director	Original Completion Date of the report	Revised Completion Date of the report	Number of recommendations in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Feb-25	Royal College	RCN Health and safety workplace inspection- Corridor care and safe staffing BGH EUCC February 2025	Community & Integrated Medicine	Chief Operating Officer	Sep-25	Sep-25 Sep-26	11	1	0	10	0	0	0	0	On track for completion by revised completion date.
Mar-25	Mid and West Wales Fire and Rescue Service	Enforcement Notice: 5438/02 The Regulatory Reform (Fire Safety) Order 2005: Article 30. Premises: Cwm Seren PICU Ward, Hafan Derwen, Jobs Well Road, Carmarthen SA31 3HB	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	Mar-26 May-26 Sep-26	2	2	0	0	0	0	0	0	Work continues to progress and is on track for completion by revised original completion date (awaiting evidence of agreement from MWWFRS re revised date).
Apr-25	Local Authority	Food Safety & Hygiene Report Withybush General Hospital	Estates & Facilities	Director of Allied Health Professions and Health Sciences	May-25	May-25 Sep-26	14	4	0	9	1	0	0	0	On track for completion by revised completion date.
Jul-25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 10, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	Mar-26 Sep-26	5	4	0	1	0	0	0	0	Recommendations awaiting evidence of implementation to be uploaded to AMAT.
Sep-25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 3 (AMAU), Ward 1, Prince Phillip Hospital, Llanelli, Carmarthenshire, SA14 8QF	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	Mar-26 N/K	5	1	0	4	0	0	0	0	Recommendation awaiting evidence of implementation to be uploaded to AMAT. Revised completion date sought.

Audits and Inspection Reports

- Overdue



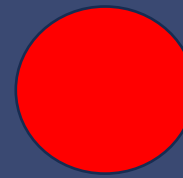
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Date of report	Report Issued By	Report Title	Clinical Care Group / Executive Function	Lead Director	Original Completion Date of the report	Revised Completion Date of the report	Number of recommendations in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Sep-25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER. September 2025	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Nov-25	Nov-25 Jul-26 Dec-26	9	5	0	4	0	0	0	0	2 recommendations awaiting evidence of implementation to be uploaded to AMAT, and 3 On track for completion by revised date.
Oct-25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 27 – Bryngolau, Prince Phillip Hospital, Carmarthenshire, SA14 8QF	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	Mar-26 N/K	4	1	0	2	1	0	0	0	Recommendation awaiting evidence of implementation to be uploaded to AMAT. Revised completion date sought.
Oct-25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Teifi Block, Bronglais General hospital, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER October 2025	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Jan-26	Jan-26 Dec-26	4	2	0	2	0	0	0	0	2 recommendations awaiting evidence of implementation to be uploaded to AMAT.
Oct-25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Dyfi Block, Bronglais General hospital, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER October 2025	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Jan-26	Jan-26 Feb-26 Apr-26 Jul-26 Dec-26	4	2	0	2	0	0	0	0	1 recommendation awaiting evidence of implementation to be uploaded to AMAT for closure. 1 recommendation on track for completion by revised date.
Oct-25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Education Centre, Bronglais General hospital, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER October 2025	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Jan-26	Jan-26 Dec-26	6	5	0	1	0	0	0	0	2 recommendations awaiting evidence of implementation to be uploaded to AMAT, and 3 on track for completion by revised date.

Audits and Inspection Reports

- Overdue



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Oct-25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Hafren Block, Bronglais General Hospital, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER October 2025	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Jan-26	Jan-26 N/K	5	1	0	4	0	0	0	0	Recommendation awaiting evidence of implementation to be uploaded to AMAT. Revised completion date sought.
Nov-25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 15 & 16, Prince Phillip Hospital, Dafen Road, Dafen, Llanelli, Carmarthenshire, SA14 8QF	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	Mar-26 N/K	3	2	0	1	0	0	0	0	Progress updates and revised completion date sought. Recommendations are aligned to Ward Staff.
Mar-26	Local Authority	Food Safety & Hygiene Report South Pembrokeshire Hospital March 2026 (NEW)	Estates & Facilities	Director of Allied Health Professions and Health Sciences	May-26	May-26 Mar-27	5	2	0	2	0	0	0	1	Overdue recommendations on track for completion by revised completion date.

Audits and Inspection Reports

– Unable to Complete



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Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Dec-26	Dec-26	9	0	1	6	0	0	0	2	2 unable to complete due to funding. Recommendations will be managed via Risk 2042 - Risk of harm to patients, staff, and visitors due to operational failures of Fire safety doors WGH, (current risk score 10) as unable to complete due to site complexities and reliance on capital bids.

Audits and Inspection Reports

– Reliant on External Factors



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Feb-25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 2 and Block 3, Amman Valley Hospital, Folland Road, Glanaman, Ammanford SA18 2BQ	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Jul-25	Jul-25 Sept-25 Dec-25 N/K	6	0	0	2	2	2	0	0	2 recommendations are reliant on receipt of revised Fire Strategy from MWWFRS.

Audits and Inspection Reports

– In Progress



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Jun-26	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1A & 1B, Occupational Health Offices, Prince Philip Hospital, Dafen Road, Llanelli, SA14 8QF June 2026 (NEW)	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Dec-26	7	0	7	0	0	0	0	0	N/A
Jul-26	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 5 & Brambly Hill Nursery, Prince Philip Hospital, Dafen Road, Llanelli, SA14 8QF July 2026 (NEW)	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Dec-26	4	0	4	0	0	0	0	0	N/A
Dec-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 2 Outpatients, Withybush General Hospital, Fishguard Road, Haverfordwest, SA61 2PZ	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-27	2	0	2	0	0	0	0	0	N/A
Dec-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 2: Labs, Withybush General Hospital, Fishguard Road, Haverfordwest, SA61 2PZ	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-27	1	0	1	0	0	0	0	0	N/A
Feb-26	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Day Surgical Unit, Prince Phillip Hospital, Dafen Road, Llanelli, SA14 8QF February 2026	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-27	5	1	2	2	0	0	0	0	Overdue recommendation due to ongoing ward pressures resulted in the delay of Practical Fire Drills, and being rescheduled
Aug-23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST, SA61 2PZ	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Apr-27	11	0	4	7	0	0	0	0	N/A

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Oct-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Withybush General Hospital, EBME Department, Fishguard Road, Haverfordwest, SA61 2P2	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Jun-27	4	0	1	3	0	0	0	0	N/A
Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: Withybush General Hospital. BFS/KS/SJM/00114719-KS/890/04	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Jul-27	4	0	1	3	0	0	0	0	N/A
Apr-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 5 GF, EBME, Physiotherapy, & CT Scanner, West Wales General Hospital, Dolgwlili, Carmarthen, SA31 2AF	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Aug-27	5	0	1	4	0	0	0	0	N/A
Apr-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 5 FF, Library, Secretaries offices & Chapel, West Wales General Hospital, Dolgwlili, Carmarthen, SA31 2AF	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Aug-27	5	0	1	4	0	0	0	0	N/A
Sep-23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: CCU, Towy Ward & Stem Corridor, West Wales General Hospital, Dolgwlili, Carmarthen, SA31 2AF.	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Aug-27	8	0	1	7	0	0	0	0	N/A
Feb-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwlili, Carmarthen, SA31 2AF	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Aug-27	12	0	4	8	0	0	0	0	N/A

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Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Oct-27	8	0	6	2	0	0	0	0	
Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Oct-27	8	0	6	2	0	0	0	0	
Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Oct-27	9	0	6	3	0	0	0	0	
Nov-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF KS/890/09	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Dec-27	1	0	1	0	0	0	0	0	
Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Feb-29	10	0	7	3	0	0	0	0	
Jun-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Apr-29	10	0	1	9	0	0	0	0	
Apr-26	Local Authority	Glangwili General Hospital Catering Department Inspection April 2026 (NEW)	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Apr-27	7	3	1	0	3	0	0	0	No barriers noted for overdue recommendations.

Audits and Inspection Reports – Complete Pending Approval To Close



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Date of report	Report Issued By	Report Title	Clinical Care Group / Executive Function	Lead Director	Original Completion Date of the report	Revised Completion Date of the report	Number of recommendations in original report	Complete
Jun-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Dec-24	Apr-29	15	15
Oct-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Residential Blocks 4 and 7, Prince Philip Hospital, Dafen Road, Llanelli SA14 8QF	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Feb-25	Mar-26	6	4
Jul-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Llys Steffan Health Clinic, Hafan Deg Road, Lampeter, Ceredigion, SA48 7BJ.	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Dec-24	Oct-25	8	7
Jul-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Teifi Block, Bronglais Hospital, Aberystwyth SY23 1ER	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Oct-24	Dec-25	5	4
Jul-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Hafren Block, Bronglais Hospital, Aberystwyth SY23 1ER	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Oct-24	Dec-25	6	5
Sep-25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER September 2025	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Nov-25	Jul-26	6	5
Jul-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Dyfi Block, Bronglais Hospital, Aberystwyth SY23 1ER	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Oct-24	Dec-25	6	5
Jul-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Aeron Block, Bronglais Hospital, Aberystwyth SY23 1ER	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Oct-24	Dec-25	6	5
Jul-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: EBME / Management Block, Bronglais Hospital Aberystwyth SY23	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Oct-24	Jul-25 N/K	9	9
Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-25	Oct-25	21	21
Jul-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Education Centre, Bronglais Hospital, Aberystwyth. SY23 1ER	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Oct-24	Mar-26	5	4

Audits and Inspection Reports – Complete Pending Approval To Close



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Date of report	Report Issued By	Report Title	Clinical Care Group / Executive Function	Lead Director	Original Completion Date of the report	Revised Completion Date of the report	Number of recommendations in original report	Complete
May-25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: BLOCK 6 WITHYBUSH GENERAL HOSPITAL, FISHGUARD ROAD, HAVERFORDWEST. SA61 2PZ	Estates & Facilities	Director of Allied Health Professions and Health Sciences	May-26	May-26	2	2
Feb-25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 6 Day Surgical Unit, Amman Valley Hospital, Folland Road, Glanamman, Ammanford SA18 2BQ	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Jul-25	Dec-26 N/K	6	6
Mar-25	Mid and West Wales Fire and Rescue Service	Enforcement Notice: 5438/02 The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Cwm Seren PICU Ward, Hafan Derwen, Jobs Well Road, Carmarthen SA31 3HB	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	Sep-26	2	2
Mar-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 17, (Pathology First Floor), Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Sep-24	Dec-25 N/K	4	4
Jul-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Tenby Surgery Gas Lane, Tenby SA70 8AG	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Oct-24	Mar-26 N/K	4	4
Sep-25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER September 2025	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Nov-25	Nov-25 N/K	9	9
Sep-25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER September 2025	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Nov-25	Nov-25 Jul-26	7	6
Oct-25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Aeron Block, Bronglais General hospital, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER October 2025	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Jan-26	Mar-26	7	7
Oct-25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: GREVILLE COURT, ALBION SQUARE, PEMBROKE DOCK, SA72 6XF October 2025	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	Mar-26	2	2
Feb-25	Royal College	RCN Health and Safety Workplace Inspection AMAU Prince Philip Hospital February 2025	Community & Integrated Medicine	Chief Operating Officer	May-25	N/A	7	7
Mar-25	Royal College	RCN Workplace Inspection - WGH A&E Department	Community & Integrated Medicine	Chief Operating Officer	Aug-25	N/A	20	20
Feb-25	Royal College	RCN Health and safety workplace inspection- Emergency Department GGH February 2025	Community & Integrated Medicine	Chief Operating Officer	Nov-25	N/K	4	4

Audits and Inspection Reports - Complete

- Closed since Previous Report



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Since the previous report presented to HSC, the following reports have been formally approved as closed:

Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Implementation Date	Number of recommendations in report	Report status
Internal Audit	Estates Condition	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Jul-24	Dec-25	8	Complete
Health and Safety Executive	HSE Notice and Letter Microbiology WGH	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	May-26	May-26	9	Complete



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Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Aug-26	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score	Risk on page no...
813	Risk of non-compliance with the Regulatory Reform (Fire Safety) Order 2005 due to ageing infrastructure	Severs, James	Statutory duty/inspections	3×5=15	3×5=15	→	1×5=5	31/08/2029	6
1745	Risk of not being able to safely deliver services due to ageing estate and infrastructure across the Health Board	Severs, James	Safety - Patient, Staff or Public	3×5=15	3×5=15	→	2×5=10	31/08/2032	11
1860	Risk of staff harm and service disruption due to violence and aggression within healthcare settings	Severs, James	Safety - Patient, Staff or Public	5×3=15	5×3=15	→	4×3=12	01/04/2027	14
2349	Risk of disruption to services and increased financial pressure arising from fuel supply constraints and rising cost	Gjini, Ardiana	Service/Business interruption/disruption	3×4=12	3×4=12	→	3×2=6	31/08/2026	18
1433	Risk to the ability to maintain routine and emergency services in the event of a severe pandemic	Gjini, Ardiana	Service/Business interruption/disruption	3×4=12	3×4=12	→	2×4=8	31/03/2027	22

RISK SCORING MATRIX					
Likelihood x Impact = Risk Score					
		Corporate Risk Description:			
Likelihood	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	This will probably never happen/recur (except in very exceptional circumstances).	Do not expect it to happen/recur but it is possible that it may do so.	It might happen or recur occasionally.	It might happen or recur occasionally.	It will undoubtedly happen/recur, possibly frequently.
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least weekly.*	Expected to occur at least daily.*
* time-framed descriptors of frequency					
Probability - Will it happen or not? (what is the chance the adverse consequence will occur in a given reference period?)	(0-5%*)	(5-25%*)	(25-75%*)	(75-95%*)	(>95%*)
*used to assign a probability score for risks related to time-limited or one off projects or business objectives.					
Risk Impact Domains	Negligible - 1	Minor - 2	Moderate - 3	Major - 4	Catastrophic - 5
Safety of Patients, Staff or Public	Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention.	Moderate injury requiring professional intervention.	Major injury leading to long-term incapacity/disability.	Incident leading to death.
	No time off work.	Requiring time off work for >3 days	Requiring time off work for 4-14 days.	Requiring time off work for >14 days.	Multiple permanent injuries or irreversible health effects.
		Increase in length of hospital stay by 1-3 days.	Increase in length of hospital stay by 4-15 days. Agency reportable incident. An event which impacts on a small number of patients.	Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.	An event which impacts on a large number of patients.
Quality, Complaints or Audit	Peripheral element of treatment or service suboptimal.	Overall treatment or service suboptimal.	Treatment or service has significantly reduced effectiveness.	Non-compliance with national standards with significant risk to patients if unresolved.	Totally unacceptable level or quality of treatment/service.
	Informal complaint/inquiry.	Formal complaint.	Formal complaint -	Multiple complaints/ independent review.	Gross failure of patient safety if findings not acted on.
		Local resolution.	Escalation.	Low achievement of performance/delivery requirements.	Inquest/ombudsman inquiry.
		Single failure to meet internal standards.	Repeated failure to meet internal standards.	Critical report.	Gross failure to meet national standards/performance requirements.
		Minor implications for patient safety if unresolved.	Major patient safety implications if findings are not acted on.		
		Reduced performance if unresolved.			

Workforce & OD	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff.	Uncertain delivery of key objective/service due to lack of staff.	Non-delivery of key objective/service due to lack of staff.
			Unsafe staffing level or competence (>1 day).	Unsafe staffing level or competence (>5 days).	Ongoing unsafe staffing levels or competence.
			Low staff morale.	Loss of key staff.	Loss of several key staff.
			Poor staff attendance for mandatory/key training.	Very low staff morale. No staff attending mandatory/ key training.	No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
			Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty.	Prosecution.
				Improvement notices.	Complete systems change required.
				Low achievement of performance/delivery requirements.	Low achievement of performance/delivery requirements.
Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.
Health Equity	Minimal or no impact on our attempts to improve health equity	Minor impact on our attempts to improve health equity or low level of certainty on the impact we are having on health equity	Moderate impact on our attempts to improve health equity or a lack of sufficient information that would demonstrate this. Indications that we are not having a positive impact on health improvement or health equity	Major impact on our attempts to improve health equity. Validated data suggesting that we are not improving the health of the most disadvantaged in our population whilst clearly supporting the least disadvantaged. Validated data suggesting we are having no impact on health improvement or health equity.	Validated data clearly demonstrating a disproportionate widening of health inequalities or a negative impact on health improvement and/or health equity.

RISK MATRIX					
IMPACT ↓	LIKELIHOOD →				
	RARE	UNLIKELY	POSSIBLE	LIKELY	ALMOST CERTAIN
	1	2	3	4	5
CATASTROPHIC 5	5	10	15	20	25
MAJOR 4	4	8	12	16	20
MODERATE 3	3	6	9	12	15
MINOR 2	2	4	6	8	10
NEGLIGIBLE 1	1	2	3	4	5

RISK ASSESSMENT - FREQUENCY OF REVIEW			
RISK SCORED	DEFINITION	ACTION REQUIRED (GUIDE ONLY)	MINIMUM REVIEW FREQUENCY
15-25	Extreme	Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have an effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required.	This type of risk is considered extreme and should be reviewed and progress on actions updated, at least monthly.
8-12	High	Very unlikely to be acceptable. Significant resources may have to be allocated to reduce the risk. Urgent action should be taken. A number of control measures may be required.	This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly.
4-6	Moderate	Not normally acceptable. Efforts should be made to reduce risk, providing this is not disproportionate. Establish more precisely the likelihood & harm as a basis for determining the need for improved measures.	This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months.
1-3	Low	Risks at this level may be acceptable. If not acceptable, existing controls should be monitored & reviewed. No further action or additional controls are required.	This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually.

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Management	Tends to be detailed assurance but lack independence
2nd Line	Corporate Oversight	Less detailed but slightly more independent
3rd Line	Independent Assurance	Often less detail but truly independent

Key - Assurance Required		<i>NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you</i>
	Detailed review of relevant information	
	Medium level review	
	Cursory or narrow scope of review	

Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective and in proportion to the risk
INSUFFICIENT	Insufficient information at present to judge the adequacy/effectiveness of the controls

Executive Director Owner:	Severs, James	Date of Review:	Aug-26
Lead Committee:	Health and Safety Committee	Date of Next Review:	Sep-26

Risk Rating:(Likelihood x Impact)	
Domain:	Statutory duty/inspections
Inherent Risk Score (L x I):	4x5=20
Current Risk Score (L x I):	3x5=15
Target Risk Score (L x I):	1x5=5
Expected Date To Achieve TRS:	31/08/2029
Trend:	

Current Risk Score

Target Risk Score

Rationale for CURRENT Risk Score:
Phased fire safety improvement works are ongoing across our sites, with significant investments being made to address the recommendations in the Mid and West Wales Fire & Rescue Service (MWWFRS) letters and Enforcement Notices (EN). All programme dates have been agreed with the Health Board, Welsh Government and MWWFRS senior inspecting officers. The progress of completed actions is regularly reviewed to determine the risk score as these works are progressed. Extensions of time particularly for EN schemes have been fully agreed by MWWFRS. A reduced scope of works has been agreed for Withybush General Hospital (WGH) and Glangwili General Hospital (GGH) Phase 2 on achievement of the following: Fire alarm systems to L1 standard (achieved). Health Board to achieve and maintain an 85% target for combined Fire Safety Training - MWWFRS have mandated that this must be achieved by 31/03/26, however the HB has not met this requirement. It has been escalated to the HB to address. Night fire wardens are in place (WGH and GGH). Bronglais General Hospital (BGH) will also be in post by 1st Sept 26. The BORIS software system has been implemented, and all fire risk assessments have been transferred across. Papers are submitted to the estates CCG meetings providing a high-level summary of the Estates and Hospital Management Risks. Currently, the risk is felt to still be extreme until further progress is made on the above fire safety improvement works.

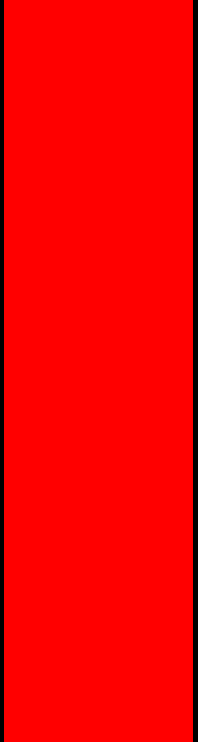
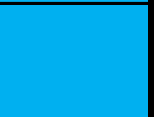
Rationale for TARGET Risk Score:
Further improvements in culture and ownership for fire safety. It is the scale of physical backlog for fire safety compliance (additional surveys) that will remain until appropriate measures are put in place to address the deficit. Despite annual investment from statutory capital and additional funding from EFAB/Tef for fire safety components, the scale of current investment is clearly not adequate to address the true scale of backlog the UHB has. Based on the planned works for completion (November 2025), it is expected that the current risk score could be reduced, this will need to be assesses in relation to the governance challenges we also experience currently. It is anticipated that when training attendance levels specifically for L2 training have reached > 85% targets and are sustained at this level continuously, coupled with the completion of all major fire enforcement schemes. The HB will then be in an informed position to look at the further reduction of risk score. The currently predicted expected date to achieve compliance across all areas is August 2029.This will be reviewed regularly inline with progress made to our infrastructure and obtaining appropriate levels of assurances that clearly evidence the HB has effective fire safety management arrangements in place.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)
Pre Planned Maintenance (PPM) checks are carried out across the UHB on fire safety components. A detailed physical estates backlog system is in place that identifies the scale (£) and risk of backlog for UHB. Data used to manage backlog maintenance & statutory decision making also regularly reported to WG. Extensive fire safety improvement works are being undertaken at WBH, GGH, BGH and Cwm Seren (following fire enforcements notices served on the HB) from WG agreed funding. All phased timelines fully agreed with MWWFRS. Regular communications and dialogue is taking place between HB and MWWFRS. Individual Fire Risk Assessments (FRA's) in place for all sites across the UHB identifying fire related risks. Boris fire safety system implemented across the UHB, giving the ability to review all risks from fire risk assessments via a dashboard and risk ownership.

