Date	**07/07/2026**
Time	**9:30 AM - 11:30 AM**
Location	**Microsoft Teams Meeting**

Virtual Health & Safety Committee Meeting

Health and Safety Committee

NHS Wales

Agenda - 7 July 2026

1 GOVERNANCE

9:30 AM, 0 min

1.1 Welcome and Apologies

9:30 AM, 0 min
Ann Murphy (Hywel Dda UHB - RCN Trade Union Rep - Independent Board Member)

1.2 Declarations of Interest

9:30 AM, 0 min
All

1.3 Minutes of Previous Meeting

9:30 AM, 5 min
Ann Murphy (Hywel Dda UHB - RCN Trade Union Rep - Independent Board Member)

1.4 Matters Arising and Table of Actions from Previous Meeting

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

1.5 Assurance and Risk Report

9:40 AM, 10 min
James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science), Gareth Cottrell (Hywel Dda UHB - Deputy Chief Operating Officer)

2 HEALTH AND SAFETY UPDATES

9:50 AM, 0 min

2.1 Health and Safety Assurance Report

9:50 AM, 10 min
Adam Springthorpe (Hywel Dda UHB - Health & Safety Manager)

2.2 Health & Safety Training Overview

10:00 AM, 10 min
Adam Springthorpe (Hywel Dda UHB - Health & Safety Manager)

2.3 Regulation Assurance Report

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

2.4 Fire Safety Risk Assessment Assurance Update (BORIS)

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

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

10:30 AM, 10 min
Adam Springthorpe (Hywel Dda UHB - Health & Safety Manager), Gareth Cottrell (Hywel Dda UHB - Deputy Chief Operating Officer)

2.6 Health & Safety/Individual Regulations Written Control Documents Status Report

10:40 AM, 10 min
James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)

3 Clinical Care Group Updates

10:50 AM, 0 min

3.1 Mental Health and Learning Disabilities

10:50 AM, 10 min
Gareth Cottrell (Hywel Dda UHB - Deputy Chief Operating Officer), Rebecca Temple-Purcell (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality and Experience)

3.2 Community and Integrated Medicine

11:00 AM, 10 min
Gareth Cottrell (Hywel Dda UHB - Deputy Chief Operating Officer), Anna Chiffi (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality)

4 Policies

11:10 AM, 0 min

4.1 Major Incident Plan

11:10 AM, 10 min
Sam Hussell (Head of Health Emergency Planning)

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5 **FOR INFORMATION**

11:20 AM, 0 min

5.1 **HSC Workplan**

11:20 AM, 0 min
Ann Murphy (Hywel Dda UHB - RCN Trade Union Rep - Independent Board Member)

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6 **ANY OTHER BUSINESS**

11:20 AM, 5 min
All

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7 **MATTERS FOR ESCALATION TO BOARD**

11:25 AM, 5 min
Ann Murphy (Hywel Dda UHB - RCN Trade Union Rep - Independent Board Member)

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8 **DATE AND TIME OF NEXT MEETING**

11:30 AM, 0 min

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07/07/2026 9:30 AM - 11:30 AM

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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

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

For approval

Attachments

2026-05-05 - Virtual Health Safety Committee Meeting - Minutes.pdf

MINUTES OF THE Health and Safety Committee MEETING

Date of Meeting:	**9:30 AM, Tuesday 05 May 2026**
Venue:	**Microsoft Teams Meeting**

Present:	Ann Murphy, Independent Board Member (*Chair*) Michael Imperato, Independent Board Member
In Attendance:	Adam Springthorpe, Health & Safety Manager Anthony Dean, Staff Side Representative Ardiana Gjini, Executive Director of Public Health (*part*) 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 (*part*) 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 Sam Hussell, Head of Health Emergency Planning Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding (*part, deputising for Sharon Daniel, Executive Director of Nursing, Quality & Patient Experience*) Ruth Poynting, Committee Services Officer (*Minutes*)
Apologies:	Andrew Carruthers, Chief Operating Officer Sarah Harraway, Independent Board Member Iwan Thomas, Independent Board Member

Minutes Ref.	Item	Action
HSC(26)024	**Welcome and Apologies** Ms Ann Murphy welcomed all to the meeting and apologies were noted as above.	
HSC(26)025	**Declarations of Interest** Board Member DOI Register	

There were no declarations of interest.

HSC(26)026 **Minutes of Previous Meeting Held on 10 March 2026**

The minutes of the previous meeting were approved.

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

HSC(26)027 **Matters Arising and Table of Actions from Meeting held on 10 March 2026**

HSC(26)017: Ms Sharon Daniel referred to an earlier discussion at the Quality, Safety and Experience Committee in June 2025, which highlighted challenges relating to the flexibility of discretionary capital funding and how the scale of Facilities and Estates work required was communicated to Welsh Government. A review of Estates work has since been completed, with a particular focus on inpatient areas.

Mr James Severs proposed that a similar exercise be undertaken within HSC, while acknowledging that the newly developed risk profiling may already address much of this work. Ms Jo Wilson further suggested inviting a representative from the Capital and Planning Team to a future HSC meeting.

Decision: The Committee NOTED the Table of Actions.

HSC(26)028 **Review of HSC Terms of Reference (TORs)**

Ms Wilson presented the amended HSC Terms of Reference, noting that Mr Gareth Cottrell will replace Mr Andrew Carruthers as an in-attendance member of the Committee.

Mr Michael Imperato sought clarification on the meaning of “work-related activities” referenced under section 2.1. Ms Wilson explained that the term relates to compliance with Health and Safety at Work legislation. Mr Severs added that it is intended as an all-encompassing term, covering a broad range of areas from stress to fire safety. Mr Imperato welcomed the clarification, noting that while patients are referenced, the focus remains on health and safety in relation to them.

Decision: The Committee APPROVED the Health and Safety Committee’s Terms of Reference (v.12) for onward ratification by the Board on 28 May 2026.

HSC(26)029 **HSC Annual Self-Assessment of Effectiveness Outcome Report**

Ms Wilson reported that only four of the eleven individuals approached had responded, making it difficult to draw firm

conclusions. However, she noted that several areas were identified as working well, particularly communication with trade unions. She added that there is a desire to strengthen awareness of, and compliance with, health and safety legislation across the organisation. She also referenced a recent Board seminar, which included feedback on how Committee papers are written and presented.

Mr Severs thanked colleagues for their support over the past year, acknowledging that it had been a challenging period. He noted that, while progress has been made, the desired level of governance has not yet been fully achieved, and further work is required to improve oversight and develop a more robust approach to managing risks.

Decision: The Committee CONSIDERED the outputs from the Committee Self-Assessment process and AGREED to the actions to be taken to improve its effectiveness.

HSC(26)030 **Health & Safety Committee Annual Report 2025/26**

Ms Wilson explained that the Annual Report has been produced to provide a summary of the Committee's activity over the year, in line with the requirements set out in the Standing Orders.

Ms Murphy thanked the Committee for their hard work throughout the year.

Decision: The Committee APPROVED the HSC Annual Report as an accurate record.

HSC(26)031 **Assurance and Risk Report**

Ms Wilson presented the report, outlining the risks currently under consideration, noting that one within the Committee's remit, together with activity relating to 40 audits and inspections and correspondence received from Mid and West Wales Fire and Rescue Service (MAWWFRS).

Mr Severs highlighted the work undertaken by the Assurance and Risk Team to reprofile risks in a different format, specifically referencing risks 1860 and 1861, and acknowledged the support provided by Ms Elin Brock in this process.

Mr Imperato drew attention to the recommendations, observing that while the risks described were significant, the associated recommendations appeared moderate. He queried whether there was a disconnect between the level of assurance being received and the severity of the risks, noting that, while the report was robust, the risks remained considerable. In response, Ms Wilson explained that work is ongoing to test the assurance provided by risk owners, ensuring that all possible actions are being taken through audits and monitoring. She added that it is for the Committee to determine how this is reported to the Board. Mr Imperato emphasised the importance of ensuring alignment,

noting a common theme across Committees regarding audits. Ms Wilson confirmed that this had been raised with Committee Chairs.

Mr Severs noted a number of overdue actions without updates, suggesting this indicates a need for further work on assurance processes. He added that actions have now been grouped by site level to provide improved clarity.

Ms Daniel emphasised the importance of ensuring actions are SMART and queried whether the Health and Safety Compliance Group may have a role, and whether the actions identified are sufficient to close the risks, suggesting that a more detailed review may be needed. Mr Severs confirmed that actions are now being linked to the action log to strengthen Committee oversight and assurance.

Ms Wilson advised that Mr Andrew Carruthers, Mr Gareth Cottrell and Mr Keith Jones are undertaking deep dives on outstanding risks.

The Committee agreed that, while there is assurance that key risks are being monitored, these remain significant and further work is required to strengthen assurance, including through clearer reporting and deep dive reviews, therefore the Board would need to be advised.

Decision: The Committee took LIMITED ASSURANCE that identified controls are in place and working effectively, 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.
Decision: The Committee took LIMITED ASSURANCE 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.

HSC(26)032 **Health and Safety Assurance Report**

Mr Adam Springthorpe advised the Committee that, although a candidate had been identified for the Head of Health and Safety post, they had subsequently withdrawn, and the appointment had therefore not progressed as planned.

The Microbiology Health and Safety Improvement Notice had now been signed off. Mr Springthorpe further advised that progress on manual handling continues, with further work underway to improve training attendance.

Mr Imperato welcomed the dashboard approach, noting that it improved understanding of the information presented. He raised the issue of absconding patients and asked which areas were of greatest concern. Mr Springthorpe advised that compliance with Martyn's Law is expected to support further improvements through enhanced ward security. He identified slips, trips and falls, manual handling, and violence and aggression (V&A) as the main areas of concern. While slips, trips and falls account for relatively small numbers, these are across a wide range of settings. Manual handling incidents remain higher due to the nature of the work, and V&A incidents are currently low in number.

Ms Daniel noted that additional assurance in relation to absconding patients would be beneficial and suggested this could form a future piece of work, including analysis of trends over several years. She also highlighted the opportunity to draw lessons learnt from previous incidents, noting the robust and technically strong process applied, which originated in Swansea Bay University Health Board (SBUHB).

Mr Severs noted that, in light of the previous discussion, any inspection or enforcement action from the Health and Safety Executive should be regarded as a serious matter for the organisation. He advised that an update is scheduled to be presented to the Health and Safety Compliance Group on 11 May 2026, which will provide an opportunity to identify any early learning from the process. He proposed that a further update be presented to a future Committee meeting for consideration.

In response the causes the greatest concern within the risks presented, Ms Elin Brock highlighted that V&A incidents are a key concern. She noted that such incidents can have a significant impact on staff wellbeing and, given the current pressures on clinical teams, there is a likelihood that incidents may be underreported.

Ms Brock also drew attention to a reduction in compliance with Restrictive Practice Training at Prince Philip Hospital. However, she provided assurance that refresher training has now been booked for the relevant staff, and it is anticipated that compliance levels will return to target within the next eight weeks.

Mr Cottrell highlighted that, while progress has been made, compliance with manual handling training is still not at the desired level. He queried whether services were receiving the appropriate level of support from the Health Board and whether the issues related to capacity or engagement. In response, Mr Springthorpe advised that a key challenge is that staff often book training but do not attend. He emphasised the need to ensure staff are adequately released to complete all training. He also noted plans to strengthen the role of workplace assessors, enabling more training and assessment to take place on site, with staff only required to return to central training facilities every three years.

Mr Severs also confirmed that interim arrangements are being established pending the recruitment of a Head of Health and Safety, with support from the Executive Team to strengthen organisational capacity.

Decision: The Committee TOOK ASSURANCE from the contemporaneous issue updates and the health and safety metrics outlined in the Health and Safety Assurance Report.

HSC(26)033 **Individual Regulation Assurance Reports**

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

Mr Springthorpe reported a year-on-year decline in the number of RIDDOR reports. Robust processes and scrutiny arrangements were noted to be in place, and the continued reduction was viewed as encouraging. However, it was acknowledged that additional years of data would be required to confirm whether this represents a sustained trend. Reporting timeliness were noted to be just under 70%.

Mr Severs commended the progress made and queried whether improvements were attributable to organisational culture or process.

Mr Springthorpe advised that both factors have contributed. Regular reporting through CCG structures has increased visibility and accountability, with more consistent follow-up at senior management level. In addition, significant work has taken place, including detailed review of incidents, staff training, and strengthened relationships within teams.

In response to a query from Mr Severs, Mr Springthorpe clarified that the focus of reporting is more aligned to localities rather than acute hospital settings. Data for each site is available however the Committee agreed the current level of reporting is appropriate.

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

HSC(26)034 **Fire Regulation Assurance Report Update**

Mr Simon Chiffi provided an update on the implementation and use of the BORIS system, which was introduced in 2021. This follows concerns raised at the previous Committee meeting regarding the volume of outstanding actions.

Assurance has been provided from the NHS Wales Shared Services Partnership (NWSSP) Senior Fire Safety Advisor that the system is extracting the necessary data.
There are currently 338 live Fire Risk Assessments (FRAs) in place, covering both clinical and non-clinical areas. Each

assessment comprises 54 questions, resulting in a significant volume of data. This represents a substantial improvement compared to previously available systems and data sets.

The ongoing fire safety programme is expected to reduce the current tolerated risk score of 15 significantly over time. Each identified action within the system is assigned a timeframe and is submitted to an action approver for either approval or closure, supporting improved risk score management. Current reporting indicates no extreme risks.

Despite promotion of BORIS by the Fire Safety Team and the delivery of training, further improvements are required to maximise effectiveness. It was noted that BORIS was developed prior to the establishment of CCGs, which has resulted in some gaps in accountability. While action owners have been identified, these were not originally assigned through CCG structures; this is now under review.

Work is also underway to enhance system functionality, including improving automated notifications to staff and increasing ease of access for users.

Letters of Fire Safety Matters have reduced significantly from 98 to 57, with 29 letters currently awaiting closure.

The target date to reduce the tolerated risk score to five is 2029. This is supported by Phase Two works at Glangwili Hospital (GGH) and significant project developments at Bronglais Hospital (BGH).

Mr Imperato commended the report, noting the reduction in high estates actions from 889 to 665 as outlined in Table 1, and requested clarification on how this improvement had been achieved. Mr Chiffi advised that the reduction is largely attributable to the completion of Phase One works at Withybush General Hospital (WGH) and GGH, where those projects addressed a significant number of actions. In addition, progress has been supported through the Targeted Estates Fund (TEF) programme, which is 70% funded by Welsh Government. Further contributing factors include the fire alarm project at WGH, a number of targeted fire door schemes, and improved accountability within the team and CCGs.

Ms Wilson asked what support was required from operational, corporate, and internal teams, and whether there were specific areas where the Committee could provide assistance, and whether there were any significant issues not already highlighted. Mr Chiffi advised that there are no major or extreme issues at present. Four Fire Safety Advisors have identified responsible owners; however, these have not yet been formally assigned to CCGs.

In relation to his own team, Mr Chiffi noted that further work is required to ensure actions are correctly categorised, particularly in determining which items require capital funding. This includes confirming whether appropriate bids have been submitted and whether they have wider Health Board support. He emphasised that this is a significant piece of work that will take time to fully develop.

Regarding corporate teams, Mr Chiffi highlighted the recent change in chairing arrangements for the Fire Safety Group (FSG) and stressed the importance of consistent attendance and ensuring all members are clear on their responsibilities.

Mr Severs added that this will be discussed at the Health and Safety Compliance Group (HSCG) to further develop a plan with clear actions, timescales, and overall clarity.

While the Committee recognised that the report demonstrated significant improvement, it was unable to take full assurance due to a lack of clarity regarding timelines and CCG accountability.

Decision: The Committee RECEIEVED LIMITED ASSURANCE from the Fire Safety Risk Assessment System (Boris) report; whilst noting progress since September 2025 in reducing outstanding FRAs and the continued oversight of the FRA Action Improvement Plan (table 1.0) by the Health and Safety Compliance Group.

HSC(26)035 **Health and Safety Inspection Actions**

Mr Springthorpe reported that progress has been made, particularly in relation to risk stratification, with a 29% reduction in moderate actions and a 30% reduction in major actions.

Mr Cottrell acknowledged the progress achieved however emphasised that further work is required. He noted that the focus needs to shift to CCGs to ensure that actions are effectively closed down.

Mr Imperato noted that overall progress remains limited and highlighted the challenge in quantifying improvement. He sought clarity on the definition of success. In response, Mr Cottrell advised that he would develop a clear trajectory to enable the Committee to more effectively hold teams to account.

Mr Severs welcomed the revised table, noting that it reflects historic issues more clearly. He added that this would also be considered further at HSCG.

The Committee was assured regarding the overall direction of travel; however, it was agreed that further development of the metrics is required to clearly define and monitor the trajectory.

Decision: The Committee TOOK ASSURANCE from the Site Visit Report and Associated Actions Report 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. It also NOTED the monitoring of the Health and Safety Actions (table 2.0 and table 3.0) by the Health and Safety Compliance Group.

HSC(26)036 **New Health and Safety Inspection Process**

Mr Springthorpe informed the Committee that a procedure for the Health and Safety Inspection Process has been developed and approved.

Mr Severs and Ms Murphy agreed that it would be useful for the procedure to be presented to the Committee for information. Ms Murphy also noted that Trade Unions own their own inspection procedures.

In response to a query from Ms Wilson, Mr Springthorpe confirmed that the procedure had been circulated through the global email prior to approval and had undergone an Equality Impact Assessment (EqIA).

Decision: The Committee RECEIVED 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.

HSC(26)037 **Revised Pandemic Framework**

Ms Sam Hussell presented the revised Pandemic Framework for approval, highlighting a significant focus on emergency planning for the coming year. She outlined the number of exercises the Health Board has participated in, including Projects Pegasus and Solaris, and explained that the framework has been updated and refreshed to reflect current requirements.

Ms Hussell confirmed that command and control structures have been fully updated and that the framework has been aligned with the Dyfed Powys Local Resilience Forum pandemic arrangements. The report sets out the key changes incorporated into the revised approach.

Ms Hussell also advised that a multi-disciplinary tabletop exercise is scheduled for the end of June 2026, with work underway to identify key leads to ensure representation from all departments. This forms part of an ongoing programme of work, alongside operational-level discussions to strengthen preparedness.

Mr Imperato queried whether recommendations from the COVID-19 Inquiry had been incorporated. Ms Hussell confirmed that these have been reflected within the framework and Ms Wilson added that lessons learned were undertaken from this inquiry.

Mr Severs referred to Appendix F and sought clarification on how operational and corporate teams would demonstrate

preparedness. Ms Hussell explained that this will be achieved through business continuity planning, service-level plans at an operational level, infection prevention and control (IPC) arrangements, and clearly defined local response plans, providing a bridge between strategic direction and operational delivery.

Decision: The Committee RECOMMENDED the Pandemic Response Framework for onward approval by the Board on 28 May 2026.

HSC(26)038 **HSC Workplan**

There were no comments on the workplan.

HSC(26)039 **ANY OTHER BUSINESS**

As the CCG Assurance reports were deferred to the next meeting, Ms Murphy noted that the Committee is now six months into the year and, following the cessation of the Health and Safety Sub-Committee (HSSC), has not received an update. She advised that, in the absence of a timely update, there is a risk this matter may require escalation to the Board.

Mr Severs acknowledged the challenge, highlighting the current absence of a Head of Health and Safety. He advised that he has commissioned a review of the HSCG terms of reference, alongside governance, management, and reporting arrangements, to ensure these remain fit for purpose in light of recent changes to the operational governance structure.

Ms Brock provided further context, explaining that a baseline assessment has been undertaken to map relevant regulations and standards. This has enabled the identification of gaps in compliance, as well as the development of key performance indicators (KPIs) and metrics. Work is ongoing to establish a comprehensive suite of KPIs, with meetings held with accountable leads and the development of a template to demonstrate compliance. She added that she is working with Mr Cottrell to determine how Health and Safety matters should be reported and to review the terms of reference.

Mr Cottrell emphasised the importance of clearly demonstrating how Health and Safety challenges and risks are being addressed and ensuring that reporting is consistent and appropriate. He reiterated a commitment to strengthening this area.

Ms Wilson provided clarification that HSCG should maintain an operational focus, while CCGs must ensure clear accountability and ownership.

HSC(26)040 **MATTERS FOR ESCALATION TO BOARD**

The Committee agreed to advise the Board of the following:

- Overdue actions and potential disconnect between assurance received and residual risk levels outlined in the **Assurance and Risk Report**.
- Gaps in clarity of action ownership and lack of alignment with CCGs identified in the **Fire Risk Assessment (Boris) report**.

DATE AND TIME OF NEXT MEETING

Tuesday 7 July 2026, 9.30am-11.30am

1.4

9:35 AM, 5 Mins

1.4 - Matters Arising and Table of Actions from Previous Meeting

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

For discussion

Attachments

H_S Actions July 2026.pdf

HEALTH AND SAFETY COMMITTEE (HSC)/ PWYLLGOR IECHYD A DIOGELWCH
05/05/2026
TABLE OF ACTIONS/TABL GWEITHREDOEDD

Key: AC-Andrew Carruthers; GC-Gareth Cottrell; JS-James Severs; KRy-Karen Ryan; SC-Simon Chiffi; 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.
11/11/2025	HSC(25)037	Health and Safety Sub-Committee Update • To clarify whether a risk assessment has been incorporated into the updated Control of Contractors policy.	SC	30/11/2025	Complete It was decided not to include a “direct copy” of HDuHB Risk Assessments in this policy, as each employed contactor would offer their own version. Specific reference has been included to other documents in conjunction to this policy, namely 156 -Risk Management Strategy & Policy and also 674 - Risk Assessment Procedure.
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. 30/06/26 Further work 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, 10 Mins

1.5 - Assurance and Risk Report

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

For assurance

Attachments

HSC Public Governance Arrangements July 2026 FINAL.pdf

Appendix 1 - Health Safety Committee Risk Register - Jun26.pdf

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

Assurance and Risk Report

Health and Safety Committee – 7 July 2026

Situation

This report provides the Health and Safety Committee (HSC) with the status of operational risks and Welsh Health Circulars (WHCs) within its remit.

The Committee is asked to seek assurance from the Lead Executive Directors that the principal risks are being refreshed and will be reported to the Board in July, and that there are processes in place to oversee operational risks to ensure these are being managed effectively, and that WHCs are being implemented by the Health Board.

Corporate risks, audit and inspection recommendations and Ministerial Directions are reported at alternate meetings, and due to be presented to HSC at its next meeting in August 2026.

Principal Risks	Operational Risks	Welsh Health Circulars
0	54	0

Risk Management - Overview

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 allocate for the management, reporting and escalation of risk.

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

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

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

Operational Risks assigned to HSC

Following identification and assessment of risks, each risk is aligned to a specific Health Board committee or sub-committee. Effective risk management requires a 'monitoring and review' structure, ensuring that risks are effectively identified and assessed, and that appropriate controls and responses are in place.

Operational risks are managed within Clinical Care Groups (CCG) and Executive Functions (collectively referred to as "Functions") under the ownership and leadership of individual Executive Directors. Each CCG must establish local arrangements for the review of their Risk Registers, which includes the validation of the information and risk scores, and the prioritisation and identification of solutions to their risks. Each CCG Integrated Governance Group (CCG IGG) is provided with an Assurance and Risk Report, with any issues escalated through the operational directorate governance structure via the 3As Report following each CCG IGG meeting.

The Health Board has formal monitoring and scrutiny mechanisms in place to provide assurance to the Board regarding the effective management of risks. Monthly assessments are made for each Function on their risk management, informing their overall level within the 'Governance' domain as part of the Health Board's internal escalation framework. A key metric in the Health Board's internal escalation process under the Governance domain is how Functions are managing risks in terms of the scale, significance, timeliness and quality, with measures extended from April 2026 to inform levels to be awarded (detailed on the next slide).

The Assurance and Risk Team provide focussed support for those Functions at levels 3 and 4 to aid their de-escalation / recovery and prevent those awarded level 2 status being further escalated. Detail is provided within each report provided and presented at Function governance meetings explaining the reasons behind their escalation status, and suggested actions required to de-escalate (where appropriate). Whilst the four levels within the escalation framework have been agreed, the Executive Team are currently determining processes to support those Functions who may be assessed as being in Level 4. Functions are currently assessed as being either level 1, 2 or 3 pending formalisation of these processes. As at May 2026 month end Community & Integrated Medicine are at level 3.

Operational Risks assigned to HSC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Measures to assess against the Governance Domain (risk management) for 2026/27

Level	Criteria
Level 4 – no assurance and insufficient actions / engagement	No plan in place and no engagement, (eg no risk action plans, no expected date to achieve Target Risk Score). Evidence where known risks are not articulated on the function's risk register. No evidence that risks are escalated via CCG management structures where necessary, no engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 3 – no assurance	Lack of evidence that risks are being managed and mitigated within expected timescales, with limited or no qualitative detail included within the risk (eg rationales for risk scores, no progress updates on risk actions.) Evidence where known risks are not articulated on the function's risk register in a timely manner. **Less than 80% compliance** of risks and risk actions being updated within required timescales Limited evidence that risks are escalated via CCG management structures where necessary, therefore not demonstrating good engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 2 – Limited assurance	Relevant risks articulated on risk registers with action plans in place, but lack of evidence that risks are being managed and mitigated within expected timescales. *(eg risk action plans not being implemented within stated action dates, or limited detail behind any date extensions, limited evidence of reduction in current risk score, risks where dates to achieve target risk scores are not being met, poor risk rationales).* **Between 80% - 89% compliance** of risks and risk actions being updated within required timescales Some evidence that risks are escalated via CCG management structures where necessary, demonstrating engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 1 – Reasonable assurance	Relevant risks articulated on risk registers with action plans in place, and evidence that the function is delivering against these (eg specific and measurable risk action plans, current risk score and target risk score clearly articulated, achieving expected target risk dates) **Over 90% compliance** of risks and risk actions being updated within required timescales Evidence that risks are escalated via CCG management structures where necessary, demonstrating good engagement and the ability for leadership to make informed decisions on prioritisation of resources

Operational Risks assigned to HSC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

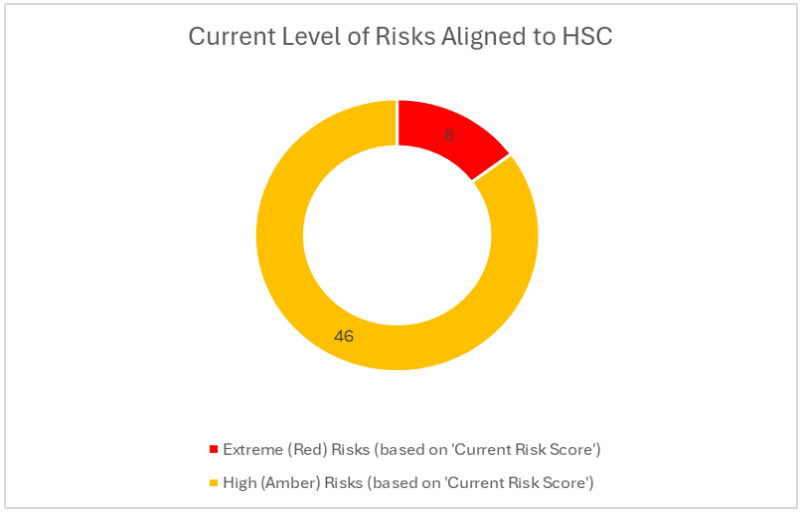
61 risks are currently aligned to HSC, with 54 identified as reportable to HSC based on the following criteria:

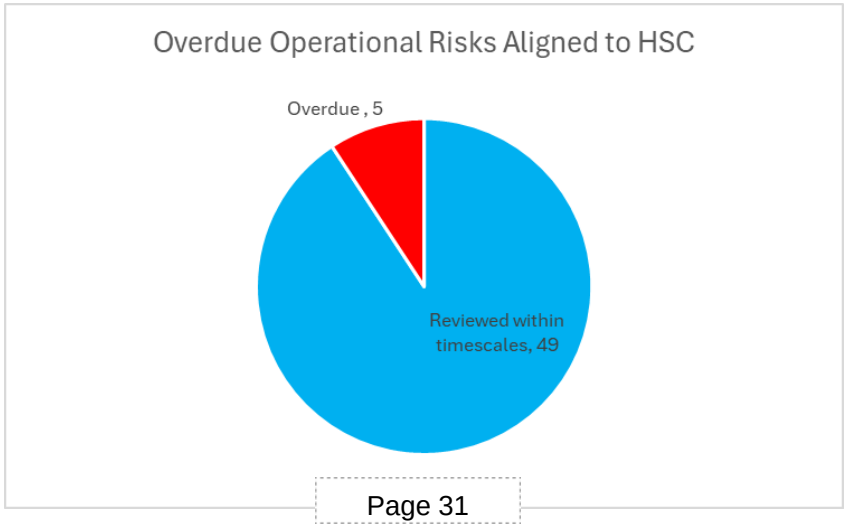
- HSC has been selected by the risk lead as the 'Assuring Committee' on Datix;
- Risks have been identified at operational level on Datix risk module;
- The current risk score is 'extreme' or 'high'; and
- The current risk score is either equal to or exceeds the target risk score.

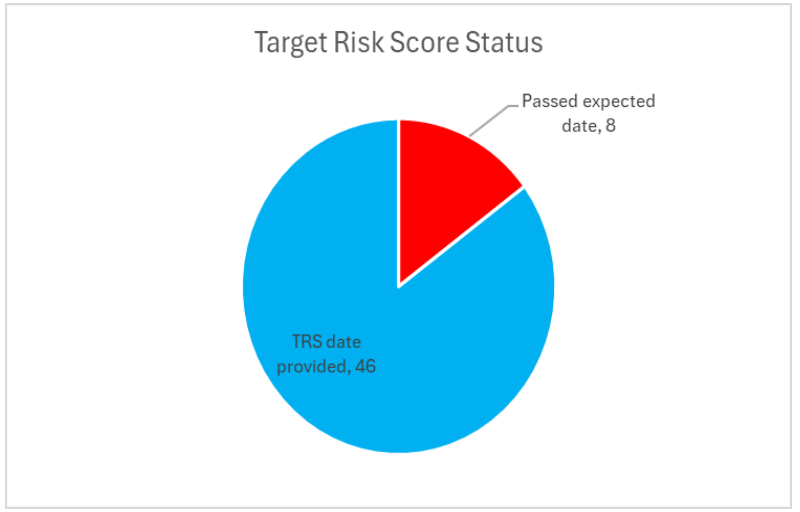
The following slides summarise the reportable operational risks aligned to HSC. The Risk Register attached at **Appendix 1,** provides full detail of reportable risks.

**Due to their sensitive nature, 2 risks are being reported to in-committee to provide discussion and assurance.*

Number of reportable risks from previous report	**50**
New risks added / newly reportable risks since last report	8
Risks closed since last report	3
Risks that are no longer reportable	1
Risks with increased Current Risk Score (CRS) since last report	0
Risks with decreased CRS since last report	0
Risks with no change in CRS since last report	46
Total number of risks meeting criteria for current report	**54**







Risks aligned to HSC by Location

The graph below identifies the risks per location to reflect local risk exposure, and to support clearer Committee oversight.

Health Board-wide risks

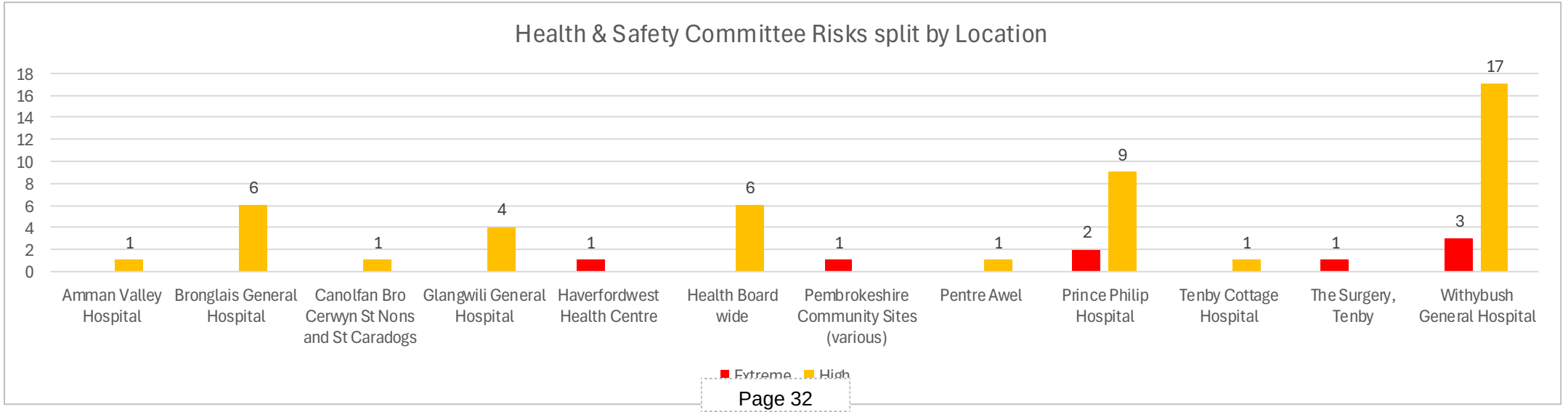
The 6 Health Board-wide risks highlight systemic issues relating to fire safety, workforce safety, training and non-compliance with regulations including the Health and Safety Act and Control of Substances Hazardous to Health (COSHH). Actions aligned to these risks are organisational-wide include the development and enhancement of training provision and improving governance arrangements to highlight risks. Specific actions are raised where needed for individual sites.

Acute site-specific risks

The 20 risks assigned to WGH are primarily linked to estate deterioration, electrical infrastructure, fire safety systems, and environmental hazards. The 11 risks assigned to PPH relate to fire safety, engineering systems, gas infrastructure, and site safety issues. The 6 risks assigned to Bronglais General Hospital (BGH) relate fire systems, medical gas, electrical compliance, and estate condition. The 4 risks assigned to Glangwili General Hospital (GGH) focus on fire safety deficiencies, doors not compliant with safety standards and emergency lighting.

Community site-specific risks

Risks in this category reflect the deteriorating condition of the estates infrastructure, utility provision to the sites (eg emergency lighting), and concerns to staff safety due to lone working requirements out of hours.



Risks aligned to HSC by Clinical Care Group / Function, and Risk Domain

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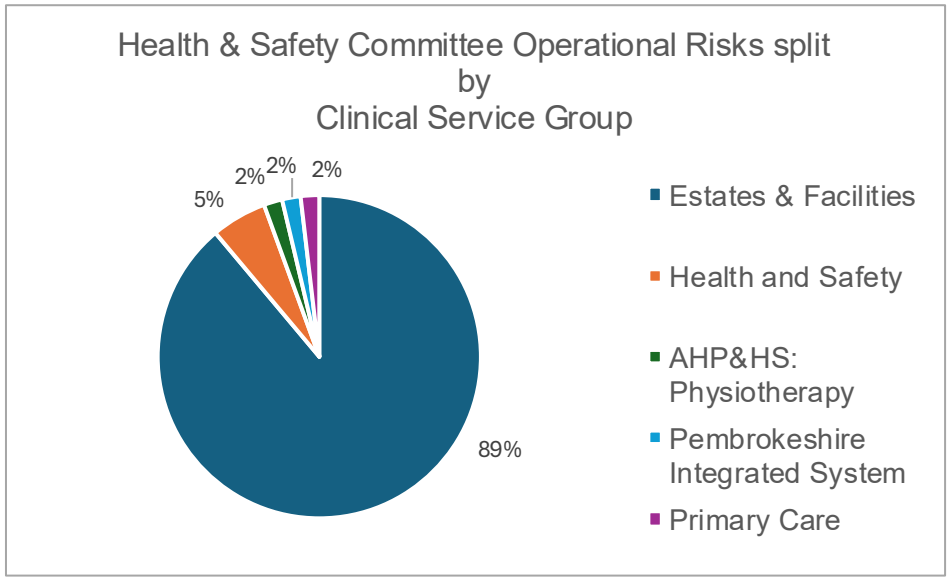
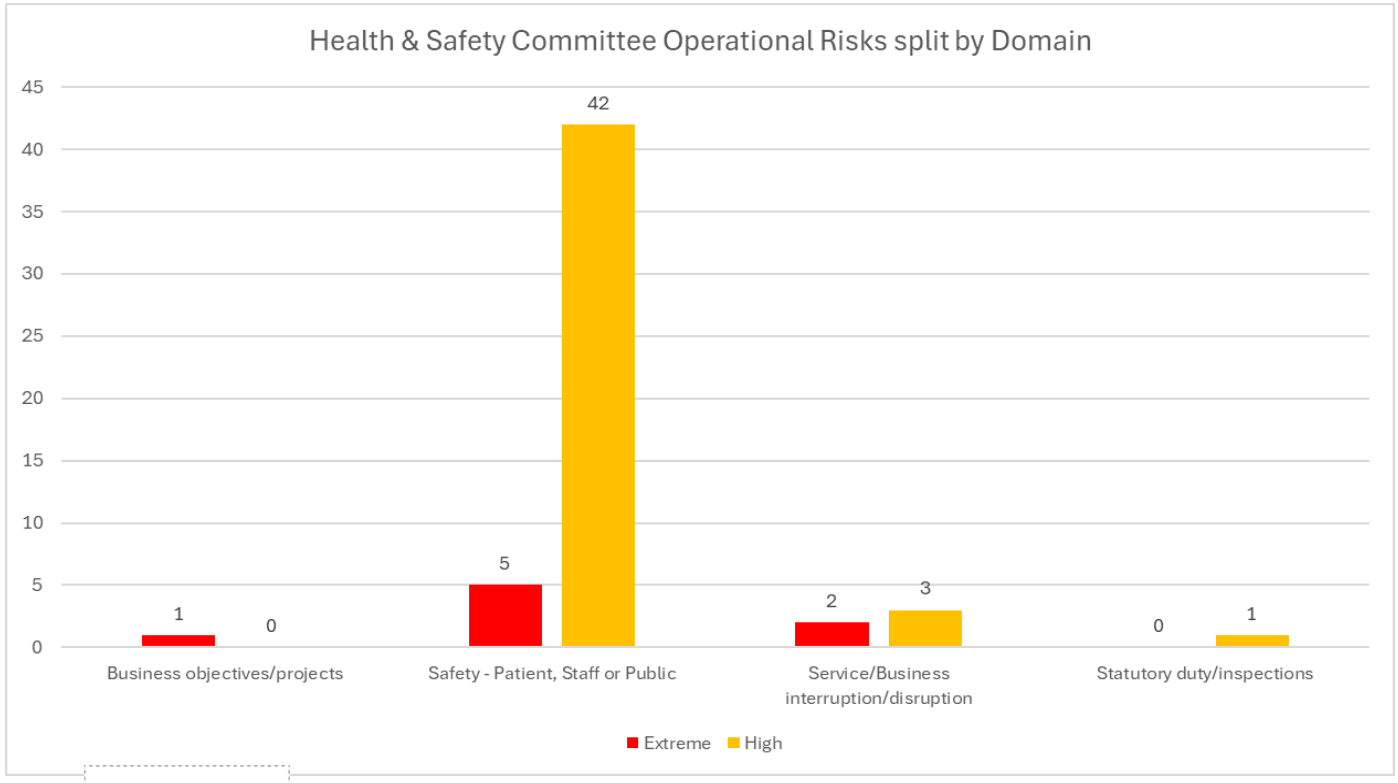
There is a significant concentration of risk exposure within infrastructure and operational support services, with 48 reportable risks owned by Estates and Facilities. This suggests a high dependency on the estate and engineering systems to maintain safe and compliant service delivery.

Reportable risks predominantly relate to fire safety, infrastructure condition, engineering systems and statutory compliance, highlighting impacts on patient staff and public safety, the exposure to regulatory and legal risk, and the risk to service delivery.

This is further reflected in the analysis of risks per domain. 47 of reportable risks are aligned to the domain of "Safety of Patients, Staff or Public", suggesting system-wide exposure to clinical and operational safety risks, with potential impacts on the quality of care, regulatory compliance, and reputational risk.



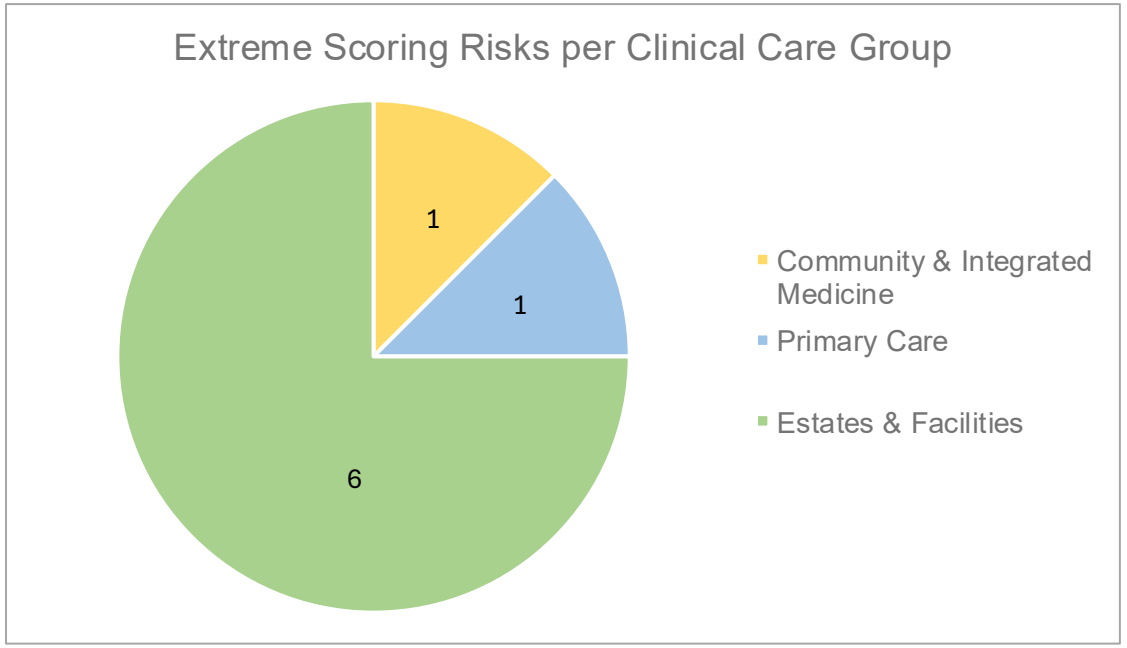


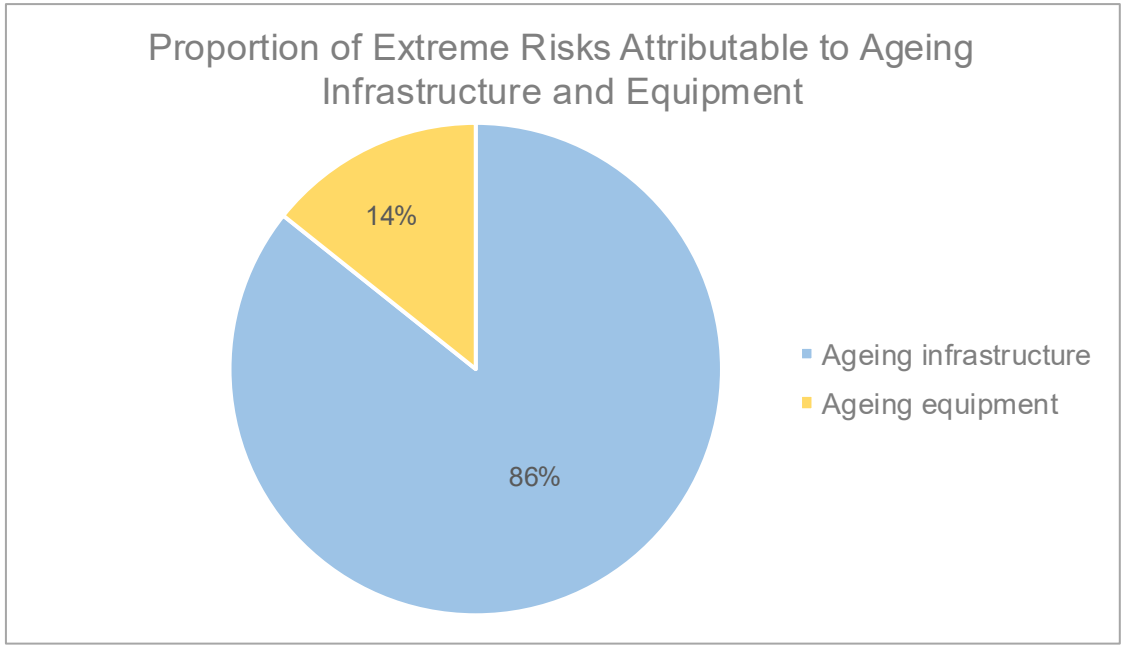
Extreme risks aligned to HSC

There are 8 extreme scoring risks aligned to HSC with a current risk score of 15 or above.

Of the extreme scoring risks identified, 6 require capital funding to mitigate. These risks are primarily associated with estate related infrastructure issues, including roof conditions and vermin challenges. One risk is related to the non-compliance with Letters of Fire Safety Matters this is being dealt with via the Health Boards fire safety improvement works. This indicates that the condition of infrastructure and equipment are contributing factors to these extreme-scoring risks, with mitigation dependent on capital investment.

A summary of the extreme risks are included in the following slides.





Extreme Level Operational Risks
(1 of 2)

GIG CYMRU NHS WALES
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	Date of last risk review
2211 - Risk to patients and staff due to a lack of assurance of safe estate as a consequence of the aging roof covering WGH	Estates & Facilities	Director of Allied Health Professions and Health Sciences	20	5	31/03/2028	09/06/2026
2354 - There is a risk of interruption to patient, staff and visitor meals due to increasing age related faults in the main dishwasher	Estates & Facilities	Director of Allied Health Professions and Health Sciences	16	1	30/09/2026	27/05/2026
1934 - Risk of non-compliance with Letters of Fire Safety Matters due to ageing building - PPH	Estates & Facilities	Director of Allied Health Professions and Health Sciences	16	8	31/03/2027	01/06/2026
1864 - Risk of harm to patients, staff and general public due to failing or lack of safety mechanisms on the automated doors - PPH	Estates & Facilities	Director of Allied Health Professions and Health Sciences	16	4	31/01/2028	01/06/2026

Extreme Level Operational Risks
(1 of 2)

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	Date of last risk review
1263 - Risk to patient safety due to ongoing Issues with vermin (Pigeons), WGH.	Estates & Facilities	Director of Allied Health Professions and Health Sciences	16	8	31/03/2030	08/06/2026
2344 - *detail reported via in-committee*	Community & Integrated Medicine	Chief Operating Officer	15	4	18/03/2027	18/05/2026
2069 - Risk of service disruption and physical harm in Tenby Surgery due to water ingress from the roof	Primary Care	Chief Operating Officer	15	4	31/07/2026	11/05/2026
1969 - Risk of harm to patients and staff due to building and roof condition of Winch Lane Surgery	Estates & Facilities	Director of Allied Health Professions and Health Sciences	15	2	30/06/2027	23/06/2026

New risks since previous report to HSC
(1 of 2)

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	Date of last risk review
2354 - There is a risk of interruption to patient, staff and visitor meals due to increasing age related faults in the main dishwasher	Estates & Facilities	Director of Allied Health Professions and Health Sciences	16	1	30/09/2026	27/05/2026
2344 - *detail reported via in-committee*	Community & Integrated Medicine	Chief Operating Officer	15	4	18/03/2027	18/05/2026
2069 - Risk of service disruption and physical harm in Tenby Surgery due to water ingress from the roof	Primary Care	Chief Operating Officer	15	4	31/07/2026	11/05/2026
2301 - Risk of regulatory non-compliance and microbial contamination due to poor condition of flooring at BGH	Estates & Facilities	Director of Allied Health Professions and Health Sciences	12	1	31/03/2027	15/04/2026
2333 - Risk of infection prevention and control breaches due to damaged floor coverings in corridors	Estates & Facilities	Director of Allied Health Professions and Health Sciences	12	1	30/09/2026	01/05/2026

New risks since previous report to HSSC
(2 of 2)

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	Date of last risk review
2309 - Risk of non-compliance due to Automatic Doors not meeting current regulations	Estates & Facilities	Director of Allied Health Professions and Health Sciences	10	3	31/03/2027	18/05/2026
2335 - Risk to patient, visitor and staff safety during fire due to obsolete emergency lighting at GGH	Estates & Facilities	Director of Allied Health Professions and Health Sciences	10	3	31/03/2027	05/05/2026
2353 - Insufficient air conditioning within the Pentre Awel Hydrotherapy Pool	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	8	4	01/12/2026	27/05/2026

Risks closed since previous report to HSC

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Rationale and date of risk closure
1567 - Risk of harm and unauthorised access to mortuary premises and facilities due to inadequate security measures	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	*Detail reported via in-committee*
1007- Risk of staff/patient harm due to lack of violence & aggression training for porters & hotel services staff (HB wide)	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Risk closed 26 February 2026 as risk consolidated with risk 2201 - Risk of harm to Portering staff when responding to violence and aggression incidents (HB wide)
2062- Risk of harm to patients, staff and visitors due to faulty/damaged fire doors on Morlais Ward	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Risk closed 13 February 2026 as required works completed to make good fire doors in question.

Risk themes (1 of 2)

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Risk owners can allocate themes to their risks, which allows the Health Board to share risk information on specific areas with relevant experts as part of the second line of defence. Themes are assigned based on additional impacts or contributory factors, with each theme aligned to the appropriate committee for oversight. Risk themes provide assurance that a holistic approach to risk management is undertaken and enables the Health Board to better identify the risk appetite, risk capacity and total risk exposure in relation to each risk, group of similar risks, or generic type of risk.

Theme owners are provided with a thematic risk register on a bi-monthly basis to identify trends, or risk clusters, and to consider whether there are gaps in controls in the Health Board's control framework, and to determine whether further action is required to prevent risks from materialising.

The following themes are currently aligned to HSC as of 3 June 2026:

Theme	Definition	Number of risks	Risk theme lead
Estates	Risks directly relating to the physical performance and condition of the organisation's estate infrastructure and its engineering assets that directly impact the delivery of our clinical and non-clinical services.	106	Head of Estates Risk and Compliance
Fire	Risks relating to fire safety and fire management, or risks which are impacted by the fire safety works taking place across the Health Board.	26	Head of Fire Safety
Health & Safety	Health and Safety includes amongst other topics the following manual handling, violence and aggression, workplace hazards and chemical/substances safety (COSHH).	120	Head of Health, Safety and Security
Natural Environment	A risk which may impact any of the following; emissions to air (carbon), pollution to land, discharge to water, use of natural resources (utilities/materials consumption), solid waste management or hazardous waste.	4	Head of Facilities Information and Capital Management
Security	Physical security related to a breech or malfunction in infrastructure such as doors, access systems or alarm systems (e.g. someone gaining unlawful access) or related to dedicated security staff employed by the Health Board. Physical security could also be attributed to the absconding of persons whilst under care in premises of Hywel Dda.	17	Head of Health, Safety and Security

Risk themes (2 of 2)

There is a significant concentration of risks across three themes, indicating that overall risk exposure is heavily weighted towards operational safety, estate condition, and compliance related risks:

- Health and Safety;
- Estates; and
- Fire.

The 120 risks aligned to the theme of Health and Safety indicates risk exposure across multiple operational areas.

With 106 estates-themed risks, this highlights the impact of an ageing estates infrastructure and the ongoing pressures in estate maintenance and capital investment.

Analysis on risk themes highlight risk interdependencies, demonstrating that risks should not be viewed in isolation. Mitigation of these risks should be co-ordinated and cross-service action plans in plans to address.

