Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Date	**05/05/2026**
Time	**9:30 AM - 11:30 AM**
Location	**Microsoft Teams Meeting**

Virtual Health & Safety Committee Meeting

HDD_Health and Safety Committee

NHS Wales

Agenda - 5 May 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 Held on 10 March 2026

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 Meeting held on 10 March 2026

9:35 AM, 5 min
Ann Murphy (Hywel Dda UHB - RCN Trade Union Rep - Independent Board Member)

1.5 Review of HSC Terms of Reference (TORs)

9:40 AM, 5 min
Ann Murphy (Hywel Dda UHB - RCN Trade Union Rep - Independent Board Member)

1.6 HSC Annual Self-Assessment of Effectiveness Outcome Report

9:45 AM, 5 min
Ann Murphy (Hywel Dda UHB - RCN Trade Union Rep - Independent Board Member), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)

1.7 Health & Safety Committee Annual Report 2025/26

9:50 AM, 5 min
Ann Murphy (Hywel Dda UHB - RCN Trade Union Rep - Independent Board Member)

1.8 Assurance and Risk Report

9:55 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

10:05 AM, 0 min

2.1 Health and Safety Assurance Report

10:05 AM, 5 min
Adam Springthorpe (Hywel Dda UHB - Health & Safety Manager)

2.2 Individual Regulation Assurance Reports

10:10 AM, 10 min
Adam Springthorpe (Hywel Dda UHB - Health & Safety Manager)

2.3 Fire Regulation Assurance Report Update

10:20 AM, 10 min
Simon Chiffi (Hywel Dda UHB - Head of Operations)

2.4 Health and Safety Inspection Actions

10:30 AM, 10 min
Adam Springthorpe (Hywel Dda UHB - Health & Safety Manager)

2.5 New Health and Safety Inspection Process

10:40 AM, 10 min
Adam Springthorpe (Hywel Dda UHB - Health & Safety Manager)

3 EMERGENCY PLANNING

10:50 AM, 0 min

3.1 Revised Pandemic Framework

10:50 AM, 10 min
Sam Hussell (Head of Health Emergency Planning)

4 FOR INFORMATION

11:00 AM, 0 min

4.1 HSC Workplan

11:00 AM, 0 min
Ann Murphy (Hywel Dda UHB - RCN Trade Union Rep - Independent Board Member)

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5 **ANY OTHER BUSINESS**

11:00 AM, 5 min
All

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6 **MATTERS FOR ESCALATION TO BOARD**

11:05 AM, 5 min
Ann Murphy (Hywel Dda UHB - RCN Trade Union Rep - Independent Board Member)

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7 **DATE AND TIME OF NEXT MEETING**

11:10 AM, 0 min

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05/05/2026 9:30 AM - 11:30 AM

1

9:30 AM, 0 Mins

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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 Held on 10 March 2026

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

For approval

Attachments

2026-03-10 - Health Safety Committee Meeting - Minutes.pdf

MINUTES OF THE Health and Safety Committee MEETING

Date of Meeting:	**9:30 AM, Tuesday 10 March 2026**
Venue:	**Microsoft Teams**

Present:	Ann Murphy, Independent Board Member (*Chair*) Sarah Harraway, Independent Board Member Iwan Thomas, Independent Board Member Michael Imperato, Independent Board Member
In Attendance:	Adam Springthorpe, Health & Safety Manager Anthony Dean, Staff Side Representative Ardiana Gjini, Executive Director of Public Health Charlotte Wilmshurst, Assistant Director of Assurance and Risk, (*deputising for Joanne Wilson, Director of Corporate Governance/Board Secretary*) James Severs, Executive Director of Allied Health Professions and Health Science Jonathan Arthur, Deputy Director of Health Sciences Sharon Daniel, Executive Director of Nursing, Quality & Patient Experience Simon Chiffi, Head of Operations Karen Ryan, Head of Occupational Health Gareth Cottrell, Deputy Chief Operating Officer (*deputising for Andrew Carruthers, Chief Operating Officer*) Heather Hinkin, Assistant Director People Management Elin Brock, Head of Research, Innovation & Improvement (observing) Ruth Poynting, Committee Services Officer (*Minutes*)
Apologies:	Andrew Carruthers, Chief Operating Officer Joanne Wilson, Director of Corporate Governance/Board Secretary

Minutes Ref.	Item	Action
HSC(26)013	**Welcome and Apologies** Ms Ann Murphy welcomed all to the meeting and apologies were noted as above. Ms Murphy apologised for the challenges experienced during the previous meeting on 13 January 2026, noting that site limitations made it difficult for attendees to hear proceedings clearly.	

Mr James Severs welcomed Ms Elin Brock as an observer to the meeting.

HSC(26)014 **Declarations of Interest**

There were no declarations of interest.

HSC(26)015 **Minutes of Previous Meeting Held on 13 January 2026**

The minutes of the previous meeting were approved as an accurate record.

Decision: The minutes of the previous meeting were approved.

HSC(26)016 **Matters Arising and Table of Actions from Meeting held on 13 January 2026**

Members were advised of one ongoing action due in May 2026 for operational leads to provide updates on outstanding Health and Safety Actions within their remit. Mr Gareth Cottrell provided assurance that the work is progressing and will be reported in May.

Decision: The Committee noted the Table of Actions

HSC(26)017 **Assurance and Risk Report**

Ms Charlotte Wilmshurst presented the current Operational Risks. Following the disestablishment of the Health and Safety Sub-Committee (HSSC), risks have been realigned to the relevant committees. A total of 48 risks now sit within the remit of the Health and Safety Committee (HSC), with two being presented to the Health and Safety In-Committee due to their sensitivity.

The majority of risks relate to Estates and Facilities. Further work is required to ensure full alignment with the HSC before the final position is presented. It was noted that the management of some risks is dependent on the availability of capital funding, and that a decision will be required on whether certain risks can be accepted pending the release of capital.

Mr Iwan Thomas highlighted the importance of training for staff, particularly those on the frontline, in relation to violence and aggression. He noted that the risk summary now reflects that training has commenced, and he asked whether any feedback had been received from staff on whether they feel more empowered as a result. In response, Mr Severs advised that this is training staff should have been accessing routinely, and that a summary of feedback is not yet available. He emphasised the need to monitor progress through the Security Management Teams to ensure staff are completing the training. He added that Facilities Managers have been actively supporting this work.

Mr Thomas suggested that a questionnaire be developed for staff, similar to the approach used by the Workforce and Organisational Development teams, drawing on existing workforce development surveys to gather staff views. Mr Severs confirmed that he would welcome this and noted that such feedback would be valuable as part of the ongoing security review. **JS**

Mr Anthony Dean sought clarification as to whether risks without an identified location applied across the Health Board or reflected missing information. Ms Wilmshurst confirmed that these risks are Health Board-wide.

Ms Sarah Harraway noted that Risk 1270 (Risk of electrical shock to staff/patients/visitors due to standard of secondary electrical wiring) appears twice on the register and that the description for Risk 471 (Risk of serious harm to patients, staff and visitors due to no walkway on access road between Acute Medical Assessment Unit (AMAU) and staff car park) does not make clear which site it relates to Mr Simon Chiffi confirmed that Risk 471 refers to Prince Phillip Hospital (PPH).

Ms Harraway also questioned whether Risk 1994 (Risk that onward referrals from Clinical Musculoskeletal Assessment and Treatment service being misdirected/wrong pathway by medical records) appropriately fell within the remit of HSC. The Committee agreed this risk would not ordinarily fall within the HSC's remit; however, it was noted that this risk has now been closed.

Ms Harraway further observed that several risks were overdue for review and queried whether a year-on-year comparison could be undertaken to assess the direction of travel. She also questioned how risks describing potential harm are being prioritised alongside operational and strategic work.

Mr Severs explained that the severity of current risks is largely dependent on the availability of capital funding. While work is progressing, many risks will take time to resolve, with some funding allocated, although delivery ongoing and other areas, still awaiting funding. He emphasised the need for clearer articulation of the actions or investment required to materially reduce risk, acknowledging that the level of residual will need to be tolerated. He also highlighted the value of more granular, building-specific level risk profiling, to support effective Committee oversight. Ms Harraway agreed that understanding risks at site level would be valuable.

Mr Chiffi provided assurance that all Estates risks detailed in the report are discussed on at least a monthly basis by the specific teams at each site. These risks are then also reported to the Health and Safety Compliance Group (HSCG). It should be recognised that the Health Board has a significantly aged estate with a backlog of around £300m, however mitigation plans have been established and reviewed regularly.

Mr Imperato recognised the significant work being undertaken however expressed concern that some risks have quite long achievement dates.

Ms Harraway highlighted the risks associated with patients being accommodated in corridor areas noting concerns raised by staff during a recent visit to Glangwili Hospital (GGH) Emergency Department (ED). She queried the absence of this issue on the risk register. Mr Cottrell confirmed that the matter is captured on the Health Board Risk Register, with an extremely high score, while Ms Wilmshurst noted that although care being provided in non-designated areas is recognised, the specific Health & Safety risk of blocked corridors is not clearly articulated.

Ms Sharon Daniel advised that individual risk assessments are being completed for each patient placed in these areas. However, she emphasised the need to ensure that immediate, patient-level risks are clearly linked to the wider systemic risks.

Ms Murphy queried whether risks would be better grouped by site, with Ms Wilmshurst confirming this is a possibility. Forthcoming regulation assurance reports should also strengthen the overall assurance position.

Mr Severs cautioned that the Committee must be mindful of its duty to assure the Board, expressing concern about a disconnect between the Committee's reading of the risk position and the current reporting.

Ms Harraway and Mr Imperato agreed that while they were assured that the necessary work was being undertaken, the current articulation of risks does not provide sufficient assurance, making it difficult to form complete view. Mr Dean added that it would be beneficial for the report to set out the mitigations in place.

While it was recognised that mitigation is constrained by limited capital, Ms Harraway stressed that the absence of funding does negate the risks and they cannot simply be tolerated due to financial limitations. The Board needs clarity on the funding required to address them.

Ms Daniel recalled a similar discussion at Quality, Safety and Experience Committee (QSEC) approximately 18 months ago relating to risk reporting to the Board and Welsh Government. She suggested that she and Mr Severs revisit the outcome of that previous discussion. **SD, JS**

Mr Thomas noted that the Committee remains supportive of the work underway, acknowledging the challenging parameters. However, he stressed that the Committee must also recognise that this situation could escalate to an alert. While detailed

evidence exists, the scale and potential impact on other services must be clearly acknowledged.
The Committee agreed to ADVISE the Board. While the Committee was assured of the professionalism of staff and supportive of the work undertaken to date, greater profiling of the risks is required, given the potential for this to escalate to an alert.

Decision: The Committee were not able to take assurance that all planned actions are credible and deliverable, and in line with agreed plans, and will be implemented within stated timescales and will reduce risks further and/or mitigate the impact should risks materialise.

HSC(26)018 **Health and Safety Assurance Report**

Mr Adam Springthorpe advised that the final response to the Health and Safety Executive (HSE) improvement notice, produced by Pathology has been submitted. He noted that two additional questions were subsequently, for which draft responses have been prepared.

Concerns have been raised around the provision of a Manual Handling Training venue in Ceredigion. Current arrangements in the Thomas Parry building in Aberystwyth have been extended to the end of March 2026. Learning and Development has identified a potential site in Aberystwyth, however this potential is still being investigated.

The second phase of the Health and Safety Dashboard is now live and now includes the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) module.

There has been no change to the Risk Stratification. The work with Clinical Care Groups (CCGs) referenced by Mr Cottrell earlier in the meeting will be able to provide better oversight.

A new Health and Safety Regulations Baseline Assessment has been developed, providing a clear starting point for reviewing existing regulations and identifying gaps where further regulatory coverage is required.

Ms Harraway enquired whether data is available to demonstrate how the dashboard is being used, as the Committee sought assurance that it is actively utilised and contributing to improvements. Mr Springthorpe advised that this would need to be confirmed with the Performance Team.

In response to a query from Ms Harraway related to a high number of smoking-related abscondments in a Mental Health ward, Mr Springthorpe noted that the smoking ban has been identified as a contributing factor.

Dr Ardiana Gjini noted that such issues are more prevalent within Mental Health settings, however clear guidance exists and the law does allow for special circumstances. She emphasised that this is not confined to one site, as similar patterns are being seen across multiple locations. She reported that the Health Board–wide Tobacco Control Group, which has not met for some time, is now being re-established. The Group will consider nicotine dependency across all sites and examine how the organisation can ensure that its sites remain smoke-free.

Ms Harraway sought clarification on plans to redesign the Manual Handling training provision and intended outcomes. Mr Springthorpe explained that the primary objective is to improve compliance, with delivery requirements determined by the All Wales Passport. Training at Withybush Hospital (WGH) has been relocated to the training centre to increase capacity, though non-attendance remains an issue despite high booking levels. Sessions can now accommodate larger groups through the use of multiple trainers, and staff from neighbouring sites are able to attend.

Mr Springthorpe confirmed that the Baseline Assessment is the initial step, with further evaluation planned to provide assurance. Work is currently focused on consolidating existing metrics and exploring identifying any additional data required, with the intention that this can ultimately be handed over to the CCGs, to support local reporting and assurance. Learning from approaches adopted by other Health Boards will be considered. He noted that the overall structure will be reviewed once the team is fully staffed and emphasised that filling the vacant Head of Health Safety post is essential in order to deliver the level of assurance required.

Ms Wilmshurst sought clarification on how DSEAR (Dangerous Substances and Explosive Atmospheres Regulations) assessments are monitored and the level of risk they present. Mr Chiffi confirmed oversight is provided through the HSCG. Progress on risk stratification work was also queried, assurance provided that these risks sit with the CCG Leads, who have reviewed them following Internal Audit input. Mr Cottrell confirmed that engagement with the CCGs had recently improved, and that outstanding actions are being actively progressed and supported by fortnightly meetings, acknowledging that some actions may remain open due to their nature.

Mr Severs expressed concern at the progress made, noting that the same issues had been raised six months earlier, with little change since July last year. He stressed the need to maintain Committee oversight and highlighted the importance of receiving a clear and detailed position from the CCGs to enable the Committee to distinguish between moderate and major risks, noting that assurance is difficult to provide without clarity.

Ms Wilmshurst requested clarification on the level of risk within the Baseline Assessment and whether there is a plan for when the

required elements will be in place. In response, Mr Severs advised that capacity within the service is currently extremely stretched, as the Head of Health, Safety and Security post remains vacant. He anticipated an improved position by the end of Quarter 2. Interviews for the Head of Health, Safety and Security role are scheduled for 18 March, with an expected start date around Quarter 3 due to the appointment process.

Mr Severs observed that some matters are being escalated directly to the Committee without prior consideration by the HSCG and emphasised the need for improved alignment to strengthen scrutiny.

Both Ms Murphy and Mr Imperato noted that the report was clear and easy to understand and highlighted positive developments, including improvements in Reducing Restrictive Practice (RRP) training though there is potential for some risks to influence discussions across the wider agenda

The Committee agreed to advise the Board that many high and major risks highlighted in internal Health and Safety inspections remain unresolved. Assurance was given that these are being reviewed, and a more detailed update will be provided in May.

Decision: The Committee were not able to take assurance from the contemporaneous issue updates, dashboard statistics and the baseline assessment.

HSC(26)019 **Individual Regulation Assurance Reports**

Mr Chiffi introduced the Individual Regulation Assurance Reports, noting that these are closely linked to the Baseline Assessment and will act as a pilot for reporting regulatory assurance going forward. He highlighted the significant amount of work involved, drawing on input from the HSCG, Estates and Facilities, Fire Safety, and other operational teams.

Mr Chiffi outlined the regulatory requirements, emphasising the need to demonstrate compliance with relevant legislation. The position is up to date against these requirements, with training previously discussed as a key component. Engagement continues with Mid and West Wales Fire and Rescue Service (MWWFRS), the enforcing authority, which is responsible for issuing enforcement and prohibition notices.

Two enforcement notices remain in place for WGH and GGH, with Phase 2 project works currently underway in collaboration with the Capital Team to address these.

Compliance is delivered through the Health Board’s approved policies, regular Fire Safety Group meetings, and systems such as BORIS and Audit Management and Tracking (AMaT), as well as training and maintenance systems. NHS Wales Shared Services Partnership (NWSSP) has also conducted audit work in this area.

Assurance was received that the fire safety governance structure is fully established.

Interim support has been provided by the Head of Estates Risk & Compliance. While no extreme risks are overdue, backlog of high, moderate, and low-level fire risks actions remain across the Estates.

The 2025/26 audit has been completed and submitted, and work on the 2026/27 audit is already underway, with submission to NWSSP scheduled for May 2026.

There are currently 57 open recommendations arising from Letters of Fire Safety Matters (LoFSM): 11 are overdue, 13 are dependent on external factors, and 23 pending closure on the Audit Management and Tracking (AMaT) system. This represents a significant reduction from approximately 96 recommendations a year ago.

Fire system maintenance, including Planned Preventative Maintenance (PPMs), is progressing well, although some areas are constrained by contractor availability. Improvement actions have been identified through the Estates Recovery Plan, and additional staff have been brought in to support fire door PPMs.

Mr Chiffi expressed thanks to Mr Springthorpe and the Health & Safety Team, recognising the significant amount of work undertaken and the scale of the Estates backlog.

The relationship with MAWWFRS remains strong, with the next meeting scheduled for April 2026. This will include updates on fire safety officer capacity, training levels, and the status of enforcement notices. A request has been made to extend the Fire Policy due to current capacity constraints within the team.

While commending the quality of the report, Ms Harraway queried where accountability sits for outstanding actions and how visibility and oversight are maintained. Mr Chiffi explained that he monitors these actions directly, supported by monthly operational risk meetings, with additional local oversight at each site. Local Fire Safety Groups report into the Health Board Fire Safety Group, providing strengthened governance. Mr Chiffi confirmed he is assured that oversight arrangements are robust.

Mr Chiffi explained that the reporting mechanism for the CCGs has been refined, with reports now shared through the local Fire Safety Groups. Each site has its own Fire Safety Advisor, and updates flow through these local groups before being reported to the Health Board Fire Safety Group. Ms Wilmshurst added that it would be helpful for future reports to include timelines for expected completion.

Mr Severs expressed concern regarding the governance and oversight arrangements for fire risk assessments. He noted that,

although actions are tracked through BORIS, the connection between operationally owned assessments and the wider operational governance structure remains unclear. Given the high number of overdue, high risk assessments, he questioned how these are being escalated and assured through the formal governance routes rather than through informal discussions.

He emphasised the need to understand how these risks are being managed at both site and Health Board level, what actions are being taken to improve the position, and how the level of risk differs between sites. He also queried whether any mitigation is reflected within the operational or corporate risk registers.

Ms Wilmshurst raised concerns that a number of fire themed risks have no associated actions to address them. Mr Chiffi advised that may reflect incorrect wording as mitigation is underway.

Ms Harraway stated that she was assured, subject to the planned review of the governance arrangements, and emphasised the importance of ensuring the position is clearly understood.

Mr Severs expressed a more cautious view, noting that he could not provide assurance on compliance while significant risks remain outstanding. He suggested that the Committee would take greater assurance if future reports included clear timelines for addressing Fire Risk Assessment actions.

The Committee agreed to advise the Board that the Individual Regulation Assurance Report for Fire Safety highlights the need to strengthen governance around action timelines and to provide greater clarity on expected outcomes. The high volume of outstanding fire risk assessment actions remains a concern.

Decision: The Committee were not able to receive assurance on fire safety compliance across the Health Board.

HSC(26)020 **Health and Safety Operational Compliance Report Template**

Mr Springthorpe presented the Health and Safety Operational Compliance Report template, explaining that it provides a model for how Health and Safety information is reported elsewhere. The template is designed for use at CCG level and within the Integrated Quality, Financial Performance and Delivery Group (IQFPDG), however at a higher level of detail to demonstrate how data is reported.

Ms Murphy welcomed the template, noting that it provides a strong foundation for CCGs and can be developed into a regular tool for review.

Ms Harraway queried whether the Health and Safety Team currently complete the template. Mr Springthorpe confirmed this, noting an intention to transition ownership to the CCGs. Ms Harraway emphasised the importance of ensuring a prompt

handover and for the template to remain consistent with the dashboard. Mr Springthorpe clarified that the template is intended to support operational reporting rather than to be presented to the Health and Safety Committee.

Mr Severs noted that he and Ms Daniel are considering a standardised template for receiving intelligence. He explained that it will support clearer methodology for operational teams to report into the operational governance structure, given that the current limitations of reporting into IQFPDG. He added that the template provides an effective transitional tool to support further development.

HSC(26)021 **HSC Workplan**

Ms Wilmshurst reported that the 2026/27 work plan has been aligned to the new Terms of Reference. She noted that she has worked with the Health and Safety Team to ensure updates are consistent and is also working with Ms Brock on the Regulation Assurance Reports, with the intention of incorporating these into future reporting to strengthen assurance.

Ms Murphy queried how reporting from the CCGs will operate. Ms Wilmshurst explained that the approach will mirror the arrangements used for QSEC, whereby CCG Directors attend and present their reports directly.

HSC(26)022 **ANY OTHER BUSINESS**

No other items were raised.

HSC(26)023 **MATTERS FOR ESCALATION TO BOARD**

The Committee wish to ADVISE the Board that:

- Greater profiling of corporate risks is needed for the **Assurance and Risk Report**.
- Further assurance is needed on the progress being made against the high and major risks highlighted in internal Health and Safety inspections as discussed in the **Health and Safety Assurance Report**.
- The **Individual Regulation Assurance Report for Fire Safety** highlights the need to strengthen governance around action timelines and to provide greater clarity on expected outcomes. The high volume of outstanding fire risk assessment actions remains a concern.

DATE AND TIME OF NEXT MEETING

Tuesday 5 May, 9:30-11:30

1.4

9:35 AM, 5 Mins

1.4 - Matters Arising and Table of Actions from Meeting held on 10 March 2026

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

For discussion

Attachments

HSC Table of Actions.pdf

HEALTH AND SAFETY COMMITTEE (HSC)/ PWYLLGOR IECHYD A DIOGELWCH
10/03/2026
TABLE OF ACTIONS/TABL GWEITHREDOEDD

Key: AC-Andrew Carruthers; GC-Gareth Cottrell; JS-James Severs; KRy-Karen Ryan; SD-Sharon Daniel

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
06/05/2025	HSC(25)009	H&S Annual Work Plan 2025/26 • To provide assurance to HSSC around the management of stress in the workforce in collaboration with the Psychological Wellbeing Group and report back to HSC.	KRy	11/11/2025	Complete Closed. Assurance received in PODCC.
13/01/2026	HSC(26)009	Site Visit Report and Associated Actions • For Operational leads to update on the outstanding Health and Safety Actions in their remit	AC, GC	05/05/2026	Complete GC 12/3/26 Update report to be drafted by AS for May 26 H&S Committee meeting
10/03/2026	HSC(26)017	Assurance and Risk Report • To look into the decision made at QSEC with regards to reporting risks that can not be mitigated due to lack of funding to see whether this can be replicated for HSC.	JS, SD	05/05/2026	In progress 05/05/26 Further discussion needed.
10/03/2026	HSC(26)017	Assurance and Risk Report • To consider a method of gathering feedback for Violence and Aggression training	JS	05/05/2026	Complete An evaulation form is completed by employees at the end of each course.

1.5

9:40 AM, 5 Mins

1.5 - Review of HSC Terms of Reference (TORs)

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

For approval

Attachments

HSC Terms of Reference SBAR.pdf

HSC Terms of Reference v12for HSCApproval.05.05.26.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	05 May 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Health and Safety Committee Terms of Reference
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Ann Murphy, HSC Chair
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Wilson, Director of Corporate Governance/Board Secretary Charlotte Wilmshurst, Assistant Director of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to ensure that the Health and Safety Committee has clear terms of reference which detail its purpose, boundaries, role, composition and operating arrangements.

The Committee are asked to approve the Health and Safety Committee's Terms of Reference for onward ratification by the Board on 28 May 2026.

Cefndir / Background

According to its terms of reference, the Committee must review its terms of reference and operating arrangements on at least an annual basis to ensure they remain fit for purpose. These must be subsequently approved by the Board and will form part of the Health Board's Standing Orders.

The Committee last reviewed its terms of reference and operating arrangements in January 2026, and these were subsequently approved by the Board, on 29 January 2026.

Asesiad / Assessment

The Health and Safety Committee Terms of Reference and operating arrangements (Appendix 1) have been reviewed, with one amendment made to the terms of reference. This is clearly marked on Appendix 1 and relates to the following:

Section	What has changed?	Why?
4.2	Membership – amendments to in-attendance Membership list	The Deputy Chief Operating Officer replaces the Chief Operating Officer as an in-attendance member, forming part of the quoracy thereby maintaining appropriate senior operational representation.

		Removal of the text 'Director of Estates and Facilities' as this post is not in existence and was replaced by the 'Estates & Facilities Service Director' (vacant post). This will require further updating when the portfolio of estates and facilities is officially divided and new structures have been agreed.

Argymhelliad / Recommendation

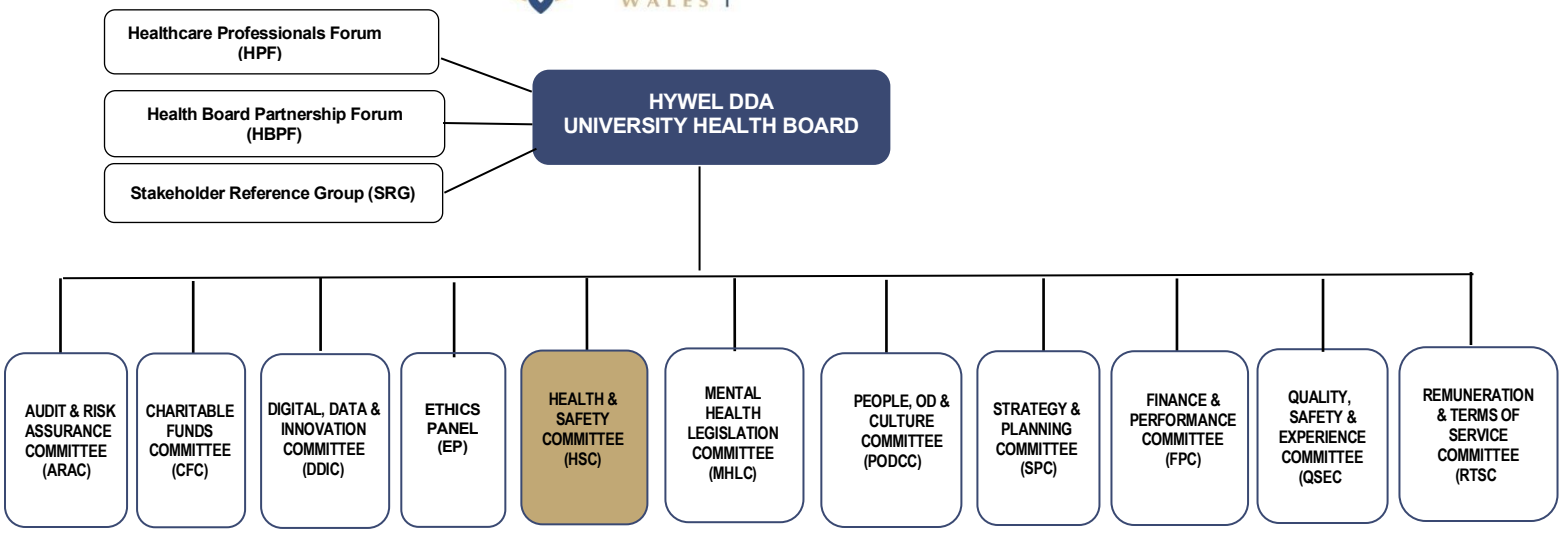
The Committee are asked to approve the Health and Safety Committee's Terms of Reference (v.12) for onward ratification by the Board on 28 May 2026.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	12.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	1. Leadership
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: **Further Information:**

Ar sail tystiolaeth: Evidence Base:	Standing Orders
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd lechyd a Diogelwch: Parties / Committees consulted prior to Health and Safety Committee:	Director of Corporate Governance/Board Secretary Director of Allied Health Professions and Health Science

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	No direct impacts
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 this legislation is not complied with as it relates to employee safety.
Risg: **Risk:**	Risk to health and safety management
Cyfreithiol: **Legal:**	Potential for enforcement action including Improvement Notices/Prosecutions and claims due to breaches in legislation.
Enw Da: **Reputational:**	Potential for enforcement action including Improvement Notices/Prosecutions and claims due to breaches in legislation.
Gyfrinachedd: **Privacy:**	N/A
Cydraddoldeb: **Equality:**	No evidence gathered to indicate a negative impact on any protected group/s. Evidence gathered indicates a positive impact on the protected characteristics of human rights and pregnancy / maternity by providing a safer workplace



HEALTH & SAFETY COMMITTEE

TERMS OF REFERENCE

Version	Issued to:	Date	Comments
V1	Hywel Dda University Health Board	26.03.2020	Approved
V1	Health & Safety Assurance Committee	14.05.2020	Approved
V2	Health & Safety Assurance Committee	17.02.2021	Reviewed
V3	Health & Safety Assurance Committee	08.03.2021	Approved (Chair's Action)
V3	Hywel Dda University Health Board	25.03.2021	Approved
V4	Hywel Dda University Health Board	29.07.2021	Approved
V5	Health & Safety Committee	09.05.2022	Approved
V6	Hywel Dda University Health Board	28.07.2022	Approved
V7	Health & Safety Committee	10.07.2023	Approved
V7	Hywel Dda University Health Board	27.07.2023	Approved
V8	Health & Safety Committee	04.03.2024	Approved
V8	Hywel Dda University Health Board	28.03.2024	Approved
V9	Health & Safety Committee	12.11.2024	Approved
V9	Hywel Dda University Health Board	28.11.2024	Approved
V10	Health & Safety Committee	04.03.2025	Approved
V10	Hywel Dda University Health Board	27.03.2025	Approved
V11	Health & Safety Committee	13.01.2026	Approved
V11	Hywel Dda University Health Board	29.01.2026	Approved
V12	Health & Safety Committee	05.05.2026	For approval

HEALTH AND SAFETY COMMITTEE

1. Constitution

1.1 Hywel Dda University Health Board (HDdUHB) has a statutory obligation by virtue of the Health & Safety at Work Act 1974 to establish and maintain a Health and Safety Committee:

- Section 2 sub section 7: 'It shall be the duty of every employer to establish in accordance with Regulations (i) a safety committee having the function of keeping under review measures taken to ensure the health and safety of employees and such other functions as prescribed'.

1.2 HDdUHB's Health and Safety Committee has been established as a formal Committee of the Board and constituted from 1 April 2020.

2. Principal Duties

2.1 Receive assurance around the adequacy of HDdUHB's arrangements and processes for the provision of an effective health and safety function to fulfil its legislative, statutory and regulatory duties, and for ensuring the health and safety of all employees and of those who may be affected by work-related activities, such as patients, members of the public, volunteers, contractors etc.

2.2 Advise and assure the Board on whether robust and effective health and safety management arrangements are in place to ensure organisation-wide compliance with all relevant health and safety legislation, regulations and industry standards requirements, and the Health Board's Health & Safety Policy.

2.3 Where appropriate, the Committee will advise the Board on where and how its health and safety management and processes may be strengthened and developed further.

2.4 Provide assurance to the Board that the Health Board's Major Incident Plan is underpinned by policy and protocols, planning and performance targets and strategies to address risks to business continuity.

3. Operational Responsibilities

3.1 The Health and Safety Committee will, in respect of its provision of advice and assurance to the Board:

3.1.1 Receive assurance through the Health & Safety Assurance Report and the work of management/operational groups and accountable leads that there is a process of review of health and safety compliance with legislative, regulatory and industry standard requirements across the whole of the Health Board's business undertakings.

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.

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.

3.1.4 Seek assurance that there is a process of review of findings of health and safety management system audits and that corrective actions are put in place.

3.1.5 Receive reports from auditors, inspectorates and regulatory bodies relating to the Health Board's health and safety arrangements, with agreed management responses to address areas of improvement.

3.1.6 Seek assurance on the delivery of the requirements arising from the Health Board's external regulatory agencies, Welsh Government and professional bodies ensuring these requirements are acted upon within achievable timescales.

3.1.7 Seek assurance that new and revised health and safety legislation and best practice guidance is considered in terms of how it may impact the Health Board, agreeing recommendations and guidance on the measures required to comply.

3.1.8 Seek assurance that there is a process of review of the efficacy of all health and safety regulations and industry standards training programmes and ensure this process is adequate to meet the Health Board's statutory and regulatory requirements.

3.1.9 Ensure there is clear and effective health and safety communication and publicity throughout the organisation to promote engagement and co-operation across the Health Board.

3.1.10 Seek assurance on delivery against all Planning Objectives aligned to the Committee, in accordance with the Board approved timescales, as set out in the Health Board's Annual Plan, considering, and scrutinising the plans and programmes that are developed and implemented, supporting and endorsing these as appropriate.

3.1.11 Seek assurance on the management of risks within the Corporate Risk Register (CRR) and Operational Risk Registers (including for hosted services and through partnerships and Joint Committees as appropriate) aligned to the Committee or other operational health and safety management groups, and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action. Where risks cannot be brought within the Health Board's risk appetite/tolerance, recommend acceptance of risks to the Board.

3.1.12 Receive assurance that service/business continuity plans are in place for service interruptions and emergency situations that affect the provision of normal services, and that staff are aware of their service plans, and have tested them, to enable them to respond to such incidents.

3.1.13 Ensure that the Health Board has a Major Incident Plan in place to support a response to major and mass casualty incidents, that responding staff have been trained in major incident response, and that lessons identified from previous incidents have been captured and incorporated into future planning.