Gaps in CONTROLS				
Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
Further action necessary to address the controls gaps				
Despite significant investments already in place following enforcement notices and letters of fire safety matters, additional investment is required to address fire safety defects at other sites within the UHB, which are being inspected by MWWFRS. We have firm plans in place to address a range of fire safety projects over the coming years and these are all fully identified as actions within this risk with anticipated timelines.	WBH - Completion of Phase 2 works - For all departments, ward areas and risk rooms.	Elliott, Rob	30/04/2025 30/04/2025 31/07/2027	Full agreement has now been reached with Welsh Government (WG)/NHS Wales Shared Services Partnership - Special Estates Services (NWSSP-SES) to change the procurement approach for Phase 2. This following a wide-ranging lessons learned exercise undertaken jointly with NWSSP-SES. Start date Sept 2024 completion mid 2027. Will be regularly reviewed.
Not all managers who are assigned actions on Boris are regularly accessing the system to close off their actions. Despite recent invitations for staff to				

Training Needs Analysis (TNA) for fire safety training in place, as defined in Fire Policy. UHB has implemented new governance structure for fire safety reporting from FSG to Estates care groups. Estate plans with fire zones, fire doors, fire compartmentation, fire infrastructure items (alarm and detection system). UHB assesses its performance in respect of operational maintenance work carried out on fire safety components and presents this information as a formal paper at all UHB wide fire safety tech meetings. Annual prioritisation of investment against high risk backlog. The HB has now embedded a fully resourced fire safety management team, with appropriate reporting arrangements for fire safety training and maintaining fire risk assessments across the UHB. The UHB has improved fire safety management culture and management ownership for fire safety, through the implementation of Level 5 management training for staff above 8b grades. The fire team also issue a regular training global e-mail as a reminder for staff on when and how to book a session. Works already completed following issue of Enforcement Notices and LoFSM at various sites. For EN sites (p1 WBH and p2 GGH) - Advanced Works and Phase 1 works now completed. Also improvements carried out under LoFSM at Tregaron, Bronglais, Glangwili and Wthybush Hospitals. Level 1 & 2 Fire Safety training is delivered via Teams. Level 3 Fire Safety training is provided face to face. Level 4 training (Fire Safety Warden training) is also a face to face session, with an external trainer. Level 5 training is provided on Teams as part of the H&S Managers induction training. There is an improving performance in terms of uptake of training (except for L2).	attend training sessions.	GGH - Completion of Phase 2 works - For all departments, ward areas and risk rooms.	Elliott, Rob	30/04/2024 30/08/2024 30/06/2025 30/11/2027	Full agreement has now been reached with Welsh Government (WG)/NHS Wales Shared Services Partnership - Special Estates Services (NWSSP-SES) to change the procurement approach for Phase 2. This following a wide-ranging lessons learned exercise undertaken jointly with NWSSP-SES.
	Fire safety training performance (for L2) is currently below the agreed level at (85%) as set by MWWFRS for the HB but specifically for WBH and GGH (sites under enforcement). The Fire Safety Team with L&D staff have introduced new training material to offer a more interactive e-learning experience with questions for each section. Performance is being regularly reviewed. As such the HB's fire policy now needs to be re-drafted.				Start date Sept 2024 completion mid 2027. Will be regularly reviewed.
	Despite making improvements to the culture of fire safety management and ownership, the HB does need to ensure this is organisational wide and embedded within it's workforce and cascaded by management.	Completion of planned fire safety enforcement work at Cwm Seren MH Facility in Carmarthen, following enforcement notice.	Evans, Paul	Completed	works complete
	A revised list of Named Responsible Persons for each site is needed to ensure the responsibilities for fire safety is fully understood.	As a fire safety policy requirement, the HB is expected to have a record of all responsible persons for each premises, to ensure that legal fire safety responsibilities are understood and acknowledged. This must also include premises where the HB is not the landlord but may occupy the premises for HB use.	Jupp, Richard	Completed	Existing list will be issued to FSG for ownership and updating by the agreed date. Still awaiting some final names to complete the list. extension required due to resource pressures in fire team.
	Improvements to fire safety governance has recently been introduced, there is a new chair person nominated for the fire safety group and membership has been altered. The FSG now reports to the Estates Governance Care Group. However, the performance reporting metrics have yet to be agreed.	To develop an initial fire safety strategy detailing specific arrangements and headings, which supports our agreed HB wide fire safety policy.	Jupp, Richard	Completed	Document template now complete, we are now populating the date of completion for each step of the process.
	Improvements to our fire strategy drawings is required to correctly	To assess and measure our ability to demonstrate effectiveness of each element of the strategy and any potential gaps/timelines to address any shortcomings.			

Regular communications processes in place to advertise L2 fire safety training. Papers are submitted to the estates CCG meetings providing a high level summary of the Estates and Hospital Management Risks.	Identify fire compartmentation and fire door locations to inform maintenance teams. This will also require additional external surveys to be carried out and additional capital to fund these surveys.	To amend the existing Fire Safety Policy noting the revised governance changes and updates now required to the training needs analysis. The timeline given is specifically for documentation change and not HB approval. An additional action will be added once the document is ready for board approval.	Jupp, Richard	Completed	extension of time approved by HSCG due to fire resource pressures at senior level.
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ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance	Required Assurance			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
		(1st, 2nd, 3rd)	 Current Level							
Maintain a zero or as low as possible number of outstanding fire risk assessments. Monitor the number of risks now held in the new Boris Fire Safety System.	Bimonthly review of outstanding actions from fire risk assessments	1st			Fire safety performance reports now submitted to monthly Estates Governance Care Group for review. SBAR submitted to each HSAC meeting, which includes themes of all fire safety risks.	General site management checks/walkaro unds on all sites				
	Site Fire wardens reporting fire safety issues	1st								
	Annual Online Fire Audit Self-Assessment submitted to NWSSP	1st								
	Review of compliance through fire safety groups	2nd								
	4 Fire Safety Sub Groups (one at each site) which report into the UHB wide Fire Safety Group (reporting into the HSC)	2nd								

	Fire Safety SBAR (3A's) reports regularly issued to HSSC and estates governance care groups	2nd			Cons Fire Safety System (UPDATE) and Fire Training Performance SBAR's submitted HSC.				
	Fire inspections by Fire Service & Fire Improvement Notices	3rd							
	NWSSP fire advisor inspections	3rd							
	High level action plan meetings with MWWFRS with very positive comments received from then on our commitment to improve fire safety performance in relation to the EN schemes in place.	2nd							

Date Risk Identified:	Aug-23
Strategic Objective:	3. Great Care

Executive Director Owner:	Severs, James	Date of Review:	Aug-26
Lead Committee:	Health and Safety Committee	Date of Next Review:	Sep-26

Risk ID:	1745	Corporate Risk Description:	There is a risk of not being able to deliver safe, effective and timely services across the HB estate, including acute, community and mental health facilities. This risk also impacts the HB's non clinical estate, educational facilities and managed practices. This is caused by further deterioration of our aging buildings and infrastructure with significant amount of the estate beyond its life expectancy. Multiple points of failure, delays in addressing reported defects and limited capital to address the increasing backlog of estate environmental issues. This could lead to an impact/affect on patient experience, our ability to deliver care in line with expected standards resulting in increased scrutiny and critical reports from auditors, regulators and inspectorates, such as HIW and HSE, and decreased public confidence and perception of our services, facilities and estate environment. Impacts also include increasing revenue costs to supplement the lack of capital funding available required to react to emerging issues, ability to comply with the Health and Safety at Work Act, including other legal regulations and engineering guidance documents such as Welsh Health Technical Memorandums (WHTMS).
Does this risk link to any Directorate (operational) risks?			1795,33,39, 838

Risk Rating:(Likelihood x Impact)

Domain: Safety - Patient, Staff or Public

Inherent Risk Score (L x I): 4×5=20

Current Risk Score (L x I): 3×5=15

Target Risk Score (L x I): 2×5=10

Expected Date To Achieve TRS: 31/08/2032

Trend:

Rationale for CURRENT Risk Score:

The current risk score is based upon the level of detailed information the Estates department has for its buildings, plant and infrastructure, including external reports, risk information and Estates and Facilities Performance Management System (EFPMS) data submitted to Welsh Government (WG), clearly articulating the scale of backlog and deficiencies across the Health Board. The Programme Business Case (PBC) has been under development with WG since 2018/19. The score also reflects lack of capital support (noting this project dates back to 2018); the Health Board has therefore changed the approach entirely and have worked since October 2024 in a partnership arrangement with NWSSP-SES to jointly develop an estates priority and risk consequence paper written as far as possible with clearly understood language. This document explains in great clarity what the potential implication could be if a specific infrastructure item was to fail. This narrative was jointly supported by Estates and NWSSP-SES engineers.

The Health Board undertook workshops directly with NWSSP-SES in August 2025 to determine the preferred options, accounting for risk mitigation, technical implications, deliverability and cost. The Health Board are engaging with WG directly to secure the resources to progress these works via the appropriate business process. On a positive note, this project is one of the supported priority projects by WG for investment in Health Board estate.

Rationale for TARGET Risk Score:

Backlog figures and risks are being reviewed regularly in order to inform the current risk score, and to determine any future risk reductions.

The currently predicted expected date to achieve improved compliance is 2032.

The achievement is directly linked to the amount of funding the Health Board (HB) will receive to address the current issues faced across the organisation and our ability to successfully deliver these improvements to reduce risk over time.

This will be reviewed regularly as schemes progress.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
Planned and Preventative Maintenance regimes CAFM system to report and prioritise breakdowns across site. Questionnaires have now been included in CAFM, to measure the performance of our maintenance service. Also to feedback any suggestions on improvements. Condition appraisals (estate survey) and NWSSP-SES audits Backlog database identifies costs of works across the estate Operational Estates staff on site to deal with breakdowns (on-call 24/7) Tef funding bids have been successful to support DCP (25/26 investment of circa £6.347m including HB's 30% contribution) Tef project group established to deliver this investment. Risks are identified by Estates and services and these inform prioritisation of DCP funding Skilled and trained Estates workforce in place. Site walkarounds in place across the 4 sites.	Limited Discretionary Capital Programme (DCP) funding to address the £250m backlog WG support for the Major Infrastructure Programme has not been confirmed Statutory, mandatory and essential maintenance jobs are prioritised over routine helpdesk jobs (on average only 50% of helpdesk jobs are completed) Reduction in annual capital funding and statutory allocations to address key items.	Development of Major infrastructure Programme for 4 main hospitals and securing external funding	Chiffi, Simon	Completed	The HB are now undertaking workshops directly with NWSSP-SES to determine the preferred options, accounting for risk mitigation, technical implications, deliverability and cost. This exercise is due for completion August 2025. At this point we will be engaging with WG directly to secure the resources to progress these works via the appropriate business process. On a positive note this project is one of the supported priority project by WG for investment in HB estate.
	Increased backlog of circa £250m+ Operational resource pressures across the acute sites. Increasing number of maintenance checks, specifically in relation to fire compliance.	AHMWW PBC submitted to WG in February 2022 remains not endorsed. Agreement required with Welsh Government on next steps and broader strategic direction.	Davies, Lee	10/10/2025 31/03/2026	The Health Board has had further constructive discussions with Welsh Government on the infrastructure challenges facing the organisation, in particular at the Withybush and Glangwili sites. Welsh Government (WG) has recently requested the Health Board produce, by early in the New Year, an addendum to the Programme Business Case (PBC) submitted in February 2022. This is a significant piece of work, which is currently being scoped, but at this stage the intention is to present this to Public Board in January 2026

		the re-introduction of regular (documented) site walkabouts by operational estates and general hospital management. To potentially identify and target defects or site issues that can potentially be quickly addressed, minimising the impact of compounding backlog issues across our sites.	Day, Simon	Completed	Walkabouts are in place
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ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance 			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
			Current Level							
Backlog figures Number of failures Cost increases due to inflation Number of call-outs	Regular review of 'environment' themed risks identified on operational service risk registers	1st								
	Feedback questionnaire on CAFM maintenance system to measure effectiveness of maintenance service and to offer additional feedback or suggestions on all closed maintenance requests	1st								
	Health and Safety Committee review of risks above tolerance	2nd								
	Independent Member & Executive Director Walkabouts	2nd								
	External surveys are undertaken, including Authorised Engineers Audits across each engineering discipline in line with Welsh Health Technical Memorandums (WHTMs)	3rd								

	NWSSP-SES Internal Audit on Estates Condition October 2024 (Limited Assurance)	3rd											
	Receipt of WHTM audit reports from NWSSP	3rd											

Date Risk Identified:	May-24
Strategic Objective:	1. Thriving Teams and 3. Great Care

Executive Director Owner:	Severs, James	Date of Review:	Aug-26
Lead Committee:	Health and Safety Committee	Date of Next Review:	Sep-26

Risk ID:	1860	Corporate Risk Description:	There is a risk that staff may be exposed to physical and/or verbal assault from patients, service users, visitors or members of the public. This is caused by incidents of violence and aggression within healthcare settings. This could lead to an impact/affect on staff experiencing physical injury, psychological harm, reduced wellbeing, and disruption to service delivery, as well as potential non-compliance with Health and Safety legislation.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)

Domain: Safety - Patient, Staff or Public

Inherent Risk Score (L x I): 5×4=20

Current Risk Score (L x I): 5×3=15

Target Risk Score (L x I): 4×3=12

Expected Date To Achieve TRS: 01/04/2027

Trend:

Date	Current Risk Score	Target Risk Score
Jun-24	15	5
Sep-24	15	5
Dec-24	15	9
Apr-25	15	9
Jul-25	15	9
Oct-25	15	9
Jan-26	15	9
Apr-26	15	9
Aug-26	15	12

Rationale for CURRENT Risk Score:

The high frequency of violence and aggression incidents contributes greatly to the current risk score, with over 1400 incidents recorded during 2025. More recent figures show that this trend is continuing in 2026 (April 107, May 120, June 99). The likelihood remains at 5 as these incidents occur numerous times daily.

Due to the number of patients with complex needs (e.g. cognitive impairment, medical confusion or substance misuse) it is unlikely that the likelihood score will reduce greatly. The lack of adequate and suitably qualified security staff to deal with these incidences means the consequences and impact of any incidents can be catastrophic, resulting in physical injury to staff, psychological harm , reduced well-being and service disruption.

Inconsistent compliance with Violence & Aggression (V&A) risk assessments and training and a lack of process surrounding the management of lone working safety measures are also contributory factors.

Rationale for TARGET Risk Score:

Whilst the likelihood of the risk occurring remains high, the impact score can be reduced by employing suitably qualified security staff at acute sites.

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Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
There is a Violence and Aggression Policy in place to support the management of V&A risks as well as the identification and assessment of foreseeable risks. Aligned to the policy is the existence of V&A Risk Assessments. There is a V&A risk assessment toolkit in place to aid managers to assess the risk of V&A at a service level. There is a V&A case manager, employed by the Health Board to support and promote this process. Education and training - there is anational NHS Violence and Aggression Training Scheme Standard in place to recognise and manage the risk of V&A in the workplace. There is a Reducing Restrictive Practice (RRP) training team in place to ensure that relevant staff are trained to restrain violent or aggressive individuals. There is a Violent Patient Warning Marker Procedure in place to provide early warning for staff caring for recorded patients. This applies to primary and secondary care settings. Lone working policy to promote the principles of safer workin for lone workers.	There is no mechanism in place to monitor compliance with the number of V&A Risk Assessments being completed and monitored. There is inconsistent application of the NHS Violence and Aggression Training Scheme standard. Better assurance required on compliance with the HB Patient Warning Marker Procedure. Service Managers are required to review within 12months the need for a warning marker to remain on the patients record. Low compliance in the use of 'People Safe' lone working devices. A lack of dedicated and suitably qualified security staff on sites to respond to V&A incidents. Some portering staff are unable to complete RRP training due to physical constraints.	Develop a process to improve oversight of V&A risk assessments.	Jenkins, Brett	30/04/2025 31/06/2026 31/08/2026	MS Forms template has been devised. Incident data supplied to management to inform their V&A risk assessments. V&A Case Manager will review the process and bring a revised process to the Security Management Group in Jul26. All managers were asked to confirm that they have a V&A risk assessment in place and report back to the V&A Case Manager by end of January 2025. Unfortunately responses have been poor and the V&A Case Manager is currently chasing assessments from all areas yet to submit. The request is reiterated via the CCG update reports.
		Undertake a thorough training needs analysis against the National V&A Training Scheme standard and improve access to training.	Wood, Rachel	31/08/2025 30/06/2026 31/07/2026	TNA has been revised and completed. The TNA will be approved at the H&S IGG in Jul26.

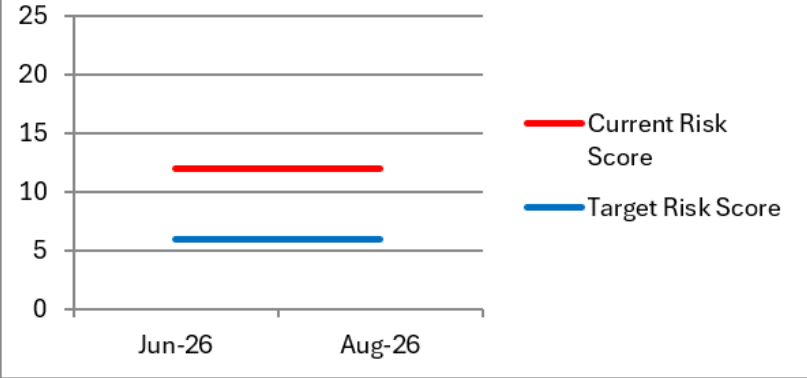
There is a Security Management Group in place to provide oversight on Violence and Aggression matters, which reports to the Health and Safety Compliance Group.	Review the HB Patient Warning Marker procedure to ensure the actions are clear and precise and to develop a mechanism for measuring compliance. To be monitored through the security group.	Jenkins, Brett	31/12/2025 30/06/2026 30/11/2026	Security Management Group have discussed compliance with the patient warning marker procedure and agreed how to progress with a procedure review. Document was reviewed and returned to SMG for key stakeholder comment. Policy widened to include other risks such as violent relatives, dangerous dogs, house risks etc, with risk assessments hosted in a central location. IG issues with this to be overcome - additional 3 month extension agreed by HSCG in August 2026.
	Review effectiveness of the use of PeopleSafe devices by staff and develop an action plan to improve access and take up.	Jenkins, Brett	30/04/2025 30/06/2026 30/09/2026	512 devices issued. Review of compliance shows 4-6% compliance. The V&A manager will develop an asset register to list all registered devices and which service they have been allocated to.
	Review incident reports to determine the severity, location by site across the Health Board. Incidents will be available via the H&S Dashboard this will include V&A incident data.	Jenkins, Brett	Completed	Reports are now submitted to the Security Management Group and are presented to the Health and Safety compliance group for scrutiny.
	Seek Executive support to employ a security resource at each acute site.	Brock, Elin	09/01/2026	A paper was presented to the Exec Team in March 2026 with further details on possible options available. A follow up paper is being presented on in Mid-Late July.
	If Executive Team approve the establishment of a security resource at each acute site, commence recruitment and procurement process	Springthorpe, Adam	30/09/2026	New action

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance	Required Assurance			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed	By Who	By When	Progress
		(1st, 2nd, 3rd)	Current Level							
Violence and aggression incident data. Training figures in line with the All Wales NHS Violence and Aggression Training Scheme.	Security incident breaches are reported via Datix and investigated	1st			Escalation paper provided to Public Board June 2023 A cost and risk analysis has been undertaken to compare the use of external security providers against the cost to employing via the Health Board, and a paper was presented to the Executive Team in December 2023	Security Report - Executive Team (Mar26)	Reports on security arrangements and related incidents are to be provided to Health and Safety Committee	Springthorpe, Adam	Completed	V&A/Security incident data is now reported to the H&S Committee via the Health & Safety Assurance Paper. V&A/Security data is also shared with each CCG on a monthly basis via the Health, Safety and Security Summary Reports.
	Reports on security arrangements and related incidents are provided to Health and Safety Committee	2nd				Security Report - HSC In-Committee (May26)				
	Reports on security arrangements and related incidents are provided to the Health and Safety Committee .	2nd				Security Report - Executive Team (Jun26)				

Date Risk Identified:	Apr-26
Strategic Objective:	1. Thriving Teams and 3. Great Care

Executive Director Owner:	Gjini, Ardiana	Date of Review:	Jul-26
Lead Committee:	Health and Safety Committee	Date of Next Review:	Sep-26

Risk ID:	2349	Corporate Risk Description:	There is a risk of disruption to services and increased financial pressure arising from fuel supply constraints and rising fuel costs across Hywel Dda University Health Board. This is caused by volatility in global and national fuel markets, ongoing inflationary pressures, reliance on fuel to support a geographically dispersed estate and fleet, dependence on fuel for staff travel and community based service delivery, and limited short term alternatives to fossil fuel use for patient transport, logistics and emergency resilience. This could lead to an impact/affect on increased operational and estates costs, reduced financial sustainability, challenges for staff in travelling to work and delivering community and domiciliary services, reduced capacity to maintain patient transport and service continuity, heightened risk to business continuity and emergency response capability, and reduced ability to invest in frontline care, estate resilience and decarbonisation objectives.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)		
Domain:	Service/Business interruption/disruption	
Inherent Risk Score (L x I):	5×4=20	
Current Risk Score (L x I):	3×4=12	
Target Risk Score (L x I):	3×2=6	
Expected Date To Achieve TRS:	31/08/2026	
Trend:		New risk

Rationale for CURRENT Risk Score:
The likelihood of adverse impact from fuel supply constraints and rising fuel costs has reduced from inherent levels due to active national fuel market monitoring, existing national and regional contingency arrangements, business continuity planning, and cost monitoring measures already in place. However, the impact remains high because the Health Board continues to rely heavily on fuel (vehicle and heating) to operate a geographically dispersed estate, maintain patient transport, and support staff travel and community based services. Sustained fuel price volatility therefore still presents a significant financial and operational risk, justifying a current risk score of 12.

Rationale for TARGET Risk Score:
With continued implementation of mitigating actions such as nationally strengthened fuel supply resilience, optimisation of fuel (heating and vehicle) procurement, review of fleet usage, increased use of hybrid and low emission vehicles, enhanced digital and remote service delivery where appropriate, enhanced business continuity planning and longer term investment in decarbonisation the potential impact of fuel disruption can be substantially reduced. While external market volatility means the likelihood cannot be reduced further in the short to medium term, these measures are expected to limit operational disruption and financial exposure, reducing the impact to a tolerable level and achieving the target risk score of 6 by the end of August .

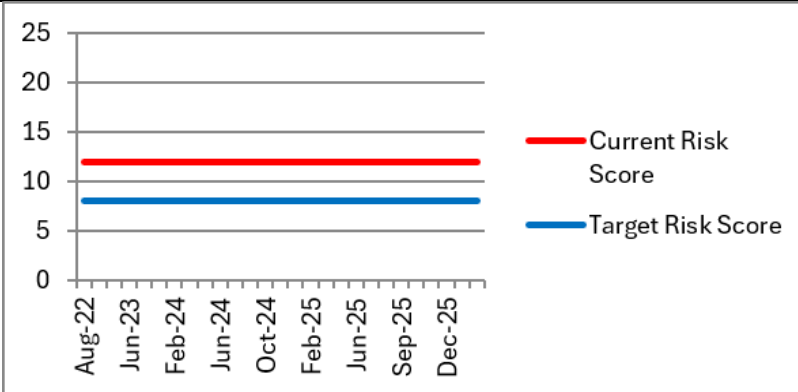
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
Fuel Supply Planning Group established to coordinate risk identification and mitigations Corporate procurement arrangements and framework contracts in place for fuel supply for 8 estates vehicles Cost pressures monitored through executive performance and finance reporting and escalated via corporate financial governance routes Communication Strategy drafted and ready for activation as required. Business continuity plans in place for all sites, including fuel dependent infrastructure (e.g. emergency generators on key sites) Fleet management arrangements in place to support patient transport, logistics and community service delivery Estates Energy and Decarbonisation programmes underway to reduce longer term reliance on fossil fuels Flexible working arrangements and local service planning to mitigate disruption to staff travel where possible Use of community based fleet and pooled vehicles to support delivery of district nursing and other community services in rural areas Failure of key supplier included in Business Continuity arrangements identify fuel disruption as a risk scenario.	Medium term financial planning assumptions relating to bunkered fuel procurement	Identify critical users to inform fuel plans going forward	Hussell, Sam	Completed	Exploring processes for identification of Essential Services/Choices Framework and criteria identifying critical workers during Covid.
	Only approximately a fifth of the workforce are able to work from home				
	Prioritisation process for fleet and pool cars should there be a fuel supply disruption	Exploring extending lease contracts for use by organisation	Skye, Gareth	Completed	Completed.
	Opportunities to strengthen heating fuel contingencies to be explored.	Develop a process of prioritisation for pool car bookings	Skye, Gareth	Completed	This action has been closed as this is on hold. A prioritisation process will be agreed if the situation deteriorates.
		Seek confirmation of data held corporately to inform critical user identification.	Hussell, Sam	Completed	Complete. Information has been provided from the Corporate Archive which will be used to inform critical user identification. Further conversations will be had with a number of teams to ascertain if they would be able to work remotely if the need arose.
		Fuel supply disruption element of Estates Business Continuity Plan to be reviewed.	Day, Simon	31/05/2026 31/08/2026	Draft developed

Executive oversight of emergency preparedness through designated executive and committee structures.		Undertake medium term financial planning assumptions include fuel scenarios.	Shaw, Terri	Completed	In progress and reported to the Fuel Supply Planning Group.
Agreement via the Dyfed Powys Local Resilience Forum (LRF) multiagency fuel sharing protocol					
Health Board a member of LRF Fuel Group					
UK Government National Fuel Plan in place					
Increase of fuel expenses via the All-Wales Fuel Cost Protocol from NHS Employers agreed from 01 June 2026					

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance 			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
			Current Level							
	Terms of Reference for Fuel Supply Planning Group	1st				Service level plans need to be reviewed with a specific fuel supply focus	To include fuel supply in the business continuity template and request business continuity plan owners consider impact to services	Hussell, Sam	Completed	Fuel supply disruption now included in Business Continuity template. Ongoing communications with services to consider fuel supply disruption contingency measures.
	SBAR to Formal Executive 25Mar26	1st								
	Service level business continuity plans	1st								
	Ratified multi agency LRF fuel sharing protocol in place	2nd								
	Fuel Supply Planning Group reports to the Emergency Preparedness, Resilience and Response Group	2nd								

Executive Director Owner:	Gjini, Ardiana	Date of Review:	Jul-26
Lead Committee:	Health and Safety Committee	Date of Next Review:	Sep-26

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	31/03/2027
Trend: 	



The chart displays two horizontal lines representing risk scores over time from August 2022 to December 2025. The red line, labeled 'Current Risk Score', is constant at a value of 12. The blue line, labeled 'Target Risk Score', is constant at a value of 8. The y-axis ranges from 0 to 25 in increments of 5. The x-axis lists dates: Aug-22, Jun-23, Feb-24, Jun-24, Oct-24, Feb-25, Jun-25, Sep-25, and Dec-25.