Recommendations

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

Risk Management

- **RECEIVE ASSURANCE** that there are processes in place to oversee operational risks to ensure these are being managed effectively.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

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Hywel Dda
University Health Board

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Detailed Risk Decision	Review date
2211	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Day, Simon	Arnold, Malcolm	5-Nov-25	There is a risk of of closure of wards and departments due to the failing roof structure. Water, in it's current state, is entering into the building through material failure. This is caused by the structure of the roof (constructed of concrete tiles which, due to wear and tear/age are becoming porous and allowing water ingress) and lack of funding to replace the roof. This will lead to an impact/affect on a potential injury or possible death if enough water penetrated the existing RAAC panels below causing sudden collapse of planks were to occur within an occupied area of the hospital. Other impacts include closure of large areas of the hospital due to ceiling collapse, Datix incidents negative media coverage, and loss of confidence from stakeholders. Risk location, Withybush General Hospital.	Process in place to monitor any water ingress on failing roof systems and promptly take any remedial works necessary Small sections of roof have undergone repair / replacement but porous tiles remain the issue Specialist structural engineers (Curtin's) engaged to undertake addition inspection of RAAC planks directly affected by water leaks. The WGH roof is in the first batch of 3 projects in the MIIP programme with Welsh government, targeted spring 2027.	Business objectives/projects	4	5	20	Risk remains extreme despite some controls in place. Surveys have been completed the roof forms part of major capital expenditure from welsh government through the MIIP programme. Funding will be required to replace whole roof and fully mitigate the risk.	targeted leak prevention,	Arnold, Malcolm	**Completed**	ongoing targeted leak prevention	Health and Safety Committee	1	5	5	Capital funding from welsh government MIIP programme to Target localised Leaking areas only, Capital funding to replace the full roof covering required to fully mitigate this risk	Treat	9-Jun-26
																major capital team project to replace the most affected areas through welsh government MIIP programme	Elliott, Rob	31/03/2028	WGH roof remains one of 3 items listed for the welsh government MIIP programme. Structural engineers/ designers capital team surveys have been completed, project start date to be confirmed.							
																develop CAFM planned maintenance for weekly inspection of known leak areas and carry out first aid response	Arnold, Malcolm	**Completed**	completed							
																engage with roofing contractors to perform localised water sealing around steel columns	Arnold, Malcolm	**Completed**	ongoing identification and locally sealing by Wales roof solutions.							
																Review of RAAC panels around leaking areas	Arnold, Malcolm	**Completed**	Curtains structural engineers have attended site and reviewed known leaking areas exposed to the RAAC. Curtains have confirmed there has been no degradation to the RAAC panels. however have expressed their concern on the risks of continued leaks onto the RAAC roofs with the potential catastrophic failure if water is aloud to penetrate the RAAC panels							

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Detailed Risk Decision	Review date
2354	Estates & Facilities	Estates & Facilities	E&F: Ceredigion	Severs, James	Brock, Elin	Jewell, Rebecca	Lepetit, Carole	21-May-26	There is a risk of of the main dishwasher stopping working imminently and being condemned beyond repair. This is caused by the age of the dishwasher. It is 18 years old and subject to repeated issues and repair. On the 21st May, Hobart attended site to attend to an issue with the machine and have recommended that no further work is carried out as due to the age and condition of the dishwasher, each repair is leading to other issues. This will lead to an impact/affect on Patient and staff safety as dishes would need to be washed by hand adding a risk of insufficient temperatures and efficient meal service due to the significant additional work. Risk location, Bronglais General Hospital.	Catering staff are all trained in how to use the dishwasher carefully Hobart have provided advice BGH Estates have provided some basic maintenance support and will continue to provide this as long as the faults are basic level, and on the advice of Hobart.	Service/Business interruption/disruption	4	4	16	There are no other controls available to address the condition of the dishwasher. It has reached the end of its serviceable life.					Health and Safety Committee	1	1	1	A replacement dishwasher would be installed and a service contract put in place to support ongoing maintenance needs.	Treat	27-May-26

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Detailed Risk Decision	Review date
1864	Estates & Facilities	Estates & Facilities	E&F: Carmarthenshire East	Severs, James	Chiffi, Simon	Day, Simon	Evans, Stewart	10-Jun-24	There is a risk of of injury/entrapment of patients, staff and the general public as well as interruption to services/site, due to automated door failure throughout PPH. This is caused by defective or non-existent safety mechanisms which are required for safe operation of the automatic doors. This will lead to an impact/affect on patients, staff and visitors if injury/entrapment occurred due to the failure of the automated doors. Closure of services/site if doors became inaccessible. Risk to Health Board finances as automated doors do not currently comply with safety standards/current regulations. Adverse impact on Health Board's reputation if a patient safety incident occurred resulting in increased numbers of claims/complaints. Risk location, Prince Philip Hospital.	Contract is in place to provide regular maintenance to automated doors throughout PPH site.	Safety - Patient, Staff or Public	4	4	16	Current risk score is high as despite the automated doors undergoing regular planned maintenance, the risk of staff, patient or visitor harm remains as the doors are non compliant with current safety standards due to defective or non-existent safety mechanisms which are required for safe operation. Capital bid has been submitted for safety devices, capital bid to be submitted as part of security risks highlighted by Head of Nursing.	Capital Bid submitted on 12.06.2024	Evans, Stewart	03/01/2027	Awaiting approval of Capital Bid	Health and Safety Committee	1	4	4	Funding required. Former capital bid rejected.	Treat	1-Jun-26

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Detailed Risk Decision	Review date
1934	Estates & Facilities	Estates & Facilities	E&F: Carmarthenshire East	Severs, James	Chiffi, Simon	Day, Simon	Evans, Stewart	1-Oct-24	There is a risk of of enforcement from the Fire service for non-compliance of the building structure. This is caused by Aged and non-compliant building. This will lead to an impact/affect on services and health and safety of the building and it's occupants. Risk location, Prince Philip Hospital.	PPM (Planned Preventative Maintenance)/Training for staff to maintain building fabric of what is currently installed on site.	Safety - Patient, Staff or Public	4	4	16	Score remains extreme, despite some controls in place, as these are insufficient funds to mitigate the risk. Possible enforcement action if funding is not allocated.	On-going Capital Bids are required as the Fire Service visit and issue LoFSM.	Evans, Stewart	31/03/2027	Ongoing.	Health and Safety Committee	2	4	8	Target risk score can be achieved if funding were allocated and revised Fire Strategy implemented (this will be ongoing as Shared Services sign off the revised Fire Strategy).	Treat	1-Jun-26
																Estates Manager has requested a meeting with the AE to verify existing drawings and to work out a new fit for purpose fire strategy plan for PPH.	Evans, Stewart	~~07/07/2026~~ 31/03/2027	Met with Richard Jupp and Anthony Pitcher (NWP SSP) on 12th August to update plans for Fire Strategy for Amman Valley Inpatient area. Further plans to be updated for Carmarthenshire East locality.							
																Capital Funding Refused for the following Fire Doors: â—•Bryngofal - door 690, door from main corridor to command area and the cut door in the medical infirmary. â—•Residential blocks (2 to 7) - a number of flat / bedroom doors within these residences (for this action refer to point 1 fire door survey) Need to review in conjunction with other priorities.	Day, Simon	**Completed**	Capital funding refused. To review in 2026 and ascertain priority.							

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Detailed Risk Decision	Review date
1263	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Day, Simon	Arnold, Malcolm	24-Oct-17	There is a risk of to patient and staff safety. This is caused by areas that are frequented by pigeons which is becoming very messy with droppings and carcasses of dead birds. Operational constraints with ongoing contractors refusing to work on equipment that is covered with droppings and a cost to trap and despatch birds only to be inundated with fresh supplies. This will lead to an impact/affect on closures of departments and infection increases such as happened in a Scottish Hospital. Potential serious harm to patients which in severe cases could lead to death. Potential Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) incident and HSE investigation. Risk location, Withybush General Hospital.	Netting placed over multiple areas within the Health Board, preventing the roosting of birds in these areas. Continuous cleaning of known areas. Vermin mesh screens are placed within the ventilation duct entrances. Routine humane trapping taking place 3 to 4 times a year. Bi-monthly Ventilation Safety Group and monthly Ventilation Sub Group.	Safety - Patient, Staff or Public	4	4	16	This is an extreme scoring risk due to the high risk of transferable disease (reported deaths due to wild birds roosting in ventilation systems). An increased numbers of complaints received (Datix) during the year from staff and visitors due to dead carcasses, or pigeon mess, covering Critical plant, pathways and entrances. Contractors are still refusing to work on machines due to droppings. Estates are required to clean which is a health & safety hazard. External companies are required to remove due to known hazards.	develop Capital bid to provide bird mesh covering over external external critical ventilation plant	Arnold, Malcolm	~~31/03/2024~~ ~~31/05/2024~~ ~~30/03/2025~~ ~~30/09/2025~~ ~~31/01/2026~~ 30/09/2026	Costs have been received and a Capital bid is to be submitted. Ongoing. update 26/03/2025 Various plant have had covering completed. an number of critical ventilation plant still require netting to prevent roosting. costs to be established	Health and Safety Committee	2	4	8	Risk can never be fully mitigated due to inability to prevent wild birds from roosting.	Treat	8-Jun-26
																Develop SLA with external pest control company for ongoing humane trapping and disposal.	Arnold, Malcolm	**Completed**	This Item has been added to the all Wales Rentokil contract.							

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Detailed Risk Decision	Review date
1969	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Chiffi, Simon	Day, Simon	21-Nov-24	There is a risk of of harm to patients, staff and visitors at Winch lane surgery. This is caused by the deterioration to the building fabric and roof structure where both gable ends have severe rot causing the roof to dip. There is a potential for large pieces of roof to break off and/or collapse. This area is open to the public. The fabric of the building has signs of cracks possible from water ingress/subsidence. This will lead to an impact/affect on a potential injury or possible death if a sudden collapse of the roof were to occur within an occupied area of the Health Centre. Other impacts include closure of the service, breaches in statutory duties, negative media coverage, and lose of confidence from stakeholders. Risk location, Haverfordwest Health Centre.	Gable ends have been fenced off from public access.	Service/Business interruption/disruption	3	5	15	The Health Board has engaged a specialist structural engineer to inspect both the building fabric and roof covering. Areas of severe roof degradation have been sectioned off from access by public to mitigate the risk of harm but until funding is received to enact the required repairs, the risk of harm to patients, staff and visitors remains extreme. As of August 2025 no response has been received following the submission of the capital bid.	Repair winch lane roof when capital funds made available.	Arnold, Malcolm	~~30/09/2025~~ ~~31/03/2026~~ 30/09/2026	As of September 2025, no response from Capital Bid submission. FEB 2026 NFP	Health and Safety Committee	1	2	2	Capital funding and ongoing planned maintenance will reduce this risk to the target risk score.	Treat	8-Jun-26

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2069	Primary Care	Primary Care	PC,CS,LTC: Managed Practice	Carruthers, Andrew	Jones, Keith -	Bond, Rhian	McGivern, Matt	13-Jan-25	There is a risk of Ongoing water ingress through the roof will disrupt service delivery. Clinical and admin rooms may become unusable due to internal water damage. Structural deterioration may worsen. This is caused by lack of adequate repairs and maintenance by landlord • Perished felting between the roof tiles and internal ceiling. • Recurrent leaks across several groundâ€'floor areas. • Inadequate and temporary patch repairs by the landlord since 2024. • Lack of a full survey or detailed findings shared by the landlord. This will lead to an impact/affect on • Unsafe delivery of services for 7,200 registered patients. • Increased health and safety risks to staff and patients due to water and electrical hazards. • Ongoing service disruption as rooms and waiting areas are periodically taken out of use. • Potential damage to equipment, furnishings, and building fabric. Risk location, The Surgery, Tenby.	• Pressuring the landlord to undertake necessary roof repairs through specialist estate services. • Closing off and preventing staff access to areas where water poses an electrical or safety risk. • Photographing, documenting, and Reporting all leaks. • Cordonâ€'off measures in parts of the waiting room as needed.	Safety - Patient, Staff or Public	3	5	15	â€¢ The risk was previously categorised as Service Disruption; however, ongoing structural deterioration and the increased likelihood of harm to patients and staff now warrant a Safety categorisation. An action has been added to work with the Health & Safety team to complete a detailed assessment. â€¢ Despite some landlordâ€'led repairs in 2024 and 2025, significant issues remain and rainwater continues to enter the building frequently. The scale and recurrence of leaks risk rendering the premises unfit for purpose. Rooms must be taken out of use during leaks, with the most recent repair completed in October 2025. â€¢ Tenby Surgery is occupied under a Tenancy at Will on a TIR basis, with a formal lease still under negotiation (holding over since 2018). The roof remains the landlordâ€™s responsibility. Water ingress has damaged contents, including electrical equipment, and decorative works completed by the Health Board in 2022. Staff routinely manage floor-level water ingress following prolonged rainfall. â€¢ The Health Board wrote to the landlord on 4 July 2025 requesting that they fulfil their responsibilities and undertake necessary repairs. The landlord advised that a contractor will assess the roof and boiler but declined to share the specialist contractorâ€™s findings or cost information. â€¢ A review meeting is being arranged between HB	An updated Health & Safety inspection site visit of the premises.	Gravell , Aled	Completed	H&S Advisor Aled Gravell attended site on 21st May 2025 to complete a follow-up inspection to the inspection completed on 16th July 2024. A revised and updated inspection report was issued to site management on 29th May 2025. Comments were added to the original report to track progress on actions (in red) and additional actions were added to the end of the report from the findings on the day (see A21-A25).	Health and Safety Committee	2	2	4	â€¢ Reduced likelihood achievable only once full roof repairs are completed or alternative premises secured. â€¢ Seasonal weather patterns influence ingress frequency. â€¢ HB continues to apply pressure on landlord and review business continuity options.	Treat	11-May-26
																Landlord to arrange an appraisal survey of the building by an approved contractor, including a focus on the roof condition.	Williams, Paul -	Completed	The landlords and the HB met on the 9th September. The landlord agreed to commission a survey to understand the extent of the damage and dilapidation. The landlord agreed to put right any issues identified in the survey.							
																Seek alternative accommodation options in order to vacate the site if necessary.	McGivern, Matt	Completed	A meeting was held with Jo Riggs, but this did not identify an option within the Tenby Walk in Centre. Other options are now being explored in the area. A verbal agreement is in place with the County Team in the event of all services having to vacate.							
																Escalated through the new Q&S process and it was agreed that a letter should be sent to the landlord by Jill Paterson.	McGivern, Matt	Completed	Letter sent from Rhian Bond to landlords and meeting to be arranged to review.							
																Review findings of survey commission by Landlord and agree timescales for repairs.	Williams, Paul -	Completed	Action closed as Landlord unwilling to share contractor correspondence and costs with HB.							

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															Estates, NWSSP Specialist Estates, the Assistant Director of Primary Care, and the landlord.	Meeting to be arranged with Landlord, HB Estates Team, NWSSP Specialist Estates Service and Assistant Director of Primary Care	Williams, Paul -	~~31/03/2026~~ 30/04/2026	Paul to arrange meeting.							
																The Health & Safety Team will be asked to undertake a detailed assessment of the building.	McGivern, Matt	30/04/2026	New action							
2333	Estates & Facilities	Estates & Facilities	E&F: Carmarthenshire East	Severs, James	Chiffi, Simon	Day, Simon	Evans, Stewart	1-May-26	There is a risk of of a breach in IP&C requirements due to the floor covering damaged throughout all corridors at Prince Philip Hospital. This is caused by The flooring is in excess of 25 years old and cannot be patched and replaced. Areas have now perished leading to exposed concrete slab. This will lead to an impact/affect on Cleaning and cleanliness of corridor areas. Risk location, Prince Philip Hospital.	Patching flooring has occurred over the years, however the flooring has perished too much to bind another floor to.	Safety - Patient, Staff or Public	4	3	12	The flooring can no longer be repaired					Health and Safety Committee	1	1	1	If funding is obtained to replace risk is mitigated.		1-May-26

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2301	Estates & Facilities	Estates & Facilities	E&F: Specialist Services (Catering/Laundry)	Severs, James	Brock, Elin	Jones, Peter -	Jewell, Rebecca	14-Jul-25	There is a risk of that contamination could be possible within the kitchen environment due to flooring in a poor state of repair. This has been raised previously in an EHO inspection, therefore it may also impact on the food hygiene score currently held by the BGH catering department. This is caused by the age of the flooring which now has numerous cracks in joints between sections. These can harbour bacteria despite high standards of cleaning. This was raised at the last EHO inspection in July 2025 and remedial action recommended at this point. It has not been actioned to date and a repeat inspection visit is due. This will lead to an impact/affect on food safety and the resulting risk to patients and staff. It could also result in the reduction in the food hygiene score and lead to a loss of trust and credibility in the health board delivery of food services. Risk location, Bronglais General Hospital.	Strict cleaning regime using health board approved cleaning agent - Diffex. Controlled access to kitchen, catering staff do not wear outdoor shoes and do not access other parts of the hospital (wards / public areas) frequently. Some filler has been used to 'patch' gaps but this is not a sustainable solution as products deteriorate quickly and do not provide the impermeable membrane needed.	Safety - Patient, Staff or Public	3	4	12	A requirement of Environmental Health environmental standards is that flooring is impermeable and a seamless surface to prevent the harbouring of bacteria which can hide and multiply in cracked areas. Despite frequent cleaning and strict hygiene standards, the condition of the flooring is still non compliant with regulations. Specifically, Regulation No 852/2004 which concerns floor coverings in food preparation areas.	Capital funding has been applied for. Waiting for confirmation.	Jewell, Rebecca	30/10/2026	Capital funding is being considered. Awaiting outcome.	Health and Safety Committee	1	1	1	Once the risk is treated by replacing the floor (dependent on capital funding), it will be compliant with regulations and will no longer present a risk of bacterial contamination.	Treat	15-Apr-26

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951	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Day, Simon	Arnold, Malcolm	1-Feb-17	There is a risk of avoidable harm to staff and patients in the event of a fire at WGH. This is caused by the Fire Alarm system not correctly reporting when the system is in Fire, due to the incomplete set up during the commissioning of the system at its implementation. Any fire will be detected but the report sent to the Panel Indication may not be correct and therefore there could be a delay in the appropriate/correct response. This will lead to an impact/affect on possible injuries or fatalities if a fire occurs. Possible enforcement or prosecution. Major disruptions to the delivery of essential services. Adverse publicity/reduction in stakeholder confidence. Risk location, Withybush General Hospital.	Currently we have Verified all detectors and identified where all interfaces are positioned. We have verified position of all power supplies for doors and Dampers and following on from zone verification this can be completed and sent for programming. Verification of loops and detectors have been completed. Fire alarm contractors have updated the 'cause and affect' system, and ongoing system verifications are taking place.	Safety - Patient, Staff or Public	3	4	12	Fire alarm contractors have updated the 'cause and affect' system, and ongoing system verifications are taking place. This will be undertaken in conjunction with the Capital fire improvement works. Current risk score remains high as there are still gaps in cover.	Implement phase of works to bring all computer graphics up to date with the units connected to the Fire Alarm system, including elements of alterations to get the system to work in the new Zones.	Arnold, Malcolm	**Completed**	All information has been passed to FSC about all the verification works that have been carried out. This quotation has come back and has been passed for payment. Computer graphic update to be scheduled in line with new decant ward commissioning Graphics update completed. ongoing minor alterations required. completed	Health and Safety Committee	1	1	1	ongoing contractor maintenance and funding to keep the system up to date will ensure this risk is held at a low level.	Treat	8-Jun-26
																Implement new Cause and effect. Further work required to identify short falls and errors in cause and effect. all works listed on RPS report. costs established and funding agreed through phase two fire improvements	Arnold, Malcolm	~~30/09/2023~~ ~~30/03/2025~~ ~~30/09/2025~~ ~~31/03/2026~~ 30/09/2026	26/03/2025 update phase 1 Fire alarm L1 upgrade commenced. floor plans and drawing updated, gap analysis in cover developed and agreed. Installation of addition devices or alterations of existing devices has commenced. estimated completion April 2026. 02/2026 update L1 coverage completed. Phase two C&E works capital order to be placed by major capital project lead.							
																FSC Autronica are in process of rewriting new 'cause and affect' scheme.	Elliott, Rob	**Completed**	Cause and affect' completed and installed. further work required and identified on RP report. capital funds required to achieve full L1 compliance. Completed. update 17/07/2024 funding agreed through phase two fire improvements							

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																Complete system verifications at WGH.	Arnold, Malcolm	~~31/12/2023~~ ~~01/09/2024~~ ~~30/03/2025~~ ~~30/03/2026~~ 30/09/2026	This is in progress. Gaps in system design, system component replacement, and verifications identified on Report. capital funding required to achieve full L1 now completed. FEB 2026 funding approved through phase two fire improvement works order to be placed for C&E review / repair.							
1270	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Day, Simon	Arnold, Malcolm	15-Oct-19	There is a risk of that the wiring carried out by small schemes in the past is not up to standards of safety in Healthcare buildings. One such area which was exposed during the fire code work of two small rooms required extra isolations due to way in which the wiring and compartmentations had been carried out. This is caused by using the wrong type of materials to allow circuits that carry 240v no compartmentation. Twin Flat, metal Conduit, Plastic C all in same area. This will lead to an impact/affect on earthing and exposure to live equipment being available. Risk location, Withybush General Hospital.	Visual Inspections and periodic testing being carried out.	Safety - Patient, Staff or Public	4	3	12	We are unable to change the cabling but are monitoring the situation.	The wiring in places is in a poor condition which has been exposed by the firecode works.	Elliott, Rob	**Completed**	No progress to report. update works to improve top floor wards completed as part of RAAC works completed permit to work in place on electrical work.	Health and Safety Committee	2	1	2	Capital investment and regular maintenance and testing would achieve the target risk score	Treat	8-Jun-26
																New wiring required or more protection in Distribution Boards.	Arnold, Malcolm	~~29/12/2023~~ ~~30/04/2024~~ ~~30/03/2025~~ ~~30/03/2026~~ 30/09/2026	No further progress update 17/07/2025 Wiring replaced top floor RAAC wards where necessary/ Ground floor/ lower ground floor capital bids required possibly when identified during 2nd phase fire improvement works							
																Fixed wiring inspections contract to be implemented.	Arnold, Malcolm	**Completed**	A new fixed wiring test programme over 5 years to test 100% of all distribution boards. completed All Electrical work on site must be completed by CP qualified electricians with APLV permit approval.							

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2054	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Chiffi, Simon	Day, Simon	10-Apr-25	There is a risk of Of business disruption due to the building soffit cladding covering of the block 7 and block 24 This is caused by degradation to the extent that its failing. This cladding is the original covering, This situation has been reported by external building contractors who have confirmed that the cladding is beyond economical repair and has reached its end of life. This will lead to an impact/affect on This will lead to an impact/effect of disruption to service delivery as rooms are becoming unusable and are being closed due to water damage. There is a risk of harm to patients and staff due to the potential danger of an electric shock (due to water ingress), of slips and trips (caused by wet and slippery flooring), risk of injury due to falling ceiling tiles (caused by longstanding roof soffet decay) and damage to health due to working in damp conditions. Staff sickness could increase and staff retention could be affected, due to the poor working conditions resulting in low staff morale and impacting financial budgets. This situation could also lead to complaints from service users and staff, resulting in reputational damage to the Health Board. Risk location, Withybush General Hospital.	localised repairs to prevent isolated objects from detaching. regular condition planned maintenance inspections. emergency repairs / isolation of areas where needed. structural survey required	Safety - Patient, Staff or Public	3	4	12	facia panels show signs of degradation, regular surveys will can only identify the worst panels for emergency patch repair. only replacement will reduce the risk to low.	capital bid to be created for the replacement facia.	Arnold, Malcolm	**Completed**	completed and submitted to MAggie Anniston 10/04/2025 ref: WGH-03-2025	Health and Safety Committee	1	2	2	capital investment and ongoing maintenance will achieve target risk score.	Treat	8-Jun-26
																replace failing facia panels block 7 and block 24 when capital funding approved.	Arnold, Malcolm	~~30/09/2025~~ 31/03/2026 30/09/2026	no further progress Capital funding approved for panel testing which is ongoing. High level light weight panel above x ray order placed to replace the panels . works ongoing. Capital works are ongoing to replace these panels							

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2056	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Chiffi, Simon	Day, Simon	14-Apr-25	There is a risk of There is a risk of business disruption due to the building cladding covering of the IT building having degraded to the extent that its failing. This is caused by This cladding is the original covering, This situation has been reported by external building contractors who have confirmed that the cladding is beyond economical repair and has reached its end of life. This will lead to an impact/affect on This will lead to an impact/effect of disruption to service delivery as rooms are becoming unusable and are being closed due to water damage. There is a risk of harm to patients and staff due to the potential danger of an electric shock (due to water ingress), of slips and trips (caused by wet and slippery flooring), risk of injury due to falling ceiling tiles (caused by longstanding roof decay) and damage to health due to working in damp conditions. Staff sickness could increase and staff retention could be affected, due to the poor working conditions resulting in low staff morale and impacting financial budgets. This situation could also lead to complaints from service users and staff, resulting in reputational damage to the Health Board. Risk location, Withybush General Hospital.	Regular planned maintenance where required. Patch repairs when items fail.	Safety - Patient, Staff or Public	3	4	12	There are several associated Health and Safety risks due to potential falling objects / water leaks, slips/trips and risk of injury to patients and staff. Staff do not have access to carry out routine maintenance	Develop capital bid to replace building facia, Repair building facia panels when capital funds are released.	Arnold, Malcolm Arnold, Malcolm	**Completed** ~~30/09/2026~~ ~~31/03/2026~~ 30/09/2026	capital bid completed 14/-4/2025 reference WGH-04-2025 no further progress.	Health and Safety Committee	1	2	2	full repairs will give assurance the building fabric will remain intact, covering all health and safety aspects or departmental disruption.	Treat	6-May-26

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1262	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Day, Simon	Arnold, Malcolm	18-Oct-17	There is a risk of of business disruption and environment hazards due to potential oil leaks from corroded oil tanks and supply pipework. This is caused by that the condition of the Oil storage tanks and supply pipework have deteriorated and failed annual soundness testing. this will lead to inevitable failure and allow all the contents into the bund. The concern is both the containment of the spill and the loss off emergency fuel for both the back up generators and main boiler plant. This will lead to an impact/affect on to business disruption, environmental hazards, enforcement from natural recourses from potential river contamination. reputational damage, lack of emergency generation fuel services. potential loss of generation. Risk location, Withybush General Hospital.	condition monitoring and Pipe work surveys where required.	Safety - Patient, Staff or Public	3	4	12	monitoring in place for leaks but pipework is beyond repair and fails soundness testing. funding required to replace silos and supply pipework.	Attended a meeting with Head of Property Performance and a capital bid is to be drawn up for removal.	Elliott, Rob	**Completed**	Continuous monitoring being carried out. completed	Health and Safety Committee	1	3	3	New bunded silos and new supply lines will prevent oil loss. condition monitoring would highlight any issues. capital funding required to achieve this target risk rating	Treat	8-Jun-26
																No further progress to report.	Elliott, Rob	**Completed**	No further progress.completed							
																We have carried out a reinspection of the pipework and the flanges onto the vessels and are noticeably deteriorating. we have to limit the volume of oil in th e tanks as they are quite corroded. This will limit fuel supplies to Hospital in times of availability of gas through normal times.	Elliott, Rob	**Completed**	No further progress to report. completed							
																develop capital bid and design for tank replacement	Arnold, Malcolm	**Completed**	No further progress Capital bid submitted April 2026							
																replace old oil tanks when capital funds are released.	Arnold, Malcolm	31/03/2027	no further progress							

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2105	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Day, Simon	Arnold, Malcolm	9-Jul-25	There is a risk of of failure to the Emergency lighting at St Brynachs Day Hospital, part of the Bro Cerwyn facility during periods of outages or periods of faults taking out the protection circuits. This is caused by the installed lighting becoming obsolete as the Software and parts of the Hardware becoming aged and not supported. Tests are becoming more difficult to achieve. This will lead to an impact/affect on the working of the hospital in periods of outages with the electricity. The Emergency lighting also forms part of the Regulatory Reform Order inspections and also does not support compliance to HTM 05 and 06. Risk location, Canolfan Bro Cerwyn St Nons and St Caradogs, Pembrokeshire.	Testing of units are still being carried out but more and more failures are being reported.	Safety - Patient, Staff or Public	4	3	12	The current score will raise higher as the test and maintenance does not enhance the lighting.	Develop capital bid to replace the lighting	Arnold, Malcolm	Completed	Capital bid submitted 09/07/2025 ref:	Health and Safety Committee	3	1	3	Capital funding and continued planned maintenance will reduce this to the target risk score.	Treat	8-Jun-26
																Install new Emergecny lighting system when capital funds are release.	Arnold, Malcolm	30/04/2026	no further progress							

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2106	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Day, Simon	Arnold, Malcolm	9-Jul-25	There is a risk of of failure to the Emergency lighting at Withybush General Hospital Renal Dialysis Unit during periods of outages or periods of faults taking out the protection circuits. This is caused by the installed lighting becoming obsolete as the Software and parts of the Hardware becoming aged and not supported. Tests are becoming more difficult to achieve. This will lead to an impact/affect on the working of the hospital in periods of outages with the electricity. The Emergency lighting also forms part of the Regulatory Reform Order inspections and also does not support compliance to HTM 05 and 06. Risk location, Withybush General Hospital.	Testing of units are still being carried out but more and more failures are being reported.	Safety - Patient, Staff or Public	4	3	12	The current score will raise higher as the test and maintenance does not enhance the lighting.	develop capital bid for emergency lighting replacement	Arnold, Malcolm	**Completed**	Capital bid submitted 09/07/2025 Ref: WGH-CB-11-2025	Health and Safety Committee	3	1	3	Capital funding and continued planned maintenance will reduce this to the target risk score.	Treat	26-May-26
																install new emergency lighting system when capital funds are released.	Arnold, Malcolm	~~30/04/2026~~ 30/09/2026	capital bid to be re evaluated and resubmitted.							

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2119	Estates & Facilities	Health and Safety	Health and Safety	Severs, James	Chiffi, Simon	TH6	Vaughn, Gemma	22-Jul-25	There is a risk of of patient and staff harm due to lack of manual handling training spaces This is caused by lack of staff and lack of suitable training venues This will lead to an impact/affect on patient safety - inappropriate assessment of patient mobility and manual handling techniques leading to injury staff safety - in correct manual handling can lead to musculoskeletal disorders incident reporting - increase in incidents and severity leading to an increase in RIDDOR reportable absences potential litigation - failure to action could be deemed as a deficiency against health and safety legislation and increase the risk of prosecution. increase in injury claims - staff and patient claims may increase Health Board reputational damage. Risk location, Health Board wide.	Training diary for 2026 has been generated and information provided to management as to the number of staff and training venues required to achieve the requires training demand. Use of Post Grad Medical Education Centre at PPH has helped with additional spaces in 2025. Course numbers have been increased in Carmarthen (by decluttering the training space) to a maximum capacity of 16. Training venue secured in Ceredigion for 16 staff in 2025.	Safety - Patient, Staff or Public	3	4	12	The risk remains at a high level as the current projected figures to maintain compliance with mandatory manual handling training for Levels 1 and 2 for 2026 is 6000 (5500 +10%) which is currently not feasible. With an additional external trainer, or a Band 5, the HB could achieve around 33% of the expected target (i.e., 2000) but this request has been refused due to the current financial climate and historic financial issues within the wider HS&S Team. (cost of external trainer equates to Â£250,000). The recruitment of a Band 2 (15 hrs) would increase capacity by a further 800 places and increase compliance with the mandatory training to around 50% (2800) but this request has also been refused due to the current financial climate. Without a recruitment campaign, the only way to achieve target would be to remove the clinical work from the Band 6 roles (x WTE 2.6) to enable another 2000 training places, i.e., a total of 4800 - 80% but this would preclude complex clinical cases. To achieve 100% compliance, the MH Manager would also have to provide training at least 3 days per week which would impact on their capacity to wholly fulfil their role. Do Not Attend to provide	Calculate costings for external trainer to cover the shortfall.	Vaughn, Gemma	Completed	Costings of £250,000 per annum to cover the shortfall.	Health and Safety Committee	1	4	4	If the department were suitably staffed and suitable training space on each site were available all staff would receive regular MH training enabling them to undertake appropriate assessments of all handling activities and utilise appropriate techniques. This would reduce the risk of injury and likelihood of prosecution/effective PI claim.	Treat	28-May-26
																To put onto TRAC for a full time Band 5 and a 15 hr Band 2 post.	Vaughn, Gemma	Completed	FSG have declined funding for these posts.							
																SBAR to be presented to the HSSC with a request for support with funding requests.	Vaughn, Gemma	Completed	New Action. completed and options appraisal presented. TNA review ongoing							
																Liaise with L&D regarding TNA review	Vaughn, Gemma	Completed	TNA completed and scheduled for Estates and Facilities CCG meeting							
																Work with L&D and Property services to evaluate and secure training space to cover delay in move to Carmarthen Hwb	Vaughn, Gemma	Completed	Move to Ystwyth building Hafan Derwen scheduled 10 Feb 26							

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															Do Not Attend rates are also having a detrimental effect on compliance rates. Options appraisal presented Oct 25. Slippage on move to Carmarthen Hwb - Temp Location Ystwyth (capacity 24) New Executive-led (JS) T&F group established 13/11/25 to consider training TNAs and training venue issues (MH, RRP & Resus).	View Canolfan Rheidol and Padarn surgery options with L&D - Ceredigion.	Vaughn, Gemma	~~30/04/2026~~ 30/06/2026	Visit to Canolfan Rheidol completed 24/02/26 with Manual Handling, H&S & Property. Positive visit. Findings fed-back to L&D. A further site has been identified (Medrus Suite). H&S, Property and L&D to visit the site on 12/05/2026.							
2078	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Day, Simon	Arnold, Malcolm	22-May-25	There is a risk of of harm to patients, staff and public due to falling concrete (from height) from the outside of the main hospital building. This is caused by degradation of cladding from weathering over time. internal corrosion to read bar causing concrete failure and spalling, to the extent that its failing, cracking and sever cases falling from height. This cladding is the original covering. Structural engineer visual surveys have been completed which has highlighted the worst of the spalling and cracks. This will lead to an impact/affect on	Visual structural survey in place to identify the worst areas. Protective barriers or scaffolding in place to prevent spalling from reaching the floor. Access restricted and controlled though Estates permit access only. Temporary emergency patch repairs completed.	Safety - Patient, Staff or Public	3	4	12	Current controls have reduced the risk however this risk remains high with scaffolding in place to mitigate the incidents of spalling and falling concrete from height evidenced near high use exit door. Facia panels show signs of degradation, regular surveys are being undertaken but can only identify the worst panels for emergency patch repair. Only full repair or replacement will fully mitigate the risk.	Provide barrier protection to prevents staff and public access.	Arnold, Malcolm	**Completed**	85 % completed. site visit planned to determine how all the protections can be achieved whilst still maintaining service. completed 07/07/2025	Health and Safety Committee	1	4	4	Full replacement or over cladding would reduce most of the risk but there is always risk of potential fall of concrete from height. Funding is required to fully mitigate the risk.	Treat	26-May-26

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									~~This will lead to an impact on~~ patients, staff and visitors due to injury from falling debris which could lead to complaints/legal claims from service users and staff, resulting in reputational and financial damage to the Health Board. Disruption to service delivery as access to areas, movement of staff, deliveries etc will become restricted due to protective scaffolding required to prevent risk of injury due to falling concrete. Internal water ingress is a possibility as the panels decay further. these situations could result in poor working conditions resulting in low staff morale and impacting on financial budgets. Risk location, Withybush General Hospital.						full inspection of facia panels required to determine extent of deterioration.	Williams, Paul -	~~30/09/2025~~ ~~31/03/2026~~ 30/09/2026	no progress yet drone survey completed and issued to Curtains for review and develop cost analysis Lewis construction organised to start concrete panel testing. Curtains and Beton Bauen involved. FEb 2026 Capital invested survey and planned repair ongoing, managed by discretionary capital.							
																carry out emergency repairs to panels identified from Curtains visual survey	Williams, Paul -	~~31/03/2026~~ 30/09/2026	M. Arnold initial meeting scheduled for 26th May. Curtains, Baton Bauen, Lewis construction. operations, capital, and property. Design consideration on repairs to be completed after full inspection of the panels is achieved. FEB 2026 Curtains Report has been received. Repair costs to be established and funded.							

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2201	Estates & Facilities	Estates & Facilities	E&F: Specialist Services (Catering/Laundry)	Severs, James	Severs, James	Brock, Elin	Jones, Peter -	12-Sep-25	There is a risk of of harm to Portering staff when reacting and responding to incidents of a violent and aggressive nature. The risk has recently increased from a risk score of 6 to a 12 (High) This is caused by unpredictability of the situations the Portering Staff react to; including lack of knowledge of the perpetrator; their own physical ability to perform restraint techniques; lack of personal protective equipment; lack of body worn video to record the event and actions taken; and lack of training for public disorder type scenarios. Annual refresher training opportunities have been missed resulting in porters requiring the full 3-day course. The lack of an in house or contracted security team on acute sites places more emphasis and risk on portering staff. This will lead to an impact/affect on health and safety of the Portering staff themselves; lack of evidence in the potential for criminal charges to be brought against the Health Board or individuals relating to physical restraint; Potential prosecution by Health and Safety Executive for breach of Management of Health and Safety at Work Regulations (Not ensuring the Health, safety and welfare of staff so far as is reasonably practicable. Risk location, Health Board wide.	Porters are provided with Reducing Restrictive Practice (RRP) training that includes 3 day plus 1-day annual refresher. 2. Verbal de-escalation used to prevent aggressive behaviours. 3. Porters are requested to â€œbuddy upâ€• when aggressive behaviour is reported to portering team. In high-risk areas like ED, mental health wards, late shifts, porters are requested to attend incidents in pairs and not attend alone. 4. Porters are requested to report incidents on Datix and Synbiotix to learn from events, log data for processing track trends and activity.	Safety - Patient, Staff or Public	3	4	12	Untrained, ill equipped, physically compromised porters undertaking security roles due to lack of trained security staff employed by the Health Board.	Quotes to be obtained for body armour to better equip staff when managing incidents of violence and aggression. The aim is to enhance staff safety and ensure they have the appropriate level of protection when responding to potentially high-risk situations. Quote for 16 sets of Body Armor - 4 per Acute site	Scarf, Charles	**Completed**	Quotes received and sent to facilities management. Presented to the next Security Management Group (03/11/25) with discussion around how funding mechanism will work. FMs now sending questionnaire to porters to seek support for PPE - completed by 1.3.26	Health and Safety Committee	2	3	6	There is a recognised need to recruit trained security staff that will be able be better equipped and to manage public disorder events. With better compliance with Reducing Restrictive Practice Training, PPE and Body Worn Video being issued to Porters will mitigate the risk down. PPE and BWV could be provided by March 2026	Treat	16-Feb-26
																Quotes to be obtained for body-worn video cameras to better evidence incidents of violence and aggression. The use of these cameras will support investigations and provide reliable footage to assist in the potential prosecution of individuals involved. This initiative aims to enhance staff safety, promote accountability, and deter aggressive behaviour across sites - 24 BWV- 6 per Acute site	Scarf, Charles	**Completed**	Quotes received and sent to facilities management. Presented to the next Security Management Group (03/11/25) with discussion around how funding mechanism will work.							
																A needs analysis and risk assessment which identifies appropriate physical measures to be conducted.	Richards, Jill	**Completed**	Facilities Management have conducted a needs analysis and risk assessment which identifies appropriate physical measures. They will be presented to the next Security Management Group (03/11/2025) with discussion around how funding mechanism will work.							
																Submit a paper to Executive Team by no later than June 11th 2026 to present security staffing options	Brock, Elin	06/11/2026	Paper will be submitted by no later than 11th June 2026							

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1549	Estates & Facilities	Health and Safety	Health and Safety	Severs, James	Severs, James	Springthorpe, Adam	Springthorpe, Adam	21-Oct-22	There is a risk of that staff will not receive the level of training identified by the TNA which is benchmarked against the All Wales V&A Passport (AWVAP) scheme. There is also a further risk of HSE scrutiny. This is caused by the Training Team not having adequate resources to deliver the AWVAP course (Modules C and D) and additional courses that focus on understanding behaviours that challenge to the wider Health Board, as highlighted by the Health and Safety Executive (HSE) review conducted in 2019. Inability of operational services to release staff to attend the required training. This will lead to an impact/affect on both staff and patient safety, with staff not being aware of relevant skills and techniques to ensure their own safety, and patient safety by applying unsafe restraint techniques if not adequately trained. This could risk catastrophic harm to the patient. Potential for HSE fines for not fulfilling and sustaining the actions stated in the Health Boards evidence submitted to the HSE in 2019. Risk location, Health Board wide.	The Reducing Restrictive Practice (RRP) Team offer 3 core courses for Modules C and D of the AWVAP and refreshers courses for each. The team also provide online training sessions for RRP and Care Planning. Classroom training is prioritised for higher risk areas, this is based on a HB-wide Training Needs Analysis. When notified via Datix incident reporting the RRP team link with departments and provide practical advice and assistance and offer training where appropriate. Contact will be made by the RRP Team if there are multiple Datix reports or if the severity of the incident indicates that follow up is necessary (i.e., severe incidents). The RRP Team liaise with the HB V&A Case Manager in the identification of incidents where training may be of benefit. There is an approved Health Board policy on Reducing Restrictive Practice. The RRP Team have a presence in clinical areas (when possible) - focussed on specific sites where risks are identified. Systematic monitoring and review of the V&A incidents which inform training needs in clinical environments, supported by the V&A Case Manager and departmental V&A risk assessments.	Safety - Patient, Staff or Public	3	4	12	Despite the various training courses being delivered and based upon the current arrangements in place, it is inevitable that staff who have yet to attend training will continue to deliver healthcare to patients who present with challenging behaviours without the appropriate training. Following a change in Exec-lead in Mid-2024, a new Training Needs Analysis has been undertaken, completed in October 2024, to help plan how best to tackle the training needs of the organisation going forwards. A task and finish group was set up to look at this workstream with other training teams, however, this work appears to be on hold. The likelihood score is reduced from the inherent risk score due to the level of training currently being delivered.	Additional Training Resource: Undertake a cost benefit analysis of recruiting additional staff and considering income generation.	Springthorpe, Adam	~~31/03/2023~~ 31/12/2026	Income generation to increase staff resource-Certification of training model confirmed November 2024. Most recent TNA (which identified that 12.9WTE extra trainers would be required to be fully compliant). No opportunity to income generate at present due to staffing levels. James Severs has indicated that he may consider income generation as part of a wider review of training provision in 2026.	Health and Safety Committee	2	3	6	The TNA process and training review will take time to complete and implement.	Treat	28-May-26
																Creation of Practice Leaders: Practice Leaders to provide clinical support and advice, supervised by the core Reducing Restrictive practice team. This would provide an extra layer of assurance in higher risk areas.	Wood, Rachel	~~31/07/2023~~ 31/12/2026	Creation of practice leaders. We have one practice leader in one area (Bryngolau) with more to follow if this proves successful (At Nov 25). A further 6 are undertaking the RRP Level 4 qualification in April 2026 and at which point will be considered as practice leaders (8 Month Course).							
																Creation of Practice Leaders: Mental Health to up skill a member of each inpatient area to work as practice leaders.	Wood, Rachel	**Completed**	This action overlaps with the previous one.							
																Certifying the training module with the restraint reduction network (RRN) charity with the purpose to use the course for income generation.	Wood, Rachel	**Completed**	This is covered by the 'Additional Training Resource' Action above.							

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																Conversation to be had with the ESR team with the intention of the V&A and restraint reduction training courses to be captured electronically.	Wood, Rachel	Completed	ESR- A conversation has been had with Learning and Development (L&D). L&D have agreed to create a new system for registration on courses which will mean when a participant attends a course, this will be automatically uploaded to ESR. This will streamline the attendance recording.							
																TNA review	Wood, Rachel	Completed	I have reviewed the training needs and will be looking at the Restraint Reduction in Older Adult Care (formerly Behaviours that Challenge) course being offered to Qualified nurses only (excluding mental health older adult areas where all staff will receive the 2 day training) in 2024. The rationale for this is the theoretical element focusses heavily on the Legal and Ethical aspects of Restrictive Practice and how to care plan any restrictive interventions or preventative strategies. This needs to be led by Qualified Nurses. Healthcare Support Workers will be offered the All Wales Violence and Aggression Passport (1 day course) and additional online teaching (via MS Teams) on Restrictive Practice. This will be reviewed 6 months into 2024 then again at 12 months. October 2024 - A new TNA has been completed following a change in Exec-Lead. This new TNA gives a helicopter perspective of the training needs in order to plan the approach to all new training going forwards.							

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1596	Estates & Facilities	Estates & Facilities	E&F: Carmarthenshire West	Severs, James	Chiffi, Simon	Day, Simon	Hill, Paul	16-Feb-23	There is a risk of of avoidable harm to patients, staff, and visitors caused by fire related deficiencies, identified by the fire officer during fire risk assessments. This is caused by the lack of fire alarm detection, missing/damaged fire doors, issues with fire compartmentation, inadequate coverage of emergency lighting etc etc. This will lead to an impact/affect on patients, staff , and visitors should a fire occur. Risk location, Glangwili General Hospital.	Estates operations staff carry out fire alarm testing on a weekly basis, and Merlin Fire the maintenance provider undertake the annual testing/maintenance. Estates operations also undertake PPM's and repairs on the fire doors. The fire officer carries out fire risk assessments on an annual basis.	Safety - Patient, Staff or Public	2	5	10	Fire deficiencies are identified by the fire officer during fire risk assessments. Estates operations staff attempt to close out the low risk deficiencies that require little to no funding. For the remaining high risk deficiencies that cant be directly funded, capital bids will need to be raised in order to address the issues. Some of these outstanding issues will be directly linked to the ongoing fire precaution scheme, however, it's worth noting that it may be a few years before the issues are addressed under the project.	Fire deficiencies are identified by the fire officer during fire risk assessments. Estates operations staff attempt to close out the low risk deficiencies that require little to no funding. For the remaining high risk deficiencies that cant be directly funded, capital bids will need to be raised in order to address the issues. Some of these outstanding issues will be directly linked to the ongoing fire precaution scheme, however, it's worth noting that it may be a few years before the issues are addressed under the project.	Jones, Kevin	~~29/03/2024~~ ~~30/03/2025~~ ~~30/03/2026~~ 30/03/2027	Maintenance team are addressing the smaller issue and information is being collated to submit for further capital funding. Capital bids need developing to address the issues that require significant funding.	Health and Safety Committee	1	1	1	The target score will be achieved when funding is provided.	Treat	18-May-26

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1546	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Day, Simon	Arnold, Malcolm	5-Dec-22	There is a risk of that the water services will remain non compliant and pathogens will be detected in increased sampling. This is caused by no flow or, compared to pipe size, not enough flow in pipework with resting in warm ceilings causing problems with pathogen growth. Oversize pipes are being used which do not allow an adequate flow of water and due to poor set up will not prevent any problems with Pseudomonas, Legionella or excessive TVC from occurring. Poor understanding of the system. Use of Vulcathene flex pipe of a large size being used and stepped down excessively. This will lead to an impact/affect on closure of services. Sickness of patients/staff/visitors coming into contact with contaminated water. Reputational damage of the Health Board and possible enforcement or Health and Safety Executive (HSE) prosecution in the event of a serious incident occurring. Risk location, Pembrokeshire, Withybush General Hospital.	Currently a frequent flushing regime is in process with extended temperature testing and monitoring. Pipes identified as large are removed as required. Empty rooms within Residential Blocks are also a major problem.	Safety - Patient, Staff or Public	2	5	10	The pipework requires to be addressed as soon as possible to alleviate any further problems. We are unable to control excess water, non functioning valves and also dead ends. Constant problems are being recorded in all areas. Constant flushing and monitoring of the system in line with HTM 04 are in place but this is not a resolution. Renal now clear following tank chlorination and increased flushing. Renal now placed on the annual flushing programme with external contractors. Very high legionella scores have been detected in Residential blocks and has been entered as a separate Datix to the main hospital. Legionella SG 1 as identified by contractors testing the water systems of the Residential Blocks at WGH. Large counts have been identified and remedial work needed to allow treatment of systems. There is a lot of Pipe Alterations and valves needed prior to treatment due to the poor installation carried out in the removal of heat sources. Scores of CFU vary from 120 to 14400.	Pipe alterations at St Thomas complete and good results received back from Carmarthen Laboratory. Next block being surveyed for same treatment. Capital bid required to replace alkathene main water supply to residences blocks.	Arnold, Malcolm	~~24/03/2023~~ ~~30/04/2024~~ ~~30/03/2025~~ ~~30/09/2025~~ ~~31/03/2026~~ 30/09/2026	Survey carried out for alterations. no further action Update 17/07/2024 capital bid required to alter all residences domestic pipework. signs of lead solder found during welsh water audit. Main cold water supply requires upgrade from duct system to residences. non compliance with welsh water capital bid required December 2025 no further progress feb 2026 NFP	Health and Safety Committee	1	2	2	capital investment and ongoing maintenance and testing would reduce this risk	Treat	26-May-26
																Parts have been ordered for alteration of rest of Blocks but needs planning due to length of outage.	Arnold, Malcolm	**Completed**	Inspections carried out. no further action Capital bid required to upgrade main water supply and main residences block connections. December 2025 no further action feb 2026 Close not a risk item							
																St Thomas has been completed but the other blocks have not been started. An anomaly in supply is compounded by the use of Alkathene Pipe.	Arnold, Malcolm	**Completed**	No further progress made. Not a risk action close							
																Pipework alterations are required as we are unable to control temps. Scheme to be compiled and entered into capital bid.	Arnold, Malcolm	~~30/03/2025~~ ~~30/09/2025~~ ~~30/12/2025~~ ~~31/03/2026~~ 30/09/2026	New Action no further action feb 2026 NFA							
																Water Board Inspection indicates water pipes too large. Capital bid to replace	Arnold, Malcolm	**Completed**	No further progress. not a risk item Close							

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																Capital Bid to be submitted for major infrastructure works to site. This has been identified as major infrastructure/backlog improvements.	Arnold, Malcolm	~~31/03/2025~~ ~~30/09/2025~~ ~~30/12/2025~~ ~~31/03/2026~~ 30/09/2026	New Action. no further action FEb 2026 Work ongoing at major capital to improve water systems						
2309	Estates & Facilities	Estates & Facilities	E&F: Carmarthenshire West	Severs, James	Chiffi, Simon	Day, Simon	Hill, Paul	16-Mar-26	There is a risk of that the organisation's automatic door sets may cause harm to service users, staff, or visitors because they do not comply with current safety standards. The absence of monitored safety sensors increases the likelihood of the doors colliding with a person, child, or object during operation. This is caused by legacy automatic door operators that are not compatible with the monitored safety sensor systems required to meet current safety and compliance standards. As a result, the existing operators cannot be upgraded to incorporate the required safety features, meaning multiple door sets require full replacement with new compliant operator packages. This will lead to an impact/affect on on the safety of patients, staff, and visitors, including potential injury from door collisions, compromised safeguarding for vulnerable individuals such as children or those with reduced mobility, and an increased likelihood of incidents requiring investigation. It may also result in non-compliance with statutory or regulatory standards, reputational damage, operational	Planned Preventative Maintenance (PPM): Regular servicing and inspection of all automatic door sets are carried out in accordance with the organisation's maintenance schedule. This helps ensure faults are identified early and that door performance remains as safe as reasonably practicable. Maintenance Contract with J Manny: A formal maintenance agreement is in place with J Manny, providing professional support for reactive repairs, technical assessments, and routine maintenance activities. Technicians identify safety issues during visits and advise on required upgrades or replacement components where possible. Local Operational Awareness: Estates and facilities staff are aware of the non-compliant door sets and monitor reported issues, escalating concerns appropriately when doors demonstrate malfunctioning behaviour or safety risks. Incident and Fault Reporting: Staff are encouraged to report door faults or safety concerns promptly through internal reporting systems, enabling timely maintenance intervention.	Statutory duty/inspections	2	5	10	The original risk score of 15 reflected a moderate to high level of concern due to the potential for injury arising from nonâ€'compliant automatic door sets lacking monitored safety sensors. At that stage, the organisation had limited assurance that existing controls could reliably prevent a collision or harm event. Following the implementation and strengthening of control measures â€" including the formal maintenance contract with J Manny, structured planned preventative maintenance (PPM), increased local monitoring, and improved fault/incident reporting â€" the overall level of unmanaged risk has been partially reduced. These controls provide a more consistent level of oversight, earlier identification of faults, and clearer escalation pathways when concerns arise. While these measures do not eliminate the underlying design non-compliance, they reduce the likelihood of an unmitigated failure going	Capital bid submitted on the 16/03/2026 requesting funding for £65,000 to replace non-compliant door operators across the GGH site.	Hill, Paul	31/03/2027	Awaiting capital funding to replace door operators.	Health and Safety Committee	1	3	3	Once all nonâ€'compliant automatic door sets have been fully replaced with new operator packages that incorporate monitored safety sensors and meet current safety standards, the underlying hazard will be substantially reduced. The new systems will provide continuous monitoring of door movement and obstruction, ensuring that the doors automatically stop or reverse if a person, child, or object is detected. This introduces a robust, engineered safety control that directly eliminates the primary cause of the original risk. The improved door sets will no longer rely on administrative controls, human vigilance, or reactive maintenance to prevent collisions. Instead, safety will be built into the design and operation of the equipment, greatly reducing both the likelihood and potential severity of harm. With compliant technology		18-May-26

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									disruption, and potential legal or financial consequences for the organisation. Risk location, Glangwili General Hospital.						unnoticed and help ensure that any issues are addressed more promptly. Consequently, the risk score has been adjusted down from 15 to 10, reflecting an improved but still incomplete risk position. The lowered score acknowledges that existing controls offer some protective benefit, but the residual risk remains until the door sets are fully upgraded to meet modern safety standards.								installed across all affected areas, the organisation will meet statutory safety requirements, significantly strengthening assurance around user safety. As a result, the residual risk becomes low and manageable, and a final target score of 3 is justified. This reflects a safe environment where modern engineering controls, compliance with standards, and ongoing maintenance provide strong, sustained protection against harm.		
2335	Estates & Facilities	Estates & Facilities	E&F: Carmarthenshire West	Severs, James	Chiffi, Simon	Day, Simon	Hill, Paul	5-May-26	There is a risk of of failure of the existing Thorlux Scanlight emergency lighting system, which is circa 20 years old and now contains obsolete components that cannot be readily repaired or replaced. This is caused by the age and condition of the existing Thorlux Scanlight emergency lighting system, which is approximately 20 years old and has reached end of life. The equipment contains obsolete components with no manufacturer support, preventing effective repair or replacement of failed fittings. As a result, the system has progressively deteriorated and no longer meets current British Standards. This will lead to an impact/affect on the safety of patients, staff, and visitors due to inadequate emergency illumination during a power failure, increasing the risk of slips, trips, and delayed or unsafe evacuation. It may also result in non-compliance with statutory fire safety standards, potential enforcement action, and reputational damage to the Health Board. Risk location, Glangwili General Hospital.	The Thorlux Scanlight system operates as a self-testing system, with faults identified through automatic testing regimes and monitored accordingly. A site-wide emergency generator is in place, capable of restoring power within approximately 15 seconds in the event of a mains failure. However, due to the obsolescence of the Thorlux system and unavailability of replacement parts, failed components cannot be effectively repaired or replaced.	Safety - Patient, Staff or Public	2	5	10	The current risk score has been reduced from 15 to 10 to reflect the presence of mitigating controls, most notably the provision of a site-wide emergency generator capable of restoring power within approximately 15 seconds in the event of mains failure. This reduces the likelihood and duration of a complete loss of lighting across the site. Additionally, faults within the existing self-testing system are identified and monitored. However, the risk remains due to the age, obsolescence, and non-compliance of the Thorlux Scanlight system, and the inability to repair or replace failed components.	Obtain quotation and develop capital bid to replace obsolete emergency lighting system.	Hill, Paul	31/03/2027	Capital bid submitted for £430,672.50 to replace obsolete emergency lighting system. Currently awaiting funding.	Health and Safety Committee	1	3	3	The target risk score of 3 will be achieved following full replacement of the existing Thorlux Scanlight emergency lighting system with a modern, compliant system designed and installed in line with current British Standards. The new system will provide reliable emergency illumination, supported by maintainable components, routine testing, and an effective PPM regime, ensuring ongoing compliance and significantly reducing the likelihood of system failure and risk to life safety.		5-May-26

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2197	Estates & Facilities	Estates & Facilities	E&F: Ceredigion	Severs, James	Chiffi, Simon	Day, Simon	Jones, Elfyn	21-Oct-25	There is a risk of of harm to patients, staff and visitors due to operational failure of Fire Doors. This is caused by failed fire doors due to their condition and age. This will lead to an impact/affect on patients, staff and visitors coming to harm in the event of a fire. If there are gaps in the doors/damage to the doors, they compromise fire containment and can lead to catastrophic spread of smoke and flames. Risk location, Bronglais General Hospital.	Pre Planned Maintenance checks in place (six-monthly/annually/quarterly) to check the condition of the fire doors. Repairs are undertaken where possible.	Safety - Patient, Staff or Public	2	5	10	The likelihood of patient harm is currently reduced as there are trained carpenters on site to check and repair the majority of the fire doors, as and when required. The risk remains high as not all fire doors are compliant.	To apply for a Capital Bid of £195,000	Jones, Elfyn	~~19/12/2025~~ 31/03/2026	16/12/2025 - Bid submitted in June and July of 2025, £96k for post grad building fire doors and £195k for B1, B2 B7 and B15. Bid currently not approved. 24/02/2026 - Bid currently not approved. 23/04/2026 - Bid currently not approved.	Health and Safety Committee	1	4	4	All fire doors across BGH would need to be compliant with standards in order to fully mitigate the risk. Funding is required to achieve this.	Treat	23-Apr-26

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2085	Estates & Facilities	Estates & Facilities	E&F: Carmarthenshire West	Severs, James	Chiffi, Simon	Day, Simon	Hill, Paul	30-May-25	There is a risk of of harm to patients, staff, and visitors. This is caused by failed fire doors due to their condition and age. This will lead to an impact/affect on Failed fire doors put lives at risk. They compromise fire containment, endanger patients and staff, and can lead to catastrophic spread of smoke and flames. This could lead to further fire enforcements, HSE investigations, fines and/or custodial sentences, and adverse publicity/reduction in stakeholder confidence. Risk location, Glangwili General Hospital.	We have planned preventative maintenance checks in place to check the condition of fire doors.	Safety - Patient, Staff or Public	2	5	10	We have suitably trained carpenters checking fire doors across the GGH estate as part of their PPM schedule. Capital bids are continuously submitted for fire doors requiring full replacement.	Capital bids will be constantly submitted requesting funding to replace fire doors as and when they are identified as requiring replacement. This will be an ongoing process.	Hill, Paul	**Completed**	Capital bids will be constantly submitted requesting funding to replace fire doors as and when they are identified as requiring replacement. This will be an ongoing process. Capital funding received in the sum of £90k (D365) to address some failed fire doors.	Health and Safety Committee	1	5	5	Once all fire doors are operationally safe the risk rating will reduce to moderate.	Treat	18-May-26
																37 fire doors identified as requiring full replacement.	Hill, Paul	~~31/03/2026~~ 31/03/2027	Capital bid submitted on the 25/06/2025, requesting funding of £142,000 to replace 37 fire doors across the GGH estate.							
																39 fire doors identified as requiring full replacement.	Hill, Paul	~~31/03/2026~~ 31/03/2027	Capital bid submitted on the 21/07/2025, requesting funding of £150,000 to replace 39 fire doors across the GGH estate.							
																Capital funding required to replace 25 fire doors.	Hill, Paul	~~31/03/2026~~ 31/03/2027	Capital bid submitted on the 25/11/2025, requesting funding of £96,250.00 to replace 25 fire doors across the GGH estate.							