3.1.14 Approve the Health Board's Health and Safety Policy and receive assurance that all organisational health and safety policies, procedures, guidelines and codes of practice (written control documents) are reviewed and approved within agreed timescales or when required by changes in legislation, regulations or standards, by the Health and Safety Compliance Group.

3.1.15 Ensure that a Health & Safety annual report is produced to measure effectiveness and performance, and to provide assurance of compliance to the Board.

4. Membership

4.1 Formal membership of the Committee shall comprise of the following:

Member
Independent Member (Chair)
Independent Member (Vice Chair)
Independent Member
Independent Member

4.2 The following should attend Committee meetings:

In Attendance
Executive Director of Allied Health Professions and Health Science (Lead Director)
Executive Director of Nursing, Quality & Patient Experience
~~Chief Operating Officer~~ Deputy Chief Operating Officer
Executive Director of Public Health
~~Director of Estates and Facilities~~ Estates & Facilities Service Director
Assistant Director People Management
Head of Health, Safety & Security
Head of Occupational Health
Staff-Side Representative (Health and Safety)

4.3 Membership of the Committee will be reviewed on an annual basis.

5. Quorum and Attendance

5.1 A quorum shall consist of no less than two of the membership and must include as a minimum the Chair or Vice-Chair of the Committee, and one other Independent Member, together with a third of the In Attendance Members.

5.2 The membership of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by Welsh Government.

5.3 Any senior officer of the Health Board or partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting, to assist with discussions on a particular matter.

5.4 The Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

5.5 Should any officer member be unavailable to attend, they may nominate a deputy with full voting rights to attend in their place subject to the agreement of the Chair.

5.6 The Chair of the Health Board reserves the right to attend any of the Committee's meetings as an ex officio member.

5.7 The Chair of the Health & Safety Committee shall have reasonable access to Directors and other relevant senior staff.

5.8 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Health & Safety Committee.

5.9 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. Agenda and Papers

6.1 The Committee Secretary is to hold an agenda setting meeting with the Chair and/ or the Vice Chair, and the Lead Director (Executive Director of Allied Health Professions and Health Science) at least **six** weeks before the meeting date.

6.2 The agenda will be based around the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year and requests from Committee members. Following approval, the agenda and timetable for papers will be circulated to all Committee members.

6.3 All papers must be approved by the Lead/ relevant Director.

6.4 The agenda and papers for meetings will be distributed **seven** days in advance of the meeting.

6.5 A draft Table of Actions will be issued within **two** days of the meeting. The minutes and action log will be circulated to members within **seven** days to check the accuracy, prior to sending to Members (including the Committee Chair) to review within the next **seven** days.

6.6 Members must forward amendments to the Committee Secretary within the next **seven** days. The Committee Secretary will then forward the final version to the Committee Chair for approval.

7. In Committee

7.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

8. Frequency of Meetings

8.1 The Committee will meet bi-monthly and shall agree an annual schedule of meetings. Additional meetings will be arranged as determined by the Chair of the Committee in discussion with the Lead Executive.

8.2 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of meetings of the Committee and procedures of such meetings.

9. Accountability, Responsibility and Authority

9.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and

accountability for ensuring the quality and safety of healthcare for its citizens, through the effective governance of the organisation.

9.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

9.3 The Committee shall embed the UHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

9.4 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee.

10. Reporting

10.1 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint/sub committees and groups to provide advice and assurance to the Board through the:

10.1.1 joint planning and co-ordination of Board and Committee business;
10.1.2 sharing of information.

10.2 In doing so, the Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

10.3 The Committee may establish sub-committees/groups or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each meeting providing an assurance on the business undertaken on its behalf.

10.4 The Committee Chair, supported by the Committee Secretary, shall:

10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report as well as the presentation of an annual report within 6 weeks of the end of the financial year;
10.4.2 Bring to the Board's specific attention any significant matters under consideration by the Committee.
10.4.3 Ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive, or Chair of other relevant Committees, of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the UHB.

10.5 The Director of Corporate Governance/Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation, including that of any Sub-Committees established. In doing so, account will be taken of the requirements set out in the NHS Effective Board Committees Guide.

11. Secretarial Support

11.1 The Committee Secretary shall be determined by the Director of Corporate Governance/Board Secretary.

12. Review Date

12.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

1.6

9:45 AM, 5 Mins

1.6 - HSC Annual Self-Assessment of Effectiveness Outcome Report

Ann Murphy (Hywel Dda UHB - RCN Trade Union Rep - Independent Board Member), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)

For assurance

Attachments

HSC SA Report 2025 2026 AG.pdf

I di

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	05 May 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Health and Safety Committee (HSC) Self- Assessment Report 2025/2026
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Director of Corporate Governance/Board Secretary
SWYDDOG ADRODD: REPORTING OFFICER:	Charlotte Wilmshurst, Assistant Director of Assurance and Risk

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 the report is to present the outcome of the Health and Safety Committee Self-Assessment 2025/2026 process to the Committee.

Cefndir / Background

In line with Section 10.2.1 of Standing Orders, the Board is required to introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Section 10.2.2 also states that each Committee must also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-Committees it has established.

In addition to the annual Committee self-assessment process, after each meeting Independent Member (IM) Reflective Sessions take place to gather feedback and insights from Members on the meeting, in terms of what has gone well, what could have gone better, and issues that need to be raised at the Committee Chair's meeting. This feedback helps with the evaluation process and continuous improvement.

During previous years, Committee self-assessments have been based on a comprehensive review of feedback provided by the Committee membership from the completion of a long questionnaire assessment. While these approaches provided valuable insights, they also led to survey fatigue and limited engagement. Feedback from a recent Corporate Governance Conference has highlighted the need for a proportionate process for assessment that avoids unnecessary complexity. This year's approach will streamline the assessment, focusing on critical governance behaviours and outcomes rather than exhaustive questionnaires.

This year's Committee self-assessment form focuses on five core areas of governance and assurance:

Board Assurance and Governance
The Committee provides effective assurance to the Board that Hywel Dda UHB is meeting its statutory health and safety responsibilities.

Compliance with Health and Safety Legislation
The Committee effectively oversees compliance with relevant health and safety legislation, regulations, and Welsh Government requirements.

Risk Management and Incident Learning
The Committee effectively monitors health and safety risks, incidents, and trends, ensuring learning and corrective action across the organisation.

Workforce Engagement, Partnership and Culture
The Committee supports effective partnership working and promotes a positive health, safety, and wellbeing culture across Hywel Dda UHB.

Committee Effectiveness and Delivery of the Terms of Reference
The Committee's membership, agenda management, reporting, and behaviours enable it to deliver its Terms of Reference effectively.

Asesiad / Assessment

To improve response rates, taking into account that there is a process of continuous improvement through the IM Post Committee Reflective Sessions, a short questionnaire was circulated to Members to gather feedback on 5 key areas for the Committee.

Respondents were asked to rate their level of agreement to 5 statements relating to key areas of focus for the Committee on a scale of 1–5. (1 - strongly disagree up to 5 – strongly agree) and to provide more information to support their rating.

Below are the statements relating to 5 key areas of focus for the Committee and the average ratings based on the responses received. 4 (out of 11) responses were received (36.4% response rate).

Area and Statement	Average Rating
Board Assurance and Governance *The Committee provides effective assurance to the Board that Hywel Dda UHB is meeting its statutory health and safety responsibilities.*	4
Compliance with Health and Safety Legislation *The Committee effectively oversees compliance with relevant health and safety legislation, regulations, and Welsh Government requirements.*	4
Risk Management and Incident Learning *The Committee effectively monitors health and safety risks, incidents, and trends, ensuring learning and corrective action across the organisation.*	4
Workforce Engagement, Partnership and Culture *The Committee supports effective partnership working and promotes a positive health, safety, and wellbeing culture across Hywel Dda UHB.*	4

Committee Effectiveness and Delivery of the Terms of Reference *The Committee's membership, agenda management, reporting, and behaviours enable it to deliver its Terms of Reference effectively.*	4

The following themes were provided:

What has gone well:

- The Committee provides a good level of assurance to the Board, with an average ratings of 4 across this assessed domains.
- Members recognised strong leadership and membership, with assurance issues carefully considered and discussed.
- Committee discussions are increasingly informed by relevant facts, insights and legislation.
- The Committee has continued to develop its role as an assurance-focused Committee, whilst acknowledging there is still more to do.
- Partnership working and trade union engagement has strengthened, with health and safety trade union groups seen as increasingly relevant and effective.
- Respondents acknowledged that the Committee has made significant progress over the last year, reflecting a clear improvement trajectory.

What we want to strengthen going forward:

- Improve clarity and visibility of the overall health and safety legislative framework, including a clearer understanding of compliance status across the organisation to ensure more effective assurance can be provided to the Board.
- Strengthen the Committee's strategic and thematic oversight to drive wider scale improvements and compliance, moving further away from consideration of individual issues in isolation.
- Enhance thematic analysis of incidents, near misses and risks to support organisation-wide learning and preventative action.
- Further improve agenda planning, including the use of themed or deep-dive agenda items on priority health and safety topics.
- Address variability in the quality and assurance focus of papers, ensuring greater consistency from all reporting groups.
- Continue to develop capability and training for contributors, particularly for Clinical Care Groups, to support high-quality, assurance-focused reporting.
- Broaden workforce engagement beyond training compliance, with greater focus on training effectiveness, outcomes and staff confidence in raising safety concerns appropriately.

Suggestions from Respondents

- Developing a clear health and safety legislative framework or overview, setting out key statutory requirements and providing clarity on compliance status.
- Introducing themed agenda items or deep-dive discussions on specific health and safety topics to support strategic oversight.
- Strengthening thematic reporting and analysis of incidents, near misses and enforcement actions to support learning and preventative action at scale.
- Continuing to improve the quality and consistency of committee papers, including further development and support for contributors to ensure reports are focused on assurance, risks, trends and required actions.
- Enhancing workforce engagement beyond mandatory training compliance, with greater focus on the effectiveness and outcomes of training and on creating confidence for staff to raise safety concerns through appropriate routes.

- Supporting ongoing development of Clinical Care Groups, including training and capability building, to ensure issues identified can be taken forward, or escalated and addressed effectively.

Overall Conclusion

The Health and Safety Committee Self-Assessment demonstrates that the Committee is functioning effectively and providing appropriate assurance to the Board, with consistent average ratings of 4 across all assessed domains.

The feedback also highlights that the Committee is on a clear improvement trajectory, having undergone significant development in recent years as it has strengthened its assurance role. The areas identified for further development are well-understood and largely relate to maturing assurance processes, improving consistency of reporting, and enhancing strategic and thematic oversight.

The Committee is well-placed to build on this progress during 2026/27 by focusing on the agreed improvement actions, supporting contributors to improve report quality, and continuing to strengthen its role in providing robust, organisation-wide assurance on health and safety.

Area for improvement	By Whom	By When
Develop a clear overview of health and safety legislative requirements and compliance position	Executive Director of Allied Health Professions and Health Science	30 September 2026
Introduce themed agenda items to support strategic assurance and deep dive discussions	Executive Director of Allied Health Professions and Health Science Executive Leads	Themed reports on compliance have been incorporated on the HSC Workplan 2026/27
Strengthen thematic analysis of incidents, near misses and trends	Executive Director of Allied Health Professions and Health Science/ Health & Safety Team	30 September 2026
Improve consistency and assurance focus of committee papers	All report authors / Secretariat	31 March 2027
Refocus workforce engagement beyond compliance with mandatory training requirements to the effectiveness of training and outcomes	Executive Director of Allied Health Professions and Health Science /Health & Safety Team	31 July 2026
Support the development of Clinical Care Groups, including training and capability building, to ensure health and safety issues can be addressed effectively	Executive Director of Allied Health Professions and Health Science /Health & Safety Team	31 July 2026

Argymhelliad / Recommendation

The Committee is asked to **CONSIDER** the outputs from the Committee Self-Assessment process and **AGREE** to the actions to be taken to improve its effectiveness.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	10.5 The Director of Corporate Governance/Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation, including that of any Sub-Committees established. In doing so, account will be taken of the requirements set out in the NHS Effective Board Committees Guide.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	HSC Terms of Reference HSC Self-Assessment digital form results
Rhestr Termau: Glossary of Terms:	Included within the report.

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd Iechyd a Diogelwch: Parties / Committees consulted prior to Health and Safety Committee:	Director of Corporate Governance Executive Director of Allied Health Professions and Health Science

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	No direct impacts
Ansawdd / Gofal Claf: **Quality / Patient Care:**	No direct impacts
Gweithlu: **Workforce:**	No direct impacts
Risg: **Risk:**	No direct impacts
Cyfreithiol: **Legal:**	No direct impacts
Enw Da: **Reputational:**	No direct impacts
Gyfrinachedd: **Privacy:**	No direct impacts
Cydraddoldeb: **Equality:**	No direct impacts

1.7

9:50 AM, 5 Mins

1.7 - Health & Safety Committee Annual Report 2025/26

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

For approval

Attachments

HSC Committee Annual Review 25 26.pdf

HEALTH AND SAFETY COMMITTEE

ANNUAL REVIEW REPORT

2025/26

1. Introduction and Chair's Summary

In line with Standing Orders the Health and Safety Committee must submit an Annual Report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any Sub-Committees it has established, evidencing how the Committee has met its Terms of Reference during the financial year.

The Board uses this annual report to inform:

- The ongoing development of its governance arrangements, including its structures and processes:
- Its Board Development Programme, as part of an overall Organisation Development framework.

Chair's Reflections

Our purpose is to provide assurance around the Health Board's arrangements for ensuring the health, safety, welfare, and security of all employees and those who may become affected by work related activities including patients, members of public, volunteers, and contractors.

This report provides an overview of the scrutiny we have applied to matters of concern and reflects the increasing attention we are giving to the impact of actions we have taken to strengthen health, safety, welfare and security over the previous year. We recognise the importance of providing assurance to the Board on our compliance with health and safety legislation and have taken steps to strengthen our supporting governance structures.

This year has seen significant change, with a restructure of the Committee, strengthening both attendance and member contribution. Alongside this, stronger partnership working has developed with trade unions, including the introduction of joint arrangements to monitor and evaluate audits collaboratively. The development of a health and safety dashboard for managers has also been a key achievement, providing access to up-to-date, live information across a range of areas covered by health and safety guidance. In addition, the security team has been developed across the Health Board this year, providing valuable support to both clinical and portering teams.

I would like to again thank our patients, visitors and staff for their ongoing cooperation and understanding as we continue to undertake reinforced autoclaved aerated concrete (RAAC) surveys and improvements to our fire safety during 2025/26 and beyond. The Committee remains committed to ensuring safety is always maintained, while keeping disruption to a minimum throughout this work.

This has been a challenging year, and we recognise the hard work and dedication of our teams who keep supporting our services day to day and keeping our patients and staff safe within our Health Board.

The work being undertaken by the Estates Department in response to the fire enforcement notices issued by Mid and West Wales Fire and Rescue Service has progressed well across Hywel Dda sites and represents a strong example of effective collaborative working. However, the ageing nature of the estate means that increasing levels of risk continue to be carried by the Health Board, particularly in relation to ongoing repairs and long-term sustainability challenges.

I would like to commend the excellent work generated by the health, safety, fire, and security teams who work diligently as the foundation to this Committee. As we look to the coming year, the Committee will continue to build its focus on topics such as health surveillance, staff welfare and issues that arise, and ensuring the voices of staff and patients are heard in relation to their experience of working in and receiving care within our environments.

2. Terms of Reference and Workplan

The Terms of Reference (TOR) for the Health and Safety Committee is reviewed on an annual basis or following any significant changes. The TORs were last reviewed in January 2026.

Health and Safety Committee Terms of Reference

The Health and Safety Committee has a work plan to enable forward planning for the forthcoming year. The workplan is produced to incorporate the duties outlined in the Committee's Terms of Reference and any suggested areas of focus identified during the annual self-assessment process.

The Health and Safety Committee workplan covers a range of activities including statutory reporting duties, regular items of business and priority planned pieces of work which support Board and Committee's objectives.

The work plan is regularly updated throughout the year to ensure it remains responsive to emerging issues and risks.

Health and Safety Committee Work Programme 2025-26

3. **Sub-Committee/s** (if applicable)

The Health and Safety Sub-Committee reported into the Health and Safety Committee with its own Terms of Reference and annual workplan and, in line with those Terms of Reference, provided a report following each meeting.

Following a review of health and safety governance arrangements across both the operational and assurance arms of the Health Board, the Health and Safety Committee agreed on 11 November 2025 to disestablish the Sub-Committee. This reflected revised governance arrangements aimed at strengthening operational ownership and accountability for health and safety, including the establishment of the Health and Safety Compliance Group within the operational arm. The review confirmed that the responsibilities previously discharged by the Sub-Committee

would be addressed through the revised operational governance arrangements, with no gaps in assurance to the Committee or the Board.

4. Table of Attendance

Membership		Date 06/05/25	Date 03/07/25	Date 09/09/25	Date 11/11/25	Date 13/01/26	Date 10/03/26
Ann Murphy	Independent Member	✓	✓	✓	✓	✓	✓
Sarah Harraway	Independent Member		✓	✓	✓	✓	✓
Michael Imperato	Independent Member	✓	✓	✓	✓	✓	✓
Iwan Thomas	Independent Member	**x**	**x**	**x**	✓	✓	✓
Chantal Patel	Independent Member	✓	✓				✓
In Attendance		06/05/25	03/07/25	09/09/25	11/11/25	13/01/26	10/03/26
Andrew Carruthers	Chief Operating Officer	**x**	✓	✓	✓	✓	✓
Sharon Daniel	Executive Director of Nursing, Quality & Patient Experience	✓	**x**	✓	✓	✓	✓
Jo Wilson	Director of Corporate Governance	✓	✓	✓	✓	✓	✓
Dr Ardiana Gjini	Executive Director of Public Health	✓	✓	✓	✓	✓	✓
James Severs	Executive Director of Allied Health Professions and Health Science	✓	✓	✓	✓	✓	✓
Rob Elliott	Programme Director Major Infrastructure Projects	**x**	**x**				
Tim Harrison	Head of Health and Safety	✓	✓				
Karen Ryan	Head of Occupational Health	✓	✓	✓	✓	✓	✓
Anthony Dean	Unite the Union Rep	✓	✓	✓	✓	**x**	✓
Simon Chiffi	Head of Operations	✓	✓	✓	✓	✓	✓
Meeting quorate?		Yes	Yes	Yes	Yes	Yes	Yes

A quorum shall consist of no less than two of the membership and must include as a minimum the Chair or Vice-Chair of the Committee, and one other Independent Member, together with a third of the In Attendance Members.

5. Committee Activities – alert, advise and assure.

The Committee is required to report to the Board after each Committee meeting by presenting a report highlighting the key discussion items at the Committee.

Alert – *The following matters were areas where the Committee was unable to take an assurance or had a lack of confidence that the action in place was sufficient to address the issue satisfactorily and/or it was within the scope of the operational team to resolve and were alerting the Board as engagement action or intervention was required.*

The Health and Safety Committee had no matters of which to alert the Board.

Advise – *The following matters were areas of concern where assurance had been taken on actions in place but required close monitoring.*

Health and Safety Sub-Committee Update

- The Health and Safety Committee was initially unable to take assurance on compliance with Level 2 Fire Safety training when updates were first considered in May and July 2025. A further update in September 2025 indicated improving compliance, supported by enhanced access to training and increased organisational awareness, providing the Committee with increased confidence in the direction of travel.

Health and Safety Update

- In May and July 2025, the Committee was unable to take adequate assurance on the reported training figures for face-to-face courses delivered by the Manual Handling Team and the Reducing Restrictive Practice Team. Further discussion with Clinical Care Groups informed actions to strengthen oversight and improve access to training, with improved compliance reported in September 2025. Additional training needs analysis was undertaken in November 2025 to further refine understanding of ongoing requirements

Health and Safety Sub-Committee (HSSC) Update Report

- The Health and Safety Sub-Committee (HSSC) update report presented in July 2025 highlighted concerns regarding delays in the submission of reports under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) across the organisation. A further update provided in November 2025 demonstrated significant improvement in

timeliness and processes, enabling the Committee to take assurance on the management of RIDDOR reporting.

Health & Safety Final Internal Audit Report 2024/25 (HDD-2425-23)

- The Internal Audit Update Report and associated Action Report presented in July 2025 demonstrated progress towards meeting the requirements of the Health & Safety Final Internal Audit Report 2024/25; however, due to the number of outstanding actions, the Committee was only able to take limited assurance at that time. A subsequent update in September 2025 confirmed that Shared Services Partnership Audit and Assurance Services had reviewed all evidence submitted via the Audit Management and Tracking System (AMaT) and were satisfied that sufficient progress had been made by the Health, Safety and Security Team, enabling the Committee to take assurance on compliance with the audit requirements.

Staff Story

- A staff story delivered in September 2025 by a Porter highlighted concerns regarding the adequacy of Personal Protective Equipment (PPE) for Porters required to respond to security incidents. A subsequent Health and Safety Sub-Committee (HSSC) update presented in November 2025 confirmed that a review of PPE provision for Portering Teams had been undertaken and that recruitment was underway for four dedicated Security staff members, enabling the Committee to take assurance on the actions implemented to address the concerns raised.

Stress at Work

- In November 2025, the Committee was unable to take assurance on Stress at Work from a health and safety perspective due to insufficient data and the need to agree which information would be most relevant for oversight. An updated position was subsequently presented to the People, Organisational Development & Culture Committee (PODCC) in February 2026, where this Committee were able to take assurance.

Health and Safety Assurance Report

- The Health and Safety Assurance Report presented in January 2026 highlighted that work was ongoing to further develop processes for reviewing, monitoring and strengthening health and safety regulatory compliance across the Health Board. An update provided in March 2026 introduced a new Health and Safety Operational Compliance Report template, designed to strengthen reporting arrangements between Clinical Care Groups (CCGs) and the Integrated Quality, Finance and Performance Delivery Group, and to support CCGs in taking greater ownership of their local health and safety processes. In March 2026, a number of high and major risks identified through internal health and safety inspections remained outstanding. The Committee received assurance that these risks were under active review and requested a more

detailed report to support further scrutiny and oversight to be presented in May 2026.

Assurance and Risk Report

- The Assurance and Risk Reports presented in January and March 2026 highlighted a number of ongoing matters requiring attention. The January report identified the need to update outstanding audit recommendations, particularly those without revised target dates, with an agreed action to engage with all directorates to resolve recommendations that had been open for more than six months. The March report reflected the realignment of risks to the Health and Safety Committee following the disestablishment of the Health and Safety Sub-Committee. While the Committee was assured that actions were in place to manage these risks, it was agreed that further profiling was required to support effective scrutiny and oversight with updated reporting expected at the May 2026 Committee meeting.

Assure – *The following matters were areas where there was confidence that robust actions are in place and are sufficient to address the issues to operate effectively.*

Health and Safety Update report

- In May 2025, the Committee took assurance on the progress being made towards the implementation of the Health and Safety Dashboard. An update provided in November 2025 confirmed that Phase One of the dashboard implementation had commenced on schedule, marking the transition from development to operational use.

Health and Safety Annual Work Plan

- In May 2025, the Committee was assured that the Health and Safety Annual Work Plan was in place and being monitored by the HSSC. Since the dis-establishment of the HSSC, responsibility for oversight of the plan has since transferred to the newly established Health and Safety Compliance Group (HSCG).

Electrical Infrastructure Risks

- In May 2025, the Committee received assurance that robust management processes were in place to effectively manage electrical infrastructure risks. This assurance was supported by evidence of established governance and control arrangements within the Estates function, including the use of authorised and certified electrical personnel, structured planning and communication processes to mitigate service disruption, and the active management and escalation of significant electrical risks through the corporate risk register.

Reinforced autoclaved aerated concrete (RAAC) Assurance Report

- The RAAC Assurance Report presented in May 2025 assured the Committee that reinspection surveys are up to date and that ongoing controls are

effectively managing RAAC risk. The report assured the Committee that re-inspection surveys across affected sites were up to date and that established operational control measures were in place to effectively monitor and manage RAAC risk on an ongoing basis.

Major Incident Plan

- The Major Incident Plan 2025/26 was approved by the Committee in July 2025 for onward recommendation to the Board. The accompanying report, which incorporated learning from the multi-agency emergency response exercise 'Exercise Tendley' conducted in February 2025, was received as evidence that the Plan had been tested and reviewed in line with Welsh Government NHS Emergency Planning Core Guidance (2015).

Management of Actions from Health and Safety Inspections

- In September 2025, the Committee received assurance that the risk stratification work undertaken in respect of historic Health, Safety and Security Team inspections had strengthened the Health Board's understanding of residual risk and enabled more effective prioritisation and management of outstanding actions.

Health and Safety Site Inspection Process

- The Health and Safety Site Inspection Process was reviewed and presented to the Committee in September 2025, resulting in the introduction of a revised approach designed to strengthen the management and oversight of actions arising from inspections.

Health and Safety Sub-Committee (HSSC) update

- The November 2025 Health and Safety Sub□Committee update provided a range of progress reports across key compliance and operational areas, from which the Committee was assured. Updates included progress with generator commissioning at Bronglais Hospital, with further resilience installations planned; ongoing monitoring of fire safety audits; and compliance review work relating to medical gas systems. The Compliance and Site Operations Group continued to oversee assurance metrics, asbestos□related matters and an identified out□of□hours coverage risk. The update also confirmed resolution of specific site□level issues, including pigeon guano at Withybush and Bronglais Hospitals, alongside a review of porter support arrangements within higher□risk environments

Proposed Health and Safety Governance Arrangements

- The November 2025 report on Proposed Health and Safety Governance Arrangements provided assurance that the Health and Safety Sub-Committee's functions had been fully mapped to a new governance model, with revised reporting, oversight and accountability arrangements in

place. In light of this assurance, the Committee approved the dis-establishment of the Health and Safety Sub-Committee.

Heavy Patient Compliance (Manual Handling Operations Regulations 1992)

- An update presented in November 2025 provided assurance on the progress made to date in fulfilling the Health Board's statutory obligations for Heavy Patient Compliance under the Manual Handling Operations Regulations 1992, including alignment with both national and local guidance, particularly in relation to the safe handling of patients.

Health and Safety Sub-Committee Table of Actions

- The Committee received assurance that outstanding actions from the dis-established HSSC Table of Actions have been assigned to the appropriate owners, with overarching responsibility now resting with HSCG, as assured in January 2026.

Items approved by the Committee during the year.

- Health and Safety Sub-Committee Terms of Reference – Approved 3 July 2025
- Major Incident Plan – Approved 3 July 2025
- Business Continuity & Planning Policy – Approved 3 July 2025
- Disestablishment of the HSSC – Approved 11 November 2025

6. Committee Effectiveness - Feedback from self-assessment process

As stipulated within Standard Orders, the Board introduced a process of regular and rigorous self-assessment and evaluation of the performance of the Health and Safety Committee.

- For the Health and Safety Committee this involved the completion of a short digital form which requested feedback on the following areas:
    - Board Assurance and Governance
    - Compliance with Health and Safety Legislation
    - Risk Management and Incident Learning
    - Workforce Engagement, Partnership and Culture
    - Committee Effectiveness and Delivery of the Terms of Reference

What has gone well:

- The Committee continues to provide a good level of assurance to the Board, with consistent average ratings of 4 across all assessed domains.
- Members recognised strong leadership and membership, with assurance issues carefully considered and discussed.
- Committee discussions are increasingly informed by relevant facts, insights and legislation.

- There has been ongoing improvement in the quality, focus and brevity of reports, supporting more effective assurance discussions.
- The Committee has continued to develop its role as an assurance-focused committee, rather than an operational forum.
- Partnership working and trade union engagement has strengthened, with health and safety trade union groups seen as increasingly relevant and effective.
- Respondents acknowledged that the Committee has made significant progress over the last year, reflecting a clear improvement trajectory.

What we want to strengthen going forward:

- Improve clarity and visibility of the overall health and safety legislative framework, including a clearer understanding of compliance status across the organisation.
- Strengthen the Committee's strategic and thematic oversight, moving further away from consideration of individual issues in isolation.
- Enhance thematic analysis of incidents, near misses and risks to support organisation-wide learning and preventative action.
- Further improve agenda planning, including the use of themed or deep-dive agenda items on priority health and safety topics.
- Address variability in the quality and assurance focus of papers, ensuring greater consistency from all reporting groups.
- Continue to develop capability and training for contributors to support high-quality, assurance-focused reporting.
- Broaden workforce engagement beyond training compliance, with greater focus on training effectiveness, outcomes and staff confidence in raising safety concerns appropriately.

The results from the self assessment process are fed into an action plan. The process was undertaken during the year and is due to be reported to the Committee on 5 May 2026.

The Committee will also receive an update on progress at the mid-year point in November 2026.

7. Conclusion

The Committee is satisfied that it continues to operate effectively and in line with its Terms of Reference. Issues have been escalated to Board as appropriate, and the Committee uses feedback from the self-assessment process to evolve and continually improve.

1.8

9:55 AM, 10 Mins

1.8 - 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 May 2026 - Final.pdf

Appendix 1 Health Safety Corporate Risk Register - April 2026.pdf

Appendix 2 Overdue Audit and Inspection Recommendations - April 2026.pdf

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University Health Board

Assurance and Risk Report

Health and Safety Committee – 5 May 2026

Situation

This report provides the Health and Safety Committee (HSC) with the current status of the corporate risks and audit and inspection recommendations within its remit. The Committee is asked to seek assurance from Lead Executive Directors that risks are being managed effectively, and that recommendations from audits and inspections are being implemented by the Health Board.

Principal risks, operational risks, Welsh Health Circulars (WHCs) and Ministerial Directions (MDs) aligned to the Committee will be presented to the next meeting.

Corporate Risks:
5
(1 In-Committee)

Audit and Inspection Reports
40

Risk Management - Overview

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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.

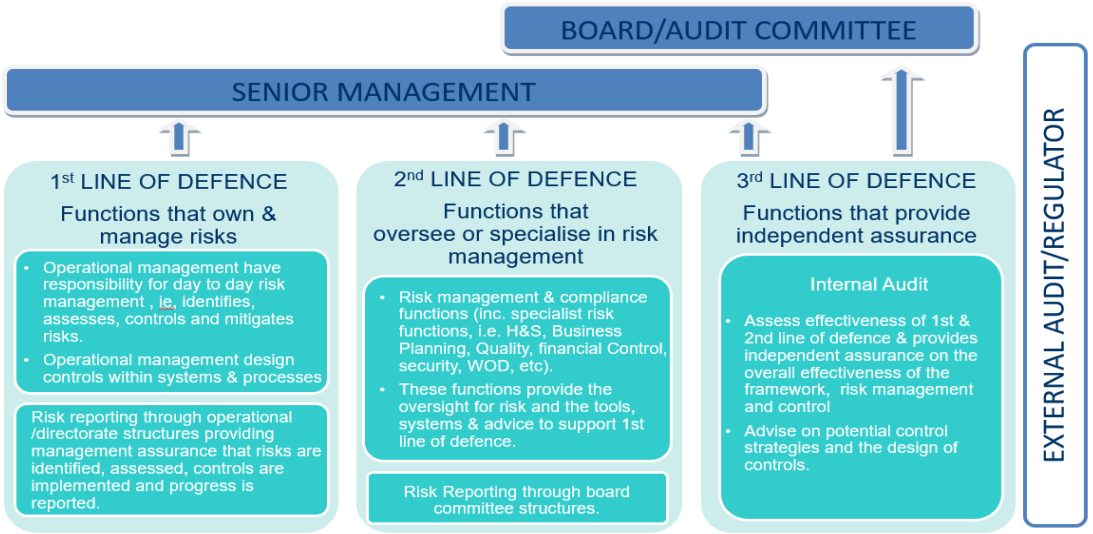
The Health Board's risk management process is recorded via the Datix Risk Register module, and enables risks to be recorded at either principal, corporate or operational level. An escalation process is in place to ensure that risks which require escalation or de-escalation are done via appropriate approval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

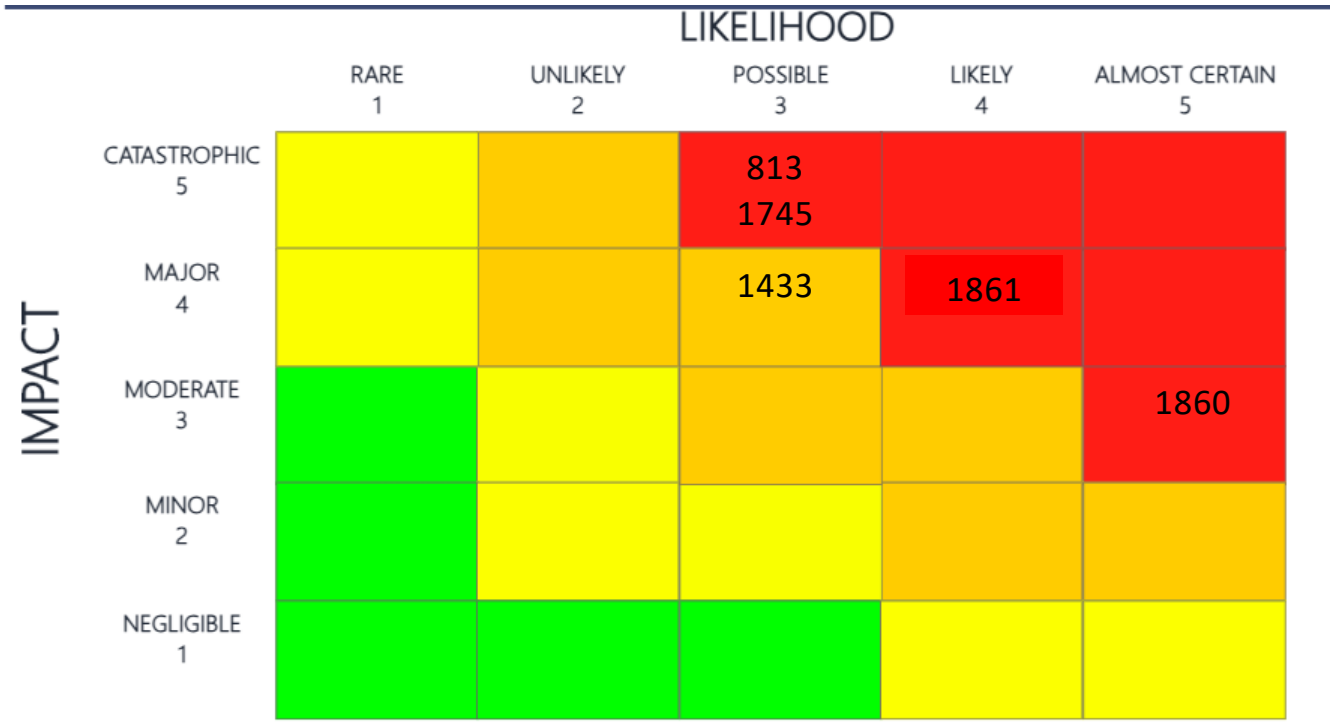
Risks are aligned to an appropriate Clinical Care Group or Executive Function (hereto referred to as "Functions"), and each has a designated risk lead responsible for reviewing in a timely and comprehensive manner.