Date	Current Risk Score	Target Risk Score
Aug-22	12	8
Jun-23	12	8
Feb-24	12	8
Jun-24	12	8
Oct-24	12	8
Feb-25	12	8
Jun-25	12	8
Sep-25	12	8
Dec-25	12	8

Rationale for TARGET Risk Score:
Following Exercise Pegasus, the UK Gov exercise report is due Winter 2026 which will identify recommendations at both government and local levels. This will be followed by the publication of the UK Gov Respiratory Pandemic Plan/Guidance which our regional and Health Board plans will need to dovetail with. Following review of our Pandemic Response Framework in April 2026 a follow up table top exercise is planned for the autumn which will further inform our own pandemic preparedness. The Target Risk Score has been amended to reflect these timescales and provide time to analyse and incorporate recommendations.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
# Major Incident Plan (detailing internal command and control structures) # Well established command and control structures for managing pandemic response both nationally and locally # Continuation of current COVID-19 and wider national immunisation programmes # Choices Framework which sets out which services could be stood down in a pandemic # Extensive knowledge across Health Board in managing a pandemic event # COVID-19 response measures which can be adapted to respond to any future pandemic event # Local Resilience Forum (LRF) multi-agency plans for managing pandemic influenza reviewed and incorporate Ex Pegasus/Solaris & Bite Back lessons, but still awaiting the UK Gov Respiratory Pandemic Response Plan/Guidance) # LRF Excess Deaths Plan (which supports the LRF multi-agency pandemic influenza management arrangements) developed as a recommendation from Exercise Cygnus. Plan was ratified by the LRF Health Group. # Health Board Pandemic Response Framework reviewed April 2026 and incorporates Ex Pegasus/Solaris & Bite Back lessons).Approved by Board in May26. # Quality assurance process via national & local exercise programmes. # Access to national counter measures stockpile # Regional Health Protection service across HB and key partners # Continuous learning from COVID-19 # Pandemic Planning Group re-established # HB participated in Exercise Pegasus - national Tier 1 Pandemic Exercise scheduled across 3 phases played in Sept, Oct and Nov 2025. # HB participated in Exercises Solaris (pre-cursor to Pegasus) and Bite Back (invasive mosquito scenario) during 2025. # Pandemic Response Framework approved at May26 Board	Further testing of service preparedness Still awaiting publication of UK Government Respiratory Pandemic Planning Guidance	Deliver internal multi-disciplinary table top exercise to inform further development of HB pandemic response arrangements.	Hussell, Sam	31/07/2026 30/09/2026	Exercise endorsed by FET as next step and is being scheduled for Autumn 2026.
		Analyse and incorporate recommendations from Exercise Pegasus Final Report and UK Gov Respiratory pandemic Plan/Guidance following anticipated publication in Winter 2026.	Hussell, Sam	31/03/2027	New action

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
			Current Level							
	Planning via Emergency Preparedness, Resilience & Response (EPRR) including LRF workstream reports to Health & Safety Committee	1st			Vaccine Equity Strategy - Board 30 May 2024	None identified.				
	Operational pandemic reporting structures from HB to WG	2nd			Vaccination Delivery Programme Update - Board via SDODC (Sep 23)					
	National, regional & local command & control structures	2nd			Major Incident Plan - Board via H&SC and Exec Team (Jul 25)					
	National groups operational for vaccination programme planning & delivery	3rd			Pandemic Response Framework - FET Apr26, HSC May26 & Board May26					
	Emergency Planning Advisory Group (EPAG) Wales meetings re Pandemic response and future planning	3rd			Pandemic Response Framework (scheduled 05 May 2026)					

Report Issued By	Report Title	Recommendation Reference	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	BFS/SM/AMD/00107788_001	R1. All doors to patient bedrooms are to be fitted with appropriately designed free-swing self-closing devices, as stated in (Table 6 WHTM 05-02).	Full action plan held by Estates.	Julian Wheeler-Jones	Mar-26	Mar-26 May-26 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	BFS/SM/AMD/00107788_003	R3. The following doors should be replaced with fire doors providing 30/60 minutes fire resistance (Dependant on the location of the door). Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. • Medication room (LSU) – this is a stable door and is not providing suitable fire resistance.	Full action plan held by Estates.	Julian Wheeler-Jones	Mar-26	Mar-26 May-26 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 1, (X-Ray & External Plant Room) Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	1012/BFS/EH/00346588_02	R2. The opening in the ceiling located in: •R12 •R13 •R48 should be in filled to achieve the same fire resistance as the rest of the ceiling. The fire separation should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Stewart Evans Via Contractor	Jun-24	Jun-24 N/K	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Hafan Derwen, Jobs Well Road, Carmarthen SA31 3BB	00108151_0125_002	R2. Remove combustible materials immediately surrounding the tumble dryer. Reduce the combustibles within the Laundry/Store area. This should apply to the whole premise		Paul Hill	Jul-25	Jul-25 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Hafan Derwen, Jobs Well Road, Carmarthen SA31 3BB	00108151_0125_003	R3. The following doors should be replaced with fire doors providing 30/60 minutes fire resistance. Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. • GDF office R17, 00006705/6, 00006707, • FF 00006734/5, 00006732, Fire resisting doors need to be fitted with • A self-closing device Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - timber-based fire door assemblies – Code of practice Compliance with this or an equivalent standard will normally satisfy the requirement		Paul Hill	Jul-25	Jul-25 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Hafan Derwen, Jobs Well Road, Carmarthen SA31 3BB	00108151_0125_004	R4. Where a fire door is required to be fitted with an air transfer grille, it should only be fitted with one that is capable of sealing both by thermal initiation and by interface with smoke sensors either directly or via a fire alarm panel. The air transfer grill should conform to a relevant standard e.g.BS 8214:2016. Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with these standards will normally satisfy the requirement		Paul Hill	Jul-25	Jul-25 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Hafan Derwen, Jobs Well Road, Carmarthen SA31 3BB	00108151_0125_005	R5. Keep waste material in suitable containers before it is removed from the premises. If bins, particularly wheeled bins, are used outside, secure them in a compound to prevent them being moved to a position next to the building and set on fire. Never place skips against a building- they should normally be a minimum of 6 metres away from any part of the premises.		Paul Hill	Jul-25	Jul-25 Sep-26	Overdue

Report Issued By	Report Title	Recommendation Reference	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Hafan Derwen, Jobs Well Road, Carmarthen SA31 3BB	00108151_0125_006	R6. Remove bolts from door(s) indicated/located First Floor Stairs 00006740/1 If the door(s) is/are required to be kept locked it/they should be fitted with an approved type of emergency security fastening that can be operated from the escape side of the door(s) without the use of a key, which is conspicuously indicated as to its method of operation. This work should be done to conform to a relevant standard e.g. Section 6 General provisions of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement.		Paul Hill	Jul-25	Jul-25 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Hafan Derwen, Jobs Well Road, Carmarthen SA31 3BB	00108151_0125_007	R7. Extend the existing fire detection and warning system by providing automatic smoke detection in the following areas: • Risers in stairwells All work involving the fire alarm system should be carried out in accordance with BS5839-1:2017.		Paul Hill	Jul-25	Jul-25 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Hafan Derwen, Jobs Well Road, Carmarthen SA31 3BB	00108151_0125_008	R8. The inner room situation located within R73 is unacceptable, because the outer room is higher fire risk with the number of electricals coming into this room.		Paul Hill	Jul-25	Jul-25 Oct-25 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Hafan Derwen, Jobs Well Road, Carmarthen SA31 3BB	00108151_0125_009	R9. To ensure the continuing good operation of the fire alarm system, routine inspections and tests should be undertaken in accordance with BS 5839-1:2017 which indicates the frequencies as follows: • Daily checks. If applicable, in premises in which some employee's only work during hours other than at which the fire alarm system is normally tested, additional tests should be carried out at least once a month to ensure familiarity of these employees with the fire alarm signals. Evidence should be kept of the date of all such tests and any resulting maintenance of the system, best practice being the recording of the abovementioned information in a logbook. This is contrary to Article 17.		Paul Hill	Jul-25	Jul-25 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Hafan Derwen, Jobs Well Road, Carmarthen SA31 3BB	00108151_0125_010	R10. During the fire safety inspection evidence of tests carried out by a competent person on the emergency lighting system was not available. Evidence of such testing should be made available during a fire safety inspection to allow the responsible person to evidence that testing has taken place; the best evidence of testing being certificates of tests carried out by the said competent person		Paul Hill	Jul-25	Jul-25 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Hafan Derwen, Jobs Well Road, Carmarthen SA31 3BB	00108151_0125_011	R11. 1. Gaps between door edge and frame are to be no more than 3 mm. Gaps between door and floor should not be more than 10mm. 2. Self-closing / Free-swing devices on all fire resisting doors are to be checked and if required be adjusted, repaired or replaced so that the doors close completely into their rebates. 3. All fire resisting doors should be hung on one and a half pairs of 100mm hinges. The central hinge is to be placed one thirds of the distance between the top and the bottom hinge and the distance being measured from the top hinge. 4. Ensure that all fire doors-sets are fitted with intumescent strips and cold smoke seals. In the case of double doors you should ensure that they close without affecting the operation of the seals. 5. Repair or replace faulty door handles throughout premises. 6. Fitted in accordance with BS 8214:2016 - Timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement		Paul Hill	Jul-25	Jul-25 Sep-26	Overdue

Report Issued By	Report Title	Recommendation Reference	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Central Core, GF Block 6, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	1012/BFS/EH/0032337_1_002	R2. The following doors should be replaced with fire doors providing 30 minutes fire resistance. Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. •Door in Sub-compartment wall leading to R30 Fire resisting doors need to be fitted with •A self-closing device •Intumescent strips and smoke seals. •Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - timber-based fire door assemblies - Code of practice Compliance with this or an equivalent standard will normally satisfy the requirement.		N/K	Sep-24	Sep-24 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Central Core, GF Block 6, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	1012/BFS/EH/0032337_1_003	R3. The following rooms are to be cleared of all storage and kept locked shut when not in use. •Tech Room R39		N/K	Aug-24	Aug-24 N/K	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cwm Seren PICU Ward, Hafan Derwen,Jobs Well Road,Carmarthen SA31 3HB	5438/BFS//00107788_002	R2. The opening in the ceiling in the following location: 0135 IT Server Room should be in-filled with non-combustible materials, to provide 60 minutes standard of fire resistance. The fire separation should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings other than dwelling houses. . Compliance with this or an equivalent standard will normally satisfy the requirement.	Action plan held by Estates team.	Phillip Astles	Feb-26	Feb-26 May-26 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cwm Seren PICU Ward, Hafan Derwen,Jobs Well Road,Carmarthen SA31 3HB	5438/BFS//00107788_003	R3. Confirm that the following hatches located: •In the corridors, above bedrooms, are fire resisting. The fire separation should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement		Phillip Astles	Feb-26	Feb-26 May-26 Sep-26	Overdue

Report Issued By	Report Title	Recommendation Reference	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cwm Seren PICU Ward, Hafan Derwen,Jobs Well Road,Carmarthen SA31 3HB	5438/BFS//00107788_006	R6.The following 30-minute fire resisting doors were found to be damaged/defective. These doors must be repaired/replaced. • Cross-Corridor doors PICU next to dining room • Seclusion room PICU • 0049 Domestic cupboards LSU • Bedroom next to LSU meeting room • 008 IT server room • 002 A&B Cross corridor doors Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement		Phillip Astles	Feb-26	Feb-26 May-26 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cwm Seren PICU Ward, Hafan Derwen,Jobs Well Road,Carmarthen SA31 3HB	5438/BFS//00107788_007	R7. The intumescent strips and cold smoke seals on the following fire resisting doors were found to be damaged/missing. The strips and seals should be replaced in order to prevent the passage of smoke and flame. • First floor Office 007 • LSU Meeting room • Bedroom next to LSU meeting room • LSU Dining room both sets of doors • Cross-Corridor doors PICU next to dining room The intumescent strips and cold smoke seals should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement.		Phillip Astles	Feb-26	Feb-26 May-26 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cwm Seren PICU Ward, Hafan Derwen,Jobs Well Road,Carmarthen SA31 3HB	5438/BFS//00107788_008	R8. The ceiling hatch and surrounding ceiling in LSU Food Prep were found to be damaged, they should be repaired or replaced to provide or reinstated a 30 minutes standard of fire resistance. The fire resistance should conform to a relevant standard e.g. Appendix A (including Table A1 A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses.		Phillip Astles	Feb-26	Feb-26 May-26 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 5 Cysgod Y Cwm Ward, Amman Valley Hospital, Folland Road, Glanamman, Ammanford SA18 2BQ	Administrator/00355458_002	R2. In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation as directed within the report should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. The fire resistance should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses. Compliance with this or an equivalent standard will normally satisfy the requirement.		Stewart Evans	Jun-25	Jun-25 Mar-26 N/K	Overdue

Report Issued By	Report Title	Recommendation Reference	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
Mid and West Wales Fire and Rescue Service	Enforcement Notice: 5438/02 The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Cwm Seren PICU Ward, Hafan Derwen, Jobs Well Road, Carmarthen SA31 3HB	BFS/00107788_001	R1. During the inspection a number of breaches in compartmentation were identified. The breaches in compartmentation would not support the existing evacuation strategy. In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. 1. Carry out a compartmentation survey. 2.Enact the findings of the AEON compartmentation survey carried out November 2024. 3. Investigate and confirm the fire resistance of the ceiling access hatches and the compartmentation of the voids above the bedrooms in PICU – provide automatic fire detection in line with BS 5839 Part 1 L1 standard. 4. Confirm the fire resistance of the glazing from the first-floor staff room and corridor onto the LSU corridor. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations.The fire resistance should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses. Compliance with this or an equivalent standard will normally satisfy the requirement		Julian Wheeler-Jones	Mar-26	Mar-26 May-26 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Enforcement Notice: 5438/02 The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Cwm Seren PICU Ward, Hafan Derwen, Jobs Well Road, Carmarthen SA31 3HB	BFS/00107788_002	R2. All doors to patient bedrooms are to be fitted with appropriately designed free-swing self-closing devices as stated in (Table 6 WHTM 05-02). 2. Carry out maintenance work as identified in previous letters of fire safety matters dated 16/05/2022 and 06/06/2024 and identified through the PPM schedule on remaining doors throughout the premises. 3. The following door should be replaced with fire doors to relevant current standard (dependant on the location of the door). Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. • Medication room (LSU) – this is a stable door and is not providing suitable fire resistance. Fire resisting doors need to be fitted with: • A self-closing device including fire alarm activated self-closers. • Intumescent strips and smoke seals. • Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. WHTM 05-02 Appendix C: Doors and door-sets Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 7273-4:2015 Actuation of release mechanisms for doors BS 8214:2016 - timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement.		Julian Wheeler-Jones	Mar-26	Mar-26 May-26 Sep-26	Overdue

Report Issued By	Report Title	Recommendation Reference	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Llandovery Hospital, Llanfair Road, Llandovery SA20 0LA	BFS/5438/00108127_001	R1. During the inspection breaches in compartmentation were identified Plant room and Clinic corridor. The breaches in compartmentation would not support the existing evacuation strategy. In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. The fire resistance should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses. Compliance with this or an equivalent standard will normally satisfy the requirement.		Paul Hill	Dec-24	Dec-24 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Llandovery Hospital, Llanfair Road, Llandovery SA20 0LA	BFS/5438/00108127_002	R2. Remove all unwanted combustible materials and store appropriately. For Example: • Plant Room • Combustibles under the stairs This should apply to the whole premises.		Paul Hill	Dec-24	Dec-24 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Llandovery Hospital, Llanfair Road, Llandovery SA20 0LA	BFS/5438/00108127_003	R3. The following doors should be replaced with fire doors providing 30 minutes fire resistance. Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. All doors on the first floor in order to protect the means of escape. Fire resisting doors need to be fitted with • A self-closing device • Intumescent strips and smoke seals. • Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - timber-based fire door assemblies – Code of practice Compliance with this or an equivalent standard will normally satisfy the requirement		Paul Hill	Dec-24	Dec-24 Aug-25 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Llandovery Hospital, Llanfair Road, Llandovery SA20 0LA	BFS/5438/00108127_004	R4. Evidence should be produced that the existing furniture/furnishings conforms to the current regulations. Alternatively, replacement of treatment should be undertaken, and certification/evidence produced to the effect that such a standard has been obtained		Paul Hill	Dec-24	Dec-24 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Llandovery Hospital, Llanfair Road, Llandovery SA20 0LA	BFS/5438/00108127_005	R5. Provide an emergency lighting system (which is to be independent of all other systems), to illuminate • Along the external exit route from the Day room. On completion of the emergency lighting system, the commission certificate is to be completed by a competent person and a copy made available to the Fire and Rescue Authority. This system is to be designed and installed in accordance BS5266-1:2016 Compliance with this or an equivalent standard will normally satisfy the requirement.		Paul Hill	Dec-24	Dec-24 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Llandovery Hospital, Llanfair Road, Llandovery SA20 0LA	BFS/5438/00108127_006	R6. Remove existing lock fastenings from door(s) indicated/located First floor kitchen Ground floor side exit door, from clinic area. If the door(s) is/are required to be kept locked it/they should be fitted with an approved type of emergency security fastening that can be operated from the escape side of the door(s) without the use of a key, which is conspicuously indicated as to its method of operation. This work should be done to conform to a relevant standard e.g. Section 6 General provisions of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement.		Paul Hill	Dec-24	Dec-24 Sep-26	Overdue

Report Issued By	Report Title	Recommendation Reference	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Llandovery Hospital, Llanfair Road, Llandovery SA20 0LA	BFS/5438/00108127_007	R7. Nominate a sufficient number of competent persons to implement procedures insofar as they relate to the evacuation of relevant persons from the premises.		Paul Hill	Dec-24	Dec-24 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Llandovery Hospital, Llanfair Road, Llandovery SA20 0LA	BFS/5438/00108127_008	R8. During the inspection the self-closing devices on the doors located at; • 00005154, 00005155, 00005166, 0005176, 00005180, 00005140, Treatment room R40, Sisters Office Were found to be ineffective/missing and should therefore be checked and maintained to a satisfactory standard so that the doors close completely into the rebate. Self-closing devices should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement.		Paul Hill	Dec-24	Dec-24 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Llandovery Hospital, Llanfair Road, Llandovery SA20 0LA	BFS/5438/00108127_009	R9. The intumescent strips and cold smoke seals on the following fire resisting doors were found to be damaged/missing. The strips and seals should be replaced in order to prevent the passage of smoke and flame. • Nurses station, Sisters office, 00005149, 00005163, 00005139 The intumescent strips and cold smoke seals should conform to a relevant standard e.g.BS 8214:2016 - Timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement		Paul Hill	Dec-24	Dec-24 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Llandovery Hospital, Llanfair Road, Llandovery SA20 0LA	BFS/5438/00108127_010	R10. Example doors • 0005176, 00005156, 00005157, first floor kitchen. Gaps between door edge and frame are to be no more than 3 mm. Gaps between door and floor should not be more than 10mm. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement		Paul Hill	Dec-24	Dec-24 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Health Care Centre, Doctors Surgery, Maes Yr Eglwys, Solva, Pembrokeshire, SA62 6TW	BFS/AT/SJM/00114070_010	R10. Establish procedures to be followed in case of fire and nominate people to put those procedures into effect.		Malcolm Arnold	Dec-24	Dec-24 Dec-25 N/K	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Withybush General Hospital, Fishguard Road, Haverfordwest, SA61 2PZ, Block 24 (A+E)	BFS/AT/SJM/00175400_002	R2. General fire precautions must be taken to ensure the safety of relevant persons on the premises		Malcolm Arnold	Jan-25	Jan-25 N/K	Overdue
Local Authority	Food Safety & Hygiene Report Amman Valley Hospital	LA_FS&H_AVH_00125_001	R1. Structural/Cleaning Issues The main lino floor covering at the sink and into in the main kitchen was showing signs of wear-and-tear and there had been historic patches and new peeling of the flooring around the walk-in chiller. You must repair the floor area where it has become detached from the wall and maintain in a clean condition in the short term. In the longer term, I feel this floor is due to a replacement and I recommend you schedule the replacement in your maintenance log.	Reported to estates for repair / action on11/08/25. Stewart Evans has applied for capital funding to repair & modernise AV kitchen.	Ben Goddard	Apr-26	Apr-26 Sep-26	Overdue
Local Authority	Food Safety & Hygiene Report Amman Valley Hospital	LA_FS&H_AVH_00125_002	R2. Structural/Cleaning Issues Ceiling repair: The paint to the ceiling in the main kitchen corner above the oil fryer was starting to flake & this is above a food preparation area. Remove any loose paint to a sound base and redecorate ensuring the finished surface will prevent the accumulation of dirt and reduce condensation, mould growth and flaking paint	Reported to estates for repair / action on11/08/25. Stewart Evans has applied for capital funding to repair & modernise AV kitchen	Ben Goddard	Apr-26	Apr-26 Sep-26	Overdue

Report Issued By	Report Title	Recommendation Reference	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
Local Authority	Food Safety & Hygiene Report Amman Valley Hospital	LA_FS&H_AVH_00125_003	R3. Structural/Cleaning Issues Walk in chiller: The walk-in wall of the refrigerator needed cleaning as the corner had started to rust and particular attention should be paid to the metal cladding area on cleaning schedule in the future if it gets worse. I would recommend you add this metal plate to the maintenance log for future repair or replacement.	Reported to estates for repair / action on11/08/25.	Ben Goddard	Apr-26	Apr-26 Sep-26	Overdue
Local Authority	Food Safety & Hygiene Report Withybush General Hospital	LA_FS&H_WGH_0425_005	R5. Some of the kitchen suspended ceiling tiles were ill fitting in their frames leaving a slight gap. Please ensure the tiles are correctly re-positioned in their frames	Estates Team were notified after the inspection. No action at this stage. There was discussion and site visit from contract looking to replace old existing tiles and mend any tiles pre pest issue. email reminder has been sent	Matthew Ricketts	May-25	May-25	Overdue
Local Authority	Food Safety & Hygiene Report Withybush General Hospital	LA_FS&H_WGH_0425_007	R7. The temperature of the walk-in fridge was recorded as +6 for the w/e 27/4/25 (Saturday evening). +6 was also recorded for the holding fridge w/e 20/4/25 (Wednesday morning), you have a clear escalation procedure on the monitoring forms for temperatures above 5 degrees, please ensure this escalation is documented appropriately.	WGH HACCP states the legal limit requirement's is 8 c and we promote 5c as our best working practise. This reflected on the daily monitoring sheets. These sheets do not state legal limit but our good working practise. I will change the doc to fit with our HACCP.	Matthew Ricketts	May-25	May-25	Overdue
Local Authority	Food Safety & Hygiene Report Withybush General Hospital	LA_FS&H_WGH_0425_009	R9. You have identified hot holding as a critical control point however it has been missed from the tables relating to establishing critical limits at CCPs. Please include details	The transfer and temperature recording is built into our new HACCP policy and will state that the patient meals will need to be probed again at a ward level by Hotel Service Staff	Matthew Ricketts	May-25	Mar-25 Sep-26	Overdue
Local Authority	Food Safety & Hygiene Report Withybush General Hospital	LA_FS&H_WGH_0425_010	R10. During the visit it was established that there are no further temperature checks (monitoring and records) at internal ward level once the regen trolleys are transferred from the kitchen. This step of transfer is not included as a process step in your HACCP. You need to verify that the temperature chain is maintained.	The temperature chain	Matthew Ricketts	May-25	Mar-25 Sep-26	Overdue
Royal College	RCN Health and safety workplace inspection- Corridor care and safe staffing BGH EUCC February 2025	RCN_EUCC_022025_011	R11. Manual handling risk extricating patients out of vehicles.	Paramedics assisting when available . Scheduled sessions in trauma training sessions. Monitor newly appointed staff for compliance.	Chris Edwards	Sep-25	Sep-25 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER September 2025	874/AM/BFS /00329500_002	R2. Fire doors not closing effectively within the laundry area	Full action plan held by Estates	Elfyn Jones	Oct-25	Oct-25 N/K	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER September 2025	874/AM/BFS /00329500_004	R4. All combustible storage to be removed from within close proximity of ignition sources are to be re located to a more suitable location. Step are to be taken to ensure that such storage does not recur	Full action plan held by Estates	Elfyn Jones	Oct-25	Oct-25 N/K	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER September 2025	874/AM/BFS /00329500_005	R5. Confirmation is required that the old detector head in the paint store, in the Boiler Room, is linked and working with the current BS5839: Part 1 fire detection and warning system within the premises.	Full action plan held by Estates	Elfyn Jones	Oct-25	Oct-25 N/K	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER September 2025	874/AM/BFS /00329500_007	R7. The emergency lighting should be suitable for people to escape in the event of darkness in accordance with BS 5966 E.G Outpatients to MRI	Full action plan held by Estates	Elfyn Jones	Nov-25	Nov-25 Jan-26 May-26 Dec-26	Overdue