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2163	Estates & Facilities	Estates & Facilities	E&F: Operations Compliance	Severs, James	Chiffi, Simon	Chiffi, Simon	Day, Simon	19-May-25	There is a risk of of harm to maintenance staff who are working Out of Hours due to the inability to maintain minimum safe staffing levels required for working in high-risk areas, such as confined spaces. This is caused by insufficient availability of On Call staff who are able to cover the minimum staffing levels and the Maintenance Procedure document for On Call being out of date and not consistently applied across all sites. This will lead to an impact/affect on staff safety as there are heightened risks for lone workers, particularly in terms of monitoring their safety throughout night shifts. Operational disruption could occur if maintenance procedures were unable to be completed during out of hours. Non compliance with regulations (e.g., Health and Safety at Work act) could incur penalties. There could also be a financial impact to the Health Board staff sustained injury whilst working out of hours, resulting in legal claims/compensation. Risk location, Health Board wide.	Operational Maintenance Policy (No 144) Contract Control Policy (No 541) On Call Maintenance Procedure document is in place.	Safety - Patient, Staff or Public	2	5	10	There are heightened risks for lone workers, particularly in terms of monitoring their safety throughout night shifts. Furthermore, the inability to adhere to permit-to-work arrangements out of hours due to insufficient staff on call adds to the overall risk. These factors potentially compromise worker safety and the effectiveness of emergency responses. Despite the current controls in place, until the group formalises and ratifies a new agreed procedure that reduces the risk to maintenance staff who are working Out of Hours, the risk remains high.	To create a working group to review the On Call Maintenance Procedure.	Day, Simon	17/11/2025	New Action	Health and Safety Committee	1	5	5	Agreed maintenance procedure to be put in place (that complies with the Health and Safety at Work Act, all regulatory guidance and law) and increased staffing levels, would enable the target risk score to be achieved.	Treat	13-Feb-25

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1382	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Day, Simon	Arnold, Malcolm	19-Apr-19	There is a risk of of harm to patients and staff at WGH. This is caused by the reinforced autoclaved aerated concrete (RAAC) planks that were used during the construction of WGH becoming insecure with the potential for large pieces to break off and/or planks collapsing into corridors and ward areas. This will lead to an impact/affect on a potential injury or possible death if a sudden collapse of planks were to occur within an occupied area of the hospital. Other impacts include closure of large areas of the hospital to undertake visual inspections and/or remedial works, breaches in statutory duties, negative media coverage, and loss of confidence from stakeholders. Risk location, Withybush General Hospital.	Specialist structural engineers (Curtins) engaged to undertake a programme of visual inspection of planks at WGH - plank by plank surveys are underway at pace, scheduled to finish March 2024. Process in place to prop identified critical planks within 24 hours to make immediate area safe and to be used or to area to remain closed until safe to re-occupy Principal contractor appointed to provide propping and undertaking remedial works, and assurance has been obtained from the engineers where areas are safe to be re-occupied. Legal advice sought on corporate manslaughter and acted upon promptly. Business Continuity Incident declared on 15Aug23 and Command Control Structure (Bronze) established to coordinate and manage Health Board response. A Management Plan is being established to manage the ongoing risks of RAAC, to include: A planned maintenance card is also included in the Maintenance Scheme for the Direct Labour Force to visually check at different point throughout the hospital. Continue to monitor any water ingress on failing roof systems and promptly take any remedial works necessary. During any work above ceiling tiles it has also been passed on to the craftsmen that it is requested that a visual inspection is also carried out. Restriction and controlled access systems in place to certain areas of the site. Introduced specialist RAAC plank training to provide awareness for site teams and how they should operate where RAAC Planks are identified. Areas have been identified to reduce to loading on the RAAC planks. Weekly inspection of props undertaken on	Safety - Patient, Staff or Public	2	5	10	Project plans are in place in terms of when remedial actions will be undertaken, and capital has been secured to fund these works. Works in ward areas are completed. Remedial works on other areas are due to commence in April 2024, with a view to completion by March 2025. There will be ongoing re-surveys in all ward areas from October 2024 onwards. All ground floor areas scheduled for 2025. Risk score is unlikely to reduce until all works are completed in March 2025.□	Complete direct award to structural engineering specialists under a compliant Framework.	Elliott, Rob	Completed	The compliant Framework, and all supporting documentation, has gone through to Shared Services at a senior level and will be considered shortly for approval by the DOF of the UHB. It is hopeful the framework will be approved by the end of April 2023.completed	Health and Safety Committee	1	5	5	The target risk score is based on the level risk following visual surveys, propping and remedial works being completed on critical P1 planks identified at WGH.	Treat	26-May-26
																Survey work of all RAAC Planks at WGH.	Elliott, Rob	Completed	Timescale amended to March 2024 for all RAAC plank by plank surveys at WGH to be completed. As of February 2024 all P1 (critical) planks have been surveyed. By March 2024 all planks will have been risk categorised, with follow on surveys to take place in 24/25. completed							
																Establish funding to carry out reparatory works of RAAC planks.	Elliott, Rob	Completed	The level of funding required is currently unknown and will be dependent on the findings of the surveys as we proceed. Welsh Government have provided funding for the P1 (critical) planks. A revised date of March 2024 has been placed against this action, as we envisage all survey work to be completed by this date. completed							
																Develop the necessary tender documentation to commission review of all other sites (including Community, Primary Care, General Practitioners Practices, leased properties etc,) which were constructed within a timeline of 1960 to 1995, which will be competitively tendered (forming part of the portfolio survey).	Elliott, Rob	Completed	The tender documentation is being developed currently and is hopeful to be agreed by the end of May 2023. completed							

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										Weekly inspection of props undertaken on site, and rectified as required. Assessment process in place for service re-occupation to ensure their safety and that the area is able to be used effectively, managed via service site management. Capital funding received to undertake remedial works to address P1 planks. Remedial works in Wards 7,9, 11 & 12 complete and the pot wash area of kitchen.						Surveys have started and remedial work carried out in Potwash area. Other remedial work is required.	Elliott, Rob	Completed	Continual progress being made with extra inspections.completed							
																Detailed plank by plank surveys across WGH by Curtins (dependent on access)	Elliott, Rob	Completed	Visual inspections have been completed, and detailed plank inspections are due to commence in October 2023. Funding has been agreed for remedial works. Remedial works in Wards 7,9, 11 & 12 complete and the pot wash area of kitchen. completed □							
																Undertaking remedial works resulting from surveys (c£13m).	Elliott, Rob	Completed	Funding has been secured for FY2023/24 and FY 2024/25 for £13m. Remedial works are scheduled to be complete across the site by March 2025. MA update all remedial works have been completed							
																Development of Management Plan to manage the position/access to areas/staff training until the works being remediated	Elliott, Rob	Completed	Management Plan has been implemented and monitored via weekly Bronze meetings. completed							
																Fast Track Visual Surveys being arranged to identify critical (P1 planks) requiring emergency propping or areas closed off.	Elliott, Rob	Completed	Fast track visual surveys completed in August 2023. completed							
																Complete remedial work in all affected ground floor areas.	Elliott, Rob	Completed	Remedial work to OPDA (Outpatients Department A) has started, with all other affected ground floor areas to be completed by March 2025. MA update all works completed							

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																Remove weight (e.g. pipework, cabeling, duck work, etc) from planks where possible to reduce the risk of deterioration and excessive weight.	Elliott, Rob	**Completed**	New action- work ongoing and the timescale will be re-assessed as work is progressed. MA Update All remedial works completed							
																carry out ongoing resurvey work to both second floor and ground floor RAAC areas.	Arnold, Malcolm	~~31/03/2026~~ 30/09/2026	Second floor completed now due 2026 . Ground Floor resurvey due October 2025 (completed) now due 2027 Ground floor survey completed by December 2025. Second floor survey planned for 2026 Additional second floor survey completed following winter rain roof water leaks (completed march 2026) no further degradation) Second floor re survey planed for the end of 2026 year							
1539	Estates & Facilities	Estates & Facilities	E&F: Carmarthenshire East	Severs, James	Chiffi, Simon	Day, Simon	Evans, Stewart	27-Jan-16	There is a risk of of harm to patients/staff/visitors plus service disruption This is caused by operational failure of Pneumatic fire dampers and fire door detents to close in the event of a fire, due to their age and condition This will lead to an impact/affect on the safety of patient, staff and general public, HSE investigations and further fire brigade enforcement, fines and/or custodial sentences, adverse publicity/reduction in stakeholder confidence. Risk location, Prince Philip Hospital.	Pre-planned Maintenance (PPM) checks in place to check operation of dampers that have not failed	Safety - Patient, Staff or Public	2	5	10	Based on ppm checks and engineering reports. Surveys have been carried out to determine the pneumatic dampers and door detents for replacement	Funding required for upgrade works on Pneumatic Dampers and Pneumatic Fire Door detaunts	Williams, Paul -	31/03/2027	Cost received on individual damper replacements, currently on Infrastructure back log engineering Maintenance as priority, Property Dept taking this to WG for funding.	Health and Safety Committee	1	5	5	Highlighted on Infrastructure list with MCP. Funding required	Treat	27-Apr-26
2042	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Day, Simon	Arnold, Malcolm	25-Mar-25	There is a risk of of Harm to patients, staff an visitors plus service disruption. This is caused by Operational failure of fire safety doors in the event of a fire due to their age and condition.	Pre planned maintenance (ppm checks) in place to check on condition of doors. Continued ppm list identifying condition of current doors within WGH locality. Localised repairs and third party accredited improvements where	tient, Staff or Public	2	5	10	Based on PPM checks and engineering reports. Surveys have been carried to determine fire door replacements. Phased project in place to replace doors on a risk based approach. Risk is	capital bid to replace defective doors highlighted on LOFSM	Arnold, Malcolm	**Completed**	Capital bid in progress. Update Capital bid submitted 25/03/2025 Capital Bid Reference No WGHCB10224 and WGHCB23225	d Safety Committee	1	5	5	Capital funding is required to replace doors and fully mitigate the risk.	Treat	8-Jun-26

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			E						This will lead to an impact/affect on the safety of patients, staff, and general public. HSE investigations, Mid and west wales fire brigade fire enforcement, fines and or custodial sentences , adverse publicity / reduction in stake holder confidence. Risk location, Withybush General Hospital.	necessary.	Safety - Pa				high as fire doors have been identified as non compliant with current legislation and unable to be repaired to required standard. Capital funding is required to replace doors and fully mitigate the risk.	install new fire doors on completion of capital funds being made available.	Arnold, Malcolm	~~29/08/2025~~ ~~31/03/2026~~ 30/09/2026	30/06/2025 no further progress 20/08/2025 still waiting for funds to be released. FEB 2026 Order replaced for RED RAG door replacement works to be completed by 20 march 2026 . Additional funding expected 2026 finacial year.	Health an						
1873	Estates & Facilities	Estates & Facilities	E&F: Carmarthenshire East	Severs, James	Chiffi, Simon	Day, Simon	Evans, Stewart	31-May-24	There is a risk of to tenants and staff in the residential blocks of a failure to identify a gas leakage on the main incoming gas mains due to the lack of ventilation. This is caused by unvented/non compliant gas meter storage. Currently, the installation does not comply with current regulations. Failure to comply would potentially lead to enforcement notices/litigation. This will lead to an impact/affect on supply of heating and hot water to the residential blocks for tenants and the possibility of unknown natural gas leakage in the building. Financial and reputational harm to the Health Board if gas leaks were to occur. Health and safety of the tenants would be adversely affected by any gas leaks and displacement of tenants. Risk location, Prince Philip Hospital.	Currently local PPM (Planned Preventative Maintenance) in place for boiler/appliance testing (monthly).	Safety - Patient, Staff or Public	2	5	10	Current risk score is high as despite current controls in place (monthly monitoring), natural ventilation ductwork is required to mitigate the risk. Capital funding has been sought.	Quotations obtained for additional ventilation, Fire curtains removed from Fire door installation to be re-instated by Discretionary Capital Team. Capital bid to be submitted.	Evans, Stewart	**Completed**	Costs partly received 15.07.2024	Health and Safety Committee	1	5	5	Funding required to move gas meters to outside	Treat	27-Apr-26
																Further TEF funding required to ventilate Blocks	Evans, Stewart	31/03/2027	Awaiting TEF funding							

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1096	Estates & Facilities	Estates & Facilities	E&F: Carmarthenshire East	Severs, James	Chiffi, Simon	Day, Simon	Evans, Stewart	27-Jan-16	There is a risk of of harm to patients/staff/visitors plus service disruption. This is caused by operational failure of Fire Safety Doors in the event of a fire due to their age and condition. This will lead to an impact/affect on the safety of patients, staff and general public, HSE investigations and further fire brigade enforcement, fines and/or custodial sentences, adverse publicity/reduction in stakeholder confidence. Risk location, Prince Philip Hospital.	Pre Planned Maintenance (PPM) checks in place to check on condition of doors.	Safety - Patient, Staff or Public	2	5	10	Based on PPM checks and engineering reports. Surveys have been carried out to determine the fire door replacements, and additional fire doors required .	PPM monitoring/surveys. Identified on infrastructure backlog maintenance. Currently under review.	Evans, Stewart	**Completed**	"Minimum funding from statuary funds will only allow for survey and drop test. External contractors have carried out drop tests, and funding has been received for remedial work following the drop tests. Capital bid to be costed and submitted for dampers that require replacement. "	Health and Safety Committee	1	5	5	Ongoing investment required	Treat	27-Apr-26
																"Costs received for individual Dampers from Contractors"	Williams, Paul	~~31/03/2023~~ ~~31/03/2024~~ ~~30/04/2025~~ ~~31/03/2026~~ 31/03/2027	Currently on backlog infrastructure works. Identified as priority 2 in infrastructure backlog maintenance meeting 11th August 2022 ,site visit due 9th Sept 2022 with design team. EFAB bid has been submitted to Welsh Government in November 2022, awaiting response." Meeting with project team on 19.01.23 to prioritise risk before submitting business case to WG No change 04.04.23 No change 12.06.23 All investments in LOFS are now agreed with the Fire Service. The final phase beyond April 2025 will potentially require a new business case to be submitted. 18/80 dampers have been replaced. Work remains ongoing.							

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																Replacement of obsolete dampers.	Evans, Stewart	~~30/03/2027~~ ~~31/03/2025~~ ~~31/03/2024~~ ~~30/09/2024~~ ~~31/03/2026~~ 31/03/2027	Capital bid currently being costed and to be submitted by the end of August 2021. Once funding received this work will go out to tender. This is identified on the backlog infrastructure list. Expecting funding for damper repairs and upgrade. Awaiting funding for further damper replacements. DCP currently replacing 14 dampers picked up as defective following testing. 14 dampers replaced from DCP Scheme, remainder requires TEF 2025-26. Work ongoing.							
																Replacement, and additional fire doors, to be put in place following survey.	Evans, Stewart	**Completed**	All investments in LOFS are now agreed with the Fire Service. The final phase beyond April 2025 will potentially require a new business case to be submitted. Completed							
																Some Fire Doors to be changed at Amman Valley Hospital and Residences PPH , Hazard rooms, where identified on Wards at PPH.	Evans, Stewart	~~28/03/2025~~ ~~31/03/2025~~ ~~31/03/2026~~ 31/03/2027	Identified for TEF (Targeted Estates Funding) funding - work ongoing.							

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471	Estates & Facilities	Estates & Facilities	E&F: Carmarthenshire East	Severs, James	Chiffi, Simon	Day, Simon	Evans, Stewart	25-Sep-17	There is a risk of serious harm to pedestrians resulting from a road traffic accident occurring on the PPH access road between the Acute Medical Admissions Unit (AMAU) and staff car park. This is caused by no pavement or pedestrian walkway available along this stretch of road and curvature of road limiting the view of motorists using this area. This will lead to an impact/affect on death or serious harm to a pedestrian or motorist. Risk location, Prince Philip Hospital.	There are existing speed restrictions in place such as speed warning signs and a two way mirror to help with visibility around the corner of the site.	Safety - Patient, Staff or Public	2	5	10	Based on a site investigation by the Operations Compliance Manager. This risk remains high until road resurfacing/marking has taken place.	Installation of a pedestrian foot path or hatched area along this stretch of road is recommended, along with road re-surfacing and road markings.	Evans, Stewart	~~31/03/2027~~ ~~31/03/2020~~ ~~31/03/2026~~ 31/03/2027	Ops have been to review the area and quotations sought for a designated hatched area along the roadway. Capital bid has not been supported since 2018/19. EFAB bid to Welsh Government was unsuccessful. Another EFAB bid will be submitted for 2025/26.	Health and Safety Committee	1	5	5	Investment needed to provide pathway from AMAU to new DSU staff car park	Treat	1-Jun-26
1746	Estates & Facilities	Estates & Facilities	E&F: Ceredigion	Severs, James	Chiffi, Simon	Day, Simon	Jones, Elfyn	27-Jun-23	There is a risk of failure to the emergency lighting system at Bronglais Hospital during periods of electrical outages or faults tripping out the protection circuits. This is caused by the current emergency lighting systems being non-compliant or obsolete. This will lead to an impact/affect on an impact/effect on the operational continuity of the hospital in the event of a power cut. Potential risk to patient and staff safety if emergency lighting failure during an evacuation. The emergency lighting also forms part of the Regulatory Reform Order inspections, letters of fire safety matters and do not comply with BS5266 (British Standard for emergency lighting). Risk location, Bronglais General Hospital.	Monthly testing of existing units.	Safety - Patient, Staff or Public	3	3	9	Risk is high as we only test and maintain what is installed and this does not comply with BS5622 regulations. This failing has been recognised by the Fire Service and is an action that has been raised in LOFSMs and is detailed on AMaT (see attached document). Funding is required in order to mitigate this risk.	Submission of business case to Welsh Government to support necessary upgrades to the site.	Jones, Elfyn	~~31/03/2024~~ ~~31/03/2026~~ ~~31/12/2025~~ 31/03/2027	17/02/2025 - No funding agreed. 15/05/2025 - WG have provided funding however emergency lighting is not on the prioritised list. To review funding options with Capital Development Manager. 14/07/2025 - Funding options to be discussed. 16/09/2025 - Ongoing discussions with NWSSP and Welsh gov to secure monies to proceed with RIBA stage 3 & 4 designs for market testing and inclusion in Business case documents. 17/11/2025 - Comments as 16/09/2025. 26/01/2026 - No Updates 12/02/2026 - Scheme currently not in the top 10 prioritised list. 24/03/2026 - No Updates	Health and Safety Committee	1	1	1	Funding is required in order to purchase and install the new equipment to fully mitigate this risk.	Treat	23-Apr-26

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934	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Day, Simon	Arnold, Malcolm	17-Aug-20	There is a risk of of potential asbestos exposure to staff at WGH. This is caused by the need to access the celling voids, which contain asbestos panels, in emergency times when blockages occur and rodding to release a blockage puts pressure on Asbestos panels. Also while fault finding in voids and attending to lighting. This will lead to an impact/affect on staff developing serious health conditions, staff sickness, complaints, Health Board reputation. Risk location, Withybush General Hospital.	Encapsulation of exposed areas has been carried out in certain areas but not complete. Easement distances is not adequate due to the services in the ceiling voids. Ensure control of contractors site induction are thorough and include reference to asbestos register and tool box talks.	Safety - Patient, Staff or Public	3	3	9	Exposure to Asbestos can cause health problems and is reduced by encapsulation or even better would be complete removal. Surveys are being carried out to ascertain the dangers.	A lot of different areas are being removed by the Firecode Works and is making the works easier to manage.	Elliott, Rob	**Completed**	Unknown number have been removed and we are waiting on reports to upgrade register. completed	Health and Safety Committee	2	1	2	only complete eradication of all asbestos on site will reduce this to the target risk score	Treat	26-May-26
																As the Fire Contract is carrying out further works then they are taking out large areas. Update on Asbestos Register is required.	Chiffi, Simon	**Completed**	Ongoing process of Asbestos removal is reoccurring. completed							
																Further encapsulations and surveys with removal as best practice.	Arnold, Malcolm	~~30/09/2020~~ ~~31/03/2022~~ 31/04/2024 ~~31/03/2026~~ 30/09/2026	Some encapsulations have been carried out, and removals via a separate contract. Further removals are planned, once this is complete a review will be carried by the team to establish any further issues. Continued encapsulations actioned during various capital schemes 26/03/2025 update. ongoing annual level two survey. Items removed on a risk based approach.							
																Further Register being actioned. removals are still taking place.	Elliott, Rob	**Completed**	Update on register required as more tests and removals being carried out. annual survey carried out by AIB contractors completed							
																Update of Asbestos register required but more AIB is removed as Firecode contract is going on.	Elliott, Rob	**Completed**	Continuous removals are happening. 29/07/2024 ITEM can be closed Compliance risk item covers this.							
																Removals are continuing by the Firecode works but awaiting update of Asbestos Register to be carried out.	Elliott, Rob	**Completed**	No further progress. complete							
																Update of Asbestos register required but more AIB is removed as Firecode contract is going on.	Elliott, Rob	**Completed**	Complete							

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1929	Estates & Facilities	Estates & Facilities	E&F: Carmarthenshire East	Severs, James	Chiffi, Simon	Day, Simon	Evans, Stewart	2-Sep-24	There is a risk of of failure of the fire alarm monitoring of the site in its entirety due to the aged/failing equipment. This is caused by failure of equipment. This will lead to an impact/affect on the site monitoring of fire alarms. Risk location, Prince Philip Hospital.	continued maintenance from contractor.	Service/Business interruption/disruption	3	3	9	Currently the aged equipment is starting to show signs of failure, replacement panels are necessary to mitigate loss of monitoring.	Capital Bid Submitted	Evans, Stewart	31/03/2027	Awaiting Capital Bid outcome	Health and Safety Committee	3	1	3	Additional funding required. TEF bid of Â£280k 25-26 unsupported.	Treat	27-Apr-26
1965	Estates & Facilities	Estates & Facilities	E&F: Ceredigion	Severs, James	Chiffi, Simon	Day, Simon	Jones, Elfyn	9-Jun-24	There is a risk of of significant to patients, staff and visitors in the event of a fire evacuation. This is caused by potential failure of fire alarm systems. This will lead to an impact/affect on the ability to safely evacuate premises in the event of a fire. Risk location, Bronglais General Hospital.	Pre planned maintenance contract in place to test the systems regularly. Regular inspections of systems.	Safety - Patient, Staff or Public	3	3	9	System does not operate when required, despite regular maintenance and visual inspections of equipment. There is a risk of harm to patients, staff and the general public in the event of a fire due to non compliant systems, in accordance with fire safety regulations. A Fire Enforcement notice could be served if not remedied.	Infrastructure Business Case currently being developed.	Jones, Elfyn	~~31/03/2025~~ ~~31/03/2026~~ 31/03/2027	16/05/2025 - Possible funding available via Targeted Estates Funding route 14/07/2025 - In discussion with compliance on funding route. 16/09/2025 - ongoing discussion with compliance on funding route 17/11/2025 - Funding approved for replacing obsolete detectors. Obtaining quotations from contractor. 26/01/2026 - Funding reduced. GGH and PPH only. 26/03/2026 - Possibly funded from 2026/2027 TEF budget awaiting confirmation. 01/06/2026 - No updates to report at present.	Health and Safety Committee	1	3	3	Funding is required in order to purchase and install the new equipment to fully mitigate this risk.	Treat	1-Jun-26

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1348	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Day, Simon	Arnold, Malcolm	21-Mar-19	There is a risk of of potential harm to staff from equipment becoming faulty electrically. Defective Equipment also being plugged into fixed equipment which is unable to safely operate to eliminate danger. This is caused by defective or not sufficient load carrying capacities to allow correct and safe operation of electrical equipment. This will lead to an impact/affect on the safety of all patients, staff and visitors whilst electrical equipment is being used in their vicinity. Risk location, Pembrokeshire, Withybush General Hospital.	A small percentage of fixed electrical equipment is tested annually by contractors plus the DLO carry out safety checks daily on both equipment and fixed wiring. Failure to fund testing will cause a backlog and will not comply with Firecode Works.	Safety - Patient, Staff or Public	3	3	9	The current budget is not sufficient to carry out all testing and identify all problems but we are keeping on managing problematic areas.	Further testing of Portable and Fixed Wiring is required to minimise risks with Electrical Equipment. Further funding and resources must be made available	Arnold, Malcolm	~~31/03/2022~~ ~~30/03/2025~~ ~~30/09/2025~~ ~~31/03/2026~~ 30/09/2026	Currently testing has been carried out and we are awaiting results schedules from Contractors no further action 5 year fixed wiring testing contract has been awarded. All electrical work on site must be completed by certified CP LV electricians and permitted by APLV for WGH site. Update 17/07/2024 tender process underway with procurement to award external contractors to carry out fixed wire testing. local testing completed to Creche/child health/ Pembroke county. orders placed to carry out PAT testing 14/04/2025 main contract has commenced with all community premises.	Health and Safety Committee	2	2	4	Capital investment would reduce this risk, and ongoing planned maintenance	Treat	8-Jun-26
																Testing of local boards carried out by internal craftsmen but not complete	Arnold, Malcolm	**Completed**	No further progress. completed							
																Further testing has been carried out on site and waiting for EICR report to be given. This is only part of the hospital and requires extra Work and Funding.	Elliott, Rob	**Completed**	Further testing is being carried out. completed							

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																Further testing has been carried out on site and waiting for EICR report to be given. This is only part of the hospital and requires extra Work and Funding.Problem is still in situ.	Elliott, Rob	**Completed**	No further progress completed						
1136	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Day, Simon	Arnold, Malcolm	12-Jun-17	There is a risk of of people, staff or patients falling or tripping in potholes or uneven road surfaces throughout all sites. This is caused by wear and tear, natural erosion through weather and vehicle travel. Road markings are also worn along with parking spaces markings which are adding to problems. Directional arrows and zebra crossings also need updating throughout the site. This will lead to an impact/affect on all visitors to site inclusive of staff, patients and visitors. Risk location, Withybush General Hospital.	Additions of temporary signage when required also barriers in use. MA Update Emergency filing of potholes when identified. low risk planned maintenance routine to inspect paths and road monthly.	Safety - Patient, Staff or Public	3	3	9	Identified and costs collected as singular units but not complete.	Directional arrows and zebra crossings need updating throughout the site.	Arnold, Malcolm	**Completed**	5% of works has been completed as of July 2021. no further progress completed	Health and Safety Committee	3	2	6	ongoing inspections and maintenance will reduce this risk but weather and road use will always cause were and tear	Treat	26-May-26
																Funding request submitted to Welsh government 2022	Arnold, Malcolm	**Completed**	completed							
																Continuous monitoring of roadway but is shown as deteriorating.	Elliott, Rob	**Completed**	Continuing to monitor complete							
																Some potholes filled in due to complaints but roads are deteriorating. Update MA planned maintenance in place to routine inspect roads on a monthly basis. Potholes identified have emergency fill products applied. this is ongoing	Arnold, Malcolm	~~25/08/2023~~ ~~30/04/2024~~ ~~31/03/2025~~ ~~30/08/2025~~ ~~31/03/2026~~ 30/09/2026	Only potholes at various points. update routine planned maintenance inspections in place, potholes identified and filled where necessary. 28/03/2025 update no further progress							
																Extra complaints are coming in and we have recently had some other people falling.We are not able to keep up with temp fixes due to the volume of traffic.	Elliott, Rob	**Completed**	Filling in deepest holes but there is a lot of damaged roads. update MA emergency pot holes filling complete. planned maintenance checks in place							
																Capital bid to resurface highest risk priority road and car park sections	Arnold, Malcolm	~~31/07/2025~~ ~~31/03/2026~~ 30/09/2026	Condition survey completed to look at immediate issues / areas over 5 years life and areas over 10 years life. Highest priority road and car park resurfacing capital bid submitted no further progress							

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1261	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Day, Simon	Arnold, Malcolm	14-Oct-21	There is a risk of that the roof and ceiling will become too badly corroded to allow the office to be used. The subframe is also showing signs of external corrosion of the frame and skirts on the floor level of the units. This is caused by weather conditions and inevitably the age of the units. This will lead to an impact/affect on closure of the offices as there are water leaks being permanently reported. The trial of using a compound on the roof was abandoned as the roof was giving way. Unfortunately the whole of the roof is not in a very good condition. Risk location, Withybush General Hospital.	Monitoring and used to be coating of the leak area but now unable to walk on roof.	Safety - Patient, Staff or Public	4	2	8	The sub frame of the building is in poor condition and will not allow more maintenance.	Continual Inspections to be carried out.	Arnold, Malcolm	~~23/09/2021~~ ~~30/03/2025~~ ~~30/10/2025~~ ~~31/03/2026~~ 30/09/2026	Frames are deteriorating. update 17/07/2024 north side of building subsided by 100 mm due to frame corrosion. structural survey completed, waiting for action plan and cost to repair the structure. Property team to carry out building survey for suitability. Update 19/02/2025 North Side works complete. Still evidence of corrosion to frame on the west side. to be monitored	Health and Safety Committee	2	1	2	Capital investment and regular maintencae will achieve the target risk score.	Treat	8-Jun-26
																Units are subject to adverse weather and are corroding badly. No further work can be determined.	Elliott, Rob	**Completed**	No further progress. Emergency works to the roofs completed June 2024 capital bid in place for full replacement. completed							
																Continuing maintenance and inspection being carried out.	Arnold, Malcolm	**Completed**	Continuous patching up of external areas. Update 17/07/2024 emergency patch repair to one section of the roof completed June 2024. Capital bid in place to replace fully. Update 19/02/2025 Capital funds release Or placed with contractor. mobilisation of scaffolding no on site. Start date to be confirmed roof completed							
																Units are subject to adverse weather and are corroding badly. No further work can be determined.Partial improvements have been carried out to a part of the roof. More funding required.	Elliott, Rob	**Completed**	No further progress. completed							

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947	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Day, Simon	Arnold, Malcolm	3-Aug-17	There is a risk of avoidable harm to patients, visitors and staff at Tenby Cottage Hospital. This is caused by the brick Pavement and Driveway into Hospital sliding down towards the bottom of the carpark allowing excessive gaps and holes to appear which are trip hazards. This will lead to an impact/affect on personnel that are entering the Hospital being exposed to the danger of such potholes, possible trips and falls, claims and complaints. Risk location, Pembrokeshire, Withybush General Hospital.	Sand is being placed between the joints but has not any long-term effect. Slippage is still occurring. Inspections being carried out by Estates staff but there is not a great deal that maintenance are able to do.	Safety - Patient, Staff or Public	4	2	8	Limited to allowing sand to be used to assist with the gaps but these are getting bigger with the volume of slippage, however the gaps are worsening. Further reports that there is still slippage happening at the Hospital. Unable to close off as this is the main entrance.	Removal of hard standing and either tarmac complete area or install concrete dividers to stop creep of brickwork.	Arnold, Malcolm	~~30/09/2020~~ ~~31/12/2021~~ ~~30/04/2024~~ ~~30/04/2025~~ ~~30/03/2026~~ 30/09/2026	New quotes to be required, after which a Capital bid will be raised. Update 16/07/2024 order placed for localised repair to main car park entrance and trip hazards at building entrance. Trip hazards completed Update 29/07/2024 Main entrance localised works still to be repaired . Contractor to mobilise for weekend working. date TBC. 22-08-2024 final repairs scheduled for weekend 31/08/2024 30/04/2025 update. No further plans for full removal and replacement. ongoing maintenance where required.	Health and Safety Committee	1	2	2	Vehicle usage will always cause wear and tear to the car park. Continuous planed maintenance and defect repair when required. Full replacement for a more hard wearing tarmac the preferred solution.	Treat	6-May-26
																Further reports that there is still slippage happening at the Hospital. Unable to close off as this is the main entrance.	Elliott, Rob	Completed	No further progress. update order placed for localised repair at main entrance. mobilisation to be confirmed. completed							
																Brick Walkways are deteriorating and larger gaps appearing. Filling put in to minimise gaps but do not last long.	Elliott, Rob	Completed	No further actions. completed							
																Inspections being carried out but there is not a great deal that maintenance are able to do.	Elliott, Rob	Completed	No further progress to report. completed							
																Removal of hard standing and either tarmac complete area or install concrete dividers to stop creep of brickwork. No requests have been carried out for costing of tarmac.	Elliott, Rob	Completed	No further progress completed							
																Local repairs to blockwork entrances	Arnold, Malcolm	Completed	Purchase order placed to repair trip hazard around entrances. Works have been completed.							

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505	Estates & Facilities	Estates & Facilities	E&F: Carmarthenshire East	Severs, James	Chiffi, Simon	Day, Simon	Evans, Stewart	1-Jan-18	There is a risk of avoidable service disruption due to high voltage (HV) electrical infrastructure problems. This is caused by the Bus Section and HV Breakers (Health Board Assets) are single point of failure. These are manufactured by South Wales Switch Gear in 1987 and are beyond life expectancy. An external audit by NWSSP-SES has confirmed this issue. Experiencing power outages could result in HV system failure. The HV Breaker is currently oil circuit cooled which degrades quicker than more modern methods of protection, and is more prone to failure. This will lead to an impact/affect on loss of electricity at the PPH site, potential service disruption (non-critical services). Risk location, Prince Philip Hospital.	Visual inspections and PPM's are in place to check components. External service contract in place with Western Power for routine annual maintenance checks over a 5 year plan. If electrical failure did occur the back up generator would generate prioritising essential services.	Service/Business interruption/disruption	2	4	8	Information has been received from external authorising engineers. External service contract in place with The National Grid for routine annual maintenance checks over a 5 year plan. These old systems result in parts being difficult to obtain. Funding is required to address the components as per a risk based approach.	Capital funding granted to address the issues as identified and for the replacement work to be undertaken.	Evans, Stewart	~~31/03/2021~~ ~~31/03/2024~~ ~~31/06/2024~~ ~~04/11/2024~~ ~~31/01/2025~~ 31/03/2027	This risk has been identified on the property and infrastructure backlog system. This will now be considered as part of the future infrastructure programme for HDUHB. This has been moved to priority 1 for the WG infrastructure bids. Unlikely to change until end of financial year.	Health and Safety Committee	1	3	3	Listed on Priority 2 of the current run schemes by MCP team for replacement. Funding required for replacement.	Treat	27-Apr-26

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1353	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Day, Simon	Arnold, Malcolm	9-Feb-18	There is a risk of of the condition of the wiring used in the hospital being in a poor condition. Tray work covers have not been put back leaving exposed cores and the use of twin flat grey has been used without containment.Some of the cables could be live. This is caused by use of the wrong specification of cable to be included in small schemes by various parties. This will lead to an impact/affect on the safety of personnel doing maintenance in ceiling voids. Risk location, Withybush General Hospital.	Fixed testing has not identified any problems as there are no complete circuits to measure. Formal discussions with Electrical Staff is carried out.	Safety - Patient, Staff or Public	4	2	8	The issues are now being realised by Contractors during the fire Code works. Discussions are frequent and isolations are being done by officers.	No further work carried out to infrastructure except for normal maintenance.	Arnold, Malcolm	**Completed**	Upgrades to electrical wiring on second floor wards as part of RAAC repairs. other areas no further progress Update:17/07/2024 Ground floor RAAC areas have had electrical infrastructure (dis boards replaced. Wiring change where needed. completed	Health and Safety Committee	3	1	3	capital investment and regular maintenance will reduce this risk	Treat	8-Jun-26
																As more areas are being exposed it is showing more and more non -compliant electrical services. Remedial works are required.	Elliott, Rob	**Completed**	No further progress into problems carried out. completed							
																Poor quality wiring is being identified through Fire code and RAAC contractual works. Ongoing identification, Fixed electrical testing contract in place. Permit to work by CP appointed contractor only. ongoing.	Arnold, Malcolm	~~23/09/2022~~ ~~30/03/2025~~ ~~30/09/2025~~ ~~31/03/2026~~ 30/09/2026	ongoing identification and modification when identified. 27/03/2025 update Fixed wiring inspection project under way to achieve 100% over 5 years. Defects identified from inspections will require funding.							
																Funding and a contract required to test such a large area.	Elliott, Rob	**Completed**	completed							
																This problem is as bad as first reported as there is much more Twin and earth being found as further works are being carried out.	Elliott, Rob	**Completed**	No further progress. completed							

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991	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Day, Simon	Arnold, Malcolm	11-Sep-17	There is a risk of of leaks being detected in the natural gas pipework at Withybush Hospital. This is caused by the Mains Gas pipework not being up to Gas Safe standards and is showing signs of corrosion and wear due to age of installation. Labelling and isolation/solenoids, and valves are not up to current standards. Soundness tests need to be completed to verify condition of distribution system. This will lead to an impact/affect on possible closure of services whilst leaks are repaired. Isolation of gas main would be a reality, which will impact the main WGH kitchen and impact on nutritional needs to the patients. If gas main shut down was needed, this would impact the renal dialysis resulting in loss of heating and domestic water. This has been identified as part of LOFSM Risk location, Withybush General Hospital.	Constant monitoring and inclusion of local contractor. SOP in place for emergency closure of kitchen, and alternative food supply.	Safety - Patient, Staff or Public	4	2	8	The unit is being monitored at the moment but further works are imminently required. When the line was installed the guidelines were not as significant a problem but having changed legislation this is not now the case. No further progress on the 2019 report received from a commercial gas contractor due to lack of funding to carry out effective repairs and ongoing annually soundness tests. Funding still awaited. 28/01/2025 update : this still sits as a high risk gas safe non conformity. early resolution required.	Inspection carried out and recommendations have been accepted. Capital bid required to eradicate problems.	Arnold, Malcolm	**Completed**	Capital Bid has been submitted to complete recommendations. Update 14/07/2024 system resurveyed and new costs established to prepare a new capital bid.	Health and Safety Committee	4	1	4	capital investment and regular statutory maintenance will reduce this risk	Treat	8-Jun-26
																No further progress on the report received from a commercial gas contractor.	Elliott, Rob	**Completed**	No further progress. 16/07/2024 updated quote received to prepare capital bid							
																Capital bid required to eradicate problems.	Elliott, Rob	**Completed**	Costs to be reviewed which will be incorporated into the Capital bid. completed							
																Capital bid submitted 19/07/2024 waiting for funding to refurbish the Commercial gas system to latest Gas safe regulations.	Arnold, Malcolm	~~31/03/2025~~ 30/09/2026	no further progress 26/03/2025 no further progress 12/09/2025 capital funds have now ben approved waiting on cost centre to progress the works 15/04/2026 Major elements of the project now completed, waiting for final commission, and snagging before formal sign off.							

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1068	Estates & Facilities	Estates & Facilities	E&F: Ceredigion	Severs, James	Chiffi, Simon	Day, Simon	Jones, Elfyn	1-Aug-12	There is a risk of avoidable harm to staff from potential electrical shocks on defective systems. This is caused by lack of periodic inspections of electrical systems. Currently testing 20% of the installation annually. This will lead to an impact/affect on serious injury and closure of facilities. Failure to undertake this along with a potential incident would result in Health and Safety Executive (HSE) investigations or prosecutions. (Linked to HB wide risk 425). Risk location, Bronglais General Hospital.	Portable appliance testing (PAT) is undertaken on a rolling programme. Fixed boards are also tested on a rolling programme. Visual checks are continually carried out by maintenance staff. Low Voltage (LV) operational group formed to discuss issues of Electrical Safety and Compliance. Ward testing on a rolling 5 year basis.	Safety - Patient, Staff or Public	2	4	8	Ongoing management as per regulations and guidance documentation. Contractors have now been appointed and will carry out the testing up until 2029 (for 5 years). The score remains high until completion of the testing works (2029).	Bid for additional Capital funding for more testing to take place, which will help the UHB achieve British Standards. Contractors have now been appointed and will carry out the testing up until 2029 (for 5 years)	Jones, Elfyn Jones, Elfyn	**Completed** 31/03/2029	Tender evaluation process completed. Tender award in process. 16/05/2025 - Targeted Estates Funding to be utilised to address the remedial works following the EICR's. 14/07/2025 - Contract documents are being produced. PO's can then be generated via our framework contractors. 16/09/2025 - Awaiting completion of contract documents before PO's can be generated via the framework route. 17/11/2025 - Awaiting completion of contract documents. 26/01/2026 - Contractor expected on site by 31/03/2026 26/03/2026 - Contractor on site carrying out remedial works and further testing. 01/06/2026 - Remedials work complete, this years EICR's in progress.	Health and Safety Committee	1	4	4	20% of the site to be tested annually, 100% completion expected by March 2029.	Treat	1-Jun-26
1069	Estates & Facilities	Estates & Facilities	E&F: Ceredigion	Severs, James	Chiffi, Simon	Day, Simon	Jones, Elfyn	1-Aug-12	There is a risk of avoidable harm to patients. This is caused by medical gas plant and equipment failure at BGH. This will lead to an impact/affect on patients if a serious incident or failure was to occur. Also this has the potential to affect services causing disruption, resulting in closure of facilities. Possible enforcement and Health and Safety Executive (HSE) prosecution in the event of a serious incident occurring. (Linked to HB wide risk 434). Risk location, Bronglais General Hospital.	Pre planned maintenance is being carried out. Visual inspections are also being undertaken and a Health Board wide Medical gas group has been established. Designated nurse officer medical gas training has also been undertaken.	Safety - Patient, Staff or Public	2	4	8	As per guidance documentation and external advice from authorising engineers.	To implement all actions listed in the Authorising Engineers (AE's) reports.	Jones, Elfyn	~~31/03/2022~~ ~~31/03/2025~~ 31/03/2026	16/05/2025 - Some actions completed from 2024/25 statutory budget. Awaiting allocation for 2025/2026. 14/07/2025 - Confirmation of £10k budget, prioritised list to be generated. 16/09/2025 - Finalising list prior to issuing PO. 17/11/2025 - Working through list to complete actions. 26/01/2026 - PO raised. 26/03/2026 - Work to be completed by 31/03/2026 01/06/2026 - Statutory budget allocation for 2026/2027 set at £10k.	Health and Safety Committee	1	4	4	It is anticipated that the target score will be following this years statutory allocation.	Treat	1-Jun-26

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1332	Estates & Facilities	Health and Safety	Health and Safety	Severs, James	Severs, James	Springthorpe, Adam	Springthorpe, Adam	23-Aug-21	There is a risk of avoidable patient and staff harm from hazardous substances. This is caused by the UHB not being fully aware of its compliance to the Control of Substances Hazardous to Health Regulations 2002 (COSHH) This will lead to an impact/affect on the safety of patients, staff and general public, closure of services, HSE investigations and prosecution, adverse publicity/reduction in stakeholder confidence. Risk location, Health Board wide.	HS&S Officer (Chemical Engineering Specialist) providing support/advice to departments. HS&S Officer is supporting Health Board Ventilation Group with Estates colleagues - surveyed Local Exhaust Ventilation systems across PPH, GGH, WGH & BGH. Also assisting Water Safety Group and Sharps Safety Groups (re: work-related biological agent exposure). Undertaken chemical waste audits with Environmental team, and provide ongoing support to team with specialist advice regarding safe handling and disposal of waste. HS&S Officer attending Sharps Safety Group - measures to reduce risk of exposure to sharps (and possible exposure to biological agents) being implemented. Assisting annual ISO 14001 audits covering some COSHH aspects. HDUHB COSHH policy and procedure - updated policy approved Jan 2022, contained two new COSHH forms (substance-based and task-based) Induction training for Managers - includes COSHH for Managers session. Over 500 managers trained since 2020. Annual COSHH audits of prioritised departments undertaken - initial program (April 2020, early pandemic) assessed key departments on all acute sites and support provided on highest risks. Other audits taken as and when possible. Annual audits undertaken. Centralised HDUHB database of identified substances and COSHH data - initiated	Safety - Patient, Staff or Public	2	4	8	We are likely to be compliant with many aspects of COSHH (due to existing control measures, training, etc), however the COSHH assessment is needed for many substance, and this will record where we are compliant and what remedial actions are necessary. Risk has been reduced slightly due to a few recent changes. Firstly, the estates inventory is significantly reduced from previous audits. Estates do not use substances of high concern. The GGH Laundry has closed so there is no longer use of the most hazardous substances in the largest quantities. HSDU now use the most hazardous substances but these are well controlled. Audits of general wards are underway and are not finding significant hazards. There is a possible risk remaining from some environmental exposures such as surgical smoke and Entonox. New processes such as HPV disinfection have introduced new but well-managed risks. Hotel Services have undergone a supplier change for their substances. Progress is ongoing towards reducing risk to a Moderate.	Completion of >50% of required COSHH assessments using forms in HDUHB COSHH Policy 703	Sellek, Gerard	~~30/12/2022~~ 31/06/2026	The following COSHH aspects are complete: Endoscopy/HSDU, Podiatry, Estates boiler treatment/feed water testing chemicals, liquid nitrogen complete, some MHLD sites, Entonox exposure; HS&S has set up a database of all substances found and assessments required/completed. The initial aim was for local managers to complete risk assessments. This is possible for small numbers of assessments, but due to overall HDUHB staff workload, HS&S generally will need to set up the assessments and then reviewed/completed locally except where local staff have the time to do so. This has been successful when undertaken. Every ward on every acute site has been visited and assessed for COSHH risks. New COSHH Intranet site under development which is intended to become the central repository for COSHH lists, MSDS's and COSHH Assessments.	Health and Safety Committee	1	4	4	Developing COSHH compliance for the Health Board is a huge task, but one that is always ongoing behind the scenes within the H&S Team. Compliance will therefore take time to fully implement.	Treat	28-May-26

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										April 2020 (1000+ substances registered). This is used to identify and log what substances are in use, what COSHH assessments are required (and what have been completed). Reducing inventory of chemicals by identifying old/obsolete items. Estates inventory has been reduced in this way. Pathology use the Q-Pulse-Pathology system and have an extensive library of COSHH assessments. Pathology have their own assessments so they will be assessed at the end of the process. HSDU (PPH, GGH, WGH. BGH) and Endoscopy (BGH) use active monitoring, ventilation, emergency procedures, COSHH training from suppliers. COSHH assessments in place on old form. Almost all COSHH assessments are in place now in HSDU. Catering and HSDU receive COSHH training from suppliers. Chemicals have changed so are being re-assessed. Estates, HSDU, Catering, Hotel Services, Laundry, some wards/clinics/ OPD, Pathology/Histology/Blood Sciences, Theatre, have been given an initial audit with follow-ups during 2024. About 150 substances require standalone assessments, and about 80 task-based assessments are needed, but the overall number of substances is much reduced due to reductions in Estates inventory. HS&S Officer in process of completing identification of hazards prior to working on the assessments. Cytotoxic medication list obtained, COSHH assessment is underway. HS&S are working with Oncology on this aspect.						Complete Detailed training for Managers on completion of COSHH assessments using new forms and completion of training package for delivery.	Sellek, Gerard	Completed	Due to work pressures, this training will not be delivered routinely but can be done according to demand and need. The presentation file will be sent to everyone who has completed the MH&SI. The existing MH&SI training package is being reworked to make it more user-focussed embedding the previous experience in this role, to ensure Managers are better equipped to identify and risk assess substances. The detailed training includes worked examples of how to complete Substance-based and Task-based assessments.							
																Complete training package for delivery of COSHH Awareness training for substance users and supervisors.	Sellek, Gerard	~~28/02/2022~~ 31/09/2026	Creation of package underway. COSHH Audits to inform contents and means of delivery of package. Some department such as HSDU and Hotel Services have existing COSHH training, this package is intended to cover gaps (and offer more tailored advice) such as nursing staff, Estates, and porters. A training package has already been developed for Porters and nursing staff who handle liquid nitrogen, and has already been delivered in PPH. Due to numerous changes in chemicals used across the HB, this needs to be tailored to suit the current needs. An Estates package is underway and will be delivered in conjunction with the Operations Compliance Officer in April 2025.							