The Board 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 areas of significant concern are reported (e.g. 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, recommending the 'acceptance' of risks that cannot be brought within risk appetite.



Corporate Risks Assigned to HSC



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.

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 5 risks currently aligned to HSC of the 24 currently on the CRR.

Due to its sensitive nature, risk 1861 is being reported in detail to the In-Committee meeting to provide discussion and assurance.

The following slides provide a summary of the reportable corporate risks aligned to the public meeting of the HSC. The risk register attached at **Appendix 1**, provides full detail of the risks, including control measures in place, risk action plans to further manage and mitigate the risk, and sources of assurance.

Corporate Risks assigned to HSC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score	Expected Date to Achieve Target Risk Score
1745 – Risk of not being able to safely deliver services due to ageing estate and infrastructure across the Health Board	Allied Health Professions and Health Sciences	Executive Director of Allied Health Professions and Health Sciences	**15** → **(Reviewed 20/03/26)**	**10**	31/08/2032

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 Welsh Government (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 (In-Committee)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score	Expected Date to Achieve Target Risk Score
1860 - Risk of serious harm to staff due to violence & aggression in the workplace	Allied Health Professions and Health Sciences	Director of Allied Health Professions and Health Sciences	**15 → (Reviewed 09/03/26)**	**9**	**01/04/2027**

Rationale for Current Risk Score

Consistently high numbers of incidents attributed to Violence and Aggression in the workplace as indicated by the Datix Reporting System during: 2024/25 Q1 (240), Q2 (292), Q3 (360) Q4 (288) incidents being recorded.

Rationale for Target Risk Score

This is based upon reduction in incidents/severity of impact of incidents. It also relates to the ability to train general ward staff in the skills to safely manage clinically challenging behaviour and the appointment of suitably trained security staff.

Corporate Risks assigned to HSC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score	Expected Date to Achieve Target Risk Score
813 – Risk of non-compliance with the Regulatory Reform (Fire Safety) Order 2005 due to ageing infrastructure	Allied Health Professions and Health Sciences	Executive Director of Allied Health Professions and Health Sciences	15 → (Reviewed 20/03/26)	5	31/08/2029

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:

1. Fire alarm systems to L1 standard (achieved).
2. 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, with the Health Board to present formal position statement at end of May 2026.
3. Night fire wardens are in place (WGH and GGH). Bronglais General Hospital (BGH) also now agreed and out to advert for these.

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. This will be reviewed regularly.

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 ma[illegible]rastructure and obtaining appropriate levels of assurances that clearly

Corporate Risks assigned to HSC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score	Expected Date to Achieve Target Risk Score
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** → **(Reviewed 20/04/26)**	**8**	31/12/2026

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

A Cabinet Review of Influenza Preparedness was due prior to COVID-19 which delayed publication. This workstream recommenced in October 2024 and together with outcomes and learning points from COVID-19 will inform our future planning approach for pandemic response.

The Government Respiratory Pandemic Guidance was due late Summer 2024, but final draft for consultation was withdrawn and a rewrite is underway. As of April 2026, no anticipated publication dates yet confirmed. It is hoped to reduce either the likelihood and/or impact score following consideration and implementation of these reviews/recommendations, and subsequent review of internal planning arrangements.

Audits and Inspections - Overview

The Health Board remains in Targeted Intervention (TI) (Level 4) status with Welsh Government (WG) as a result of challenges relating to financial sustainability, strategy and planning, service delivery and organisational performance. Whilst the Health Board has been de-escalated for 'Governance and Leadership' from Targeted Intervention (Level 4) to Routine Arrangements (Level 1), the Health Board must meet the revised set criteria:

- 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; and
- Demonstrate a prompt response to any HIW inspections, concerns, incidents, never-events, coroners requests and regulation 28s – *which has replaced the previous criteria of 'Effective response from the Health Board to external reports and reviews including those from Audit Wales, the Ombudsman, Royal Colleges and HIW resulting in sustainable improvements.'*
- The Board acts on, and addresses appropriately, concerns raised through NHS regulators such as HIW.

All reports from audits, inspections and reviews undertaken across the Health Board are logged and tracked via the **AMaT (Audit Management and Tracking)** system, with progress updated by relevant service leads against each recommendation and evidence required to be uploaded to demonstrate implementation.

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

Recommendations that have exceeded original timescales, along with the management responses, completion dates and barriers to implementation as provided by the lead officer on AMAT are included in **Appendix 2**.

Audit & Inspection Reports assigned to HSC

Internal Audit, Royal College, Health & Safety Executive, Local Authority Reports (1 of 3)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

There are 40 open reports aligned to HSC (29 from MWWFRS and 11 'other') to enable them to undertake the following responsibility set out in their Terms of Reference: -

- *3.17 Seek assurances on the requirements arising from the Health Board's regulators, Welsh Government and professional bodies.*

Each recommendation raised within audit and inspection reports are assigned a status category. Detailed below is the status of the 154 recommendations received from 'other' reports, i.e., Internal Audit, Royal College, Health & Safety Executive and Local Authority reports: -

Status Category	Definition	Number of recommendations
Overdue	The recommendation is behind schedule to the timescale provided by the lead officer.	34
Unable to Complete (NEW)	The 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.	0
Pending Decision (NEW)	The 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 recommendation is overdue or not whilst decision pending.	0
In Progress	The recommendation is currently in progress, and within the agreed original timeframe for implementation.	3
Reliant on External Factors	The recommendation is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	1
Complete Pending Formal Approval (NEW)	The Service / Function have completed the recommendation and currently awaiting formal approval to close.	42
Complete	The recommendation has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.	74

Audits and Inspection Reports assigned to HSC

Internal Audit, Royal College, Health & Safety Executive, Local Authority Reports (2 of 3)

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

11 'other' reports have been assigned to HSC to enable them to undertake their responsibility as set out in their Terms of Reference.
This slide summarises the progress of 5 reports aligned to the Committee, which have been received from Internal Audit, the Royal College and the Health & Safety Executive.
Appendix 2 contains all overdue recommendations. The requirement for revised dates is included in the Assurance and Risk reports provided to each function on a monthly basis.

Date of report	Report Issued By	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Comment
Nov-23	Internal Audit	Estates Condition	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Jul-24	N/A	8	1	0	6	0	1	0	0	Internal Audit are currently reviewing the remaining recommendations. Advice awaited.
Mar-25	Royal College	RCN Workplace Inspection - WGH A&E Department	Community & Integrated Medicine	Chief Operating Officer	Aug-25	N/A	20	0	0	20	0	0	0	0	All recommendations implemented.
Feb-25	Royal College	RCN Health and safety workplace inspection- Corridor care and safe staffing BGH EUCC	Community & Integrated Medicine	Chief Operating Officer	Sep-25	N/K	11	2	0	9	0	0	0	0	No progress or revised completion dates provided
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	3	0	1	0	0	0	0	No progress or revised completion dates provided
Oct-25	Health and Safety Executive	HSE Notice and Letter Microbiology WGH	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Apr-26	N/K	9	2	0	0	7	0	0	0	No progress or revised completion dates provided

Audits and Inspection Reports assigned to HSC

Internal Audit, Royal College, Health & Safety Executive, Local Authority Reports (3 of 3)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

11 'other' reports have been assigned to HSC to enable them to undertake their responsibility as set out in their Terms of Reference.
This slide summarises the progress of 6 reports aligned to the Committee, which have been received from the Local Authorities across the region.
Appendix 2 contains all overdue recommendations. The requirement for revised dates is included in the Assurance and Risk reports provided to each function on a monthly basis.

Date of report	Report Issued By	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Comment
Mar-25	Local Authority	Food Safety & Hygiene Report - Prince Philip Hospital, Ty Bryngwyn and Mynydd Mawr	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Sep-25	Apr-26	12	3	0	9	0	0	0	0	Work continues to progress. Facilities Manager has assured this is on track for completion by revised completion date.
Mar-25	Local Authority	Food Safety & Hygiene Report Glangwili General Hospital	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Jul-25	N/K	14	10	0	4	0	0	0	0	No progress or revised completion dates provided. Escalated to CSG.
Feb-25	Local Authority	Food Hygiene Inspection Report Bronglais General Hospital	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Feb-25	N/A	9	0	0	2	7	0	0	0	All recommendations implemented. Awaiting closure.
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	5	0	3	2	0	0	0	0	Work continues to progress. Facilities Manager has assured this is on track for completion by revised completion date.
Mar-25	Local Authority	Food Safety & Hygiene Report South Pembrokeshire Hospital	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Apr-25	Sep-26	15	5	0	3	7	0	0	0	Work continues to progress and is on track for completion by revised completion date.
Apr-25	Local Authority	Food Safety & Hygiene Report Withybush General Hospital	Estates & Facilities	Director of Allied Health Professions and Health Sciences	May-25	Sep-26	14	3	0	0	11	0	0	0	Work continues to progress and is on track for completion by revised completion date.

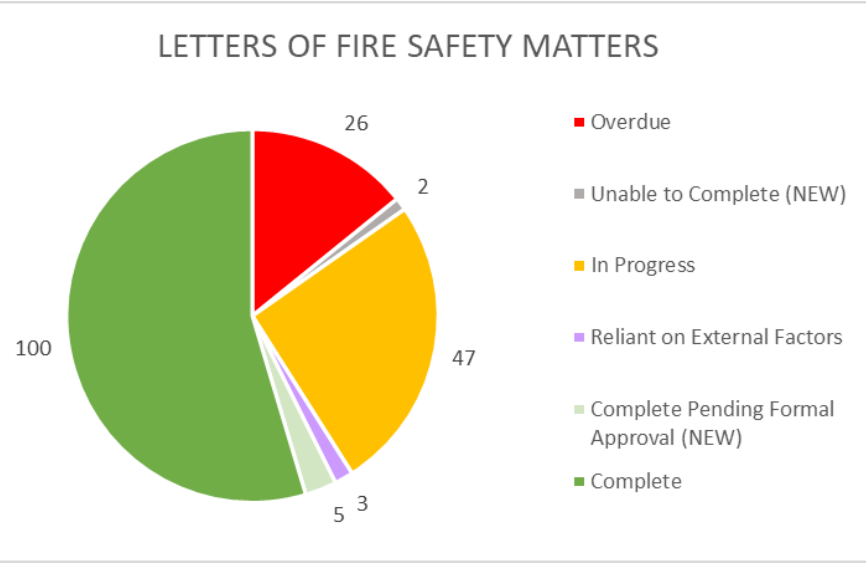
Audits and Inspection Reports assigned to HSC

Mid & West Wales Fire & Rescue Service:
Enforcement Notices and Letters of Fire Safety Matters (1 of 10)

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Status Category	Definition	Number of recommendations
Overdue	The recommendation is behind schedule to the timescale provided by the lead officer.	26
Unable to Complete (NEW)	The 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.	2
Pending Decision (NEW)	The 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 recommendation is overdue or not whilst decision pending.	0
In Progress	The recommendation is currently in progress, and within the agreed original timeframe for implementation.	47
Reliant on External Factors	The recommendation is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	3
Complete Pending Formal Approval (NEW)	The Service / Function have completed the recommendation and currently awaiting formal approval to close.	5
Complete	The recommendation has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.	100

There are 3 Enforcement Notices (ENs and 26 Letters of Fire Safety Matters (LOFSM) currently open. Of the 183 recommendations, 47 are in progress, 3 of which have revised completion dates of March 2027, with MWWFRS informed accordingly. Reasons for the revised timeframes include recommendations forming part of the Phase 2 Fire Project, delays in the undertaking of compartmentation survey work by specialist external contractors, and delays in the revision of fire strategy drawings (advised by NHS Wales Shared Services Partnership). There is regular discussions between the Health Board's Head of Estates, Risk and Compliance and MWWFRS in respect of fire safety visits and the ENs/ LOFSMs. 26 recommendations are overdue, 1 having passed its original completion date of October 2024, 5 having passed their original completion dates of November/December 2025 and 20 having passed their original completion dates of February/March 2026; 10 are without revised dates (having just passed their original completion dates of March 2026) and will be presented at the next CCG meeting for escalation on 29 April



Audits and Inspection Reports assigned to HSC

Mid & West Wales Fire & Rescue Service: Enforcement Notices (2 of 10)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Comment
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	May-26	N/A	2	2	0	0	0	0	0	0	Work continues to progress and is on track for completion by revised original completion date (agreed with MWWFRS).
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	N/A	4	0	1	3	0	0	0	0	Work continues to progress and is on track for completion by revised original completion date (agreed with MWWFRS).
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	N/A	1	0	1	0	0	0	0	0	Work continues to progress and is on track for completion by revised original completion date (agreed with MWWFRS).

Audits and Inspection Reports assigned to HSC

Mid & West Wales Fire & Rescue Service: Letters of Fire Safety Matters - Ceredigion (3 of 10)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Comment
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	N/A	8	0	6	2	0	0	0	0	Work continues to progress and is on track for completion by revised original completion date (agreed with MWWFRS).
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	N/A	8	0	6	2	0	0	0	0	Work continues to progress and is on track for completion by revised original completion date (agreed with MWWFRS).
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	N/A	9	0	6	3	0	0	0	0	Work continues to progress and is on track for completion by revised original completion date (agreed with MWWFRS).
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	N/A	10	1	6	3	0	0	0	0	Work continues to progress and is on track for completion by revised completion date (agreed with MWWFRS).

Audits and Inspection Reports assigned to HSC

Mid & West Wales Fire & Rescue Service: Letters of Fire Safety Matters - Ceredigion (4 of 10)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Comment
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	Jul-26	9	1	0	7	0	1	0	0	Work continues to progress and is on track for completion by revised completion date (agreed with MWWFRS).
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	Mar-26	6	1	0	3	2	0	0	0	Awaiting revised completion date and progress update report.
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	Apr-26	4	2	0	1	1	0	0	0	Work continues to progress and is on track for completion by revised original completion date (agreed with MWWFRS).

Audits and Inspection Reports assigned to HSC

Mid & West Wales Fire & Rescue Service: Letters of Fire Safety Matters - Carmarthenshire West (5 of 10)

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Comment
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, Dolgwili, Carmarthen, SA31 2AF.	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Aug-27	N/A	8	0	1	7	0	0	0	0	Work continues to progress and is on track for completion by revised original completion date (agreed with MWWFRS).
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	N/K	9	7	0	2	0	0	0	0	Awaiting revised completion date and progress update report.
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, Dolgwili, Carmarthen, SA31 2AF	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Aug-27	N/A	5	0	1	4	0	0	0	0	Work continues to progress and is on track for completion by revised original completion date (agreed with MWWFRS).
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, Dolgwili, Carmarthen, SA31 2AF	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Aug-27	N/A	5	0	1	4	0	0	0	0	Work continues to progress and is on track for completion by revised original completion date (agreed with MWWFRS).

Audits and Inspection Reports assigned to HSC

Mid & West Wales Fire & Rescue Service: Letters of Fire Safety Matters - Carmarthenshire West (6 of 10)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Comment
Feb-24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Aug-27	N/A	12	0	4	8	0	0	0	0	Work continues to progress and is on track for completion by revised original completion date (agreed with MWWFRS).
May-22	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	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	N/K	13	2	0	11	0	0	0	0	Awaiting revised completion date and progress update report.
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	N/K	5	4	0	1	0	0	0	0	Awaiting revised completion date and progress update report.

Audits and Inspection Reports assigned to HSC

Mid & West Wales Fire & Rescue Service: Letters of Fire Safety Matters - Pembrokeshire (7 of 10)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Comment
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	N/A	4	0	1	3	0	0	0	0	Work continues to progress and is on track for completion by revised original completion date (agreed with MWWFRS).
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	N/A	2	0	2	0	0	0	0	0	Work continues to progress and is on track for completion by revised original completion date (agreed with MWWFRS).
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	N/A	1	0	1	0	0	0	0	0	Work continues to progress and is on track for completion by revised original completion date (agreed with MWWFRS).
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	N/A	11	0	4	7	0	0	0	0	Work continues to progress and is on track for completion by revised original completion date (agreed with MWWFRS).

Audits and Inspection Reports assigned to HSC

Mid & West Wales Fire & Rescue Service: Letters of Fire Safety Matters - Pembrokeshire (8 of 10)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Comment
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	N/K	4	1	0	3	0	0	0	0	Awaiting revised completion date and progress update report.
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	N/A	9	0	1	6	0	0	0	2	Work continues to progress and is on track for completion by revised original completion date (agreed with MWWFRS).

Audits and Inspection Reports assigned to HSC

Mid & West Wales Fire & Rescue Service: Letters of Fire Safety Matters - Carmarthenshire East (9 of 10)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Comment
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	N/A	6	0	0	2	2	2	0	0	All recommendations completed apart from 2 recommendations which are reliant on receipt of revised Fire Strategy from MWWFRS (External Factors).
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	N/K	5	1	0	4	0	0	0	0	Awaiting revised completion date and progress update report.
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	N/K	4	2	0	2	0	0	0	0	Awaiting revised completion date and progress update report.

Audits and Inspection Reports assigned to HSC

Mid & West Wales Fire & Rescue Service: Letters of Fire Safety Matters - Carmarthenshire East (10 of 10)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Comment
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	N/K	3	2	0	1	0	0	0	0	Awaiting revised completion date and progress update report.
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	N/A	5	1	3	1	0	0	0	0	Work continues to progress and is on track for completion by revised original completion date (agreed with MWWFRS).

Recommendations

The Committee is requested, in relation to the areas presented in this paper, to: -

Risk Management

- **RECEIVE ASSURANCE** that identified controls are in place and working effectively
- **RECEIVE ASSURANCE** that all planned actions are credible and deliverable, and in line with agreed plans, and will be implemented within stated timescales and will reduce risks further and/or mitigate the impact should risks materialise.

Audits, Inspections and Regulatory Reports

- **RECEIVE ASSURANCE** from the lead Executive Director or Supporting Officer on the management of recommendations raised in audit, inspection and regulatory reports within their area of responsibility, particularly in respect of confirming the full implementation of recommendations, any barriers to delivery and subsequent impacts of non/late delivery, and assurance that the risks associated with these are being managed effectively.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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Hywel Dda
University Health Board

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Mar-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
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	31/12/2026	14

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.	Increase in length of hospital stay by >15 days.	An event which impacts on a large number of patients.
			Agency reportable incident.	Mismanagement of patient care with long-term effects.	
			An event which impacts on a small 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.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
		Reduced performance levels if unresolved.	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.
				Critical report.	Severely critical report.
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	
	Detailed review of relevant information
	Medium level review
	Cursory or narrow scope of review

NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you

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

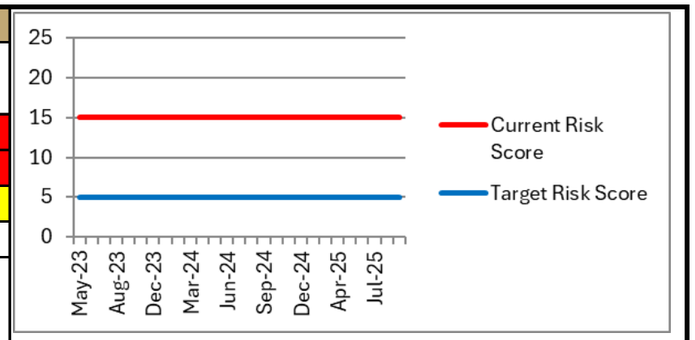
Date Risk Identified:	Oct-19
Strategic Objective:	3. Great Care

Executive Director Owner:	Severs, James	**Date of Review:**	Mar-26
Lead Committee:	Health and Safety Committee	**Date of Next Review:**	Apr-26

Risk ID:	**813**	**Corporate Risk Description:**	There is a risk of failing to fully comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO). This is caused by 1: The age, condition and scale of physical backlog, circa £20m (+) relating to fire safety (i.e. non compliant fire doors, compartmentation defects and general fire safety management issues) across our estate significantly affects our ability to comply with the requirements of the RRO in every respect. 2:Difficulties managing the quantity of actions within the current fire safety risk assessment system (Boris) - assigned to responsible persons and action approvers. 3: Management responsibilities for fire safety not fully understood by all responsible managers. 4: Fire safety training attendance figures are not reaching HB agreed targets. This could lead to an impact/affect on the safety of patients, staff and general public, HSE investigations and further fire brigade enforcement (already served on Withybush and Glangwili General Hospitals and recently at Cwm Seren MH Facility), fines and/or custodial sentences, adverse publicity/reduction in stakeholder confidence.

Does this risk link to any Directorate (operational) risks?	1965, 1934, 1096, 951, 2085, 1040, 2062, 2042, 1929, 1596, 1539

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



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 MWWFRS letters and Enforcement Notices. All programme dates have been agreed with the Health Board, Welsh Government (WG) and MWWFRS senior inspecting officers. We intend to review the progress of our completed actions to determine the risk score as we progress with these works. Extensions of time particularly for EN schemes have been fully agreed by MWWFRS. Reduced scope of works now agreed for WGH and GGH Phase 2 on achievement of the following. 1 Fire alarm systems to L1 standard (WGH complete and GGH by 31/03/26 as agreed) 2 UHB to achieve and maintain an 85% target for combined Fire Safety Training - MWWFRS have mandated that this be achieved by 31/03/26. UHB to present formal position statement 31/03/26. 3 Night fire wardens are in place (WGH and GGH). BGH also now agreed and we are out to advert for these. The BORIS system is now in place 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. This will be reviewed regularly.

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)	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** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
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	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. Not all managers who are assigned	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.

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. 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 Withybush 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).	actions on Boris are regularly accessing the system to close off their actions. Despite recent invitations for staff to attend training sessions. 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. 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. A revised list of Named Responsible Persons for each site is needed to ensure the responsibilities for fire safety is fully understood. 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. Improvements to our fire strategy drawings is required to correctly	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. Start date Sept 2024 completion mid 2027. Will be regularly reviewed.
		Completion of planned fire safety enforcement work at Cwm Seren MH Facility in Carmarthen, following enforcement notice.	Evans, Paul	~~28/11/2025~~ ~~31/01/2026~~ 31/03/2026	works almost complete, some final doors to be delivered and fitted which will conclude all works, delay due to incorrect doors from principle contractor.Letter to MWWFRS to inform them of this slight delay.
		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.
		To develop an initial fire safety strategy detailing specific arrangements and headings, which supports our agreed HB wide fire safety policy. To assess and measure our ability to demonstrate effectiveness of each element of the strategy and any potential gaps/timelines to address any shortcomings.	Jupp, Richard	Completed	Document template now complete, we are now populating the date of completion for each step of the process.

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.

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 / Current Level			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
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. Boris Fire Safety System (UPDATE) and Fire Training Performance SBAR's	General site management checks/walkarounds 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								

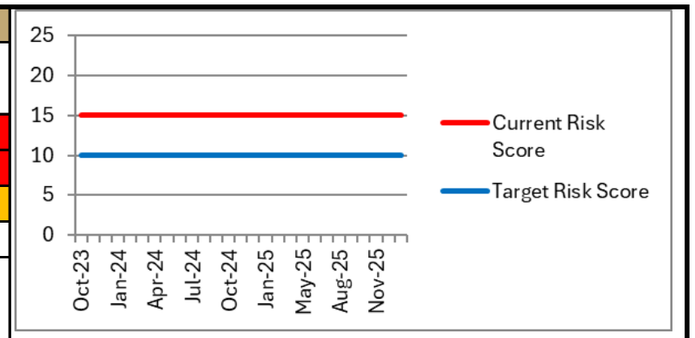
Fire Safety SBAR (3A's) reports regularly issued to HSSC and estates governance care groups	2nd			submitted to Sept 24 HSAC.					
Fire inspections by Fire Service & Fire Improvement Notices	3rd								
NWSSP fire advisor inspections	3rd								
High level action plan meetings with MWWFRS with very positive 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:**	Mar-26
Lead Committee:	Health and Safety Committee	**Date of Next Review:**	Apr-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** Further action necessary to address the controls gaps	**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. Increased backlog of circa £250m+ Operational resource pressures across the acute sites. Increasing number of maintenance checks, specifically in relation to fire compliance.	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.
		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

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 / Current Level			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
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								

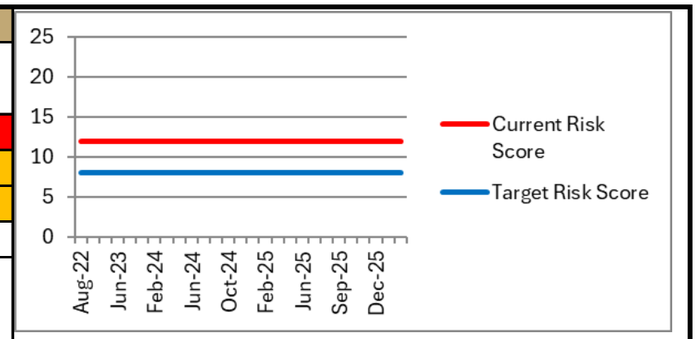
NWSSP-SES Internal Audit on Estates Condition October 2024 (Limited Assurance)	3rd							
Receipt of WHTM audit reports from NWSSP	3rd							

Date Risk Identified:	May-22
Strategic Objective:	1. Thriving Teams and 2. Healthier Communities and 3. Great Care

Executive Director Owner:	Gjini, Ardiana	**Date of Review:**	Jan-26
Lead Committee:	Health and Safety Committee	**Date of Next Review:**	Mar-26

Risk ID:	**1433**	**Corporate Risk Description:**	There is a risk the Health Board being unable to maintain routine and emergency service provision across the organisation in the event of a severe pandemic event. This is caused by a novel virus/bacteria (or emerging variant or mutation of concern) causing a pandemic as declared by the World Health Organisation (WHO) and the subsequent ability of the Health Board to respond to the scale and severity of the outbreak. This could lead to an impact/affect on patients being able to access appropriate and timely treatment, the UHB being able to maintain safe and effective levels of staffing, financial loss, adverse publicity/reduction in stakeholder confidence, increased mortality and ill-health across our population.
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):	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:	31/12/2026
Trend:	⟺



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:

A Cabinet Review of Influenza Preparedness was due prior to COVID-19 which delayed publication. This workstream recommenced in October 2024 and together with outcomes and learning points from COVID-19 will inform our future planning approach for pandemic response.

The Government Respiratory Pandemic Guidance was due late Summer 2024, but final draft for consultation was withdrawn and a rewrite is underway. As of April 2026, no anticipated publication dates yet confirmed. It is hoped to reduce either the likelihood and/or impact score following consideration and implementation of these reviews/recommendations, and subsequent review of internal planning arrangements.

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** Further action necessary to address the controls gaps	**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 # 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 (working draft issued Aug 2025 now under review to incorporate Ex Pegasus 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 Influenza Response Framework and associated plan(currently under review) # 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.	Lack of ratified Pandemic Response Framework reviewed which broadens remit from Influenza focus to generic pandemic events.	Pandemic Response Framework reviewed which broadens remit from Influenza focus to generic pandemic events.	Hussell, Sam	~~31/03/2026~~ ~~31/05/2024~~ ~~31/08/2024~~ ~~31/10/2024~~ ~~30/05/2025~~ ~~31/12/2025~~ 31/03/2026	Awaiting publication of UK Gov Respiratory Pandemic Planning Guidance, final draft version out for consultation currently and content being used to inform Pandemic Response Framework.
		Learning from participation in Exercises Solaris and Pegasus, to inform the review of existing pandemic framework.	Hussell, Sam	31/03/2026	Learning currently being collated from exercise participation

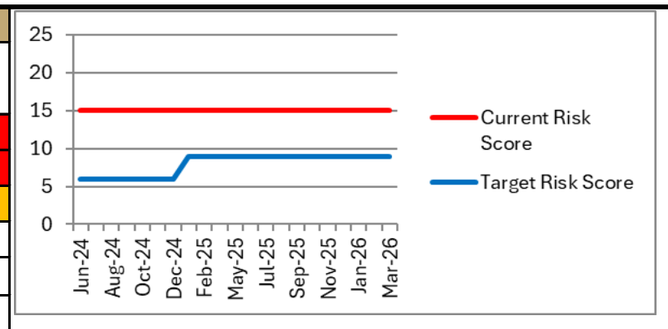
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the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

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

Executive Director Owner:	Severs, James	**Date of Review:**	Mar-26
Lead Committee:	Health and Safety Committee	**Date of Next Review:**	Apr-26

Risk ID:	**1860**	**Corporate Risk Description:**	There is a risk of serious harm to staff from assault. This is caused by violence & aggression in the workplace by patients, visitors and others. This could lead to an impact/affect on the health, safety and wellbeing of employees. Risk of non compliance with Health and Safety at Work Act and Management of Health and Safety at Work Regulations.
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):	3×3=9
Expected Date To Achieve TRS:	01/04/2027
Trend:	⟷



Rationale for CURRENT Risk Score:
Consistently high numbers of incidents attributed to Violence and Aggression in the workplace as indicated by the Datix Reporting System during: 2024/25 Q1 (240), Q2 (292), Q3 (360) Q4 (288) incidents being recorded.

Rationale for TARGET Risk Score:
This is based upon reduction in incidents/severity of impact of incidents. It also relates to the ability to train General Ward staff in the skills to safely manage clinically challenging behaviour and the appointment of suitably trained Security Staff.

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** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
V&A Risk Assessment Process: There is a Violence and Aggression (V&A) Risk Assessment toolkit available to aid managers to assess the risk of V&A at department level. This is promoted by the V&A Case Manager. Education and Training: There is a national NHS Violence and Aggression Training Scheme standard to recognise and manage the risk of violence and aggression in the work place. V&A Case Management: There is a process for V&A Case Management across the Health Board. Violent Patient Warning Marker Procedure in place: This procedure provides early warning for staff caring for certain patients. This applies to Primary and Secondary Care settings. Lone Working Policy: There is a policy to promote principles of safer working for lone workers.	Whilst V&A Case Manager requests V&A risk assessments are undertaken following incidents no mechanism exists to monitor compliance with the numbers 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	Develop a process to improve oversight of V&A risk assessments.	Jenkins, Brett	~~30/04/2025~~ 31/06/2026	MS Forms template has been devised. Incident data supplied to management to inform their V&A risk assessments. 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.

Violence and Aggression Poster/Information: Posters are displayed in key locations across the HB premises. Informing the public of Health Board tolerance towards unacceptable behaviour towards staff. Security Management Group monthly meeting to monitor progression of actions relating to this risk. 'People Safe' lone working devices in operation across various areas in the Health Board (primarily Community teams).	marker to remain on the patients record. Low compliance in the use of 'People Safe' lone working devices. Understanding of correlation of V&A incidents to location. Lack of dedicated trained SIA licenced or equivalent security staff to respond to V&A incidents.	Undertake a thorough training needs analysis against the National V&A Training Scheme standard and improve access to training.	Wood, Rachel	~~31/08/2025~~ 31/06/2026	TNA has been revised following input from Clinical Education Manager. SBAR Paper to be drafted for Health and Safety Sub-Committee in October 2025. Further work required. New Exec-led Task & Finish group commenced November 2025 to address TNA and Training Venue Needs (V&A training, Manual Handling and Resus).
		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~~ 31/06/2026	Security Management Group have discussed compliance with the patient warning marker procedure and agreed how to progress with a procedure review. Document to be reviewed and returned to SMG for key stakeholder comment.
		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	512 devices issued. Review of compliance shows 4-6% compliance. SMG discussed moving to the People Safe mobile phone application. A free trial has been discussed with the supplier, however the Peoplesafe agenda has not progressed in the absence of a Head of Health, Safety & Security.
		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	V&A Case Manager produces incident reports for CCG until dashboard in place. Incident Dashboard is live and contains information on V&A/assaults/behaviour incidents. CCG's have been notified
		Require £1.3m investment to employ staff at each General Hospital site.	Jenkins, Brett	31/03/2026	Consideration by Exec Team: 02/07/2025.