Report Issued By	Report Title	Recommendation Reference	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER September 2025	874/AM/BFS /00329500_008	R8. It is essential all staff, including agency and temporary staff, are fully trained in evacuation procedures for the premises. You should ensure that staffing levels are sufficient and available at all material times to facilitate the movement of residents to safety within the determined safe evacuation time. Evidence of this training must be made available to fire safety inspecting officers when they audit your premises. It is good practise to have a live evacuation training session to ensure the evacuation procedure is suitable and sufficient.	Full action plan held by Estates	Mike Gilbert	Oct-25	Oct-25 Jul-26 Dec-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Dyfi Block, Bronglais General hospital, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER October 2025	BFS/00113169_001	R1. During the inspection breaches in compartmentation were identified. The breaches in compartmentation would not support the existing evacuation strategy. In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. The fire resistance should conform to a relevant standard e.g. Appendix A (including Table A1 A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates	Richard Jupp	Nov-25	Nov-25 Mar-26 N/K	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Dyfi Block, Bronglais General hospital, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER October 2025	BFS/00113169_003	R3. Provide an emergency lighting system (which is to be independent of all other systems), to illuminate On completion of the emergency lighting system, the commission certificate is to be completed by a competent person and a copy made available to the Fire and Rescue Authority. This system is to be designed and installed in accordance with the latest version of BS5266-1. Compliance with this or an equivalent standard will normally satisfy the requirement. • Clarification is required that the Emergency lighting is sufficient to the external areas as previously requested.	Full action plan held by Estates	Elfyn Jones	Dec-25	Dec-25 Feb-26 Apr-26 Jul-26 Dec-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 10, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	BFS/00133694_002	R2. The damage in the wall of the first-floor corridor near doors 1006 and 1003 should be in-filled with non-combustible materials, to provide 30 minutes standard of fire resistance. The fire separation should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held with Estates	Paul Hill	Mar-26	Mar-26 Jun-26 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 10, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	BFS/00133694_003	R3. Remove all unwanted combustible materials. For Example: • GF Switch room (0012) This should apply to the whole premises	Full action plan held with Estates	Paul Hill	Mar-26	Mar-26 Sep-26	Overdue

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Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 10, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	BFS/00133694_004	R4. The following doors should be repaired/replaced with fire doors providing 30 minutes fire resistance. Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. • 0002 GF – Cross corridor – not fully closing into the rebate. • 0003 GF – Transport office - letterbox • 0013 GF – Cross corridor – top hinge damaged • 0344 GF – Store – vent • FF – Overflow kitchen, not on PPM – door requires upgrading to FD30S • 2041 – SF – not fully closing into rebate • 2006 – SF – Strips and seals missing • 3006 – TF – Letterbox and obsolete keyholes • 3009 – TF – Strips and seals missing Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - timber-based fire door assemblies – Code of practice. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held with Estates	Paul Hill	Mar-26	Mar-26 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 10, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	BFS/00133694_005	R5. Ceiling tiles throughout the building were found to be damaged, they should be repaired or replaced to provide appropriate level of fire resistance. The fire resistance should conform to a relevant standard e.g. Appendix A (including Table A1 A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses.	Full action plan held with Estates	Paul Hill	Mar-26	Mar-26 Sep-26	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 27 – Bryngolau, Prince Phillip Hospital, Carmarthenshire, SA14 8QF	BFS/00173908_004	R4. The following doors should be repaired/replaced with fire doors providing 30 minutes fire resistance. Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. • Check strips and seal on all fire doors as most were damaged during the inspection • 0077A/B – damage to door frame • 0065 – strips and seals were painted over Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement	Full action plan held by Estates	Stewart Evans	Mar-26	Mar-26 N/K	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 15 & 16, Prince Phillip Hospital, Dafen Road, Dafen, Llanelli, Carmarthenshire, SA14 8QF	BFS/00334378_002	R2. The routes to emergency exits from premises and the exits themselves must be kept clear and free of obstruction at all times to allow persons to evacuate the premises as quickly and safely as possible. • A number of hospital beds were located through out the hospital street	Full action plan held by Estates	Susan Davies	Mar-26	Mar-26 N/K	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 15 & 16, Prince Phillip Hospital, Dafen Road, Dafen, Llanelli, Carmarthenshire, SA14 8QF	BFS/00334378_003	R3. The routes to emergency exits from premises and the exits themselves must be kept free from ignition sources at all times to allow persons to evacuate the premises as quickly and safely as possible. • Portable x-ray machines were on charge in the means of escape	Full action plan held by Estates	Fiona Osell	Mar-26	Mar-26 N/K	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Day Surgical Unit, Prince Phillip Hospital, Dafen Road, Llanelli, SA14 8QF February 2026	BFS/00337255_004	R4. Although training is provided on what to do in case of fire; it is strongly recommended that practical drills be carried out at least once a year and recorded to effectively test and if necessary, improve on the evacuation plan.	Full action plan held with Estates	Karen Waters	Jun-26	Jun-26 Sep-26	Overdue

Report Issued By	Report Title	Recommendation Reference	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 3 (AMAU), Ward 1, Prince Phillip Hospital, Llanelli, Carmarthenshire, SA14 8QF	BFS/00345962_005	R5. The following doors should be repaired/replaced with fire doors providing 30 minutes fire resistance. Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. • 1820/1821 – Cross corridor doors – hole in door frame • 6475/6476 – Cross corridor doors – excessive gap • 6467/6468 - Cross corridor doors – in need of repair • 6469/6472 – Cross corridor doors – strips and seals missing • 1799/1800 – Cross corridor doors – not fully closing into rebate Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement	Full action plan held by Estates	Stewart Evans	Mar-26	Mar-26 N/K	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Teifi Block, Bronglais General hospital, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER October 2025	CAW/BFS/00113166_001	R1. During the inspection breaches in compartmentation were identified. The breaches in compartmentation would not support the existing evacuation strategy. In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. The fire resistance should conform to a relevant standard e.g. Appendix A (including Table A1 A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates	Richard Jupp	Nov-25	Nov-25 Mar-26 N/K	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Teifi Block, Bronglais General hospital, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER October 2025	CAW/BFS/00113166_003	R3. Cables / trunking which passes through fire resisting walls / ceilings must be fire stopped providing at least the standard of separation provided by the surrounding construction. Fire stopping is to conform to a relevant standard e.g. Section 11 (Protection of openings and fire stopping) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates	Mike Gilbert	Oct-25	Oct-25 Mar-26 N/K	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Hafren Block, Bronglais General hospital, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER October 2025	CAW/BFS/00113168_002	R2. Cables / trunking which passes through fire resisting walls / ceilings must be fire stopped, providing at least the standard of separation provided by the surrounding construction. Fire stopping is to conform to a relevant standard e.g. Section 11 (Protection of openings and fire stopping) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement	Full action plan held by Estates	Mike Gilbert	Oct-25	Oct-25 Mar-26 N/K	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Education Centre, Bronglais General hospital, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER October 2025	CAW/BFS/00352660_001	R1. During the inspection breaches in compartmentation were identified. The breaches in compartmentation would not support the existing evacuation strategy. In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. The fire resistance should conform to a relevant standard e.g. Appendix A (including Table A1 A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates	Richard Jupp	Nov-25	Nov-25 Mar-26 Dec-26	Overdue

Report Issued By	Report Title	Recommendation Reference	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Education Centre, Bronglais General hospital, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER October 2025	CAW/BFS/00352660_003	R3. • Ensure Fire Extinguishers are positioned on stands or wall mounted. Portable fire extinguishers should conform to BS 5423 or BS EN3. Specifications for portable fire extinguishers should be selected in accordance with the latest version of BS 5306-8:2012. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates	Elfyn Jones	Nov-25	Nov-25 Dec-25 N/K	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Education Centre, Bronglais General hospital, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER October 2025	CAW/BFS/00352660_004	R4. Emergency escape routes throughout must be indicated by adequate escape signage. Signs should be designed and installed in accordance BS 5499-4:20 Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates	Mike Gilbert	Nov-25	Nov-25 Jan-26 N/K	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Education Centre, Bronglais General hospital, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER October 2025	CAW/BFS/00352660_005	R5. The flooring/carpet within the lobby is loose and uneven and should be repaired.	Full action plan held by Estates	Elfyn Jones	Nov-25	Nov-25 Dec-25 N/K	Overdue
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Education Centre, Bronglais General hospital, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER October 2025	CAW/BFS/00352660_006	R6. During the inspection the self-closing devices on several fire doors were found to be ineffective and should therefore be checked and maintained to a satisfactory standard so that the doors close completely into the rebate. Self-closing devices should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement. All fire doors are to be checked to ensure intumescent strips and cold smoke seals conform to a relevant standard e.g.BS 8214:2016, self-closers / automatic closers operate correctly, and door hardware is installed as per guidance ADBW App B.	Full action plan held by Estates	Elfyn Jones	Jan-26	Jan-26 N/K	Overdue
Local Authority	Food Safety & Hygiene Report South Pembrokeshire Hospital March 2026	LA_FS&H_SPH_0326_001	R1. The floor outside the main kitchen in the hallway was still worn in a number of areas. It was also taped in areas and the tape was worn and frayed. Please retape the taped areas in the short term so that they are clean and in good condition Regulations (EC) 852/2004, Annex II, Chapter 1, para 1 Timescale: Retape immediately	Flooring to be repaired/replaced.	Matthew Ricketts	Jun-26	Jun-26 Mar-27	Overdue
Local Authority	Food Safety & Hygiene Report South Pembrokeshire Hospital March 2026	LA_FS&H_SPH_0326_003	R3. The in the fan in the Sunderland ward was in a dirty/greasy condition. It must be thoroughly cleaned and maintained in a clean condition. Regulation (EC) No 852/2004 Annex II Chapter I Para 1 Timescale: Immediately	Work/Job Request Number: 002707863 – March 2026.	Matthew Ricketts	Jun-26	Jun-26 Sep-26	Overdue
Local Authority	Glangwili General Hospital Catering Department Inspection April 2026	LA_FS&H_GGH_0426_001	R1. Your documented food safety management system needs to be consistently applied, on a daily basis (the HACCP review needs to be completed and implemented across hospital food operations).	Finalise, approve and fully implement revised HACCP covering all food pathways from receipt of food through to ward service.	Richard Daniel/Melanie Jones	Apr-26	Apr-26 N/K	Overdue
Local Authority	Glangwili General Hospital Catering Department Inspection April 2026	LA_FS&H_GGH_0426_002	R2. Listeria controls require full implementation and consistent application across all wards and catering areas.	Implement and monitor Listeria control measures in accordance with FSA guidance and HACCP procedures.	Richard Daniel/Melanie Jones	Apr-26	Apr-26 N/K	Overdue
Local Authority	Glangwili General Hospital Catering Department Inspection April 2026	LA_FS&H_GGH_0426_006	R6. Food safety responsibilities not clearly defined throughout food chain, particularly at ward level.	Define and document food safety responsibilities within HACCP for catering, ward and clinical staff.	Richard Daniel/Melanie Jones	Jun-26	Jun-26 N/K	Overdue

2 - HEALTH AND SAFETY UPDATES

2.1

9:50 AM, 10 Mins

2.1 - Health and Safety Assurance Report

***Adam Springthorpe
(Hywel Dda UHB -
Health & Safety
Manager)***

| For assurance

Attachments

[2.1a SBAR H S Assurance Report September 2026.pdf](#)

[2.1b HSS Assurance Report Sept 2026 V1.4.pdf](#)



Pwyllgor Iechyd a Diogelwch/ Health and Safety Committee

DYDDIAD Y CYFARFOD: DATE OF MEETING:	10 SEPTEMBER 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Health and Safety Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	James Severs, Executive Director of Allied Health Professions and Health Science
SWYDDOG ADRODD: REPORTING OFFICER:	Adam Springthorpe, Health & Safety Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/ For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This Health and Safety Assurance Report is presented to the Health and Safety Committee (HSC) to provide an update on the following topics:

- Key risks and emerging issues;
- Performance against key safety indicators;
- Areas of compliance and non-compliance;
- Actions in place to mitigate identified risks.

Cefndir / Background

This report forms part of the Committee's arrangements for receiving regular assurance regarding the effectiveness of health and safety management across the Health Board. The accompanying Health and Safety Assurance Report provides an assessment of current performance against key indicators, including mandatory training compliance, incident reporting, investigation timeliness, workforce safety risks and emerging issues.

The report draws upon information from the Datix incident reporting system, mandatory training compliance data, corporate risk data and professional assessment by the Health, Safety and Security Team. An overall assurance rating is provided together with areas requiring continued management focus and improvement.

Asesiad / Assessment

The accompanying report provides an overall assessment of Moderate Assurance (Amber). Strongest assurance is provided in relation to incident reporting and core mandatory training compliance. Areas below the Health Board's expected compliance standards include:

- Manual Handling Level 2 training compliance remains below the organisational target. Action is being taken through targeted training delivery, monitoring of compliance at

directorate level and escalation through management structures where improvement is not demonstrated;

- Violence and aggression related incidents continue to present a significant workforce safety risk. Improvement actions include implementation of targeted preventative interventions, strengthened local risk assessment arrangements and continued monitoring through relevant governance groups;
- Incident investigation timeliness remains below the required standard in some areas. Actions include enhanced oversight of overdue investigations and regular performance reporting.

These areas will continue to be monitored through the Health and Safety Compliance Group and reported to Committee through future assurance reports.

Argymhelliad / Recommendation

The Health & Safety Committee is asked to:

- **TAKE ASSURANCE** from the Health and Safety Assurance Report regarding the effectiveness of current health and safety management arrangements across the Health Board;
- **NOTE** the areas currently below compliance targets and the improvement actions being progressed to address these;

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	2.1 Provide assurance around the UHB arrangements for ensuring the health, safety, welfare and security of all employees and of those who may be affected by work-related activities, such as patients, members of the public, volunteers, contractors etc.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	N/A
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable

Nodau Cynllunio 2026/27 Planning Goals 2026/27	8. Fit for Purpose, Modern Facilities and Services
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	3. Create people-centred employment and development opportunities that support workforce transformation, reflect the changing needs of
Model Cymdeithasol ar gyfer lechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (<i>complete for strategic change and/or significant service changes</i>)	Not Applicable
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Contained within the body of the report and associated Health Board policies.
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Health and Safety Compliance Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impact
Ansawdd / Gofal Claf: Quality / Patient Care:	There is a positive impact on staff and patient safety, health and wellbeing through compliance with health and safety regulations.
Gweithlu: Workforce:	Potential for adverse future staffing impacts if health and safety legislation is not complied with as they relate to employee safety.
Tegwch lechyd: Health Equity:	No direct impact

Risg: Risk:	Risk to health and safety management.
Cyfreithiol: Legal:	A breach of health and safety regulations, such as the Workplace (Health, Safety and Welfare) Regulations 1992, could result in the issue of prohibition or improvement notices or criminal proceedings.
Enw Da: Reputational:	Prosecutions and claims due to breaches in legislation or personal injury claims can lead to negative publicity.
Gyfrinachedd: Privacy:	Not Applicable.
Cydraddoldeb: Equality:	No evidence gathered to indicate a negative impact on any protected group/s.

Health and Safety Assurance Report

Health and Safety Committee

September 2026

This report aims to provide assurance to the Health & Safety Committee on the effectiveness of health and safety arrangements across the Health Board.

The report outlines:

- Key risks and emerging issues
- Performance against key safety indicators
- Areas of compliance and non-compliance
- Actions in place to mitigate identified risks



Purpose and Scope

This report provides an evidence-based assessment of health and safety effectiveness across the Health Board as of September 2026.

Risk and Compliance Monitoring

It includes an analysis of workforce risks, compliance with mandatory training, and incident reporting trends.

Governance and Evidence Sources

The report uses multiple data sources like incident reports and management actions to assess strengths and vulnerabilities.

Assurance Levels and Recommendations

Assurance conclusions help to classify risk control effectiveness and guide Committee decisions for ongoing improvements.

Executive Assurance Summary



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Area	RAG	Assurance Position	Key Message
Core H&S Mandatory Training (Health, Safety & Welfare and Violence & Aggression)	Green	Substantial Assurance	Compliance remains consistently high across most service areas, demonstrating effective governance arrangements.
Manual Handling Training (Level 2 Patient Handling)	Red	Limited Assurance	Compliance remains significantly below other mandatory training subjects and represents the Health Board's most significant workforce safety control weakness.
Violence & Aggression Risk	Red	Limited Assurance	Violence & Aggression is now the leading cause of RIDDOR-reportable incidents, indicating a shift in the workforce risk profile and continued staff exposure to harm.
Incident Investigation Timeliness	Yellow	Moderate Assurance	Significant numbers of overdue investigations remain, particularly within Community & Integrated Medicine, reducing organisational learning opportunities.
Incident Reporting Culture and Governance	Green	Substantial Assurance	Reporting levels remain stable and consistent, indicating a mature reporting culture and providing confidence in the reliability of safety intelligence.

The Health Board continues to demonstrate effective health and safety governance, with strong compliance in core mandatory training and a mature incident reporting culture providing reliable organisational safety intelligence.

However, assurance is reduced by persistent low compliance with Manual Handling Level 2 (Patient Handling) training, continued staff exposure to violence and aggression, and overdue incident investigations within some service areas. These issues present the principal workforce safety and governance risks requiring ongoing management focus

Violence & Aggression

Issue:

- Violence and aggression is the leading cause of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable incidents so far in 2026/27, replacing Slips/Trips/Falls as the predominant cause in previous years.

Assurance:

- Reporting and governance arrangements are identifying incidents appropriately;
- The change reflects a mature reporting culture and enables clearer identification of workforce safety risks within high-risk clinical services

Risk:

- Persistent staff exposure to violence and aggression remains a significant workforce safety concern requiring sustained preventative action and management oversight.

Ceredigion Training Venue

Issue: Loss of Ceredigion training venue.

Assurance:

- New location agreed; Contract in development;
- New flooring to be installed in early September 2026 ahead of occupation.

Risk: No Ceredigion training location for interim period.

Heat Stress

Issue: Significant issues with heat Health Board-wide during recent extreme heat periods.

Assurance:

- Updated heat stress risk assessment template;
- Updated heat stress intranet page. Including other resources including new Fan Guidance from IP&C and Hot Weather Advice.

Health and Safety Mandatory Training E-learning Compliance (at 31/07/2026): (Target: ≥ 85% Compliance)

Health, Safety & Welfare Level 1

Function	Headcount	% compliance
Executive Allied Health Professions and Health Sciences	2	100.0%
Finance	101	98.0%
Digital	381	96.6%
Mental Health and Learning Disabilities	1379	93.7%
Workforce and Organisational Development	257	93.0%
Operational Allied Health and Health Sciences	1368	91.7%
Pharmacy and Medicines Management	270	90.7%
Chief Operating Officer Management	139	90.6%
Medical	142	90.1%
Nursing, Quality and Patient Experience	211	88.6%
Community and Integrated Medicine	3924	88.2%
Public Health	169	87.6%
Strategy and Planning	56	87.5%
Estates and Facilities	1034	87.0%
Planned and Specialist Care	2711	84.3%
Chief Executive	95	84.2%
Primary Care	338	83.7%

Display Screen Equipment (DSE)

Function	Headcount	% compliance
Finance	101	100.0%
Pharmacy and Medicines Management	17	100.0%
Workforce and Organisational Development	215	100.0%
Mental Health and Learning Disabilities	172	99.4%
Estates and Facilities	87	98.9%
Medical	86	98.8%
Strategy and Planning	47	97.9%
Digital	368	97.6%
Public Health	93	96.8%
Nursing, Quality and Patient Experience	121	96.7%
Primary Care	135	96.3%
Community and Integrated Medicine	442	95.5%
Operational Allied Health and Health Sciences	132	94.7%
Planned and Specialist Care	416	94.5%
Chief Executive	90	88.9%
Chief Operating Officer Management	36	88.9%

Violence & Aggression Module A

Function	Headcount	% compliance
Executive Allied Health Professions and Health Sciences	2	100.0%
Chief Operating Officer Management	139	99.3%
Finance	101	99.0%
Workforce and Organisational Development	257	98.8%
Medical	142	98.6%
Digital	381	98.4%
Mental Health and Learning Disabilities	1379	97.9%
Nursing, Quality and Patient Experience	211	97.6%
Operational Allied Health and Health Sciences	1368	97.1%
Public Health	169	96.4%
Strategy and Planning	56	96.4%
Estates and Facilities	1034	95.7%
Pharmacy and Medicines Management	270	95.6%
Community and Integrated Medicine	3924	94.3%
Planned and Specialist Care	2711	93.2%
Primary Care	338	91.4%
Chief Executive	95	88.4%

Manual Handling (MH) Compliance (at 31/05/2026 and 31/07/2026 for comparison):

Level 1 MH (Non-Patient Handling) at 31/05/2026: Level 1 MH (Non-Patient Handling) at 31/07/2026:

Function	Headcount	% compliance
Executive Allied Health Professions and Health Sciences	2	100.0%
Digital	373	94.4%
Finance	103	93.2%
Workforce and Organisational Development	260	90.8%
Medical	142	89.4%
Public Health	164	87.2%
Chief Operating Officer Management	129	85.3%
Nursing, Quality and Patient Experience	210	83.8%
Operational Allied Health and Health Sciences	1382	82.5%
Estates and Facilities	1035	82.4%
Pharmacy and Medicines Management	275	82.2%
Strategy and Planning	58	81.0%
Chief Executive	95	80.0%
Community and Integrated Medicine	3930	77.9%
Mental Health and Learning Disabilities	1374	77.5%
Primary Care	335	77.0%
Planned and Specialist Care	2696	74.1%

Function	Headcount	% compliance	
Finance	101	95.0%	+ 1.8%
Digital	381	92.9%	- 1.5%
Workforce and Organisational Development	257	89.9%	- 0.9%
Chief Operating Officer Management	139	88.5%	+ 3.2%
Medical	142	88.0%	+ 1.4%
Public Health	169	85.8%	- 1.4%
Operational Allied Health and Health Sciences	1368	85.5%	+ 3.0%
Nursing, Quality and Patient Experience	211	84.4%	+ 0.6%
Pharmacy and Medicines Management	270	80.7%	- 1.5%
Strategy and Planning	56	80.4%	- 0.6%
Mental Health and Learning Disabilities	1379	80.3%	+ 2.8%
Primary Care	338	80.2%	+ 3.2%
Chief Executive	95	80.0%	=
Estates and Facilities	1034	79.3%	- 3.1%
Community and Integrated Medicine	3924	78.7%	+ 0.8%
Planned and Specialist Care	2711	74.4%	+ 0.3%
Executive Allied Health Professions and Health Sciences	2	50.0%	- 50%

(Target: ≥ 85% Compliance)

Improvement actions:

- Monthly compliance reports provided to Care Groups/Functions;
- Targeted booking of staff onto available training sessions;
- Local management review of non-compliant staff;
- Escalation through Care Group governance arrangements where compliance remains below target;
- Monitoring through the Health & Safety Compliance Group.