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																Undertake annual COSHH audit of acute sites.	Sellek, Gerard	Completed	Initial audits already carried out was intended to identify the substances in use in the HB. New audits will check for updates to initial audits; will collect information on usage/exposure/methods of use that will be needed to complete COSHH assessments. Estates has largest inventory but effort now being supported by Compliance Officer. This is an ongoing action. COSHH audits are undertaken whenever HS&S visits a site/department, and support provided as needed. The new H&S Advisor also assisting with this. New audits in 2024 covering wards.							
																Develop improved waste procedures with Environmental team.	Sellek, Gerard	Completed	Waste process for HSDU has been implemented to reduce risk of chemical containers entering incorrect waste streams. Procedure for obsolete chemicals required to support Waste Management Policy. This can be placed on Intranet and communicated via Global e-mail. Recent work on this has included developing (with Environmental) and communicating a procedure for disposal of waste anaesthetic liquids for Theatre and ITU (June 2023). HS&S works with Departments and Environmental team to deal with identified instances of chemicals requiring disposal by specialist contractors. HS&S provides ongoing support to Environmental in this regard so will log this action as complete.							

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1099	Estates & Facilities	Estates & Facilities	E&F: Carmarthenshire East	Severs, James	Chiffi, Simon	Day, Simon	Evans, Stewart	1-Aug-12	There is a risk of of avoidable harm to staff and Patients from potential electrical shocks on defective systems. This is caused by lack of periodic inspections of electrical systems. This will lead to an impact/affect on serious injury and closure of facilities. Failure to undertake this along with a potential incident would result in Health and Safety Executive (HSE) investigations or prosecutions. (Linked to HB wide Risk 425). Risk location, Amman Valley Hospital, Prince Philip Hospital.	Portable appliance testing (PAT) testing is undertaken on a rolling programme. Fixed boards are also tested on a rolling programme as and when funds are made available. Visual checks are continually carried out by maintenance staff. Low Voltage (LV) operational group formed to discuss issues of Electrical Safety and Compliance.	Safety - Patient, Staff or Public	2	4	8	Electrical Testing Inspections to be undertaken on a regular basis to ensure safe systems. To include visual checks through regular PPMs. Fixed testing has been carried out and continues to be undertaken.	LV Safety Group have received returned tenders for 24-25 period. 40K allocated for testing. Principal contractor appointed to undertake tests for April 26-27. Fixed testing ongoing for 2025-26, remedial works has been funded from TEF.	Evans, Stewart	~~27/03/2024~~ ~~10/07/2024~~ ~~31/03/2025~~ ~~31/03/2026~~ 31/03/2027	Additional Capital Funding required to provide Satisfactory test reports	Health and Safety Committee	1	4	4	Ongoing investment required	Treat	27-Apr-26
1106	Estates & Facilities	Estates & Facilities	E&F: Carmarthenshire East	Severs, James	Chiffi, Simon	Day, Simon	Evans, Stewart	1-Aug-12	There is a risk of of avoidable harm to patients and the loss of services. This is caused by medical gas plant and equipment failure , and oxygen supply to COVID ward area's due to pipe sizing This will lead to an impact/affect on patients if a serious incident or failure was to occur. Also this has the potential to affect services causing disruption, resulting in closure of facilities. Possible enforcement and Health and Safety Executive (HSE) prosecution in the event of a serious incident occurring. Risk location, Prince Philip Hospital.	Pre planned maintenance is being carried out. Visual inspections are also being undertaken and a Health Board wide Medical gas group has been established. Designated nurse officer medical gas training has also been undertaken.	Safety - Patient, Staff or Public	2	4	8	Guidance documentation and external advice from Authorising Engineers advises that all plant has a life span - anything over 10 years increases the risk of being unable to replace worn/damaged parts. Despite the controls in place, the risk cannot be fully mitigated until funding is in place to replace the equipment.	TEF Funding required from 2026-27 allocation.	Evans, Stewart	30/03/2027	Order to be placed for the increased pipe size installation feeding Ward 1 & AMAU.	Health and Safety Committee	1	4	4	Investment required for aged plant replacement.	Treat	27-Apr-26

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1133	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Severs, James	Chiffi, Simon	Day, Simon	Arnold, Malcolm	12-Jun-17	There is a risk of of patient, staff and visitor harm (slips, trips and falls) This is caused by unsafe surface conditions of pathways and roads at WGH. This will lead to an impact/affect on Health Board reputational damage with complaints received and patient safety incidents recorded. An increasing number of legal claims could be received if surfaces not made good. Risk location, Withybush General Hospital.	Routine planned maintenance in place to check roads and pathways. Emergency pot hole repairs, where identified. In severe weather, established gritting policy.	Safety - Patient, Staff or Public	2	4	8	Risk remains high. Planned maintenance completed, emergency pot hole repairs undertaken but funding is required to replace road surface. An incident occurred outside A&E on the service duct covers (which forms the pathway) at the end of March 2025. CCTV evidence of a member of the public falling over. All duct covers have now been reset but a legal claim is anticipated.	monitor conditions of roads and paths during inclement weather	Arnold, Malcolm	Completed	no further action completed	Health and Safety Committee	1	4	4	Funding is required to mitigate this risk. However, there is always going to be a risk of slips trips and falls due to wear and tear on road surfaces and pathways, coupled with possible mobility issues of patients and members of the public which increases the risk of falls.	Treat	26-May-26
																Road surfaces are deteriorating to the extent of further potholes appearing.	Arnold, Malcolm	Completed	No further progress update 17/07/2024 planed maintenance task in CAFM to check condition. pot hole filled with emergency fill materials. funding application to welsh government to resurface road conditions. currently denied. ongoing							
																Carry out condition survey of roads for capital funding.	Arnold, Malcolm	Completed	06/08/2025 MA condition survey completed highlighted priority 1,2,3 areas.							
																develop capital bid to resurface priority 1 roadways and car parks (areas to be completed within two years Capital bids for priority two (within 5 years) and priority 3 (within 10 years) on hold	Arnold, Malcolm	Completed	Capital bid completed reference WGH-CB-13-2025							
																Resurface priority roads and car parks on release of capital funds	Arnold, Malcolm	~~31/03/2026~~ 30/09/2026	no further progress							

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2353	Operational Allied Health Professions & Health Sciences	AHP&HS: Physiotherapy	AHP&HS: Physiotherapy	Carruthers, Andrew	Quarrie, Sara	Davies, John	Evans, Nick	26-May-26	There is a risk of that patients or staff could come to harm This is caused by insufficient air conditioning within the Hydrotherapy pool area. Guidance is that the air temperature should be 5 deg C below water temp. Air and pool temp were both 36 deg C on 26/05/26. This will lead to an impact/affect on Patient and staff satisfaction, use of the hydrotherapy pool during periods of extreme heat Risk location, Carmarthenshire.	. Carmarthenshire County Council exploring options . Staff having more regular breaks . Cutting sessions short . Increased hydration . Checking on patient and staff checking on each other more frequently	Safety - Patient, Staff or Public	2	4	8	As staff are aware of the risk, they are completing the management as shown above, but as the air temperature is excessively high there is a risk of the staff or patients coming to harm, or, should the risk continue, sessions may have to be stood down which will effect capacity and throughput of patients.	Email sent to CCC to ask for mitigation options and timescales	Evans, Nick	Completed	Action completed	Health and Safety Committee	1	4	4	When the air temp and water temp is at the normal state, there is minimal risk due to the thermocline.		27-May-26
																Staff to ensure they take regular breaks, regular hydration, shorter sessions, check on patients more regularly and check on each other regularly. Email regarding ensuring hydration and checking on patients and each other more often sent.	Evans, Nick	Completed	Email sent								
																CCC to develop options to better manage air temperature in Hydrotherapy Pool area	Evans, Nick	04/01/2027	New Action								
2278	Estates & Facilities	Estates & Facilities	E&F: Fire	Severs, James	Severs, James	Chiffi, Simon	Evans, Paul	31-Oct-25	There is a risk of of not having fully accurate information to determine our agreed fire safety engineering strategies for a selection of our buildings to meet the requirements of Regulation 38 of Building Regulations, BS9999 and the Regulatory Reform (Fire Safety) Order 2005. This is caused by having incomplete or the lack of data in many cases to support the verification of fire safety engineering strategies within estates operations/fire team, for a selection of our estate buildings. In addition to this a lack of complete transparency of ownership and responsibility of the individual components of a fire strategy between operational estates and the fire team. This will lead to an impact/affect on potentially increased or additional	Established PPM regimes across a range of fire safety engineering components. Regular KPI reporting to Fire Safety Groups and IGG. Fire Door barcoding is currently being rolled out across the estate Fire Door Surveys Fire Compartmentation Surveys CAD and Fire team appointed to manage and update fire safety engineering drawings (fire strategy) providing advice to the operational estates managers to ensure they can fulfil their responsibilities to address other agreed elements of the strategy. Fully developed and dated phased FIRE STRATEGY GAP analysis on what sites require strengthening and updating and who is responsible for completion of each phase of work. Tef funding agreed to address and improve a range of fire infrastructure items	Service/Business interruption/disruption	4	2	8	This risk score is based on the information and evidence within both estates and fire compliance teams.	To fully agree and complete the FIRE STRATEGY GAP analysis document that is shared between all stakeholders.	Evans, Paul	~~31/03/2026~~ 31/03/2027	The FSG are tracking this and the progress of completion. Document agreed, now agreeing appropriate timelines for completion for all sites, this will be reviewed regularly.	Health and Safety Committee	4	1	4	This risk score is based on the information and evidence within both estates and fire compliance teams.	Treat	20-May-26

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									operational maintenance frequencies for planned maintenance work, lack of clarity in some cases on what elements of the building form part of the strategy (i.e. fire door locations or fire compartmentation walls) in addition, for more complex buildings, potentially outdated cause and affect matrix to determine what and how engineering components perform and react when fire alarms are activated. Risk location, Health Board wide.	Fire safety drawings are available and accessible from the estates drawing portal Cause and affect matrix documents are available for complex sites Boris system has been implemented to record the findings of the Fire Risk Assessments and assignment of actions to nominated staff. Fully approved job descriptions for specific roles in estates that are responsible for fire safety						To meet and fully agree the appropriate ownership of actions that are created from Fire Risk Assessments. Looking at the questions asked in the FRA's to ensure clarity of ownership/responsibility of actions raised.	Evans, Paul	~~31/03/2026~~ 01/07/2026	The FSG are tracking the progress of this action. Meetings have taken place and this will be addressed by the revised date provided.							

2

9:50 AM, 0 Mins

2 - HEALTH AND SAFETY UPDATES

2.1

9:50 AM, 10 Mins

2.1 - Health and Safety Assurance Report

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

For assurance

Attachments

2.1a SBAR HS Assurance Report July 2026 V1.0.pdf

2.1b HS Assurance Report July 2026 V1.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	07 July 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Health and Safety Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	James Severs, Executive Director of Allied Health Professions and Health Science
SWYDDOG ADRODD: REPORTING OFFICER:	Adam Springthorpe, Health & Safety Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

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

Cefndir / Background

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

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

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

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

Asesiad / Assessment

Please see the accompanying Health and Safety Assurance Report (Appendix 1).

Argymhelliad / Recommendation

The Health & Safety Committee is asked to **take assurance** that appropriate processes and governance arrangements are in place to support effective health and safety management,

noting the continued strong performance in incident reporting and associated oversight arrangements, and that targeted improvement actions are being implemented to address identified risks, including improving mandatory training compliance, strengthening manual handling arrangements, and effectively managing behaviour-related risks.

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:	• Health and Safety Compliance Group

Parties / Committees consulted prior to Health and Safety Committee:	

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

July 2026

Situation

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

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

Health & Safety Assurance Report

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Purpose and Scope

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

Risk and Compliance Monitoring

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

Governance and Evidence Sources

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

Assurance Levels and Recommendations

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

Executive Assurance Summary

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Area	Level of assurance (RAG)	Key items to consider
Manual Handling		Local risk linked to bariatric case
Training Compliance		Variation across sites
Incident Reporting		Stable trends
Violence and aggression		Variability due to patient cohort
Reducing Restrictive Practice (RRP) compliance		Significant variation illustrated

Key Risks & Issues

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Manual Handling Incidents

Issue:
Increase in incidents April–May 2026 (Clinical Decision Unit (CDU), Glangwili Hospital (GGH))

- **Assurance:**
- Specialist support in place
- Controls implemented
- Case-specific risk (not systemic)
- **Gap / Risk:**
- Continued incidents during period
- Pressure from complex bariatric care

Estate / Training Risk

Issue: Seeking sustainable training venue in Ceredigion.
Assurance:
•Alternative identified
•Lower complexity option
Risk:
•Deadline (mid-July 2026 vacation of current venue)

Workforce / Leadership Risk

Issue: Vacant Head of Health and Safety role
Assurance:
Recruitment now successful
Stability expected; with successful applicant starting on 12 October 2026.
Risk:
Temporary leadership gap;

Governance / Information Access

Reducing Restrictive Practice (RRP) intranet site has now been developed
Assurance:
•Improved access to guidance and training
•Positive governance development

Manual handling risk and assurance position

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Increased Manual Handling Risk

Temporary rise in manual handling incidents due to complex bariatric patient care increased physical demands on staff.

Response and Controls Implemented

Manual Handling Team involvement, patient-specific risk assessments, and specialist equipment improved safety measures.

Management Review and Assurance

Senior managers reviewed and confirmed appropriate controls balancing staff safety and compassionate patient care.

Learning for Future Planning

Incident highlighted need for early escalation, better equipment availability, and workforce support in high-risk cases.

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
Executive Allied Health Professions and Health Sciences	2	100.0%
Finance	103	98.1%
Digital	373	96.5%
Workforce and Organisational Development	260	93.8%
Medical	142	93.7%
Mental Health and Learning Disabilities	1374	93.2%
Operational Allied Health and Health Sciences	1382	91.5%
Public Health	164	90.9%
Nursing, Quality and Patient Experience	210	90.5%
Estates and Facilities	1035	88.9%
Chief Operating Officer Management	129	88.4%
Pharmacy and Medicines Management	275	88.4%
Strategy and Planning	58	87.9%
Community and Integrated Medicine	3930	87.5%
Primary Care	335	83.9%
Planned and Specialist Care	2696	83.8%
Chief Executive		80.0%

Zoom Out

Display Screen Equipment (DSE)

Function	Headcount	% compliance
Finance	103	100.0%
Medical	85	100.0%
Pharmacy and Medicines Management	18	100.0%
Workforce and Organisational Development	216	100.0%
Digital	361	98.9%
Estates and Facilities	87	98.9%
Mental Health and Learning Disabilities	174	98.9%
Strategy and Planning	49	98.0%
Primary Care	132	97.0%
Nursing, Quality and Patient Experience	122	96.7%
Public Health	91	96.7%
Community and Integrated Medicine	433	96.1%
Operational Allied Health and Health Sciences	134	94.8%
Planned and Specialist Care	407	94.3%
Chief Operating Officer Management	36	88.9%
Chief Executive	90	87.8%

Violence & Aggression Module A

Function	Headcount	% compliance
Executive Allied Health Professions and Health Sciences	2	100.0%
Chief Operating Officer Management	129	99.2%
Workforce and Organisational Development	260	98.8%
Medical	142	98.6%
Digital	373	98.1%
Finance	103	98.1%
Nursing, Quality and Patient Experience	210	97.6%
Mental Health and Learning Disabilities	1374	97.5%
Operational Allied Health and Health Sciences	1382	96.7%
Public Health	164	95.7%
Estates and Facilities	1035	95.1%
Pharmacy and Medicines Management	275	94.5%
Community and Integrated Medicine	3930	93.8%
Strategy and Planning	58	93.1%
Planned and Specialist Care	2696	92.6%
Primary Care	335	89.3%
Chief Executive	95	86.3%

Manual Handling (MH) Compliance (at 31/03/2026 and 31/05/2026 for comparison):

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%
Digital	370	93.5%
Finance	102	93.1%
Medical	141	92.9%
Public Health	167	88.6%
Strategy and Planning	57	84.2%
Nursing, Quality and Patient Experience	208	84.1%
Chief Executive	93	82.8%
Chief Operating Officer Management	132	82.6%
Pharmacy and Medicines Management	274	82.1%
Operational Allied Health and Health Sciences	1389	81.8%
Primary Care	320	80.6%
Estates and Facilities	1043	80.4%
Mental Health and Learning Disabilities	1375	79.2%
Community and Integrated Medicine	3912	77.7%
Planned and Specialist Care	2678	76.6%

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

Function	Headcount	% compliance	
Executive Allied Health Professions and Health Sciences	2	100.0%	=
Digital	373	94.4%	+ 0.9%
Finance	103	93.2%	+ 0.1%
Workforce and Organisational Development	260	90.8%	- 3.1%
Medical	142	89.4%	- 3.5%
Public Health	164	87.2%	- 1.4%
Chief Operating Officer Management	129	85.3%	+ 2.5%
Nursing, Quality and Patient Experience	210	83.8%	- 0.3%
Operational Allied Health and Health Sciences	1382	82.5%	+ 0.7%
Estates and Facilities	1035	82.4%	+ 2.0%
Pharmacy and Medicines Management	275	82.2%	+ 0.1%
Strategy and Planning	58	81.0%	- 3.2%
Chief Executive	95	80.0%	- 2.8%
Community and Integrated Medicine	3930	77.9%	+ 0.2%
Mental Health and Learning Disabilities	1374	77.5%	- 1.7%
Primary Care	335	77.0%	- 3.6%
Planned and Specialist Care	2696	74.1%	- 2.5%

Manual Handling (MH) Compliance (at 31/03/2026 and 31/05/2026 for comparison):

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

Function	Headcount	% compliance
Workforce and Organisational Development	36	80.6%
Public Health	71	77.5%
Estates and Facilities	141	69.5%
Planned and Specialist Care	2168	60.9%
Operational Allied Health and Health Sciences	736	59.2%
Community and Integrated Medicine	3313	59.2%
Medical	33	57.6%
Digital	7	57.1%
Mental Health and Learning Disabilities	1034	54.6%
Pharmacy and Medicines Management	4	50.0%
Nursing, Quality and Patient Experience	73	49.3%
Primary Care	77	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 31/05/2026:

Function	Headcount	% compliance	
Workforce and Organisational Development	33	81.8%	+ 1.2%
Public Health	71	71.8%	- 5.7%
Estates and Facilities	141	68.8%	- 0.7%
Operational Allied Health and Health Sciences	748	62.2%	- 3.0%
Community and Integrated Medicine	3320	60.5%	+ 1.3%
Medical	35	60.0%	+ 2.4%
Planned and Specialist Care	2182	58.0%	- 2.9%
Digital	7	57.1%	=
Mental Health and Learning Disabilities	1038	54.1%	- 0.5%
Nursing, Quality and Patient Experience	75	49.3%	=
Primary Care	95	32.6%	- 10.3%
Pharmacy and Medicines Management	4	25.0%	- 25.0%
Chief Operating Officer Management	12	8.3%	=
Chief Executive	1	0.0%	=
Executive Allied Health Professions and Health Sciences	1	0.0%	=
Strategy and Planning	4	0.0%	=

Reducing Restrictive Practice (RRP) Team training compliance (at 31/05/2026):

Mental Health / Learning Disabilities:

- Morlais 100% **=**
- LSU 78% **(Up 21%)**
- St Caradog 82% **(Down 22%)**
- PICU 97% **(Up 13%)**
- Bryngofal 94% **(Up 1%)**
- Begelly 100% **(Up 13%)**
- Enlli 40% **(Up 5%)**
- St Non 77% **=**
- Bryngolau 80% **(Up 29%)**

Porter Training:

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

- PPH 72% **(Down 12%)**
- GGH 74% **(Down 12%)**
- BGH 93% **=**
- WGH 92% **(Up 4%)**

What is the data telling us?

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Training Compliance

- **Assurance:**
- Core training is largely embedded
- **Risk:**
- Variation remains
- Inconsistent compliance across services and modules

RRP Training Compliance

Significant variation (40% - 100%)

Assurance:

Improvements have been noted in a number of areas

Risk:

Some low compliance areas that need targeted intervention (e.g. Enlli)

Manual Handling Compliance

What the data shows:

Mixed improvement / decline across areas

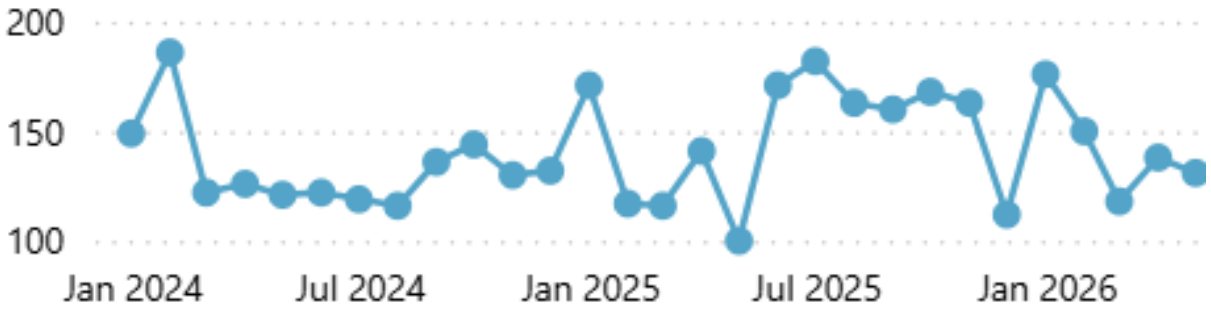
Risk:

No consistent systemic deterioration

Some areas require targeted intervention

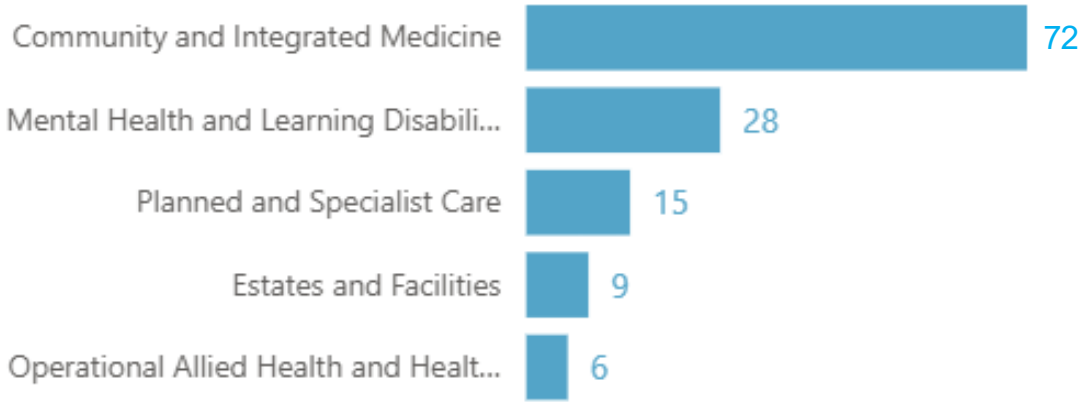
All staff can access the dashboard here (internally): **Health and Safety dashboard - Power BI**

Staff / Contractor Incidents Reported on Datix (at 31/05/2026):

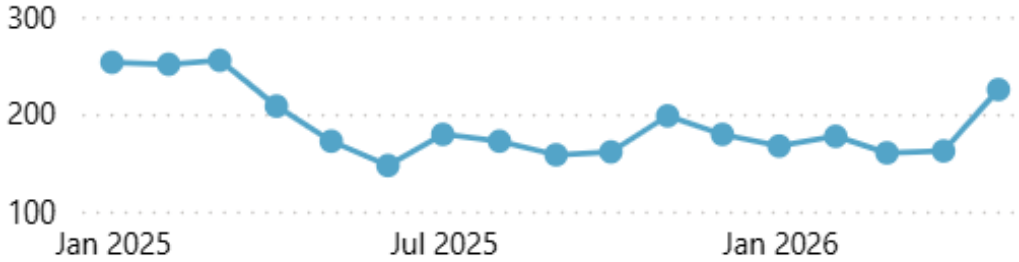


Staff / Contractor incident rate per 100 staff by Clinical Compliance Group (CCG) in May 2026:

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

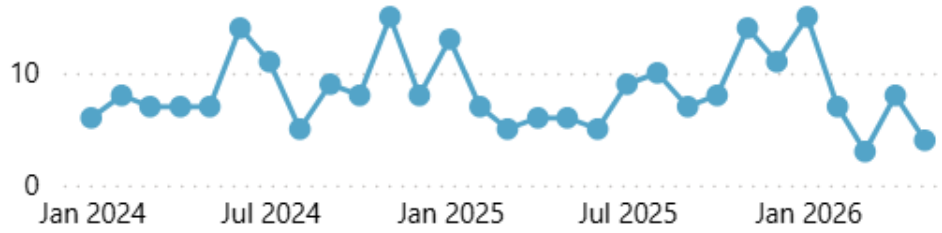


Staff / Contractor incidents still awaiting review after 30 Days:



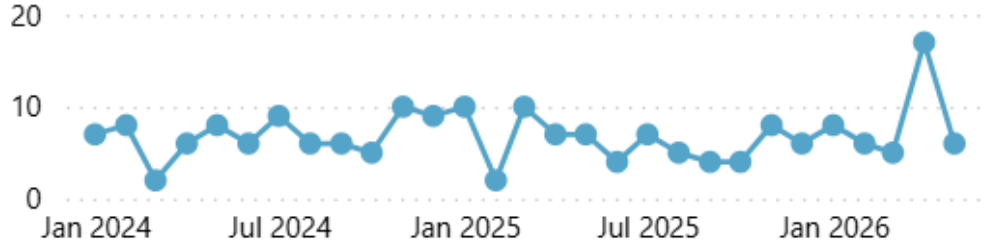
Staff / Contractor Incidents Reported on Datix (at 31/05/2026):

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



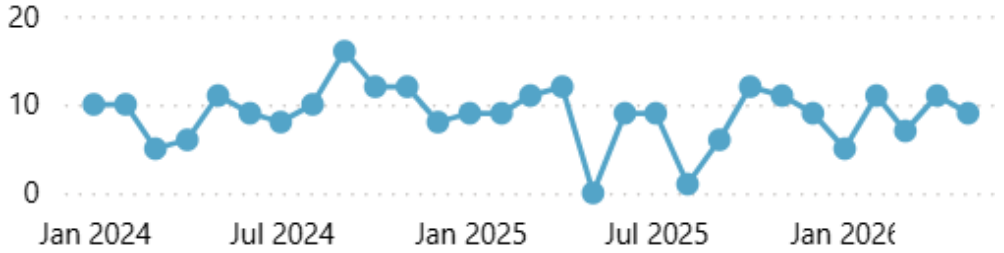
Peaks are notable in the winter months in consecutive years, suggesting a climatic link.

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



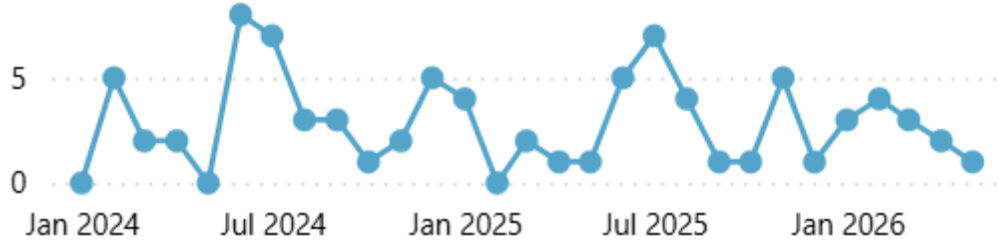
For further information on the peak in Manual Handling / MSK incidents, please refer to slide 3.

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



Incident rates are relatively stable.

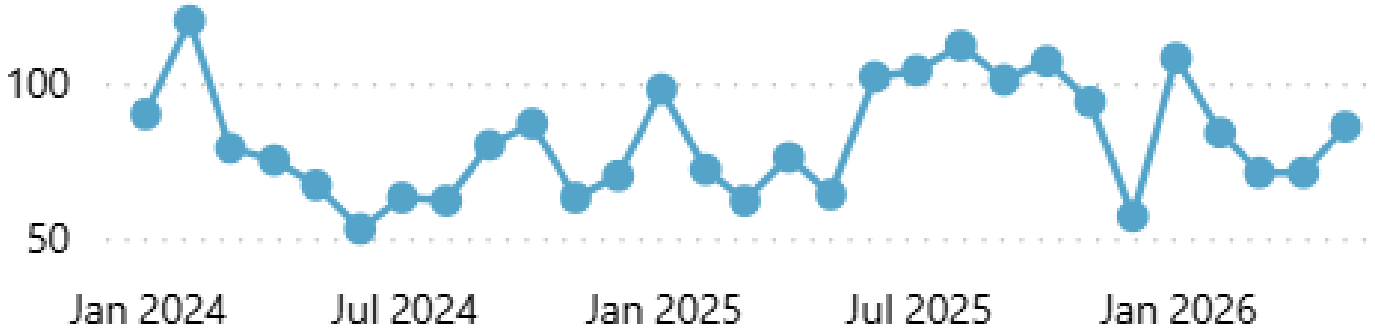
All 'Contact with or exposure to chemicals'(i.e. COSHH) incidents reported via Datix by month:



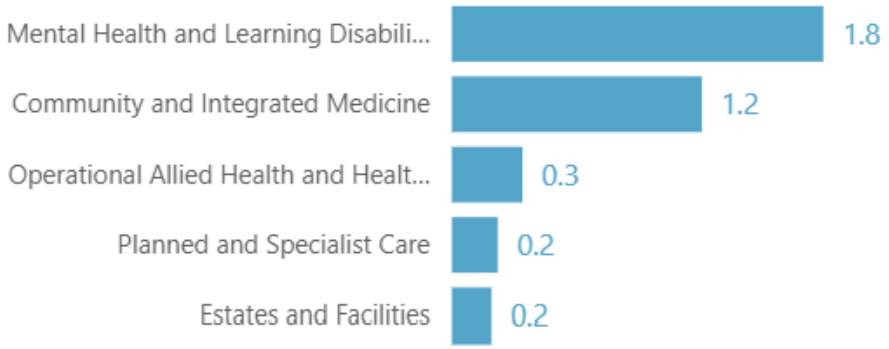
Despite the peaks and troughs, the actual incident rates remain relatively low.

Staff / Contractor Behaviour Incidents Reported via Datix (at 31/05/2026):

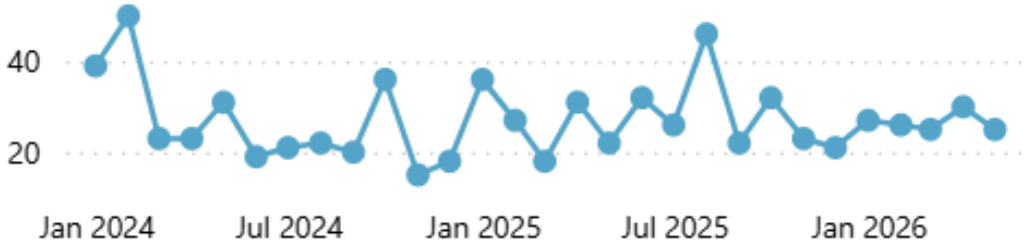
All behaviour incidents reported via Datix by month:



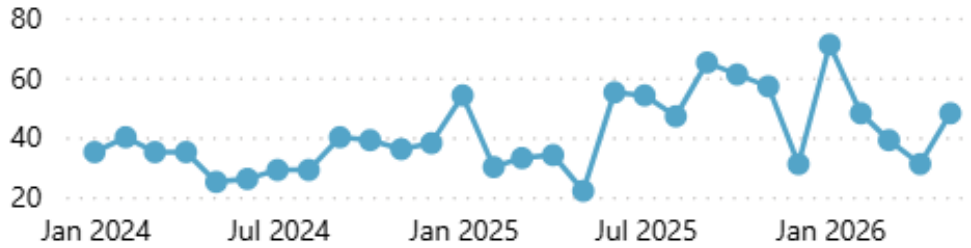
Staff / Contractor behaviour incident rate per 100 staff by CCG in May 2026:



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.

What's the data telling us?

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

- **Incident Reporting**

- Stable reporting trends
- Seasonal variation (winter peaks)

- **Assurance:**
- Strong reporting culture
- No unexpected systemic increase
- Substantial Assurance can be provided

What's the data telling us?

Behaviour Incidents → Stable in MH/LD → Variable in CIM → Medical confusion and older adult mental health are the main cause of violence and aggression incidents.

Overall Assurance Statement

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Overall Assurance Level: MODERATE

- The Health & Safety Committee can take **moderate assurance** that appropriate health and safety systems are in place and functioning.
- **Strengths:**
- Stable incident trends, with no alarming new trends
- Strong reporting culture
- Improvements in key training areas
- **Key Risks:**
- Variability in compliance across services
- Localised manual handling risk
- Dependence on patient cohort for behaviour incidents
- **Focus Areas:**
- Targeted compliance improvement
- Continued monitoring of high-risk areas
- Embed new leadership and communication tools

Recommendation

The Health and Safety Committee (H&SC) is asked to:

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

2.2

10:00 AM, 10 Mins

2.2 - Health & Safety Training Overview

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

For assurance

Attachments

2.2 SBAR HS Training Overview July 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:	07 July 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Health and Safety Training Overview
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 provides the Health and Safety Committee with an overview of health and safety training compliance, key risks, and actions being taken to improve performance across the Health Board.

Cefndir / Background

Health and safety training is currently delivered across Hywel Dda University Health Board through:

- **E-learning modules** (mandatory training)
- **Face-to-face training** (high-risk, competency-based training such as:
  - Manual Handling
  - Reducing Restrictive Practice (RRP)

Training is aligned to statutory requirements and organisational policy, and compliance is monitored through ESR and local systems.

Overall position:

- E-learning compliance is strong **(≥88%)**
- Face-to-face training compliance remains below target in key risk areas:
  - Manual Handling Level 2: **59.6%**
  - Manual Handling Level 1: **80.4%**
  - RRP overall: **81% (target 85%)**

The assessment below illustrates that training capacity is significantly underutilised due to high non-attendance rates.

Asesiad / Assessment

- **Manual Handling and Reducing Restrictive Practice (RRP) training**

Manual handling and RRP training both represent **high-risk, safety-critical competencies**, yet compliance remains below target:

- Manual Handling Level 2: **59.6%**
- RRP overall: **81% (target 85%)**

Manual Handling

The following table shows the current compliance levels for the two manual handling competencies Health Board wide on 30/04/2026.

Competency	Compliance
Manual Handling - Level 1	80.40%
Manual Handling - Level 2	59.60%

The Manual Handling team also collate data on the efficacy of its training offer, as outlined below:

Period	Course	Places Offered	Places Booked	Actual Attendance	DNA / Withdrawn
01/04/25 – 31/03/26	All M&H Courses	5279	4537	2794	1743
			85.94%	52.93%	38.42%

DNA	877	19.33%
Withdrawn	866	19.09%

As shown above, only 2,794 out of a possible 5,279 training places were filled, representing approximately 53% uptake.

Of staff who registered for courses, 38% did not attend (DNA) the training session, with 19% recorded as DNA and a further 19% withdrawing in advance. The team recognises that staffing pressures and the associated challenges in releasing staff from clinical areas to attend training are the primary contributing factors.

Reducing Restrictive Practice

Reducing Restrictive Practice (RRP) training compliance at 30/04/2026 is shown below:

Performance Metric	Target	Apr-26	May-26	Trend
% RRP training compliance - Overall	85%	81%	81%	↔

% RRP training compliance breakdown - MHLD: • Morlais • LSU • St Caradog • PICU • Bryngofal • Begelly • Enlli • St Non • Bryngolau	85%	 100% 57% 82% 84% 93% 87% 35% 77% 51%	 100% 78% 60% 97% 94% 100% 40% 77% 80%	 ↔ ↑ ↓ ↑ ↑ ↑ ↑ ↔ ↑
% RRP training compliance breakdown - Porters: • PPH • GGH • BGH • WGH	85%	 77% 87% 92% 93%	 72% 74% 93% 92%	 ↓ ↓ ↑ ↓

Period	Course	Places Offered	Places Booked	Actual Attendance	DNA / Withdrawn
01/04/2025 – 31/03/2026	All RRP Courses	1584	885	658	227
			55.87%	41.54%	25.65%

RRP training courses experience a lower rate of non-attendance and withdrawals compared to Manual Handling; however, at 25.7%, this still has a significant impact on the team's capacity.

In terms of utilisation, the RRP team achieved only 42% of available training capacity, which is notably lower than the 53% achieved by Manual Handling.

These represent direct risks to staff and patient safety, particularly in responding to violence and aggression incidents.

2. Capacity verses Attendance Problem

The information outlined above raises concerns about capacity verses attendance with:

- Manual Handling attendance: 53% utilisation of available places,
- RRP attendance: 42% utilisation of available places.

Both training modules experience high DNA rates and withdrawal rates:

  - Manual Handling: **38%**
  - RRP: **25.7%**

This is primarily an issue of staff release, prioritisation and administrative coordination, rather than training capacity. Further review is required to understand and streamline the booking and course-arrangement processes, ensuring it is as easy as possible for staff to attend.

3.Demand verses Resource Gap (RRP)

The current ways of working and resource levels do not meet full organisational need.

A Training Needs Analysis for RRP has also identified **unmet demand**, particularly in Emergency and urgent care settings. The RRP data highlighted above does not include training data for frontline staff working in emergency/urgent care settings or wards identified as using restrictive practices. This represents a critical area of training, which the RRP Team seeks to support wherever possible.

4. Improvement Plan:

A number of actions have already been implemented to improve training compliance, including:

- Monthly reporting of compliance data to the CCG Quality, Health and Safety Groups, to raise the profile of manual handling training compliance;
- Increasing training capacity within the system (subject to trainer availability) through:
  - Relocation of training delivery in Pembrokeshire to the Conference Centre, increasing course capacity from 16 to 24 participants;
  - Temporary relocation of training delivery in Carmarthenshire from Glien House to Ystwyth at Hafan Derwen, increasing capacity from 16 to 24 participants. The team will subsequently relocate to the Atriwm/Hwb (former Debenhams site) once this facility is completed;
- Collaboration with the Learning and Development Team (L&D) to reduce incorrect bookings through the separation of courses MH102, MH103, and MH104;
- The team provide dates in November/December each year for a full 12-month period to enable managers and staff to forward plan.
- The Reducing Restrictive Practice Team has confirmed that all staff groups currently below the minimum 85% compliance threshold in Mental Health & Learning Disabilities (MHLD), and Portering have improvement plans in place to support achievement of the required standard.
- Digital delivery options have been explored and implemented where feasible. Currently, six hours of the Restraint Reduction course are delivered by e-learning, allowing staff to complete this element in their own time.

Further actions required to improve compliance include:

- Reviewing how training is organised; and identify behavioural nudges that can be implemented;
- Work with L&D to support a collaborative review of the current Trainee Nursing Associates (TNAs), reporting arrangements, and operational oversight for Manual Handling and Reducing Restrictive Practice training. The outcome of this joint work will be presented to Strategic People Planning and Education Group (SPPEG) for further consideration and direction.
- Strengthening senior management accountability for ensuring staff receive suitable and sufficient manual handling training to undertake their roles safely.
- Support CCGs/Functions to identify interventions that could further help release staff to attend training to reduce the DNA/withdrawal rate;
- Support and encourage time for trained Workplace Assessors (WPAs) to complete assessments, supporting overall compliance.
  - If wards and departments adopt the WPA model at a suggested ratio of 1:15, each staff member would require 9.5 hours over a 3-year cycle (1 classroom session and 2 assessments), compared to 21.5 hours currently (3 classroom sessions);
  - This approach would reduce the number of classroom sessions required, enabling the training team to spend more time in clinical areas delivering reinforcement training and providing targeted support with workplace assessments in underperforming areas.

Other Considerations:

The L&D Team is progressing a project to manage course bookings through a new app. Once implemented, the app is expected to improve training attendance and reduce DNA rates through automated reminders issued to delegates in advance of courses.

5. E-Learning

E-learning compliance continues to be above the 85% target for all three dedicated health and safety e-learning modules. Compliance figures for each module at 30/04/2026 were:

	Compliance
Health, Safety and Welfare	88.4%
Violence and Aggression – Module A	94.8%
Display Screen Equipment	96.8%

6. Manager's Health & Safety Induction

Since the Manager's Health and Safety Induction course launched in October 2020, 757 managers and aspiring managers have successfully completed the full 4 x 0.5-day course. Figures from the last 12 months have been included below:

Course	Number
May/Jun 2025	22
Sept/Oct 2025	10
Nov/Dec 2025	20
Jan/Feb 2026	16
Apr/May 2026	8

7. Qualitative Face-Fit Train-the-Tester (For Respiratory Protective Equipment (RPE))

Fit-testers trained (new and/or refresher) by the Health, Safety and Security (HSS) Deptartment for the periods November 2024 to December 2025 and January 2026 to April 2026 were as follows:

Site	Nov 24 - Dec 25	Jan – Apr 2026
Prince Philip Hospital and locality	27	9
Glangwili Hospital and locality	45	11
Withybush Hospital and locality	30	31
Bronglais Hospital and locality	22	8

Fit-tester training is valid for two years. Therefore, the current total of fit-testers trained at each locality since the HSS Team updated their recording mechanisms in November 2024 are:

Site	Number
Prince Philip Hospital and locality	36
Glangwili Hospital and locality	56
Withybush Hospital and locality	61
Bronglais Hospital and locality	30

Argymhelliad / Recommendation

The Health & Safety Committee is requested to:

- **NOTE** current compliance levels and associated risks outlined in the Health and Safety Training Overview Report
- **TAKE ASSURANCE** that improvement plans are in place to improve compliance
- **RECEIVE** further updates on:
    - Impact of actions and improvement plans on the efficacy of manual handling and Reducing Restrictive Practice (RRP) training
    - Progress against Training Needs Analysis

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:	1549 – Score 12 2119 – Score 12 1540 – Score 8
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 • 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 Workplace (Health, Safety and Welfare) Regulations 1992, could result in the issue of prohibition or improvement notices or criminal proceedings.
Enw Da: Reputational:	Prosecutions and claims due to breaches in legislation or personal injury claims can lead to negative publicity.
Gyfrinachedd: Privacy:	Not Applicable.
Cydraddoldeb: Equality:	No evidence gathered to indicate a negative impact on any protected group/s.

2.3 **10:10 AM, 10 Mins**

2.3 - Regulation Assurance Report

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

Corporate Health and Safety covering the following regulations:

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

For assurance

Attachments
2.3 SBAR HSS Regs Report July 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:	07 July 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Compliance Against Health and Safety Regulations.
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	James Severs, Executive Director of Allied Health Professions and Health Science
SWYDDOG ADRODD: REPORTING OFFICER:	Adam Springthorpe, Health & Safety Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report is presented to the Health and Safety Committee (HSC) as part of a new programme of regular reports assessing the Health Board's compliance against specific Health and Safety regulations, as well as relevant topic areas not covered by standalone regulations. This paper considers compliance with the following regulations/topics:

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

Cefndir / Background

Management of Health and Safety at Work Regulations 1999 (MHSWR)

These regulations require:

- Suitable and sufficient risk assessments
- Effective health and safety governance arrangements
- Competent advice, training and supervision
- Health surveillance and protection of vulnerable groups

The Health Board has established robust arrangements to comply with the MHSWR 1999, including risk assessment processes, risk registers, health surveillance programmes, competent health and safety advice, staff training, and incident reporting systems. Effective arrangements are also in place for vulnerable groups and for contractor and partner coordination.

Workplace (Health, Safety and Welfare) Regulations 1992

These regulations require:

- Safe and well-maintained premises
- Appropriate environmental conditions (e.g. ventilation, temperature, lighting)

- Adequate welfare provision

Health Boards must provide and maintain safe, suitable workplaces, ensuring buildings, equipment, and systems are kept in good repair and efficient working order. They must ensure appropriate environmental conditions, including ventilation, lighting, temperature, cleanliness, and safe layout of floors, routes, and workspaces. They are also required to provide adequate welfare facilities such as toilets, washing facilities, drinking water, rest areas, and changing spaces. For Health Boards, this is delivered through estates and facilities management systems, inspection regimes, and planned maintenance programmes.

The Health Board has established arrangements to support compliance with the Workplace (Health, Safety and Welfare) Regulations 1992 through workplace inspections, audits, maintenance programmes, and defined responsibilities across Estates, Hotel Services, and operational managers.

Safety Signs and Signals Regulations 1996

These regulations require:

- Provision of clear, standardised safety signage where risks remain
- Appropriate staff awareness and understanding

This is supported through inspection regimes, fire risk assessments, and Estates-led signage management.

Health Boards must provide safety signs and signals where significant residual risks remain, ensuring they are clear, standardised, and appropriately placed. Signs must communicate key information such as hazards, required actions (e.g. personal protective equipment (PPE), prohibitions, and emergency routes or equipment. They must also ensure staff understand and respond correctly to signage, supported through training and the consistent application of signage standards across sites. This includes visual signs, alarms, and other signals, used as an additional control measure rather than a substitute for risk reduction.

The Health Board demonstrates compliance with the regulations through a programme of workplace inspections and fire risk assessments that routinely review the adequacy, condition, and placement of safety signage. Compliance is further supported by Estates maintaining stocks of standard safety signs and through in-house sign production capabilities, enabling the timely provision, replacement, and adaptation of signage to meet operational and statutory requirements.

Asesiad / Assessment

Health and Safety Legislative Assurance Summary:

Regulation	RAG	Key Message	Areas for Improvement	Assurance
Management of Health and Safety at Work Regulations 1999		Strong health and safety management systems are in place, including risk assessment, risk registers, occupational health surveillance, competent advice, training, and incident reporting arrangements.	Further work required by the Clinical Care Groups (CCGs)/Functions to be able to evidence that required risk assessments are in place in local areas.	Risk assessment processes; CCG / Function risk registers; Occupational Health surveillance data; incident reporting system; training records; policy and governance framework.

Workplace (Health, Safety and Welfare) Regulations 1992		Core compliance achieved through inspections, audits, maintenance programmes, and welfare provision.	Improvement required in ventilation, temperature management, space utilisation, DSE assessment completion, traffic management, and staff welfare facilities. Compliance is constrained in some areas by the age and design of the estate.	Planned Health & Safety inspection programme; workplace inspection checklist data; risk stratification reports; Estates assurance reports; Ventilation Safety Group oversight; audit findings.
Health and Safety (Safety Signs and Signals) Regulations 1996		Effective systems are in place to monitor, maintain, and replace safety signage across the estate.	Continued monitoring through inspections and fire risk assessments to ensure signage remains appropriate as services and environments change.	Planned Health & Safety inspections; Fire Risk Assessments; Estates signage records; no significant concerns identified through assurance processes.

Management of Health and Safety at Work Regulations 1999 (MHSWR)
The Health Board demonstrates substantial compliance with the MHSWR, supported by established systems including Datix Risk for the identification, assessment, and control of risks. Suitable and sufficient risk assessments are routinely undertaken across all activities, covering staff, patients, visitors, contractors, and volunteers, with evidence recorded through care plans, departmental processes, and Clinical Care Group (CCG)/Function risk registers. In addition to corporate risk assessments, examples include manual handling risk assessments, violence and aggression/security risk assessments, Control of Substances Hazardous to Health (COSHH) assessments, pregnancy care plans, patient-specific risk assessments, and many others.

Control measures are implemented in line with the hierarchy of risk control, with practical examples evident across clinical and non-clinical services.

Arrangements are in place to ensure the effective management of specific risk groups, including young persons and new or expectant parents, through targeted risk assessments. In addition, health surveillance programmes are delivered via Occupational Health services for staff exposed to higher-risk activities, supporting early identification and management of work-related ill health.

The Health Board has appointed competent persons to provide health and safety advice and support, underpinned by established governance arrangements, policies, procedures, and management structures. Systems are in place to provide information, instruction, training, and supervision, including management induction and role-specific guidance. Further details on health and safety training provision and compliance are provided within the separate *Health and Safety Training Overview* report.

The Health, Safety and Security Team is responsible for 22 approved health and safety policies and procedures, all of which are currently within their review date. Further information on written control document compliance is provided within the separate *6-Month Summary of Health and Safety Related Written Control Documents* report.

A well-established incident reporting system (Datix) supports staff in fulfilling their duties to report hazards, incidents, and near misses, contributing to organisational learning and continuous improvement.

Effective arrangements exist for cooperation and coordination with other employers, particularly within shared premises and integrated care environments, with processes in place to exchange risk information and align control measures.

The Health Board can provide reasonable assurance that robust arrangements are in place to support compliance with the MHSWR 1999, including established processes for risk assessment, health surveillance, training, incident reporting, and health and safety governance. While there is evidence that suitable and sufficient risk assessments are routinely undertaken across a wide range of activities, the Health Board does not currently have a comprehensive mechanism to provide assurance that all required risk assessments are in place and remain up to date. To address this, the Health and Safety Compliance Group is working with Clinical Care Groups / Functions to develop risk assessment metrics and reporting arrangements that will strengthen oversight and enable more comprehensive assurance to be provided in future.

Workplace (Health, Safety and Welfare) Regulations 1992 (WHSWR)
Overall, the Health Board demonstrates amber (RAG-rated) compliance with the Workplace (Health, Safety and Welfare) Regulations 1992, with a structured approach to assurance through workplace inspections, audits, and defined responsibilities across Estates, Hotel Services, and departmental management.

The following RAG-Rated table shows compliance against each individual regulation, followed by a more detailed narrative below.