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 / Current Level			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
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		Reports on security arrangements and related incidents are to be provided to Health and Safety Committee	Jenkins, Brett	31/12/2025	Security Manager collating Security related incident examples. Incident data by means of dashboard will also be shared with the HSC.
	Reports on security arrangements and related incidents are provided to Health and Safety Committee	2nd								
	CTSA updated review undertaken in February 2023 .	3rd								

Report Issued By	Report Title	Recommendation Reference	Recommendation	Management Response	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Status Category	Barriers
Internal Audit	Estates Condition	HDU-SSU-2324-03_005	R5. A full review should be undertaken of the Estates workforce to analyse the current position in terms of capability and capacity based on the current configuration of the estate - pre any redevelopment. Following this, a clear financial model for the revenue support needed in the estate should be developed.	Accepted - Management will undertake a review of its workforce based of the current estate configuration.	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Dec-25	~~Dec-25~~ N/K	Overdue	Awaiting Advice from Internal Audit
Local Authority	Food Safety & Hygiene Report Glangwili General Hospital	LA_FS&H_GGH_0325_001	R1. Food Hygiene & Safety Procedures: a) Poor temperature monitoring and maintenance of the cold chain b) Hotel Services have been designated to check fridge temperatures within ward kitchens – however there were gaps in the monitoring records I reviewed. Ward staff may not have received adequate training; ward staff may not have understood the importance of chill-chain controls. Random checks highlighted on multiple days fridge temperature were not recorded in several ward kitchens:	All ward based catering staff are required to complete food safety training. Richard Daniel has met with Andrew Kelly & James Whitehead to advise of a target for completion. Work is ongoing within Hotel services department to achieve this. Also discussed issues where supervisory staff are signing documents without rectifying issues	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-25	~~Mar-25~~ N/K	Overdue	None Noted
Local Authority	Food Safety & Hygiene Report Glangwili General Hospital	LA_FS&H_GGH_0325_002	R2. Supervision and training of implemented controls – ward kitchens Review food safety procedures and templates used on the wards, train staff handling food on the ward and in ward kitchens and secure the commitment of ward/hotel services and medical staff to follow procedures. Establish procedures to supervise and ensure controls are implemented. I note that there is a shortage of hotel services staff on the wards that may be impacting procedures to ensure controls are implemented.	Discussed issues with Hotel Service managers where supervisory staff are signing documents without rectifying issues. Hotel services supervisory staff to check records daily & use corrective actions where required & to inform ward-based caterers of correct procedures then signed off that this has been completed	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Apr-25	~~Mar-25~~ N/K	Overdue	None Noted
Local Authority	Food Safety & Hygiene Report Glangwili General Hospital	LA_FS&H_GGH_0325_003	R3. Food Hygiene & Safety Procedures: I note that ward staff are now receiving food safety training, ensure that staff understand food safety procedures and are adequately supervised to ensure food safety throughout the food chain. I understand that Glangwili Hospital intends to introduce internal food safety audits in the coming months, which will include ward audits. This will help to identify issues and address matters, prior to an inspection by the local authority.	All ward based catering staff are required to complete food safety training. Richard Daniel has met with Andrew Kelly & James Whitehead to advise of a target for completion. Work is ongoing within Hotel services department to achieve this.	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Apr-25	~~Mar-25~~ N/K	Overdue	None Noted
Local Authority	Food Safety & Hygiene Report Glangwili General Hospital	LA_FS&H_GGH_0325_005	R5. Replace the sealant around the sink in the salad room to aid ensure surfaces can be kept clean. Assimilated Regulation (EC) No 852/2004 Annex II Chapter II Para. 1(f)	Contacted Estates department contacted to repair seal on sink in Salad room	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-25	~~Mar-25~~ N/K	Overdue	None Noted
Local Authority	Food Safety & Hygiene Report Glangwili General Hospital	LA_FS&H_GGH_0325_008	R8. Ward Kitchens Replace the damaged and torn fridge seal in Ward Gwen/Padarn, this may be the reason the fridge is struggling to maintain temperatures below 5C.	Discussed with Andrew Kelly & James Whitehead to advise the seal to be changed immediately	Estates & Facilities	Richard Daniel (Catering Manager) & Paul Hill (Estates Manager)	Mar-25	~~Mar-25~~ ~~Feb-26~~ N/K	Overdue	None Noted

Local Authority	Food Safety & Hygiene Report Glangwili General Hospital	LA_FS&H_GGH_0325_009	R9. Structural/Cleaning Issues Dishwasher temps on wards Review dishwasher temperatures in ward kitchens and ensure the equipment is capable of disinfecting cups, plates, cutlery etc used by hospital patients. I note that the Hospice ward has reported that the dishwasher is not reaching 82C on the rinse cycle and the dishwasher needs descaling.	Call out repair company to investigate & repair as required	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-25	~~Mar-25~~ N/K	Overdue	None Noted
Local Authority	Food Safety & Hygiene Report Glangwili General Hospital	LA_FS&H_GGH_0325_010	R10. Confidence in Management/Control Procedures NHS Trusts must ensure food safety controls are implemented in relation to the production and provision of food at all stages of the food chain, including service to the final consumer. The regulations require Food Business Operators (FBOs) to implement food safety management systems based on HACCP principles. A food safety management system requires an FBO to identify all the food safety hazards present - physical, biological and chemical including allergens. FBOs must implement controls and monitoring to ensure those hazards critical to food safety are managed. I believe it is a failing for the central catering responsibility for food safety to stop once the food is placed in trolleys to go to the wards. Hywel Dda University Health Board is responsible for food safety, and the food safety standards should be applied and verified throughout the food chain. The management system should cover all steps from delivery of raw materials, through to manufacture/central catering up until the delivery of food to the final consumer on the ward. There needs to be a uniform consistent approach; currently procedures are not consistently applied on the wards: - Fridge controls are set to a maximum of 8 Celsius in ward kitchens compared to 5 Celsius in the main catering kitchen and stores. - Poor stock controls/date labelling of food stored in ward kitchens.	Richard Daniel has been working on a draft HACCP, which will be completed and implemented in 2025/2026	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-25	~~Mar-25~~ ~~Mar-26~~ N/K	Overdue	None Noted

Local Authority	Food Safety & Hygiene Report Glangwili General Hospital	LA_FS&H_GGH_0325_011	R11. Confidence in Management/Control Procedures The hygiene regulations also require that food handlers are trained and/or supervised and instructed in food hygiene to a level appropriate to their work activities and responsibilities. Do not overlook training of non-catering staff on the wards, this has not been included in your food safety management system. Where ward staff prepare, handle or serve food, NHS Trusts must ensure they are also trained and/or supervised and instructed in food hygiene. Ward staff, such as nurses are often those with responsibility for time/temperature and shelf-life controls at the point of service to the patient. You need to review Training within your HACCP and ensure it covers ward/medical staff. Currently you state “As a minimum - staff will be expected to hold or attain within 3 months of employment the Level 2 Award in Food Safety Staff will also receive Allergen Awareness training (in-house) plus completion of the FSA Allergen on-line training package where possible”. Please provide details of the percentage of hotel services staff trained to Level 2 Food Hygiene and Allergen Awareness training and a timescale to complete training of all relevant staff.	Richard Daniel has been working on a draft HACCP, which will be completed and implemented in 2025/2026	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-25	~~Mar-25~~ N/K	Overdue	None Noted
Local Authority	Food Safety & Hygiene Report Glangwili General Hospital	LA_FS&H_GGH_0325_012	R12. Confidence in Management/Control Procedures Please provide an update of what percentage of staff have now been trained at ward level.	Richard Daniel has met with Andrew Kelly & James Whitehead to advise of a target for completion. Work is ongoing within Hotel services department to achieve this.	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-25	~~Mar-25~~ N/K	Overdue	None Noted
Local Authority	Food Safety & Hygiene Report Glangwili General Hospital	LA_FS&H_GGH_0325_013	R13. Confidence in Management/Control Procedures Your HACCP does not document monitoring arrangements, it is not clear what are your monitoring arrangements. All measures to control Listeria monocytogenes across all food pathways must be validated to prove they are effective. The continued effectiveness of these measures should then be regularly verified at a pre-determined and documented frequency. Verification methods will depend on the size and nature of the operation and can include: day to day supervision, workplace observations, internal and external food safety audits, IP & C audits of ward kitchens, complaint/incident monitoring, patient/customer feedback, temperature monitoring, environmental swabbing and microbiological testing	Ward kitchens have historically been undertake as part of overall ward audit. In the future separate audits will be implemented via Synbiotix system across hospital setting to include main kitchen & ward areas.	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Jul-25	~~Mar-25~~ N/K	Overdue	None Noted

Local Authority	Food Safety & Hygiene Report - Prince Philip Hospital, Ty Bryngwyn and Mynydd Mawr	LA_FS&H_PPH_0325_001	R1. Food safety at ward level was repeatedly found to be a contributory factor, as were weak procurement requirements with regards to food safety. Key failings included, cold chain integrity issues, e.g., unclear procedures for checking fridge/chilled trolley temperatures at ward level/ inadequate cleaning/disinfection of food contact surfaces and inadequate shelf-life controls. Review the Listeriosis guidance (https://www.food.gov.uk/sites/default/files/media/document/listeria-guidance-june2016-rev.pdf) and consider the issues identified on this inspection, review and revise your food safety management system and implement appropriate controls.	All ward based catering staff are required to complete food safety training. Ben Goddard has met with Susan Davies & Christine Choudry to advise of 3-month target for completion. Work ongoing within hotel services dept to achieve this. Also discussed issues where supervisory staff are signing documents without rectifying issues. See 3b) below	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Sep-25	~~Sep-25~~ ~~Mar-26~~ N/K	Overdue	None Noted
Local Authority	Food Safety & Hygiene Report - Prince Philip Hospital, Ty Bryngwyn and Mynydd Mawr	LA_FS&H_PPH_0325_006	R6. Food Safety Management System - Item remains outstanding from 25th January 2024 inspection report. The documented food safety management procedures lack detail commensurate with this type of business (providing food to large cohort of vulnerable people/visitors and staff). You need to ensure adequate training and clear food safety management procedures are in place to ensure the commitment of ward and medical staff to follow procedures within the individual units and hospital wards. You must implement clear food safety management procedures (HACCP) and supervise effectively to ensure controls are implemented and working effectively. To ensure all your procedures are working as intended you should undertake verification checks and audits to review the different areas in the hospital setting regularly.	Continuing work on catering & cleaning split. Now confirmed to be that ward-based catering will move over to be under the control of the kitchen catering team. This will ensure that all relevant food safety concerns, training & documentation are under one team rather than split	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Sep-25	~~Sep-25~~ ~~Mar-26~~ N/K	Overdue	None Noted
Local Authority	Food Safety & Hygiene Report - Prince Philip Hospital, Ty Bryngwyn and Mynydd Mawr	LA_FS&H_PPH_0325_011	R11. Decide upon allergen controls and document this within the Food Safety Management System, other hospital settings provide complete separation as good practice.	Exploring possibility of having exterior freezer storage to aid in the main kitchen being able to separate entirely the allergen free meals so they can be in their own area. Has been added to 3As report and potential SBAR to be complete	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Sep-25	~~Sep-25~~ Apr-26	Overdue	None Noted
Local Authority	Food Safety & Hygiene Report South Pembrokeshire Hospital	LA_FS&H_SPH_0325_006	R6. The floor outside the main kitchen in the hallway was worn in a number of areas. Repair/renew/reseal the floor to leave in good repair and condition. (8 weeks) (This was mentioned in the last two inspections report)	Quotes for flooring have been submitted , the flooring has been added to the Health and Safety Risk Registers. Estates team are working on a capital bid to raise the money for the work to be completed	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Apr-25	~~Mar-25~~ N/K	Overdue	None Noted
Local Authority	Food Safety & Hygiene Report South Pembrokeshire Hospital	LA_FS&H_SPH_0325_012a	R12. You must ensure that staff are trained on your HACCP and associated documents. Staff must be able to locate these documents and be implementing them at all times.	Health Board wide review of the HACCP is currently in place and new HACCP documents are being created	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Apr-25	~~Apr-25~~ Sep-26	Overdue	None Noted
Local Authority	Food Safety & Hygiene Report South Pembrokeshire Hospital	LA_FS&H_SPH_0325_012b	R12. You must ensure that your monitoring records relate to a specific fridge/freezer unit so that you can demonstrate which units are working within your critical control points (CCPs). Immediate and ongoing	Health Board wide review of the HACCP is currently in place and new HACCP documents are being created	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Apr-25	~~Mar-25~~ N/K	Overdue	None Noted
Local Authority	Food Safety & Hygiene Report South Pembrokeshire Hospital	LA_FS&H_SPH_0325_013	R13. Review your documentation, practices and procedures to ensure that your systems are fully implemented. You must ensure that staff are properly trained and are aware of the controls they need to carry out. Staff must also be supervised and checked as necessary, so you are sure that all controls that are critical to food safety are being properly implemented and maintained.	Current review in place of HACCP documentation and waiting for the Documents approval.	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Apr-25	~~Mar-25~~ N/K	Overdue	None Noted

Local Authority	Food Safety & Hygiene Report South Pembrokeshire Hospital	LA_FS&H_SPH_0325_014	R14. If you wish to remove foods from the original packaging (boxes), you must retain any important information including the ingredient list and the manufacturers' details and the Best Before/Use by date for traceability purposes. This can be achieved by removing and retaining the labels until that product has been used or taking a photograph of the labels. These labels should be kept on site.	Current review in place of HACCP documentation and waiting for the Documents approval.	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Apr-25	~~Mar-25~~ N/K	Overdue	None Noted
Local Authority	Food Safety & Hygiene Report South Pembrokeshire Hospital	LA_FS&H_SPH_0325_015	R15. There were no written allergen policies or procedures for inspection. These must be included as part of your documented food safety management system. These policies and procedures must include the controls you have on foods coming in, storage, preparing and service to the final consumer. Ensure that your allergen policies and procedures are available and implemented. These should be available for inspection at all times. (Immediate and Ongoing).	Current review in place of HACCP documentation and waiting for the Documents approval.	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Apr-25	~~Mar-25~~ N/K	Overdue	None Noted
Local Authority	Food Safety & Hygiene Report Withybush General Hospital	LA_FS&H_WGH_0425_003	R3. The fly zapper in the St Caradog's kitchen is not working. I recommend it is serviced/repaired and maintained in good working order. This was escalated to the maintenance department.[	Spoke with staff fly zapper Fly zapper is still not fixed. Requested new fly zapper to be purchased for St Caradog kitchen 05.02.26	Estates & Facilities	Director of Allied Health Professions and Health Sciences	May-25	~~Mar-25~~ N/K	Overdue	None Noted
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	Estates & Facilities	Director of Allied Health Professions and Health Sciences	May-25	~~Mar-25~~ N/K	Overdue	None Noted
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	Estates & Facilities	Director of Allied Health Professions and Health Sciences	May-25	~~Mar-25~~ N/K	Overdue	None Noted
Royal College	RCN Health and safety workplace inspection- Corridor care and safe staffing BGH EUCC February 2025	RCN_EUCC_022025_001b	R1. Risk assessments of departments and patients (with agreed number) who can be corridor nursed	Risk assessments for requesting over base line staff to safely corridor nurse – approval by HoN	Community & Integrated Medicine	Chief Operating Officer	Sep-25	~~Sep-25~~ N/K	Overdue	None Noted
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.	Community & Integrated Medicine	Chief Operating Officer	Sep-25	~~Sep-25~~ N/K	Overdue	None Noted
Royal College	RCN Health and safety workplace inspection- Emergency Department GGH February 2025	RCN_H&SWI_ED_GGH_0225_002a	R2. Oxygen cylinder storage was not sufficient, cylinders were witnessed not in brackets, and cylinders were left on trolleys along the external corridors.	2a)Urgent memo to ED and CDU staff regarding not leaving trollies nor Oxygen cylinders on the escape route/corridor	Community & Integrated Medicine	Chief Operating Officer	Nov-25	~~Nov-25~~ N/K	Overdue	None Noted
Royal College	RCN Health and safety workplace inspection- Emergency Department GGH February 2025	RCN_H&SWI_ED_GGH_0225_002b	R2. Oxygen cylinder storage was not sufficient, cylinders were witnessed not in brackets, and cylinders were left on trolleys along the external corridors.	2b)Incorporating oxygen checks within the ED porters shift routine.	Community & Integrated Medicine	Chief Operating Officer	Nov-25	~~Nov-25~~ N/K	Overdue	None Noted

Royal College	RCN Health and safety workplace inspection- Emergency Department GGH February 2025	RCN_H&SWI_ED_GGH_0225_002c	R2. Oxygen cylinder storage was not sufficient, cylinders were witnessed not in brackets, and cylinders were left on trolleys along the external corridors.	2c)Clinical Site Manager to support monitoring the area and ensure any left trollies/cylinders are removed	Community & Integrated Medicine	Chief Operating Officer	Nov-25	~~Nov-25~~ N/K	Overdue	None Noted
Royal College	RCN Health and safety workplace inspection- Emergency Department GGH February 2025	RCN_H&SWI_ED_GGH_0225_002d	R2. Oxygen cylinder storage was not sufficient, cylinders were witnessed not in brackets, and cylinders were left on trolleys along the external corridors.	2d)SNM to monitor in hours, the area and ensure any left trollies/cylinders are removed	Community & Integrated Medicine	Chief Operating Officer	Nov-25	~~Nov-25~~ N/K	Overdue	None Noted
Royal College	RCN Health and safety workplace inspection- Emergency Department GGH February 2025	RCN_H&SWI_ED_GGH_0225_003b	R3. Overcrowding within the ED; ED seen as an extension of the wards; 'Corridor care' was seen as normal practice. Unable to meet patients hygiene needs due to the lack of space.	3b)Speciality Pathway Reviews underway. Surgical SDEC (Phase 1 Complete) and Trauma Ambulatory Care opened. Review of Urology, ENT & Gynea Pathways. Change in pathway for medical referrals from GP to GGH SDEC (embedded since perfect week).	Community & Integrated Medicine	Chief Operating Officer	Nov-25	~~Nov-25~~ N/K	Overdue	None Noted
Royal College	RCN Health and safety workplace inspection- Emergency Department GGH February 2025	RCN_H&SWI_ED_GGH_0225_003f	R3. Overcrowding within the ED; ED seen as an extension of the wards; 'Corridor care' was seen as normal practice. Unable to meet patients hygiene needs due to the lack of space.	3f)Role of the Senior Nurse Manager, Clinical Site Manager and 'Manager of the Day' strengthened, supporting key escalation of actions, status and risk	Community & Integrated Medicine	Chief Operating Officer	Nov-25	~~Nov-25~~ N/K	Overdue	None Noted
Royal College	RCN Health and safety workplace inspection- Emergency Department GGH February 2025	RCN_H&SWI_ED_GGH_0225_004f	R4. Staff anxiety and burnout identified; staff identified that they cannot mentor and supervise new staff; junior staff they were often in situations beyond their experience.	4f)All Wales Staff Survey 2024 – improvement plan to be developed in line with feedback.	Community & Integrated Medicine	Chief Operating Officer	Nov-25	~~Nov-25~~ N/K	Overdue	None Noted
Health and Safety Executive	HSE Notice and Letter Microbiology WGH	HSE_Microbiology_WGH_1025_005b	R5. Microbiological safety Cabinet (MSCs) (Ref MT211025/5)	To explore the practicability of installing an audible alarm to indicate if airflow falls below the required levels	Community & Integrated Medicine	Chief Operating Officer	Mar-26	~~Mar-26~~ N/K	Overdue	None Noted

Health and Safety Executive	HSE Notice and Letter Microbiology WGH	HSE_Microbiology_WGH_1025_009	R9. Improvement notice: Your current arrangements for planning, organising, monitoring and review of the preventative and protective measures necessary to minimise the risk of exposure of your employees to hazardous biological agents handled at the microbiology department for diagnostic purposes, are inadequate, in that they failed to appropriately prioritise, follow up and address issues relating to 1. safe handling of contaminated laboratory waste and 2. the impermeability of laboratory benches	Review the management arrangements for your work with hazardous biological agents and implement arrangements that ensure that your employees (and others as relevant) are not exposed to a risk of harm from work activities associated with your diagnostic microbiology service at WGH. The revised arrangements implemented should include: 1. A mechanism to ensure that preventative and protective measures necessary to work safely with hazardous biological agents are monitored and reviewed effectively to ensure that those measures are working as required on an ongoing basis and are providing the necessary and sustained levels of control. This should take into account the changing and developing nature of any identified issues which could result in changes in hazard and/or risks and associated escalation. AND 2. A mechanism to ensure that issues identified in the microbiology department with the potential to impact the health and safety of employees (and others as relevant) and/or the ability to effectively control the risks associated with the work, are addressed in an appropriately timely manner (commensurate with the risk) AND 3. Where interim arrangements are deemed necessary to deal with any health and safety issues identified in the microbiology department, that the risks associated with those interim	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Mar-26	~~Mar-26~~ N/K	Overdue	None Noted

Report Issued By	Report Title	Recommendation Reference	Recommendation	Management Response	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Status Category	Barriers Noted
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.	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	~~Mar 26~~ N/K	Overdue	There is now a procurement delay associated with the ironmongery for the doors required for the betterment works. As a result of the delays the scheme will now be completed midway through the next FY (25/26),
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.	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	~~Mar 26~~ N/K	Overdue	There is now a procurement delay associated with the ironmongery for the doors required for the betterment works. As a result of the delays the scheme will now be completed midway through the next FY (25/26),
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_001	R1. The fire safety measures evaluated in the fire risk assessment must be implemented .	Full action plan held by Estates	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Feb-26	~~Feb 26~~ N/K	Overdue	None noted
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.	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Feb-26	~~Feb 26~~ N/K	Overdue	None noted

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	Full action plan held by Estates	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Feb-26	~~Feb-26~~ N/K	Overdue	None noted
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 Domestics cupboard 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	Full action plan held by Estates	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Feb-26	~~Feb-26~~ N/K	Overdue	There is now a procurement delay associated with the ironmongery for the doors required for the betterment works. As a result of the delays the scheme will now be completed midway through the next FY (25/26),
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.	Full action plan held by Estates	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Feb-26	~~Feb-26~~ N/K	Overdue	There is now a procurement delay associated with the ironmongery for the doors required for the betterment works. As a result of the delays the scheme will now be completed midway through the next FY
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 r.elevant standard e.g. Appendix A (including Table A1 A2} of Approved Document B Volume 2 Buildings Other Than Dwelling Houses.	Full action plan held by Estates	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Feb-26	~~Feb-26~~ N/K	Overdue	None noted
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_009	R9. The Responsible Person must ensure that his employees are provided with adequate safety training, and that the training is repeated periodically at appropriate intervals. The percentage for training completion was lower than average for staff on PICU and LSU Ward	Full action plan held by Estates	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Feb-26	~~Feb-26~~ N/K	Overdue	None noted

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	Full action plan held by Estates	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	~~Mar 26~~ N/K	Overdue	None noted
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.	Full action plan held by Estates	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	~~Mar 26~~ N/K	Overdue	There is now a procurement delay associated with the ironmongery for the doors required for the betterment works. As a result of the delays the scheme will now be completed midway through the next FY (25/26),
Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Tenby Surgery Gas Lane, Tenby SA70 8AG	BFS/KS/00203555_003	R3. The fire resisting door to the server room needs to be fitted with • Intumescent strips and smoke seals. 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	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Oct-24	~~Oct 24~~ ~~Mar 26~~ N/K	Overdue	None noted
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	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Nov-25	~~Nov 25~~ ~~Jan 26~~ May-26	Overdue	None noted
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_002	R2. Ensure that display boards/stands are fire retardant or have been treated with a proprietary fire-retardant treatment designed to enhance their fire performance. • Clarification is required that boarding along the banister on the staircase is suitable and sufficient in relation to fire resistance.	Full action plan held by Estates	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Dec-25	~~Dec 25~~ ~~Feb 26~~ Apr-26	Overdue	None noted

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	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Dec-25	~~Dec 25~~ ~~Feb 26~~ Apr-26	Overdue	None noted
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	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	~~Mar 26~~ N/K	Overdue	None noted
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	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	~~Mar 26~~ N/K	Overdue	None noted
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	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	~~Mar 26~~ N/K	Overdue	None noted
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	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	~~Mar 26~~ N/K	Overdue	None noted
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_003	R3. An air transfer grille is fitted above the fire door for Staff Rest Room (R64), 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 room has a fridge within. 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	Full action plan held by Estates	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	~~Mar 26~~ N/K	Overdue	None noted

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	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	~~Mar 26~~ N/K	Overdue	None noted
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	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	~~Mar 26~~ N/K	Overdue	None noted
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	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	~~Mar 26~~ N/K	Overdue	None noted
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_003	R3. The route 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. During the inspection, hospital beds (one in particular with an oxygen cylinder) were located within the means of escape	Full action plan held with Estates	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	~~Mar 26~~ N/K	Overdue	None noted
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	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	~~Mar 26~~ N/K	Overdue	None noted
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	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Nov-25	~~Nov 25~~ ~~Mar 26~~ N/K	Overdue	None noted

2

10:05 AM, 0 Mins

2 - HEALTH AND SAFETY UPDATES

2.1

10:05 AM, 5 Mins

2.1 - Health and Safety Assurance Report

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

For assurance

Attachments

SBAR HSS Update Report May 2026 V1.0.pdf

H_S Assurance Report to HSC May 2026 V1.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	05 May 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:

- Contemporaneous issues;
- Health and safety metrics.

Cefndir / Background

Contemporaneous Issues

The work of the Health, Safety and Security (HSS) Team is wide ranging, from providing expert specialist and professional advice to senior management throughout Hywel Dda University Health Board (HDdUHB) to investigating serious incidents, monitoring regulatory requirements, and working with managers to ensure safe environments for staff, patients, and visitors.

Health & Safety Metrics

The HSS Team designed and developed a Health and Safety (H&S) Dashboard in conjunction with the Performance and Datix teams which launched in late 2025 and is available to all internal staff via the intranet. The majority of the metrics within this section of the report are taken from the dashboard, with additional information provided by the Violence and Aggression, Security and Reducing Restrictive Practice Teams.

Asesiad / Assessment

Please see the accompanying Health and Safety Assurance Report.

Argymhelliad / Recommendation

The Health & Safety Committee is asked to:

TAKE ASSURANCE

- from the contemporaneous issue updates and the health and safety metrics outlined in the Health and Safety Assurance Report.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	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 a Sgôr 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
Amcanion Cynllunio Planning Objectives	1 Workforce Stabilisation 9 Digital plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

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 Pwyllgor Ansawdd Iechyd a Diogelwch: Parties / Committees consulted prior to Health and Safety Committee:	• Health and Safety Compliance Group

Effaith: (rhaid cwblhau)

Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	No direct costs.
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.
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

May 2026

Situation

The purpose of this report is to provide the Health and Safety Committee (HSC) with an overview of health and safety across the Health Board.

This report provides information on the following topics:

- Contemporaneous issues;
- Health and safety metrics.

Notes:

- Please see agenda item 2.2 for the 2025/26 year-end report on Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) compliance.
- Please see agenda item 2.4 for the current position of the risk stratification exercise.

Contemporaneous Issues

Appointment of a New Head of Health and Safety

It can be confirmed that the new Head of Health and Safety will be joining Hywel Dda University Health Board (HDdUHB) on 01 June 2026 following successful interview. The new appointee will bring a wealth of knowledge and experience to the Health, Safety and Security Team in HDdUHB, having served as Associate Director of Health, Safety, Fire and Security and Head of Health, Safety and Security in recent roles within the NHS.

HSE Improvement Notice – Successful Sign-Off

It has been confirmed that the Improvement Notice served in 2025 against the Microbiology Laboratory has now been fully signed off by the Health and Safety Executive. A fantastic effort by all those involved.

Ceredigion Training Venue (Thomas Parry Building)

The Ceredigion training venue currently utilised by the Manual Handling team has been extended until mid-July 2026, at which point it has been confirmed that HDdUHB must vacate. It is hoped that the Learning and Development Department can confirm a new training venue soon to minimise the impact on Ceredigion-based staff requiring face-to-face training.

Health and Safety Metrics

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Health and Safety Mandatory Training E-learning Compliance (at 31/03/2026):

Health, Safety & Welfare Level 1

Function	Headcount	% compliance
Digital	370	96.2%
Finance	102	96.1%
Medical	141	95.0%
Workforce and Organisational Development	263	93.9%
Mental Health and Learning Disabilities	1375	93.0%
Strategy and Planning	57	91.2%
Nursing, Quality and Patient Experience	208	90.9%
Operational Allied Health and Health Sciences	1389	90.5%
Public Health	167	89.2%
Community and Integrated Medicine	3912	88.0%
Estates and Facilities	1043	87.8%
Chief Operating Officer Management	132	87.1%
Primary Care	320	86.3%
Pharmacy and Medicines Management	274	85.8%
Planned and Specialist Care	2678	83.3%
Chief Executive	93	82.8%

Display Screen Equipment (DSE)

Function	Headcount	% compliance
Finance	102	100.0%
Medical	87	100.0%
Pharmacy and Medicines Management	17	100.0%
Workforce and Organisational Development	216	99.5%
Mental Health and Learning Disabilities	176	98.9%
Digital	358	98.3%
Strategy and Planning	49	98.0%
Estates and Facilities	86	97.7%
Public Health	94	96.8%
Nursing, Quality and Patient Experience	122	96.7%
Primary Care	136	96.3%
Community and Integrated Medicine	425	96.2%
Operational Allied Health and Health Sciences	135	94.8%
Planned and Specialist Care	407	93.6%
Chief Executive	88	88.6%
Chief Operating Officer Management	38	86.8%

Violence & Aggression Module A

Function	Headcount	% compliance
Workforce and Organisational Development	263	99.6%
Medical	141	99.3%
Finance	102	99.0%
Digital	370	97.8%
Mental Health and Learning Disabilities	1375	97.6%
Nursing, Quality and Patient Experience	208	97.6%
Operational Allied Health and Health Sciences	1389	96.6%
Chief Operating Officer Management	132	96.2%
Estates and Facilities	1043	95.3%
Public Health	167	95.2%
Strategy and Planning	57	94.7%
Community and Integrated Medicine	3912	93.8%
Pharmacy and Medicines Management	274	93.4%
Planned and Specialist Care	2678	92.0%
Primary Care	320	91.6%
Chief Executive	93	87.1%

Manual Handling (MH) Compliance (at 31/03/2026 and 31/01/2026 for comparison):

Level 1 MH (Non-Patient Handling) at 31/01/2026:

Function	Headcount	% compliance
Executive Allied Health Professions and Health Sciences	2	100.0%
Finance	100	96.0%
Medical	141	92.9%
Workforce and Organisational Development	264	92.8%
Digital	366	91.3%
Public Health	166	89.8%
Primary Care	332	83.7%
Chief Operating Officer Management	128	83.6%
Nursing, Quality and Patient Experience	211	82.9%
Strategy and Planning	57	82.5%
Pharmacy and Medicines Management	278	82.4%
Chief Executive	96	82.3%
Operational Allied Health and Health Sciences	1388	81.8%
Estates and Facilities	1037	78.7%
Mental Health and Learning Disabilities	1376	78.5%
Community and Integrated Medicine	3874	76.6%
Planned and Specialist Care	2667	76.4%

Level 1 MH (Non-Patient Handling) at 31/03/2026:

Function	Headcount	% compliance	
Executive Allied Health Professions and Health Sciences	2	100.0%	=
Workforce and Organisational Development	263	93.9%	+ 1.1%
Digital	370	93.5%	+ 2.2%
Finance	102	93.1%	- 2.9%
Medical	141	92.9%	=
Public Health	167	88.6%	- 1.2%
Strategy and Planning	57	84.2%	+ 1.7%
Nursing, Quality and Patient Experience	208	84.1%	+ 1.2%
Chief Executive	93	82.8%	+ 0.5%
Chief Operating Officer Management	132	82.6%	- 1.0%
Pharmacy and Medicines Management	274	82.1%	- 0.3%
Operational Allied Health and Health Sciences	1389	81.8%	=
Primary Care	320	80.6%	- 3.1%
Estates and Facilities	1043	80.4%	+ 1.7%
Mental Health and Learning Disabilities	1375	79.2%	+ 0.7%
Community and Integrated Medicine	3912	77.7%	+ 1.7%
Planned and Specialist Care	2678	76.6%	+ 0.2%

Increases noted for most functions.

Manual Handling (MH) Compliance (at 31/03/2026 and 31/01/2026 for comparison):

Level 2 MH (Patient Handling) at 31/01/2026:

Function	Headcount	% compliance
Workforce and Organisational Development	35	80.0%
Public Health	75	70.7%
Estates and Facilities	136	66.9%
Planned and Specialist Care	2150	60.7%
Medical	31	58.1%
Operational Allied Health and Health Sciences	737	57.7%
Community and Integrated Medicine	3292	57.6%
Mental Health and Learning Disabilities	1034	54.4%
Pharmacy and Medicines Management	4	50.0%
Nursing, Quality and Patient Experience	74	44.6%
Primary Care	83	44.6%
Digital	7	42.9%
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	3	0.0%

Level 2 MH (Patient Handling) at 31/03/2026:

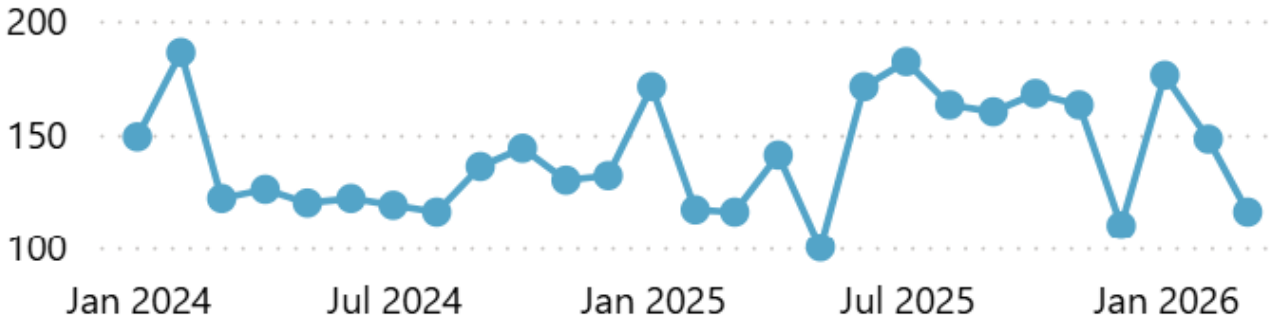
Function	Headcount	% compliance	
Workforce and Organisational Development	36	80.6%	=
Public Health	71	77.5%	+ 6.8%
Estates and Facilities	141	69.5%	+ 2.6%
Planned and Specialist Care	2168	60.9%	+ 0.2%
Operational Allied Health and Health Sciences	736	59.2%	+ 1.5%
Community and Integrated Medicine	3313	59.2%	+ 1.2%
Medical	33	57.6%	- 0.5%
Digital	7	57.1%	+ 14.2%
Mental Health and Learning Disabilities	1034	54.6%	- 0.4%
Pharmacy and Medicines Management	4	50.0%	=
Nursing, Quality and Patient Experience	73	49.3%	+ 4.7%
Primary Care	77	42.9%	- 1.7%
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	3	0.0%	=

Increases noted for many functions.