Manual Handling (MH) Compliance (at 31/05/2026 and 31/07/2026 for comparison):

Level 2 MH (Patient Handling) at 31/05/2026:

Function	Headcount	% compliance
Workforce and Organisational Development	33	81.8%
Public Health	71	71.8%
Estates and Facilities	141	68.8%
Operational Allied Health and Health Sciences	748	62.2%
Community and Integrated Medicine	3320	60.5%
Medical	35	60.0%
Planned and Specialist Care	2182	58.0%
Digital	7	57.1%
Mental Health and Learning Disabilities	1038	54.1%
Nursing, Quality and Patient Experience	75	49.3%
Primary Care	95	32.6%
Pharmacy and Medicines Management	4	25.0%
Chief Operating Officer Management	12	8.3%
Chief Executive	1	0.0%
Executive Allied Health Professions and Health Sciences	1	0.0%
Strategy and Planning	4	0.0%

Level 2 MH (Patient Handling) at 31/07/2026:

Function	Headcount	% compliance	
Digital	8	75.0%	+ 17.9%
Workforce and Organisational Development	33	72.7%	- 9.1%
Public Health	74	71.6%	+ 0.2%
Operational Allied Health and Health Sciences	736	68.2%	+ 6.0%
Estates and Facilities	144	64.6%	- 4.2%
Community and Integrated Medicine	3229	61.7%	+ 1.2%
Mental Health and Learning Disabilities	1040	58.2%	+ 4.1%
Planned and Specialist Care	2165	57.8%	- 0.2%
Medical	36	55.6%	- 4.4%
Nursing, Quality and Patient Experience	77	49.4%	+ 0.1%
Primary Care	97	38.1%	+ 5.5%
Pharmacy and Medicines Management	4	25.0%	=
Chief Operating Officer Management	18	16.7%	+ 8.4%
Chief Executive	1	0.0%	=
Executive Allied Health Professions and Health Sciences	1	0.0%	=
Strategy and Planning	4	0.0%	=

(Target: ≥ 85% Compliance)

Key message: Level 2 compliance remains significantly below the Health Board target of 85% across all major operational service areas and represents the most significant health and safety compliance risk identified within this report.

Improvement actions:

- Clinical Care Group (CCG) leads to ensure staff are released to attend booked manual handling training sessions;
- Enhanced monitoring of compliance through CCG and Directorate performance reporting arrangements;
- The Manual Handling Team has maximised available training capacity to deliver the highest possible number of training sessions;
- Targeted support and engagement from the Manual Handling Team to areas with the lowest levels of compliance;
- Continued oversight through the Health & Safety Compliance Group, with progress reported to the Health & Safety Committee.

Reducing Restrictive Practice (RRP) Team training compliance (at 31/07/2026): (Target: ≥ 85% Compliance)

Mental Health / Learning Disabilities (MH/LD):

- Morlais 100% =
- LSU 80% (Up 2%)
- St Caradog 66% (Up 6%)
- PICU 98% (Up 1%)
- Bryngofal 89% (Down 5%)
- Begelly 100% =
- Enlli 68% (Up 28%)
- St Non 89% (Up 12%)
- Bryngolau 73% (Down 7%)

Key message:

Most services have demonstrated improvement since the previous reporting period, with notable gains within Enlli, St Nons and St Caradogs. However, compliance reductions in Bryngofal and Bryngolau indicate continued challenges in maintaining competence levels within some clinical areas.

Portering compliance has also improved across most acute sites.

Porter Training:

The percentage of Portering staff that have completed the Restraint Reduction short course (Module D) for acute sites:

- Prince Philip Hospital (PPH) 75% (Up 3%)
- Glangwili Hospital (GGH) 80% (Up 6%)
- Bronglais Hospital (BGH) 93% =
- Withybush Hospital (WGH) 96% (Up 4%)

Actions undertaken:

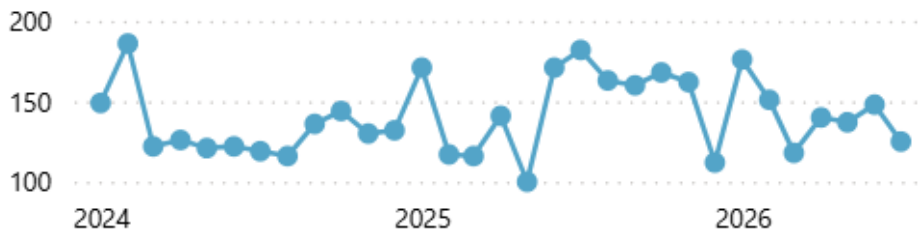
- Additional training sessions delivered;
- Local monitoring of refresher requirements;
- Improved oversight through MH/LD governance arrangements.

Next steps:

- Targeted recovery plans for Bryngofal and Bryngolau;
- Continued focus on refreshers nearing expiry;
- Review of barriers to attendance in areas where compliance has declined.

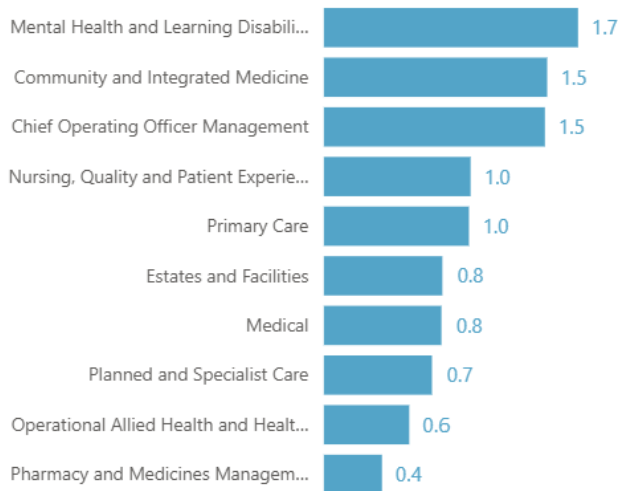
All staff can access the dashboard here (internally): [Health and Safety dashboard - Power BI](#)

Staff / Contractor Incidents Reported via Datix (at 31/07/2026):
By month of occurrence

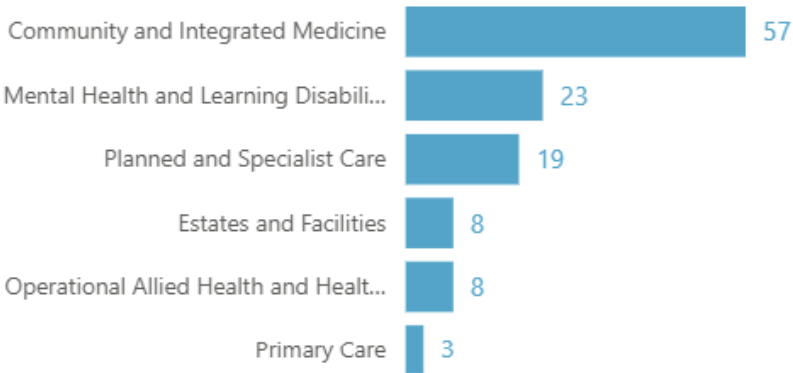


Incident reporting levels have returned to expected levels following previous peaks and remain stable overall.

Staff / Contractor incident rate per 100 staff by Clinical Compliance Group (CCG) in July 2026:



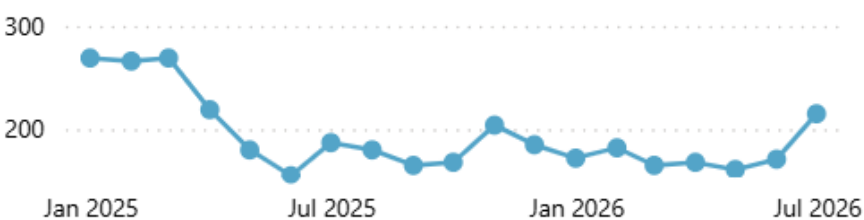
All Staff / Contractor incidents in July 2026 (3+):



Community & Integrated Medicine (CIM) continues to account for the highest number of incidents, however when viewed as an incident rate per 100 (see top right), MHLD report the highest level, reflecting the higher-risk nature of services delivered.

Staff / Contractor incidents still awaiting review after 30 Days:

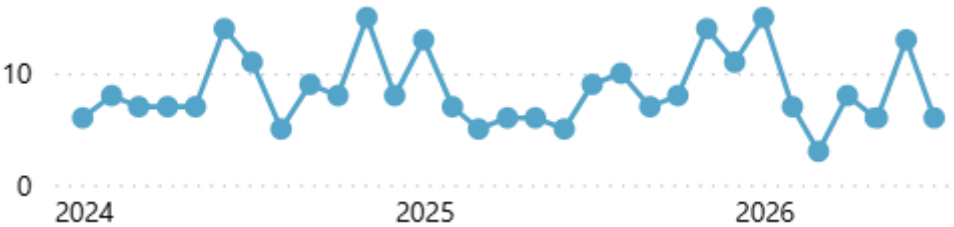
Monthly trend



The reduction in overdue reviews compared to earlier periods is encouraging; however, a backlog remains in some service areas, limiting timely organisational learning.

Staff / Contractor Incidents Reported via Datix (at 31/07/2026):

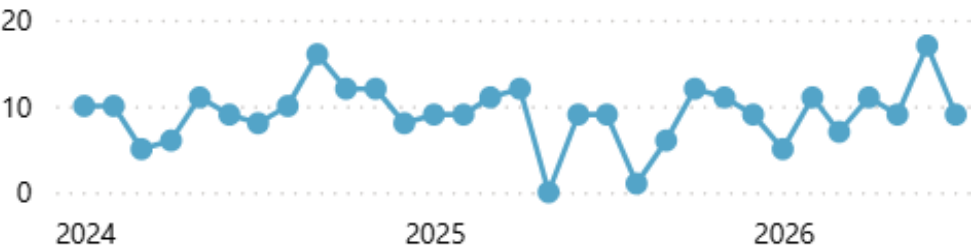
All Slip/Trip/Fall incidents reported via Datix by month:



Seasonal increases continue to be observed.

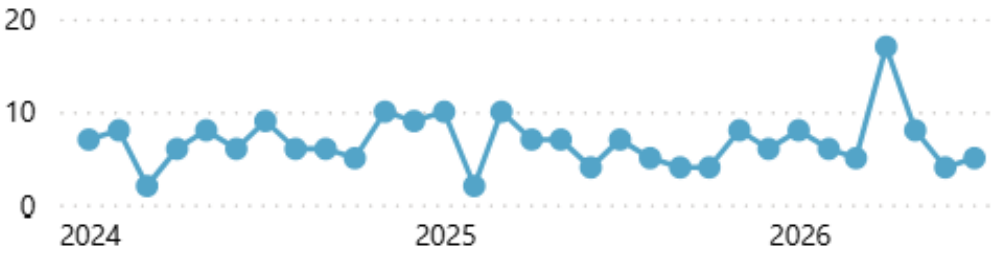
Peaks are notable in the winter months in consecutive years, suggesting a climatic link. Summer peak of 2024 repeated in 2026.

All Needlestick / Medical Sharps incidents reported via Datix by month:



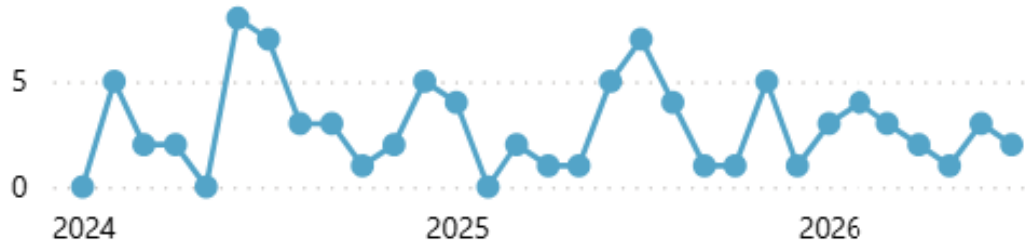
The increase in needlestick/sharps incidents observed during June 2026 was attributable to incidents reported within the CIM CCG. Incident levels returned to expected levels during July 2026, indicating that the June increase does not currently represent a sustained trend. The incidents have been highlighted through the CCG’s monthly H&S metrics report. Review of the incidents identified no common themes or recurring causes requiring additional Health Board-wide control measures at this time.

All Manual Handling / MSK incidents reported via Datix by month:



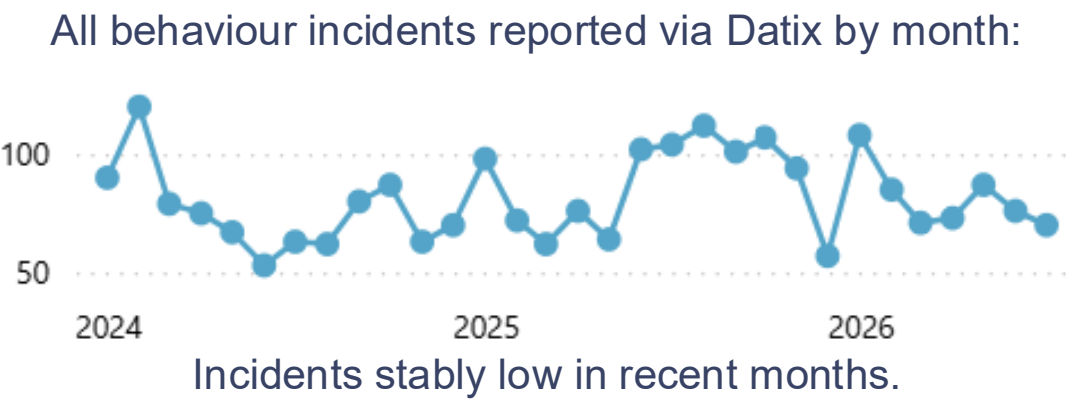
Incidents have returned to normal reporting levels following the peak in highlighted to the committee in the July 2026 assurance report. The peak related to one particularly complex bariatric case.

All ‘Contact with or exposure to chemicals’(i.e. COSHH) incidents reported via Datix by month:



Despite the peaks and troughs, the actual incident rates remain relatively low.

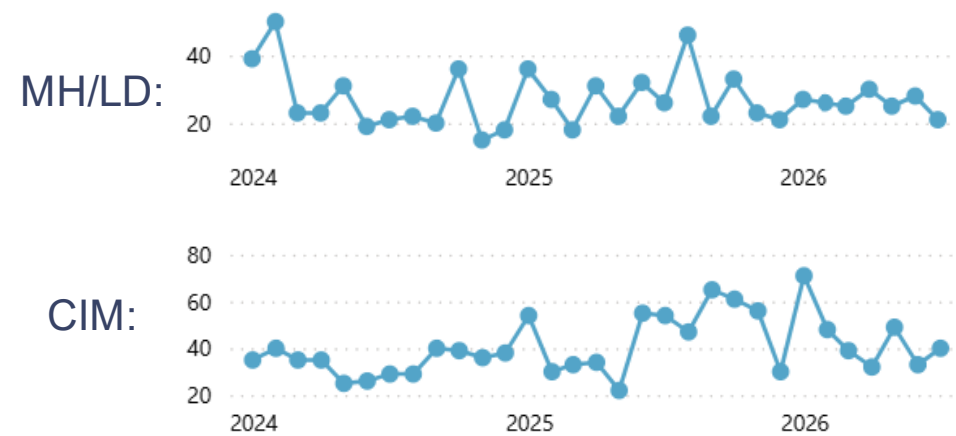
Staff / Contractor Behaviour Incidents Reported via Datix (at 31/07/2026):



Staff / Contractor behaviour incident rate per 100 staff by CCG in July 2026:



MH/LD and CIM CCG behaviour incidents reported via Datix by month:



Committee attention is drawn to the following:

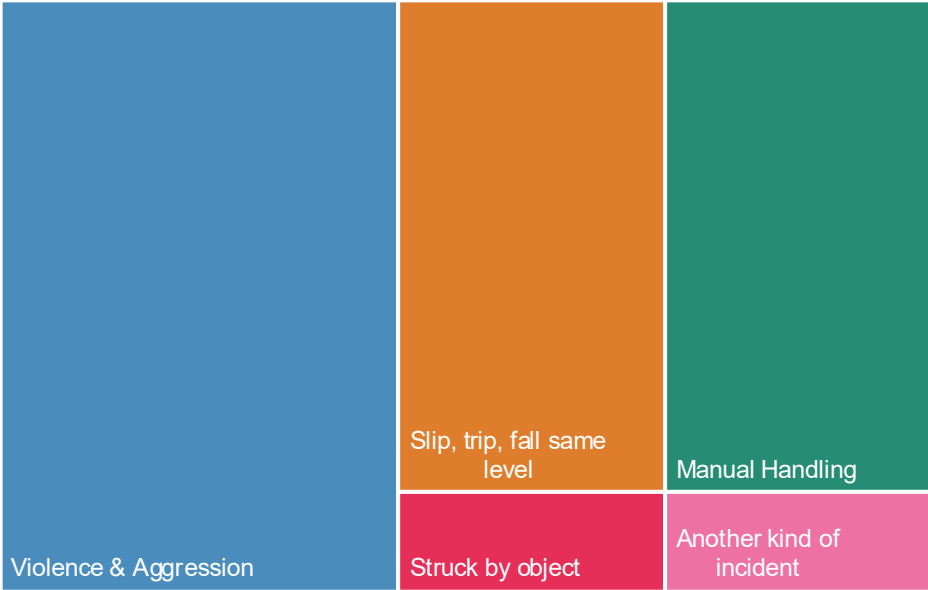
- CIM and Mental Health & Learning Disabilities (MH/LD) continue to experience the highest incident rates;
- Whilst overall incident numbers remain relatively stable, the level of staff exposure to violence and aggression remains a significant workforce safety concern;
- Violence and aggression has become the leading cause of RIDDOR-reportable incidents during 2026/27 (see next slide).

Actions being taken:

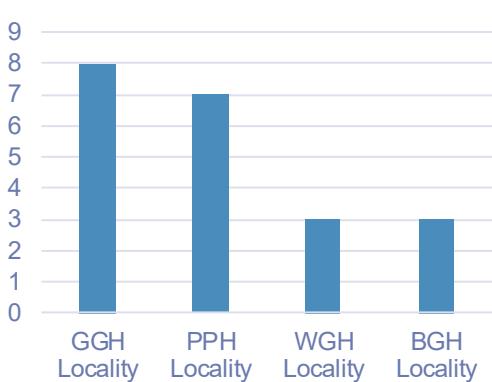
- Review of incidents through established governance forums;
- Focus on local violence and aggression risk assessments;
- Promotion of reporting and post-incident support arrangements;
- Continued monitoring of high-risk clinical environments.

Incidents reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) in 2026/27 (at 31/07/2026):

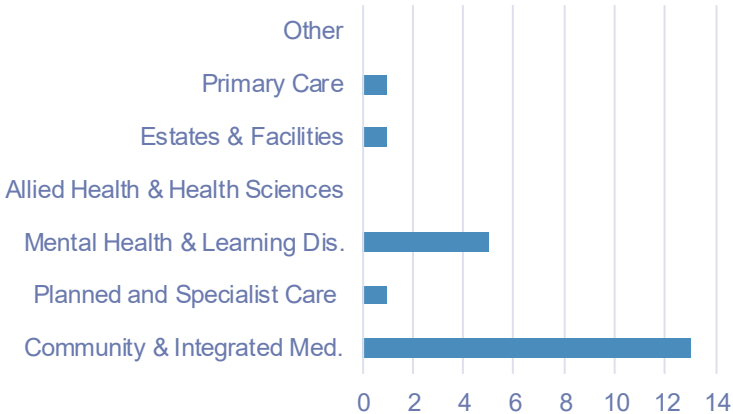
2026/27 Incidents by Cause



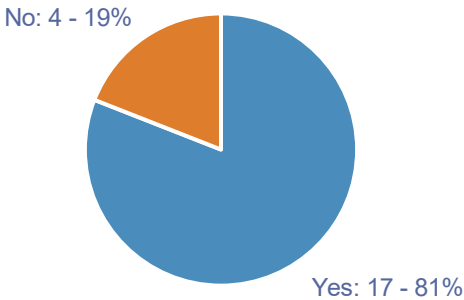
2026/27 Incidents by Locality



2026/27 Incidents by Care Group / Function



2026/27 Incidents Reported on Time



What is the data telling us?

- CIM CCG accounts for the majority of reportable incidents;
- Violence and aggression has emerged as a significant contributor to reportable injuries;
- 81% reported on time so far in 2026/27 which is a great achievement by the H&S Team in the absence of a Head of Service.

Actions being taken:

- Review of RIDDOR incidents to identify common themes and learning;
- Targeted intervention within high-incidence areas;
- Ongoing monitoring through H&S governance arrangements;
- Sharing of learning from significant incidents across the Health Board.



Overall Assurance Level: Moderate Assurance (Amber)

- The Committee can take moderate assurance that appropriate health and safety management arrangements are established and operating across the Health Board. Core mandatory health and safety training compliance remains strong, incident reporting levels remain stable, and there is evidence of a mature reporting culture supporting effective organisational oversight.
- However, assurance is moderated by several significant residual risks. Manual Handling Level 2 (Patient Handling) compliance remains below acceptable levels across a number of service areas, violence and aggression has emerged as the leading cause of RIDDOR-reportable incidents during 2026/27, and a backlog of overdue incident investigations persists within parts of the organisation. These factors increase workforce safety risk and limit the level of assurance that can currently be provided.
- **Strengths:**
 - Strong compliance in core Health, Safety & Welfare and Violence & Aggression mandatory training;
 - Stable incident reporting trends and a mature reporting culture;
 - Effective identification and governance of health and safety risks through established monitoring arrangements.
- **Key Risks:**
 - Low Manual Handling Level 2 (Patient Handling) compliance;
 - Violence and Aggression as the leading cause of RIDDOR-reportable incidents;
 - Overdue incident investigations, particularly within Community & Integrated Medicine.
- **Focus Areas / Improvement Measures:**
 - Improve compliance with Manual Handling training, particularly patient handling competencies, through targeted recovery plans;
 - Continue focused work to reduce violence and aggression related harm through risk assessment, governance oversight and incident review;
 - Maintain strong reporting culture and assurance arrangements;
 - Strengthen monitoring and escalation of overdue incident investigations, particularly within Community & Integrated Medicine.

2.2 - Regulation Assurance Report

Adam Springthorpe
(Hywel Dda UHB -
Health & Safety
Manager)

- Control of Substances Hazardous to Health Regulations 2002 (as amended) (COSHH)
- REACH (Amendment) Regulations 2023
- Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR)
- Personal Protective Equipment at Work Regulations 1992 (PPE)

| For assurance

Attachments

[2.2 SBAR HSS Regs Report Sept 2026.pdf](#)



Pwyllgor Iechyd a Diogelwch/ Health and Safety Committee

DYDDIAD Y CYFARFOD: DATE OF MEETING:	10 SEPTEMBER 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Compliance Against Health and Safety Regulations
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	James Severs, Executive Director of Allied Health Professions and Health Science
SWYDDOG ADRODD: REPORTING OFFICER:	Adam Springthorpe, Health & Safety Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/ For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This report is presented to the Health and Safety Committee (HSC) as part of a new series of regular papers seeking to provide assurance on the Health Board's compliance against specific Health and Safety regulations or topic areas without their own direct set of regulations. This paper addresses compliance with the following regulations/topics:

- Control of Substances Hazardous to Health Regulations 2002 (as amended) (COSHH);
- Registration, Evaluation, Authorisation, and Restriction of Chemicals (UK REACH) (Amendment) Regulations 2023;
- Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR);
- Personal Protective Equipment at Work Regulations 1992 (PPE).