Reg.	Topic	RAG	Current Position	Continued Compliance / Improvement Required
4	Workplace requirements		Inspection arrangements and audit processes established.	H&S Inspection programme paused until Head of Health, Safety and Security (HoHSS) starts. Risk stratification programme actions under review by CCGs and monitored by the HSCG.
5	Maintenance		Maintenance systems in place through Estates and specialist services.	Maintain assurance reporting and planned preventative maintenance compliance.
6	Ventilation		Some ward areas may not achieve Health Technical Memorandum (HTM) ventilation standards.	Monitored closely by the Ventilation Safety Group. Prioritised capital investment programme required.
7	Temperature		Largely reactive management of heat stress. Aging infrastructure and ventilation are contributory factors.	Proactive planning required. H&S Team provide dedicated intranet resources. Monitored by the Ventilation Safety Group.
8	Lighting		Estates maintenance and inspection arrangements in place.	Continue planned inspections and emergency lighting testing.
9	Cleanliness & Waste		Robust cleaning, waste management and inspection processes.	Sustain audit performance and address local findings promptly.
10	Room Dimensions & Space		Some areas may exceed recommended occupancy standards.	Historic building design limits compliance in some areas. Estate modernisation and relocation of non-patient-facing staff, including through the Picton Terrace project, will

				reduce occupancy pressures and enhance compliance.
11	Workstations & Seating		DSE arrangements in place, but assessments not consistently completed.	Increase DSE assessment completion and monitor actions.
12	Floors & Traffic Routes		Parking pressures create local traffic-route risks.	Review parking controls and strengthen traffic management plans.
13	Falls/Falling Objects		Controls, permits and work at height / confined space arrangements in place.	Maintain inspection and permit-to-work assurance.
14	Windows & Transparent Surfaces		Requirements managed through inspections and building standards.	Continue periodic inspection programme.
15	Windows, Skylights & Ventilators		Restrictors and building compliance measures in place.	Verify restrictor inspections and maintenance records.
16	Window Cleaning		Some buildings require risk-assessed alternative access arrangements.	Develop long-term engineered access solutions where practicable.
17	Organisation of Traffic Routes		Vehicle-pedestrian interface risks require ongoing monitoring.	Undertake site traffic assessments and improve segregation.
18	Doors & Gates		Generally compliant through building standards and local controls.	Maintain inspection and service programme.
19	Escalators & Moving Walkways	N/A	Not applicable.	No action required.
20	Sanitary Conveniences		Suitable facilities available across sites.	Continue maintenance and cleaning assurance.
21	Washing Facilities		Appropriate washing and shower facilities provided.	Review capacity during refurbishments.
22	Drinking Water		Adequate supply and governance arrangements in place.	Maintain Water Safety Group oversight.
23	Accommodation for Clothing		Locker/storage provision constrained by capacity.	Increase locker provision within estates improvement plans.
24	Changing Facilities		Facilities available but insufficient in some locations.	Expand changing facilities during redevelopment projects.
25	Rest Facilities		Provision varies across departments.	Deliver staff welfare and rest-space improvement programme.

A formal inspection regime is in place, supported by a standardised Workplace Inspection Checklist completed biannually, alongside wider audit activity and health and safety governance arrangements.

Through planned Health and Safety Inspections, it is known that there is good compliance in core infrastructure systems, including maintenance arrangements (Reg. 5), lighting (Reg. 8), cleanliness and waste management (Reg. 9), and provision of welfare facilities such as drinking water, sanitary conveniences, and washing facilities (Regs. 20–22). These are supported by established operational processes, specialist teams, and compliance with relevant technical standards (e.g. HTMs), providing a solid baseline of statutory adherence.

However, compliance with engineering and environmental controls is variable, particularly in relation to ventilation and thermal comfort. While critical areas such as theatres and ITU consistently meet required standards, some ward environments do not consistently achieve recommended air change rates. This is monitored and managed by the Ventilation Safety Group, which reports into the Health and Safety Compliance Group. It is recognised that a number of these areas were constructed prior to the introduction of current standards, and in many cases are operating with original ventilation systems not designed to meet modern requirements. Retrofitting is not always feasible due to structural or operational constraints, and in some instances, changes in room use have altered the original design intent.

In addition, temperature management tends to be reactive, with challenges observed during periods of extreme heat and limited evidence of proactive mitigation planning. These risks are managed locally, where reasonably practicable, through existing Health Board processes, including Infection Prevention and Control measures and estates-led interventions. Nevertheless, this presents a potential gap against current regulatory expectations, in terms of ensuring 'thermal comfort'. The regulations do not explicitly state a maximum working temperature.

Workplace design and utilisation present further compliance pressures, notably in relation to room space standards, workstation assessments, and traffic routes (Regs. 10–12, 17). Although processes such as DSE assessments and occupancy evaluations exist, coverage is inconsistent, and some areas may exceed recommended occupancy levels or lack completed assessments. Compliance is impacted by historic estate design and constrained accommodation capacity. Ongoing estate rationalisation programmes, including relocation of appropriate staff from clinical sites and the Picton Terrace development, will improve space utilisation and support compliance.

There are also constraints in welfare and support facilities, including limited provision of lockers, changing space, and rest facilities (Regs. 23–25). While facilities are available across sites, capacity does not always meet demand, particularly given workforce size and evolving models of working. Window safety, cleaning arrangements, and safe access are generally managed through risk assessment, though not all buildings are optimally designed for full compliance without additional controls.

In summary, the Health Board can provide reasonable assurance that suitable arrangements are in place to achieve compliance with the WHSWR 1992, so far as is reasonably practicable. This assurance is derived principally from the planned Health and Safety inspection programme, the outcomes of which are routinely reported to the Health and Safety Committee through the risk stratification process. Future compliance monitoring and assurance reporting will be supported through the Audit Management and Tracking (AMaT) system, enhancing oversight, reporting efficiency, and governance.

Nevertheless, full compliance has not yet been achieved, particularly in older estate areas and where operational pressures influence workspace conditions. Targeted improvements in environmental controls, space utilisation, and welfare provision are required to strengthen compliance and reduce residual risk.

Health and Safety (Safety Signs and Signals) Regulations 1996
The Health Board can provide reasonable assurance that good arrangements are in place to support compliance with the Health and Safety (Safety Signs and Signals) Regulations 1996, with established processes in place to monitor and maintain appropriate signage across its estate. Signage is routinely reviewed through the Health and Safety Team's planned inspection programme, ensuring ongoing oversight of condition, suitability, and placement. Additional

assurance is provided through regular fire risk assessments, during which the Fire Team also reviews the adequacy and effectiveness of fire safety signage. No significant concerns have been identified through either inspection route, indicating that signage arrangements are generally appropriate and maintained to a satisfactory standard.

Operationally, the Estates Department supports compliance by maintaining adequate stock levels of standard fire safety signage, enabling timely replacement or installation where required. This ensures that statutory and safety-critical signage can be sustained without undue delay.

Furthermore, the introduction of an in-house sign production capability through a dedicated sign printer strengthens responsiveness and flexibility, allowing bespoke safety signage to be developed as needed. This enhances the Health Board's ability to address emerging risks and maintain compliance across diverse and changing environments.

Argymhelliad / Recommendation

The Health & Safety Committee is asked to **TAKE ASSURANCE** that the Health Board is operating in compliance with the following regulations as far as reasonably practicable, whilst acknowledging the challenges presented by an aging estate:

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

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.

2.4

10:20 AM, 10 Mins

2.4 - Fire Safety Risk Assessment Assurance Update (BORIS)

Simon Chiffi (Hywel Dda UHB - Head of Operations)

For assurance

Attachments

HSC SBAR Boris Fire System Update 26.6.26 v3.pdf

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	07 July 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Fire Safety Risk Assessment System (Boris)
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	James Severs, Executive Director of Allied Health Professionals 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

Following the Health and Safety Committee (HSC) in May 26 declaring a lack of assurance regarding outstanding fire safety actions within the Health Board's (HB) Fire Safety Risk Assessment System (Boris), this report provides a further update regarding the measures being implemented to strengthen management arrangements for action escalation and improved ownership.

Cefndir / Background

As a result of the Regulatory Reform (Fire Safety) Order 2005, the Health Board is required to undertake suitable and sufficient Fire Risk Assessments (FRA) of its premises, accurately record the information and escalate all significant findings to the nominated responsible persons. This mechanism is articulated as part of the organisation's Fire Safety Policy.

To support the Health Board to discharge its duties, the Boris system is used by the Fire Safety Team (FST) to undertake all FRA and assign any actions to respective action owners.

Although the number of outstanding actions has been on a downward trajectory as shown in the table below, the HSC remains concerns about the overall level of outstanding actions and the pace at which improvements are being delivered.

Fig 1.0 Boris Table of Actions – Trend Analysis

Date	Extreme Estates	Extreme Hospital Management (HM)	High Estates	High HM	Moderate Estates	Moderate 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
Feb 26	0	0	655	435	1535	981	254	145
March 26	0	0	653	451	1503	974	202	147

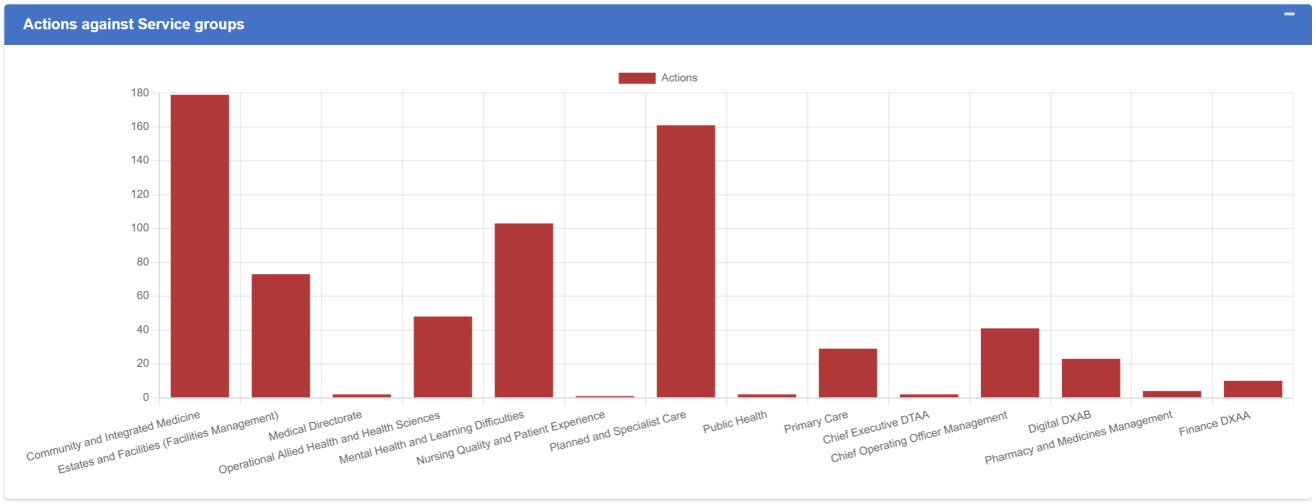
April 26	0	0	615	425	1479	993	200	156
May 26	0	0	560	372	1424	1021	187	154
June 26	0	0	547	361	1414	1015	186	154

Asesiad / Assessment

As a result of improvements made to the Boris system by its developers, data extraction capability has improved, and fire safety actions can now be extracted by Clinical Care Group (CCG). This development has improved the visibility of outstanding actions and provides the opportunity for timely escalation.

Figure 2.0 details an extract from the new dashboard view. Users may select a specific CCG segment and display the outstanding actions assigned to it.

Figure 2.0 CCG New Dashboard (example image only)



Action Details (Service Groups)

Action No	Site	Location	Service Group	Action	Date of FRA	Action Owner	Due Date
10205/3	Prince Philip Hospital - Llanelli	Template 17 First Floor Pathology	Operational Allied Health and Health Sciences	Finding: Steel cabinets containing admin and stationery items on a single means of escape, one of which was unlocked. Action: Relocate items away from the Means of escape entrance to stairwell and within a protected 30 min room.	09-01-2026	Ben Davies	10-01-2026
10464/7	Glangwilli General Hospital	Block 08 FF - Pathology Department	Operational Allied Health and Health Sciences	Finding: Plastic container Bottles in escape routes, also newer processes within Pathology departments mean that less flammable liquids are used or the liquids remain in enclosed cassettes however there are still some processes where the use of flammable liquidscannot be avoided. Staff are correctly trained in the use of such products, storage of flammable liquids in use is kept to a minimum, and bulk storage is also controlled. Action: Managers to make sure combustibles & chemicals are kept away from escape routes. These need to be placed inside compartments behind 30min fire doors & chemicals inside secured cabinets or bunded units / hazard rooms. Hazard signs on these doors.	09-10-2025	Catrina Richards	10-10-2025

The action details provide a clear description of the action, the date of the original FRA, the action owner and the due date.

All data can be manually exported to Microsoft Excel for further analysis and cascading.

A recent meeting and system training provided to the Deputy Chief Operating Officer (DCOO) concluded that these developments were a significant step forward that will aid improved distribution of data to CCG leads/directors. In order to provide improved assurance, outstanding actions will be scrutinised and discussed at monthly CCG Delivery Review meetings chaired by the DCOO.

A trajectory of timelines is also being developed by each CCG (including Estates & Facilities) to provide an indication of action closure, offering increased assurance and visibility. This is an extensive task, which can be presented to the Committee as part of the next update status and forms part of our agreed actions table below.

To further support compliance and improved communication, the Boris system will issue automated e-mails to assigned action owners monthly reminding them to address their assigned actions.

Action owners are considered duty holders under the Regulatory Reform (Fire Safety) Order 2005, as they exercise control within their area of responsibility. In this capacity, they support the Responsible Person (the Chief Executive / Health Board) in discharging statutory fire safety duties. It is the responsibility of the allocated duty holder to ensure that actions arising from FRA are completed within the required timescales provided.

The FST will provide competent advice, guidance, and practical support to assist duty holders in completing these actions. Progress and completion will be recorded within the designated system. While support is provided, accountability for timely completion of actions remains with the duty holder.

To ensure clarity and accountability, it has been agreed that actions will be assigned to named individuals rather than job roles. This approach removes ambiguity where multiple individuals may hold similar roles within the same area and ensures there is clear ownership of each action.

Actions agreed to improve the management of Boris:

The following table 1.0 below has been produced to indicate a series of actions to improve the management of Boris.

Table 1.0

Action No	Action Description	By when	By Whom
1	Prepare and extract all Estates & Facilities Clinical Care Group (CCG) Boris data. For risk/action owners to facilitate the production of an action completion trajectory.	Completed	Paul Evans
2	Analyse all circa 2140 Estates & Facilities CCG Boris actions and develop an action completion trajectory.	31.08.26	Simon Day
3	Provide Boris system access and training for the DCOO.	Completed	Paul Evans
4	Provide a function in Boris for the DCOO to extract all CCG actions (excluding Estates & Facilities).	Completed	Paul Evans
5	Prepare and extract all CCG (excluding Estates & Facilities) Boris data. For risk/action owners to facilitate the production of an action completion trajectory.	03.07.26	Gareth Cottrell
6	Analyse all circa 1529 CCG (excluding Estates & Facilities) Boris actions and develop an action completion trajectory.	31.08.26	Gareth Cottrell
7	Review BORIS approval process from two-stage approval to one-stage approval to expedite BORIS	Completed	Paul Evans

	reviews. This will remove circa 230 actions immediately from the system.		
8	Modernise (with support from Learning and Development) the existing L5 Fire Safety Training module. To create a new interactive platform, encouraging action owners to update Boris in a timely manner. This will form part of the new Training Needs Analysis (TNA) for Fire Safety. This is in addition to the scrutiny/intervention already agreed by the DCOO.	31.08.26	Paul Evans
9	Ensure action users (who accept their role on receipt of the FRA) then relocate or leave the HB, inform line management and/or the FST of this change. Minimising the opportunity of actions left dormant in the system. Regular scrutiny/intervention by DCOO already agreed.	Completed	Gareth Cottrell
10	Actions that maybe more complex to address requiring significant investment or service disruptions may take longer to complete and action. Scrutiny/intervention/escalation agreed by DCOO through appropriate HB governance channels.	Completed	Gareth Cottrell
11	Ensure continual communications of Fire Themed Risks at Fire Safety Group (FSG) and CCG meetings, to ensure appropriate capital bids are being submitted to manage (as far as reasonably practicable), mitigate and address the risks we face in relation to fire safety. Note the two corporate risks 813 (fire) 1745 (infrastructure) and significant investment already agreed to address Enforcement Notice (EN) works.	Completed	Paul Evans Simon Day& Simon Chiffi
12	Boris system change, to include the functionality of an automatic monthly (reminder) e-mail to all Boris action owners. (Attaching the risks/actions in their ownership.	01.08.26	Paul Evans

The improvements noted above will have a significant impact on the HB's ability to communicate and clarify ownership whilst offering increased traceability of actions. Through the HSC, the Health Board will regularly evidence trends of risk reduction over time offering improved confidence and assurance.

To provide further assurance, it is proposed that a six-monthly update report be presented, highlighting the status of all risk categories, by management ownership, using the Boris Dashboards evidencing the improvements made.

Argymhelliad / Recommendation

The Health and Safety Committee is requested to **Receive assurance** from the actions being implemented to strengthen governance, oversight and ownership of Fire Risk Assessment actions, whilst recognising that further evidence of sustained improvement is required.

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
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)	2. Safe Care 1. Staying Healthy 3. Effective Care
Amcanion Strategol y BIP: UHB Strategic Objectives:	5. Safe sustainable, accessible and kind care 4. The best health and wellbeing for our individuals, families and communities
Amcanion Cynllunio Planning Objectives	2a Staff health and wellbeing 5a Estates Strategies 7a Population Health
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

2.5 **10:30 AM, 10 Mins**

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

Adam Springthorpe (Hywel Dda UHB - Health & Safety Manager), Gareth Cottrell (Hywel Dda UHB - Deputy Chief Operating Officer)

Attachments
2.5 SBAR PoL Position July 2026 V1.0.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	07 July 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Compliance with Environmental Ligature Anchor Point Assessments and Adoption of the All-Wales Procedure
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 paper provides assurance to the Health and Safety Committee (HSC) regarding Hywel Dda University Health Board's (HDdUHB) management of environmental ligature anchor point risks and the planned adoption of the new All-Wales Ligature Anchor Point Procedures.

Specifically, the HSC is asked to note that, regarding ligature anchor point risks, HDdUHB:

- has arrangements in place which support compliance with:
  - The Health and Safety at Work etc. Act 1974 (HSWA) including:
    - Section 3 – protecting persons not in their employment;
    - Section 4 – ensuring premises are safe and without risks to health;
  - The Management of Health and Safety at Work Regulations 1999 (MHSWR) including:
    - Regulation 3 – "suitable and sufficient" assessments of risks posed by Ligature Anchor Points in mental health wards and other relevant areas;
    - Regulation 4 – application of the principles of prevention.
- Has fully implemented and embedded Procedure 1069, Assessment and Management of Environmental Ligature Risks, ensuring a consistent approach to environmental ligature risk assessment and control across all Mental Health and Learning Disability (MHLD) sites.
- Has an approved and active implementation plan to transition to the All-Wales Ligature Anchor Point Procedures during the second half of 2026.
-

Cefndir / Background

Ligature anchor point risks are well established within mental health care environments and require management across three interdependent domains:

- Environmental (physical environment and fixtures);
- Procedural (policies, processes, assessments);
- Relational (clinical observation, supervision, care planning).

This paper focuses principally on environmental risk assessments, while also providing a high-level overview of relevant procedural aspects.

While risk cannot be fully eliminated, there is a statutory duty to reduce risk "so far as is reasonably practicable" and to evidence compliance with relevant legal requirements. In 2022,

HDdUHB introduced the *1069: Assessment and Management of Environmental Ligature Risks Procedure,* which:

- Formalised and standardised environmental ligature risk management;
- Was supported by the Manchester Audit Tool;
- Was embedded through training and multidisciplinary engagement;
- Established a consistent approach to environmental assessments, action planning and annual reviews.

The 1069 Procedure has been applied across:

- All inpatient mental health units;
- Learning disability inpatient/residential settings;
- All relevant outpatient and community MHLD services.

A new All-Wales Ligature Anchor Point Procedure has since been developed and will be applied specifically to HDdUHB's inpatient Mental Health wards. The procedure introduces:

- A more holistic and integrated approach;
- Enhanced documentation (single record vs assessment + action plan);
- Inclusion of training, awareness, and incident response;
- Greater consistency across NHS Wales.

Asesiad / Assessment

Position summary

- HDdUHB has an approved procedure in place – *1069 Assessment and Management of Environmental Ligature Risks Procedure (Review date: 09.02.2029),* which requires HDdUHB to address ligature risks in a balanced, objective and systematic way using a standardised audit tool. The procedure primarily applies to all MHLD adult, dementia, older adult, rehabilitation, forensic and learning disability inpatient/service user units and residential learning disability settings. The procedure also covers community-based MHLD settings;
- A Teams-based monitoring system demonstrates that all applicable sites (see Appendix 1) have environmental ligature risk assessments in place, including action plans where required.
- Current procedure risk assessment compliance is achieved and evidenced;
- Implementation of the All-Wales Anchor Point Procedure is underway, with a defined plan and target completion during the second half of 2026.

Scope of Application

- The All-Wales Policy and Procedures will apply only to inpatient Mental Health wards.
- The existing Procedure (1069) will continue to apply to all other acute and community MHLD settings.
- There is no specific statutory requirement to undertake ligature risk assessments in non-MHLD settings. However, in practice, HDdUHB extends ligature risk management principles beyond MHLD settings and applies them proportionately, based on the level of risk identified.

Current Compliance

HDdUHB can demonstrate strong, sustained, and evidenced compliance with statutory and organisational requirements via the implementation of *1069: Assessment and Management of Environmental Ligature Risks Procedure*.

Coverage and Governance

- 100% of MHLD sites (inpatient, outpatient, and LD residential) have:
  - Completed a Point of Ligature (PoL) assessment in line with Procedure 1069;

- Established documented Action Plans;
- Maintained annual reviews since 2022.

- All PoL assessments were:
  - Initially led by clinical managers and the Health, Safety & Security Officer;
  - Transitioned to locally owned processes (particularly in outpatient settings);
  - Supported by ongoing expert oversight and review;
  - Additional reviews are triggered by environmental changes, incidents or emerging risks.

The table below outlines the PoL risk assessment audit compliance for the nine Mental Health inpatient facilities at 21/05/2026 (Adult / Older Adult). All sites have a completed risk assessment in place, with reviews undertaken within the last 12 months at all but one location. The exception is St Non's, where Estates works are currently underway. The Health and Safety Compliance Group has requested a further audit recognising that the new All-Wales assessment template has not yet been implemented.

Service	Unit	Date Audit Last Completed
OAMH	Enlli	30/12/2025
OAMH	Bryngolau	12/03/2026
OAMH	St Non's	02/05/2025
Adult MH	Morlais	29/10/2025
Adult MH	Bryngofal	15/03/2026
Adult MH	St Caradog	20/03/2026
Adult MH	ECT	18/03/2026
Adult MH	PICU	07/03/2026
Adult MH	LSU	06/03/2026

Quality and Detail of Assessments

The PoL assessments completed under internal Procedure 1069:

- Systematically map every room, aligned to Estates floor plans;
- Clearly define patient accessibility (unsupervised, supervised, restricted) and environmental characteristics (e.g. door access, ceilings);
- Identify and record all ligature anchor points and all ligature-resistant fixtures (demonstrating consideration, not an assumption of safety);
- Include immediate risk controls (make-safe actions) and detailed, room-by-room risk analysis.

Action Planning

- All identified risks are documented, with recommendations for elimination, substitution, mitigation, or ongoing management, as appropriate;
- Where risks cannot be eliminated, controls include observation, supervision, and patient risk assessment;
- Action plans are RAG-rated by clinical teams and include immediate, short, and longer-term actions;
  - The current reporting arrangements do not enable all outstanding actions across the action plans to be viewed and monitored collectively, limiting both oversight and the ability to quantify the overall position. Work is underway to address this limitation, as outlined in the 'Future Compliance Position' section.

Compliance with Legislation

The above arrangements provide assurance that HDdUHB has effective systems and processes in place to support compliance with:

- HSWA through ensuring that safe environments are maintained and risks are reduced "so far as reasonably practicable";
- MHSWR through "suitable and sufficient" risk assessments and the application of the principles of prevention.

Wider Impact and Assurance

Procedure 1069:

- Enabled environmental improvements across MHLD inpatient units;
- Supported safe care of high-risk patients in acute/general settings;
- Increased awareness of Ligature Anchor Point risks outside MHLD settings and how high-risk patients can be accommodated outside inpatient units:
  - Improvement works within Emergency Departments (EDs) have included PoL assessments, recognising that EDs may receive patients presenting with a wide range of risk factors. While this work remains under development, it is already demonstrating wider patient safety benefits both within MHLD and across the wider Health Board.;
- Demonstrates organisational maturity in risk identification, risk mitigation and cross-departmental learning.

Risk Register

The MHLD Operational Risk Register includes a risk relating to ligature assessment:

- 139 - Risk of harm due to inpatient units & community facilities not compliant with Points of Ligature (PoL) standards.
- Current score 10: The risk notes that:
  - It is unlikely that all points of ligature will ever be completely eliminated;
  - There is a regular programme of audits and a process in place for prioritising capital funding based on operational risk registers. Significant infrastructure development and changes are required in order to reduce risks across the inpatient estate, which would require significant capital investment;
  - A proportionate approach is being taken to assess risk and apply mitigation through clinical practices, though this has limitations. Without environmental changes this risk will remain scored at 10.

Challenges of Addressing Ligature Risks

- Addressing risks identified through ligature assessments can be challenging. In many cases, mitigation requires capital investment, and the associated approval and delivery processes are often lengthy. As a result, responding to identified risks can take significant time. As outlined in the 'Action Planning' section, the development of a consolidated overview of outstanding actions will support improved quantification and oversight.
- A specific concern relates to current non-compliance with Welsh Health Building Notes (WHBN) for acute mental health units, particularly in relation to ceiling design (WHBN 03-01, section 10.65). While suspended grid ceilings in patient bedrooms are consistently identified as a ligature risk through audits, the complexity and cost of remedial works present a significant barrier. Consequently, current risk management relies on mitigating controls, including relational and observational approaches.

Risk Context and Emerging Learning

It should be noted that suicide risks can also arise from:

- Non-anchored ligatures (e.g. plastic bags, personal items and other readily available materials);
- Everyday items used unpredictably.

Recent legal cases (e.g. NHS Trust prosecutions) highlight:

- The importance of comprehensive risk management beyond anchor points;
- The need for clear evidence of assessment and controls.

This identifies a potential area for further policy development within HDdUHB.

Recent learning from a ligature incident within HDdUHB highlighted how individuals may identify and exploit less obvious environmental opportunities. This reinforced the importance of dynamic risk assessment alongside environmental controls and informed further environmental improvements within inpatient settings, including enhancements to ceiling-mounted fixtures.

Safety Alerts / Local Safety Notices

HDdUHB has an established process for responding to and cascading all Safety Alerts and Local Safety Notices relating to ligature risks. A recent example includes a Local Safety Notice issued by Swansea Bay University Health Board in April 2026, highlighting risks associated with a specific anti-ligature wardrobe following a reported incident.

Future Compliance Position – In Progress (2026 Delivery)

Scope of Implementation

The new All-Wales Ligature Anchor Point Procedures apply to:

- All inpatient mental health units;
- Learning disability inpatient sites.

2026 Plan:

- All sites yet to complete a 2026 review will undertake Ligature Anchor Point assessments using the new All-Wales template;
- All reviews previously completed using HDdUHB Procedure 1069 will be transferred to the new template.
- All new and outstanding actions arising from Ligature Anchor Point Assessments Action Plans will be captured within a single reporting framework to enhance visibility, oversight and assurance. The Built Environment Audit “Risk Stratification” approach will be applied to provide a clear overview of the number and status of all outstanding risks; this approach has already been tested and proven useful.

Key Improvements Introduced

The new All-Wales Ligature Anchor Point Procedures:

- Integrate risk identification, controls, actions, escalation, training and awareness, and incident response;
- Removes duplication (no separate action plan);
- Improves documentation quality, consistency, auditability and efficiency;
- Supports electronic data entry and version control (e.g. SharePoint);
- Place a strong emphasis on undertaking assessments using a tripartite approach, involving clinical leads, H&S and Estates, which is a shift for HDdUHB. This multi-disciplinary tripartite approach reinforces the integration of:
  - Environmental controls (Estates / H&S);
  - Procedural controls (clinical governance);
  - Relational controls (patient observation and care).

Governance and Alignment

Existing HDdUHB procedure 1069 will be revised to continue to apply to:

- Outpatient MHLD settings;
- Community services;
- LD residential settings.

Consideration will be given to the development of a new procedure for non-anchored ligatures and risk items, strengthening compliance coverage.

In June 2026, the Health and Safety Compliance Group approved the establishment of an Anti-Ligature Sub-Group to support the implementation of the All-Wales policy and to assist the development of fit for purpose metrics for the topic area. This will need to be a collaborative approach, including representatives from nursing, MHLD, Estates and Health and Safety.

Additional Controls
It is vital that HDdUHB ensures that information which could identify environmental ligature risks is not made publicly available, while continuing to meet its transparency and governance obligations. As documents relating to Health and Safety Committee (and potentially other meetings) are publicly available, specific details of ligature points and assessments must not be included.

The new All-Wales Procedures will be used to promote organisation-wide learning to expand awareness beyond MHLD into acute hospitals, EDs and community settings.

In Summary
HDdUHB has a clear, structured transition plan to implement the All-Wales Ligature Anchor Point Procedures. The All-Wales approach represents a clear enhancement to existing arrangements and provides an opportunity to strengthen consistency, oversight and assurance across relevant services; implementation is underway but not yet complete (planned 2026 delivery).

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

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:	139 – Score 10
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 3. Effective 6. Person-Centred
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply

Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Great care
Amcanion Cynllunio Planning Objectives	5 Mental health and CAHMS
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives

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 Ceisiadau Gofal Sylfaenol: Parties / Committees consulted prior to the Health and Safety Compliance Group Committee:	• Health and Safety Compliance Group • Key Stakeholders

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The findings of Ligature Risk Assessments may have cost implications to rectify to ensure safe environments for patients.
Ansawdd / Gofal Claf: Quality / Patient Care:	There is a positive impact on patient safety, health and wellbeing through compliance with health and safety regulations.
Gweithlu: Workforce:	No impact identified.
Risg: Risk:	Risk to health and safety management.
Cyfreithiol: Legal:	A breach of health and safety regulations, such as the Management of Health and Safety at Work Regulations 1999, 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: Applicable Sites – MHLD Inpatient & Community Sites

Dept.	Site	Location
Mental Health (MH) – Inpatient units		
Adult Mental Health (AMH)	PICU	Block 2, Cwm Seren, Hafan Derwen
	LSU and Stepdown	Block 2, Cwm Seren, Hafan Derwen
	Morlais	Block 21, GGH
	Bryngofal	Template 28, PPH
	St. Caradog's	Bro Cerwyn, WGH
Older Adult Mental Health (OAMH)	Enlli	Enlli (Block 3, BGH
	Bryngolau	Template 27, Caebryn, PPH
	St. Non's	Bro Cerwyn, WGH
Specialist Child and Adolescent Mental Health Service (S-CAMHS)	Rainbow Suite	Cilgerran ward, Block 3, Room R22/R23, GGH
Learning Disabilities (LD) – Inpatient/residential units		
Learning Disabilities (LD) residential	Begelly	14 Church Close, Kilgetty
	Greville Court	2 Greville Court, Pembroke Dock
MHLD - Outpatient units in the community		
Adult Mental Health (AMH)	Brynmair Clinic	Llanelli
	Swn Y Gwynt	Ammanford
	Wellfield Road	Carmarthen
	Bro Cerwyn	Off site, opposite WGH
	Havenway	SPH
	Gorwelion	Aberystwyth
	Hafan Hedd	Newcastle Emlyn
Older Adult Mental Health (OAMH)/Community Mental Health Team (CMHT)	Heddfan (North Carms OA CMHT)	Block 21/25, GGH
	St. Brynachs Day Hospital (Pembs CMHT)	Bro Cerwyn, WGH
	Enlli CMHT	Block 3, BGH
	Caebryn	Template 26, PPH
Community Teams for Learning Disabilities (CTLD)	Ty Elwyn	Council Offices, Llanelli
	Llanion House	Pembroke Dock
	Coleshill Day Centre	Llanelli
	Penlan	Carmarthen
Integrated Psychological Therapies Service (IPTS)/Local Primary Mental Health Support Services (LPMHSS)	Llys Steffan	Lampeter
	Ty Myddfai	Johnstown
	Brynhaul	Template 27, PPH
Specialist Child and Adolescent Mental Health Service (S-CAMHS)	Elizabeth Williams Clinic	Llanelli
	Ty Llewelyn	Block 18d, GGH
	Canolfan Gwili	Block 20, GGH
	Preseli Centre	Block 14; WGH
	Bro Myrddin	Carmarthen
	Ty Helyg	Block 13, BGH
Adult ADHD Service	Ty Gwili	Off site, opposite GGH
Electro-Convulsive Therapy (ECT)	ECT Department	Alun, Hafan Derwen

2.6

10:40 AM, 10 Mins

2.6 - Health & Safety/Individual Regulations Written Control Documents Status Report

James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)

For assurance

Attachments

2.6 SBAR WCD Summary July 2025 V1.0.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	07 July 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	6 Month Summary of Health & Safety Related Written Control Documents
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

The purpose of this report is to present the Health & Safety Committee (H&SC) with a 6-month summary position on the status of health and safety related written control documentation (WCDs) i.e. health and safety policies, procedures, guidelines and codes of practice.

Cefndir / Background

Whilst the Health & Safety Compliance Group (HSCG) is the 'approving' group identified for all health and safety related WCDs (other than for the Health Board's over-arching Health & Safety Policy and its Major Incident Plan) and is required to maintain a database of WCDs which fall within its remit identifying their status in terms of up to date, extension requested or overdue, it has been agreed that a summary of the status of health & safety related WCDs will be presented to the Committee every 6 months for assurance purposes.

All health and safety related WCDs are uploaded onto the Hywel Dda University Health Board (HDdUHB) website on the Corporate Written Control Documentation Page. Please see Appendix 1 for all health and safety related WCDs captured on the Health & Safety Written Control Document Database.

Asesiad / Assessment

This 6 monthly summary provides assurance on the current status of relevant WCDs including their review dates, together with details of those written control documents approved during Quarter 4 2025/26 and Quarter 1 2026/27 in line with HDdUHB's 190 - Written Control Document Policy.

During Quarter 4 2025/26 and Quarter 1 2026/2027, the following written control documents were reviewed and approved by the HSCG:

- 843 – Reducing Restrictive Practice Policy - Update;
- 1069 – Assessment and Management of Environmental Ligature Risks Procedure - Update;
- 1389 – H&S Site Inspection Procedure - New WCD;
- 285 – Violence & Aggression Policy – Update – 3-month extension granted;
- 749 – Lockdown Policy – Update – 3-month extension granted;
- 761 – Violent Patient Marker Procedure – Update – 3-month extension granted;

- 1138 – Security Management Policy – Update.

As of 30 June 2026:
- All WCDs are currently within their review dates;
- No written control documents have exceeded their review dates.
    - WCDs with extended review dates (due for renewal) are as follows:
        - 285 – Violence & Aggression Policy – Update – 3-month extension granted;
        - 749 – Lockdown Policy – Update – 3-month extension granted;
        - 761 – Violent Patient Marker Procedure – Update – 3-month extension granted.

The following new written control document has been initiated and as of 30 June 2026, is still in development. This is being developed in line with Policy 190 – Written Control Documentation and should be ready for approval later in the year:
- Physical Restraint Policy (separate from the Reducing Restrictive Policy).

Argymhelliad / Recommendation

The Health & Safety Committee is requested to **RECEIVE ASSURANCE** on the current status of Health and Safety related Written Control Documentation.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	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.
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)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are 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:	Health & Safety Written Control Document Database
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:	Health & Safety Compliance Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impact.
Ansawdd / Gofal Claf: Quality / Patient Care:	The intention of this report is to improve health and safety arrangements to drive improvements within HDdUHB.
Gweithlu: Workforce:	No direct impact.
Risg: Risk:	No direct impact.
Cyfreithiol: Legal:	A breach of health and safety regulations can 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:	No direct impact
Cydraddoldeb: Equality:	Each individual WCD is subject to an Equality Impact Assessment (EqIA).

Appendix 1 - Health & Safety Written Control Document Database

No.	Title	Current Lead	Due Date
761	Violent Patient Warning Marker Procedure	Brett Jenkins / AS	Extended to 11/08/2026
285	Violence & Aggression Policy	Brett Jenkins /AS	Extended to 11/08/2026
749	Lockdown Policy	Charles Scarf / AS	Extended to 11/08/2026
273	Manual Handling Policy	Gemma Vaughan / AS	11-Sep-26
649	Workplace Slips Trips and Falls Policy	Adam Springthorpe	11-Sep-26
770	Medical Laser Safety Policy	Adam Springthorpe	11-Sep-26
1132	Control of Vibration Policy	Adam Springthorpe	11-Sep-26
1198	Safe Working at Height Policy	Adam Springthorpe	13-Nov-26
10	Health and Safety Policy	Adam Springthorpe	10-Sep-27
323	Close Circuit Television (CCTV) Policy	Charles Scarf	06-Feb-28
170	Lone Worker Policy	Brett Jenkins	06-Feb-28
767	New and Expectant Mothers / Birthing Parent Procedure	Adam Springthorpe	06-Feb-28
431	Latex Policy	Adam Springthorpe	06-Feb-28
703	Control of Substances Hazardous to Health (COSHH) Policy	Gerard Sellek / AS	24-Feb-28
814	Fit Testing for Respiratory Protective Equipment PPE Procedure	Adam Springthorpe	03-May-28
463	Display Screen Equipment DSE and Workstation Assessment Procedure	Adam Springthorpe	03-Jun-28
1383	Noise at Work Policy	Adam Springthorpe	21-Aug-28
696	First Aid at Work Procedure	Adam Springthorpe	02-Dec-28
1389	Health and Safety Site Inspection Procedure	Adam Springthorpe	09-Feb-29
843	Reducing Restrictive Practice Policy	Rachel Wood / AS	09-Feb-29
1069	Assessment and Management of Environmental Ligature Risks Procedure	Gerard Sellek / AS	09-Feb-29
1138	Security Management Policy	Charles Scarf / AS	08-Jun-29

3

10:50 AM, 0 Mins

3 - Clinical Care Group Updates

3.1

10:50 AM, 10 Mins

3.1 - Mental Health and Learning Disabilities

Gareth Cottrell (Hywel Dda UHB - Deputy Chief Operating Officer), Rebecca Temple-Purcell (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality and Experience)

For assurance

Attachments

MHLD CCG Health Safety Update Report to H_S Committee July 2026.pdf
Appedix 1 MHLD CCG Health and Safety Metrics.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	07 July 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Mental Health and Learning Disabilities Clinical Care Group Health & Safety Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Caruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Becky Temple-Purcell, Assistant Director of Nursing, Patient Safety, Quality and Experience (Mental Health and Learning Disabilities Clinical Care Group)

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides an update on Health and Safety performance within the Mental Health and Learning Disabilities (MH/LD) Clinical Care Group (CCG), providing information on governance arrangements, compliance with statutory requirements, and management of key risks. The Committee is asked to take assurance from current performance, whilst noting areas requiring improvement, including Manual Handling training compliance and higher levels of training, management of historical inspection actions, and immediate actions arising from a recent Health Inspectorate Wales (HIW) inspection.

Cefndir / Background

Since April 2026, a Health and Safety dashboard has been implemented within the MH/LD Clinical Care Group, providing monthly performance data to strengthen oversight, transparency, and accountability. Health and Safety is a standing core agenda item at the MHLD Clinical Care Group Integrated Governance Group, with further development underway to incorporate trend reporting and enhance proactive risk identification.

A Health Board–wide audit of Health and Safety inspections (2023–2025) identified a gap in assurance relating to tracking and closure of approximately 1,000 actions. Responsibility for outstanding moderate and major risks, totaling 91 actions for the Mental Health and Learning Disabilities Clinical Care Group, has now been transferred to services to ensure appropriate local ownership, leadership and review within a set timescale.

Additionally, an unannounced HIW inspection of Enlli Ward, Bronglais Hospital, undertaken on 15–17 June 2026, identified an immediate assurance action relating to compliance with Reducing Restrictive Practices (RRP) which sits under Health and Safety compliance. The Health Board is currently developing its formal response, including action already underway to deliver team-based RRP training (planned for 7 July 2026).

Asesiad / Assessment

Governance and Assurance

- Monthly dashboard reporting embedded since April 2026, supporting routine scrutiny through the Integrated Governance Group. The most recent set of dashboard data is provided as Appendix 1.
- Development of trend reporting is underway to strengthen proactive risk management.
- Planned approach to building and enhancing monthly dashboard reports to include locally held data is being developed and expected to be implemented by Quarter 3.

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

- 2 RIDDOR incidents (April 2026) with 100% (2/2) submitted within statutory timescales
- Financial year-to-date compliance with statutory timescales remains 100% against a 60% target

Incidents and Risk Trends

- Total staff incidents: 28 → 32 → 28 (↓ improving)
- Violence & Aggression incidents: 50 → 61 → 49 (↓ improving)
- Ligature incidents: (↓ improving)
- Near misses stable: 10 → 12 → 12 (↔)

Manual Handling and Workforce Safety

- Level 1 compliance: ~77.5% (↓ below 85% target)
- Level 2 compliance: ~54% (significantly below target)
- Overall 30–50% training non-attendance impacting compliance (not specific to MHLD CCG)
- MHLD CCG meeting planned with Manual Handling lead to review role-specific training requirements and confirm appropriate courses and delivery models across Mental Health and Learning Disabilities services.
- Feedback given to Health and Safety Compliance Group regarding lack of availability of training in some localities, reported last minute cancellations, need to improve Electronic Staff Record (ESR) course information, ensuring target audiences are clearly defined, and clearer venue information to promote attendance.
- Strengthening oversight of compliance and follow-up, with regular monitoring and escalation through governance structures.

Workforce Health and Sickness Monitoring

- Monthly sickness absence rates are routinely monitored within the CCG, including analysis of reasons for absence
- The service does not currently have the capability to reliably report on work-related sickness absence (e.g. stress, violence-related)
- Work is planned with workforce colleagues to explore how data can be generated to strengthen understanding of the impact of health and safety risks on staff wellbeing.

Wider Training and Safety Systems

- Health & Safety training: ~93% (compliant)
- Violence & Aggression training: ~97% (compliant)
- Display Screen Equipment training: ~99% (sustained compliance)
- Reducing Restrictive Practice training: ~81% (below 85% target) Recovery plans in place and being monitored. Enlli Ward has a pre planned team based session taking

place on 7 July 2026 which will address current deficits highlighted through HIW inspection.
- Infection Prevention and Control Level 1: ~89.2% (sustained compliance)
- Infection Prevention and Control Level 2: ~80.8% (near compliance)
- Fire Safety Level 1:~95.44% (sustained compliance)
- Fire Safety Level 2: ~78.20%. Recovery plans being revisited.
- Fire Safety Level 3: No data held. Urgent review of competency allocation across MHLD CCG to be undertaken.

Historical Health and Safety Inspection Actions and Risk Management

- Outstanding actions:
  - Moderate: 69/75 outstanding
  - Major: 22/25 outstanding
  - Catastrophic: 0 (fully compliant)
- Handover of actions from Health and Safety team to MHLD CCG undertaken 21 June 2026. Structured service-led review and tracking arrangements are now in place with completion date set for 30 September 2026.

Risk Assessment Assurance

- Violence and Aggression risk assessments linked to incidents: ~95–96% compliance
- Ligature assessments in date:
  - Inpatient MH: ~89% which currently has a scheme of work to address previously identified risks. Re assessment will take place upon completion.
  - Outpatient MHLD: ~72% (gap identified) Prioritisation being given to re assessment of inpatient wards, utilising new national policy and assessment framework to ensure alignment with national standards at the earliest point. Outpatient assessments will follow.
  - The Committee is reminded of the previous paper presented in July 2026 regarding the Health Board's position on Point of Ligature (PoL) risk assessments and adoption of the All-Wales policy and procedure. This highlighted the active involvement of MHLD services in both local and national work to strengthen consistency, governance and learning in this area, including the planned transition to the All-Wales Policy and Assessment framework during 2026.

Key Risks Identified

- Low compliance in Manual Handling training (particularly Level 2)
- Improvement needed with Fire Safety Training Level 2 and Infection Prevention and Control Training Level 2
- Gap in training data for Fire Safety Training Level 3
- Gaps in ligature risk assessment coverage, particularly outpatient settings
- High volume of outstanding historical inspection actions requiring sustained oversight
- HIW immediate assurance requirements relating to Reducing Restrictive Practice
- Limited current capability to report on work-related sickness absence trends
- Need to enhance trend analysis capability for proactive risk management

Argymhelliad / Recommendation

The Committee is asked to:

- **Take assurance** on the Mental Health and Learning Disabilities Clinical Care Group Health & Safety Assurance position, including strong compliance with statutory reporting requirements, strengthened governance arrangements, improving incident trends, progress in training compliance across key areas, structured management of

historical inspection actions, and the response to HIW immediate assurance requirements.

- **Note** the key areas requiring continued oversight and improvement, namely manual handling and specific training compliance levels, Reducing Restrictive Practice requirements, gaps in ligature risk assessments, development of work-related sickness absence reporting, enhancement of dashboard trend analysis, and the timely closure of outstanding inspection actions.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.3 Receive bi-annual assurance reports from each Clinical Care Group Service Director on their individual Clinical Care Group health and safety arrangements.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are 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:	Contained within the body of 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:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	N/A
Ansawdd / Gofal Claf: Quality / Patient Care:	N/A
Gweithlu: Workforce:	N/A
Risg: Risk:	N/A
Cyfreithiol: Legal:	N/A
Enw Da: Reputational:	N/A
Gyfrinachedd: Privacy:	N/A
Cydraddoldeb: Equality:	N/A

APPENDIX 1: CCG Health and Safety Metrics

This Clincal Care Group Assurance Report provides details of the organisation's compliance with its statutory duties under health and safety legislation, including:

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

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

Reporting Period	March-May 2026		Unable to report compliance
Responsible Head of Service	Rebecca Temple-Purcell		Non-compliant
Date	24-Jun-26		Non-compliant but tracking Executive agreed plan
Author	Rebecca Temple-Purcell		Compliant

Performance Metric	Target	Mar-26	Apr-26	May-26	Interim Target	Trend	
Sickness absence (WTE) attributed to violence & aggression		No current capability to reliably report on work-related sickness absence (e.g. stress, violence-related). To be further explored with workforce colleagues.				↑ ↓ ↔	
Sickness absence (WTE) attributed to musculoskeletal injury						↑ ↓ ↔	
Sickness absence (WTE) attributed to stress / work-related mental ill-health						↑ ↓ ↔	
Total number of staff/contractor incidents reported via Datix	N/A	28	32	28	N/A	↓	
Staff/contractor incidents rate per 100 staff	N/A	2.1	2.4	2.1	N/A	↓	
Number of RIDDOR reportable incidents	N/A	0	0	<5	N/A	↑	
% of RIDDOR reportable incidents submitted within timescales (Financial year to date)	60%	100%	N/A	100%	60%	↑	
Number of health and safety near-miss staff/contractor incidents reported	N/A	10	12	12	N/A	↔	
Number of violence & aggression incidents (from V&A Case Manager Database)	N/A	50	61	49	N/A	↓	
Number of manual handling / MSK staff/contractor incidents	N/A	<5	0	0	N/A	↔	4 Categories on Dashboard - MH Equipment / Non-Patient / Patient & MSK
Number of slips, trips and falls staff/contractor incidents	N/A	0	<5	0	N/A	↓	
Number of needlestick staff/contractor incidents	N/A	0	0	0	N/A	↔	
Number of COSHH related staff/contractor incidents	N/A	<5	0	0	N/A	↔	
Number of electric shock staff/contractor incidents	N/A	0	0	0	N/A	↔	
Number of abscoding incidents (from Security Manager Database)	N/A	0	0	<5	N/A	↑	Review of these areas needed to ensure linked to datix incidents.
Number of ligature related incidents	N/A	<5	5	<5	N/A	↓	
% overdue actions related to health and safety incidents		Not Known	Not Known	Not Known		↑ ↓ ↔	Not currently possible to report on. To be explored with Health and Safety, Datix Teams.
% overdue actions on Datix related to violence, aggression and security		Not Known	Not Known	Not Known		↑ ↓ ↔	
% of overdue actions on Datix related to manual handling		Not Known	Not Known	Not Known		↑ ↓ ↔	
Number of staff/contractor incidents still awaiting review after 30 days	TBC	10	9	18	TBC	↑	
Outstanding moderate actions from internal H&S inspections (Old system - risk stratification)	0	70 of 75	69 of 75	69 of 75	TBC	↔	
Outstanding major actions from internal H&S inspections (Old system - risk stratification)	0	24 of 25	22 of 25	22 of 25	TBC	↔	
Outstanding catastrophic actions from internal H&S inspections (Old system - risk stratification)	0	0	0	0	0	↔	
Outstanding moderate actions from internal H&S inspections (AMaT)	0	Not Available	Not Available	Not Available	0	↔	Identified as future areas to report on through Health and Safety function.
Outstanding major actions from internal H&S inspections (AMaT)	0	Not Available	Not Available	Not Available	0	↔	
Outstanding catastrophic actions from internal H&S inspections (AMaT)	0	Not Available	Not Available	Not Available	0	↔	
% completion of mandatory Health, Safety & Welfare training	85.0%	93.0%	93.7%	93.2%	85.0%	↓	
% compliance level 1 manual handling	85.0%	79.2%	79.0%	77.5%	85.0%	↓	

% compliance with level 2 manual handling training	85.0%	54.6%	54.9%	54.1%	85.0%	↓	
% compliance with V&A training Module A	85.0%	97.6%	97.8%	97.5%	85.0%	↓	
% compliance with DSE training	85.0%	98.9%	98.9%	98.9%	85.0%	↔	
% of Managers Health and Safety Induction completed		Not Known	Not Known	Not Known		↑ ↓ ↔	Total number known. Health and Safety not able to split compliance by CCG. Local reporting to be implemented.
% level 1 fire safety training	85.0%	95.55%	95.49%	95.44%	85.0%	↓	
% level 2 fire safety training	85.0%	78.68%	78.43%	78.20%	85.0%	↓	
% level 3 fire safety training	85.0%	Not known			85.0%		Urgent review of competency allocation across MHLD CCG Services needed
Overdue fire risk assessment actions due	0	Available from July	Available from July	Available from July	0	↑ ↓ ↔	
% compliance with Infection Prevention and Control Level 1 training	85.0%	89.16%	89.14%	89.2%	85.0%	↑	
% complaince with Infection Prevention and Control Level 2 Training	85.0%	80.64%	80.65%	80.8%	85.0%	↑	
% compliance with COSHH assessments		Not Known	Not Known	Not Known		↑ ↓ ↔	Local systems to be developed by MHLD CCG to capture and monitor this data.
% Training in date for trained Fit-Testers		Not Known	Not Known	Not Known		↑ ↓ ↔	
% of staff who have been fitted for fit mask		Not Known	Not Known	Not Known		↑ ↓ ↔	
% of first aid needs assessments in place		Not Known	Not Known	Not Known		↑ ↓ ↔	
% of areas with suitable and sufficient first aiders		Not Known	Not Known	Not Known		↑ ↓ ↔	
% of V&A/Security risk assessment in place		Not Known	Not Known	Not Known		↑ ↓ ↔	
% V&A/Security risk assessments in place for reported incidents	100%	90.0%	96.7%	95.9%	95%	↓	
% of lone worker risk assessment in place		Not Known	Not Known	Not Known		↑ ↓ ↔	Local systems to be developed by MHLD CCG to capture and monitor this data.
% of staff latex risk assessments in place		Not Known	Not Known	Not Known		↑ ↓ ↔	
% of risk assessments in place for use of sharps without safety devices		Not Known	Not Known	Not Known		↑ ↓ ↔	
% of Pregnancy Care Plan Form 1s in place		Not Known	Not Known	Not Known		↑ ↓ ↔	
% of Pregnancy Care Plan Form 2s in place		Not Known	Not Known	Not Known		↑ ↓ ↔	
Number of redundant outlets		Not Known	Not Known	Not Known		↑ ↓ ↔	Data held is qualitative and not split by CCG - Any concerns will be escalated via the Water Safety Group at the Health and Safety Compliance Group.
% flushing regimes completed as scheduled		Not Known	Not Known	Not Known		↑ ↓ ↔	
% compliance with water cooler cleaning checks (where applicable)		Not Known	Not Known	Not Known		↑ ↓ ↔	
% RRP training compliance - Overall	85%	81%	81%	81%	85%	↔	
% RRP training compliance breakdown - MHLD: • Morlais • LSU • St Caradog • PICU • Bryngofal • Begelly • Enlli • St Non • Bryngolau	85%	 97% 72% 75% 73% 88% 87% 78% 88% 64%	 100% 57% 82% 84% 93% 87% 35% 77% 51%	 100% 78% 60% 97% 94% 100% 40% 77% 80%	85%	 ↑ ↑ ↓ ↑ ↑ ↑ ↑ ↔ ↑	
Number of CCG RRP incidents reported (On Datix, in the 'Restrictive Practices' category)	N/A	18	40	36	N/A	↓	Review of these areas needed to ensure linked to datix incidents.
Number of MHLD RRP incidents reported (Figures collated by RRP Team)	N/A	43	61	39	N/A	↓	
Number of RRP incidents with lawful justification (MHA)	N/A	Not Available	Not Available	37	N/A	↔	
Number of RRP incidents with lawful justification (MCA/DoLS/Common Law)	N/A	Not Available	Not Available	<5	N/A	↔	
Number of RRP incidents with lawful justification not recorded	0	Not Available	Not Available	<5	0	↔	
Number of RRP incidents (female)	N/A	Not Available	Not Available	11	N/A	↔	
Number of RRP incidents (male)	N/A	Not Available	Not Available	28	N/A	↔	
Number of RRP incidents (trans/non-binary)	N/A	Not Available	Not Available	0	N/A	↔	
Number of RRP incidents (gender not recorded)	N/A	Not Available	Not Available	0	N/A	↔	
Total time duration of all RRP incidents	N/A	Not Available	Not Available	175 mins	N/A	↔	
Average time duration of RRP incidents	N/A	Not Available	Not Available	4m 29s	N/A	↔	
% of Ligature Audits / Risk Assessments in date - Inpatient MH	100%	Not Available	Not Available	88.9%	100%	↔	
% of Ligature Audits / Risk Assessments in date - Inpatient LD	100%	Not Available	Not Available	100.0%	100%	↔	
% of Ligature Audits / Risk Assessments in date - Outpatient MHLD	100%	Not Available	Not Available	72.4%	100%	↔	

3.2

11:00 AM, 10 Mins

3.2 - Community and Integrated Medicine

Gareth Cottrell (Hywel Dda UHB - Deputy Chief Operating Officer), Anna Chiffi (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality)

For assurance

Attachments
Health Safety SBAR CIM June26.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	07 July 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Community and Integrated Medicine Clinical Care Groups Health & Safety Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Peter Skitt, Clinical Care Group Service Director
SWYDDOG ADRODD: REPORTING OFFICER:	Anna Chiffi, Assistant Director of Nursing, Patient Safety, Quality

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 the Committee with an overview of Community & Integrated Medicine (CIM) performance against statutory health and safety requirements, informed by the June 2026 metrics dataset. It highlights areas of improving performance alongside emerging risks and limitations in reporting capability that impact the organisation's ability to provide full assurance.