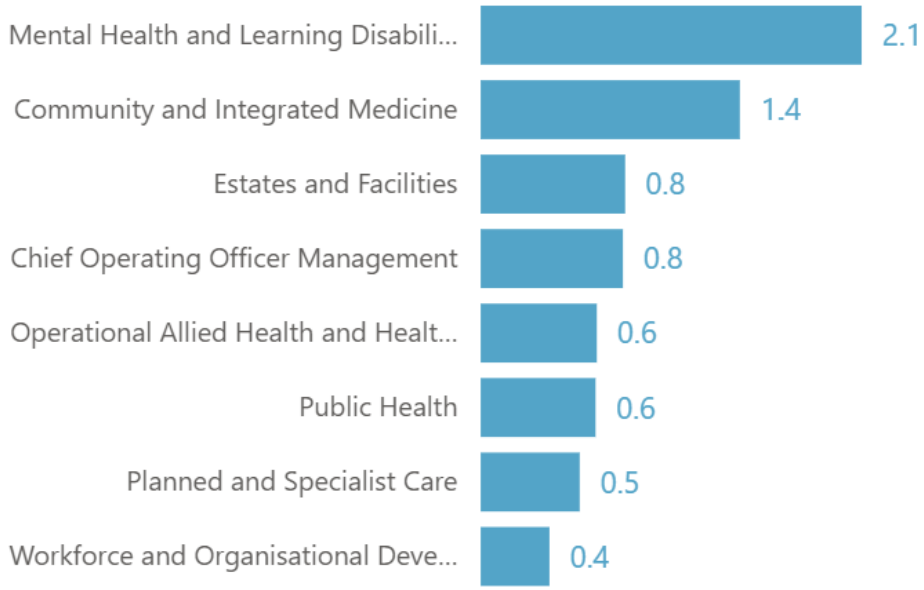
The Health and Safety Dashboard has been well received by the Clinical Care Groups (CCGs) and other key stakeholders.

All staff can access the dashboard here (internal only): **Health and Safety dashboard - Power BI**

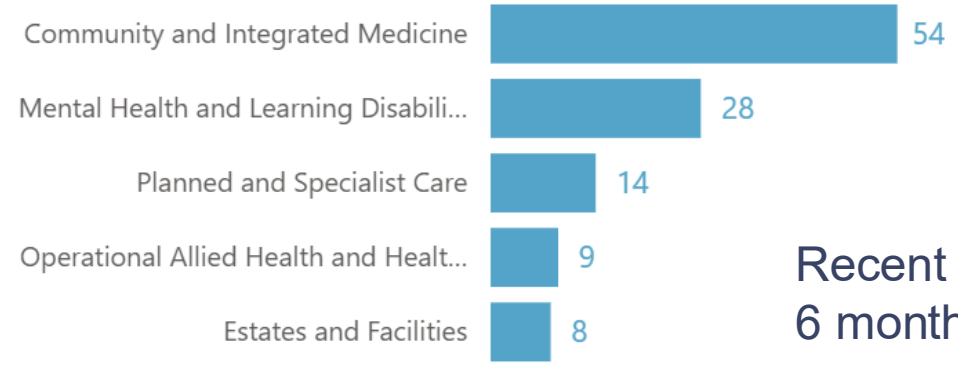
Staff / Contractor Incidents Reported via Datix (at 31/03/2026):



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



All Staff / Contractor incidents in March 2026 (2+):

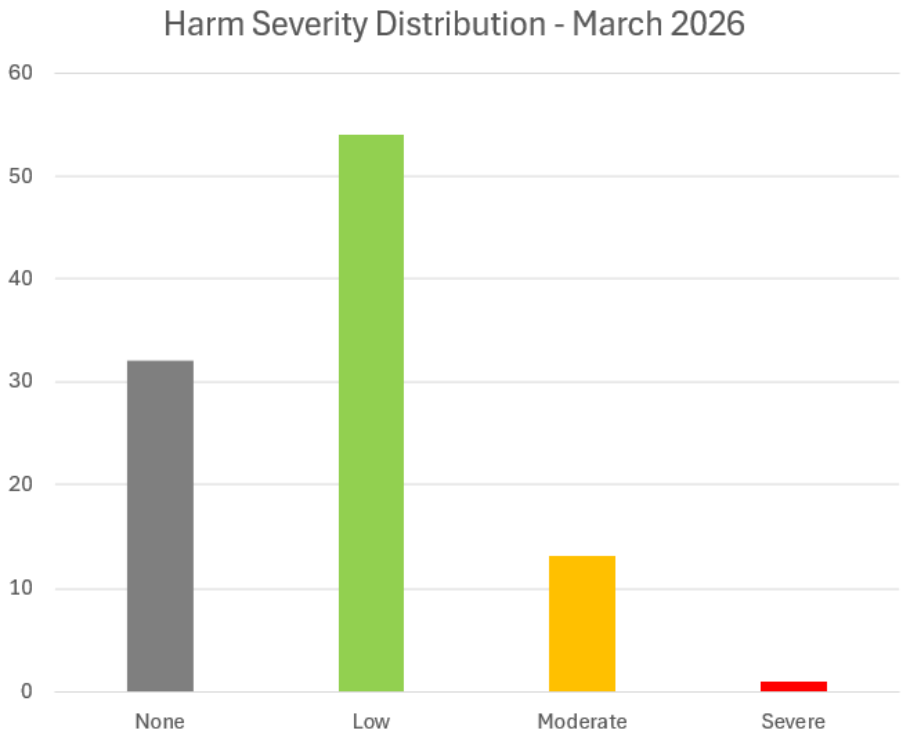


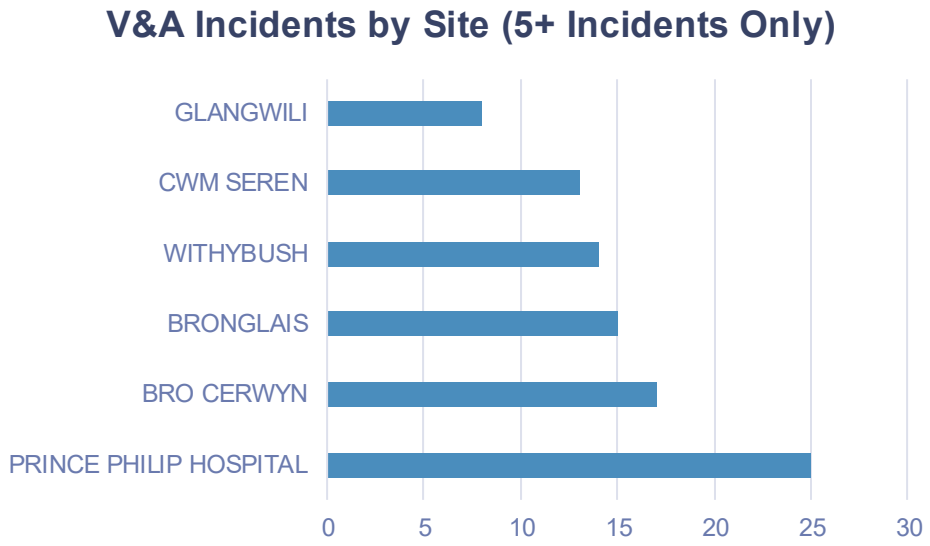
Recent months have seen some lower incident rates than the previous 6 months. This predominantly relates to a reduction in violence and aggression incidents in the Community and Integrated Medicine CCG (see slide 7). Incident rates have been fed-back to the individual CCGs for their information and analysis.

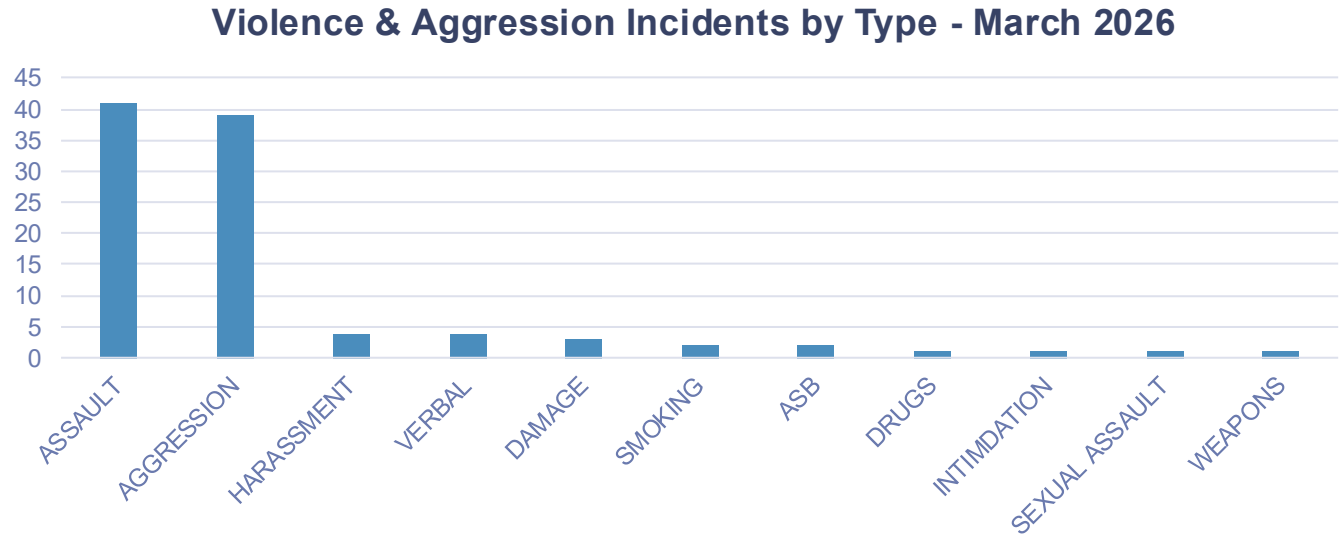
Behaviour (inc. Violence & Aggression (V&A)) Staff / Contractor Incidents Reported via Datix (at 31/03/2026):

V&A Incident Summary for March 2026:

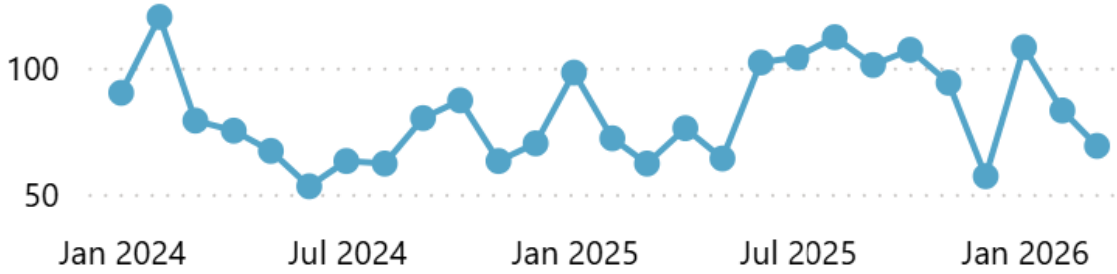
- **Total incidents:** 100 across 12 sites;
- **Service groups (CCG):** MHLD 50, CIM 47, AHS 2, PSC 1;
- **Harm:** None 32, Low 54, Moderate 13, Severe 1;





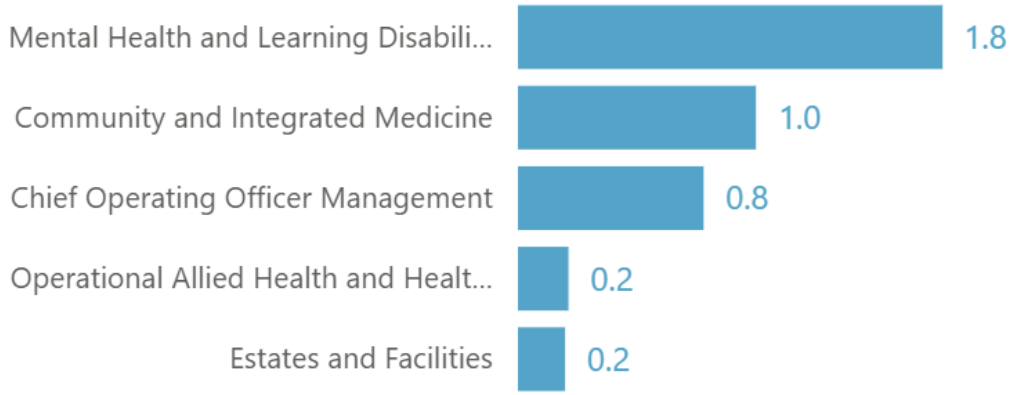


Staff / Contractor Behaviour Incidents Reported via Datix (at 31/03/2026):

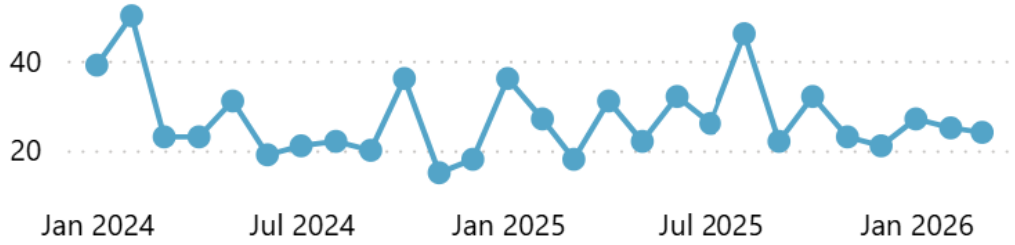


All Staff / Contractor behaviour incidents reported via Datix in March 2026 (5+):

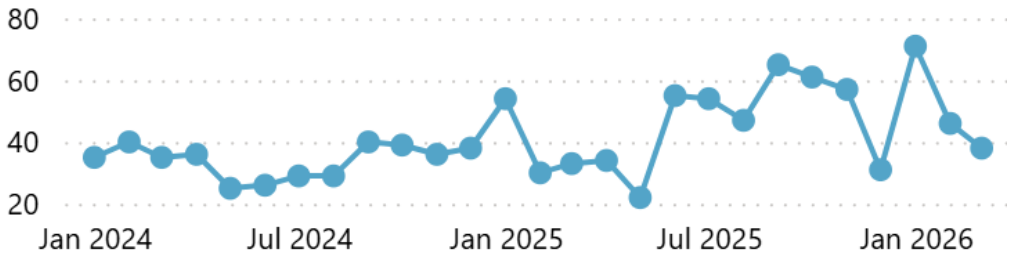
Staff / Contractor behaviour incident rate per 100 staff by CCG in March 2026:



Mental Health / Learning Disabilities (MH/LD) CCG behaviour incidents reported via Datix by month:



Community and Integrated Medicine (CIM) CCG behaviour incidents reported via Datix by month:



MH/LD behaviour incidents remain relatively stable, whereas CIM incidents vary widely dependent on the current patient cohort. The majority of CIM incidents relate to medical confusion / older mental health.

Reducing Restrictive Practice (RRP) Team training compliance (at 09/04/2026):

Mental Health / Learning Disabilities:

- Morlais 100% **(Up 3%)**
- Low Secure Unit (LSU) 57% **(Down 15%)**
- St Caradog 82% **(Up 7%)**
- Psychiatric Intensive Care Unit (PICU) 84% **(Up 11%)**
- Bryngofal 93% **(Up 5%)**
- Begelly 87% =
- Enlli 35% **(Down 43%)**
- St Non 77% **(Down 11%)**
- Bryngolau 51% **(Up 13%)**

Porter Training:

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

- Prince Phillip Hospital (PPH) 84% **(Down 16%)**
- Glangwili Hospital (GGH) 86% **(Up 3%)**
- Bronglais Hospital (BGH) 93% **(Up 6%)**
- Withybush Hospital (WGH) 88% **(Up 28%)**

Absconding Patients:

A total of 5 absconding patient incidents have been recorded January-March 2026.

Recommendations

The Health and Safety Committee (HSC) is asked to note the contents of this report.

The Health and Safety Committee is asked to:

- Take assurance from the contemporaneous issue updates and the health and safety metrics presented.

2.2 **10:10 AM, 10 Mins**

2.2 - Individual Regulation Assurance Reports

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

- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

For assurance

Attachments

SBAR HSS Regs Report May 2026 V1.1.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	05 May 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Compliance Against Health and Safety Regulations. RIDDOR Focus.
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 looking at the Health Board's compliance against specific Health and Safety regulations or topic areas without their own direct set of regulations. This paper looks at compliance with the following regulations/topics:

- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Cefndir / Background

RIDDOR places a duty on employers and people in control of work premises to report certain serious workplace accidents, occupational diseases and specified dangerous occurrences to the Health and Safety Executive (HSE).

Regulations 1-3 cover citation, interpretation, and the role of the Responsible Person.

Regulations 4-6 require deaths and injuries to be reported only when:

- there has been an **accident** which caused the injury; and
- the accident was **work-related;** and
- the injury is of a type which is **reportable.**

What is an 'accident'?

In relation to RIDDOR, an accident is a separate, identifiable, unintended incident, which causes physical injury. This specifically includes acts of non-consensual violence to people at work. Injuries themselves, e.g. 'feeling a sharp twinge', are not accidents. There must be an identifiable external event that causes the injury, e.g. a falling object striking someone. Cumulative exposures to hazards, which eventually cause injury (e.g. repetitive lifting), are not classed as 'accidents' under RIDDOR.

What is meant by 'work-related'?

RIDDOR only requires accidents to be reported if they arise 'out of or in connection with work'. The fact that there is an accident on work premises does not, in itself, mean that the accident is

work-related, the work activity itself must contribute to the accident. An accident is 'work-related' if any of the following played a significant role:

- the way the work was carried out
- any machinery, plant, substances, or equipment used for the work
- the condition of the site or premises where the accident happened.

What are 'reportable' injuries?

The following injuries are reportable when they result from a work-related accident:

- The death of any person (Reg. 6).
- Specified injuries to workers (Reg. 4).
- Injuries to workers that result in their incapacitation for more than seven days (Reg. 4).
- Injuries to non-workers that result in them being taken directly to hospital for treatment, or specified injuries to non-workers that occur on hospital premises. (Reg. 5).

Regulation 7 covers dangerous occurrences, which are certain, specified near-miss events with a high potential to cause death or serious injury. They are listed in Schedule 2 of RIDDOR and include events related to lifting equipment, pressure systems, overhead electric lines, electrical incidents causing explosion or fire, explosions, biological agents, radiation generators and radiography, collapse of scaffolding etc.

Regulation 8 requires employers to report cases of certain diagnosed reportable diseases which are linked with occupational exposure to specified hazards i.e. where these are likely to have been caused or made worse by their work. A reportable disease must be diagnosed by a doctor. Diagnosis includes identifying any new symptoms, or any significant worsening of existing symptoms. For employees, they need to provide the diagnosis in writing to their employer. Reportable occupational diseases include, carpal tunnel syndrome, cramp of the hand or forearm, occupational dermatitis, hand arm vibration syndrome, occupational asthma and tendonitis or tenosynovitis.

Regulation 9 covers reporting incidents where, in relation to a person at work, the responsible person receives a diagnosis of:

- any cancer attributed to an occupational exposure to a known human carcinogen or mutagen (including ionising radiation); or
- any disease attributed to an occupational exposure to a biological agent.

RIDDOR also sets timeframes within which the HSE should be notified of certain work-related incidents. For most types of incidents including accidents resulting in the death of any person, specified injuries to workers, non-fatal accidents requiring hospital treatment to non-workers and dangerous occurrences, the responsible person must notify the HSE without delay, and a report submitted within 10 days of the incident. For accidents resulting in the over-seven-day incapacitation of a worker, the HSE must be notified within 15 days of the incident.

Asesiad / Assessment

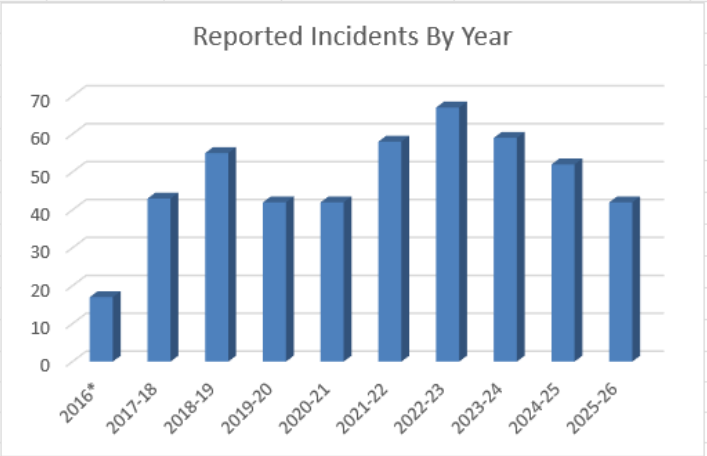
Number of Incidents Reported

In Hywel Dda University Health Board (HDdUHB), all RIDDOR notifications are submitted to the HSE by members of the Health, Safety and Security (HSS) Team to ensure consistency and quality of reports and to allow the centralised recording of information.

As a result of awareness raising activities by the HSS Team over the last eight years, the number of reported incidents have grown significantly compared to the figures from 2016, as can be seen by the table and chart at the top of the next page.

Year	Reported Incidents
2016*	17
2017-18	43
2018-19	55
2019-20	42
2020-21	42
2021-22	58
2022-23	67
2023-24	59
2024-25	52
2025-26	42

(*12-month benchmarking period, not financial year.)



Following a peak in 2022/23, the last three years have now seen a steady decline in RIDDORs reported compared to the previous year. This could be an early indication of incidents moving in the right direction, however further years figures would be required to confirm this pattern.

As has been shown by the three All-Wales Benchmarking exercises previously presented to the Health and Safety Committee, most recently in November 2024, HDdUHB can take assurance that it is not under-reporting RIDDOR incidents when compared to similar organisations across Wales. A repeat of the benchmarking exercise is planned for 2026.

Distribution of RIDDOR Incidents

The distribution of 2025/26 RIDDORs reported across the four localities can be seen in the table below (using bed numbers as the comparative measure). The figures for 2023/24 and 2024/25 have also been included for comparison.

Locality	RIDDOR No.	Hospital size	2025/2026 RIDDORs per Bed	2024/2025	2023/2024
GGH Locality	11	403 beds	0.027	0.050	0.062
PPH Locality	12	218 beds	0.055	0.092	0.073
WGH Locality	14	213 beds	0.066	0.033	0.061
BGH Locality	5	155 beds	0.032	0.032	0.032

Glangwili Hospital (GGH) is the stand-out figure having become the lowest reporting comparatively. Bronglais Hospital (BGH) has remained consistently low year-on-year. Prince Philip Hospital (PPH) has experienced a decline since last year, while Withybush Hospital (WGH) has recovered to previous levels following a dip in 2024/25.

These findings will be raised for discussion at the Clinical Care Group (CCG) Quality, Health and Safety (QHS) meetings attended by the HSS Team in May 2026.

Breakdown by Cause

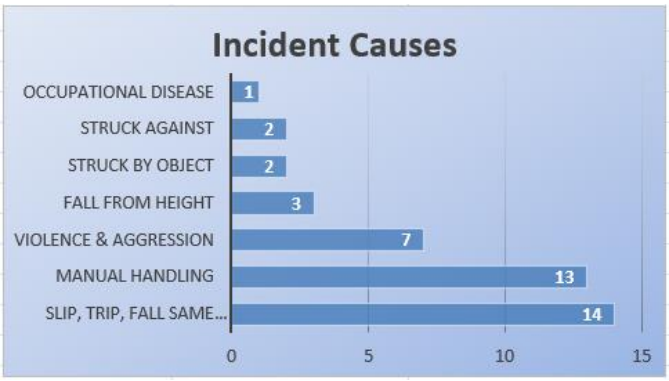
The table and chart at the top of the next page show a breakdown of the RIDDORs reported in the 2025/26 financial year by the main cause of the incident. Below it, the breakdown of the RIDDORs reported in the 2024-25 financial year has been included for comparison.

From the 2025/26 figures it can clearly be seen that there is a two-way split between the top two incident causes i.e. slips, trips and falls (STFs) and manual handling (MH), with STFs as

the overall highest cause, by a small margin. This is of no surprise as STFs have been the leading cause of RIDDOR reportable incidents in HDdUHB for the last 8 years.

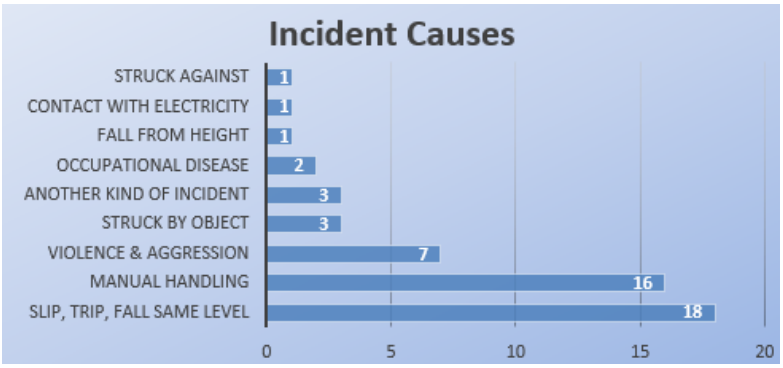
2025/26

Breakdown by Cause	No.
Slip, trip, fall same level	14
Manual Handling	13
Violence & Aggression	7
Fall from height	3
Struck by object	2
Struck against	2
Occupational Disease	1



2024/25 (For Comparison)

Breakdown by Cause	No.
Slip, trip, fall same level	18
Manual Handling	16
Violence & Aggression	7
Struck by object	3
Another kind of incident	3
Occupational Disease	2
Fall from height	1
Contact with electricity	1
Struck against	1



Pre-2024/25 incident reporting typically reflected a three-way split between STFs, MH and violence and aggression (V&A) incidents. For the second consecutive year running, however, RIDDOR reportable V&A incidents have remained low, with seven cases reported, representing a marked reduction compared with STFs and MH.

The HSS Team continue to raise awareness with managers on all three key topics through dedicated sections on the Manager's Health and Safety Induction on the management of workplace STFs, MH and V&A (amongst many other topics). A total of 749 managers and aspiring managers have completed the Manager's Health & Safety Induction course.

Timeliness of Reporting

Year	% Reported in Time
2018-19	54.5%
2019-20	66.6%
2020-21	61.9%
2021-22	56.9%
2022-23	62.7%
2023-24	64.4%
2024-25	59.6%
2025-26	69.1%

In 2025-26 the HSS Team has continued to promote the RIDDOR reporting requirements and timeframes through discussions at the CCG QHS groups across the Health Board and other meetings attended by the team, such as the Professional Nurses Forum.

The year-end compliance figure was the best that the team have ever achieved since records began in 2018 at 69.1%. This is all credit to the HSS Team that have still managed to maintain (and improve) their RIDDOR performance, despite the challenges that the team has experienced without a Head of Health, Safety and Security in position since October 2025.

Timeliness by Clinical Care Group / Function

The table below outlines the timeliness of RIDDOR reportable incidents for the 2025-26 financial year split by CCG / Function.

2025/26

	Total	On Time	% on Time
Community & Integrated Medicine	26	19	73%
Estates & Facilities	11	6	55%
Allied Health & Health Sciences	2	2	100%
Planned and Specialist Care	2	1	50%
Mental Health & Learning Disabilities	1	1	100%
Primary Care	0	0	N/A
Other	0	0	N/A

Due to the formation of the CCGs / Functions, it is not possible to make direct comparisons to previous years for all areas. The table below therefore presents the timeliness of RIDDOR reportable incidents for the 2024-25 financial year split by the former Directorates.

			2024-25
	Total	On Time	% On Time
Unscheduled Care	23	12	52%
Operations	0	0	N/A
Community	6	4	67%
Mental Health	3	3	100%
Womens / Childrens	2	1	50%
Scheduled Care	5	3	60%
Estates / Facilities	9	4	44%
Therapies	2	2	100%
Corporate Nursing	1	1	100%
Primary Care	1	1	100%
Workforce & OD	0	N/A	N/A

The Community and Integrated Medicine CCG (based on the former Unscheduled Care and Community Directorates) demonstrated a notable improvement in RIDDOR timeliness compliance, achieving 73% in 2025/26, compared with 52% and 67% respectively in 2024/25.

Estates and Facilities (E&F), achieved a compliance rate of 55% in 2025/26, representing an improvement from 44% in 2024/25. Performance has been above 60% for much of 2025/26, however, this position was adversely affected by two late RIDDOR submissions in the last two months of the reporting period.

The remaining CCGs reported very low numbers of RIDDOR reportable incidents in 2025/26, as a result the findings are not statistically significant, with results reflecting small volumes i.e. 1/1 reported on time (100%) or 1/2 (50%).

These findings will be raised for discussion at the CCG QHS meetings attended by the HSS Team in May 2026.

Argymhelliad / Recommendation

The Health & Safety Committee is asked to:

TAKE ASSURANCE that the Health Board is operating in compliance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	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 a Sgôr 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
Amcanion Cynllunio Planning Objectives	1 Workforce Stabilisation 9 Digital plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

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 Pwyllgor Ansawdd Iechyd a Diogelwch: Parties / Committees consulted prior to Health and Safety Committee:	Key stakeholders.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	No direct costs.
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.
Risg: **Risk:**	Risk to health and safety management.
Cyfreithiol: **Legal:**	A breach of health and safety regulations, such as the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR), 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 **10:20 AM, 10 Mins**

2.3 - Fire Regulation Assurance Report Update

Simon Chiffi (Hywel Dda UHB - Head of Operations)

For assurance

Attachments

HSC SBAR Boris FRA Update April 2025.pdf

Appendix A.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	05 May 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Fire Safety Risk Assessment System (Boris)
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	James Severs, Executive Director of Allied Health Professions and Health Science
SWYDDOG ADRODD: REPORTING OFFICER:	Simon Chiffi, Head of Estates Operations

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 to the Health and Safety Committee (HSC) in relation to the Fire Safety Risk Assessment System (Boris) used by Hywel Dda University Health Board (HDdUHB). Following recent concerns raised at HSC in March 2026 on the scale and quantity of outstanding actions from fire risk assessments (FRAs).

This report also offers a brief explanation on how the Boris system has been developed, it's current functionality and reporting, along with the improvements being considered to assist with improved ownership of actions.

Cefndir / Background

HDdUHB is required by fire safety law, the Regulatory Reform (Fire Safety) Order 2005 to undertake suitable and sufficient FRAs of our premises, accurately record the information and escalate all significant findings to the nominated responsible persons. This mechanism is clearly articulated as part of our approved Fire Safety Policy.

To enable the Health Board (HB) to achieve this, the Boris system was introduced in 2021 as a direct result of significant limitations experienced with the previous fire safety system hosted by NHS Wales Shared Services Partnership Specialist Estates Services (NWSSP-SES). A decision was made by the Fire Safety Team (FST) and agreed by the Fire Safety Group (FSG) to a acquire a new, more advanced system for the HB. Which the HB were able (and still are) to customise and develop to their own specifications.

The Boris system boasts many advanced features such as handheld tablet data gathering and data entry of FRAs, moving away from the older paper-based system. At the time of development advanced reporting and interrogating of data, including ownership of FRA actions across the entire HB.

The HB has also worked closely with the Boris developers to produce a detailed risk dashboard as shown in Appendix A, specifically designed by the Hospital General Managers to offer a greater level of visibility of risk and increased assurance. This data is now being tabled

at all FSG meetings and by all fire safety sub-groups across the HB to communicate the quantity of actions in Boris.

Despite the investment in the Boris system there still remains a significant quantity of risk actions outstanding, which the HB are ultimately carrying. Although we are regularly evidencing reduction of actions over time as part of FSG reporting (noted below) and fully acknowledge that due to the ever-evolving risk assessment process we will always have risks to manage, it is still felt that the scale of remaining items is a concern for the HB.

This report therefore sets out our assessment of where it is believed that improvements can be made to address these concerns.

Asesiad / Assessment

In order to provide some initial context, the Boris system currently records 338 live FRAs within the system for the HB, ensuring all clinical and non-clinical areas are assessed by the appropriate acute based Fire Safety Advisor. Each FRA has approximately 54 questions (with some questions triggering additional questions depending on response), thus potentially generating a significant amount of data (risk actions) from a question set of circa >18k questions across the FRA range. Whilst also taking into consideration the scale, complexity and estate condition / backlog challenges experienced as a HB.

On completion, or release of an FRA the document is issued automatically by Boris system to the nominated responsible person and all actions that are identified within the FRA are assigned an appropriate action owner. The action owners are prompted to access the system to address the actions that have been assigned to them within agreed timelines specified by the FRA. Each action will have been issued with a specific timeframe determined by the assessor to address the action, with particular focus on any extreme or high-risk items as a priority. Once these are completed, they are issued to the action approver (a more senior member of staff) for final approval/closure and removal from the system. The system was intentionally designed with a two-stage approval process and agreed by the FSG.

In order to simplify the identification of risk actions, the Boris system has been developed to ensure risk criteria scores for each action match the HB's own risk score system which are:

- Extreme (15-25)
- High (8-12)
- Moderate (4-6)
- Low (0-3)

All risk actions within the system are assigned to one of two ownership areas: Estates (building fabric, structural issues, etc.) or Hospital General Management (HM) (ward housekeeping, storage, fire doors wedged open, etc.).

All risks have been assigned to a specific individual to ensure total clarity and accountability.