Cefndir / Background

Control of Substances Hazardous to Health Regulations 2002 (as amended) (COSHH)

To comply with the COSHH Regulations, Hywel Dda University Health Board (HDdUHB) must identify substances hazardous to health, assess the risks arising from their use, and implement measures to eliminate or adequately control exposure. This includes maintaining COSHH risk assessments, applying suitable control measures, ensuring exposure limits are not exceeded, and maintaining effective arrangements for the inspection and maintenance of controls.

The Health Board must also provide information, instruction and training to staff, monitor exposure where required, undertake appropriate health surveillance, and maintain arrangements for dealing with accidents, incidents and emergencies involving hazardous substances. Compliance should be monitored to ensure COSHH risks are effectively managed across the organisation.

Registration, Evaluation, Authorisation, and Restriction of Chemicals (UK REACH) (Amendment) Regulations 2023

UK REACH is a regulatory regime intended to ensure the safe manufacture, supply and use of chemical substances. The majority of obligations fall on chemical manufacturers, importers and suppliers and have limited direct applicability to Health Boards. The principal requirement

relevant to the Health Board is the mandatory training of professional users of products containing diisocyanates, which are known respiratory sensitisers. Such products are used primarily within Plaster Rooms and, to a very limited extent, by Estates staff undertaking specific maintenance activities.

Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR)

To comply with the DSEAR, the Health Board must identify and assess the risks arising from flammable, explosive or oxidising substances used, stored or generated during its activities. Risks must be eliminated or reduced so far as is reasonably practicable by applying the hierarchy of control, including minimising quantities held, using safer alternatives where possible, ensuring safe storage arrangements, and controlling ignition sources.

The Health Board must ensure that appropriate control measures, equipment, maintenance regimes and emergency procedures are in place wherever dangerous substances are present. Staff must receive suitable information, instruction and training, and DSEAR risk assessments must be reviewed periodically and when significant changes occur to substances, processes or premises. Compliance should be monitored through local management arrangements, inspection and audit to provide assurance that fire and explosion risks are effectively controlled.

Personal Protective Equipment at Work Regulations 1992 (PPE)

To comply with the PPE Regulations, the Health Board must assess workplace risks, provide suitable PPE free of charge, and ensure that it is appropriate, compatible, properly maintained and supported by adequate information, instruction and training. While clinical PPE requirements are governed by infection prevention arrangements, the Health Board must also ensure that non-clinical staff, including Estates, Portering and Facilities teams etc, receive task-specific PPE identified through risk assessments.

Where Respiratory Protective Equipment (RPE) is required, the Health Board must ensure that users are trained and that tight-fitting respirators are face-fit tested and periodically reviewed. Compliance with respiratory fit testing followed by provision of RPE also forms part of our compliance with the COSHH Regulations, as these are effective controls against exposure to chemical and biological agents in the workplace. Compliance should be supported through suitable arrangements for maintenance, replacement, monitoring and audit to ensure PPE remains effective across all Health Board services.

Asesiad / Assessment

Health and Safety Legislative Assurance Summary:

<u>Regulation</u>	<u>RAG</u>	<u>Key Message</u>	<u>Areas for Committee Attention</u>	<u>How Do We Know?</u>
Control of Substances Hazardous to Health Regulations 2002 (as amended) (COSHH)		HDdUHB is compliant with many aspects of COSHH through established controls, monitoring arrangements, occupational health support, specialist advice and a corporate COSHH policy. However, the completion of outstanding COSHH assessments remains a significant assurance gap.	Completion of remaining COSHH assessments (Target: December 2026); Development of central COSHH repository (Target: March 2027); Delivery of role-specific training for remaining staff groups (Target: June 2027).	Corporate Risk Register Ref. 1332; COSHH Policy 703; Central COSHH database (>1,000 substances); Audit programme; Exposure monitoring; Specialist support arrangements.

Registration, Evaluation, Authorisation, and Restriction of Chemicals (UK REACH) (Amendment) Regulations 2023		UK REACH has limited applicability to the Health Board. All identified staff requiring mandatory diisocyanate training have completed the required training.	Continued review of Estates activities using diisocyanate-containing products and progression of substitution opportunities where practicable.	Training records confirm 100% compliance for identified Plaster Room staff; Estates staff provided with information and instruction on sensitiser hazards.
Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR)		Significant progress has been made through the introduction of a formal DSEAR compliance programme and completion of DSEAR assessments at three of the four acute hospital sites.	Completion of Bronglais DSEAR assessment (Target: February 2027); Transfer and monitoring of actions through AMaT (Target: March 2027); Approval of DSEAR Policy (Target: December 2026).	Completed DSEAR assessments; Estates review process; Action tracking arrangements; Policy development programme.
Personal Protective Equipment at Work Regulations 1992 (PPE)		Appropriate PPE is provided across clinical and non-clinical services and is supported by corporate policies, training, fit-testing arrangements and local management processes.	Ongoing consideration of opportunities to improve corporate assurance regarding RPE fit-testing records; Consideration of the quantitative approach adopted by other Health Boards during Covid-19.	PPE Policy; Fit Testing Procedure; Trained fit-tester network; Local fit-test record keeping arrangements; Infection Prevention and Health & Safety governance processes.

Control of Substances Hazardous to Health Regulations 2002 (as amended) (COSHH)

The table below shows compliance against the key requirements of the Control of Substances Hazardous to Health Regulations 2002 (as amended) (COSHH):

<u>COSHH Requirement</u>	<u>RAG</u>	<u>Current Position</u>
COSHH Risk Assessments (Regulation 6)		Corporate COSHH Policy in place. Central COSHH database contains >1,000 substances and supports assessment tracking. Approximately 30-40% of required substance-based and task-based COSHH assessments have been completed, with the initial focus having been on the higher-risk locations and activities.
Control of Exposure		Extensive controls in place including ventilation systems, Local Exhaust Ventilation (LEV), safe systems of work, chemical substitution, specialist controls within Hospital Sterilisation and Decontamination Unit (HSDU), Pathology, Catering and Endoscopy, and PPE/RPE where required. Remaining assessment work is needed to identify and document all controls.
Maintenance of Control Measures		Established arrangements for maintenance of ventilation and LEV systems, supported through Estates and specialist groups. Records and inspection arrangements are in place.

Exposure Monitoring		Exposure monitoring capability now established and has been used in areas including Entonox exposure assessment. Monitoring is undertaken where identified through risk assessment.
Health Surveillance		Occupational Health arrangements are in place to provide health surveillance where identified through COSHH assessment. Further assessment completion will improve identification of surveillance requirements.
Information, Instruction and Training		COSHH awareness is included within the Manager's Health and Safety Induction course. Over 750 managers trained since 2020, with bespoke COSHH training delivered to higher-risk groups. Further role-specific training remains required for some staff groups, including Nursing and Portering services.
Accident and Emergency Arrangements		Emergency planning requirements are embedded within assessment templates and specialist departments have established emergency arrangements. Further completion of COSHH assessments will strengthen assurance.
Employee Responsibilities		Responsibilities are clearly defined within Policy 703, including use of control measures, PPE/RPE, reporting defects and participation in health surveillance.
Governance, Audit and Assurance		Health Board-wide risk register in place. COSHH audits ongoing. Priority departments audited and central repository under development. Current corporate risk score remains High (8), with a target reduction to Moderate (4) by December 2027.

The Health Board has well-established COSHH governance arrangements in place through Policy 703, a dedicated COSHH specialist within the Health and Safety Team, a Health Board-wide COSHH risk register, audit programmes and a central COSHH database containing over 1,000 substances.

Significant progress has been made since 2020 in developing a systematic approach to COSHH compliance, including the introduction of new substance-based and task-based assessment templates, expansion of management training, and development of specialist arrangements for higher-risk areas such as HSDU, Pathology, Endoscopy, Catering and Estates.

Exposure monitoring capability has also been established, with recent work undertaken in relation to Entonox exposure and environmental monitoring. Ventilation and Local Exhaust Ventilation (LEV) systems continue to provide an important control measure and are subject to separate inspection and maintenance arrangements.

Whilst the Health Board is considered compliant with many aspects of the COSHH Regulations through existing controls, training, monitoring and occupational health arrangements, a significant programme of work remains to fully document compliance through COSHH assessments. A number of lower-risk COSHH assessments remain outstanding, with particular focus required on ward chemicals, certain medicines, and some Estates activities.

A central COSHH repository is currently being developed to provide managers with access to assessments, inventories and safety data sheets, while ongoing audits continue to identify gaps and support improvement.

The corporate risk register entry for COSHH (Risk 1332) currently holds a residual risk score of 8 (High), reflecting the remaining assurance gap associated with incomplete assessments rather than evidence of widespread uncontrolled exposure. The Health Board's target is to reduce this risk to a Moderate rating by December 2026 through completion of assessments, continued audits, enhanced training and further development of central COSHH management systems.

Overall RAG Assessment: Amber - Substantial Compliance with Improvement Programme Ongoing. This rating was chosen due to the outstanding COSHH assessments which represent an assurance gap under Regulation 6.

Registration, Evaluation, Authorisation, and Restriction of Chemicals (UK REACH) (Amendment) Regulations 2023

As outlined in the Background section, UK REACH has limited applicability to the Health Board. The principal users of diisocyanate-containing products are Plaster Room staff, who are therefore the main group requiring training under the UK REACH Regulations. In addition, the British Orthopaedic Association recommends diisocyanate awareness training for plaster room staff and others at risk of exposure. This training has been provided through an externally developed e-learning package delivered by Essity, which is proportionate to the level of risk. The table below confirms that all relevant staff have completed the required training and that the plaster service is compliant with the current UK REACH training requirements.

Site	No. of staff trained	% trained (of total staff)
PPH / GGH	8	38
GGH only	5	24
WGH	5	24
BGH	3	14
Total	21	100

A small number of Estates staff also use products containing diisocyanates and have received information and instruction on sensitiser hazards from the Health and Safety Team. Work is ongoing with Estates to identify and implement suitable alternatives to diisocyanate-containing products, with the aim of eliminating the associated health risks and reducing the Health Board's obligations under UK REACH. Current use is restricted to a small number of low-frequency maintenance activities, and exposure levels are considered extremely unlikely to approach the Workplace Exposure Limit (WEL).

Overall RAG Assessment: Green - Compliant.

Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR)

The table below shows compliance against the key duties under the Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR), rather than trying to assess compliance against the individual Regulations, of which there are many.

<u>DSEAR Requirement</u>	<u>RAG</u>	<u>Current Arrangements</u>
Identification of dangerous substances and hazardous activities		Dangerous substances identified through COSHH assessments, fire risk assessments and dedicated DSEAR assessments.

Assessment of fire and explosion risks (DSEAR Risk Assessment)		DSEAR assessments completed for three of the four acute hospital sites. Assessment of Bronglais Hospital planned for completion during 2026/27.
Elimination or reduction of risks so far as reasonably practicable		Findings from completed DSEAR assessments reviewed by Estates and Health & Safety teams, with remedial actions identified.
Implementation of suitable control measures		Control measures identified through assessments are being progressed by Estates teams. A number of engineered control measures are already in place and documented in existing Fire Risk Assessments.
Classification and management of hazardous areas where required		Addressed through completed DSEAR assessments and associated recommendations.
Maintenance of plant, equipment and safety measures		Existing Estates maintenance arrangements in place, with DSEAR-specific actions being incorporated following assessment findings.
Emergency procedures and arrangements for incidents involving dangerous substances		Existing fire and emergency arrangements in place, with DSEAR-specific requirements being reviewed through the assessment process.
Information, instruction and training		DSEAR considerations currently managed through existing health and safety arrangements. Development of a dedicated DSEAR Policy will strengthen governance and awareness.
Monitoring, audit and governance arrangements		Actions from assessments are being transferred to Audit Management and Tracking (AMaT) for tracking and monitoring. Dedicated DSEAR Policy under development.

Historically, the Health Board did not have a dedicated DSEAR compliance programme and relied primarily on fire risk assessments, COSHH assessments and local management arrangements to identify and control risks from dangerous substances. Whilst these arrangements provided a degree of risk management, they did not provide comprehensive evidence of compliance with the specific requirements of DSEAR. During the last 12 months, however, significant progress has been made in establishing a formal DSEAR compliance framework across the organisation.

Dedicated DSEAR assessments have now been completed for three of the four acute hospital sites, representing a substantial improvement in the Health Board's understanding and management of fire and explosion risks associated with dangerous substances. The final acute site, Bronglais General Hospital, is scheduled for assessment during the latter part of the 2026/27 financial year.

Findings from the completed assessments have been reviewed by the Estates teams with support from the Health and Safety Team's COSHH specialist, and the resulting actions will be transferred onto the (AMaT) system to enable monitoring, accountability and compliance tracking.

To further strengthen governance arrangements, the Health and Safety Team is developing a dedicated DSEAR Policy to complement the existing COSHH Policy and provide a clear

organisational framework for the assessment and management of dangerous substances. Subject to approval processes, this document is expected to be available by late 2026.

Overall RAG Assessment: Amber – Partially Compliant (Significant Progress Being Made).

Whilst the Health Board cannot yet evidence full compliance with all aspects of DSEAR due to the outstanding assessment work and implementation of identified actions, the programme of work currently underway represents a significant step forward and provides assurance that the organisation is moving towards full compliance with the Regulations.

Personal Protective Equipment at Work Regulations 1992 (PPE)

The table below shows compliance against the key duties under the PPE at Work Regulations 1992 (as amended), rather than trying to assess compliance against every sub-paragraph of the Regulations.

<u>PPE Regulation Requirement</u>	<u>RAG</u>	<u>Current Arrangements</u>
PPE provided where risks cannot be adequately controlled by other means		PPE requirements identified through infection prevention, COSHH assessments and work-specific risk assessments. PPE provided across clinical and non-clinical services.
PPE is suitable for the risks and users		Health Board policies specify appropriate PPE selection. PPE is selected according to clinical, infection prevention and occupational risks. Face-fit testing arrangements support suitability of Respiratory Protective Equipment (RPE).
PPE is maintained, inspected, replaced and stored appropriately		Local arrangements exist for storage, maintenance, decontamination and replacement of PPE, including reusable PPE and RPE.
Information, instruction and training provided		PPE forms part of Infection Prevention training. Additional training is provided where specialist PPE is required, including RPE and fit-testing.
Employees use PPE correctly and report defects		Responsibilities are defined within policy and procedure documents and supported through local management arrangements.
RPE is suitable and face-fit tested where required		RPE Fit Testing Procedure in place, trained fit-testers available across the Health Board.
RPE face-fit record keeping		Fit-testing records are maintained locally by managers and departments, including arrangements for periodic re-testing. The Health and Safety Team maintains a central register of trained fit-testers but does not hold a central database of individual fit-test outcomes. A corporate database was maintained during the COVID-19 response; however, this was not sustainable once pandemic resources stood down. Options to record fit-test compliance through Electronic Staff Record (ESR) have been explored but are not currently available.
Monitoring and assurance arrangements in place		Compliance monitoring undertaken through Infection Prevention audits, operational management arrangements and Health & Safety governance processes.

The Health Board has arrangements in place to comply with the PPE Regulations through the provision of suitable PPE identified by risk assessment and supported by corporate policies, procedures and training.

In clinical areas, PPE requirements are primarily governed through Infection Prevention and Control arrangements, whilst non-clinical risks requiring PPE are managed through risk assessments, COSHH assessments and task-specific assessments. Appropriate PPE is provided to staff free of charge and includes gloves, eye protection, protective clothing, footwear and respiratory protective equipment (RPE) where required.

Beyond clinical services, PPE requirements are identified and managed for staff undertaking operational activities, including Estates, Facilities, Portering, Waste and Engineering functions. Training, supervision, maintenance, replacement arrangements and compliance monitoring are in place to support the safe and effective use of PPE across the organisation, providing assurance of substantial compliance with the PPE Regulations.

Respiratory Protective Equipment (RPE)

The Health Board operates a long-established RPE fit-testing programme delivered through a train-the-trainer model. The Health and Safety Team provides fit-tester training, maintains a central register of trained fit-testers, and provides ongoing advice and governance, while fit-testing is undertaken locally by trained staff within wards, departments and service areas. This approach was established before the COVID-19 pandemic and enabled the Health Board to respond to increased demand without creating a dedicated fit-testing workforce. Consequently, the Health Board has continued to utilise the qualitative fit-testing methodology, which remains a recognised and compliant method for suitable types of RPE.

Unlike several Health Boards that invested in quantitative fit-testing equipment and dedicated RPE personnel following the pandemic, the Health Board has retained its devolved model, with fit-testing delivered locally by trained staff and supported centrally by the Health and Safety Team. Fit-test records are required to be held locally by managers and departments, and these arrangements remain in place. Whilst a central database of individual fit-test records was maintained during the COVID-19 response, this was not sustainable once pandemic arrangements stood down. The Health Board therefore maintains a central register of trained fit-testers rather than individual fit-test outcomes. Consideration has been given to recording fit-testing compliance through ESR, however current system functionality does not support this requirement. Whilst this limits the ability to report a corporate fit-testing compliance rate, compliance is demonstrated through the established fit-testing procedure, local record keeping arrangements and the network of trained fit-testers across the organisation.

Overall RAG Assessment: Green - Compliant. Despite the minor amber point about where records are located, the Health Board has documented policies, training arrangements, fit-testing processes and operational controls in place that demonstrate compliance with the key duties of the Personal Protective Equipment at Work Regulations.

Overall Position Statement

Overall, the Health Board is substantially compliant with the regulations reviewed within this report. Compliance is strongest in relation to UK REACH and PPE requirements, while ongoing programmes of work are required to achieve full assurance in relation to COSHH assessment completion and DSEAR implementation.

Whilst areas requiring further development have been identified, no evidence has been found of systemic regulatory failure requiring immediate escalation.

Argymhelliad / Recommendation

The Health & Safety Committee is asked to:

TAKE ASSURANCE

That the Health Board is operating in compliance with the following regulations as far as reasonably practicable:

- Control of Substances Hazardous to Health Regulations 2002 (as amended) (COSHH);
- Registration, Evaluation, Authorisation, and Restriction of Chemicals (UK REACH) (Amendment) Regulations 2023;
- Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR);
- Personal Protective Equipment at Work Regulations 1992 (PPE).

NOTE

The ongoing improvement programmes relating to COSHH and DSEAR compliance.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	2.1 Provide assurance around the UHB arrangements for ensuring the health, safety, welfare and security of all employees and of those who may be affected by work-related activities, such as patients, members of the public, volunteers, contractors etc.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	N/A
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	8. Fit for Purpose, Modern Facilities and Services

Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	3. Create people-centred employment and development opportunities that support workforce transformation, reflect the changing needs of
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (<i>complete for strategic change and/or significant service changes</i>)	Not Applicable
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Contained within the body of the report and associated Health Board policies.
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Key stakeholders.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impact
Ansawdd / Gofal Claf: Quality / Patient Care:	There is a positive impact on staff and patient safety, health and wellbeing through compliance with health and safety regulations.
Gweithlu: Workforce:	Potential for adverse future staffing impacts if health and safety legislation is not complied with as they relate to employee safety.
Tegwch Iechyd: Health Equity:	No direct impact
Risg: Risk:	Risk to health and safety management.
Cyfreithiol: Legal:	A breach of health and safety regulations, such as the Workplace (Health, Safety and Welfare) Regulations 1992, could result in the issue of prohibition or improvement notices or criminal proceedings.

Enw Da: Reputational:	Prosecutions and claims due to breaches in legislation or personal injury claims can lead to negative publicity.
Gyfrinachedd: Privacy:	Not Applicable.
Cydraddoldeb: Equality:	No evidence gathered to indicate a negative impact on any protected group/s.

2.3 - Electrical Safety

***Simon Day (Hywel
Dda UHB - Head of
Maintenance &
Engineering)***

- Electricity at Work Regulations 1989

| For assurance

Attachments

[HSC - Electrical Safety Assurance Report - August 2026.pdf](#)

[Appendix 1 - HSC Electrical Safety Compliance Metrics.pdf](#)



Pwyllgor Iechyd a Diogelwch/ Health and Safety Committee

DYDDIAD Y CYFARFOD: DATE OF MEETING:	10 SEPTEMBER 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Electrical Safety Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	James Severs, Executive Director of Allied Health Professions and Health Science
SWYDDOG ADRODD: REPORTING OFFICER:	Simon Day, Head of Maintenance and Engineering

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/ For Assurance

ADRODDIAD SCAA **SBAR REPORT**

Sefyllfa / Situation

The purpose of this paper is to provide a compliance report to the Health and Safety Committee on the Health Board's (HB) compliance for Electrical Safety. Electrical Safety is governed by the following regulations/industry standards:

- Electricity at Work Regulations 1989

In addition to the Electricity at Work Regulations all Health Boards in Wales must conform to the Welsh Health Technical Memorandum's (WHTM's).

The WHTMs are a suite of best practice guidance documents published by the Department of Health specifically for healthcare engineering. Their primary purpose is to provide estates and facilities teams with comprehensive advice and guidance for the management, design and procurement of business critical engineering components within a healthcare facility to ensure optimum safety, reliability and resilience.

The specific WHTM's / HTM's are detailed below:-

- WHTM 06-01 Electrical services supply and distribution 2018
- WHTM 06-02 Electrical safety guidance for low voltage systems 2024
- WHTM 06-02 Electrical Safety Handbook 2024
- WHTM 06-03 Electrical safety guidance for high voltage systems 2024
- HTM 06-03 Authorised Persons Logbook 2006

The final revision of the suggested metrics was passed by the Health Board's Electrical Safety Group (ESG) to demonstrate compliance are listed in Appendix 1.

Cefndir / Background

This report has been compiled from intelligence captured through Computer Aided Facility Management (CAFM) planned maintenance data, electrical repair/replacement records, Datix risk and incident information, Audit Management and Tracking (AMAT), Authorising Engineer (AE) and NHS Wales Shared Services Partnership Specialist Estates Services (NWSSP/SES) audit outputs, Authorised Person(AP)/Competent Person (CP) appointment matrices, Distribution Network Operator (DNO) service arrangements, generator/Uninterruptible Power Supply (UPS) testing records, fixed wire testing records and policy compliance information.

Governance

The Electrical Safety Group (ESG) meet regularly, in line with the defined requirements of the WHTM. The Group is well attended and the required quorum as defined by the Terms of Reference (ToR) is always met. There are also Electrical Safety sub-groups that regularly meet between the ESG to resolve issues at a working group level.

There is a robust AP & CP appointment process in the Health Board.

Statutory finance is provided annually to carry out fixed-wire testing. This funding is essential.

Planned Preventative Maintenance (PPM) programme is well established in the HB and PPMs are tracked on the CAFM system.

The report has also been informed by discussion through membership of the ESG which provide a forum for which subject matter experts, including AP AEs, site teams and compliance leads; to consider Electrical Risk, compliance issues, escalation and improvement actions.

Asesiad / Assessment

The complete set of performance metrics are attached in **Appendix 1**. Overall, July 2026 provides reasonable assurance for Electrical Safety compliance, with a positive direction of travel in the key maintenance completion indicators.

Electrical Low Voltage (LV) PPM completion improved from 97% in April to 100% in July 2026. Generator testing is reported at 100%, UPS testing is reported as complete, portable appliance registers are maintained, safety incidents remain at zero, overdue risk actions are reported at 0%

The main area requiring continued attention is the electrical repairs/replacements completion rate, which was 84% in July 2026. This demonstrates relative stability, however, remains below the level of performance that the HB want to see for a stable compliance position.

As Chair of the ESG, I am drawing the attention of the Health and Safety Committee to the following areas:

- The overall position is broadly positive across the majority of the Electrical Safety metrics.
- Electrical repair/replacement completion rates remain below the required trajectory and will continue to be managed through site operational review.
- Fixed wire testing is currently reported as compliant; however, this in an ongoing body of works with an external Service Level Agreement (SLA). Remedial actions to fixed wiring defects are often substantial and will likely require Capital funding.