The Committee is asked to take assurance on the current position, recognising both areas of progress and those requiring further strengthening, particularly in relation to incident trends, workforce safety, and governance oversight.

Cefndir / Background

The Health Board is required to demonstrate compliance with a range of statutory frameworks, including the Management of Health and Safety at Work Regulations, Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), Control of Substances Hazardous to Health (COSHH), Manual Handling Regulations, and Violence & Aggression arrangements. The monthly reporting dataset provides an overview of compliance across these domains, including incident reporting, workforce training, and risk controls.

The data also reflects the current maturity of reporting systems. There are known limitations in the ability to extract and align data across systems such as Datix and Electronic Staff Record (ESR), resulting in gaps where compliance cannot be fully evidenced. As a result, some areas are reported as non-compliant or unquantifiable, and require narrative escalation and ongoing development to strengthen assurance

Asesiad / Assessment

The overall incident profile demonstrates a continued increase in reporting activity across the period, with both total incidents and the rate per 100 staff rising month on month. While this indicates sustained exposure to operational risk, it also provides positive assurance that

reporting culture is strengthening, with staff increasingly confident to report incidents, enabling better visibility of risk and opportunity for learning.

There are specific areas of concern where incident trends are increasing. Violence and aggression incidents have risen, alongside an increase in needlestick injuries and restrictive practice-related incidents. These trends represent direct risks to workforce safety and require sustained focus on preventative measures. However, there is assurance in the organisation's ability to identify, track and respond to these risks through established Datix reporting mechanisms and escalation processes, ensuring that incidents are visible and subject to governance oversight.

There are also areas demonstrating improvement. Manual handling incidents have reduced following a peak, and slips, trips and falls incidents show a downward trend. In addition, compliance with RIDDOR reporting timescales has improved, despite static numbers of reportable incidents. This provides clear assurance of strengthening regulatory compliance and improved responsiveness in statutory reporting, indicating that improvement actions in this area are having a positive effect.

Governance and oversight present a more mixed position. There is an increasing number of incidents awaiting review beyond 30 days and a sustained backlog of outstanding actions from internal health and safety inspections. This reflects a reduced level of grip in parts of the system and introduces a risk that learning is not consistently translated into timely improvement. Notwithstanding this, there is assurance that no catastrophic risks are currently identified through inspection processes, and that action tracking systems are in place, albeit requiring strengthening to improve timeliness and completion rates.

Workforce training compliance continues to provide a mixed level of assurance. Overall health and safety training compliance remains above interim targets, although it is showing a downward trend. Manual handling compliance remains below target across both Level 1 and Level 2, while violence and aggression training compliance remains high but slightly declining. Display Screen Equipment (DSE) compliance continues to remain stable and above target. This provides partial assurance that core safety training frameworks are in place and largely embedded and highlights the need for renewed focus on compliance in high-risk training areas linked to incident prevention.

A consistent and material issue within the dataset is the limitation in reporting capability, which impacts the overall assurance position. Several key indicators, including overdue Datix actions and compliance with a range of risk assessments, cannot currently be quantified. Additionally, data relating to health and safety-related sickness absence and manager induction compliance is not available within the current reporting framework. This limits the organisation's ability to demonstrate comprehensive assurance. However, there is assurance that these gaps have been identified and are being progressed through system development and improved data alignment, including work to strengthen integration between reporting systems and the development of future metrics.

Overall, the position indicates a developing assurance landscape, with evidence of improvement alongside areas requiring continued focus. There is clear evidence of a strengthening reporting culture, improving compliance in specific regulatory areas, and established governance frameworks. However, this is balanced by increasing incident trends in key risk areas, backlogs in review and action management processes, and continued limitations in data maturity. These factors require sustained executive oversight and targeted improvement to ensure that risks are effectively mitigated and that full assurance can be demonstrated to the Committee.

Argymhelliad / Recommendation

The Committee is asked to:

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

- **Note** the continuation of the improvement programme, recognising the focus on strengthening Datix governance and oversight, enhancing workforce training compliance, and improving the maturity and alignment of reporting systems.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.3 Receive bi-annual assurance reports from each Clinical Care Group Service Director on their individual Clinical Care Group health and safety arrangements.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are 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:	Contained withing the body of the report.

Rhestr Termau: Glossary of Terms:	Contained withing 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:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable

Cydraddoldeb: Equality:	Not Applicable

4

11:10 AM, 0 Mins

4 - Policies

4.1

11:10 AM, 10 Mins

4.1 - Major Incident Plan

Sam Hussell (Head of Health Emergency Planning)

For approval

Attachments

SBAR for H_S Committee July 2026.pdf
HDUHB MIP 2026-27 DRAFT v1.pdf

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	07 July 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Major Incident Plan
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)

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 Health & Safety Committee is asked to review and approve the revised Major Incident Plan (MIP) 2026/27 for Hywel Dda University Health Board.

The plan supersedes the 2025/26 version and sets out the organisation-wide framework for responding to major incidents across Carmarthenshire, Ceredigion, and Pembrokeshire. The updated plan has been developed through multi-agency consultation and reflects current statutory guidance and evolving operational requirements.

Cefndir / Background

The Civil Contingencies Act 2004 provides a framework for integrated emergency management to ensure civil protection across the U.K. Hywel Dda University Health Board (UHB) is classed as a Category 1 Responder under the Act. This means that in partnership with the Local Authorities, Emergency Services, Natural Resources Wales and other health bodies, the UHB is part of the first line of response in any emergency affecting its population.

The Health Board is required under the Act to undertake risk assessments and produce emergency plans. Additionally, within the Welsh Government's Emergency Planning Core Guidance 2015, Health Boards are required to have up to date plans to deal with major incidents and emergency situations that are compliant and tested, in accordance with national guidance.

The annual review process has been undertaken via the EPRR Group which has involved multi-disciplinary and partner agency participation. Consultation of the revised plan has been undertaken with partner agencies

The plan:

- Provides the overarching structure for command, control, and coordination during major incidents
- Is aligned with Dyfed Powys Local Resilience Forum (LRF) arrangements

- Is supported by hospital site-specific plans, action cards, and business continuity arrangements

The plan has also been informed by recent exercises (e.g. Exercise Tendley, Clinical Capacity Group Activation Exercises, South Wales Trauma Network (SWTN) Major Incident Exercise), relevant incidents (e.g. Powys Rail Collision) and national inquiries (e.g. Manchester Arena Inquiry, Hillsborough Inquiry)

Asesiad / Assessment

The 2026/27 revision represents a strengthening of operational, governance, and multi-agency interoperability arrangements, with the following material updates:

1. Revised activation process and dedicated Switchboard update.
2. Update to scene management and pre-hospital approach, utilising Ten Second Triage and Major Incident Triage Tool.
3. Amended details within the Management of Burns section, embedding latest position and linking to Swansea Bay University Health Board (SBUHB) Burns Services and access to the Burns network.
4. Formal inclusion of the Clinical Capacity Group as a core mechanism during major and mass casualty incidents, providing real-time NHS Wales-wide situational awareness and capacity management, including casualty dispersal decision-making
5. Alignment with NHS Wales Mass Casualty Arrangements (v5, Oct 2025) – highlighting strengthened integration with SWTN, national casualty dispersal processes and escalation from major incident to mass casualty event.

Argymhelliad / Recommendation

The Committee is asked to approve the Major Incident Plan for onward ratification by the Board on 30 July 2026.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	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.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
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)	3. Effective Care 4. Dignified Care

Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Striving to deliver and develop excellent services
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:	Civil Contingencies Act (2004) NHS Wales Emergency Planning Guidance (2015)
Rhestr Termau: Glossary of Terms:	Contained within the Major Incident Plan
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd Iechyd a Diogelwch: Parties / Committees consulted prior to Health and Safety Committee:	• EPRR Group • NHS Wales Performance & Improvement • Welsh Ambulance Services Trust (WAST) • Executive Director with lead for EPRR • Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The main costs associated with the Emergency Planning agenda are staffing; training; exercising and equipment.
Ansawdd / Gofal Claf: Quality / Patient Care:	Major Incident Plan revised with relevant multi-professional input across the sites.
Gweithlu: Workforce:	On-going training issues form part of the UHB's Civil Contingencies Act preparedness and subsequent exercises test its response, plans and communication systems.
Risg: Risk:	The whole Emergency Planning agenda is based on risk and taking every practical step to mitigate against the risk of an event occurring. Identification of the highest risks, and development of plans and procedures to address and respond to them places the Health Board in a better state of preparedness.

Cyfreithiol: **Legal:**	The Major Incident Plan forms part of our response to the requirements of the Civil Contingencies Act and our duty as a Category One responder under the Act.
Enw Da: **Reputational:**	Potential. The Major Incident Plan demonstrates our level of preparedness to respond effectively to a major incident event and safeguard the reputation of the organisation.
Gyfrinachedd: **Privacy:**	No issues identified.
Cydraddoldeb: **Equality:**	Impact Assessment with no negative impacts identified.

MAJOR INCIDENT PLAN 2026/27

Carmarthenshire, Ceredigion & Pembrokeshire

Plan information:

Supersedes: MIP 2025/26
Version number: MIP 2026/2027

Approval information:

Endorsed by Executive Team (XXXX)
Approved by Health & Safety Committee (XXXX)
Recommended by Board: (XXXX)
Date of approval:
Date made active:
Review date: July 2027

Summary of document:

An operational plan that details the Hywel Dda University Health Board response to a major incident event. This plan has been prepared in consultation with Dyfed Powys LRF partner health agencies, and in accordance with the Civil Contingencies Act (2004), NHS Wales Emergency Planning Guidance (2015), Medical Care at the Scene of Major Incidents (2010), Guidance on Access to UK Reserve Stock for Major Incidents (2024) and other related guidance.

Scope:

Organisation wide

To be read in conjunction with:

Major Incident Plan Action Cards (opens in a new tab)
Business Continuity Plans
Departmental Major Incident Plans
Dyfed Powys LRF Joint Major Incident Procedures Manual
Mass Casualty Arrangements for NHS Wales v5

Owning group:

Emergency Preparedness, Resilience & Response (EPRR) Group → Formal Executive Team (XXXX) → Health & Safety Committee (XXXXX) → Board (XXXX)

Executive Director job title:
Executive Director of Public Health

Reviews and updates:
2015/2016 – approved 28.05.2015
2016/2017 – approved 02.06.2016
2017/2018 – approved 27.07.2017
2018/2019 – approved 27.09.2018
2019/2020 – approved 26.09.2019
2022/2023 – approved 28.07.2022
2023/2024 – approved 27.07.2023
2024/2025 – approved 25.07.2024
2025/2026 – approved 31.07.2025
2026/2027 – approved XXXX

Keywords:
Major Incident, Civil Contingencies, Emergency Planning, Lockdown, Mass Casualties

CONTENTS

STOP

IF THIS IS A MAJOR INCIDENT SITUATION AND YOU HAVE NOT READ THIS DOCUMENT…

DO NOT READ IT NOW!

- **IF YOU ARE IN THE HOSPITAL, REPORT TO YOUR NORMAL WORK AREA AND CONTACT YOUR MANAGER**
- **IF YOU ARE REPORTING FROM A CALL-IN, REPORT TO YOUR NORMAL WORK AREA, UNLESS YOU ARE A KEY MANAGER, IN WHICH CASE REPORT TO THE HOSPITAL CO-ORDINATION CENTRE**
- **REFER TO YOUR ACTION CARD AND BE PREPARED TO BE RE-DEPLOYED IF NECESSARY**
- **UNDERTAKE ASSIGNED DUTIES OR READ THE CARD AND IMPLEMENT THE ACTIONS**

STATEMENT ON HEALTH AND SAFETY

In a major incident it is very easy to become absorbed by the events unfolding around you and to forget that the usual rules and regulations regarding health and safety still apply.

It is essential that these regulations are observed during a major incident and that the same thought processes with regard to risk assessment and management are adhered to in the same manner as any other task during the working day.

Appropriate personal protection equipment - PPE (opens in a new tab) and procedures will be provided, and must be used and followed, as must the Health Board's Policy and Procedures for issues such as responding to an infectious disease emergency, infection control, manual handling or the safe use of hazardous substances. As with any other task, if you are unsure of anything during a major incident seek advice from the nearest appropriate person.

INTRODUCTION

The Civil Contingencies Act (2004) defines a Major Incident as:
'An event or situation which threatens serious damage to human welfare in a place in the UK, war or terrorism which threatens serious damage to the security of the UK.'

(Ref: Civil Contingencies Act, 2004)

Within the NHS:
'Any occurrence that presents a serious threat to the health of the community, disruption to the service or causes, or is likely to cause, such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance trusts or primary care organisations'.

(Ref: NHS Wales Emergency Planning Guidance 2015)

At Hywel Dda University Health Board, responsibility for amending, updating, and testing the Major Incident Plan has been delegated by the Chief Executive to the Executive Director of Public Health and the Head of Emergency Preparedness, Resilience & Response (EPRR), together with the EPRR Group.

This Plan has been prepared in consultation with Dyfed Powys Local Resilience Forum (DPLRF) partner agencies and reviewed by the NHS Executive. It is only a guide and those NHS personnel on duty at the time of an incident should use their discretion regarding any need for which provision has not been made.

This Plan should be read in conjunction with the Health Boards' current Risk Management, Health, Safety and Environment Protection Strategy and relevant Business Continuity Plans. Additionally, many departments have well developed major incident response plans specific to their service, which will be activated in conjunction with this over-arching major incident plan. External risks, as identified in the Wales Risk and Preparedness Register and the Dyfed Powys LRF Community Risk Register (dplrf-crr---english.pdf (dyfed-powys.police.uk)) have also been considered in the development of the Health Boards' major incident preparedness and response. Specific Welsh Government guidance is also available on a range of issues to support a major incident response and should also be consulted where appropriate. The Welsh Government, in conjunction with the Department for Health and other UK Health Departments, has established a UK stockpile of health countermeasures for use in the event of a deliberate or accidental release of chemical, biological, radioactive, or nuclear materials. The "Access to CBRN Health Countermeasures" protocol is held in the Hospital Co-ordination Centre(s) and by the Medical Controllers and Head of Medicines Management.

Departments should review their Action Cards at regular intervals and new personnel must be made aware of the existence of such plans, and their roles and responsibilities within them. Any suggested amendments to this Plan should be made by staff to the Head of EPRR. Action cards are "live" documents and will be amended as necessary to ensure validity, and are available on the EPRR Intranet Page.

As a minimum requirement, the Health Board is required to undertake:

- A 'live' exercise every three years
- A 'table-top' exercise every year
- A 'communications' exercise every six months

(Ref: NHS Wales Emergency Planning Guidance 2015)

A training and exercising programme has been developed to assist with the development and roll out of appropriate training opportunities to support a resilient and robust major incident response.

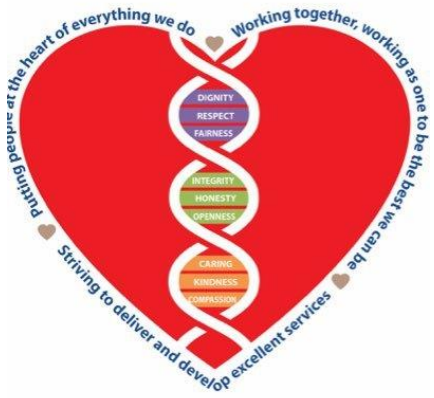
Recommendations and lessons identified from a range of incidents, public inquiries and debriefs have also been reflected within the plan (for example: RAAC Internal Major Incident 2023/4; Hillsborough Inquiry; Withybush Internal Incident June 2023, Health Prepared Wales, Exercise Red Kite, Exercise Celtic Consolidation, Kerslake Report, Manchester Arena Inquiry, Powys Train Crash 2024 and Exercise Tendley 2025).

AIM

The aim of the Major Incident Plan is to save life and mitigate injury in circumstances where routine services may prove inadequate and to provide co-ordination to ensure that limited resources are deployed most effectively.

This Plan is based on the use of Glangwili Hospital (as a designated Trauma Unit) and Withybush & Bronglais Hospital (as designated Rural Trauma Facilities). Prince Phillip Hospital will act in a supporting role during a major incident. All the facilities of the Health Service would be available in the event of a Major Incident. If the number of casualties exceeds the available capacity at the time, it may be necessary, in order to release beds, to call other hospitals to assist by accepting casualties from the incident and/or patients transferred from these hospitals. Equally, the Health Board may assist neighbouring Health Boards in responding to incidents that do not originate within the Hywel Dda catchment area. All major incident notifications will be communicated to all Health Boards by WAST (where there are casualties involved) to enable the Major Trauma Network model of casualty dispersal to be activated.

The Major Incident Plan has been developed, incorporating the organisation's values at the core of the response.



Additionally, the Charter for Families Bereaved by Public Tragedy developed following the Hillsborough Disaster to ensure the lessons of the disaster and its aftermath, from the perspective of the bereaved families was not lost, was signed up to by the Health Board in 2021 and who reaffirmed its commitment to the Charter in 2025. The Health Board agreed to adopt the principles below and supports staff to strive towards:

1. In the event of a public tragedy, support the activation of emergency plans and deployment of resources to rescue victims, to support the bereaved and to protect the vulnerable.
2. Place the public interest above our own reputations.
3. Approach forms of public scrutiny – including public inquiries and inquests – with candour, in an open, honest, and transparent way, making full disclosure of relevant documents, material and facts. Our objective is to assist the search for the truth. We accept that we should learn from the findings of external scrutiny and from past mistakes.
4. Avoid seeking to defend the indefensible or to dismiss or disparage those who may have suffered where we have fallen short.

5. Ensure all members of staff treat members of the public and each other with mutual respect and with courtesy. Where we fall short, we should apologise straightforwardly and genuinely.
6. Recognise that we are accountable and open to challenge. We will ensure that processes are in place to allow the public to hold us to account for the work we do and for the way in which we do it. We do not knowingly mislead the public or the media.

COMMAND AND CONTROL

During a Major Incident, Hywel Dda University Health Board will participate in the multi-agency hierarchical framework known as "Command and Control". The process for the activation of these structures is detailed in the Dyfed Powys Local Resilience Forum's Emergency Command Protocol. This framework works on the basis of three levels of response:

- Strategic (also known as Gold)
- Tactical (also known as Silver)
- Operational (also known as Bronze)

Strategic Co-ordinating Group (Multi-Agency Gold)

This multi-agency Director level group will meet either virtually (using MS Teams) and/or at the Strategic Co-ordination Centre in Police HQ, Llangunnor, Carmarthen. The group will initially be led by the Police Gold Commander, but depending on the type of incident, the chair may move to another agency. The group will make the strategic level decisions relating to the incident (i.e. what is to be done). For Hywel Dda, the Gold on-call will attend with EPRR and Loggist support. Welsh Government will also be notified of any SCG activation in response to a major Incident.

Health Board Gold (Strategic) Response

Dependent upon the nature of the incident, and in addition to a Strategic Co-ordinating Group, an internal Gold (Strategic) Group may be convened if necessary. The decision to convene a Health Board Gold Command will be made by the Gold on-call at the time of the incident and following a review of the incident details. The aim of the group will be to provide the strategic management and co-ordination of Health Board resources during the emergency by ensuring secondary, community and primary care service delivery for both the incident and for normal operational delivery. The Gold (Strategic Group) would consist of the Gold on-call together with members of the Executive Team, EPRR, Loggist, and a Communications Team representative, together with any additional personnel as requested at the time.

The Gold (Strategic) Group would be based in Corporate Offices, Block C, Government Buildings, Picton Terrace, Carmarthen, but meetings may also be convened utilising MS Teams.

Tactical Co-ordinating Group (Multi-Agency Silver)

This multi-agency Senior Manager level group is responsible for formulating the tactics to be adopted by their organisation to achieve the desired goal (i.e. how to do it). Silver should not become personally involved with activities close to the incident but remain detached. These meetings will normally be located in the County Police Stations, but other venues may also be utilised if more appropriate. Meetings may also be convened virtually via MS Teams. For Hywel Dda, the Gold on-call will task an appropriate Executive Director/Senior Manager with attendance at this group.

Health Board Silver (Tactical) Response

The Health Board Silver Command will provide the tactical management and co-ordination of resources (including staff) during the emergency by directing secondary, community and primary care services. Based in the Hospital Co-ordination Centre(s), and activated on receipt of a declared major incident with casualties, this team will comprise of:

- System General Manager or on-call
- System Head of Nursing or Deputy
- Hospital Clinical Lead or Deputy
- Clinical Site Lead/Manager
- Loggist
- Additional managerial, nursing, support & administrative staff as required
- HALCO (Hospital Ambulance Liaison Control Officer) – activated by WAST

The Hospital Co-ordination Centre at Glangwili Hospital will act as the lead HCC for ensuring Health Board wide co-ordination of the response. The Carmarthenshire System General Manager (or deputy) will convene a multi-site Teams call immediately following receipt of the major incident declaration to provide a system wide approach to casualty allocation and receipt, repatriation of patients, possible medical and surgical diverts and if required temporary boundary changes. Information and updates will also be provided to the Gold (Strategic) Group (if activated), or relevant members of the Executive Team/Gold on-call as appropriate.

The Hospital Co-ordination Centre will endeavour to maintain and support routine services throughout the incident whilst promoting a rapid return to normal service where possible.

Operational Response (Multi-Agency Bronze)

The Operational response (Bronze) refers to those who provide the main ‘hands on’ response to an incident, at the scene, implementing the tactics defined by the Tactical Co-ordination Group (Silver).

Health Board Operational (Bronze) Response

For Hywel Dda, the Bronze level response will mainly be provided on the acute hospital sites where the hospital has been designated as a “Receiving” or “Supporting” hospital. The Operational response is our front-line services which will be managed via the relevant Hospital Co-ordination Centre. Information/updates will be fed into the Hospital Co-ordination Centre(s) to ensure comprehensive situational awareness.

Joint Major Incident Procedures Manual

To complement, and inform the above structures, Dyfed Powys Local Resilience Forum has produced a guide that details the framework used to respond to, and manage, on a multi-agency basis, a major incident that occurs within or affects the Dyfed Powys Area. The manual describes the responses and responsibilities of key responders during a Major Incident and outlines how responding organisations will work in collaboration as part of a coherent multi-agency effort to coordinate the response, implement the measures necessary to control and contain an incident and protect people, emergency responders, and the environment from the effects of such an event.

TYPES OF INCIDENT

There are five types of incident which require varying levels of response, both by the Health Board, and by partner agencies.

Mass Casualty Incident – a much larger-scale event affecting significant numbers of casualties and potentially multiple scenes. These will require a collective response by NHS Wales organisations and potentially mutual aid from other UK (and wider) countries.

Major Incident – an occurrence that presents a serious threat to the health of the community, disruption to the service or causes, or is likely to cause such numbers or types of casualties as to require special arrangements to be implemented. Any agency can declare a major incident, and notification will be cascaded to all LRF partners via DPLRF (for all incidents) and from WAST (for incidents with casualties). A Health Board response will be required.

Internal Major Incident – a significant internal incident that requires the set-up of a Management Response Group together with a multi-agency response (e.g. large fire, flooding, large scale evacuation) and may also require additional resources to respond.

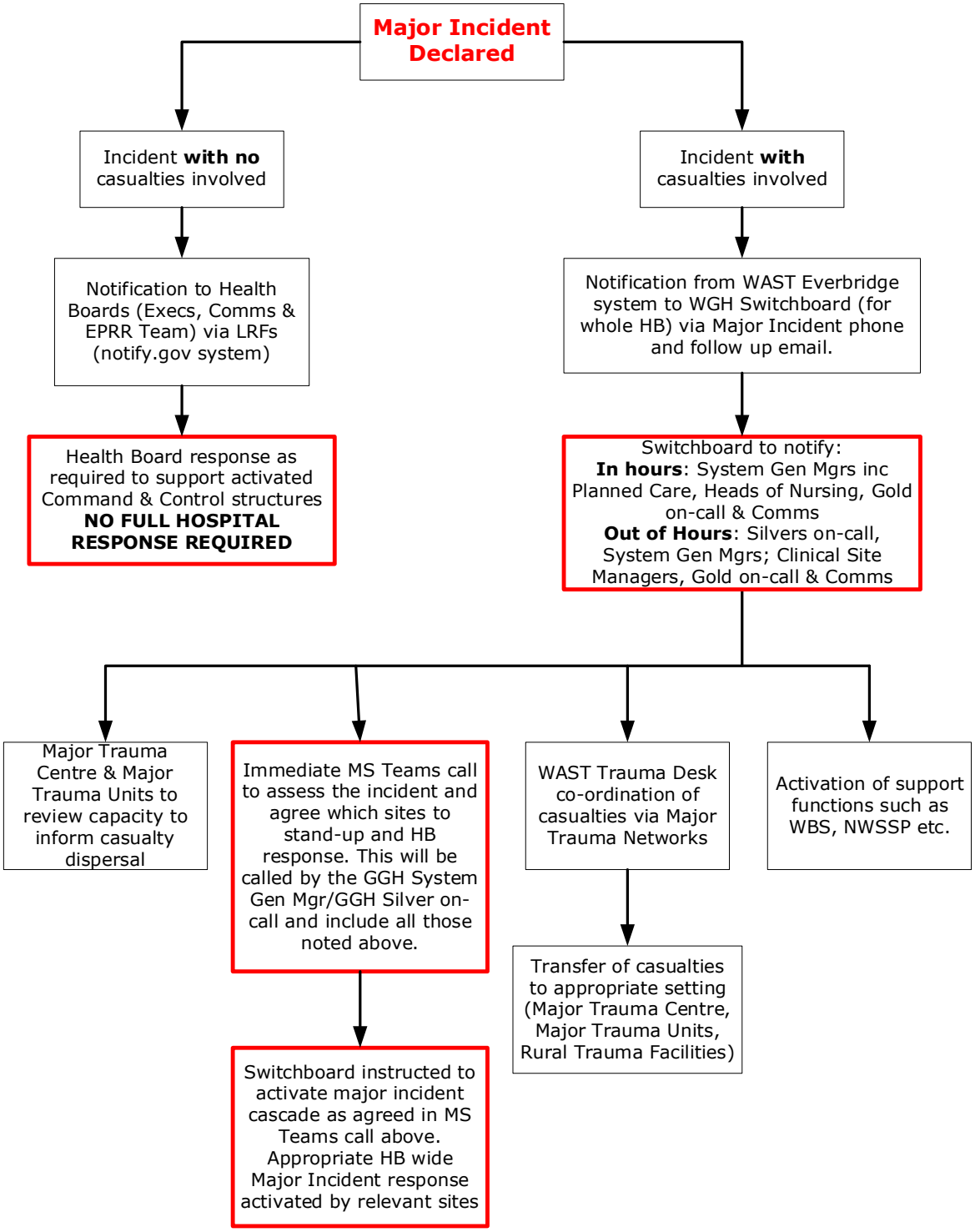
Internal Incident – a specific occurrence that requires the set-up of a Management Response Group to respond to, and co-ordinate the Health Board response, but that can be managed internally.

Business Continuity Incident – an occurrence that interrupts routine service delivery and requires a response to enable critical functions to the restored within maximum tolerable periods. Locally developed Business Continuity Plans will be activated to inform and support the response. For further details see Business Continuity Planning Policy (opens in a new tab).

ACTIVATION & RESPONSE PROCEDURES

A major incident notification is received in the following way:

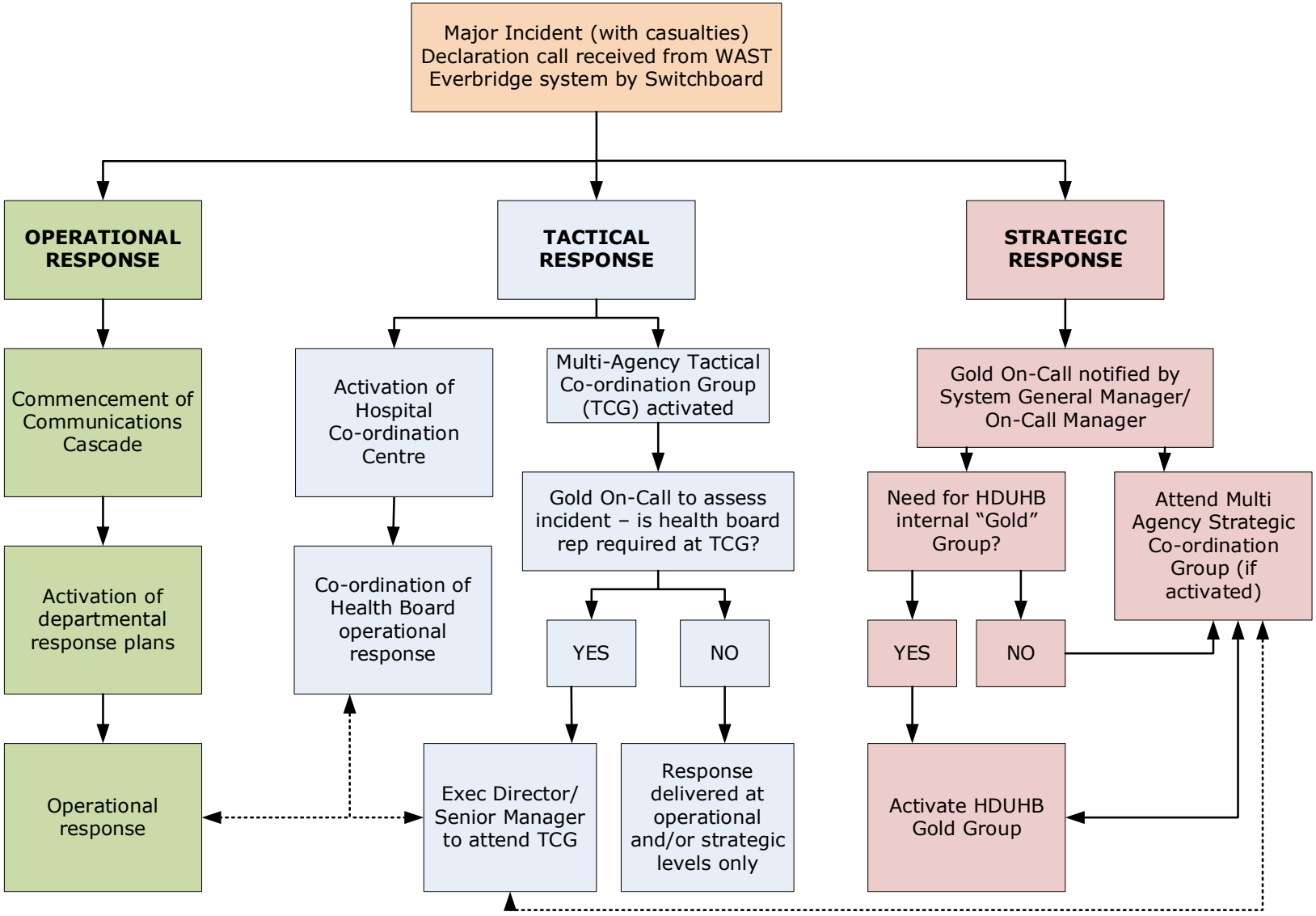
Major Incident Notification Process



* At the time of writing the WAST Trauma Desk only services the South Wales Trauma Network

Following receipt of the notification, and commencement of the hospital communications cascade, the following response is activated:

Major Incident with Casualties - Response Flowchart



ALERT LEVELS

There are five levels of alert:

1. **Major Incident Standby -** this is when the incident does not require an immediate response, but there is the potential for the incident to escalate and a decision will be made to send out a 'stand by alert' to the Health Board and the incident will be monitored and if necessary, a major incident can be declared.

2. **Major Incident Declared –** this is when the incident requires an immediate response, and the Health Board major incident plan is activated.

3. **Major Incident Declared: Mass Casualty Incident –** when the threshold of the mass casualty definition has obviously been met (where the number/type of casualties overwhelms the conventional major incident response) and the activation of the Mass Casualty Incident Arrangements for NHS Wales is required. Where there is uncertainty if the threshold for a mass casualty incident has been met, the incident will be declared as a major incident in the first instance and the threshold discussed at the Clinical Capacity Group that meets 30 minutes post incident declaration.

4. **Major Incident Cancelled –** Cancels either the first or second message.

5. **Major Incident Stand Down –** notifies us when an incident is over at scene. It is the responsibility of all responding agencies to determine when their organisation should stand down.

MAJOR INCIDENT - STANDBY

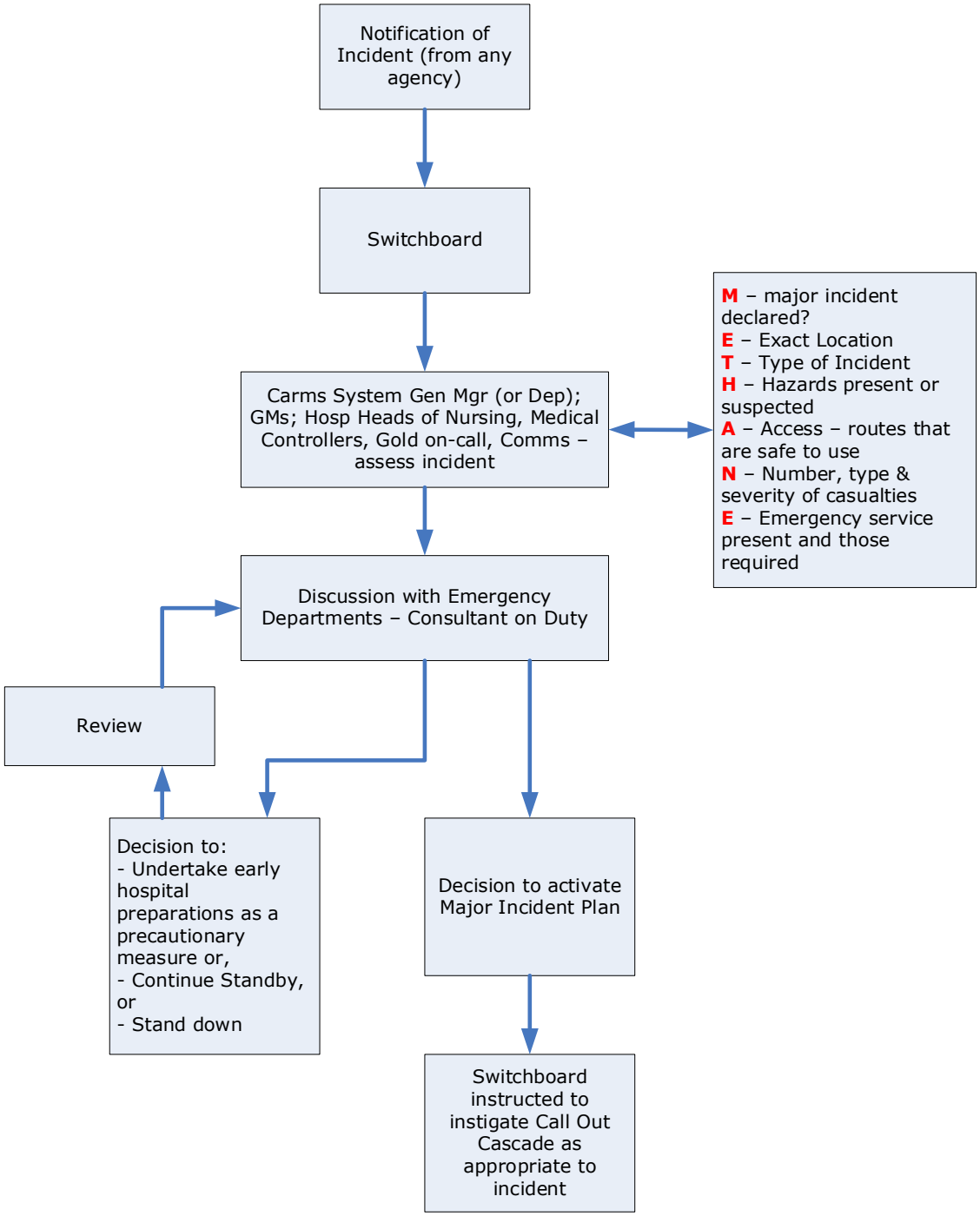
The decision on the action to be taken on a standby alert will vary depending on the incident location and whether the hospital is likely to be required as a receiving or supporting hospital.

In all cases, an initial limited response will be instigated i.e.

- Switchboard will notify:
    - System General Manager/On-Call Manager
    - System Head of Nursing/deputy (Nurse Controller)
    - Hospital Clinical Lead/deputy (Medical Controller)
    - Clinical Site Lead/Manager

Who will:

- The General Manager – Carmarthenshire System (or deputy) will call an immediate Teams call to assess the incident and agree early preparations. Participants will include Community & Integrated Medicine System General Managers, System Heads of Nursing, Medical Controllers, Gold on-call and Communications Director (or deputies, depending on the time of day).
- Consider the need to establish a Hospital Co-ordination Centre (H.C.C.)
- Establish the current bed state.
- If required, instigate commencement of the Call Out Cascade – this will be decided by the above group following liaison with the Emergency Dept/Unit Consultant on duty.
- Switchboard will await this decision and further instruction before commencement of the full cascade.



HOSPITAL CO-ORDINATION CENTRES

With a Major Incident, there will be a need to ensure a co-ordinated approach to on-going service provision. The Health Board will need to ensure that key decisions are made by a group of managers and staff with the necessary skills and authority. The core group will co-opt other managers and staff dependant on the type and scale of the emergency.

Key functions:

1. Ensure a co-ordinated response to emergencies by all departments and services.
2. Ensure communications with tactical and strategic co-ordination groups, emergency and other health agencies is timely, accurate and managed.
3. Ensure all resources & equipment (phones, radios, emails, runners etc.) are utilised in the most effective and productive way in terms of the ongoing emergency.

4. Ensure that all emerging risks to safe service delivery and health and safety are identified and managed within the available resources including:
    - Staff
    - Patients
    - Public
    - Other agencies
5. Ensure that all staff are briefed with timely and accurate information regularly.

The core membership should include:

- System Head of Nursing or Deputy
- System General Manager or on-call
- Hospital Clinical Lead or Deputy
- Clinical Site Lead/Manager
- Clinical Leads/on call consultant as appropriate.
- Other Service Leads as required
- WAST Hospital Ambulance Liaison Control Officer (HALCO) *[activated by WAST]*

MAJOR INCIDENT DECLARED

This section details the actions that the hospital is required to take in the event of a major incident being declared. Upon receipt of the declaration call from WAST, Switchboard will print out the Everbridge Notification email, which will detail the METHANE information.

M	Major Incident declared? Yes/No
E	Exact Location
T	Type of Incident
H	Hazards present or suspected
A	Access - routes that are safe to use
N	Number, type & severity of casualties
E	Emergency services present and those required

Initial notification details of the casualties may be very scant but further details will become available as the Ambulance Service make an assessment at the scene.
The telephonist's next action is to call for assistance at the hospital switchboard, and commence the communications cascade to alert staff, stating:

*Switchboard at Withybush Hospital here, a Major Incident has occurred. This is not an exercise. I repeat **NOT** an exercise. Report to your place of duty in the Major Incident Plan, informing the Hospital Co-ordination Centre of your arrival, and follow the instructions on your Major Incident Action Card. You should attend in uniform and/or carry hospital identification.*

MAJOR INCIDENT STAND-DOWN AND ASSOCIATED FUNCTIONS

When all live casualties have been evacuated from the Incident Site, the emergency services will agree the Site Incident Stand Down. The Ambulance Service will notify the designated and supporting hospitals of the Site Incident Stand Down. Where possible, the Ambulance Incident

Officer will make it clear whether any casualties are still en-route. However, the Medical Controller in the Hospital Co-ordination Centre will decide whether it is appropriate for the hospital to go to Stand Down at this time, or at a later stage. The Medical Controller will ensure that the stand-down message is communicated to all Departments when appropriate. Consideration should be given however to the potential for a further influx of incident related casualties to self-present in subsequent days (as experienced in previous incidents). This should be reflected in staffing numbers and response arrangements.

THE CLINICAL CAPACITY GROUP is a scalable group that is established for a declared major incident/ mass casualty incident, to provide a real time conduit between NHS Wales organisations, to share situational awareness on casualty numbers and priorities and map these against appropriate hospital capacity across NHS Wales and beyond.

Chaired by the EMRTS Strategic Medial Advisor, the Clinical Capacity Group will establish capacity at each potential receiving hospital and ensure that the appropriate networks are involved in the conversation.

Upon declaration of a Mass Casualty/Major Incident and the invocation of this plan, appropriate representatives from all stakeholder organisations will join the Clinical Capacity Group through a virtual meeting link. The link is contained within the relevant key staff's Action Cards and also within the Mass Casualty Arrangements for NHS Wales.

The group will convene **30 minutes** after a declared mass casualty or major incident, to coordinate the response.

This group will be attended by staff from each area (WAST, HBs, WBS, NHS Wales Performance & Improvement, networks etc) who are empowered to make rapid decisions regarding capacity.

Once the picture is clear in terms of capacity, arrangements will be put in place to stand down the dispersal plan.

Where the Clinical Capacity Group has been set up to respond to a major incident, it will assess the incident and where appropriate escalate to a mass casualty incident if the triggers are met.

SCENE MANAGEMENT

The Welsh Ambulance Services University NHS Trust (WAST) will:

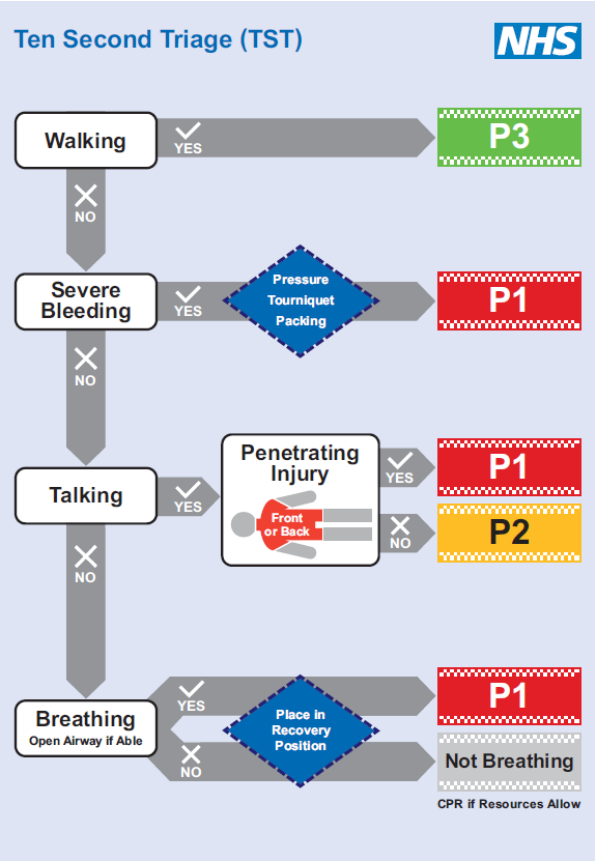
- Deploy the Pre-Determined Attendance (PDA) for the scale and nature of the emergency
- Alert the Emergency Medical Retrieval and Transfer Service (EMRTS), who will deploy critical care teams by air and road
- Initiate effective command arrangements and employ joint working principles, to save life and reduce harm, at operational, tactical and strategic command levels
- Work in partnership with EMRTS personnel who will undertake Medical Advisory roles at Strategic, Tactical and Operational command
- Prioritise the safety and wellbeing of the injured and survivors, emergency services and the general public affected by the incident
- Initiate and maintain effective communications at scene with other emergency services and responding partners, as well as the chain of command
- Warn and inform the public to reduce risk in conjunction with other responding partners
- Conduct an initial and ongoing assessment of the scene and communicate it effectively with other responding partners
- Perform initial triage – Ten Second Triage (TST) in conjunction with other emergency services and perform life-saving interventions (LSI's) to save lives and reduce harm
- Perform clinical triage using the Major Incident Triage Tool (MITT) to support ongoing patient management

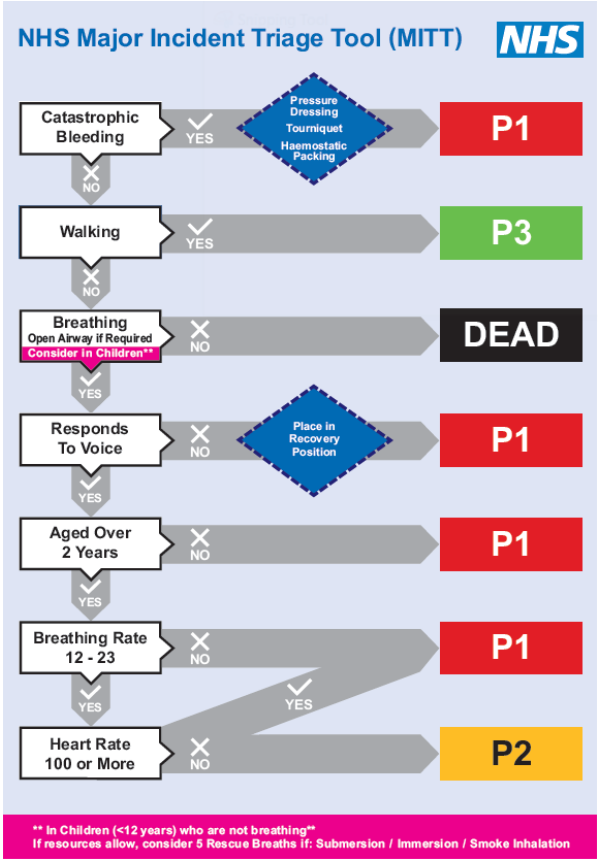
- Provide appropriate treatment in line with clinical guidelines and resource constraints
- Appropriately transport patients according to their clinical need and triage category (see below), in the most appropriate resource, to an appropriate treatment facility
- Provide NHS Wales partners and wider stakeholders with regular updates through the Clinical Capacity Group, that will convene within 30 minutes of a major incident declaration
- The Clinical Capacity Group will provide NHS Wales situational awareness and enable receiving facilities not required to support the response to stand down at the earliest opportunity

Triage:

Triage Priority	Order of Treatment	Description of Casualties Needs
P1	1st	**IMMEDIATE** – Severe injury or illness likely requiring immediate life saving clinical interventions.
P2	2nd	**URGENT** – Significant injury or illness likely requiring urgent clinical interventions in the next few hours
P3	3rd	**DELAYED** – Mild to moderate injury may or may not require clinical intervention but not on a time critical basis.
Not Breathing		Unconscious and not breathing - This triage category is temporary until re triage using MITT
Dead		No signs of life on clinical assessment.

Casualties will be triaged at the incident site utilising the major incident Ten Second Triage (TST) model together, where appropriate with the Major Incident Triage Tool (MITT). TST Tags and SMART cards are utilised for recording triage status and medical information/interventions.





WAST possesses a range of capabilities and resources that can be deployed to a major incident.

The PDA will include Strategic, Tactical and Operational Commanders, emergency ambulances, solo response vehicles (SRV's), Non-Emergency Patient Transport Service (NEPTS), Hazardous Area Response Team (HART), Specialist Operations Response Team (SORT) and specialist response assets, such as Mass Casualty Vehicles (MCV's), Incident Support Units (ISU's) and Chemical, Biological, Radiological and Nuclear (CBRN) ISU's

EMRTS will deploy critical care teams by air and land, who will also support WAST through providing medical advisors to all three command levels.

Major Trauma Network

The South Wales Trauma Network (SWTN) was launched in September 2021. Serving the population of South Wales, West Wales and South Powys, the network is made up of hospitals, emergency services and rehabilitation services across the region, working together to ensure patients with life-threatening or life-changing injuries receive the best possible treatment and care.

Within the network there is an Adult & Paediatric Major Trauma Centre (at the University Hospital of Wales, Cardiff) and the following:

Trauma Units:

- Morriston Hospital (with specialist services)
- Grange University Hospital
- Prince Charles Hospital
- Glangwili Hospital
- Royal Glamorgan Hospital

Local Emergency Hospitals/Rural Trauma Facilities:

- Withybush Hospital
- Bronglais Hospital
- Princess of Wales Hospital

An Operational Delivery Network and a Trauma Desk (hosted by WAST) based in Ambulance Control 24/7) together with a robust governance structure complete the network.

Decisions on casualty dispersal from the scene of a major incident will be taken in conjunction with the Medical Advisor following discussion with HBs at the Clinical Capacity Group SWTN to facilitate casualty transfer to the most appropriate facility.

HOSPITAL ARRANGMENTS

BLOOD

The Regional Blood Transfusion Centre in Cardiff has a Major Incident Procedure and will be informed of the major incident by WAST and may be requested to assist if required. The Consultant Haematologist will update the Blood Transfusion Centre in accordance with the Department's Action Card. Where appropriate the agreed Major Haemorrhage Protocol should be activated.

INTENSIVE CARE

The Adult Intensive Care Teams will make as many beds available as possible following arrangements detailed in their unit response plans and ensuring implementation of the All Wales Critical Care Escalation Guidance and Plans.

INFECTIOUS DISEASE EMERGENCIES

Arrangements will be made for suitable isolation facilities for self-referring infectious patients within the Emergency Department, as appropriate, following consultation with IP&C and Microbiology teams. This area will be identified at the time of the incident and according to numbers. This will link into Incident Management Team processes were appropriate.