The following table below (Table 1.0) has been included to provide an overview of the current number of Boris actions by risk category that are held in the system. It is also used to evidence trend analysis and show where the HB has reduced the number of actions in the system noting there are currently no extreme risks to manage.

Table 1.0 Boris Table of Actions – Trend Analysis

Date	Extreme Estates	Extreme HM	High Estates	High HM	Mod Estates	Mod HM	Low Estates	Low HM
Sept 25	0	0	889	620	1724	1117	214	187

Nov 25	0	0	808	547	1674	1089	225	153
Early Feb 26	0	0	655	435	1535	981	254	145
March 26	0	0	653	451	1503	974	202	147
April 26	0	0	615	425	1479	993	200	156

Despite recent efforts by the Fire Safety Team to promote Boris training workshops via Microsoft Teams, aimed at supporting staff responsible for managing actions, it is acknowledged that further improvement is needed.

The Boris system was not designed to allow the extraction of data by clinical care group (CCG) ownership. It simply allows data extraction by Site and Area. The Head of Estates Risk and Compliance, in conjunction with the Interim-Head of Fire Safety are working to progress the actions within the FRA Action Improvement Plan (table 1.0) below:

Action No	Action Description	Action Timescale	Action Owner
1	Prepare data by Clinical Care Group for oversight and management within local integrated governance meetings.	01.07.2026	Head of Estates Risk & Compliance
2	BORIS system will be configured to enable reminder notifications to each action owner to prompt completion.	31.07.2026	Head of Estates Risk & Compliance
3	Improve access to BORIS system by adding BORIS icon for all computers on start-up.	30.06.2026	Head of Estates Risk & Compliance
4	Review BORIS approval process from two-stage approval to one-stage approval to expedite BORIS reviews.	29.05.2026	Head of Estates Risk & Compliance
5	Develop a process for ensuring action owners are updated in a timely manner.	29.05.2026	Head of Estates Risk & Compliance

Table 1.0 - FRA Action Improvement Plan

It is acknowledged that, despite these enhancements, the system will inevitably continue to record some actions where the associated risks are more complex or challenging to address. In many instances, these actions require capital investment and may therefore remain open within the system for longer periods.

It is also recognised that a significant proportion of Estates-led actions requiring funding are linked to the major fire enforcement programmes currently underway, alongside Targeted Estates Funding (TEF) and specific capital bids submitted by Estates managers. As these programmes are completed, a substantial number of related actions within Boris will be progressed and closed. This has been a key contributing factor in the significant reduction of over 250 High Risk Estates-led actions since September 2025.

The Health and Safety Compliance Group will maintain oversight of the actions outlined in the table 1.0 above to ensure progress in achieved in line with the proposed timescales.

Argymhelliad / Recommendation

The Health and Safety Committee is requested to:

- **Receive assurance** from the Fire Safety Risk Assessment System (Boris) report with specific reference to FRA Action Improvement Plan (table 1.0)
- **Note** the progress since September 2025 to reduce the number of outstanding FRAs
- **Note** the monitoring of the FRA Action Improvement Plan (table 1.0) by the Health and Safety Compliance Group.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.11 Ensure reports and factual information from external regulatory agencies are acted upon within achievable timescales.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Estates and Facilities Risk No 813 Score 15
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 3. Effective
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	2. Healthier communities 3. Great care
Amcanion Cynllunio Planning Objectives	8 Estates plans
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	From the HB's approved and ratified Fire Safety Policy and the Legislation and Guidance referenced to in the report.
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.

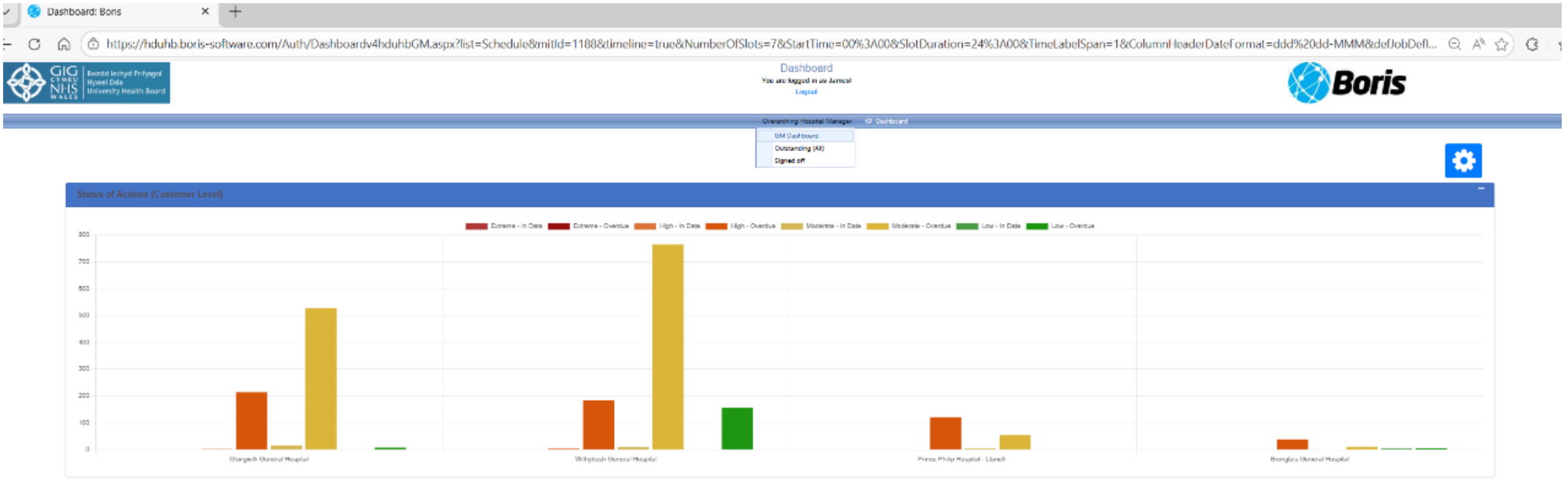
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd Iechyd a Diogelwch: Parties / Committees consulted prior to Health and Safety Committee:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Funding sought from Welsh Government.
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Delivering a safe working environment
Risg: Risk:	Estates and Facilities Risk No 813
Cyfreithiol: Legal:	Potential for legal challenge if HDdUHB does not comply with requirements of Fire Enforcement Notices.
Enw Da: Reputational:	Potential for legal challenge if HDdUHB does not comply with requirements of Fire Enforcement Notices.
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

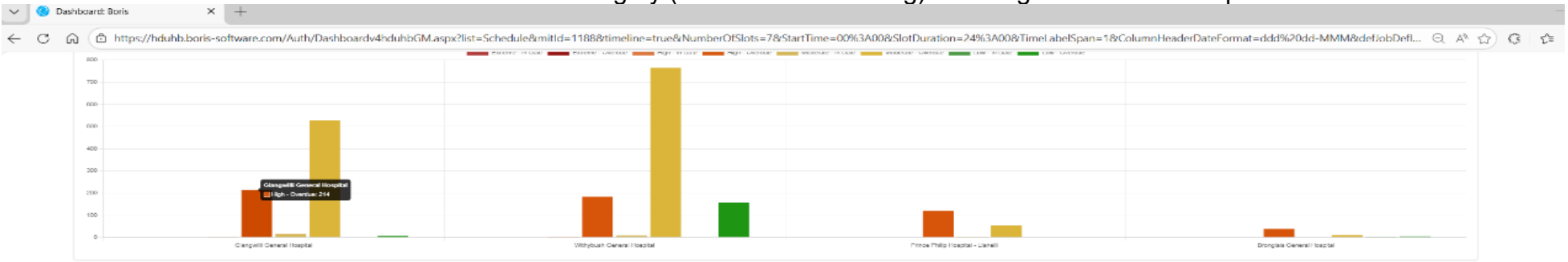
Appendix A – Boris Risk Dashboard

From the home screen, nominated managers can select GM Dashboard (live) and the following acute sites will display, or you can select outstanding all or items signed off. In addition, the KPI dashboard is also available to use.

The following acute sites are on this profile.



On selecting one of the bar chart values for GGH site, the following (STATUS OF ACTIONS) locations table is created below detailing the site, location of FRA and number of actions in each risk category (in date or outstanding) including what's been completed.



Status of Actions (Locations)

Customer	Location	Extreme - Overdue	Extreme - In Date	High - Overdue	High - In Date	Moderate - Overdue	Moderate - In Date	Low - Overdue	Low - In Date	Completed
Glangwili General Hospital	Block 07 FF - Main Kitchen & Dining Room	0	0	20	0	5	0	0	0	0
Glangwili General Hospital	Block 32 SF Theatre 6	0	0	18	0	5	0	5	0	0
Glangwili General Hospital	Block 08 FF - Public Health Wales	0	0	17	0	18	0	0	0	2
Glangwili General Hospital	Block 32 FF - Day Surgical Unit & Urology Offices	0	0	13	0	8	0	0	0	0
Glangwili General Hospital	Block 24 GF - Dialysis Centre	0	0	12	0	8	0	0	0	1
Glangwili General Hospital	Block 14 Boiler House (All levels)	0	0	11	0	5	0	0	0	4
Glangwili General Hospital	Block 22 Ty Cadell	0	0	9	0	8	0	0	0	3
Glangwili General Hospital	WB3 - GF - Cilgerran Ward & PACU	0	0	8	0	8	0	0	0	0
Glangwili General Hospital	Block 08 FF - Pathology Department	0	0	7	0	21	0	0	0	1
Glangwili General Hospital	Block 18S Children's centre (Ty Arthur)	0	0	7	0	12	0	0	0	0
Glangwili General Hospital	Block 31 GF - Emergency Unit & MRI Scan	0	0	6	0	21	0	0	0	0
Glangwili General Hospital	Block 32 GF - Endoscopy Unit	0	0	5	0	8	0	0	0	0

Users can then select any of the values from the table above and obtain specific detail (Action Detail), for example High Outstanding (13) for Block 32 FF DSU was selected. The following report is generated for 13 actions. Indicating the action No, Action description, Date of FRA, Action Owner, Due Date.

Action Details

Action No	Action	Date of FRA	Action Owner	Due Date
10244/2	Finding: The urology office has a fridge, microwave, and kettle in it, placed on a trolley with the microwave. Action: The microwave & fridge must be removed ASAP and placed inside a designated kitchen area and not kept inside the urology offices. As the escape route is shared by departments housing complex highly vulnerable patients, a fire within the urology offices could potentially compromise the evacuation strategy for the DSU department.	27-02-2026	Fiona James	28-02-2026
10244/1	Finding: Managers/ staff to ensure that all portable electrical appliances are included within the PAT programme and carry out regular visual checks to ensure the wiring and extension leads have not been damaged. Extension leads should not be used for portable heaters, fans, kettles, fridges, microwaves, etc. For longer-term use of electrical equipment, additional wall mounted sockets should be fitted instead of the use of extension leads. Fridges and microwave ovens in office areas. Action: Fridge and microwave in urology office, the microwave & fridge must be removed ASAP and placed inside a designated kitchen area and not kept inside the urology offices. As the escape route is shared by departments housing complex highly vulnerable patients, a fire within the urology offices could potentially compromise the evacuation strategy for the DSU department.	27-02-2026	Fiona James	28-02-2026
10244/4	Finding: Fire and smoke dampers are fitted to the ventilation system. These are serviced, checked, and maintained by an external contractor on behalf of the estates department. The date of last inspection 03.04.2025 next inspection due 02.04.2026 continue to maintain and manage in accordance with BS 9999. However, it was noted that a number of deficiencies were present at the time of the inspection. These Damper systems should be maintained and managed in accordance with BS 9999 Action: Complete all actions listed in the engineers' report and the recommended survey highlighted in section A 3.7 of this report	27-02-2026	Andrew Stephens.	28-02-2026
10244/5	Finding: Managers to liaise with FSA & estates department to update evacuation plan. Action: This document needs to be reviewed following the identification of significant fire safety defects within the building.	27-02-2026	Andrew Stephens.	28-02-2026
10244/10	Finding: The current secondary means of escape is not compliant with Firecode requirements and is unsuitable for the occupancy of high-risk patients undergoing long, invasive procedures under general anaesthesia. As a consequence, the department is effectively reliant on a single direction of escape. This arrangement significantly exceeds the limits permitted under multiple fire safety regulations, including the provisions of WHTM 05-02. Action: A practical evacuation drill was conducted to assess the use of the secondary staircase. The drill demonstrated that evacuation via this route was extremely challenging, even in controlled conditions without the additional pressures and environmental factors associated with an actual fire. The time required for preparation, patient movement, and navigation of the restricted escape route was found to be unacceptable, particularly when considered alongside the identified deficiencies in fire compartmentation within the modular Yorkon Block 32 structure. Not with standing these concerns, the escape routes provided would be acceptable for ambulant occupants, including those with reduced mobility, provided they are physically capable of negotiating the narrow escape corridor.	27-02-2026	Judith Davies	28-02-2026
10244/1	Finding: The current secondary means of escape is not compliant with Firecode requirements and is unsuitable for the occupancy of high-risk patients undergoing long, invasive procedures under general anaesthesia. As a consequence, the department is effectively reliant on a single direction of escape. This arrangement significantly exceeds the limits permitted under multiple fire safety regulations, including the provisions of WHTM 05-02. Action: All doors fitted were with security devices easily opened in the event of an emergency. Managers continue to manage.	27-02-2026	Andrew Stephens.	28-02-2026
10244/2	Finding: The current secondary means of escape is not compliant with Firecode requirements and is unsuitable for the occupancy of high-risk patients undergoing long, invasive procedures under general anaesthesia. As a consequence, the department is effectively reliant on a single direction of escape. This arrangement significantly exceeds the limits permitted under multiple fire safety regulations, including the provisions of WHTM 05-02. Action: Estates to introduce annual cause-and-effect testing this testing should document and confirm the release of any locking devices required by the buildings evacuation strategy and cause-and-effect matrix this testing forms part of the maintenance requirements to accord with BS 5839 Part 1 section 43.3	27-02-2026	Andrew Stephens.	28-02-2026
10244/4	Finding: The current secondary means of escape is not compliant with Firecode and is unsuitable for the occupancy of high-risk patients undergoing long, invasive procedures under general anaesthesia. As a result, the department is effectively reliant on a single, unprotected direction of escape. This arrangement significantly exceeds the limits set out in multiple fire safety regulations, including the requirements of WHTM 05-02, which permits a maximum single-direction travel distance of 15 m for high-risk healthcare areas. Short-Term Measures: Management must immediately prohibit the use of general anaesthetic procedures within the Block 32 building, DSU. Robust admission controls must be implemented to ensure that any patient entering Block 32, DSU has the capacity for self-evacuation or assisted self-evacuation and is physically capable of navigating the narrow access corridor leading to the rear escape staircase. These measures are essential to maintain a safe evacuation strategy given the current constraints of the building. Action: Long-Term Measures: All remedial works identified within the Appendix M document must be completed to address the significant fire safety deficiencies and restore compliance with relevant Firecode requirements. As an alternative long-term option, consideration may be given to re-purposing Block 32, DSU for a lower-risk clinical activity. Should this approach be adopted, the fire evacuation strategy and associated building provisions must be reassessed and aligned with the revised risk profile of the area.	27-02-2026	Andrew Stephens.	28-02-2026
10244/11	Finding: The current secondary means of escape is not compliant with Firecode and is unsuitable for the occupancy of high-risk patients undergoing long, invasive procedures under general anaesthesia. As a result, the department is effectively reliant on a single, unprotected direction of escape. This arrangement significantly exceeds the limits set out in multiple fire safety regulations, including the requirements of WHTM 05-02, which permits a maximum single-direction travel distance of 15 m for high-risk healthcare areas. Measured travel distances significantly exceed these limits. These distances are therefore non-compliant for high-risk patient groups and do not meet the required standard for areas where general anaesthesia or highly invasive procedures are undertaken. However, for ambulant occupants—provided they are physically capable of navigating the narrow corridor system—the available escape routes offer travel distances that are acceptable when used as part of a two-direction means of escape arrangement. Action: Short-Term Measures: Management must immediately prohibit the use of general anaesthetic procedures within the Block 32, DSU. Robust admission controls must be established to ensure that any patient scheduled for treatment within Block 32, DSU, has the capacity for self-evacuation or assisted self-evacuation and is physically capable of navigating the narrow corridors leading to the rear escape staircase. These controls are essential given the current non-compliant means of escape arrangements and associated travel-distance constraints. Long-Term Measures: All remedial works identified within the Appendix M document must be completed to address the significant deficiencies in fire safety provisions, including compartmentation, means of escape, and supporting infrastructure. As an alternative long-term option, consideration may be given to re-profiling the clinical use of Block 32 to a lower-risk activity. Should this approach be adopted, the fire evacuation strategy and building fire precautions must be reviewed and aligned with the revised clinical risk profile.	27-02-2026	Judith Davies	28-02-2026
10244/12	Finding: At the time of the risk assessment, it would appear that the following rooms do not meet the criteria of fire resisting hazard room. Plant room situated through the back of the rear utility room had penetrations through the floor and ceiling area. Action: Compartmentation issues between floors. Guidance: Rooms should be upgraded to fire resisting hazard rooms ie plant room, the doors should be FD30s type, walls should provide 30 minutes fire resistance to the underside of the floor slab, alternatively the ceiling can provide the 30 minutes fire resistance. Any vents in the door should be fitted with smoke and heat dampers connected to the fire alarm system. Vents in ceilings should have fire dampers. Alternatively, all storage should be removed.	27-02-2026	Andrew Stephens.	28-02-2026
10244/13	Finding: Following inspection, ceiling tiles were lifted & dampers were not fire stopped going between compartment walls. This has highlighted areas where remedial works are required (breaches in compartmentation). There is no fire collar on cabling for the server / plant room between floors. Following an in-depth review undertaken during a period when the theatre was non-operational, multiple breaches of both horizontal and vertical fire compartmentation were identified. In the event of a fire within the department, these deficiencies would allow smoke and fire to spread rapidly, compromising adjacent rooms, circulation spaces, and designated escape routes. Compartmentation surrounding the equipment lift and the escape staircase was also found to be compromised, particularly where post-construction services had been installed without adequate fire stopping. Inspection of the interstitial floor voids revealed the presence of combustible materials and insulation, including areas where polystyrene was identified. These voids are unprotected and contain numerous unsealed vertical penetrations between sections of the structure. In their current state, these voids could act as a conduit for rapid fire spread, placing floors both above and below at immediate risk of early fire and smoke compromise. A full compartmentation survey for Block 32 has been completed as part of the Phase 2 Fire Improvement Scheme, and the associated remedial actions have been formally identified. Action: Short Term Measures: Management must immediately prohibit the use of general anaesthetic procedures within the Block 32 building (DSU). Robust admission controls must be implemented to ensure that any patient entering the day surgery unit has the capacity for self-evacuation or assisted self-evacuation and is physically capable of negotiating the narrow corridor leading to the rear escape staircase. These controls are critical given the current non-compliant means of escape and the associated compartmentation defects. Long-Term Measures: All remedial works identified within the Appendix M document must be completed to address the significant fire safety deficiencies within the building. As an alternative long-term strategy, management should consider re-profiling the clinical use of Block 32 to a lower-risk activity. Should this approach be adopted, fire precautions and evacuation arrangements must be reviewed and aligned with the revised risk profile. Part B contractors & Ops teams will be completing the Phase 2 scope of works on in-patient areas from 2026. There appears to be inappropriate compartmentation and sub-compartmentation provided throughout all floors of block 32.	27-02-2026	Judith Davies	28-02-2026
10244/5	Finding: A compartmentation survey has been completed at the hospital site and has highlighted a number of areas where compartmentation is compromised. Action: Cavity barriers should be included within the compartmentation work. Plans of cavities/walls should be produced as part of this work.	27-02-2026	Andrew Stephens.	28-02-2026
10244/14	Finding: The provision of escape lighting to the rear of the escape staircase is currently inadequate. The route contains multiple changes in direction and level, all of which must be appropriately illuminated as part of a compliant emergency lighting system. These features require specific consideration to ensure safe evacuation under emergency conditions. The existing emergency lighting installations are maintained by the Estates Department as part of the Planned Preventive Maintenance (PPM) inspection programme; however, the present provision does not meet the requirements necessary for a safe and compliant means of escape. Action: Management must review the existing emergency escape lighting provision, ensuring it accounts for the extended travel distances and the need for safe re-entry into the building, in accordance with the requirements of BS 5266. Additional luminaires must be installed where necessary to provide adequate illumination throughout all changes in direction, level, and other high-risk points along the escape route. The system must continue to be inspected, tested, and maintained in full compliance with BS 5266 as part of the Estates Department's ongoing Planned Preventive Maintenance (PPM) programme.	27-02-2026	Andrew Stephens.	28-02-2026

EXPORT

2.4

10:30 AM, 10 Mins

2.4 - Health and Safety Inspection Actions

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

For assurance

Attachments

SBAR H_S Inspection Actions May 26 V1.0.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	05 May 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Site Visit Report and Associated Actions
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) to provide an update on the management of actions from health and safety (H&S) inspections. The report focuses on the monitoring of historic H&S inspection actions from the risk stratification exercise.

Cefndir / Background

The Health, Safety and Security (HSS) Team complete an ongoing programme of H&S inspections of each department, ward and building currently managed by Hywel Dda University Health Board (HDdUHB). The purpose of the inspections is to ensure compliance with health and safety legislation and provide guidance and recommendations as part of a continuous improvement process.

An Internal Audit of Health and Safety in 2024 was critical of the inspection process, commenting *'Actions are assigned a priority rating but this is based on how quickly an issue can realistically be addressed rather than the significance or urgency. A central log of actions is not maintained – these are detailed only within individual site reports, and actions are not monitored through to implementation by the H&S Team, with reliance placed on the site manager/lead to provide updates. Consequently, there is no oversight of the significance of issues raised or outstanding'*.

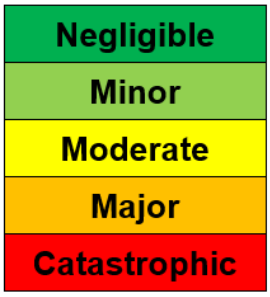
In response, the HSS Team pursued two routes to improve H&S inspection performance:

1. Undertaking a risk stratification exercise in order to quantify / visualise the risk of the outstanding unmanaged/unresolved risks from the visits undertaken in 2023 and 2024;
2. Creating a new improved system for all inspections going forwards, utilising the Audit Management and Tracking System (AMaT) that is used elsewhere in HDdUHB.

Risk Stratification

The HSS Team proceeded to review every outstanding unmanaged / unresolved risk from the inspections undertaken in 2023 and 2024 and assess whether the outstanding risks posed by

the action was negligible, minor, moderate, major or catastrophic, and colour coded using the recognised green to red risk-rating convention, as shown adjacent. The purpose of the risk-rating is to help managers focus their attention on the hazards that pose the highest risk and help prioritise corrective actions.



Early assurance was taken from the risk stratification exercise that there were no outstanding unmanaged / unresolved risks rated as catastrophic. The completed list was split by Clinical Care Group (CCG) and taken to all of the CCG Quality, Health and Safety meetings attended by the HSS Team in July/August 2025. The totals in each risk category by CCG are outlined in table 1.0 below:

N/A	Resolved	Managed	Negligible	Minor	Moderate	Major	Catastrophic
Primary Care Clinical Care Group (to include Medicines Management)							
0	1	25	8	54	28	5	0
Planned and Specialist Care Clinical Care Group							
0	1	22	2	27	13	2	0
Allied Health and Health Sciences Clinical Care Group							
0	2	25	0	17	7	3	0
Estates and Facilities Group							
1	1	78	4	62	68	7	0
Mental Health and Learning Disabilities Clinical Care Group							
0	18	122	18	168	75	25	0
Community and Integrated Medicine Clinical Care Group							
15	16	225	19	245	156	33	0
Other							
0	1	48	0	43	20	4	0

Table 1.0: Risk actions by CCG/ function as of August 2025

The CCGs were requested to instruct their managers to review all outstanding actions and provide feedback to the HSS Team for central monitoring and reporting. The HSS Team recommended that negligible and minor risks be tolerated, allowing focus to shift toward reducing the 82 major and 375 moderate risks identified i.e. those that pose a higher level of concern. However, it remained the responsibility of each CCG to determine the level of risk they were willing to tolerate.

Action owners were asked to report the status of their outstanding actions to the HSS Team, indicating whether each action had been:

- Resolved or eliminated;
- Mitigated to a minor or negligible level;
- Was being actively managed or tolerated;
- Or was still outstanding.

A process document covering the requirements of the risk stratification exercise was approved by the Estates and Facilities Clinical Care Group, Integrated Governance Group Quality, Health and Safety meeting in August 2025 then escalated to the Integrated Quality, Financial Performance and Delivery Group (IQFPDG).

New H&S Inspection Process

Following the risk stratification process the HSS Team temporarily paused their site visit programme to concentrate on exploring the feasibility of utilising AMaT. The temporary pause continued following the departure of the previous Head of Health, Safety and Security.

A new control document (1389 - Health and Safety Site Inspection Procedure) detailing the new and improved H&S inspection process has been approved by the Health and Safety Compliance Group. Once the new Head of Health and Safety is in position, the new audit programme is expected to commence in Q2 2026 27. As per the new procedure, all new H&S inspections will have a report issued and all moderate, major and catastrophic hazards identified, and their recommended corrective actions will be logged on AMaT.

Asesiad / Assessment

Since this time, there has been limited progress in the reduction of the number of actions aligned to each CCG except for Health Records, which resulted in a reduction in moderate risks from 19 to 3 and a reduction of major risks from 4 to 0.

Further work has taken place, supported by the Deputy Chief Operating Officer in early 2026 to ensure CCGs/functions had clarity of the work required to mitigate outstanding actions.

The total for each category of risk, categorised by each CCG/ function as of April 2026 is outlined in table 2.0 below:

	N/A	Resolved	Managed	Negligible	Minor	Moderate	Major	Catastrophic
	Community and Integrated Medicine Clinical Care Group							
At 08/07/25	15	16	225	19	245	156	33	0
At 30/11/25	22	48	212	14	212	125	27	0
At 16/04/26	23	56	216	14	249	89	22	0
	Primary Care Clinical Care Group (to include Medicines Management)							
At 08/07/25	0	1	25	8	54	28	5	0
At 30/11/25	0	1	20	6	61	32	5	0
At 16/04/26	0	9	22	5	63	26	5	0
	Planned and Specialist Care Clinical Care Group							
At 08/07/25	0	1	22	2	27	13	2	0
At 30/11/25	0	2	28	2	29	16	3	0
At 16/04/26	0	2	25	2	27	12	2	0
	Allied Health and Health Sciences Clinical Care Group							
At 08/07/25	0	2	25	0	17	7	3	0
At 30/11/25	0	2	26	0	17	6	3	0
At 16/04/26	0	2	26	3	18	5	0	0
	Estates and Facilities Group							
At 08/07/25	1	1	78	4	62	68	7	0
At 30/11/25	1	1	78	4	62	68	7	0
At 16/04/26	1	10	86	4	64	53	3	0
	Mental Health and Learning Disabilities Clinical Care Group							
At 08/07/25	0	18	122	18	168	75	25	0
At 30/11/25	6	19	131	18	171	70	24	0
At 16/04/26	6	20	131	18	173	69	22	0
	Health Records							
At 08/07/25	0	0	41	0	37	19	4	0
At 30/11/25	0	14	47	0	37	3	0	0
At 16/04/26	0	14	47	0	37	3	0	0
	Other							
At 08/07/25	0	1	15	3	22	8	3	0
At 30/11/25	0	1	21	6	26	9	3	0
At 16/04/26	0	1	22	6	32	4	1	0

Table 2.0: Progress of risk actions by CCG/ function as of 16 April 2026
Note: Some inspection actions were originally assigned to the incorrect CCG, hence some scores have increased where actions have been reassigned.

A copy of the full risk stratification master as of 16 April 2026 can be found in Appendix 1 of this report. The above figures were reported to the April CCG/ function governance via the Health, Safety and Security Summary Reports (except for Health Records, and 'Other'). Table 3.0 (below) shows the progress made by each of the CCG/ function towards specifically addressing their moderate and major risks.

	Moderate	Major	
Community and Integrated Medicine Clinical Care Group	156 to 89	33 to 22	Progress
	67	11	Reduction
	33%	43%	% Reduction
Primary Care Clinical Care Group (Now part of CIM)	32 to 26	5 to 5	Progress
	6	0	Reduction
	19%	0	% Reduction
Planned and Specialist Care Clinical Care Group	16 to 12	3 to 2	Progress
	4	1	Reduction
	25%	33%	% Reduction
Allied Health and Health Sciences Clinical Care Group	7 to 5	3 to 0	Progress
	2	3	Reduction
	29%	100%	% Reduction
Estates and Facilities Group	68 to 53	7 to 3	Progress
	15	4	Reduction
	22%	57%	% Reduction
Mental Health and Learning Disabilities Clinical Care Group	75 to 69	25 to 22	Progress
	6	3	Reduction
	8%	12%	% Reduction
Health Records	19 to 3	4 to 0	Progress
	16	4	Reduction
	84%	100%	% Reduction
Other	9 to 4	3 to 1	Progress
	5	2	Reduction
	56%	66%	% Reduction
Overall Total	367 to 261	79 to 55	Progress
	106	24	Reduction
	29%	30%	% Reduction

Table 3.0: Progress of risk actions addressed by CCG/ function between August 2025 and April 2026.

Overall progress can also be found at the base of the table. A 29% reduction in Moderate risks and a 30% reduction in Major risks has been achieved by the exercise.

Each CCG/ function have been asked to consider actions from their respective risks and how these will be managed locally within a given time scale.

The Health and Safety Compliance Group will maintain oversight of the actions outlined in the table 2.0 and table 3.0 above to ensure progress in achieved in line with the proposed timescales.