METRICS DEMONSTRATING NON-COMPLIANCE OR CONCERNING TRENDS (RAG rated red in Appendix 1):

Data analysis and findings

Performance Metric	Target	Apr-26	May-26	Jun-26	Jul-26	Interim Target	Trend
Electrical repairs /replacements % Completion Rate	90%	81%	86%	86%	84%	90%	↓
Electrical (LV) PPMs % Completion Rate	95%	90%	97%	99%	100%	95%	↑

Reasons for gaps in compliance

The reason for the gap in compliance is outlined below:

Performance Metric	Reason for gap in compliance
Electrical repairs /replacements % Completion Rate	The completion rate for July 2026 was 84%; therefore, the metric remains below the expected trajectory. This is driven by operational demand, prioritisation of safety critical issues, staffing issues, access and specialist parts/contractor support.

How Compliance is to be Achieved

To address the lack of compliance with the above metrics, the following actions / improvement plan will be implemented

Performance Metric	Target Set	Actions to improve compliance (SMART actions)	By when	By who
Electrical repairs /replacement s % Completion Rate	>=90% by Sept 2026, sustained thereafter	Review open work orders weekly by site; prioritise safety critical items; confirm blockers; close completed work in CAFM within month; escalate through Estates Operational Management Team (OMT).	30 Sept 2026	Estates Managers (EMs) / Senior Estates Officers (SEOs)
Electrical (LV) PPMs % Completion Rate	Sustain >=95%	Maintain weekly review of PPM completion; confirm reason codes and recovery dates for missed PPMs; maintain focus on safety critical electrical PPMs.	Monthly	EMs / SEOs

By implementing the actions above, the timeline for improvement is expected to follow the trajectory below:

Performance Metric	Interim Target for May 2026	Interim Target for Jun 2026	Interim Target for Jul 2026	Interim Target for Aug 2026	Interim Target for Sept 2026	Interim Target for Oct 2026
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Electrical repairs /replacement s % Completion Rate	86% actual	86% actual	84% actual	90%	>=90%	>=92%
Electrical (LV) PPMs % Completion Rate	97% actual	99% actual	100% actual	Sustain >=95%	Sustain >=95%	Sustain >=95%

Risk Management

It has been confirmed that all Electrical Risks and Risk Actions are reviewed in date and all risk actions are currently in-date.

Policies

The Health Board's Electrical Policy is confirmed as having been recently reviewed and is therefore within its review date.

Argymhelliad / Recommendation

The Health & Safety Committee is requested to:

- **RECEIVE ASSURANCE** on the current Electrical Safety compliance position.
- **RECEIVE ASSURANCE** regarding the management of electrical repair and replacement backlog pressures and the actions in place to achieve compliance targets.
- **NOTE** the positive improvement in low-voltage planned preventative maintenance compliance.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.1.2 Receive assurance on the Health Board's compliance against individual health and safety regulations, on rotation, with their regularity determined by their current risk status.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	N/A
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable

Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	8. Fit for Purpose, Modern Facilities and Services
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	10. Not Applicable
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (<i>complete for strategic change and/or significant service changes</i>)	Not Applicable
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Health & Safety Committee Terms of Reference Establishment/Dis-establishment of Committees/Sub-Committees (SOP for the Management of Board and Committees)
Rhestr Termiau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Director of Corporate Governance (Board Secretary) Assistant Director of Assurance and Risk Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impact

Ansawdd / Gofal Claf: Quality / Patient Care:	The intention of this report is to improve health and safety governance arrangements to drive improvements within the Health Board
Gweithlu: Workforce:	No direct impact
Tegwch lechyd: Health Equity:	No direct impact
Risg: Risk:	No direct impact
Cyfreithiol: Legal:	No direct impact
Enw Da: Reputational:	No direct impact
Gyfrinachedd: Privacy:	No direct impact
Cydraddoldeb: Equality:	No direct impact

APPENDIX 1: Electrical Safety Metrics

This Electrical Safety Compliance Report provides details of the organisation's compliance with its statutory duties under health and safety legislation, including:

Electricity at Work Regulations 1989

Further detail about the actions needed to improve the current position are included in the main body of the report.

Reporting Period	Jul-26		Unable to report detailed compliance metrics
Responsible Head of Service	Simon Day		Non-compliant
Date	03/08/2026		Non-compliant but tracking Executive agreed plan
Author	S.Day		Compliant

Performance Metric	Target	Apr-26	May-26	Jun-26	Jul-26	Interim Target	Trend
Number of Electrical (LV) PPMs Issued		50	58	70	58		
Number of Electrical (LV) PPMs completed		45	56	69	58		
Electrical (LV) PPMs % Completion Rate	95%	90%	97%	99%	100%		↑
High voltage system PPMs completed by DNO as per schedule		Yes	Yes	Yes	Yes		↔
Number of Electrical repairs/replacements generated		113	80	79	68		
Number of Electrical repairs/replacements completed		92	69	68	57		

Electrical repairs /replacements % Completion Rate	90%	81%	86%	86%	84%		↓
% of generator testing completed as scheduled	95%	100%	100%	100%	100%		↔
% of UPS testing completed as scheduled	95%	100%	100%	100%	100%		↔
Number of infrastructure upgrades in progress		3	3	3	3		
Register of portable appliances maintained		Yes	Yes	Yes	Yes		↔
Number of electrical safety incidents	0	0	0	0	0		↔
Number of electrical safety risks		24	24	24	24		↔
% of overdue risk actions		0	0	0	0		↔
Number of audits completed by NWSSP/SES		All audits within date	All audits within date	All audits within date	All audits within date		
% of completed actions following NWSSP/SES audit		In progress	In progress	In progress	In progress		
Number of audits completed by authorising engineer audit		All audits within date	All audits within date	All audits within date	All audits within date		
% of completed actions following AE audit		In progress	In progress	In progress	In progress		
AP appointment following AE assessment	12 APs	7 APs Appointed. 3 Identified for training and appointment	7 APs Appointed. 3 Identified for training and appointment	7 APs Appointed. 3 Identified for training and appointment	7 APs Appointed. 3 Identified for training and appointment	8 APs	↔
CP appointments		All CPs Appointed	All CPs Appointed	All CPs Appointed	All CPs Appointed		↔
Fixed wire testing		Yes	Yes	Yes	Yes		↔
Compliance with electrical safety training		Yes	Yes	Yes	Yes		↔
Policy in date		Yes	Yes	Yes	Yes		↔

2.4 - Water Safety

***Simon Day (Hywel
Dda UHB - Head of
Maintenance &
Engineering)***

- Water Supply (Water Fittings) Regulations 1999)

| For assurance

Attachments

[HSC - Water Safety Assurance Report - August 2026.pdf](#)

[Appendix 1 - Water Safety Compliance Metrics.pdf](#)



Pwyllgor Iechyd a Diogelwch/ Health and Safety Committee

DYDDIAD Y CYFARFOD: DATE OF MEETING:	10 SEPTEMBER 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Water Safety Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	James Severs, Executive Director of Allied Health Professions and Health Science
SWYDDOG ADRODD: REPORTING OFFICER:	Simon Day, Head of Maintenance and Engineering

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/ For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to provide an assurance report to the Health and Safety Committee on the Health Board's (HB) compliance for Water Safety. Water Safety Compliance is governed by the following regulations/industry standards:

- Water Supply (Water Fittings) Regulations 1999;
- Control of Substances Hazardous to Health Regulations 2002 (as amended) (COSHH);
- Management of Health and Safety at Work Regulations 1999 (MHSWR);
- HSIS6 – Managing the risk of hot water and surfaces in Health & Social care

In addition to the above regulations all Health Boards in Wales must conform to the Welsh Health Technical Memorandum's (WTHMs).

The WHTMs are a suite of best practice guidance documents published by the department of health specifically for healthcare engineering. Their primary purpose is to provide estates and facilities teams with comprehensive advice and guidance for the management, design and procurement of business critical engineering components within a healthcare facility to ensure optimum safety, reliability and resilience.

The specific WHTM's / HTM's for Water Safety are detailed below:-

- WHTM 04-01 Safe water in healthcare premises Part A: Design, installation and commissioning 2016
- WHTM 04-01 Safe water in healthcare premises Part B: Operational management 2016
- WHTM 04-01 Safe water in healthcare premises Part C: Pseudomonas aeruginosa – advice for augmented care units 2016
- WHTM 04-01 Performance specification D 08: thermostatic mixing valves (healthcare premises)

Cefndir / Background

This report has been compiled from intelligence captured through the Health Board's Computer Aided Facility Management (CAFM) system, Estates operational compliance returns, Water Safety Group (WSG) reporting arrangements and local site engineering team updates.

Governance

The WSG meet regularly, in line with the defined requirements of the WHTM. The Group is well attended and the required quorum as defined by the Terms of Reference (ToR) is always met. There are also Water sub-safety groups that regularly meet between the Water Safety Group to resolve issues at a working group level.

There is a robust Responsible Person (RP) and Deputy Responsible Person (DRP) appointment process established in the Health Board.

Statutory finance provided annually to carry important minor upgrades to the system. This funding is essential and the site teams utilise each year to address NHS Wales Shared Services Partnership Specialist Estates Services (NWSSP/SES) audit actions and statutory compliance, Welsh Water audits.

Planned Preventative Maintenance (PPM) programme is well established in the HB and PPMs are tracked on the CAFM system.

The report has also been informed by discussion through membership of the WSG which provide a forum for which subject matter experts; including RPs/DRPs and Authorising Engineers (AEs), site teams and compliance leads; to consider Water Risks, compliance issues, escalation and improvement actions.

Asesiad / Assessment

The complete set of performance metrics are attached in Appendix 1.

This report provides further detail about the performance metrics where non-compliance is reported (RAG rated red) or where we are currently unable to demonstrate compliance (indicated as grey) against an agreed metric. It sets out the actions in place to achieve compliance for these areas.

As Chair of the Water Safety Group, I am drawing the attention of the Health and Safety Committee to the following areas:

- The overall position is broadly positive across the majority of the Water Safety metrics.
- Temperature monitoring, Thermostatic Mixing Valve (TMV) PPMs, Pseudomonas PPMs, shower head / hose PPMs and other water system PPMs are reporting at or above the agreed target.
- The areas requiring attention are calorifier PPMs and water system repairs, both of which are below the agreed 95% compliance target for the reporting period.

METRICS DEMONSTRATING NON-COMPLIANCE OR CONCERNING TRENDS (RAG rated red in Appendix 1):

Data analysis and findings

Performance Metric	Target	Apr-26	May-26	Jun-26	Jul-26	Interim Target	Trend
% of Water System repairs completed	95%	93%	71%	75%	90%	95%	↑
% of calorifier PPMs Completed	95%	90%	92%	100%	72%	95%	↓
% of Other Water System PPMs Completed	95%	100%	96%	94%	97%	95%	↑

Reasons for gaps in compliance

The reason for the gap in compliance is outlined below:

Performance Metric	Reason for gap in compliance
% of Water System repairs completed	Completion increased further in July 2026 despite some continued staffing issues. Priority has been ensuring completion of high-priority PPMs and critical breakdowns.
% of calorifier PPMs Completed	Calorifier PPM completion was down due to 2x PPMs that were missed at Prince Philip Hospital (PPH) in the community, due to ongoing repairs at Amman Valley Hospital and a missed PPM in Swn Y Gwynt. <i>*Only 7PPMs generated for the whole HB.</i>
% of Other Water System PPMs Completed	Priority has been ensuring completion of high-priority PPMs and critical breakdowns.

How Compliance is to be Achieved

To address the lack of compliance with the above metrics, the following actions / improvement plan will be implemented.

Performance Metric	Target Set	Actions to improve compliance (SMART actions)	By when	By who
% of Water System repairs completed	95%	Review the water system repair backlog, confirm risk prioritisation, allocate available support across the site team and track closure of outstanding repair tasks through weekly operational reviews.	31 August 2026	Water RPs
% of calorifier PPMs Completed	95%	Ensure any associated repair actions are completed prior to PPM. Allocate staff for community PPMs.	31 July 2026	Water RPs
% of Other Water System PPMs Completed	95%	Allocate available support across the site team and track closure of outstanding repair tasks through weekly operational reviews.	31 July 2026	Water RPs

By implementing the actions above, the timeline for improvement is expected to follow the trajectory below:

Performance Metric	Interim Target for May 2026	Interim Target for Jun 2026	Interim Target for Jul 2026	Interim Target for Aug 2026	Interim Target for Sept 2026	Interim Target for Oct 2026
% of Water System repairs completed	71%	75% Actual	90% Actual	90%	95%	95%
% of calorifier PPMs Completed	92%	100% Actual	72% Actual	95%	95%	95%
% of Other Water System PPMs Completed	95%	94% Actual	97% Actual	95%	95%	95%

Risk Management

It has been confirmed that all Water Risks and Risk Actions are reviewed in date and all risk actions are currently in-date.

Policies

The Health Board policy governing the Water Safety regulations and legislation is confirmed as within its regulatory review date.

Argymhelliad / Recommendation

The Health & Safety Committee is requested to:

- **RECEIVE ASSURANCE** on the overall water safety compliance position;
- **NOTE** the areas of non-compliance and the improvement actions in place to achieve the agreed compliance targets; and
- **NOTE** the requirement for the Water Safety Group to validate the 12-monthly reporting basis for thermostatic mixing valve planned preventative maintenance.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.1.2 Receive assurance on the Health Board's compliance against individual health and safety regulations, on rotation, with their regularity determined by their current risk status.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	N/A
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable

Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	8. Fit for Purpose, Modern Facilities and Services
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	10. Not Applicable
Model Cymdeithasol ar gyfer lechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (<i>complete for strategic change and/or significant service changes</i>)	Not Applicable
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Health & Safety Committee Terms of Reference Establishment/Dis-establishment of Committees/Sub-Committees (SOP for the Management of Board and Committees)
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Director of Corporate Governance (Board Secretary) Assistant Director of Assurance and Risk Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impact
Ansawdd / Gofal Claf: Quality / Patient Care:	The intention of this report is to improve health and safety governance arrangements to drive improvements within the Health Board

Gweithlu: Workforce:	No direct impact
Tegwch Iechyd: Health Equity:	No direct impact
Risg: Risk:	No direct impact
Cyfreithiol: Legal:	No direct impact
Enw Da: Reputational:	No direct impact
Gyfrinachedd: Privacy:	No direct impact
Cydraddoldeb: Equality:	No direct impact

APPENDIX 1: Water Metrics

This water safety compliance report provides details of the organisation's compliance with its statutory duties under health and safety legislation, including:

Water Supply (Water Fittings) Regulations 1999;
Control of Substances Hazardous to Health Regulations 2002 (as amended) (COSHH);
Management of Health and Safety at Work Regulations 1999 (MHSWR);
HSIS6 – Managing the risk of hot water and surfaces in Health & Social care

Further detail about the actions needed to improve the current position are included in the main body of the report.

Reporting Period	Jul-26		Unable to report detailed compliance metrics
Responsible Head of Service	Simon Day		Non-compliant
Date	03/09/2026		Non-compliant but tracking Executive agreed plan
Author/s	Simon Day		Compliant

Performance Metric	Target	Apr-26	May-26	Jun-26	Jul-26	Interim Target	Trend
Number of Temperature Monitoring PPMs Generated		135	142	145	141		
Number of Temperature Monitoring PPMs Completed		134	142	145	141		
% Temperature Monitoring PPMs Completed	95%	99%	100%	100%	100%	95%	↔
Number of Water System repairs generated		14	14	40	10		

Number of Water System repairs completed		13	10	30	9		
% of Water System repairs completed	95%	93%	71%	75%	90%	90%	↑
Number of TMV PPMs Generated		13	14	14	17		
Number of TMV PPMs Completed		13	14	14	17		
% of TMV PPMs Completed	95%	100%	100%	100%	100%	95%	↔
Number of 12 Monthly TMV PPMs Generated		0	0	0	0		
Number of TMV PPMs Completed		0	0	0	0		
% of TMV PPMs Completed		0	0	0	0		
Number of calorifier PPMs Generated		10	12	5	7		
Number of calorifier PPMs Completed		9	11	5	5		
% of calorifier PPMs Completed	95%	90%	92%	100%	72%	90%	↓
Number of Pseudomonas PPMs Generated		6	3	2	5		
Number of Pseudomonas PPMs Completed		6	3	2	5		
% of Pseudomonas PPMs Completed	95%	100%	100%	100%	100%	95%	↔
Number of Shower Head / Hose PPMs Generated		17	33	50	20		
Number of Shower Head / Hose PPMs Completed		17	33	50	20		

% of Shower Head / Hose PPMs Completed	95%	100%	100%	100%	100%	95%	↔
Number of Other Water System PPMs Generated		162	168	176	95		
Number of Other Water System PPMs Completed		162	161	166	92		
% of Other Water System PPMs Completed	95%	100%	96%	94%	97%	95%	↑
Number of sites that require Water Risk Assessments							
Number of sites with valid Water Risk Assessments							
Number of Water Risk Assessment actions (AMAT)							
Number of Water Risk Assessment actions overdue (AMAT)							
% Water Risk Assessment actions overdue							
% Flushing regimes completed as scheduled							
Number of water safety incidents		0	0	0	0		↔
Water Safety Policy in date		Yes	Yes	Yes	Yes		↔

2.5

10:30 AM, 15 Mins

2.5 - Heatwave Response & Action Plan

***Ardiana Gjini (Hywel
Dda UHB - Executive
Director of Public
Health)***

Deferred

| For assurance

3 - Clinical Care Group Updates

3.1

10:45 AM, 10 Mins

3.1 - Planned and Specialist Services

Gareth Cottrell
(Hywel Dda UHB -
Deputy Chief
Operating Officer),
Tamara Bromley
(Hywel Dda UHB -
Assistant Director of
Nursing)

| For assurance

Attachments

3.1 Planned Care Specialist Services CCG Compliance Report September 2026.pdf



Pwyllgor Iechyd a Diogelwch/ Health and Safety Committee

DYDDIAD Y CYFARFOD: DATE OF MEETING:	10 SEPTEMBER 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Planned Care and Specialist Services Clinical Compliance Group Update Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Olwen Morgan, Assistant Director of Nursing, Quality & Patient Experience

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/ For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This report provides an update on Health and Safety performance within the Planned Care & Specialist Services Clinical Care Group (PC&SS CCG) providing information on governance arrangements, compliance with statutory requirements, and management of key risks. The Health & Safety Compliance Group is asked to note the current position, areas requiring improvement including manual handling training and higher levels of training and management of historical inspection actions

Cefndir / Background

Since April 2026, a Health and Safety dashboard has been implemented providing monthly performance data to strengthen oversight, transparency, and accountability. Health and Safety is a standing core agenda item at the PC&SS Clinical Care Group Integrated Governance Group

The performance metrics have been agreed by the Health and Safety Compliance Group on the advice of the Accountable Lead for Corporate Health and Safety. These metrics will capture the requirements against the health and safety regulations and industry standards outlined above to demonstrate the Health Board's level of compliance. A Health Board-wide audit of Health and Safety inspections (2023–2025) identified a gap in assurance relating to tracking and closure of approximately 1,000 actions.

Asesiad / Assessment

This report provides some detail about the performance metrics where non-compliance is reported (RAG rated red or where we are currently unable to demonstrate compliance (indicated as grey in Appendix 1) against an agreed metric.

It is acknowledged that data and information is incomplete and further work is required

METRICS DEMONSTRATING NON-COMPLIANCE OR CONCERNING TRENDS (RAG rated red in Appendix 1):

Data analysis and findings

Performance Metric	Target	Mar-26	Apr-26	May-26	Jun-26	Interim Target	Trend
Total number of staff/contractor incidents reported via Datix	N/A	15	11	17	14	N/A	↓
Staff/contractor incidents rate per 100 staff	N/A	0.6	0.4	0.6	0.5	N/A	↓
Number of RIDDOR reportable incidents	N/A	0	0	0	1	N/A	↑
% of RIDDOR reportable incidents submitted within timescales (Financial year to date)	60%	50%	N/A	N/A	100%	60%	↔
Number of health and safety near-miss staff/contractor incidents reported	N/A	4	0	5	7	N/A	↑
Number of violence & aggression staff/contractor incidents reported	N/A	1	4	6	2	N/A	↓
Number of manual handling / MSK staff/contractor incidents	N/A	2	0	3	0	N/A	↓
Number of slips, trips and falls staff/contractor incidents	N/A	1	0	0	1	N/A	↑
Number of needlestick staff/contractor incidents	N/A	3	2	1	1	N/A	↔
Number of COSHH related staff/contractor incidents	N/A	1	2	1	1	N/A	↔
Number of electric shock staff/contractor incidents	N/A	0	0	0	0	N/A	↔
Number of absconding incidents (from Security Manager Database)	N/A	0	0	0	0	N/A	↔
Number of ligature related incidents	N/A	0	0	0	0	N/A	↔
Number of staff/contractor incidents still awaiting review after 30 days	N/A	22	19	29	34	N/A	↑
Outstanding moderate actions from internal H&S inspections (Old system - risk stratification)	0	16 of 16	12 of 16	12 of 16	12 of 16	0	↔
Outstanding major actions from internal H&S inspections (Old system - risk stratification)	0	3 of 3	2 of 3	2 of 3	2 of 3	0	↔
Outstanding catastrophic actions from internal H&S inspections (Old system - risk stratification)	0	0	0	0	0	0	↔
Outstanding moderate actions from internal H&S inspections (AMaT) (Programme currently paused)	0	0	0	0	0	0	↔
Outstanding major actions from internal H&S inspections (AMaT) (Programme currently paused)	0	0	0	0	0	0	↔
Outstanding catastrophic actions from internal H&S inspections (AMaT) (Programme currently paused)	0	0	0	0	0	0	↔
% completion of mandatory Health, Safety & Welfare training	85.0%	83.3%	83.0%	83.8%	84.1%	85.0%	↑
% compliance level 1 manual handling	85.0%	76.6%	76.2%	74.1%	75.2%	85.0%	↑
% compliance with level 2 manual handling training	85.0%	60.9%	60.0%	58.0%	58.5%	85.0%	↑
% compliance with V&A training Module A	85.0%	92.0%	92.4%	92.6%	92.9%	85.0%	↑
% compliance with DSE training	85.0%	93.6%	94.3%	94.3%	94.4%	85.0%	↔
% compliance with Infection Prevention and Control Level 1 training	85.0%	Not Available	Not Available	83.0%	82.6%	85.0%	↓
% V&A/Security risk assessments in place for reported incidents	100%	0.0%	20.0%	42.9%	50.0%	85.0%	↑
Number of CCG RRP incidents reported (On Datix, in the 'Restrictive Practices' category)	N/A	0	0	0	0	N/A	↔

Governance & Assurance

- It is evident that several compliance metrics require improvement and action will be taken to improve compliance within the services.
- It is positive to see that compliance across a significant number of metrics is improving, although it is recognised that further and sustained improvement is required.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) Compliance

- 1 RIDDOR incident (June 2026) reported within statutory timescale.

Incidents & Risk Trends

Manual Handling & Workforce Safety

- Level 1 compliance: ↑75.2% but below 85% target
- Level 2 compliance: ↑58.5% well below 85% target
- Overall, 30–50% training non-attendance impacting compliance (Health Board wide)

Action:

Regular monitoring and escalation required through governance structures of the service groups to strengthen oversight of compliance and follow-up.

Workforce Health & Sickness Monitoring

- Sickness and absence rates are routinely monitored within the CCG. Hot spot trend noted within Acute Paediatrics at Glangwili Hospital (GGH) with 33% absence due to work related stress.

Action:

Service to undertake a 'deep dive' to identify themes and trends to address issues.

Risk Assessment Assurance

- Violence & Aggression (V&A) Security Risk Assessments in place for reported incidences: ↑50%

Action:

Services to undertake a review and develop a plan to strengthen compliance and monitoring

Wider Training & Safety Systems

- Health, Safety & Welfare Training compliance: ↑84.1%
- Violence & Aggression Training Module A: ↑92.9%
- Infection Prevention & Control (IP&C) Training Level 1: ↓82.6%
- Display Screen Equipment Training: →94.4%
- Fire Training: Level 1 78.44%; Level 2 68.27%

Action:

Improvement plan request to Service Delivery Group (SDG) and report through service group quality & safety meeting.