VOLUNTARY AID SOCIETIES

The title "Voluntary Aid Society" is taken in this context to mean the British Red Cross, Cruse, League of Friends and St. Johns Ambulance Brigade, all of whom have skills and resources, which may be relevant to the health care and welfare of casualties.

If the Incident involves large numbers and/or is likely to be prolonged, the Voluntary Aid Societies can provide much valuable support to the Health Board. This support would be requested through the Hospital Control Centre and co-ordinated by the Partnerships, Diversity & Inclusion Team.

INCIDENT CARE TEAMS

Following a major incident involving Transport for Wales vehicles, an Incident Care Team may be deployed to provide logistical assistance to casualties involved. The Incident Care Teams will attend the scene and also follow up casualties at Survivor Reception Centres and in hospitals.

RELIGIOUS AND CULTURAL SENSITIVITY

The Health Boards response in a major incident must continue to respect the religious, ethnic, and cultural background of patients who may present for treatment. Staff should continue to display sensitivity in working with patients and their families in the event of a major incident.

The Chaplaincy Service can advise where required and has access to the regions Faith Communities Major Incident Response Plan. They will support the Health Board in responding in the most appropriate way to the distinctive needs of patients, carers, and staff. The Chaplaincy Service will be able to draw on multi-faith personnel to comply with and to consider the wide spiritual, religious, sacramental, ritual, and cultural requirements during, and after the incident. They offer full consideration to the needs, background, and traditions of those who practice a faith and people of no specified faith. Hospital Chaplains will report to the Hospital Control Centre where they will be deployed to either the Relatives' Reception Area or the Chapel.

INTERPRETATION AND TRANSLATION SERVICES

The Health Board will provide access to appropriate interpretation services to communicate effectively and safely with people who do not speak English. This can be accessed via the Partnerships, Diversity, and Inclusion Team.

STAFF WELFARE

Responding to incidents puts staff under more pressure than normal. It is therefore vital that staff welfare issues are given a high priority. In order to achieve this, those staff with management responsibility will ensure that the following issues are continually addressed:

- Health and safety
- The availability of food and other refreshments
- Working hours
- Rest breaks
- Travel arrangements
- Consideration of personal circumstances

- Emotional support during and after the incident including access to Staff Psychological Well Being Service

To assist staff in the response to an incident, regular briefings will be given by senior staff, particularly at the start of a shift at shift changes and handovers.

HEALTH AND SAFETY

A major incident may involve staff working in areas they are unfamiliar with. During the response to an incident, members of staff will not be expected to compromise their personal health and safety and the Health Boards' Health & Safety Policy (opens in a new tab) will continue to apply. Appropriate PPE will be provided to support this (including for CBRN incidents)

COMMUNICATIONS TEAM

In a multi-agency Major Incident, we have a duty under the Civil Contingencies Act to warn and inform the public. This not only protects the dissemination of accurate information (countering potential misinformation), but can be a tool for protecting lives, reducing harm and help manage the incident when live and in its aftermath.

The Communications Team will activate their departmental major incident plan that covers all elements of their response from multi-agency working, to media and social media monitoring and handling. They will be responsible for informing and advising all staff of the response level to the incident as well as key information relating to it, as appropriate and depending on the nature of the incident. This may require the development of communication materials including press statements, social media posts and internal messages via the intranet, all staff emails, Viva Engage, and pop-up desktop messaging as needed, as well as face to face briefings/printed materials, depending on the incident.

Staff, stakeholders, and the public will likely receive updated on the incident from social media. This information may be speculative and inaccurate. The communications team will also establish itself at the earliest opportunity as a trusted source of information on the incident, issuing timely statements or pointing to statements from the lead agency in the instance of a multi-agency response. This will need to be maintained through regular, sharing of information.

Any media calls received by Switchboard (9am-5pm Monday to Friday) should be re-directed to the dedicated communication/media line – 07464 523370 unless directed otherwise by the Communications Director. Out of hours, Switchboard can direct media enquiries through the Director of Communications and Engagement. A reactive statement will need to be drafted as soon as is practically possible so that there is a holding line, this should also help to prevent the dissemination of misinformation. If a spokesperson is required the Communications Team will be responsible for identifying this person, briefing them, and liaising with media outlets. To ensure consistency of messaging and alignment with official health board communication, members of Hywel Dda staff should not speak to the press or media during a major incident without the support and approval of a member of the Communications Team. The Communications Team will work in partnership with other agencies and agree the appropriate messaging and lead agency, depending upon the nature of the major incident.

Depending on the nature of the major incident, additional offline and local communication methods may be required e.g. posters, in-person staff briefings.

LOCKDOWN

A lockdown of individual buildings or a specific location may be required to either contain the major incident or prevent an external threat from gaining access to Health Board facilities. Lockdown can only be effective if is conducted quickly, either in response to a localised incident or intelligence

received. More information is contained within the Health Board Lockdown Policy (opens in a new tab).

For a localised lockdown to be effective, standard operating procedures need to be understood and practised by staff. Any decisions to lockdown should be taken by the Chief Operating Officer or Hospital Management Team. Factors to be included are Risk; Duration; Communication and Multi-agency involvement/liaison.

CHILDREN AND MAJOR INCIDENTS

Children have specific needs, both physiological and psychological. Advice and support must be obtained initially from the Nurse in Charge, Children's Ward/Unit and the Paediatric Consultant on call. A Senior Nurse/ Manager can be contacted through the Major Incident cascade process.

If children are uninjured but accompany casualties, support from the play leader/nursery nurse should be sought to minimise any distress experienced during the hospital episode. The child's GP/School Nurse/Health Visitor must be informed of any child involved in an incident.

In-patient children`s services are provided 24 hours a day in both Glangwili General Hospital, Carmarthen and Bronglais General Hospital, Aberystwyth. Where adults and children from the same family are involved in a major incident, and the facilities for adults and children are in separate hospitals, the following guidance should be used:

- If both adults and children are seriously injured, they may need to be taken to separate facilities, but a balance needs to be struck between the benefits to children of being kept close to their parents, and their distress at seeing severely injured patients.
- If adults are seriously injured, but children are uninjured or have only minor injuries, then the family should be taken to the hospital receiving the adults where arrangements for the care of the children should be made.
- If the children are seriously injured, but the adults uninjured or have only minor injuries, then the family should be taken to the children's hospital (Children's Hospital for Wales), where the adults can be treated and help in the children's care.

Dyfed Powys does not have a separate children's facility but with the use of the air ambulance the above separation may occur. Liaison should take place with the Ambulance Service and if separation has occurred non injured parties may require transport to the other sites. Appropriate transport should be arranged to facilitate this via local taxi firms, voluntary services etc. If transportation is inappropriate communication links should be established with the other sites so that family members can be kept informed.

MATERNITY SERVICES

Following assessment at the scene, any casualties that are pregnant and require further specialist maternity care will be prioritised and transferred directly to the Maternity Unit at Glangwili Hospital. Those casualties requiring emergency treatment as well as maternity care will be transferred to the Emergency Department where the Maternity Team will attend to provide care as appropriate.

POLICE HOSPITAL DOCUMENTATION TEAM

Depending on the scale and nature of the incident, a Police Documentation Team may be deployed to the Hospital(s). They will be established in one or more of the three rooms allocated for this purpose within the hospitals identified for Dyfed-Powys Police use, which are:

- Withybush: CCTV room/Police room, Reception Area, Emergency Department
- Glangwili: ED Seminar Room, Emergency Department

- Bronglais: CCTV room/Porter's room (rear of the Dining room)

The Police Documentation Team will pass generic casualty information electronically via the Police Holmes4 system to the Police Casualty Bureau which will be established at Police Headquarters, Carmarthen.

POLICE CASUALTY BUREAU

The Police Casualty Bureau information will be collated from the hospital and the general public. To assist this process, a unique Casualty Bureau telephone number and website address for the major incident public portal (https://mipp.police.uk/) will be publicised by the Police through the media for members of the public to enquire regarding their missing loved ones and provide information. This unique Police Casualty Bureau number will be issued as soon as practically possible during incidents.

The Police will refer all enquiries about the medical condition of identified casualties to the special ex-directory numbers at the relevant hospital. The Police have the responsibility for informing relatives of the location of their family member and will inform the next of kin of any deceased victim.

ARRANGEMENTS FOR VIP VISITS

In the event of a major incident occurring in the catchment area of the hospital, it is likely that a VIP (or VIPs) will ask to meet with casualties. The normal arrangements will be required (i.e. early notification to Director of Communication and Engagement and Assistant Director of Corporate Legal Services and Public Affairs who will liaise with the Police etc) as with any other visit. However, the hospital will be under abnormal operating pressure so consideration must be given to calling in additional staff in order to minimise the impact on operational services. A designated reception area will be identified area for any VIP(s).

Potentially, there will be a high level of media interest on such occasions. The Communications Team will deal with the media and will liaise with the Senior/On-Call Manager (as appropriate) in identifying support staff to undertake various duties in connection with the increased press and public interest.

General security matters will be dealt with by the Head of Hotel Services/Head Porter in liaison with the Security Advisor and Head of Health, Safety & Security together with the Police. As appropriate, the Police Press Officer will liaise with the Hywel Dda UHB Communications Teams in dealing with the press and media.

Post Incident Follow Up/Counselling Support For Patients/Relatives

For patients managed within the Emergency Department a copy of their patient notes will be sent to the patient's GP for appropriate follow up. This will include a letter informing the GP of the patients' involvement in the Major Incident. For in-patients, GP's will be notified via the patient's discharge letter.

C.A.L.L. Helpline

Community Advice and Listening Line offers emotional support and information/literature on Mental Health and related matters to the people of Wales. **C.A.L.L. Helpline** offers a confidential listening and support service 24 hours a day, 7 days per week:
Freephone: 0800 132 737 or Text 'help' to 81066
http://www.callhelpline.org.uk

Incident Debriefing

A hot de-brief will be held with the main responding staff within 48 hours of the end of the incident. A more inclusive debrief for staff will occur within two weeks, with the option of a follow-up if the team requests it. Debriefing not only gives people a chance to talk through their own emotional feelings but also helps staff to review the operational processes and check to see if any changes need to be made. It also enables recognition of a job well done.

The outcomes of the internal debrief are likely to be fed into a wider multi-agency debrief which will be facilitated by the Dyfed Powys Local Resilience Forum Partnership Team. Lessons learned/identified will inform future planning and highlight opportunities for future training and exercising.

Further guidance on supporting staff after a critical incident can be found on the Staff Psychological Well-Being Services pages on the Intranet. Managers needing additional advice can contact the Service directly.

If there is a need for any ongoing team or individual psychological support, this support can be obtained from the Staff Psychological Well-Being Service and/or Occupational Health Department

COMMUNITY INCIDENT

Hywel Dda Community staff may be involved in a Major Incident situation when the rest of the Health Board Major Incident Plan has not been invoked. A request may be received from the Local Authority Emergency Planning Team for health service support at uninjured Survivor Reception Centres and Evacuation Centres, e.g. a flooding incident or a large fire where there are no casualties, but local residents have been evacuated from their homes; or an evacuation of a Nursing / Residential Home.

In any community there are likely to be groups of vulnerable individuals. Information may be sought in relation to chronically ill patients and frail/disabled persons within a given community, where evacuation may be considered by the Police.

In particular, we may be called upon to provide:

- Nursing and Pharmacy support at Survivor Reception Centres and Rest Centres.
- Nursing support for patients discharged early.
- Assistance in the administration of vaccines and/or emergency antidotes.

Where the Hywel Dda Major Incident Plan has not been activated, activation of Community Services will be from the Local Authority Emergency Planning Team to the relevant Community Manager/on-call or relevant System Lead.

Pharmacy may be asked to also assist with the provision of medication in such an event and should be contacted via the Lead Pharmacist during office hours and via Switchboard out of hours.

CYBER INCIDENTS

Much work is currently being undertaken at national and local levels to respond to the increasing risk and levels of cyber-attack on public organisations. It is likely that in the future, cyber resilience and response will be aligned more with Civil Contingencies. Currently though, in the event of a cyber-attack within the Health Board, the technical response will be led by Digital Services whilst the service level response will be led from a business continuity perspective. However, if the impact is significant the Major Incident Plan and declaration of an Internal Incident could be activated to respond to the incident.

Further information is detailed in the Cyber Security Incident Response Plan which details the steps that should be taken in the event of an incident that may affect the confidentiality, integrity and availability of the Health Boards information and information processing assets. This should also be read in conjunction with Digital Health and Care Wales "NHS Wales Cyber Attack and ICT Incident Response Communications Framework" and "NHS Wales Cyber Incident Notification".

INTEROPERABILITY

Joint Emergency Services Interoperability Programme (JESIP)

In order to improve a multi-agency response JESIP establishes five principles which organisations need to be aware of, including:

1. Co-location of commanders as soon as practicable at a single, safe, and easily identified location near to the scene.
2. Communicate clearly using plain English.
3. Coordinate by agreeing the lead service. Identify priorities, resources and capabilities for an effective response, including the timings of further meetings.
4. Jointly understanding risk by sharing information about the likelihood and potential impacts of threats and hazards to agree potential control measures.
5. Establish shared situational awareness by using METHANE and the Joint Decision Model (JDM).

If the principles are followed then the result should be a jointly agreed working strategy where all parties understand what is going to happen when and by who, this strategy should include:

• **What** are the aims and objectives to be achieved?
• **Who by** – police, fire, ambulance and partner organisations?
• **When** – timescales, deadlines and milestones
• **Where** – what locations?
• **Why** – what is the rationale? Is this consistent with the overall strategic aims and objectives?
• **How** are these tasks going to be achieved?

Joint Decision Model (JDM)

The Joint Decision Model will be used by multi-agency partners and the Health Board Gold and Silver Commanders to ensure a consistent approach to assessing the situation and planning the response to an incident.

Gather Information and Intelligence	Assess Threats & Risks	Power & Policies	Identify Options and Contingencies	Action & Review
Defining the situation	**Assessing the situation**	**What is applicable to the situation**	**Consider options with least risk of harm**	**Make & implement action, then review**
What is happening? What do you know so far? What further information/ intelligence do you want/need?	Do you need to take action immediately? Do you need to seek more information? What could go wrong? What could go well? How probable is the risk of harm? How serious would it be? Is that level of risk acceptable? Is this a situation for the Health Board alone to deal with? Are you the appropriate person to deal with this? What are you trying to achieve? Develop a working strategy to guide subsequent stages.	What legislation applies? Does the Health Board have the power to initiate action? Is there any guidance covering this situation? Do any NHS, LRF or WG plans or guidance apply?	What options are open to you? Will the response be proportionate, legitimate and necessary? Will the response be reasonable in the circumstances facing you at the time? What will you do if things do not happen as anticipated?	Implement option selected Does anyone else need to know what you have decided? Record what you did and why Monitor What happened as a result of your decision? Was it what you wanted or expected to happen? Review your decisions using the JDM What lessons can you take from how things turned out? What might you so differently next time?

BUSINESS CONTINUITY

Business Continuity is a process which compliments the Major Incident Plan and extends beyond it. Business Continuity Management is an essential tool in establishing the organisation's resilience to maintain critical activities and provides a framework for identifying and managing risks that could disrupt normal service. It addresses potentially serious disruptions in the services provided by the Health Board that may not be of sufficiently high risk to trigger the Major Incident Plan.

Each service will have identified critical services within their Business Impact Analysis that must be maintained during a disruption or interruption.

Further information on dealing with a wide range of events can be found in Service level Business Continuity Plans.

Mutual Aid

Mutual Aid is an agreement to lend assistance across neighbouring boundaries and partner organisations. This may occur due to a significant incident response that exceeds local resources. It can involve offering resources to help support partners e.g. man-hours, materials etc. Prior to Mutual Aid being agreed, the Health Board will take reasonable appropriate steps to assess that all services and supplies are self-protected during a Major Incident or emergency. Depending on the circumstances, mutual aid can be requested directly with a partner agency, or via the Command and Controle structures of Dyfed Powys Local Resilience Forum.

RECORD KEEPING

Casualty Documentation

Documentation packs will be available at the Casualty Reception Area/Triage Points. Each pack contains an identity bracelet, a Police documentation form and a property bag, all uniquely numbered. These will be issued on triage and take precedence over existing documentation. Casualties arriving with a completed SMART or Cruciform card detailing any pre-hospital triage sort & sieve and treatment will need to have the cards' Unique Reference Number attached to all further documentation to ensure all records can be collated.

The SMART or Cruciform card and the property bag will remain with the patient until admitted to ward or discharged. If the Police require the property as evidence, it must be signed for - see Health Board Patient Property & Monies Policy (opens in a new tab). The Police will be responsible for the completion of the Police documentation form.

Preservation of Documents

Following a major incident, the Health Board may be invited or required to provide evidence to an appropriate enforcement agency (e.g. HSE), a judicial inquiry, a coroner's inquest, the Police or a civil court hearing compensation claims. During any or each of these, we may well be obliged or advised to give access to documents produced prior to, during and because of the incident. Under no circumstances must any document which relates or may in any way relate (however slightly) to the incident, be destroyed, amended, held back or mislaid.

Definition of "Documents"

For these purposes "documents" means not only pieces of paper but also photographs, video, CCTV footage, Teams/Zoom recorded calls, Teams Chat, WhatsApp/Text, and digital information held on computers. It also includes internal email. The vital message 'Preserve and Protect' – needs to be spread very quickly during a Major Incident and must reach those who might quite unknowingly hold significant documents.

Incident Log Sheets

It is especially important that a record is kept of all key decisions, including the date and time they are made, who made them and the reasons for so doing. All information, including actions and reports relating to the running of the Incident must be recorded on Incident Log Sheets (page 64). The log sheets should provide a single comprehensive record of the action card holders actions and involvement in the Incident, details actions taken and information both sent and received. It is not necessary that incoming information be transcribed fully onto the Log record. It is sufficient that reference is made to such document on the Log. A stock of these log sheets will be held at the Hospital Co-ordination Centre. Each Department is encouraged to photocopy this Log Sheet, so that Departmental decisions can be documented from the outset of an Incident being declared.

It is also essential that when attending multi-agency command and control structures, the Health Board representatives at the Strategic Co-ordination Group (Gold) and the Tactical Co-ordination Group (Silver) record their decisions contemporaneously. As a minimum, the record should contain:

- Date
- Time
- Situation
- Hazards and Risks
- Options Available
- Option Chosen
- Rationale for Option Chosen and those Not Taken

Each responsible manager should also keep their own records, whether personally or assisted by a trained Loggist.

Decisions and actions also need to be recorded within internal command and control structures. It is recognised however, that for longer protracted incidents it may not be possible, or necessary for a trained Loggist to be in attendance for an extended response. In such circumstances, where it is deemed that Loggists and decision logs are not necessary, any alternative means (including command-and-control group minutes) must ensure that key decisions are easily identifiable and captured clearly and concisely in order to demonstrate transparency and accountability. In order to achieve this, it is recommended the decisions are identified in the same was as actions and a tracker/log kept to comply with the requirement detailed.

Incident recording

All Action Card holders must keep a record of all instructions received, actions taken and other incidents which may enable the Health Board to assess the success of the emergency response and provide evidence to any enquiry which may follow. The records should remain intact; no part should be destroyed, removed or erased because, no matter how trivial notes may appear, the total content may form an important contribution in assessment of the continuity of response. The records must be handed on if the holder is relieved during the incident and following stand-down they must to be returned to the Hospital Co-ordination Centre team for safe storage.

MANAGEMENT OF BURNS

Burn care is organised using a tiered model of care (centres, units and facilities). The most severely injured are cared for in burn centres with those requiring less intensive support being cared for in burn units. Patients with smaller burn injuries are cared for in facility level burn care services.

- **Burn Centres** – This level of in-patient burn care is for the highest level of injury complexity and offers a separately staffed, geographically discrete ward. The service is skilled to the highest level of critical care and has immediate operating theatre access.

- **Burn Units** – This level of in-patient care is for the moderate level of injury complexity and offers a separately staffed, discrete ward.

- **Burn Facilities** – This level of in-patient care equates to a standard plastic surgical ward for the care of non-complex burn injuries

The Welsh Burns Centre is situated at Morriston Hospital, Swansea and offers:

- Adults: Centre, Unit & Facility level care
- Children: Unit & Facility level care

Children who sustain burns which require centre level care require transfer to the Paediatric Burns Centre at Bristol Children's Hospital.
The criteria for referral to burn services has been agreed by the National Network of Burn Care and has been widely circulated to all Emergency Departments.

- (Ref: National Network for Burn Care: National Burn Care Referral Guidance (2012)

The Burns Centre at Morriston Hospital forms part of the South West UK Burn Care Operational Delivery Network which includes burn care services at Southmead Hospital, Bristol; Salisbury District Hospital, Salisbury and Derriford Hospital in Plymouth.

In the event of a major incident involving patients with burns the Co-ordinating Medical Officer in the H.C.C. will liaise directly with the on-call Burns Consultant at Morriston Burns Centre to discuss patient care/treatment.

Relatively small numbers of burn-injured patients can overwhelm burn care capacity particularly if children and young people are involved. It is important that those patients admitted to the Centre are those who are likely to benefit most from the specialised facilities.

The Burns Centre in Morriston hospital is funded for a maximum of 3 major burns cases (>30% body surface area). In the event of a major incident, the expectation is that burn bed capacity will be doubled but this would be dependent upon the bed occupancy rate of the centre at the time and availability of staff.

This may mean that in the event of an incident involving multiple burns, all casualties arriving at the receiving hospital will require admission and stabilisation prior to transfer to a specialist burn service appropriate for their level of injury.

Acute Phase (24 hours) - Admit all patients to hospital. Inform on-call team at Morriston Burns Centre. Depending on the number of casualties a Burns Incident Response Team (BIRT) may be sent to assist with triage and advise on initial treatment. A BIRT team may be identified from outside of Wales to assist.

As many patients as possible will be transferred to Morriston Burns Centre up to capacity. When capacity is reached the on-call Burns Consultant will advise on availability of beds within the South West UK Burn Care Operational Delivery Network.

Patients should be transferred to a level of care that is appropriate for their level of injury. National burn bed availability can then be identified via discussion with the National Burns Bed Bureau (NBBB). The NBBB can be contacted 24 hours a day on 01384 679036.

It is anticipated that patients with minor burns would remain at the Receiving Hospital or be discharged and be treated locally by Emergency Department /Surgical staff with subsequent advice and assistance of a Burns Specialist Care Team (BSCT).

After 24 hours - The Emergency Department/Surgical Staff of the Receiving Hospital together with the Burns Incident Response Team (BIRT) from Morriston Burns Centre (or other Burns Network facility) will confer and decide on the management of patients remaining at the Receiving Hospital.

Further information can be obtained from:

- NHS Emergency Planning Guidance: Planning for the management of burn-injured patients in the event of a major incident (2011)
- NHS-E Concept of Operations for the management of Mass Casualties (Burns Annex) (2019)
- South-West UK Burn Care Operational Delivery Network: Burn Major Incident Plan Guidance Document (2012)
- National Network for Burn Care: National Burn Care Referral Guidance (2012)

copies of which are held in the Emergency Departments and the Hospital Co-ordination Centres, and on-line at: southwest-burncare-network.nhs.uk

MANAGEMENT OF CHEMICAL INCIDENTS

In the event of a major incident involving chemical decontamination, consideration should be given to activate the Hospital Lockdown Procedure, to prevent contaminated personnel entering the Hospital building and potentially spreading the contamination.

Hywel Dda has a responsibility of care to provide facilities for the decontamination of any persons involved in an incident, where that person or persons, may become contaminated by a substance known or unknown. Hywel Dda has therefore a responsibility to ensure the decontamination of casualties is undertaken in a safe and responsible manner.

Personal Protective Equipment (PPE)

Hywel Dda Emergency Departments and the Ambulance Service are equipped, and are able to deal with contaminated casualties, utilising appropriate PPE throughout. All casualties at the scene will be decontaminated by the Ambulance Service, prior to transfer to hospital.

Both Ambulance and Fire Services are equipped with mobile decontamination equipment for mass casualty chemical decontamination. Valero Refinery at Pembroke, also has a Decontamination Unit. When patient numbers exceed local capacity, liaison will take place between the HCC and local Fire Service to provide extra decontamination facilities.

The hospital decontamination unit must be utilised in the event of any chemical, radiation or biological incident, this may be necessary for patients self-presenting from the scene that have not been decontaminated by the Ambulance Service.

Advice must be sort from the On-call Public Health Consultant (AWaRE Team) Tel: 0300 003 0032 Email: aware@wales.nhs.uk

Once the nature of the chemical contamination has been ascertained further advice may be obtained from the 24-hour Chemical Incident Hotline Tel: 0344 8920 555.

Other Sources of Information/Advice

UK Health Security Agency Radiation, Chemical & Environmental Hazards Directorate (Wales)
In hours Tel: 02920 256216 or (not for public use out of hours Tel: 0344 8920555)

Provides support and advice to local authorities and health bodies in the event of an acute chemical related incident and related issues such as contaminated land. 24-hour advisory service on environmental, chemical, medical toxicological, epidemiological and public health aspects of chemical health hazards.

CHEMSAFE: Tel: 01235 836002 (24hr line)

The 'Chemsafe' scheme is operated by the British Chemical Industry and aims to provide accurate information on the nature of spilled chemicals, and practical assistance when required from incidents involving the transportation of dangerous chemicals.

National Focus for Chemical Incidents: Tel: 0541 545654

The National Focus provides a telephone specialist advice and is available 24/7. It can provide direct specialist advice, usually for incidents of national significance, or will direct callers to the appropriate sources of expertise and advice.

National Poisons Information Service: Tel: 0344 892 0111

This service is only available to NHS professionals, and is staffed 24-hours a day, 365 days a year by trained NPIS specialists in poisons information.

Water Research Centre: Tel: 01793 865000 available Monday to Friday 08.30-17.00

The Water Research Centre through its national Centre for Environmental Toxicology, offers advice on a wide range of issues concerning the potential effect of chemical contaminants.

Known Hazardous Sites in the Hywel Dda area:

Top Tier COMAH Sites (Control of Major Accident Hazards):

- Puma Refinery, Tiers Cross, Milford Haven (formally known as Murco)
- Valero Pembroke Refinery (previously known as Chevron refinery)
- VPOT Fuel storage site, Waterston, Milford Haven, (formally known as Petrol Plus/SemLogistics),
- Dragon LNG Terminal, Waterston, Milford Haven. (Located on SemLogistics site)
- South Hook LNG terminal, Herbrandson, Milford Haven.
- Tata Steel Plant, Trostre, Llanelli, Carmarthenshire.

The Notification of Installations Handling Hazardous Substances (Amendment) Regulations 2002 (N.I.H.H.S.)

- Ministry of Defence, RAC Range Castle Martin, Pembroke

MANAGEMENT OF RADIATION INCIDENTS

1. Management of radioactively contaminated/ irradiated casualties in hospital

These incidents may result from a Chemical, Biological, Radiation, and Nuclear (CBRN) terrorist attack such as a "dirty bomb" or result from a non-terrorist incident such as an accident involving transport of nuclear materials.

Radioactive material can harm individuals if:

- contaminated material is inhaled
- there is direct contact with a radiation source;
- contaminated material is ingested;
- contaminated material is allowed to ingress through cuts and open wounds.

Unlike chemical or biological hazards, radiation resulting from such events is easily measurable and quantifiable.

Radioactively contaminated casualties are those that have been exposed to contaminated radioactive material. Although such casualties should be decontaminated in the same manner used for chemical incidents, they are *highly unlikely* to emit radiation that is harmful to rescuers and staff and *provision of lifesaving treatment must always take priority over decontamination.*

Radioactively irradiated casualties are those that have been exposed to a radioactive source and radiation has passed through them. The irradiated casualty *does not* re-emit harmful radiation and *does not* pose a hazard to staff.

Contaminated/irradiated casualties with injury or requiring treatment will normally be taken to the Emergency Department at Glangwili Hospital. Those with life-threatening injuries will be taken to the nearest Emergency Department.

The Hospital Co-ordination Centre (HCC) will make the necessary contact with the agencies required to support the management of the incident including:

a) Medical Physicists (including a Radiation Protection Adviser) based in Medical Physics at Singleton Hospital in Swansea can attend and perform radiation monitoring of casualties and to provide advice on decontamination requirements. Medical Physicists can be contacted via the Singleton hospital switchboard emergency call-out on 01792 205666.

b) The UK Health Security Agency (UKHSA) Radiation Emergency Response Group is available to provide support via their on-call officer on 01235 834590/ 01235 831818.

Public Health Wales will provide appropriate advice to the Strategic Co-ordination Group (Gold) who are responsible for co-ordinating mobile media information.

As soon as possible, information must be obtained from the incident scene regarding numbers and medical condition of expected casualties. Affected persons should be split into 3 groups:

a) **Uninjured persons** should be decontaminated at the incident scene using conventional fire and rescue/ ambulance materials and methods

b) **Non-critically injured** persons should be decontaminated at incident scene using conventional ambulance service materials and methods before transfer to the most appropriate treatment unit

c) **Critically injured persons** should be treated at the nearest Emergency Department. ***Treatment and stabilisation of injuries for these persons should be the first priority followed by decontamination***

If Biological Sampling Kits are required, five are stored in the Emergency Dept - WGH, and a further five are kept in the Biochemical Laboratory at WGH. However, if more kits are required, they can be obtained from the Chemical Pathology Laboratory at Morriston Hospital. (During working hours: contact Secretary to Consultant Chemical Pathologist on 01792 703988, out of hours: the on-call Chemical Pathologist / Clinical Scientist via Morrison Switchboard 01792 702222).

Hospital staff involved in the management of casualties should wear standard hospital biohazard precautions plus double gloves. No other specialist PPE will be required.

As soon as casualties are stabilised and decontaminated where required, they should, in liaison with the Medical Team and the Radiation Protection Advisor, be transferred to an appropriate facility which is suitably equipped to deal with them.

It will be necessary to perform radiation monitoring and establish, where possible, movements of all staff who have had contact with contaminated patients (including Ambulance personnel). Once their immediate duties have been completed, they should be kept in a separate prepared area of the Emergency Department for monitoring and be subject to decontamination where required. This area will be identified at the time of the incident and according to numbers.

Staff who are, or may be, pregnant must be informed of the situation. A decision will then be made, based on the specialist advice obtained, whether they can participate in the patient(s) care.

The HCC must ensure that notices are posted, and the Hospital Information/ Media Centre utilise local media to advise any self-referrals to the Emergency Department that a decontamination process will be required prior to entering the hospital building. This may also require the support of the Police controlling large numbers of people / patients.

The HCC must ensure that advice is obtained and implemented in relation to any contamination of the hospital environment by means of biological/ chemical/ radiation agents. The HCC will need to liaise with Public Heath Wales/ Ambulance Control to access supplies of antidotes as appropriate to the situation.

Public monitoring

There may be a requirement to establish a temporary radiation monitoring unit (RMU) to undertake radiation monitoring of the public (public monitoring). An RMU is used to determine levels of radioactive contamination in or on people and any subsequent requirement for decontamination. It will also inform decisions regarding need for any medical interventions for persons contaminated with radioactive material. The emergency planning team with the support of a Radiation Protection Adviser, based at Singleton hospital will establish the location and requirements for the RMU.

2. Management of other types of radiation incident

2.1 National Arrangements for Incidents Involving Radiation (NAIR)

The NAIR scheme is coordinated by the UK Health Security Agency and intended to provide timely advice and assistance **to the civil police** in the event of an incident involving radioactivity which might give rise to a hazard to the public.

NAIR is not intended for situations where pre-planning for emergencies already exist (e.g. management of irradiated/ contaminated casualties in hospitals).

Medical Physicists based in Singleton hospital in Swansea provide a voluntary stage 1 NAIR response and can be contacted by the emergency services through the UK HSA or directly via the hospital switchboard emergency call-out list.

2.2 Conventional transport accident involving radioactive materials

RADSAFE is a company that has been established to provide assistance to the emergency services in the event of a conventional transport accident involving radioactive materials belonging to a RADSAFE member. It does not cover the movement of nuclear weapons or transport of radioactive materials made by non-members.

MANAGEMENT OF BIOLOGICAL INCIDENTS

Public Health Departments are responsible for preparing and maintaining their plans for the management of incidents of communicable diseases including clusters or outbreaks. This excludes incidents of food and water borne infections for which plans are maintained by local authority environmental health departments.

Public health legislation for the control of communicable diseases is vested in local authorities;

- Public Health (Control of Diseases) Act 1984
- Public Health (infectious Diseases) Regulations 1988

Within Hywel Dda, the Infection Control Departments in conjunction with the Consultant Microbiologists are responsible for Infection Control Policies.

In cases of outbreaks of Smallpox or SARS, a specified area within the Emergency Department will be used and cordoned off for self-referral patients. This area will be identified at the time of the incident and according to numbers.

The Infection Control team led by the Consultant Microbiologist should be contacted for isolating these and other patients in a designated area of the hospital. This area will be identified at the time. These patients will be held in the designated area for a short time. After stabilisation, these patients will be transferred to the Infections Ward, University Hospital of Wales, Cardiff.

The Consultant Microbiologist (or Infection Control Team) will inform the HCC and the Executive Director of Public Health of an outbreak. Public Health Wales has a lead role in the managing an outbreak of infectious diseases.

If requested by the Strategic Co-ordination Group, Public Health Wales will establish and chair a Scientific and Technical Advisory Cell (STAC). Public Health Wales is responsible for appointing members of the STAC. This would not necessarily be a local group but is more likely to be a virtual group or based in Cardiff.

In major biological incidents in which large numbers of people need treatment, the Heath Board may be under pressure to maintain services. In such situations arrangements will need to be put in place to ensure adequate resources are in place. This may include invoking emergency planning procedures.

Where investigations lead to suspect that clusters of a communicable disease may be due to bioterrorism, the Police should be informed, and arrangements for handling deliberate release should be put in place.

MORTUARY FACILITIES AND DECEASED PERSONS

No deceased at the scene should be brought to the hospital without prior agreement with the Hospital Co-ordination Centre and Mortuary Manager.

The deceased are the responsibility of His Majesty's Coroner (via the Police). As a general rule, no such persons shall be moved without the advice of the Police.

NOTE: Where a large number of fatalities occur at an incident site, there will be covered temporary body storage, known as **Body Holding Area** (not to be confused with a Temporary Mortuary).

Temporary Mortuary

HM Coroner may request a Temporary Mortuary. In this case, no deceased person should be transferred from the incident site to the hospital mortuary, except in circumstances where a small number of fatalities occur. In these circumstances, it may be possible to accommodate them at a Hywel Dda mortuary. However, the confidential footprint of the Mortuary perimeter would need to be assessed to maintain dignity for the deceased and/or confidentiality of incident.

Dyfed Powys Mass Fatalities Plan

The temporary mortuary arrangements within Dyfed Powys are facilitated via the **Dyfed Powys LRF Mass Fatalities Plan**. This plan details the multi-agency arrangements. Local Authorities have the statutory duty to provide temporary mortuary facilities on behalf of HM Coroner. The four Local Authorities within Dyfed Powys maintain contracts with specialist providers of such services (e.g. Blake Emergency Services) and are the identified licence holders. HM Coroner will request the commissioning of a Temporary Mortuary at one of the designated sites within the county. This is specifically intended to reduce pressure on the hospital mortuaries.

As such, a temporary mortuary facility will be jointly operated by the Police and the Local Authority on behalf of HM Coroner in premises arranged by the Lead Local Authority, in whose area the incident takes place.

Hywel Dda University Health Board supports the Designated Individual (D.I.) responsible for overseeing the activity within the Temporary Mortuary whilst operational. Hywel Dda mortuaries have only a limited capacity to expand to accommodate fatalities (subject to existing occupancy).

National Emergency Mortuary Arrangements (NEMA)

The UK NEMA capability has been decommissioned. As a result, additional body storage facilities have been acquired, and located within the Dyfed Powys LRF area. These include:

- Nutwell Storage Unit – located with Dyfed Powys Police
  Access via Specialist Operations on 01267 226352

- NEMA Unit – serviced and maintained and available for deployment.
  Access via NWSSP

These units are available to partner agencies to provide additional body storage capacity in the event of a major incident.

Forensic Considerations

Any major incident (which is not a natural occurrence) where fatalities occur, will be the subject of a criminal inquiry and every effort must be made to preserve forensic evidence for subsequent investigation.

All forensic material including clothing, personal effects and any other artefacts brought to the receiving hospital in relation to a patient/victim of a major incident must be **retained in a clear plastic bag** and labelled with details, if known, of the owner. Any material not identifiable as being the property of an individual must also be clear bagged and labelled with the date, time and location where it was found. Dyfed Powys Police Forensic Officers will collect material from hospitals.

Under the authority of the Coroner, Dyfed Powys Police will undertake work relating to identification of bodies and management of their belongings etc. known as **Disaster Victim Identification (DVI)**.

MASS CASUALTY INCIDENTS

Definition of a mass casualty incident

A mass casualty incident is defined as “a disastrous single or simultaneous event(s) or other circumstances where the normal major incident response of several NHS organisations must be augmented by extraordinary measures in order to maintain an effective, suitable and sustainable response”. (Welsh Government “Wales Emergency Planning Guidance: Mass Casualty Incidents: A framework for Planning. Nov 2015)

A mass casualty incident will consequently be defined by the circumstances and apparent nature of the episode and not by the initial assessment of numbers of casualties. Numeric assessments are not possible in such incidents often for hours or days. It will generally be recognised by its scale and the fact that normal major incident responses will be insufficient.

General information

Responding effectively to a mass casualty incident requires an integrated approach to service delivery by the Health Board, working in partnership with WAST, South Wales Trauma Network, other Health Boards, Trusts and partner Category 1 and 2 responders. In planning their response to these types of incidents, all Health organisations will need to ensure business continuity and escalation processes, and the on-going provision of services for patients who require urgent medical attention but not associated with the incident/s.

Command, control and co-ordination arrangements of NHS Wales for dealing with a mass casualty incident, building on existing major incident plans, are set out in the “Mass Casualty Incident Arrangements for NHS Wales” document issued by Welsh Government v.5 (Oct 2025).

The arrangements provide a response framework for NHS Wales organisations to escalate and combine their capabilities, while allowing each of their respective major incident plans to address internal capacity, staffing and resource issues and/or local multi-agency arrangements.
The content of this Major Incident Plan dovetails with the Mass Casualty Arrangements for NHS Wales and response structures and casualty dispersal arrangements are reflected throughout both documents.

Clinical Capacity Group

The Clinical Capacity Group is a scalable group that is established for a declared major incident/ mass casualty incident, to provide a real time conduit between NHS Wales organisations, to share

situational awareness on casualty numbers and priorities and map these against appropriate hospital capacity across NHS Wales and beyond.

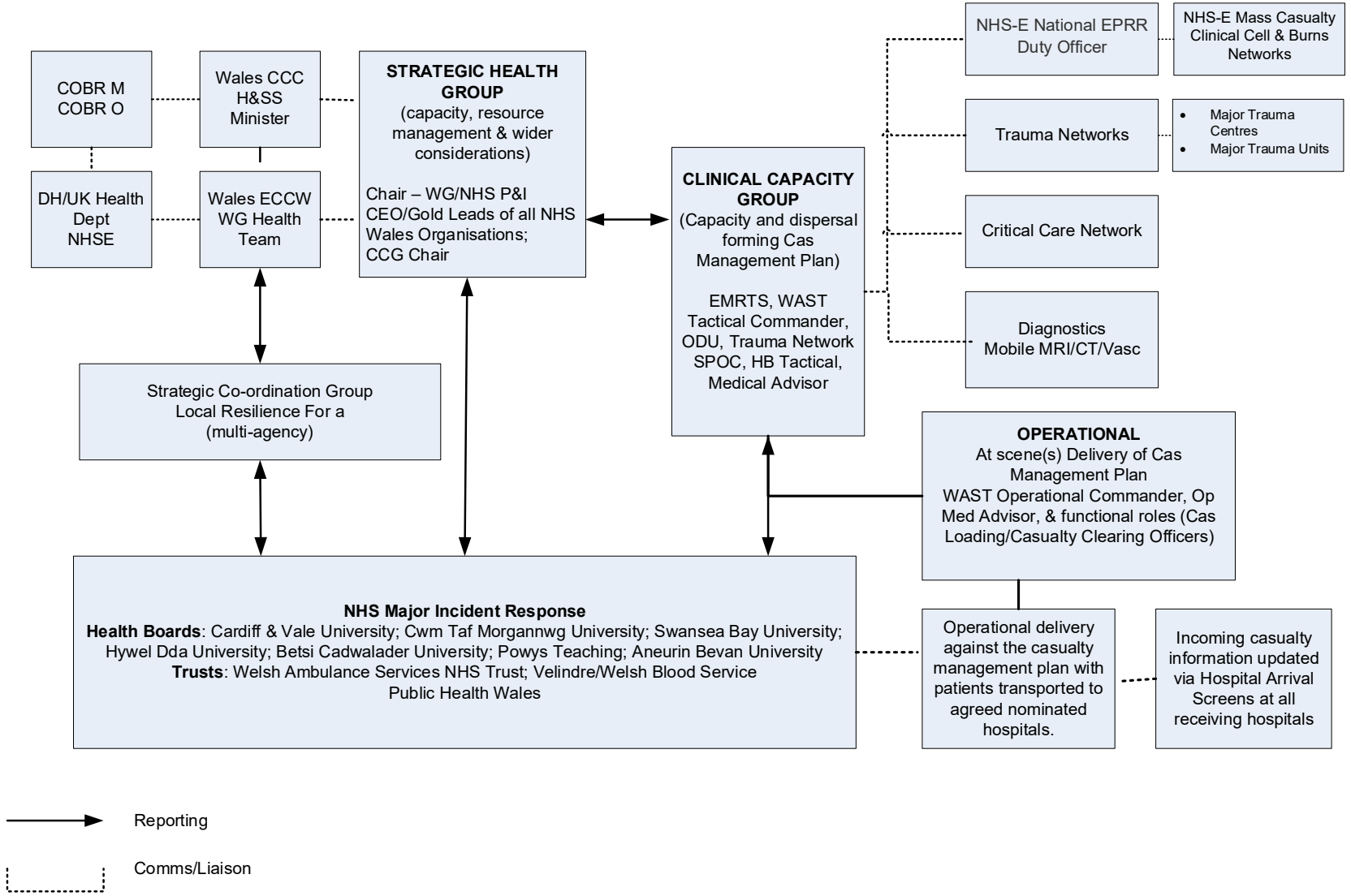
- Chaired by the EMRTS Strategic Medial Advisor, the Clinical Capacity Group will establish capacity at each potential receiving hospital and ensure that the appropriate networks are involved in the conversation.
- This group is attended by staff from each organisation (WAST, HBs, WBS, NHS Wales Performance & Improvement, Networks etc) who are empowered to make rapid decisions regarding capacity.

Casualty Dispersal Plan

All hospital sites in Wales have predetermined capacity figures that can be utilised during a major incident. These figures represent the number of patients a hospital will accept within the initial two hours following a major incident declaration (see detail in site actions below).

Operational teams at scene will automatically initiate the distribution of patients to hospital sites based on the capacity figures.

NHS Wales Mass Casualty Response Structure



BRONGLAIS HOSPITAL SITE ACTIONS

Staff will, on notification of a Major Incident, carry out the instructions on their Major Incident Action Cards unless modified by instructions from the Hospital Co-ordination Centre.

	General Site Arrangements
Hospital Co-ordination Centre	MDT/Meeting Room, 1st Floor, Management Offices, BGH The Hospital Co-ordination will be required, early in the incident, to join a multi-site Teams call (co-ordinated by GGH HCC) to provide a system wide approach to casualty allocation and receipt, repatriation of patients, possible medical and surgical diverts and if required temporary boundary changes.
Parking	On arrival at the hospital, staff should park in the Frongoch car park – the shuttle bus will be operational to transport staff to site.
Hospital Preparations	Senior Manager on site will inform all ward areas/departments and services to **prepare** for possible discharge/transfer and receipt of additional patients. If further clearance does prove necessary on the wards they will be notified by the HCC.
Hotel Services	Hotel Services staff are to provide portering, traffic control and security activities along with other areas of activity at a very early stage in the alert and in the preparation of the hospital. Staff, including domestic, catering and portering will proceed in accordance with the detailed current departmental plan. This entails an early attendance at the Emergency Department by a Duty Porter whether in working hours or out of working hours. The first Duty Porter is to make sure that the doors in the Postgraduate Centre and Reception entrance are opened, and that the main entrance to the Horseshoe entrance, Penglais Hill is locked. Allocation of additional Porters is arranged in the departmental plan, providing assistance in a variety of areas. Appropriate arrangements will be made in terms of catering, dependent upon information received from the Hospital Co-ordination Centre and similar activities should follow in terms of availability and usage of domestic staff. A designated person will be responsible for traffic control duty at the Ambulance Discharge Point, to prevent blocking access by vehicles.
Post-Operative	The post-operative admission ward/area(s) will be nominated by the HCC, based on the beds available after decanting etc.
Relatives	Relatives arriving at Bronglais Hospital should be directed to the Dining Room via lower ground entrance, Caradog Road (Pharmacy entrance). This entrance should be manned by 2 staff members/volunteers. The dining area will act as a point of contact for the Voluntary Services and other agencies involved. Hospital Chaplains should be asked to assist in this role. Relatives will be asked to give information to assist in locating/identifying their relative who may be involved in the incident. This should be clearly documented. Person to be designated by HCC to be based by door between Dining Room and DSU to prevent unauthorised access to the DSU from Dining Room and from the top floor car park to the rest of hospital.
Intensive Care Unit	The ICU Consultant Anaesthetist and Senior Nurse in Charge will advise on ICU & HDU bed availability. The ICU Consultant Anaesthetist will advise on the patient's that need to be admitted to ICU/HDU for treatment
Media	The designated area for use by the media is the **Postgraduate Lecture Theatre,** noting however, that media may request access to other areas of the health board site, which will be considered and dealt with by the Communications Director and team.

	General Site Arrangements
	Media may also film from the highways (as is their right and particularly if the major incident site is on hospital grounds itself), the Communications Director will arrange for a Communications Team member to be present as staffing and situation allows, to manage filming permissions and interaction with the press and media. Staff should not share photos, information or film, from the site of the incident, nor should they take recording devices on to the site of the incident on behalf of the media/press. Otherwise, media representatives will be directed to the Postgraduate Lecture Theatre. Beverages will be made available by Hotel Services staff. A senior manager or nominated deputy will be responsible for liaison between media, the HCC and the LRF Media Cell until the arrival of the Communications Team. The LRF Media Cell will usually take the lead in joint-agency co-ordination of media information. Liaison must occur between the Communications Team and the other agencies to agree media involvement and press statements. Only the On-Call Executive (or nominated deputy) should give media interviews. Interviews will be under the guidance of the Communications Team member on site and in agreement with the Communications Director or deputy. Outside broadcast vehicles will be sited in the access road to the National Library (adjacent to the Hospital).
Communication with staff	Staff will be kept informed of the incident response at appropriate intervals via existing communication and I.T. systems.
Radio	A communication link will be provided between Bronglais Hospital and Ambulance Control by the Ambulance Liaison Officer. If necessary, an additional link will be set up in the Emergency Department by Ambulance Personnel. Care should be taken regarding interference with medical devices. Copies available in HCC and ED.
Helicopter Landing Facilities	Helicopters carrying casualties can be landed in the Penglais School and/or Blaendolau fields prior to transfer by WAST to the Emergency Department. Helicopter transfers from Bronglais to other hospitals e.g. Morriston will also be co-ordinated by the Ambulance Service/EMRTS. In hours of darkness, lighting will be placed on landing areas by Maintenance & Engineering personnel.
Discharge Holding Area	Will be in the Medical Day Unit and supported by Occupational Therapy staff (detailed on relevant action cards). The following information will be recorded: 1. Patient name on arrival; ward of origin; any planned mode of transport; whether for transfer or discharge. 2. On discharge; time of leaving; mode of transport, where discharged or transferred to. These records should be held until completion of the incident and then forwarded to the HCC. Patients may be transferred to Community Hospitals or other neighbouring Health Board hospitals. Inter-hospital transfers will be arranged in conjunction with the Ambulance Service, and Central Transport Unit.

CASUALTY HANDLING

All hospital sites in Wales have predetermined capacity figures that can be utilised during a major incident. These figures represent the number of patients a hospital will accept within the initial two hours following a major incident declaration.

Hospital	P1		P2		P3	
	D	N	D	N	D	N
Bronglais Hospital, Aberystwyth	2		4		10	

Because of this limit to the hospital's capacity, it will be important for the Medical Controller to liaise with the Triage Officer so that prior to saturation point, notification is made to WAST Trauma Desk in order for casualties to be dispersed to other hospitals.

	Emergency Department Arrangements
Triage	The Emergency Department will be converted into a facility for the handling of casualties, however emergency admissions for non-incident patients will also be maintained where possible. Triage will be carried out, as the casualties arrive, by the Triage Doctor, or if not available, the Senior ED Nurse. The details of the preparation and conversion of the ED to this role are held in the EUCC Department Major Incident Plan.
Non incident Emergency Department Patients	Any patients arriving who need treatment but who are not part of the major incident will be advised of the current situation, assessed and informed of appropriate alternative treatment options. If they decide to wait, they will be treated as incident patients but recorded as not so in their documents on triage. CDU Room C will be utilised for serious non-incident patients and Out-patients used to support non-serious injury patients.
Out Of Hours Service	**Normal Working Hours:** During normal working hours the unit is not functional. **Out Of Hours:** Out of hours the unit is functional and is located in Out-Patients. The aim will be to continue to function as normal. Non incident Emergency Department patients to be redirected to the GP in the unit where possible to alleviate any extra burden on the Emergency Department. If incident numbers/type is such that unit cannot continue then HCC to be informed immediately
Emergency Ambulance Release	To enable WAST to respond to the incident with an appropriate number of resources to provide clinical care to patients at the scene, the following release of emergency ambulances from outside hospital emergency departments has been agreed: • 50% of vehicles released within 10 minutes. • 75% of vehicles released within 20 minutes. • 100% of vehicles released within 30 minutes. Further details contained within ED Major Incident Action Cards.

PATIENT FLOW/ALLOCATION FROM EMERGENCY DEPARTMENT

The planned allocation of patients is as outlined below however the Hospital Co-ordination Centre may deviate from this plan as dictated by the nature of the Incident (numbers and case mix of casualties). Following Triage, patients will be allocated as follows:

HYWEL DDA UNIVERSITY HEALTH BOARD

BGH EMERGENCY DEPARTMENT MAJOR INCIDENT PATIENT FLOW

MAJOR INCIDENT TRIAGE IN AMBULANCE BAY

If possible, casualties requiring end of life care will be directed to, and cared for in, an alternative environment within the ED – CDU Rooms A/B

This environment will be dependent on the nature of the Major Incident and the number of casualties requiring end of life care

P1
RESUS / MAJORS 3, 4, 5 & 6

Once stabilised ➔ Intensive Care Unit, Main Theatres (or Endoscopy: holding area), Day Surgery Unit (for minor surgical procedures) or best placed ward area

As per individual Action Cards

P2
CDU Rooms D,E & F
(Alternative location: CDU corridor /best placed ward area)

Once stabilised ➔ Main Theatres (or Endoscopy: holding area), Day Surgery Unit (for minor surgical procedures) or best placed ward area

As per individual Action Cards

P3
EMERGENCY DEPARTMENT

Once assessed, stabilised and treated ➔ to best placed ward area or to be discharged

As per individual Action Cards

PAEDIATRICS

PAEDIATRICS P1
RESUS

Once stabilised ➔ PAA, Main Theatres or DSU (for minor surgical procedures)

PAEDIATRICS P2 / P3
MINORS

Once stabilised ➔ PAA, Main Theatres or DSU (for minor surgical procedures)

PATIENTS CURRENTLY IN THE EMERGENCY DEPARTMENT

The Nurse in Charge is to briefly inform members of the public of the situation and to clear the department. Instructing patients to return to their own GP, attend the ED the following day, or if they have minor injuries requiring treatment – **In Hours**: patients can be redirected to the Outpatients Department

Out of Hours: patients can be redirected to call the NHS 111 Service – see below

Existing CDU patients to be re-located to ward C / Existing core ED patients to be re-located into the CDU / Existing Paediatric patients to be re-located to Paeds Room 8

IN HOURS:

Outpatients' staff (after clearing their department) will assist with the treatment of ED patients / minor injuries. However, serious non-incident patients will re-locate to CDU3

Once assessed and treated ➔ to the best placed ward area or to be discharged

As per the Outpatients Action Card

OUT OF HOURS:

Link with the Out Of Hours Service to assist with current ED patients within the Outpatients area, please be aware of the current availability/capacity of the OOH Service

Once assessed and treated ➔ to the best placed ward area or to be discharged

As per the Out Of Hours Services Action Card

GLANGWILI HOSPITAL SITE ACTIONS

Staff will, on notification of a Major Incident, carry out the instructions on their Major Incident Action Cards unless modified by instructions from the Hospital Co-ordination Centre.