Argymhelliad / Recommendation

The Health & Safety Committee is asked to:

- **Take assurance** from the Site Visit Report and Associated Actions that the H&S inspection risk stratification work has enabled the Health Board to understand and manage the residual risks from historic HSS Team inspections.
- **Note** the monitoring of the Health and Safety Actions (table 2.0 and table 3.0) by the Health and Safety Compliance Group.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	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 a Sgôr 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
Amcanion Cynllunio Planning Objectives	1 Workforce Stabilisation 9 Digital plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

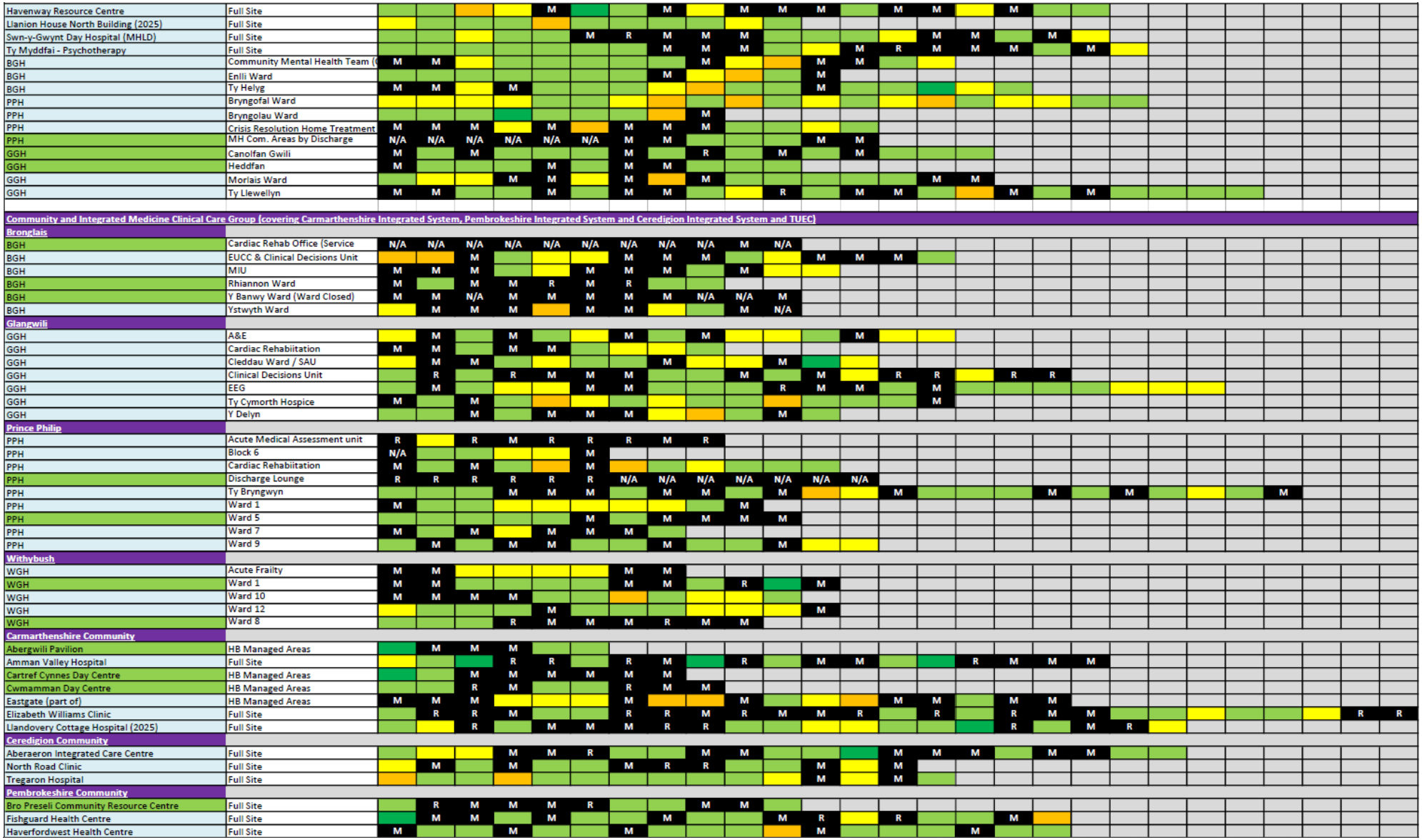
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Contained within the body of the report and associated Health Board policies.
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd Iechyd a Diogelwch: Parties / Committees consulted prior to Health and Safety Committee:	All CCG IGG QHS Meetings

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

Appendix 1: Risk Stratification Master on 16 April 2026

Key: Negligible | Minor | Moderate | Major | Catastrophic

Site Name	Department	Action 1	Action 2	Action 3	Action 4	Action 5	Action 6	Action 7	Action 8	Action 9	Action 10	Action 11	Action 12	Action 13	Action 14	Action 15	Action 16	Action 17	Action 18	Action 19	Action 20	Action 21	Action 22	Action 23	Action 24	Action 25	Action 26	Action 27
Primary Care Clinical Care Group (to include Medicines Management)																												
Ashgrove Medical Centre (2025)	Full Site																											
Johnston Surgery (Branch Surgery)	Full Site	M		M		M	M							M			M											
Meddygfa Minafon - (Kidwelly) (2025)	Full Site																											
Meddygfa'r Sarn - Pontyates Surgery (2025)	Full Site																											
Neyland Health Centre	Full Site																											
Solva Surgery	Full Site	M							M		M			M	M			M	M	R	M							
Tenby Surgery	Full Site			M	R	M	M		R	M	R		M			M		R	M	R	M		M	R	R	R		
Planned and Specialist Care Clinical Care Group (covering Scheduled Care, Cancer & Oncology, and Children, Women & Family Health Clinical Service Groups)																												
BGH	Endoscopy	M			M																							
BGH	Theatres			M	M			M	M																			
GGH	Labour Ward / Delivery Room	M		M		M	M			M																		
GGH	Picton Ward	M							M	M	M																	
GGH	Outpatients						M			R	M	M	M		R													
PPH	Breast Care (Ward 7)																											
Blk 24 Stradey - School Nurses (part 1F)	HB Managed Areas	M			M		M			M		M	M															
Allied Health and Health Sciences Clinical Care Group																												
BGH	Pathology	M	M	R	M	R		M			M	M		M	M													
BGH	Podiatry & Surgical Appliances	M	M	M							M																	
GGH	Mortuary			M			M	M			M	M	M	M		M												
WGH	Physiotherapy	M		M	M						M	M	M															
Estates and Facilities Group																												
BGH	External Areas		M		M				R					M														
BGH	Medical Gas Stores				M	M		M	M	M	M																	
Tregaron Hospital	Medical Gas Stores	M					M		M																			
GGH	Boiler Room	M		M	M	M				M	M	M			M													
GGH	External Areas	M					M		M		M	R		M														
GGH	Gwili Railway Carpark	M	M	M	M	M	M	M	M	M																		
GGH	Medical Gas Stores		M					M			M	M	M	M														
Llandovery Cottage Hospital	Medical Gas Stores				M		M	M	M																			
PPH	Block 5 (H&S Office)	N/A		M	M	R	M		M	R	M	R	M															
PPH	External Areas			M					M									M		M	M							
PPH	Hotel Services - Housekeeping,																											
PPH	Hotel Services, Estates & Facilities																											
PPH	Medical Gases Stores		M						M	M	M	M	M	M			M		M									
Amman Valley Hospital	Medical Gas Stores							M	M	M	M	M																
WGH	Medical Gas Stores					M		M	M	M																		
WGH	Waste Compound Area	R	M	M	M					M		M	R	M	R	M	R											
South Pembrokeshire Hospital	External Areas				M			M	R	M	M	M	M															
Mental Health and Learning Disabilities Clinical Care Group																												
22 Wellfield Road (MHLD)	Full Site	M			M	M		M										M	M		M							
Brynmair Clinic (MHLD)	Full Site	M		M		M		M			M				M			M										
Canolfan Bro Cerwyn St Nons and St Caradogs	Bro Cerwyn centre	R	R		M			M			M			M	M	M	M				M							
Canolfan Bro Cerwyn St Nons and St Caradogs	St Brynach Day Hospital					M	M	M	M				M	M	M	M	M												
Canolfan Bro Cerwyn St Nons and St Caradogs	St Caradog Ward	M				M								M				M	R		M							
Canolfan Bro Cerwyn St Nons and St Caradogs	St Non's Ward		R	R		R		R	R	R								R	R		R							
Gorwelion (MHLD)	Full Site		M	R	R	R			R	M			M	M	M	M			M									
Hafan Derwen	Cwm Seren - Low Secure Unit									M		M		M	M	M												
Hafan Derwen	Cwm Seren - PICU			M		M																						
Hafan Derwen	Block 5 (St Brides)			M	M																							
Hafan Derwen	Block 6 (Ty Bryn)	M			M		M																					
Hafan Hedd (MHLD)	Full Site						M	M	M	M	M						M											



Havenway Resource Centre	Full Site					M			M		M	M	M		M	M		M												
Llanion House North Building (2025)	Full Site																													
Swn-y-Gwynt Day Hospital (MHLD)	Full Site						M	R	M	M	M						M	M		M										
Ty Myddfai - Psychotherapy	Full Site								M	M	M			M	R	M	M	M		M										
BGH	Community Mental Health Team (	M	M							M			M	M																
BGH	Enlli Ward								M				M																	
BGH	Ty Helyg	M	M		M								M																	
PPH	Bryngofal Ward																													
PPH	Bryngolau Ward									M																				
PPH	Crisis Resolution Home Treatment	M	M	M		M		M	M	M																				
PPH	MH Com. Areas by Discharge	N/A	N/A	N/A	N/A	N/A	N/A	M	M				M	M																
GGH	Canolfan Gwili	M		M				M		R		M		M																
GGH	Heddfan	M				M		M	M																					
GGH	Morlais Ward				M	M		M		M								M	M											
GGH	Ty Llewellyn	M	M			M		M	M			R		M	M					M		M								
Community and Integrated Medicine Clinical Care Group (covering Carmarthenshire Integrated System, Pembrokeshire Integrated System and Ceredigion Integrated System and TUEC)																														
Bronglais																														
BGH	Cardiac Rehab Office (Service	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	M	N/A																		
BGH	EUCC & Clinical Decisions Unit			M				M	M	M			M	M	M															
BGH	MIU	M	M	M			M	M	M		M																			
BGH	Rhiannon Ward	M		M	M	R	M	R																						
BGH	Y Banwy Ward (Ward Closed)	M	M	N/A	M	M	M	M	M	N/A	N/A	M																		
BGH	Ystwyth Ward		M	M	M		M	M			M	N/A																		
Glangwili																														
GGH	A&E		M		M			M		M				M																
GGH	Cardiac Rehabiitation	M	M		M	M																								
GGH	Cleddau Ward / SAU		M	M					M			M																		
GGH	Clinical Decisions Unit		R		R	M	M	M			M		M		R	R		R	R										
GGH	EEG		M				M	M				R	M	M		M														
GGH	Ty Cymorth Hospice	M		M												M														
GGH	Y Delyn			M		M	M	M				M																		
Prince Philip																														
PPH	Acute Medical Assessment unit	R		R	M	R	R	R	M	R																				
PPH	Block 6	N/A					M																							
PPH	Cardiac Rehabiitation	M		M			M																							
PPH	Discharge Lounge	R	R	R	R	R	R	N/A	N/A	N/A	N/A	N/A	N/A	N/A																
PPH	Ty Bryngwyn				M	M	M		M	M		M			M				M		M		M			M				
PPH	Ward 1	M									M																			
PPH	Ward 5						M		M	M	M	M																		
PPH	Ward 7	M		M		M	M	M																						
PPH	Ward 9		M		M	M			M			M																		
Withybush																														
WGH	Acute Frailty	M	M					M	M																					
WGH	Ward 1	M	M					M	M		R		M																	
WGH	Ward 10	M	M	M	M																									
WGH	Ward 12					M							M																	
WGH	Ward 8				R	M	M	M	R	M	M																			
Carmarthenshire Community																														
Abergwili Pavilion	HB Managed Areas		M	M	M																									
Amman Valley Hospital	Full Site				R	R		R	M		R		M	M				R	M	M	M									
Cartref Cynnes Day Centre	HB Managed Areas			M	M	M	M	M	M																					
Cwmamman Day Centre	HB Managed Areas			R	M			R	M	M																				
Eastgate (part of)	HB Managed Areas	M	M	M				M			M				M	M			M	M										
Elizabeth Williams Clinic	Full Site		R	R	M			R	R	M	R	M	M	R		R		R	M	M								R	R	
Llandovery Cottage Hospital (2025)	Full Site			R		M	M	M	R	R									R		M	R								
Ceredigion Community																														
Aberaeron Integrated Care Centre	Full Site				M	M	R			M	M				M	M	M		M	M										
North Road Clinic	Full Site		M		M			M	R	R			M		M															
Tregaron Hospital	Full Site												M		M															
Pembrokeshire Community																														
Bro Preseli Community Resource Centre	Full Site		R	M	M	M	R			M	M																			
Fishguard Health Centre	Full Site		M	M		M			M			M	R		R			M												
Haverfordwest Health Centre	Full Site	M			M			M					M				M													

Milford Haven Health Centre	Full Site						M	M				N/A																			
Narberth Health Centre	Full Site	M	R					M			M																				
New Tenby Hospital (22/08/23)	Full Site																														
Pembroke Dock Health Centre	Full Site	M					M						M	M		M															
South Pembrokeshire Hospital	Archives, Basement & Main	M	M							M			M	M				M	M												
South Pembrokeshire Hospital	Cleddau Ward		M								M			M																	
South Pembrokeshire Hospital	Sunderland Ward	M				M			M			M	M			M															
South Pembrokeshire Hospital	Full Site					M				M							R	M	R												
Health Records																															
BGH	Medical records	M		M		T	R			M	R																				
GGH	Medical Records (Health Records)	M		M	M	R			M		R																				
PPH	Medical Records (Health Records)				M		M		M																						
WGH	Health Records (Medical Records)	R	M		M	M	M	R	T																						
WGH	Health Records (Filing Library)	M			R		M			M																					
Stradey Business Centre - Unit 2	Full Site	M	M	M			M	M	M		R	M	M	R	M	M	M		R	M											
Stradey Business Centre - Unit 4	Full Site	R		M	M			R	T			M	M	M			M	M													
Dafen Ind. Est. - Unit 3	Full Site	R	M	M	M	M	M	M		M	M		M	R		M	M														
Other																															
BGH	Clinical Coding Department	M	M			M	R	M																							
Brynteg (Branch Surgery)	Full Site	M				M					M		M	M	M																
GGH	Library		M			M	M																								
Hafan Derwen	Block 1 & 3			M			M		M				M	M																	
Hafan Derwen	Block 4				M		M																								
Hafan Derwen	Block 7 (Tudor, Ystwyth, Alun)					M			M																						

Key to the current table:

M = Managed / Tolerated Risk

R = Resolved / Eliminated / Addressed Risk

Coloured Green – Red = Actions that, to the knowledge of the HSS Team, have not yet been addressed.

2.5

10:40 AM, 10 Mins

2.5 - New Health and Safety Inspection Process

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

For assurance

Attachments

New Health and Safety Inspection Process.pdf

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	05 May 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	New Health and Safety Inspection Process
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) to provide assurance relating to the new health and safety inspection process.

Cefndir / Background

The purpose of the health and safety inspection process is to ensure compliance with health and safety legislation and provide guidance and recommendations as part of a continuous improvement process.

Asesiad / Assessment

A new control document (1389 - Health and Safety Inspection Procedure) details the new H&S inspection process has been developed to ensure compliance with health and safety legislation across the Health Board.

Following any new H&S inspection a report is issued that documents all hazards observed, unsafe practices witnessed and areas of non-compliance. Each hazard observed is accompanied by recommended corrective actions to eliminate or control the hazards. Each hazard is then risk assessed by the inspector based on their assessment of the risk presented at the time of the site inspection, then categorised using the same classification as detailed in the risk stratification exercise.

Once a report has been completed, all moderate, major and catastrophic hazards and their recommended corrective actions are then logged on the Inspection module of the Audit Management and Tracking System (AMaT) system for management and tracking. The responsible manager is then able to update each action using the system, as and when hazards are controlled or eliminated, or to document that a decision has been made to tolerate an identified risk.

Negligible	Report Only
Minor	Report Only
Moderate	**Must Do** MD
Major	**Must Do** MD
Catastrophic	**Must Do** MD

All actions on AMaT are then assigned a timeframe within which to address the risk. These timeframes should be seen as a guide only, with the final decision on any timeframes at the discretion of the Inspector.

The AMaT system will automatically notify a manager should an action become overdue. The system also generates a weekly round-up e-mail to bring outstanding actions to the attention of the responsible manager.

Argymhelliad / Recommendation

The Health & Safety Committee is requested to **take assurance** that a new methodology for Health and Safety inspections has been implemented, together with a procedure for managing actions arising from all new inspections.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	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 a Sgôr 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
Amcanion Cynllunio Planning Objectives	1 Workforce Stabilisation 9 Digital plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

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 Pwyllgor Ansawdd lechyd a Diogelwch: Parties / Committees consulted prior to Health and Safety Committee:	H&S Compliance Group

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

3

10:50 AM, 0 Mins

3 - EMERGENCY PLANNING

3.1

10:50 AM, 10 Mins

3.1 - Revised Pandemic Framework

Sam Hussell (Head of Health Emergency Planning)

For approval

Attachments

SBAR for H_SC Pandemic Response Framework April 2026.pdf

HDUHB Pandemic Response Framework v2 FINAL DRAFT FET Endorsed.pdf

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	05 May 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Pandemic Response Framework
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr Ardiana Gjini, Executive Director of Public Health
SWYDDOG ADRODD: **REPORTING OFFICER:**	Sam Hussell, Head of Emergency Preparedness, Resilience & Response (EPRR) Marie Evans, Health Protection Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Through the Pandemic Planning Group, the Health Board has updated its Pandemic Response Framework.

The Framework sets out a tactical-level, multi-disciplinary approach enabling the Health Board to prepare for, respond to, and recover from pandemic events. Executive approval is now sought to endorse the Framework for organisational adoption.

Cefndir / Background

As detailed in both the UK Security Risk Assessment and the Wales Risk & Preparedness Register, pandemics remain one of the highest risks to the UK. The Civil Contingencies Act (2024) places statutory duties on Category 1 responders, including health boards, to maintain robust emergency preparedness and response arrangements.

The Health Board has had a Pandemic Influenza Framework in place since 2013, and this review incorporates a comprehensive shift from disease-specific planning (e.g., influenza) to an all-hazards, multi-vector approach.

Asesiad / Assessment

The current update now incorporates:

- Lessons from the COVID-19 pandemic.
- Findings from national and local exercises, including Exercise Pegasus, Exercise Solaris, and Exercise Bite-Back.
- Alignment with the latest UK-level and Welsh national pandemic plans and guidance, including the UK Respiratory Pandemic Response Plan (Draft v6), the Communicable Disease Outbreak Plan for Wales, and the Dyfed Powys Local Resilience Forum (DPLRF) multi-agency arrangements.

And

- Broadens the scope to cover any pandemic pathogen, not solely respiratory or influenza-based.
- Further embeds a standardised Gold–Silver–Bronze command structure aligned with NHS Wales EPRR standards and DPLRF governance structures.
- Reflects new national expectations on surveillance, Infection Prevention and Control (IPC), testing, vaccination, data/digital, excess deaths, and supply chain preparedness.
- Updates activation triggers based on WHO declarations, UK national escalation, and local epidemiological indicators.
- Provides operational checklists, flowcharts, templates, and annexes to support implementation, including IPC, vaccination prioritisation, communications, SitRep reporting, and risk assessment templates.

The framework now provides a comprehensive, multi-agency aligned, operationally actionable approach to multi-vector pandemic response with specific additions covering:

1. Strengthened Surveillance and Early Warning
2. IPC and Countermeasures Framework
3. Vaccination and Antiviral Framework
4. Operational Readiness approach
5. Workforce and Capacity Planning
6. Updated Excess Deaths Management
7. Digital and Data Integration for Situational Awareness
8. Legal and Ethical considerations
9. Command, Control and Governance

Challenges

One of the issues identified during Exercise Pegasus was limitations of paediatric critical care across Wales, with the only established Wales capacity being in the University Hospital of Wales (UHW). Lack of specifically trained paediatric critical care staff required to maintain a sustained escalation was also a concern should the pandemic especially target children.

Additional contingency measures and potential mitigation measures are still being developed and will be added to this revised Framework in due course.

Overall risk assessment

The Framework significantly mitigates organisational and statutory risk and ensures:

- statutory compliance with CCA 2024
- control measure/mitigation to corporate risk 1433
- multi-agency interoperability
- assurance for Welsh Government and NHS Wales EPRR standards
- readiness for emerging pandemics, including zoonotic threats

Next steps

A multi-disciplinary table-top exercise is being planned for Summer 2026 to further explore some of the challenges highlighted and areas that can enhance Health Board preparedness.

Argymhelliad / Recommendation

The Committee is asked to **Recommend** the Pandemic Response Framework for onward approval by the Board on 28 May 2026.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.12 Receive assurance that service/business continuity plans are in place for service interruptions and emergency situations that affect the provision of normal services, and that staff are aware of their service plans, and have tested them, to enable them to respond to such incidents.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	1433
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	UK Security Risk Assessment Wales Risk and Preparedness Register phw.nhs.wales/topics/the-communicable-disease-outbreak-plan-for-wales1/ Pandemic Hub WHO Pandemic Agreement - Global
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd lechyd a Diogelwch:	• Pandemic Planning Group • Executive Director with lead for EPRR • Formal Executive Team

Parties / Committees consulted prior to Health and Safety Committee:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Delivery of a future pandemic response will incur additional financial pressures but would align to WG assistance provision.
Ansawdd / Gofal Claf: Quality / Patient Care:	It is important that there are effective plans in place to prepare for the impact of future pandemics, to protect those at risk, maintain critical services and minimise impact on wider health services.
Gweithlu: Workforce:	As for Quality / Patient care impact.
Risg: Risk:	Risks are detailed within report and corporate risk 1433 including mitigation approaches.
Cyfreithiol: Legal:	Not Applicable.
Enw Da: Reputational:	The Pandemic Framework will align priorities and focus on response approach, in line with regional and national partners and both Welsh and UK Government direction.
Gyfrinachedd: Privacy:	Not Applicable.
Cydraddoldeb: Equality:	Framework designed to consider inequalities and inequities.

Pandemic Response Framework

Date: March 2026

Document Control	
Work Stream	Pandemic Planning Group
Oversight Group	Health Protection Oversight and Co-ordination Group
Status	DRAFT
Version	2
Date	March 2026
Review Date	3 yearly and on publication of new guidance, exercise recommendations or incident response.

Document Ownership, Control and Distribution

This framework has been developed by the Hywel Dda UHB Pandemic Planning Group. All users are requested to advise the Group Chair or Emergency Preparedness, Resilience and Response (EPRR) Team of any change in circumstances that may materially affect this document.

This framework is subject to formal review via the Pandemic Planning Group. The document will be tested and validated through local exercises, learning from incidents or feedback received on an on-going basis. Reviews and substantive changes must be agreed and endorsed by the Pandemic Planning Group, following consultation as necessary.

Document Version:

Date	Version	Amended by	Amendment/Comment
09/2013	1.00		Ratified by Operational Performance Board and CDG.
03/2026	2.00	Pandemic Planning Group	Approach broadened to cover any pandemic (not just influenza) and incorporates lessons from COVID-19 and Exercises Solaris, Pegasus and Bite-Back.

Executive Summary

This framework outlines the Health Board's approach to preparing for, responding to, and recovering from any future pandemic, drawing on UK-wide guidance, Welsh national policy, Local Resilience Forum arrangements, and lessons learned from COVID-19 and subsequent exercises. It establishes the structures, processes, and capabilities required to protect population health, sustain essential services, and support workforce and community resilience throughout a pandemic.

The framework describes how the Health Board will monitor emerging threats through integrated surveillance systems including international alerts. It sets out proportionate, evidence-based interventions for infection prevention and control across healthcare and community settings, alongside the planning and delivery of equitable vaccination programmes, antiviral deployment, and PPE utilisation.

Clear expectations are defined for primary care, community care, and secondary care services, including surge planning, patient flow, isolation capacity, and activation of specialist pathways. Testing and sampling arrangements are detailed, covering diagnostic capacity, laboratory resilience, community accessibility, and data integration.

The framework also addresses workforce resilience, outlining processes for redeployment, surge staffing, well-being support. Supply chain and logistics arrangements include PPE, medicines, testing supplies, transport, and contingency planning for shortages. Communications principles ensure alignment with national messaging, countering misinformation, and maintaining staff and public confidence.

Dedicated sections cover excess deaths management, mortuary surge capacity, bereavement support, cultural considerations, and multi-agency coordination. Zoonotic risk management arrangements ensure close working between human and animal health agencies.

Activation triggers are defined, and the framework embeds a Gold–Silver–Bronze command and control structure, with defined roles, reporting processes, information governance requirements, and decision-logging standards.

Finally, the framework outlines the Health Board's approach to recovery, including phased restoration of services, workforce recovery, community support, long-term public health impacts, and structured learning to strengthen future preparedness.

Contents

Purpose

To safeguard public health, maintain essential services, and ensure equitable access during any pandemic scenario.

Hywel Dda University Health Board has a duty to ensure that a robust framework is in place to plan for, and respond to a pandemic, as set out in the requirements of the Civil Contingencies Act 2024.

Recent experience of the COVID-19 pandemic and participation in the UK Tier 1 Exercise Pegasus has demonstrated the need for planning to be wider than only known diseases.

A tabletop exercise will be undertaken ahead of every review period during an inter-pandemic period to ensure that key staff are familiar with the requirements of this framework and are able to operationalise it.

Strategic Objectives

1. Protect life and health through timely interventions.
2. Maintain essential services during disruption.
3. Ensure equitable access to care and resources.
4. Support workforce resilience and wellbeing.
5. Enable rapid recovery and lessons identified.

Key Components of the Pandemic Framework

Surveillance and Intelligence

A multi-agency, international robust and integrated surveillance system underpins the Health Board’s ability to anticipate, detect, and respond to emerging infectious threats. This includes the continuous collection, analysis, and interpretation of global, national, and local epidemiological intelligence to understand transmission patterns, assess risk, and inform timely decision-making.

Key surveillance inputs include:

- International and national alerts from bodies such as WHO, UKHSA and PHW.

- Primary care and secondary care surveillance to monitor symptomatic trends and clinical presentations
- Genomic sequencing to identify variants of concern and track pathogen evolution
- Wastewater surveillance to support early detection of community transmission
- Monitoring the effectiveness and utilisation of antiviral treatments to understand clinical impact and inform therapeutic strategies
- A framework for assessing and responding to hidden harms

Interventions and Infection Prevention & Control (IPC)

Effective infection prevention and control (IPC) measures are essential to limiting transmission during periods of heightened infectious disease activity. The Health Board will implement proportionate, evidence-based interventions across healthcare and community environments to protect patients, staff, and the wider population.

Core IPC measures include:

- Isolation and cohorting of patients – the separation of symptomatic or confirmed cases to minimise cross-transmission within clinical and residential settings.
- Enhanced environmental cleaning and decontamination including strengthened cleaning protocols, with a focus on high-touch surfaces and shared spaces, aligned with national IPC guidance.
- Use of face coverings or respiratory protection, and PPE in high-risk settings - targeted mask use for staff, patients, visitors, and service users where transmission risk is elevated or vulnerable populations are present.
- Outbreak management in care homes, schools, and other community settings with the rapid deployment of IPC support, case and contact management, and implementation of control measures to contain spread and maintain service continuity.

Vaccination

Vaccination remains one of the most effective public health interventions for reducing morbidity, mortality, and transmission during a pandemic. The Health Board will work with national and local partners to ensure timely access to vaccines, high uptake across priority groups, and equitable delivery across all communities.

Key components include:

- Strategic planning and delivery of vaccination programmes. To include co-ordinated deployment of seasonal, pandemic-specific, or variant-targeted vaccines across primary care, mass vaccination centres, community pharmacies, and outreach settings.
- Prioritisation of high-risk groups - alignment with national guidance to protect those at greatest risk, including older adults, clinically vulnerable individuals, frontline health and social care staff, and residents of care homes.
- Equitable access and targeted outreach to include tailored approaches to reach underserved or hesitant populations, including mobile clinics, community partnerships, and culturally appropriate engagement.
- Monitoring uptake and effectiveness through real-time surveillance of vaccination coverage, breakthrough infections, and vaccine effectiveness to inform operational decisions and public messaging.
- Cold chain and supply management to ensure the safe storage, distribution, and handling of vaccines across all delivery sites.
- Communication to enhance staff and public confidence through the provision of clear, consistent messaging to support informed decision-making and maintain trust in vaccination programmes.
- Additional multi-agency operational groups may also be required to prepare the plan for the distribution of antivirals and immunisation programme as/when these requirements are identified.

Countermeasures and PPE

The use of personal protective equipment (PPE) is regulated by Health and Safety legislation. All staff who use PPE must do so in compliance with local risk assessments and appropriate training.
Managers and Senior Nurses are responsible for ensuring that appropriate stock levels of suitable PPE are maintained.

All respiratory infectious diseases require the same approach i.e.

Face to face contact

When treating a patient with either confirmed or suspected infection the member of staff will wear fluid repellent surgical face mask, eye protection and gloves.

Aerosol generating procedures

When undertaking procedures on patients who have either confirmed or suspected infection the member of staff will wear eye protection, face mask to FFP3 standard, gloves and gown.
Aerosol generating procedures are any procedures that result in potentially infected droplets being produced e.g. intubation.

A poster is available at the end of this document which can be printed off and displayed in clinical areas as an aide memoir for the correct use of PPE.

During an inter-pandemic period, small supplies of PPE will be stored in high-risk areas such as respiratory medicine. All PPE listed above is available in the Oracle catalogue. For those members of staff who require nonstandard size FFP3 masks a non-catalogue order should be raised on Oracle. The Procurement Department can provide the appropriate codes.

When a pandemic is imminent PPE from the national Wales stockpile may be deployed. Where this is used and by whom must be considered and planned for as it may not be compatible with products in present use, and may result in an additional fit testing programme.

Primary Care Services

During an inter-pandemic period maintain business continuity plans and review on a regular basis. When the risk of a pandemic is imminent revise the plans to take into consideration potential staff sickness levels and increased workload. Consult with Contractor services on their level of preparedness.

At an early stage disseminate diagnosis and treatment algorithms.

Assess the volume of additional consumables that will be required and requisition accordingly.

Be prepared to ‘fast track’ any Direct Enhanced Service (DES) or Locally Enhanced Service (LES) agreements.

Develop structured safeguarding triggers and referral routes.

Identify team members of the operational group and be prepared to convene a group.

Community Care Services

During an inter-pandemic period maintain business continuity plans and review on a regular basis. When the risk of a pandemic is imminent revise the plans to take into consideration potential staff sickness levels and increased workload.

At an early stage disseminate diagnosis and treatment algorithms.

Consider the flow of infected patients through Community Hospitals and isolation areas – see Infection Prevention & Control guidance/procedures

Assess the volume of additional consumables that will be required and requisition accordingly.

Identify staff who can become part of an immunisation programme.

Identify team members of the operational group and be prepared to convene a group.

Secondary Care Services

During an inter-pandemic period maintain business continuity plans and review on a regular basis. When the risk of a pandemic is imminent revise the plans to take into consideration potential staff sickness levels and increased workload.

Assess the volume of additional consumables that will be required and requisition accordingly.

At an early stage disseminate diagnosis and treatment algorithms to Emergency Medicine Departments.

Have a clear plan for patient flow and isolation i.e. clearly identified cohort wards

As soon as the profile of the pandemic is available prepare to enhance services or capacity in:

- Emergency Care Centres
- Intensive Therapy Units/High Dependency Units
- Pharmacy (particularly for antivirals/vaccine)
- Paediatrics/Special Care Baby Units
- Maternity
- Mortuary SOPs
- Care after Death Team

Also include any other areas that it is forecast to be impacted upon

Identify team members of the operational group and be prepared to convene a group.

Testing and Sampling

Rapid and reliable diagnostic testing is essential for early case identification, timely clinical management, and effective public-health action. In line with national guidance and the determination of priority groups (where applicable), the Health Board will maintain accessible testing pathways, robust specimen handling, and scalable laboratory capacity to support surveillance and outbreak control.

Core elements

- Maintain the provision of PCR testing for definitive diagnosis and genomic analysis, alongside validated rapid antigen tests for timely screening and triage in clinical and community settings (in line with national guidance and direction).
- Ensure the identification and availability of a network of community testing sites, mobile units, and primary-care testing options to maximise accessibility, reduce barriers to testing, and support targeted responses in high-risk populations.
- Standardise specimen collection, transport, and reporting protocols to preserve sample integrity and enable rapid turnaround of results and sequencing where required.
- Develop and maintain plans to expand laboratory throughput (for Health Board labs) during periods of increased demand, including workforce surge arrangements, cross-site collaboration, and agreements with regional or national reference laboratories.
- Ensure test results feed promptly into surveillance platforms, contact-tracing workflows, and clinical care pathways to inform public health decisions and patient management.
- Maintain quality control, external validation, and regular review of testing modalities to ensure accuracy, reliability, and appropriateness of diagnostic tools across settings.

Workforce and Capacity

Maintaining adequate staffing and healthcare capacity during surge periods is essential to sustain safe care and public health response.

The Health Board will adopt proactive workforce planning, flexible deployment mechanisms, and comprehensive staff support to preserve service continuity and staff wellbeing.

Once the alert level changes, or in the event of a trigger being activated these guidance documents must be reviewed in light of the pandemic profile planning assumptions.

Core objectives

- Ensuring safe staffing levels across acute, primary, community, and social-care settings.
- Enabling the rapid redeployment of trained staff to critical areas.
- Building surge capacity through scalable workforce models and mutual aid.
- Protecting staff wellbeing with accessible mental health and occupational support.
- Utilise national guidance to explore further options for enhancing workforce.

Operational measures

- Redeployment protocols
    - Pre-agreed redeployment pathways and role descriptions for clinical and non-clinical staff.
    - Clear governance for authorisation, indemnity, and pay arrangements during redeployment.
- Flexible rostering and surge rotas
    - Use of bank, agency, and volunteer pools with streamlined onboarding.
    - Cross-cover arrangements between sites and services to prioritise critical functions.
- Workforce surge agreements
    - Memoranda of understanding with neighbouring health boards, local authorities, and independent sector partners for staff sharing and mutual aid.
- Further workforce enhancements

  In line with national guidance consider the use of recently retired staff and other appropriate measures.

Training and capability development

- Pandemic-specific role training
    - Rapid training packages for redeployed staff covering IPC, PPE use, basic clinical tasks, testing, sampling and vaccination, and role-specific competencies.

- Just in time training and simulation
    - Short refresher modules, competency checklists, and scenario drills to accelerate safe deployment.
- Development and approval of practice guidance
    - Clear guidance on delegated tasks, supervision requirements, and escalation routes for staff working outside usual roles.

Staff wellbeing and support

Protecting the physical and psychological wellbeing of staff is essential to sustain the pandemic response and maintain safe services and prevent burnout. Hywel Dda Health Board ensures there is provision of proactive mental health and psychosocial support, Staff health and wellbeing information, advice and resources including counselling, peer-support networks, and occupational health access How to contact us for referrals & Influenza vaccines.

Delivery of practical support such as rest facilities including safe spaces for de-briefs or decompression, transport assistance, childcare solutions, and temporary accommodation may be considered where required. Ensure recognition and clear communication is maintained through regular briefings, transparent decision making, and visible leadership to preserve morale and trust.

Monitoring and assurance

- Workforce capacity dashboard
    - Real-time tracking of staffing levels including sickness absence, vacancies, bank/agency usage, and critical skill gaps.

- Proactive identification of workforce groups disproportionately affected.

- Monitoring of psychological resilience actions (trauma-informed support, fatigue mitigation)

- Feedback from Staff Psychology Wellbeing service and Occupational Health
    - Receive, review and act upon, as appropriate, non-identifiable feedback on key themes or issues being presented by staff.

- Trigger points and escalation
    - Defined thresholds for activating surge plans, requesting mutual aid, or standing up emergency rostering.

- After-action review and workforce learning
    - Capture lessons from each surge to refine training, redeployment protocols, and wellbeing offers.

Supply Chain and Logistics

In line with the wider NHS in Wales, working through NHS Wales Shared Services Partnership (NWSSP) and Welsh Government, the Health Board will ensure the secure procurement, management, and distribution of essential supplies and equipment required to support an effective pandemic response.

Key functions include:

- **PPE and Medication Stock Management**
  Ensuring adequate stocks of personal protective equipment (PPE), essential medicines, and medical countermeasures, including antivirals and immunisation products. This includes routine monitoring of stock levels and coordinating timely replenishment.
- **Testing and Sampling Supplies**
  Maintaining sufficient laboratory consumables, testing kits, reagents, and sampling materials to support scaled testing operations across community and healthcare settings.
- **Transport and Storage Solutions**
  Providing reliable logistics for the movement and storage of critical supplies, including temperature-controlled systems for items such as vaccines and certain medicines.
- **Contingency Planning for Shortages**
  Developing and maintaining contingency arrangements to mitigate supply chain disruption. This includes identifying alternative suppliers, activating emergency procurement processes, and prioritising distribution to critical services.

Communications

Building trust and promoting compliance through clear communication. This may require:

- Participation in local, regional and national communications networks to ensure messaging aligns with national direction
- Communication campaigns for staff and the public
- Engagement with community leaders and proactive sharing of partners communications where appropriate

- Addressing misinformation (monitoring and rebuttal strategy).
- Digital exclusion mitigations (offline comms, community outreach, mobile units).
- Community engagement pathways (leveraging the Community Development Outreach Team).
- Enhanced community language resources.
- Participation in the formal role of DPLRF Warning & Informing Group.