Incident & Risk Management

- Total staff/contractor incidents in first quarter: 42 (↓11 ↑17 ↓14)
- Violence & Aggression incidents showing an improvement: 12 (↑4 ↑6 ↓2)
- H&S Near-miss incidents showing an increasing trend: (↓0 ↑5 ↑7)
- Incidents awaiting review over 30 days showing a deteriorating trend: (↓19 ↑29 ↑34)

Action:

Further detail requested of incidents to identify trends to support governance and improvement
Services to undertake a review and trajectory for closure.

Historical Health and Safety Inspection Actions and Risk Management

Handover of actions from Health & Safety Team planned end of August 2026.

Key Risks Identified

- Low compliance in Manual Handling training (particularly Level 2)
- Improvement needed with Level 2 Fire Safety Training
- Low compliance with V&A Security risk assessments
- Improvement needed in timely review and investigation of H&S incidents <30 days
- Limited current capability to report on work-related sickness absence trends

- Limited data availability and need to enhance trend analysis capability for proactive risk management

Management plans/actions will be developed to address these and included in the next Corporate Health and Safety compliance report to the Health and Safety Compliance Group.

Argymhelliad / Recommendation

The Health & Safety Committee is requested to:

- **Receive assurance** on the current position and the management of historical inspection actions, while noting the areas requiring further improvement.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.1.3 Receive bi-annual assurance reports from each Clinical Care Group Service Director on their individual Clinical Care Group health and safety arrangements.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	N/A
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	1. Leadership
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	8. Fit for Purpose, Modern Facilities and Services
Hypergyswilt i Amcanion Llesiant HDdUHB 2026	10. Not Applicable

Hyperlink to HDdUHB Well-being Objectives 2026	
Model Cymdeithasol ar gyfer lechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (complete for strategic change and/or significant service changes)	Not Applicable
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Health & Safety Committee Terms of Reference Establishment/Dis-establishment of Committees/Sub-Committees (SOP for the Management of Board and Committees)
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Director of Corporate Governance (Board Secretary) Assistant Director of Assurance and Risk Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impact
Ansawdd / Gofal Claf: Quality / Patient Care:	The intention of this report is to improve health and safety governance arrangements to drive improvements within the Health Board
Gweithlu: Workforce:	No direct impact
Tegwch lechyd: Health Equity:	No direct impact
Risg: Risk:	No direct impact
Cyfreithiol: Legal:	No direct impact
Enw Da: Reputational:	No direct impact
Gyfrinachedd: Privacy:	No direct impact

**Cydraddoldeb:
Equality:**

No direct impact

3.2

10:55 AM, 10 Mins

3.2 - Primary Care

Gareth Cottrell
(Hywel Dda UHB -
Deputy Chief
Operating Officer),
Rhian Bond (Hywel
Dda UHB - Assistant
Director of Primary
Care)

| For assurance

Attachments

[3.2 Primary Care CCG Compliance Report September 2026.pdf](#)



Pwyllgor Iechyd a Diogelwch/ Health and Safety Committee

DYDDIAD Y CYFARFOD: DATE OF MEETING:	10 SEPTEMBER 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Primary Care Clinical Compliance Group Update Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Rhian Bond, Assistant Director of Primary Care

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/ For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to provide a compliance report to the Health and Safety Committee on the Health Board's compliance for Corporate Health and Safety. Corporate Health and Safety is governed by the following regulations/industry standards:

- Management of Health and Safety at Work Regulations 1999 (MHSWR);
- Workplace (Health, Safety and Welfare) Regulations 1992 (WHSWR);
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)
- Manual Handling Operations Regulations 1992;
- Control of Substances Hazardous to Health Regulations 2002 (as amended) (COSHH);
- Personal Protective Equipment at Work Regulations 1992 (PPE);
- Violence & Aggression;
- Safety Representatives and Safety Committees Regulations 1977;
- Health and Safety (Consultations with Employees) Regulations 1996;
- Ligation Risk Management (Inc: Emergency Workers Act 2017);
- Health and Safety (Sharp Instruments in Healthcare) Regulations 2013;
- Personal Protective Equipment at Work Regulations 1992 (PPE)

Cefndir / Background

This report has been compiled from intelligence captured through Datix Risk, Our Performance Dashboard, Primary Care Information Portal, EMIS extract and NHS Wales Shared Services Partnership (NWSSP) reports.

The performance metrics have been agreed by the Health and Safety Compliance Group on the advice of the Accountable Lead for Corporate Health and Safety. These metrics will capture the requirements against the health and safety regulations and industry standards outlined above to demonstrate the Health Board's level of compliance.

Primary Care Contractors

In relation to General Medical Services (GMS), General Dental Services (GDS), Personal Dental Services (PDS), General Ophthalmic Services (GOS) and Community Pharmacy, responsibility for compliance with health and safety legislation rests with individual contractors. The Health Board's role is to obtain assurance, through contractual monitoring arrangements under the National Health Service (General Medical Services Contracts) (Wales) Regulations 2023, The National Health Service (General Dental Services Contracts and Patient Charges) (Amendment) (Wales) Regulations 2026, The National Health Service (Personal Dental Services Agreements) (Wales) Regulations 2006, The National Health Service (Ophthalmic Services) (Wales) Regulations 2023 and the National Health Service (Pharmaceutical Services) (Wales) Regulations 2020 respectively, that contractors have appropriate policies, procedures, risk assessments and governance arrangements in place to comply with relevant legislation.

Health Board Managed Practices

There are six Health Board managed practices within Hywel Dda, three in Carmarthenshire (Ash Grove Medical Centre in Llanelli, Meddygfa Minafon in Kidwelly and Meddygfa'r Sarn in Pontyates) and three in Pembrokeshire (Tenby Surgery, Neyland & Johnston Surgery and Meddygfa Penrhyn in Solva). Health and Safety features on the agendas of the monthly Quality, Health & Safety Integrated Governance Group (QHS) and Performance, People and Planning Group (PPP) meetings, with attendance by the Health and Safety Team subject to availability.

Health and Safety audits of the individual practices conducted by the Health and Safety Team with the respective Service Delivery Managers have accompanying action plans. The majority of incomplete actions relate to actions within estates. Repeat practice visits to monitor compliance and any new issues are due later in 2026.

Mandatory training compliance stands at 88.4% across the six Managed Practices with lowest achievement in Moving and Handling and Infection Prevention and Control. Recent Protected Time for Learning (PT4L) sessions have afforded protected time for staff to maintain compliance, and managers are proactively working on areas of lower compliance with their teams.

Compliance with Fire Safety Level 2 training is of concern in managed practices, however this is as a result of the clinical staff being identified as requiring level 2 training when the statutory requirement is for Level 1, which they are compliant with.

Community Dental Services

Community Dental Services provides care across seven Health Board clinics: two in Carmarthenshire, two in Ceredigion and three in Pembrokeshire. Health and safety compliance, incident management, risk, and workforce compliance are reviewed through routine Community Dental Services governance arrangements, including monthly QHS meetings and PPP meetings.

The service is undergoing a period of improvement activity, including renewed health and safety and violence and aggression risk assessments across all clinic sites, due for completion

by the end of September 2026. This work will provide a refreshed baseline of environmental and operational risk and support prioritised action planning.

Although current incident data shows no longstanding open investigations, the low number of reported incidents should not be interpreted as an absence of risk. Managers within the Community Dental Services recognise that incident and near-miss reporting have historically been lower than expected for a geographically dispersed clinical service. Managers are therefore reinforcing the Health Board incident reporting procedure through team meetings, supervision and local governance routes, with the aim of improving reporting culture, learning and assurance.

Out of Hours Service

The Out of Hours service operates out of each hospital site as well as from space in Llynfrfan Surgery. Health and safety compliance, incident management, risk, and workforce compliance are reviewed through routine Out of Hours governance arrangements, including monthly QHS and PPP meetings.

May 2026 data identified seven incidents that had been open over 120 days; a focussed effort is required to review and close these incidents as well as ensuring that other incidents do not breach 120 days. The service has two risks 803 and 2059 that are outside the review timescale and have overdue actions.

Training compliance against the core skills framework is below target across all areas excluding Dementia Awareness, Safeguarding Children Level 1 and Resuscitation Level 1.

Data analysis and findings

Performance Metric	Target	Mar-26	Apr-26	May-26	Jun-26	Interim Target	Trend
Outstanding moderate actions from internal H&S inspections (Old system - risk stratification)	0	32 of 32	32 of 32	26 of 32	26 of 32	0	↔
Outstanding major actions from internal H&S inspections (Old system - risk stratification)	0	5 of 5	5 of 5	5 of 5	5 of 5	0	↔
% compliance with level 2 manual handling training	85.0%	42.9%	35.1%	32.6%	40.2%	85.0%	↑
% Violence and Aggression (V&A)/Security risk assessments in place for reported incidents	100%	N/A	N/A	N/A	50%	100%	↑

Reasons for gaps in compliance

The reason for the gap in compliance is outlined below:

Performance Metric	Reason for gap in compliance
Outstanding moderate actions from internal H&S inspections (Old system - risk stratification)	
Outstanding major actions from internal H&S inspections (Old system - risk stratification)	

80% compliance with level 1 manual handling training	272 staff (out of 340) have achieved level 1 moving and handling training on Electronic Staff Record (ESR). Across the service 48 staff do not have this competency or it has expired. A further eight staff are due to expire soon. Two teams in particular need to focus on this competency: • Out of Hours – 73% - 25 needed • Primary Care (PC) Management – 71% - 10 needed
% V&A/Security risk assessments in place for reported incidents	

How Compliance is to be Achieved

To address the lack of compliance with the above metrics, the following actions/ improvement plan will be implemented

Performance Metric	Target Set	Actions to improve compliance (SMART actions)	By when	By who
Outstanding moderate actions from internal H&S inspections (Old system - risk stratification)		• Identify outstanding actions from these inspections • Implement actions where still appropriate	November 2026	• PC Leads (Heads of) • PC Leads (Heads of)
Outstanding major actions from internal H&S inspections (Old system - risk stratification)		• Identify outstanding actions from these inspections • Implement actions where still appropriate	November 2026	• PC Leads (Heads of) • PC Leads (Heads of)
% compliance with level 2 manual handling training	85.0%	• Communication to staff to encourage booking and completion of level 2 manual handling training • Monitor uptake of training • Raise with individual team members in line management	November 2026	• PC Leads (Heads of) • PC Leads (Heads of) • Line managers
% V&A/Security risk assessments in place for reported incidents	100%	• Identify where risk assessment has not been completed • Ensure completion • Communicate need to ensure that risk assessments are reviewed following V&A incidents.	November 2026	• PC Leads (Heads of) • PC Leads (Heads of) • PC Leads (Heads of)

Risk Management

One of the eight risks for the Managed Practices relates explicitly to Health & Safety, that being 2069 - Risk of service disruption and physical harm in Tenby Surgery due to water ingress from the roof. This risk is assessed as High at a score of 15 and is reviewed monthly. A visit by the Health Board Health & Safety Team took place in July 2026 with a recommendation for an inspection report to be completed. Measures to minimise any related incidents and harms have been reviewed and implemented. Work is underway with business continuity planning to identify an alternative solution to accommodate the Managed Practice with room utilisation reviews being undertaken in the Practice and in the Walk-In Centre next door.

METRICS WHERE COMPLIANCE CANNOT CURRENTLY BE REPORTED:

Reasons why compliance cannot be reported

There are some metrics that cannot currently be reported for Corporate Health and Safety. The reasons for this are detailed below:

How compliance is to be reported

To address the lack of compliance reporting with these metrics, the following actions/improvement plan will be implemented:

Performance Metric	Target Set	Actions to enable reporting (SMART actions)	By when	By who
All H&S measures	TBC	Set up Task & Finish Group for Primary Care H&S reporting	October 2026	Primary Care Business Support Team
All H&S measures	TBC	Identify reporting route for incoming Clinical Compliance Group (CCG) H&S reporting	September 2026	PC Leads (Heads of)
All H&S measures	TBC	Add all domains of H&S compliance reporting to data pack collated for QHS meetings & Primary Care and Community Services Groups (PCCSG) for a full PC-wide view	Dec 2026	Primary Care Business Support Team

By implementing the actions above, the timeline for reporting compliance for these metrics is expected to follow the trajectory below:

Performance Metric	Interim Target May 2026	Interim Target Jun 2026	Interim Target Jul 2026	Interim Target Aug 2026	Interim Target Sept 2026	Interim Target Oct 2026
All H&S measures	December 2026					

Risk Management

The current risks identified for the reporting against these metrics are as follows, together with their management plans/actions:

Performance Metric	Current Risks	Management Plan/Actions
H&S CCG reports	Lack of access to timely CCG level reporting would hamper ability on a service area level to address compliance on a targeted basis.	Activity to address compliance list in previous section would address these risks.
All remaining currently non-reportable metrics	Non-reporting of these metrics at PCCSG level hampers assurance of the delivery of services in line with H&S regulation.	Activity to address compliance list in previous section would address these risks.

Argymhelliad / Recommendation

The Health & Safety Committee is requested to:

- **Receive assurance** regarding the ongoing work to improve health and safety compliance, recognising the differing approaches required across primary care contractors and Health Board-provided services.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.1.3 Receive bi-annual assurance reports from each Clinical Care Group Service Director on their individual Clinical Care Group health and safety arrangements.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	N/A
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	1. Leadership
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	8. Fit for Purpose, Modern Facilities and Services
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	10. Not Applicable
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau)	Not Applicable

A Social Model for Health and Wellbeing : (complete for strategic change and/or significant service changes)	
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Health & Safety Committee Terms of Reference Establishment/Dis-establishment of Committees/Sub-Committees (SOP for the Management of Board and Committees)
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Director of Corporate Governance (Board Secretary) Assistant Director of Assurance and Risk Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impact
Ansawdd / Gofal Claf: Quality / Patient Care:	The intention of this report is to improve health and safety governance arrangements to drive improvements within the Health Board
Gweithlu: Workforce:	No direct impact
Tegwch Iechyd: Health Equity:	No direct impact
Risg: Risk:	No direct impact
Cyfreithiol: Legal:	No direct impact
Enw Da: Reputational:	No direct impact
Gyfrinachedd: Privacy:	No direct impact
Cydraddoldeb: Equality:	No direct impact

4 - FOR INFORMATION

4.1

11:05 AM, 0 Mins

4.1 - HSC Workplan

***Ann Murphy (Hywel
Dda UHB - RCN
Trade Union Rep -
Independent Board
Member)***

| For information

Attachments

[HSCCommittee Work Programme 2026-27.pdf](#)

HEALTH & SAFETY COMMITTEE WORK PLAN APRIL 2026 – MARCH 2027

Currently, Health & Safety Committee (HSC) meets bi-monthly. Based on this, the following table represents a proposal to incorporate the duties as outlined in the Committee's Terms of Reference into a basic work plan April 2026 – March 2027.

AGENDA ITEM/ ISSUE	Purpose	LEAD	Responsible Officer	5 May 2026	7 July 2026	10 Sept 2026	3 Nov 2026	12 Jan 2027	9 March 2027
GOVERNANCE & RISKS									
Welcome and Apologies	N/A	Chair	All	✓	✓	✓	✓	✓	✓
Declarations of Interests	N/A	Chair	CSO	✓	✓	✓	✓	✓	✓
Minutes from previous meeting	N/A	Chair	CSO	✓	✓	✓	✓	✓	✓
Matters Arising (not on agenda)	N/A	Chair	All	✓	✓	✓	✓	✓	✓
Table of Actions (ToAs)	N/A	Chair	CSO	✓	✓	✓	✓	✓	✓
Review of Terms of Reference (TORs)	Approval	Chair	JW	✓				✓	
HSC Annual Self-Assessment of Effectiveness / 6 Month Update	Assurance	Chair	JW	✓			✓		
Health & Safety Committee Annual Report 2026/27	Assurance	Chair	JS	✓					✓
Assurance and Risk Report (3.1.11)	Assurance	JS	RW	✓	✓	✓	✓	✓	✓
H&SC Governance Review	Assurance	Chair	JW					✓	
HEALTH AND SAFETY UPDATES									
Health and Safety Assurance Report (3.1.1)	Assurance	JS	DE&F	✓	✓	✓	✓	✓	✓
Methodology for Site Visits	Assurance	JS	AS	✓					
Review of efficacy of the health, safety, fire and security training programmes (3.1.8)	Assurance	JS	AS		✓				
Health and Safety Annual Report for Board (3.1.15)	Approval	JS	HHSS					✓ draft	✓ final
COMPLIANCE AGAINST INDIVIDUAL REGULATIONS ASSURANCE REPORTS (3.1.2)									
Health & Safety (Part 1) – covering the following regulations:	Assurance	JS	HHSS	✓				✓	

AGENDA ITEM/ ISSUE	Purpose	LEAD	Responsible Officer	5 May 2026	7 July 2026	10 Sept 2026	3 Nov 2026	12 Jan 2027	9 March 2027
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)									
Health & Safety (Part 2) – covering the following regulations: - Management of Health and Safety at Work Regulations 1999 (MHSWR) - Workplace (Health, Safety and Welfare) Regulations 1992 (WHSWR) - Health and Safety (Safety Signs and Signals) Regulations 1996	Assurance	JS	HHS&S		✓				
Health & Safety (Part 3) – covering the following regulations: - Control of Substances Hazardous to Health Regulations 2002 (as amended) (COSHH) - REACH (Amendment) Regulations 2023 - Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR) - Personal Protective Equipment at Work Regulations 1992 (PPE)	Assurance	JS	HHS&S			✓			
Health & Safety (Part 4) – covering the following regulations: - Health and Safety (Display Screen Equipment) Regulations 1992 (as amended) (DSE) - Slips/Trips/Falls - New & Expectant Mothers - Latex	Assurance	JS	HHS&S				✓		
Health & Safety (Part 5) – covering the following regulations:								✓	

AGENDA ITEM/ ISSUE	Purpose	LEAD	Responsible Officer	5 May 2026	7 July 2026	10 Sept 2026	3 Nov 2026	12 Jan 2027	9 March 2027
- Manual Handling Operations Regulations - First Aid Regulations - Health and Safety (Consultations with Employees) Regulations 1996) - Safety Representatives and Safety Committees Regulations 1977									
Health & Safety (Part 6) – covering the following regulations: - Workplace Stress, Depression & Anxiety - Ligature Risk Management - Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 - HSIS6 – Managing the Risk of Hot Water and Surfaces in Health & Social Care	Assurance	JS	HHS&S						✓
Security – covering the following regulations: - Violence & Aggression (including Emergency Workers Act 2017) - Terrorism (Protection of Premises) Act 2025 (Martyn's Law)	Assurance	JS	CS(IC)	✓	✓				
Electrical Safety – covering the following regulation: Electricity at Work Regulations 1989	Assurance	JS	SD			✓			
Water Safety - covering the following regulation: Water Supply (Water Fittings) Regulations 1999)	Assurance	JS	SD			✓			
Medical Gas	Assurance	JS	SD				✓		
Ventilation Safety	Assurance	JS	SD				✓		
Decontamination	Assurance	JS	SD					✓	

AGENDA ITEM/ ISSUE	Purpose	LEAD	Responsible Officer	5 May 2026	7 July 2026	10 Sept 2026	3 Nov 2026	12 Jan 2027	9 March 2027
Operational Estates Maintenance – covering the following regulations: • Work at Height Regulations • Control of Vibration at Work Regulations • Control of Noise at Work Regulations • Confined Spaces Regulations 1997 • Provision and Use of Work Equipment Regulations 1998 (PUWER) • Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) • Lifts	Assurance	JS	SD					✓	
Estates Compliance - covering the following regulations: • Construction (Design and Management) Regulations 2015 (CDM) • Control of Asbestos Regulations 2012	Assurance	JS	PE						✓
Radiation Protection – covering the following regulations: • Control of Artificial Optical Radiation at Work Regulations 2010 • Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) • Ionising Radiation Regulations 2017 (IRR17) • Electromagnetic Fields at Work Regulations 2016	Assurance	JS	RPA						✓
Fire Safety – covering the following regulation: • Regulatory Reform (Fire Safety) Order 2005 (RRO)	Assurance	JS	RJ	✓	✓				
Facilities – covering the following regulations: • Food and Environmental Protection Act 1985 • Food Safety Act 1990	Assurance	JS	PJ				✓		

AGENDA ITEM/ ISSUE	Purpose	LEAD	Responsible Officer	5 May 2026	7 July 2026	10 Sept 2026	3 Nov 2026	12 Jan 2027	9 March 2027
- Food Standards Act 1999 - Food Hygiene (Wales) Regulations 2006 - Food Hygiene Rating (Wales) Act 2013 - Food Hygiene Rating (Wales) Regulations 2013 - Food Information (Wales) Regulations 2014 - Food Hygiene Rating (Promotion of Food Hygiene Rating) (Wales) Regulations 2016 - All Wales Nutrition and Catering Standards for Hospital Inpatients - National Standards for Cleaning in NHS Wales (2009, Revised 2021)									
Environmental – covering the following legislation: - Environment (Wales) Act 2016 - Well-being of Future Generations (Wales) Act 2015 - Environment (Principles, Governance and Biodiversity Targets) (Wales) Bill – 2025	Assurance	JS	PW			D	✓		
Clinical Care Groups Health & Safety Assurance Reports (3.1.3): - Planned & Specialist Care - Community & Integrated Medicine - Allied Health & Health Sciences - Mental Health & Learning Disabilities - Estates & Facilities	Assurance	AC	PG PS SQ LC DE&F	CIM MH/LD	✓		✓ ✓	✓ ✓	✓
Health & Safety/Individual Regulations Written Control Documents Status Report (3.1.14)	Assurance	JS	DE&F/ CJ		✓			✓	
PREVENT and CONTEST: Update 6-monthly update		AG	TH						
Heatwave Response & Action Plan	Assurance	AG	SH			D	✓		

AGENDA ITEM/ ISSUE	Purpose	LEAD	Responsible Officer	5 May 2026	7 July 2026	10 Sept 2026	3 Nov 2026	12 Jan 2027	9 March 2027
Policies									
Major Incident Plan (3.1.13) (Review Date July 2026)	Approval	AG	SH		✓				
Administration									
Agenda setting meeting with Chair & Exec Lead (at least 6 weeks before the meeting)	N/A	CSO	N/A	✓	✓	✓	✓	✓	✓
Draft agenda to go to Executive Team	N/A	CSO	N/A	✓	✓	✓	✓	✓	✓
Call for papers (at least 6 weeks before the meeting to receive papers at least 14 days before the meeting)	N/A	CSO	N/A	✓	✓	✓	✓	✓	✓
Disseminate agenda/papers 7 days prior to meeting	N/A	CSO	N/A	✓	✓	✓	✓	✓	✓
Issue a draft TOA within two days of the meeting	N/A	CSO	N/A	✓	✓	✓	✓	✓	✓
Circulate minutes and TOA to the Lead Director within 7 days of meeting	N/A	CSO	N/A	✓	✓	✓	✓	✓	✓
Issue minutes and TOA to Members (including the Committee Chair) following Lead Director review	N/A	CSO	N/A	✓	✓	✓	✓	✓	✓

Chair: Ann Murphy **Vice Chair:** Sarah Harraway **Lead Executive:** James Severs

JS James Severs
SC Simon Chiffi
CS Charles Scarf
CJ Christine James
PJ Peter Jones
RPA Radiation Protection Advisor

JW Joanne Wilson
CW Charlotte Wilmshurst
RJ Richard Jupp
LC Liz Carroll
HHSS Head of Health, Safety & Security
PF Philip Flear

AC Andrew Carruthers
SA Shaun Ayres
PS Peter Skitt
PG Paula Goode
PW Paul Williams
RJ Richard Jupp
GR Gareth Rees

AG Ardiana Gjini
SH Sam Hussell
SQ Sara Quarrie
DE&F Director of Estates & Facilities
SD Simon Day
RW Rachel Williams

CSO

Committee Services
Officer

D

Deferred

IC

In Committee

5

11:05 AM, 5 Mins

5 - ANY OTHER BUSINESS

All

6 - MATTERS FOR ESCALATION TO BOARD

*Ann Murphy (Hywel
Dda UHB - RCN
Trade Union Rep -
Independent Board
Member)*

7 - DATE AND TIME OF NEXT MEETING

Tuesday 3 November 2026, 9.30am-11.30am