The Health Board communications team will support the distribution of briefing notes, deal with media enquiries as agreed with Public Health Wales.

All appropriate pandemic response documentation is to be forwarded to the archivist for any potential future inquiry or litigation.

Workforce and Organisational Development

Support the organisation with timely advice and guidance. Be prepared to produce ad hoc guidance to support a measured response to the pandemic. All appropriate pandemic paperwork is to be forwarded to the archivist for any potential future inquiry or litigation.

Finance

Establish a cost centre code for all pandemic related spend. All financial impacts of the pandemic need to be tracked and fed into the Corporate financial position.

Data and Digital

Effective use of digital systems is essential for timely detection, response, and coordination during a pandemic. The Health Board will utilise a suite of technology enabled tools to enhance surveillance, streamline operational processes, and support evidence-based decision making.

Real-Time Dashboards for Case Tracking

The Health Board will deploy real-time epidemiological dashboards capable of integrating data from laboratory systems, primary care, hospital admissions, and community surveillance. These dashboards will:

- Provide up-to-date case counts, trends, and geographic mapping.
- Support early identification of emerging clusters and anomalies.

- Enable executive teams, outbreak control groups, and operational leads to make rapid, informed decisions.
- Allow scenario modelling and forecasting to guide resource allocation and intervention planning.

Testing and Sampling Recording and Results Management

Robust digital systems will be maintained for recording samples, managing laboratory workflows, and reporting results. This includes:

- Electronic test ordering and sample tracking to reduce errors and delays.
- Automated result integration into clinical records and public health surveillance systems.
- Rapid notification pathways for both positive cases and high-risk categories.
- Interfaces with national testing programmes for consistency and comparability of data.

Digital Tools for Contact Tracing

Technology-enabled contact tracing solutions will support the Health Board's capacity during periods of high transmission. These tools may include:

- Secure digital case management systems to record interviews, contacts, exposures, and follow-up actions.
- Mobile or web-based portals that allow cases to submit contact information electronically.
- Automated SMS or app-based notifications for low-risk exposures where appropriate.
- Analytical features that help identify transmission patterns, common exposure settings, and high-risk environments.

Secure Data Sharing Across Agencies

Timely, secure information exchange is central to multi-agency response efforts. The Health Board will utilise:

- Agreed data-sharing protocols with local authorities, NHS partners, laboratories, and national agencies.
- Where available, integrated dashboards with PHW and NHS Wales (modelling, R-rate, inequalities).
- Clear standards for minimum data reporting during activation.

- Data feeds for vulnerable groups and hidden harms.
- Encrypted digital platforms to share situation reports, risk assessments, and operational updates.
- Role-based access controls to ensure that sensitive data is available only to authorised personnel.
- Standardised formats to support interoperability and reduce duplication of effort.

Legal and Ethical Frameworks

All pandemic response activities must be delivered within the boundaries of relevant legislation and aligned with core public health ethics. The Health Board is committed to ensuring that every action taken during a pandemic upholds legal duties, respects individual rights, and promotes fairness across communities.

Quarantine and Isolation Orders

The Health Board will ensure that all measures involving restriction of movement, such as isolation of cases or quarantine of contacts, are legally justified, proportionate, and time-limited. This includes:

- Applying statutory powers only when voluntary cooperation is insufficient or when required to protect public health.
- Ensuring individuals subject to restrictions receive clear information about the legal basis, duration, and their rights to challenge decisions.
- Providing appropriate support (e.g., welfare, medication access, mental health assistance) to reduce the burden of compliance.
- Working closely with local authorities, legal teams, and enforcement partners to maintain consistency and avoid misuse of powers.

Data Protection and Confidentiality

Pandemic response relies heavily on the collection and sharing of personal and health information. The Health Board will:

- Adhere to data protection legislation, including GDPR and national health information governance standards.
- Limit the collection of identifiable information to what is necessary for public health action.
- Ensure secure storage, controlled access, and robust cyber-security measures for all data systems.

- Use clear privacy notices to explain how data will be used, who it may be shared with, and the safeguards in place.
- Facilitate anonymisation or pseudonymisation wherever full identifiers are not required.

Equitable Access to Healthcare and Vaccines

Equity is a fundamental ethical requirement in pandemic preparedness and response. The Health Board will work to ensure that all individuals have fair access to prevention, treatment, and support by:

- Prioritising vulnerable and high-risk groups based on transparent, evidence-informed criteria.
- Monitoring uptake and outcomes across demographic groups to identify inequalities early.
- Addressing barriers such as language, digital exclusion, disability, geography, or socioeconomic disadvantage.
- Ensuring vaccine distribution follows ethical allocation frameworks and is supported by clear, culturally sensitive public communication.
- Working with community organisations to reach populations who may experience health inequities.

Excess Deaths Management Plan

Planning for the respectful, safe and effective management of increased mortality is a critical component of pandemic preparedness. The Health Board will work in partnership with local agencies, mortuary services, the Care after Death team and the Dyfed Powys Local Resilience Forum (LRF) to ensure that processes remain dignified, legally compliant and operationally sustainable during periods of excess deaths.

Surge Capacity for Mortuary and Body Storage Facilities

The Health Board will maintain plans to expand mortuary and temporary body storage capacity when required. This includes:

- Identifying sites and infrastructure that can be rapidly activated during surge conditions.
- Clear thresholds for switching to temporary mortuary arrangements.
- Ensuring sufficient equipment, such as refrigerated units and body bags are available.
- Coordinating capacity across acute hospitals and any temporary local authority facilities. Activation thresholds for temporary

mortuary facilities must be clearly defined and aligned with Cellular Pathology and Mortuary leads. Planning should also ensure:

- Full traceability and audit trails
- Dignified storage conditions in line with Human Tissue Authority regulation and standards
- Appropriate security arrangements that ensure the safe, secure and dignified storage of the deceased
- Separation of infectious and non-infectious remains where required.
- Contract assurance mechanisms for transport arrangements/funeral/mortuary services.

Bereavement Office operational capacity

Bereavement services will be the main contact for bereaved families. This service may experience significant increases in workload during periods of excess mortality. Planning should include:

- Prioritisation of daily planning meetings.
- Surge administrative support.
- Remote working capability where possible.
- Extension of operating hours.
- Clear pathways for death certification, documentation and protocols for escalation of identified delays in process.
- Guidance for communicating with families whilst they navigate registration and funeral arrangements.
- Paediatric death-specific bereavement & family liaison guidance.

Cultural and religious considerations

Hywel Dda University Health Board will work with families, staff, chaplaincy services and community faith leaders to ensure that cultural and religious practices are respected wherever possible. This may include:

Faith specific preparation requirements including:

- Burial timeframes.
- Support for family rituals.
- Liaison with community representatives during periods of high mortality.

Family communication and liaison

During a pandemic, visiting restrictions or clinical pressures may possibly limit direct contact between deceased patients and bereaved families. Compassionate and consistent communication with families remains a

priority and the Heath Board Care after Death Service and Mortuary will factor this into planning arrangements.

Management of property of the deceased

Systems must be in place to safely document, store and return personal belongings of the deceased.

These processes should include:

- Clear documentation
- Infection prevention guidance where required
- Timely return of property to families from ward or bereavement office as per wishes of the family.

Coordination with Funeral Directors and Crematoria

During periods of increased demand, close collaboration with funeral directors, crematoria, cemeteries, and associated services will ensure continuity and dignity in end-of-life processes. This will involve:

- Establishing regular communication channels to monitor capacity and constraints.
- Agreeing mutual aid arrangements and contingency plans for peak periods, in addition to business-as-usual contingency arrangements.
- Working with local authorities to support resilience in mortuary and funeral services.

Infection Prevention and Control (IPC) for Safe Handling of the Deceased

Clear, evidence-based IPC protocols will be maintained to ensure the safe handling, transport, viewing, and disposal of the deceased. Measures include:

- Guidance for clinical staff, mortuary teams, and funeral professionals on PPE, transport, and body preparation.
- Safe viewing procedures for bereaved families.
- Procedures to minimise risks of transmission from infectious remains.
- Ensuring staff are trained, equipped, and supported to follow national IPC standards.

Psychological and Bereavement Support for Families and Staff

The Health Board will ensure that compassionate support remains a core element of excess death management. This includes:

- Access to bereavement services for families, including culturally sensitive support.
- Signposting to specialist bereavement support organisations.
- Psychological wellbeing resources, trauma-informed support and the provision of de-briefs for staff involved in fatality management.
- Consideration of alternative viewing or memorial arrangements if restrictions are required.

Legal Compliance for Death Certification and Reporting

The Health Board will ensure that all death management activities comply with relevant legislation, which may be adapted during a pandemic. This includes:

- Following national guidance on streamlined or emergency death certification processes.
- Ensuring timely notification of deaths to registrars, coroners, and relevant agencies.
- Supporting clinicians and staff to understand temporary legal changes related to certification, reporting, or verification of death.

Integration with DPLRF Processes

The Health Board will align its plans with the DPLRF's established death management structures. This includes:

- Participation in DPLRF death management subgroups and multi-agency planning exercises.
- Integration with regional body storage, transport, and emergency mortuary arrangements.
- Consistent, coordinated multi-agency decision-making during surge periods.

Communication Protocols for Sensitive Public Messaging

Clear, compassionate communication will underpin the Health Board's approach to fatality management. Communication protocols will ensure:

- Timely and accurate public messaging about changes to death management processes.
- Sensitivity to cultural, religious, and community needs.

- Alignment with national and regional communication leads to maintain public trust and minimise distress.

Zoonotic Risk Management

Zoonotic risks are a significant consideration during any pandemic response, as the pandemic itself may originate from an animal source or involve ongoing animal to human transmission. The Health Board will therefore work closely with the Animal and Plant Health Agency (APHA), Public Health Wales (PHW), and Local Authority Environmental Health teams to ensure early identification and assessment of any zoonotic factors that could influence the course of the pandemic or create additional risks for staff and the public.

APHA will lead on animal health investigations, movement controls, and biosecurity at affected sites, while the Health Board and PHW will coordinate the corresponding human health response such as targeted surveillance, testing, and infection prevention and control (IPC) measures. Joint operational working will ensure consistent, risk proportionate communication for farmers, animal workers, frontline staff, and the public, helping maintain confidence and minimise misinformation.

Clear data sharing arrangements between APHA, PHW and the Health Board will support timely flow of intelligence for inclusion in epidemiological reporting, tactical briefings, and situation updates.

Activation Triggers

The Health Board's pandemic response will be activated in line with the principles and escalation processes outlined in the Communicable Disease Outbreak Plan for Wales or a declaration by WHO (see below for details).

The Communicable Disease Outbreak Plan for Wales is national plan provides the core framework for identifying abnormal patterns of communicable disease activity and determining when an incident should be escalated to an Outbreak Control Team (OCT) or a wider coordinated response.

Pandemic response activation will be considered when one or more of the following triggers are identified:

- **Emergence of a novel pathogen** with the potential for sustained human-to-human transmission, identified through national or international surveillance systems.

- **Significant increases in cases, clusters, or community transmission** that exceed expected seasonal or baseline levels, prompting notification under the Wales Outbreak Plan arrangements.
- **Early epidemiological or clinical signals indicating severity**, such as unusual morbidity, mortality, or rapid geographic spread.
- **Alerts or declarations from Public Health Wales, the Welsh Government, the UK Health Security Agency, or WHO**, indicating a shift in threat level or recommending enhanced preparedness actions.
- **Operational pressures** within health or social care settings—such as bed capacity issues, staffing impact, or disruption to essential services—that suggest the need for coordinated escalation.
- **Cross-sector impacts** affecting wider partners (e.g., local authorities, education, emergency services) and requiring multi-agency collaboration under Local Resilience Forum structures.

Upon identification of any of these triggers, the Health Board will adopt the initial response actions described within the *Communicable Disease Outbreak Plan for Wales*, including:

- Notification of Public Health Wales and relevant professional leads.
- Convening an Outbreak Control Team or Incident Management Team to assess risk, define the problem, and determine the level of response required.
- Rapid implementation of surveillance, case definition, testing, and control measures proportionate to the assessed threat.
- Initiation of early communication with partners, including the Dyfed Powys Local Resilience Forum if multi-agency coordination is anticipated.

These activation triggers ensure that the Health Board's pandemic response shifts from routine operations to enhanced coordination at the earliest appropriate stage, maintaining alignment with national guidance while enabling flexible escalation as the situation evolves.

A. WHO Declaration of a Public Health Emergency of International Concern (PHEIC)

A PHEIC signals a global health threat requiring international coordination. Examples include:

- WHO declares a PHEIC for a novel influenza strain with sustained human-to-human transmission.
- WHO issues a PHEIC for an emerging respiratory virus with high morbidity and mortality rates.

B. UK Government Pandemic Alert Escalation

The UK Government may raise the pandemic alert level based on national risk assessments and expert advice.

Examples:

- Transition from "Preparedness" to "Containment" phase under the UK Influenza Pandemic Preparedness Strategy.
- Activation of COBR (Cabinet Office Briefing Rooms) meetings and issuance of national guidance for healthcare providers.

C. Local Epidemiological Indicators

Local data provides early warning of community transmission and healthcare impact.

Examples:

- Detection of multiple linked cases in a single locality or healthcare setting.
- Significant increase in hospital admissions for severe respiratory illness beyond seasonal norms.
- Positive laboratory confirmation of the pathogen in local surveillance samples.

Health Board Command and Control and Governance

This seeks to ensure clear leadership, decision-making, and co-ordination during a pandemic response, aligned with national guidance and local operational needs.

No matter how severe the impact of the pandemic the same management arrangements will be established within the Health Board.

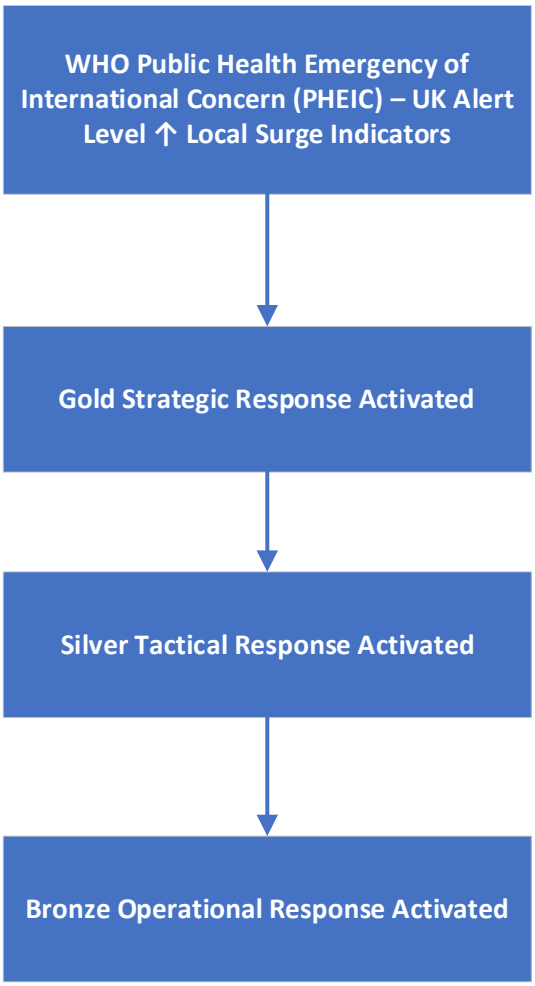
The frequency of tactical group meetings will depend on the severity of the impact of the pandemic. The Chair of the tactical group (or a

nominated representative) will represent the Health Board at the Strategic Co-ordination Group and any additional groups established by the Welsh Government.

Command and control structures will be activated as appropriate to co-ordinate the Health Board response which will also link into national and regional response structures. Appropriate Chairs and group membership will need to be identified to form the structures below. Appropriate training is provided on an ongoing basis for staff as part of the Major Incident response training which details command and control structure roles. These structures will include:

- Gold (Strategic): Health Board Executive Team, Silver Chairs and appropriate membership to include EPRR, Loggist, Corporate Governance and co-opted members as required.
- Silver (Tactical): Service Leads and Operational/Bronze cell chairs.
- Bronze (Operational): Service level teams.
- Reporting: SITREP reports to Welsh Government, NHS Wales Performance Improvement and Public Health Wales as required during an active response.
- Information Governance**:** Compliance with GDPR, NHS Wales Data Security Standards.

Activation & Escalation



Data collection processes for Command and Control

The requirement to gather, collate and submit large quantities of data on a regular basis must not be underestimated.

It is unlikely that the Health Board will be able to influence this requirement. Therefore, at an early stage, key personnel must be identified to undertake this role and trained if required. Some Departments may also require additional manpower support to undertake this commitment.

Information Management

During a pandemic the flow of information into the organisation will be overwhelming. It is essential to try and manage this to ensure that only relevant information is either processed or cascaded on into the organisation.

All meetings that take place as part of the Health Board's internal command and control structures will be appropriately recorded and all actions, decisions and rationale for decisions will be logged in line with principles for decision logging, and retained to support the identification of lessons learnt, and could be utilised to provide evidence in the event of future inquiries. These will be submitted to the Health Board Archivist for categorisation.

Strategic Level (Gold)

- **Role:** Provides overall direction, sets priorities, and allocates resources.
- **Membership:**
  - Chief Executive (Chair)
  - Executive Team
  - EPRR Lead / Comms / Corporate Governance
  - Loggist
- **Responsibilities:**
  - Approve pandemic response strategy and major decisions.
  - Receive and respond to issues escalated by the Silver/Tactical groups.
  - Agree a Health Board communications strategy.
  - Agree the financial impact and response to the pandemic.
  - Agree representation at Dyfed Powys Local Resilience Forum Strategic Co-ordinating Group.
  - Liaise with Welsh Government and UK national bodies.
  - Authorise escalation and recovery actions.

    Example Actions:
    - Approve surge capacity plans for hospitals.
    - Decide on suspension of elective procedures.

Tactical Level (Silver)

- **Role:** Translates strategic decisions into operational plans across services. There may be a number of f groups with specific areas of focus (Finance, Operations, PPE etc).
- **Membership:**
  - Senior Clinicians and Managers from all sectors of the Health Board
  - Loggist and Admin support
- **Responsibilities:**
  - Coordinate service delivery and workforce deployment.
  - Ensure infection prevention and control measures are implemented.

Operational Level (Bronze)

- **Role:** Delivers frontline response in specific sites or services. These may include a number of Bronze groups as appropriate. The operational group chairs will report to the Health Boards tactical (silver) groups.
- **Membership:**
  - The operational groups will consist of core members with additional members being called upon as and when required.
- **Responsibilities:**
  - Operationalise the decisions of the Silver and Gold groups.
  - Manage day-to-day operations and local incidents.
  - Report status and issues to Silver Response groups.

Pandemic Recovery

Pandemic recovery begins as soon as the immediate threat stabilises and continues until health services, communities, and systems return to a sustainable level of functioning. The Health Board will adopt a phased approach to recovery that restores core services, supports staff and communities, and strengthens resilience for future events.

Restoration of Health Services

The Health Board will prioritise the safe and equitable restoration of routine clinical services, address backlogs and ensuring continued access for vulnerable groups. Recovery will be coordinated with primary care, community services, and social care partners to balance demand and capacity across the system.

Workforce Recovery and Wellbeing

Supporting the health and wellbeing of staff is central to effective recovery. This includes access to psychological support, rest and recovery time, and initiatives to re-establish normal working patterns. Lessons learned from the pandemic response will be used to strengthen workforce resilience and preparedness.

Public Health Recovery

The Health Board will work with Public Health Wales and local partners to monitor the longer-term health impacts of the pandemic, including mental health, chronic conditions, and delayed presentations. Prevention and health promotion activities will be prioritised to help communities recover and rebuild resilience.

Multi-Agency and Community Recovery

Recovery will be coordinated through established Local Resilience Forum structures, ensuring alignment across health, local authorities, emergency services, and voluntary sector partners. The needs of affected communities will inform recovery planning, with attention to inequalities exacerbated by the pandemic.

Learning, Evaluation, and Preparedness

A structured review process will be undertaken to identify lessons learned, evaluate the effectiveness of response actions, and update plans accordingly. Findings will inform improvements to pandemic preparedness, business continuity, digital capability, and surge planning.

References

phw.nhs.wales/topics/the-communicable-disease-outbreak-plan-for-wales1/

Pandemic Hub

WHO Pandemic Agreement - Global

Annexes

- Annex A: Activation & Escalation Flowchart
- Annex B: IPC Checklist
- Annex C: Vaccination Prioritisation Framework
- Annex D: Communications Plan Template
- Annex E: SitRep Template
- Annex F: Risk Assessment Template
- Annex G: PPE poster

Annex A: Activation & Escalation

1. Surveillance & Early Warning

- Trigger: Unusual increase in cases or international alerts (e.g., WHO, UKHSA).
- Action: Health Protection Team (HPT) conducts initial risk assessment.
- Escalation Criteria: Confirmed cases with potential for community transmission.

2. Initial Activation

- **Lead:** Public Health Wales or WHO
- **Action:**
    - Convene Incident Management Team (IMT).
    - Begin enhanced surveillance and contact tracing.
- Escalation Criteria: Sustained transmission or multiple clusters.

3. Strategic Coordination

- **Lead:** Executive Director of Public Health
- **Action:**
    - Escalate position to Executive Team.
    - Activate Pandemic Response Framework.
    - Coordinate with NHS Wales, UKHSA, and Welsh Government.
    - Establish Strategic Coordination Group (SCG) if required.
- **Escalation Criteria:** Pressure on healthcare services or cross-sector impact.

4. Full Response Activation

- **Action:**
    - Implement pandemic control measures (e.g., IPC, vaccination, public messaging).
    - Mobilise mutual aid and surge capacity.
    - Daily situation reporting and media briefings.

- **Escalation Criteria:** National emergency declaration or multi-agency Gold Command.

5. Recovery & De-escalation

- **Action:**
    - Stand down IMT and SCG.
    - Transition to recovery phase.
    - Conduct debrief and lessons learned exercises.
    - Update pandemic plans and policies.

Annex B: IPC Checklist

Governance & Leadership

- Confirm IPC lead and escalation pathways.
- Activate IPC section of Pandemic Response Plan.
- Ensure communication with Health Board Gold/Silver Command.

Risk Assessment

- Assess transmission risk in healthcare and community settings.
- Review PPE requirements based on pathogen risk level.
- Identify high-risk areas (e.g., wards, care homes).

PPE & Supplies

- Verify stock levels of masks, gowns, gloves, eye protection.
- Implement PPE distribution and monitoring system.
- Ensure fit testing for FFP3 masks where required.

Environmental Controls

- Increase cleaning frequency in high-touch areas.
- Ensure ventilation standards are met.
- Implement isolation protocols for suspected/confirmed cases.

Staff Training & Compliance

- Deliver refresher IPC training to all staff.
- Monitor hand hygiene compliance.
- Reinforce donning/doffing procedures.

Patient & Visitor Management

- Screen patients and visitors for symptoms.
- Enforce mask-wearing and distancing in clinical areas.
- Provide clear signage and information.

Waste & Laundry Management

- Ensure safe disposal of clinical waste.
- Follow protocols for contaminated linen.

Monitoring & Reporting

- Daily IPC compliance audits.
- Report breaches and corrective actions.
- Update IPC dashboard for leadership review.

Annex C: Vaccination Prioritisation Framework

1. Guiding Principles: need to be discussed

- Protect life and reduce severe disease.
- Maintain essential health and social services.
- Ensure equity and transparency.

2. Priority Groups – as instructed by national guidance but may include a phased approach targeting the following:

- Frontline health and social care workers.
- Residents and staff in care homes.
- Individuals with severe immunosuppression or high-risk clinical conditions.
- Population age groups as determined by national guidance.

3. Operational Considerations

- **Supply Chain**: Secure vaccine storage and distribution.
- **Consent & Documentation**: Ensure informed consent and accurate records.
- **Monitoring**: Track uptake, adverse events, and coverage by priority group.
- **Equity Measures**: Outreach to vulnerable and hard-to-reach populations.

4. Escalation & Adaptation

- Adjust prioritisation based on national guidance, in response to:
    - Vaccine availability.
    - Epidemiological trends.
    - Emerging variants and updated guidance.

Annex D: Communications Template

Communications Objectives

- Provide clear, accurate, timely, and evidence-based information
- Support operational response and surge management
- Maintain public confidence and organisational reputation
- Ensure staff are aware of guidance, expectations, and support
- Ensure alignment with national guidance (UKHSA, PHW, Welsh Government)

Key Messaging Framework

Staff Messaging

- Current pandemic status
- Infection prevention & control changes
- PPE guidance
- Testing/vaccination updates
- Workforce support (rotas, wellbeing, HR policies)
- Any changes to services or escalation levels

Template Staff Message:

Subject: *Operational Update – Pandemic Response Level [X]*
To: All Health Board Staff
From: Health Board Gold/Strategic Response Group

Key Summary:

- Current situation
- What's changing
- Required staff actions
- Where to find resources/guidance
- Next update due

Public Messaging

- Service changes
- Visiting restrictions
- Symptoms, testing, vaccination availability

- How to access care safely
- Self-care advice
- Appeals for public cooperation
- Multilingual accessibility

Template Public Statement:
Headline: *Health Board Response to [Pandemic Pathogen]*
Message:

- What is happening
- What services are affected
- What we are asking the public to do
- Where to seek help, and reassurance/safety measures

Partner / Stakeholder Messaging

For: Local Authorities, WAST, PHW, WG, social care, community partners.

Template Stakeholder Briefing:

- Status update and impact on shared services
- Joint actions required
- Contact points for operational and communications escalation

Command Structure Communications

Gold Command

- Strategic updates
- Approval of public-facing communications
- Decisions requiring organisation-wide communication
- Daily/weekly situation reports

Silver Command

- Operational coordination messaging
- Directorate/service updates
- Escalation trigger communications

Bronze Command

- Local site/service briefings
- Frontline operational instructions
- Feedback loops upwards

Annex E: SitRep Template

Pandemic Integrated Reporting – Gold / Silver / Bronze (SitRep Template)

The following table provides a standardised format for integrated reporting across gold, silver, and bronze command levels during pandemic response operations.

Section	Content Prompt	Gold (Strategic)	Silver (Tactical)	Bronze (Operational)
1. Summary	Status, key changes since last report	System-wide position; escalation level	Operational overview; demand picture	Local service snapshot
2. Objectives	Current priorities and aims	Strategic objectives and risk appetite	Tactical priorities and allocations	Immediate tasks and targets
3. Risks/Issues	Top risks and mitigations	Strategic risks; legal/ethical	Operational risks; mitigations required	Front-line safety and IPC issues
4. Capacity	Beds, ICU, ED, community	System capacity picture	Hospital & community capacity actions	Ward/service status and constraints
5. Workforce	Availability, sickness, redeployment	Strategic staffing position	Sickness & redeployment plans	Actual vs required; urgent gaps
6. Supply Chain	PPE, meds, equipment	Critical shortages, mutual aid	Procurement, distribution, stocks	Current stock levels; requests
7. Testing & Vaccination	Activity & constraints	Strategic direction & targets	Throughput and access issues	Daily activity; operational barriers

Section	Content Prompt	Gold (Strategic)	Silver (Tactical)	Bronze (Operational)
8. Comms	Public, staff, partner comms	Key messages; media risks	Partner comms, briefings	Local messaging & queries
9. Decisions	Made and required	Decisions taken; asks of WG/LRF	Decisions for Gold; inter-dept actions	Requests to Silver
10. Forecast	24–72h outlook	Scenarios; triggers to escalate/de-escalate	Resource forecast; shifts & plans	Expected pressures next period

Annex F: Risk Assessment Template

Command and Control structures to hold individual pandemic risk log. An example is provided

This template is designed to support the identification, evaluation, and mitigation of risks during a pandemic response. Some example risks are given below:

Risk	Likelihood (Low/Medium/High)	Impact (Low/ Medium/ High)	Risk Rating (RAG)	Mitigation Measures	Responsible Person	Review Date
PPE Shortage	Increased risk of infection among staff and patients	High	Establish emergency stockpile; implement PPE conservation protocols; source alternative suppliers			
Staff Absenteeism	Reduced capacity to deliver essential services	High	Activate surge staffing plans; cross-train staff; implement remote work options			
Vaccine Supply Delays	Delayed immunization of priority groups	Medium	Coordinate with national supply chain; prioritise high-risk groups; communicate transparently with public			
IT System Failure	Disruption to data reporting and communications	Medium	Implement backup systems; conduct regular system testing; ensure manual reporting protocols			

Risk	Likelihood (Low/Medium/High)	Impact (Low/ Medium/ High)	Risk Rating (RAG)	Mitigation Measures	Responsible Person	Review Date
[Enter details]	[Enter details]	[Enter details]	[Enter details]	[Enter details]	[Enter details]	[Enter details]
[Enter details]	[Enter details]	[Enter details]	[Enter details]	[Enter details]	[Enter details]	[Enter details]
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[Enter details]	[Enter details]	[Enter details]	[Enter details]	[Enter details]	[Enter details]	[Enter details]
[Enter details]	[Enter details]	[Enter details]	[Enter details]	[Enter details]	[Enter details]	[Enter details]

Annex G: PPE Poster

All staff entering a room with symptomatic patients or having contact with symptomatic patients must wear correct Personal Protective Equipment (PPE).

- **Gloves** (for invasive procedures, contact with sterile sites, non-intact skin, mucous membranes and all activities that carry a risk of exposure to blood, body fluids, secretions and excretions).
- **Plastic apron** (**full sleeve water proof gown** if there is a risk of gross contamination and aerosol generating procedure).

FOR NON AEROSOL GENERATING PROCEDURES

Use a fluid repellent surgical mask, Type IIR, with goggles/visor or a mask with integral visor. Do not touch mask once put on. Change if they become moist. Only wear once. Do not let the mask hang down around the neck.

FOR AEROSOL GENERATING PROCEDURES

Use a FFP3 facemask conforming to EN149:2001 with goggles/visor.

If patients are cohorted in one area then it may be practical to wear a fluid repellent surgical mask, Type IIR, and eye protection (or fluid shield mask) upon entry and to keep it on the duration of the activity. However, other PPE (gloves, apron) must be removed between patients, hand decontaminated and clean PPE put on. All PPE to be disposed of as clinical waste.

AEROSOL GENERATING PROCEDURES (AGP'S)

Procedures that may produce higher concentrations of infectious respiratory particles than coughing, sneezing or talking. On the best currently available evidence, examples include:-

- Bronchoscopy
- Sputum induction
- Tracheal intubation
- Post mortem procedures involving high speed devices
- Cardio-pulmonary resuscitation
- High FREQUENTY OSCILLATING VENTILATION
- Non-invasive ventilation including CPAP

Note this list is not exhaustive, local risk assessment may identify additional procedures for which AGP precautions are indicated.

These procedures are not normally considered to be aerosol generating:

- Nebulisation
- Routine tracheostomy care (FFP3 may be considered, following local risk assessment, if the procedure is deemed likely to cause prolonged or vigorous coughing).

4

11:00 AM, 0 Mins

4 - FOR INFORMATION

4.1

11:00 AM, 0 Mins

4.1 - HSC Workplan

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

For information

Attachments

HSCommittee 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	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 – 6 Monthly 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
• Management of Health and Safety at Work Regulations 1999 (MHSWR) • Workplace (Health, Safety and Welfare) Regulations 1992 (WHSWR) • Slips/Trips/Falls • Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)									
Health & Safety (Part 2) – covering the following regulations: • First Aid Regulations • Health and Safety (Display Screen Equipment) Regulations 1992 (as amended) (DSE) • Control of Substances Hazardous to Health Regulations 2002 (as amended) (COSHH) • REACH (Amendment) Regulations 2023 • Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR) • Health and Safety (Sharp Instruments in Healthcare) Regulations 2013	Assurance	JS	HHS&S		✓				
Health & Safety (Part 3) – covering the following regulations: • Personal Protective Equipment at Work Regulations 1992 (PPE) • Manual Handling Operations Regulations • Health and Safety (Consultations with Employees) Regulations 1996) • Safety Representatives and Safety Committees Regulations 1977 • Latex	Assurance	JS	HHS&S			✓			

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
Health & Safety (Part 4) – covering the following regulations: • Health and Safety (Safety Signs and Signals) Regulations 1996 • New & Expectant Mothers • Workplace Stress, Depression & Anxiety • Ligature Risk Management • 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						
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)	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
• Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) • Lifts									
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 • 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	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 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						
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	✓ ✓	✓ ✓		✓ ✓	✓ ✓	✓
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						
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	✓	✓	✓	✓	✓	✓

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
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	**JW**	Joanne Wilson	**AC**	Andrew Carruthers	**AG**	Ardiana Gjini
SC	Simon Chiffi	**CW**	Charlotte Wilmshurst	**SA**	Shaun Ayres	**SH**	Sam Hussell
CS	Charles Scarf	**RJ**	Richard Jupp	**PS**	Peter Skitt	**SQ**	Sara Quarrie
CJ	Christine James	**LC**	Liz Carroll	**PG**	Paula Goode	**DE&F**	Director of Estates & Facilities
PJ	Peter Jones	**HHSS**	Head of Health, Safety & Security	**PW**	Paul Williams		
RPA	Radiation Protection Advisor			**RJ**	Richard Jupp	**SD**	Simon Day
		PF	Philip Flear	**GR**	Gareth Rees	**RW**	Rachel Williams
		CSO	Committee Services Officer	**D**	Deferred	**IC**	In Committee

5

11:00 AM, 5 Mins

5 - ANY OTHER BUSINESS

All

6

11:05 AM, 5 Mins

6 - MATTERS FOR ESCALATION TO BOARD

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

7

11:10 AM, 0 Mins

7 - DATE AND TIME OF NEXT MEETING

Tuesday 7 July 2026, 9.30am-11.30am