	General Site Arrangements
Hospital Co-ordination Centre	Meeting Rooms 1&2, Ty Nant, Glangwili Hospital. The Hospital Co-ordination Centre at Glangwili Hospital will act as the lead HCC for ensuring Health Board wide co-ordination of the response. The General Manager (or deputy) will convene a multi-site Teams call early in the incident to provide a system wide approach to casualty allocation and receipt, repatriation of patients, possible medical and surgical diverts and if required temporary boundary changes
Parking	On arrival at the hospital, all staff must avoid parking in the immediate vicinity of the Emergency Unit.
Hospital Preparations	Key personnel (including General Managers and Senior Nurse Managers) should report their arrival or presence at the hospital to the Hospital Control Centre (Meeting Room 1/2, Ty Nant, extension 8743). Emergency Department staff will report direct to the Emergency Department. Middle Grade Doctors should go to the Emergency Department Staff Base and report to the Senior Emergency Department Doctor. FP1& 2 Post Holders should report to their specialty wards. The On-Call Orthopaedic and General Surgery Consultants should report to the Senior Emergency Department Doctor in the Emergency Department Staff Base. Once casualty numbers have been estimated/determined and they exceed the current capacity of the Emergency Department, then existing patients may be moved to the Endoscopy Unit to release capacity. This will be determined by the Senior Emergency Department Doctor and the Nurse in Charge in conjunction with the Hospital Co-ordination Centre. The Hospital/On-Call Manager will establish regular liaison with the Ambulance Liaison Officer, situated in the Outpatient Department. The Nurse Controller will inform senior nursing staff of the incident and assess nursing resources. The Nurse Controller will call in the Night Nurse Practitioners and Senior Sister OPD as required and arrange for the recall of nursing and essential administrative staff as necessary. If requested by the Medical Controller, the Nurse Controller will ask the Operating Theatres Department to make arrangements for the cessation of non-emergency surgery and to prepare the Theatres for the treatment of the injured.
Organisation Of Beds	The organisation of beds will be the responsibility of the Medical Controller, who will be the Hospital Clinical Lead who will be based in the Hospital Control Centre. The Medical Controller will assume responsibility for co-ordinating the discharge of patients nearing convalescence or waiting for non-urgent surgery, in order to make beds available to accommodate casualties from the incident. They will decide on the cancellation of routine admissions and advise on any matters of medical priority as necessary.

	General Site Arrangements
Bed State	The Site Manager (holder of Bleep 070) will be responsible for keeping the Medical Controller up to date with the bed state in the hospital and for establishing the bed state at neighbouring hospitals. In Glangwili General Hospital beds may be needed in several wards and Ward Sisters (or senior nurse on the ward) should liaise with their respective FP1 & FP2 post holders in order to advise on patients suitable for discharge. All inpatients suitable for discharge from specialty wards will be sent to Out-Patients Reception for collection. Patients from Ward Blocks 1, 2, 3 and 4 should be directed to use Out-Patients exit. (Discharge sheet to be completed on patients discharged – see Page 63).
Theatres	If required, the Senior Theatre Nurse on duty will prepare operating theatres for substantive treatment of the injured.
Intensive Care Unit	The ICU Consultant Anaesthetist and Senior Nurse in Charge will advise on ICU & HDU bed availability. The ICU Consultant Anaesthetist will advise on the patient's that need to be admitted to ICU/HDU for treatment
Helicopter Landing Facilities	Helicopters carrying casualties can be landed in the field adjacent to the roundabout prior to transfer to the Emergency Department. Helicopter transfers from Glangwili to other hospitals e.g. Morriston will be co-ordinated by the Ambulance Service.
Relatives	Relatives arriving at the hospital should be directed to the Relatives' Reception Area located in the **Cardiac Respiratory Unit**. This area will act as a point of contact for the voluntary services and other agencies involved. Beverages will be made available by Hotel Services staff.
Communications	**Communication with Staff** Staff will be kept informed of the incident response at appropriate intervals via existing communication and I.T. systems. **Internal Communication** Volunteer and off-duty staff will be used as runners between the Hospital Control Centre and hospital departments. The current system of internal radio links will also facilitate effective two-way communication. If necessary, hand-set radios may be issued to the Medical Controller, Nurse Controller, by Head of Hotel Services or deputy. **Media** The Hospital Co-ordination Centre will arrange for an area to be set aside for the use of the media - the **Post Grad Centre,** noting however, that media may request access to other areas of the health board site, which will be considered and dealt with by the Communications Director and team. Media may also film from the highways (as is their right and particularly if the major incident site is on hospital grounds itself), the Communications Director will arrange for a Communications Team member to be present as staffing and situation allows, to manage filming permissions and interaction with the press and media. Staff should not share photos, information or film, from the site of the incident, nor should they take recording devices on to the site of the incident on behalf of the media/press.

	General Site Arrangements
Communication	Otherwise, media representatives will be directed to the Postgraduate Lecture Theatre. Beverages will be made available by Hotel Services staff. A senior manager or nominated deputy will be responsible for liaison between media, the HCC and the LRF Media Cell until the arrival of the Communications Team. The LRF Media Cell will usually take the lead in joint-agency co-ordination of media information. Liaison must occur between the Communications Team and the other agencies to agree media involvement and press statements. Only the On-Call Executive (or nominated deputy) should give media interviews. Interviews will be under the guidance of the Communications Team member on site and in agreement with the Communications Director or deputy. Outside broadcast vehicles to be sited in the parking area to the rear of the Cambrian Room.

CASUALTY HANDLING

All hospital sites in Wales have predetermined capacity figures that can be utilised during a major incident. These figures represent the number of patients a hospital will accept within the initial two hours following a major incident declaration.

Hospital	P1		P2		P3	
	D	N	D	N	D	N
Glangwili Hospital, Carmarthen	3	2	8	6	40	25

Not all life-threatened casualties would require surgery as the condition of some could be life-threatening by virtue of, for example, the need for airway management rather than surgery.

Because of this limit to the hospital's capacity, it will be important for the Medical Controller to liaise with the Triage Officer so that prior to saturation point, notification is made to WAST Trauma Desk in order for casualties to be dispersed to other hospitals.

If the number of patients exceeds the maximum capacity of the Emergency Unit, patients in lower priority categories will be treated in the following locations:

- Green Suite, OPD (Priority 3 patients only)
- Appropriate Specialty Wards

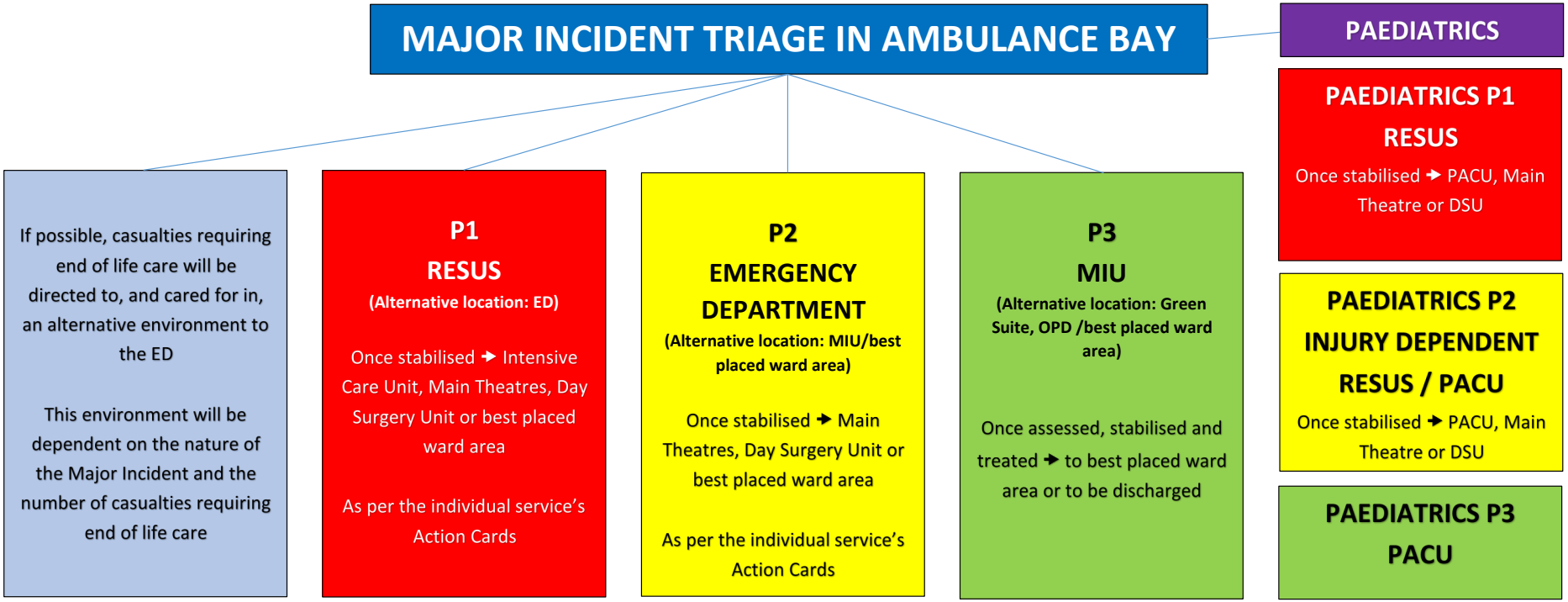
Decisions on the location of patients will be determined by the Triage Officer. All patients found to be dead on arrival will be sent to Mortuary.

The needs of children will be recognised as far as practical with the resources available. Paediatric expertise will be called as required.

If there are paediatric casualties, the Nurse in Charge/Deputy Nurse in Charge will notify the Hospital Co-ordination Centre who will inform the Consultant Paediatrician On-Call.

	Emergency Department Arrangements
Triage	A Triage Area will be established at the Emergency Department Ambulance Entrance Foyer. The Triage Officer will be the Emergency Department **Consultant On-Call** (supported by a Senior Emergency Department Nurse) Deputy – Senior Emergency Department Doctor. The Triage Officer will divide the medical and nursing staff into teams so that patients can be assessed as soon as they enter the hospital.
Non incident Emergency Department Patients	Any patients arriving who need treatment but who are not part of the major incident will be advised of the current situation, assessed, and informed of appropriate alternative treatment options. The Medical Day Unit will be used, in hours, to assist with the treatment of minor injuries.
Out Of Hours Service	**Normal Working Hours:** During normal working hours the unit is not functional. **Out Of Hours:** Out of hours, the unit is functional and is located in the Medical Day Unit. The aim will be to continue to function as normal. Non incident Emergency Department patients to be redirected to the GP in the unit where possible to alleviate any extra burden on the Emergency Department. If incident numbers/type are such that unit cannot continue, then HCC to be informed immediately.
Emergency Ambulance Release	To enable WAST to respond to the incident with an appropriate number of resources to provide clinical care to patients at the scene, the following release of emergency ambulances from outside hospital emergency departments has been agreed: • 50% of vehicles released within 10 minutes. • 75% of vehicles released within 20 minutes. • 100% of vehicles released within 30 minutes. Further details contained within ED Major Incident Action Cards.

GGH EMERGENCY DEPARTMENT MAJOR INCIDENT PATIENT FLOW



PATIENTS CURRENTLY IN THE EMERGENCY DEPARTMENT

The Nurse in Charge is to briefly inform members of the public of the situation and to clear the department. Instructing patients to return to their own GP, attend the ED the following day, or if they have minor injuries requiring treatment - **In Hours**: patients can be redirected to the Medical Day Unit
Out of Hours: patients can be redirected to call the NHS 111 Service – see below

IN HOURS

Medical Day Unit staff (after clearing their department) will assist with the treatment of minor injuries
Once assessed and treated → to the best placed ward area or to be discharged
As per the Medical Day Unit Action Card

OUT OF HOURS

Link with the Out Of Hours Service to assist with current ED patients within the Medical Day Unit area, please be aware of the current availability/capacity of the OOH Service
Once assessed and treated → to the best placed ward area or to be discharged
As per the Out Of Hours Action Card

SUPPORTING HOSPITAL - PRINCE PHILIP HOSPITAL

Staff will, on notification of a Major Incident, carry out the instructions on their Major Incident Action Cards unless modified by instructions from the Hospital Co-Ordination Centre.

	General Site Arrangements
Hospital Co-ordination Centre	Management Offices, PPH (the Board Room may also be utilised). The Hospital Co-ordination Team will be required, early in the incident, to join a multi-site Teams call (co-ordinated by GGH HCC) to provide a system wide approach to casualty allocation and receipt, repatriation of patients, possible medical and surgical diverts and if required temporary boundary changes.
Hospital Role	Prince Phillip Hospital's main role in a Major Incident would be to continue the intake of medical emergencies from Carmarthenshire, provide a decant facility from Glangwili General Hospital, and where appropriate management of walking patients involved in the Major Incident.
Hospital Capacity	Prince Phillip Hospital has no capacity to stabilise causalities requiring definitive surgical management but could in extreme circumstances manage patients requiring airway management prior to transfer for definitive treatment. At Prince Philip Hospital the maximum capacity to stabilise "serious casualties" by resuscitative treatment is 2 in a two-hour period.
Hospital Alerting Procedure	Any notification of a major incident will be received from GGH General Manager/Manager on call as part of their action card responsibilities. If the call is received via any other external route, the call **must** be directed to GGH Switchboard for verification and determination of the nature and scope of the incident. If the Hospital/On-Call Manager is not present on the PPH site, they should immediately arrange for an alternative senior manager to deputise in this role.
Parking	On arrival at the hospital, all staff must avoid parking in the immediate vicinity of the Minor Injury Unit (MIU) and Acute Medical Assessment Unit (AMAU). The car parking areas in front of the MIU and AMAU Units must be cleared and reserved for ambulances. Head of Hotel Services (or deputy) will arrange for the clearing of the area as soon as possible.
Hospital Preparations	Key personnel should report their arrival or presence at the hospital to the Hospital Co-Ordination Centre (Management Offices Co-ordination Hub Ext. 3709, 3530, 3073 or 3450). MIU and AMAU staff will report directly to their respective units. Medical staff should report to their normal place of work and await further instruction (unless action card holders). Staff with no particular departmental duties should make themselves available to be called by the Hospital Co-ordination Centre, to assist in the provision of a system of "runners/messengers". When a major incident is declared Paediatric casualties of any type **should not** be admitted or received by Prince Phillip Hospital.
Organisation of Beds	The organisation of beds will be the responsibility of the Site Manager/Bleep 600 Holder

	General Site Arrangements
	The Medical Controller will be based in the Hospital Co-ordination Centre. The Medical Controller will assume responsibility for co-ordinating the discharge of patients nearing convalescence or waiting for non-urgent surgery, to make beds available to accommodate for casualties from the incident. They will decide on the cancellation of routine admissions and advise on any matters of medical priority as necessary. The Site/Bed Manager (the holder of bleep 600) will be the Nurse Controller until relieved by the Head of Nursing or Senior Nurse Manager and will be based in the Hospital Co-Ordination Centre. The Nurse Controller will inform senior nursing staff of the incident and assess nursing resources. The Nurse Controller will call Emergency Nurse Practitioners, as required.
Bed State	The Site/Bed Manager (holder of bleep 600) will be responsible for keeping the Medical Controller up to date with the bed state in the hospital and for establishing the bed state at neighbouring hospitals. In Prince Philip Hospital beds will be needed in several wards and Ward Sisters (or senior nurse on the ward) will liaise with their respective medical teams to advise on patients suitable for discharge. All inpatients suitable for discharge from specialty wards will be sent to the Discharge Lounge/Gerontology Day Hospital for collection
Intensive Care / High Dependency Unit	The ICU Consultant Anaesthetist and Senior Nurse in Charge will advise on ICU & HDU bed availability. The ICU Consultant Anaesthetist will advise on the patient's that need to be admitted to ICU/HDU for treatment
Helicopter Landing Facilities	There are no helicopter landing facilities on site, however it may be possible to land locally in Dafen. Helicopter transfers from Prince Phillip to other hospitals will be co-ordinated by the Ambulance Service.
Relatives	Relatives arriving at the hospital should be directed to the Post Grad Lecture Theatre.
Communications	**Media Facilities** The Hospital Co-ordination Centre will arrange for an area to be set aside for the use of the media - the **Caebryn Conference Room,** noting however, that media may request access to other areas of the health board site, which will be considered and dealt with by the Communications Director and team. Media may also film from the highways (as is their right and particularly if the major incident site is on hospital grounds itself), the Communications Director will arrange for a Communications Team member to be present as staffing and situation allows, to manage filming permissions and interaction with the press and media. Staff should not share photos, information or film, from the site of the incident, nor should they take recording devices on to the site of the incident on behalf of the media/press. Otherwise, media representatives will be directed to the Postgraduate Lecture Theatre. Beverages will be made available by Hotel Services staff. A senior manager or nominated deputy will be responsible for liaison between media, the HCC and the LRF Media Cell until the arrival of the Communications Team.

	General Site Arrangements
	The LRF Media Cell will usually take the lead in joint-agency co-ordination of media information. Liaison must occur between the Communications Team and the other agencies to agree media involvement and press statements. Only the On-Call Executive (or nominated deputy) should give media interviews. Interviews will be under the guidance of the Communications Team member on site and in agreement with the Communications Director or deputy. Outside broadcast vehicles will be sited in the Consultants car park at the front of the hospital **Communication with Staff** Staff will be kept informed of the incident response at appropriate intervals via existing communication and I.T. systems. **Internal Communication** Volunteer and off-duty staff will be used as runners between the Hospital Co-ordination Centre and hospital departments. The current system of internal radio links will also facilitate effective two-way communication. If required, hand-set radios will be issued to Medical Controller and Nurse Controller by Head of Hotel Services or deputy.

WITHYBUSH HOSPITAL SITE ACTIONS

Staff will, on notification of a Major Incident, carry out the instructions on their Major Incident Action Cards unless modified by instructions from the Hospital Co-ordination Centre.

	General Site Arrangements
Hospital Co-ordination Centre	Patient Flow Office, 1st Floor (above EUCC), WGH. The Hospital Co-ordination will be required, early in the incident, to join a multi-site Teams call (co-ordinated by GGH HCC) to provide a system wide approach to casualty allocation and receipt, repatriation of patients, possible medical and surgical diverts and if required temporary boundary changes.
Hospital Preparations	The Switchboard operator will call out key staff in accordance with the cascade system. If on-call personnel of a department are unavailable this should be reported to the Hospital Co-ordination Centre (Tel. No. 3547, 3548 or 3576) on completion of calls as listed. The Senior Manager/On-Call Manager will establish the Hospital Control Centre. On arrival at the Hospital, all Action Card holders must either attend or report (action card will specify) to the Hospital Co-ordination Centre where a record of their attendance will be maintained and a brief incident update given.
Hospital Discharges / Maximising Bed Availability	The organisation of beds will be the responsibility of the Medical Controller. The Medical Controller will assume responsibility for co-ordinating the discharge of patients nearing convalescence or waiting for non-urgent surgery, in order to make beds available to accommodate for casualties from the incident. They will decide on the cancellation of routine admissions and advise on any matters of medical priority as necessary. Arrangements will be made for the discharge or transfer to South Pembrokeshire Hospital, Health & Social Care Resource Centre, Tenby Cottage Hospital, commissioned beds within the community and Community Services of patients from the relevant wards, depending upon the type of Major Incident. This will be co-ordinated by the Bed Manager / Senior Nurse in charge of each ward supported by the medical staff. Patients nominated as Discharges / transfers from wards will be relocated to the facilitated Patients' Discharge Waiting Area in the Physiotherapy Treatment area. The staff in the Patients Discharge Waiting Area will co-ordinate and document all inpatient movements via the Discharge / Transferred Patients log (page 63) and ensure that the Hospital Co-ordination Centre is kept informed. The Bed Manager (holder of bleep 2138) will be responsible for keeping the Medical Controller up to date with the bed state in the hospital and for establishing the bed state at neighbouring hospitals. All patients leaving the hospital will exit the hospital via the Physiotherapy Department entrance.
Intensive Care Unit	The ICU Consultant Anaesthetist and Senior Nurse in Charge will advise on ICU & HDU bed availability. The ICU Consultant Anaesthetist will advise on the patient's that need to be admitted to ICU/HDU for treatment

	General Site Arrangements
Relatives And Friends Reception Centre	Relatives arriving at Withybush should be directed to the Ante-Natal area. This area will act as a point of contact for the voluntary services and other agencies involved. Hospital Chaplains will be asked to assist in this role.
Communications	**MEDIA CENTRE** The Hospital Co-ordination Centre will arrange for an area to be set aside for the use of the media - the **Auditorium at the Conference Centre,** noting however, that media may request access to other areas of the health board site, which will be considered and dealt with by the Communications Director and team. Media may also film from the highways (as is their right and particularly if the major incident site is on hospital grounds itself), the Communications Director will arrange for a Communications Team member to be present as staffing and situation allows, to manage filming permissions and interaction with the press and media. Staff should not share photos, information or film, from the site of the incident, nor should they take recording devices on to the site of the incident on behalf of the media/press. Otherwise, media representatives will be directed to the Postgraduate Lecture Theatre. Beverages will be made available by Hotel Services staff. A senior manager or nominated deputy will be responsible for liaison between media, the HCC and the LRF Media Cell until the arrival of the Communications Team. The LRF Media Cell will usually take the lead in joint-agency co-ordination of media information. Liaison must occur between the Communications Team and the other agencies to agree media involvement and press statements. Only the On-Call Executive (or nominated deputy) should give media interviews. Interviews will be under the guidance of the Communications Team member on site and in agreement with the Communications Director or deputy. Outside broadcast vehicles will be sited in the parking area adjacent to the Conference Centre and/or other suitable area of the hospital grounds. **COMMUNICATION WITH STAFF** Staff will be kept informed of the incident response at appropriate intervals via existing communication and I.T. systems. Radios will be held by core staff members to ensure effective and timely communication. A list of designated holders is maintained in the Switchboard. **EXTERNAL COMMUNICATIONS LINK** A communications link will be provided between the Co-ordinating Medical Officer, Ambulance Service Major Incident Vehicle and the Medical Incident Commander as a priority and should be kept open at all times. Radio users need to be aware that sensitive information should not be transmitted on radio links, as these are insecure and can be scanned by public and media scanners. All sensitive information should be transmitted by landline or face to face and not mobile communication.

	General Site Arrangements
Helicopter Landing Facilities	Helicopters carrying casualties can be landed on the helipad to the rear of the Emergency Department and/or Withybush Airport. Helicopter transfers from Withybush to other hospitals e.g. Morriston will be co-ordinated by the Ambulance Service. WAST will notify Switchboard if a helicopter is to land on the helipad, Switchboard with notify the Fire Service and the Creche (located adjacent to helipad).

CASUALTY HANDLING

All hospital sites in Wales have predetermined capacity figures that can be utilised during a major incident. These figures represent the number of patients a hospital will accept within the initial two hours following a major incident declaration.

Hospital	P1		P2		P3	
	D	N	D	N	D	N
Withybush Hospital, Haverfordwest	2	1	4	2	12	20

Not all life-threatened casualties would require surgery as the condition of some could be life-threatening by virtue of, for example, the need for airway management rather than surgery.

Because of this limit to the hospital's capacity, it will be important for the Medical Controller to liaise with the Triage Officer so that prior to saturation point, notification is made to WAST Trauma Desk for casualties to be dispersed to other hospitals.

	Emergency Department Arrangements
Triage	A Casualty Triage point will be established inside the Ambulance entrance to the Emergency Department. Triage will be carried out as the casualties arrive by the allocated experienced Nurse and the Emergency Department Middle-Grade Doctor.
Patient Flow/Allocation From Emergency Department	The planned allocation of patients is as outlined below however the Hospital Co-ordination Centre may deviate from this plan as dictated by the nature of the Incident (numbers and case mix of casualties) Following Triage, patients will be allocated as follows: a) Minor casualties and apparently non-injured will be directed to the waiting areas designated within the Outpatients Department or treated within the Emergency Department and discharged. b) Casualties requiring Urgent/Emergency surgery should be transferred to Main Theatres (after being stabilised). If Theatre capacity is full, patients are to be placed in the most appropriate facility to await transfer to Theatre (e.g. Day Surgery Unit / Same Day Admit / High Dependency Unit). c) Casualties requiring hospitalisation but not urgent surgery will be

	Emergency Department Arrangements
	allocated ward beds as appropriate. d) Casualties requiring end of life care will be directed to and will be cared for in an alternative environment to the Emergency Department. The environment (e.g. Endoscopy, Medical Day Unit, CDU) will be dependent on the nature of the Major Incident and the numbers of casualties requiring end of life care.
Out Of Hours Service	The Out of Hours service is based in the out-patient corridor adjacent to the Emergency Department. Therefore, the service will continue to function as normal during a major incident. The aim will be to continue to function as normal. Non incident Emergency Department patients to be redirected to the GP in the unit where possible to alleviate any extra burden on the Emergency Department.
Emergency Ambulance Release	To enable WAST to respond to the incident with an appropriate number of resources to provide clinical care to patients at the scene, the following release of emergency ambulances from outside hospital emergency departments has been agreed: • 50% of vehicles released within 10 minutes. • 75% of vehicles released within 20 minutes. • 100% of vehicles released within 30 minutes. Further details contained within ED Major Incident Action Cards.

WGH EMERGENCY DEPARTMENT MAJOR INCIDENT PATIENT FLOW

MAJOR INCIDENT TRIAGE IN AMBULANCE BAY

If possible, casualties requiring end of life care will be directed to, and cared for in, an alternative environment to the ED

This environment (e.g. Endoscopy, MDU, PHODU) will be dependent on the nature of the Major Incident and the number of casualties requiring end of life care

P1
RESUS
(Alternative location: ED)

Once stabilised → Intensive Care Unit, Main Theatres, Day Surgery Unit or best placed ward area

As per the individual service's Action Cards

P2
EMERGENCY DEPARTMENT
(Alternative location: MIU/best placed ward area)

Once stabilised → Main Theatres, Day Surgery Unit or best placed ward area

As per the individual service's Action Cards

P3
MAJORS / MIU / SDEC / PUFFIN UNIT

Once assessed, stabilised and treated → to best placed ward area or to be discharged

PAEDIATRICS

PAEDIATRICS
P1 RESUS
Continuation of care to be discussed with Paediatric Team

PAEDIATRICS
P2 / P3 MIU
Continuation of care to be discussed with Paediatric Team

PATIENTS CURRENTLY IN THE EMERGENCY DEPARTMENT

As per the Action Card, the Nurse in Charge is to briefly inform members of the public of the situation and to clear the department. Instructing patients to return to their own GP, attend the ED the following day, or if they have minor injuries requiring treatment - **In Hours**: patients can be redirected to the Outpatients Department
Out of Hours: patients can be redirected to call the NHS 111 Service – see below

IN HOURS:

Outpatients' staff (after clearing their department) will assist with the treatment of ED patients / minor injuries
Once assessed and treated → to the best placed ward area or to be discharged
As per the Outpatients Action Card

OUT OF HOURS:

Link with the Out Of Hours Service to assist with current ED patients within the Outpatients area, please be aware of the current availability/capacity of the OOH Service
Once assessed and treated → to the best placed ward area or to be discharged
As per the Out Of Hours Services Action Card

INTERNAL INCIDENTS AND INTERNAL MAJOR INCIDENTS

An incident within Health Board premises that warrant special arrangements for the co-ordination, command and control of the situation, by a management response group.

Serious situations affecting small numbers of patients and/or staff may also be co-ordinated in this manner, if deemed appropriate.

However, **responses to escalating emergency pressures are not covered by this plan.**

HDUHB must plan to handle incidents in which its own facilities - or neighbouring ones – may be overwhelmed. The organisation itself may be affected by its own internal major incident or by an external incident that impairs its ability to work normally. Fire, breakdown of utilities, major equipment failure, hospital acquired infections, violent crime or the need to deal with one or more contaminated person(s) may paralyse the provision of services and jeopardise safety arrangements. This plan should be considered in conjunction with service level Business Continuity Plans.

There are three levels of internal incident that the relevant Senior Manager(s) can consider during their assessment of the situation.

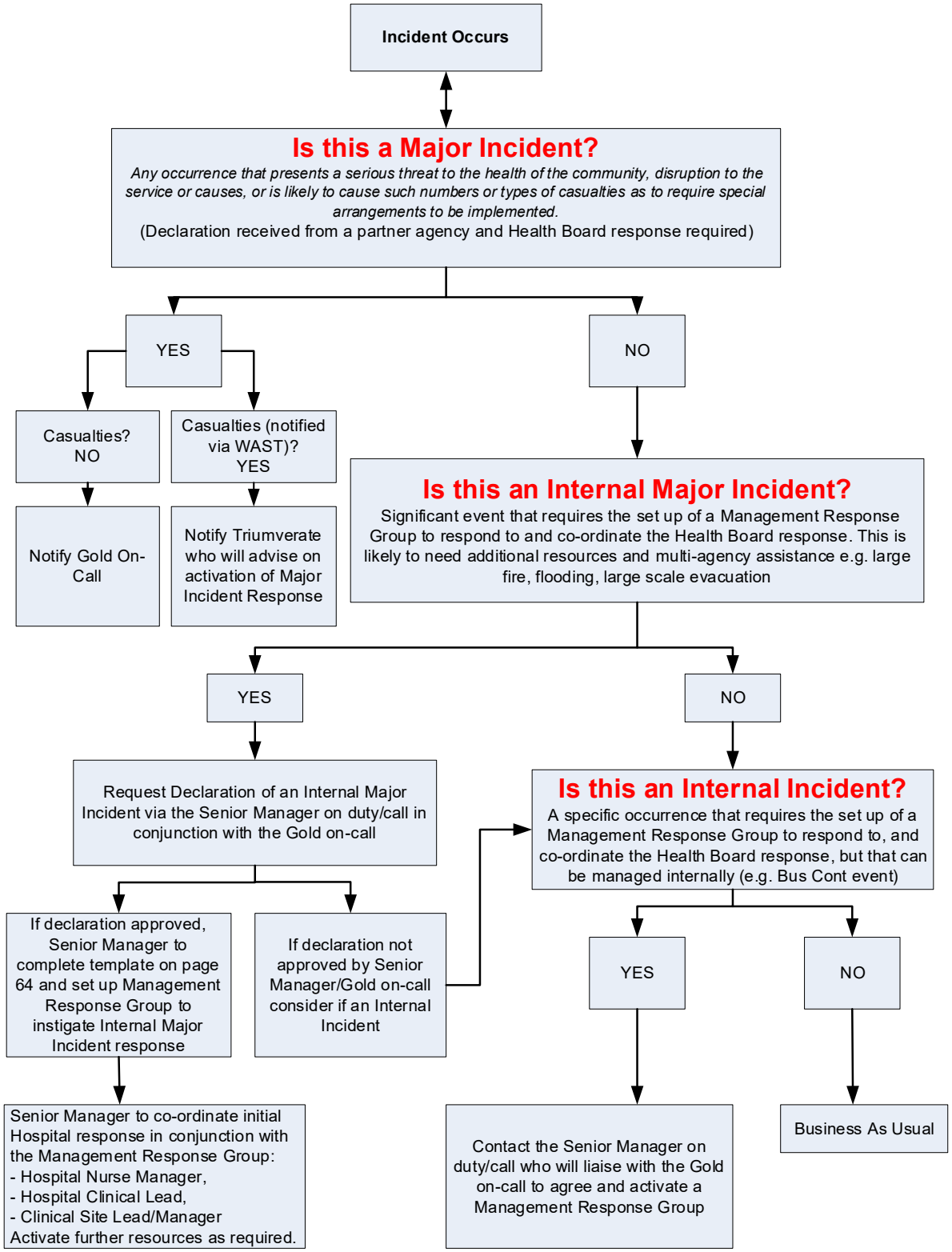
- **Internal Major Incident** – significant event that is likely to require additional resources and multi-agency assistance
- **Internal Incident** – specific occurrence that can be managed internally
- **Business Continuity event** – can be managed via activation of relevant business continuity plans

SELF DECLARATION OF A MAJOR INCIDENT

In the RARE event of the hospital needing to self-declare its own major incident, the most Senior Manager on duty/call shall:

- Assess the situation and discuss with the Gold On-Call
- Advise the Switchboard to activate the communications cascade to notify staff.
- Advise Ambulance Control of the situation on 01267 229476 (Duty Manager) or 999 if unavailable)
- Advise Dyfed Powys Police control of the situation (Tel 01267 226144, identify yourself and ask to speak to the Control Room Duty Inspector urgently).
- Set up a Management Response Group to co-ordinate the response.

The following flowchart highlights the process required following assessment of the incident, and agreed level of declaration, and response.


Incident Occurs
Is this a Major Incident?
Any occurrence that presents a serious threat to the health of the community, disruption to the service or causes, or is likely to cause such numbers or types of casualties as to require special arrangements to be implemented.
(Declaration received from a partner agency and Health Board response required)
YES
NO
Casualties? NO
Casualties (notified via WAST)? YES
Notify Gold On-Call
Notify Triumverate who will advise on activation of Major Incident Response
Is this an Internal Major Incident?
Significant event that requires the set up of a Management Response Group to respond to and co-ordinate the Health Board response. This is likely to need additional resources and multi-agency assistance e.g. large fire, flooding, large scale evacuation
YES
NO
Request Declaration of an Internal Major Incident via the Senior Manager on duty/call in conjunction with the Gold on-call
Is this an Internal Incident?
A specific occurrence that requires the set up of a Management Response Group to respond to, and co-ordinate the Health Board response, but that can be managed internally (e.g. Bus Cont event)
If declaration approved, Senior Manager to complete template on page 64 and set up Management Response Group to instigate Internal Major Incident response
If declaration not approved by Senior Manager/Gold on-call consider if an Internal Incident
YES
NO
Senior Manager to co-ordinate initial Hospital response in conjunction with the Management Response Group:
- Hospital Nurse Manager,
- Hospital Clinical Lead,
- Clinical Site Lead/Manager
Activate further resources as required.
Contact the Senior Manager on duty/call who will liaise with the Gold on-call to agree and activate a Management Response Group
Business As Usual

INTERNAL INCIDENT REQUIRING EVACUATION

FOR BRONGLAIS HOSPITAL ONLY:

Use of Aberystwyth University

Aberystwyth University has kindly agreed to assist us if possible, in providing temporary patient holding facilities if we need to evacuate part/whole of the hospital. The degree of assistance will depend on their circumstances e.g. examinations etc. It is anticipated that the Sports Cage/Hall or Pantycelyn would be the initial areas of choice due to access, size and services available.

Procedure to request assistance:

Ceredigion County Director/Senior Manager in charge to contact University Helpdesk during daytime hours and University security out of hours

Main switchboard – 01970 623111
Estates helpdesk – 01970 622999
Security – 01970 622649

↓

University internal procedure will be activated

↓

Ideally only patients who are full/partially mobile should be evacuated off site in the first instance. To increase bed capacity this will be patients from the affected and unaffected area. All immobile patients should be evacuated to an area of safety on site into emptied beds where possible. Patient trolleys are available in the ED, Endoscopy suite, Theatre and Tirion Ward.

If transport is required contact Ambulance Control in the first instance (an internal Major Incident should have been declared by the Health Board at this stage), other alternatives are local taxi firms and the Local Authority.

CONTACT TELEPHONE NUMBERS

Dyfed Powys Hospitals:		
Glangwili General Hospital Carmarthen		01267 235151
Prince Phillip Hospital Llanelli		01554 756567
Withybush General Hospital Haverfordwest		01437 764545
Bronglais General Hospital Aberystwyth		01970 623131
Other Hospitals in Wales:		
Ysbyty Gwynedd		01248 384384
Wrexham Maelor General Hospital		01978 291100
Ysbyty Glan Clwyd		01745 583910
University Hospital of Wales		02920 747747
Prince Charles Hospital		01685 721721
Llandough Hospital		02920 711711
Royal Gwent Hospital		01633 234234
Nevill Hall Hospital		01873 732732
Morriston Hospital		01792 702222
Princess of Wales Hospital		01656 752752
Welsh/English Border Hospitals/Trusts:		
Royal Shrewsbury Hospital		01743 261000
Hereford Hospital		01432 355444
Gloucester Royal NHS Trust		08454 222222
East Gloucester NHS Trust		08454 222222
Local Authority Emergency Planners:		
Ceredigion County Council		07970 261425
Carmarthenshire County Council		07900 570431
Pembrokeshire County Council		07964 577671
Powys County Council		07970 005072
	Emergency (24 hours)	01597 825275/08450 544847
Duty Emergency Planning Officer for Carms, Ceredigion & Pembs – 24/7	Contacted via Careline out of hours	01558 824283
Directors of Environmental Health:		
Ceredigion	Daytime	01545 572105
	Out of Hours	08457 566766
Carmarthenshire	Daytime	01267 234567/228736
	Out of Hours	01267 224398
Pembrokeshire	Daytime	01437 764551
	Out of Hours	08456 015522
Powys	Daytime	01597 826659
	Out of Hours	08450 544847
Directors of Social Services:		
Ceredigion		01545 572562
	Out of Hours	08456 015392
Carmarthenshire		01267 224697
	Out of Hours	0300 3332222
Pembrokeshire		01437 775831
	Out of Hours	08708 509508
Powys		01597 826906
	Out of Hours (via Brecon Hospital switchboard)	01874 622443

National Bodies:		
Welsh National Poisons Unit	24 hours	02920 709901 / 02921 825554
National Blood Transfusion Service (Wales)	Daytime	01443 622000
Welsh Water	24 hours	0800 0520130
Natural Resources Wales	Anytime	0800 807060
Ministry of Agriculture Food & Fisheries (Wales)		
BASIS Registration Ltd (Pesticides)	Daytime	01335 343945
Health & Safety Executive	Daytime	01267 244230
	Emergency	08453 009923
Public Analyst (Cross Hands)		01269 833990
Military – Joint Regional Liaison Officer	Daytime 24 hours	01874 613381 07766 420496
RVS Emergency Services	24 hours	02476 681369
Coroners Offices:		
Ceredigion		01970 612567/617931
Carmarthenshire		01558 822215
Pembrokeshire		01646 698129
Dyfed Powys Local Resilience Forum:		
Partnership Team		01267 248454
Strategic Co-ordination Centre		01267 226201

BRONGLAIS INTERNAL CONTACT NUMBERS

Key Activity Centres used in the event of a major incident	Location	Tel Ext.
Hospital Co-ordination Centre	MDT/Meeting Room, 1st Floor, Management Offices	**5432** **01970 617006**
Emergency Department	Reception Nurse Office Plaster Room Resus Room Team Leader Doctors Room Base Station 1 Base Station 2	**5753** **5736** **5740/Bleep 3302** **5502** **7615** **5738/7810/5450** **5736/7807** **7809**
Operating Theatres **Main Theatres**	Main Number Back Office/Manager Staff Room	**7114** **7117** **7113**
DSU 2	Main Number Recovery	**8866** **8865**
DSU 3	Theatre Office Theatre 1/2 Theatre 3 Recovery	**5606** **5611** **5612** **5608**
HSDU		**5701**
Wards	Endoscopy ITU Ceredig Rhiannon Short Stay Gwenllian Angharad Meurig Dyfi East Dyfi West Dyfi Reception Ystwyth Enlli	**5925/8876** **5621/2** **5644/5646/8847** **5640** **5633** **5757** **5752** **5941** **5746** **5745** **5986** **5932**
Radiology	Reception CT - Reception	**5681** **5697**
Medical Records		**7038 /5664 / 8892**
Pathology	Blood Bank Coagulation Laboratory Biochemistry Histopathology Laboratory Mortuary	**5945** **5712** **5786 Sec. 5934** **5715** **5743**
Press Centre	Postgraduate Centre	**5806**
Porters	 Head Porter	**5570/7026 Bleep 3506** **5349**
Information	Senior person	**7001**
IT Helpdesk		**01267 232000**
Pharmacy		**5732/5733**
Clinical Engineering		**5926**

GGH INTERNAL CONTACT TELEPHONE NUMBERS

Key Activity Centres used in the event of a major incident	Location	Tel Ext.
Hospital Co-ordination Centre	Based in Meeting Rms 1&2, Ty Nant	8743
Media Reception Area	Based in Cambrian/Coracle Rooms	6270
Family Reception Area	Based in Cardiac Respiratory Unit	
Staff Rest Centre	Based in Staff Restaurant	2053
Patients Discharge Area	Based in Out-Patients Department	
Ambulance Liaison Officer	Based in Out-Patients Department	2022
Police Documentation team	Based in 2nd Consultant Office in EU	3979/68
Key Departmental Numbers		
Emergency Unit	Navigator	Bleep 194
	Reception	3961
	Nurse's Main Duty Office	3987
	Staff Base	3960
	Sisters Office	3971/72
	Resuscitation Rooms	3980,3966
	Plaster Room	3969
Operating Theatres	Reception	2333
	ODP - Bleep	107
	Theatre Senior Sister/ Manager - Bleep	176/2424/226
	Theatre – 1	2571
	Theatre – 2	2572
	Theatre – 3	2573
	Theatre – 4	2574
	Theatre – 5	2776
	Theatre – 6	6092
	Recovery	2576
	Day Surgical Unit	2372
	Endoscopy Unit	2355
Wards	CDU	8721
	Adult Critical Care	2043
	CADOG	2624
	CCU	2760
	TOWY	2621
	PADARN	2612
	STEFAN	2950
	PICTON	2784
	PRESELI	2963
	SAU/CLEDDAU	2606
	TEIFI	6491
	MERLIN	2418
	TYSUL	2173
	DINEFWR	2591
	CERI	2600
	COTHI	2624
	Y LOLFA	2403
Radiology	X-RAY (Bleep 125)	2092,2645
	CT SCAN	2556
Pathology	Reception	2453
	Biochemistry Lab -Out of Hrs Bleep – 110	2456
	Haematology & Blood Bank - Out of Hrs Bleep – 109	2458
	Microbiology Infection Control (Bleep 100)	2502 2596,2422
Pharmacy		2465
Physiotherapy	(Bleep 118 / 119)	2808
Physiological measurements		2084

CSSD		2369 2061/ 62/ 63
Occupational Health		0300 3039674
Clinical Engineering		2793, 2499
Estates		2942-Hotline 2332 -Secretary
Fire Officer		2107
Medical Records		2097 / 8490

PRINCE PHILLIP CONTACT NUMBERS

Key Activity Centres used in the event of a major incident	Location	Tel Ext.
Hospital Co-Ordination Centre	Management Offices Co-ordination Hub	3709/3530/3073/3450
Press Room	Based in Postgrad Conference Room	1385
Relatives Reception Area	Based in Postgrad Lecture Theatre	6662
Volunteers Reception Area	Based in Seminar Room 2	6663
Staff Rest Centre	Based in Staff Restaurant	3029
Patients Discharge Area	Based in Discharge Lounge/Geriatric Day Hospital	3213
Key Departmental Numbers		
Minor Injuries Unit	Reception	3230
	Sisters Office	3237
Operating Theatres	Reception	3088
	Theatre Senior Sister/ Manager	6690
	Theatre – 1	3096
	Theatre – 2	3095
	Theatre – 3	3094
	Theatre – 4	3527
	Recovery	3093
	Day Surgical Unit	3551/6763/6762
	Endoscopy Unit	3117
Wards	Ward 1	3217
	AMAU	3303
	Ward 3	3131
	Ward 4	3136
	Ward 5	3105
	Ward 6	3108
	Ward 7	3380
	Ward 9	3313
	Critical Care	3121/3118
Radiology	X-RAY	1416
	CT Scan	3268
Pathology	Reception	3520
	Biochemistry Lab	3062
	Haematology	3056
	Microbiology	3068
	Infection Control	3066
Pharmacy		3212/3209
Physiotherapy		3204
Physiological measurements		3157
HSDU		3299
Occupational Health		0300 303 9674
Clinical Engineering		0300 303 6115 Option 1
Estates		3689

WITHYBUSH CONTACT NUMBERS

Key Activity Centres used in the event of a major incident	Location	Tel Ext.
Hospital Co-ordination Centre	Based in 24/7 Room, E&UCC	3547/3548/3576
ED Triage Area	Based in ED-Ambulance Entrance Foyer	3081
Relatives Reception Area	Based in Ante-Natal Area	3286
Press Room	Based in Conference Centre Auditorium	3150
Patients Discharge Area	Based in Physiotherapy Treatment Area	3263
Ambulance Liaison Officer	Based in Out-Patients Department	3666
Police Documentation Team	Based in Consultant's Office in ED	3380
Additional Staff Reception	Based in New Outpts Ophthalmology Reception	2435
Communications Team	Based in the Springfield Block	4476/4482
Key Departmental Numbers		
Emergency Department	Reception	3446/3142
	Sisters Office	2364/2492
	Staff Base	3447/3503
	Staff Office	3380
	Staff Rest Room	3457
	Resuscitation Rooms	2369
	Plaster Room	3276
Operating Theatres	Reception	3500
	Theatre Manager	3577
	Theatre One	2416
	Theatre Two	2415
	Recovery	3141/3274
	Theatre Supply Office	3294
	Central Department	3551
	Theatre Bleep	2159
	ODP Bleep	2233
	Day Surgical Unit	3277
	Day Theatre Manager	3316
	Endoscopy Unit Reception	3421
	Endoscopy Nurse Station	3477
	Endoscopy Recovery	2547
	Endoscopy Sister	2548
Wards	Ward 1	3201/3001
	Ward 3	3203/4284
	Ward 4	3204/2455
	Ward 7	3707
	Ward 8	3868/3062
	Maternity	3306
	PACU	3209
	Ward 10	3210/3580
	Ward 11	3211/3911
	Ward 12	2352/3212
	ACDU (Adult Clinical Decision Unit)	3214/2471
	CCU	3558
	ITU	3337/3440
Radiology	X-RAY	3279
	Radiology Manager	3178
	Radiology Office	3385
Pathology	Blood Transfusion	3230
	Haematology	3271
	Biochemistry	3293
	Microbiology	3318
Pharmacy		3137
Physiotherapy		3260
HSDU		3475
Clinical Engineering		3130/3076
Estates		3463
Medical Records		3108 / 3106

SWITCHBOARD LOG SHEET FOR MAJOR INCIDENT CALL
NOTIFICATION OF A MAJOR INCIDENT FOR:

Bronglais Hospital ☐ Glangwili Hospital ☐
Withybush Hospital ☐ Prince Phillip Hospital ☐

Major Incident Stand-By ☐ Major Incident Declared ☐

Identity of Caller (Agency)	
Tel No	
Name	
Title/Rank	
Time of Call	Time of Incident

M Major Incident?	**YES**	**NO**
E Exact Location		
T Type of Incident		
H Hazards present		
A Access		
N Number, type & severity of casualties		
E Emergency services present		

Any additional information?	

Authenticity verified by ringing caller back	Yes ☐ No ☐

Signature & name of person receiving call:……

……Date……..……...

INCIDENT LOG RECORD SHEET

Date:	**Incident:**
Role being carried out:	**Name of Person undertaking role:**

Time	Message/Decision/Action	Signature

HYWEL DDA UNIVERSITY HEALTH BOARD

DISCHARGE/TRANSFERRED PATIENTS LOG SHEET

Name of Patient	Hospital Number	Transferred/ Discharged from:	Transferred/ Discharged to:	Escort Required? Yes/No	Notes, X-Rays to go with patient? Yes/No

REPORT FOR DECLARATION OF INTERNAL MAJOR INCIDENT

Incident Site:	
Date/Time:	
Name of Person initiating request for internal Major Incident declaration:	
Name of Duty Manager receiving request:	
Time of discussion with County on-call/Executive Director:	
Time of alert call to Ambulance Control:	
Time of alert call to Dyfed Powys Police Control Room:	
Other agencies notified:	
Nature of Incident:	
Number of known casualties:	
Nature of injuries:	
Decision process that led to Major Incident request: - who was consulted: e.g. other colleagues/external agencies - bed state at time (if relevant) i.e. incident due to volume as opposed to type of injury - additional resources required to respond to incident - any other relevant information	

Signature & name of person completing form:……

……Date…….……..

Example Major Incident Alert to Day Patients/Visitors:

We have received notification that a major incident has occurred and this hospital is on standby to receive casualties.

It is policy to cancel all clinics and procedures. Day patients, outpatients, and visitors must be evacuated immediately. Our medical teams will be proceeding to their designated areas to take up their roles in a major incident.

We apologise for the inconvenience of this situation and ask you to do the following:-

- If you are able to leave the hospital by your own means, please do so without delay.
- If you came to the hospital by ambulance, please wait in the designated area in the Outpatients department. A member of staff will be in attendance shortly to make arrangements.
- If you have any problems with your transport, please wait in the Outpatients department until a member of staff arrives to assist.

You will need to reschedule your appointment by contacting the relevant area in 2 working days' time (contact numbers to be handed out by all clinic areas)

Enghraifft Digwyddiad Mawr Rhybudd I Gleifon Dydd/Ymwelwyr:

Rydym wedi cael ein hysbysu bod digwyddiad mawr wedi digwydd a bod yr ysbyty hwn wrth gefn i dderbyn y rhai a anafwyd.

Mae'n bolisi gennym i ganslo pob clinig a thriniaeth. Rhaid ceisio gwagio'r ysbyty o gleifion dydd, cleifion allanol ac ymwelwyr yn syth. Bydd ein timau meddygol yn mynd i'w hardaloedd dynodedig i ymgymryd â'u rolau mewn digwyddiad mawr.

Ymddiheurwn am anghyfleustra'r sefyllfa hon a gofynnwn i chi wneud y canlynol:

- Os oes modd i chi adael yr ysbyty ar eich pen eich hun, gwnewch hynny yn ddioed.
- Os daethoch i'r ysbyty mewn Ambiwlans, arhoswch yn yr ardal ddynodedig yn yr adran Cleifion Allanol. Bydd aelod o staff yn dod atoch cyn bo hir i wneud trefniadau.
- Os oes gennych broblemau gyda'ch trafnidiaeth, arhoswch yn yr adran Cleifion Allanol hyd nes bod aelod o staff yn cyrraedd i'ch helpu.

Bydd angen i chi aildrefnu eich apwyntiad drwy gysylltu â'r adran berthnasol ymhen 2 ddiwrnod gwaith

DEFINITIONS

EMERGENCY SERVICES
The Ambulance, Fire, Police, Mountain Rescue & Coast Guard services. (Military personnel deployed in support of civil powers are not included in this designation).

POLICE CASUALTY BUREAU
A bureau set up by the Police to maintain a list of casualties resulting from a major incident (including casualties dealt with at the site without referral to hospital).

POLICE DOCUMENTATION TEAM
A team provided at a Receiving Hospital by the local Police Force to pass information regarding casualties to the Police Casualty Bureau.

COMMAND SUPPORT UNIT
The vehicle on site provided by the Ambulance Service, which acts as the base for the Medical Incident Commander/Medical Advisor and the Ambulance Incident Commander. It will serve as the Health Service communication centre on site.

MEDICAL ADVISOR
The Medical Officer with overall responsibility, in close liaison with the Ambulance Incident Commander, for the management of medical resources at the scene of a major incident. He/she **should not** be a member of the MERIT (Medical Emergency Response Incident Team) during the incident.

AMBULANCE STRATEGIC COMMANDER
The Senior Ambulance Officer who manages, in close liaison with the Medical Incident Officer/Medical Advisor, the NHS resources at the scene of the incident

LISTED HOSPITALS
Hospitals equipped to receive casualties on a 24-hour basis.

RECEIVING HOSPITALS
Hospitals selected by the Ambulance Service to receive casualties in the event of a major incident.

DESIGNATED HOSPITAL
The **first** Receiving Hospital designated to receive casualties.

SUPPORTING HOSPITALS
A hospital which receives casualties after the Designated Hospital or receives patients transferred from the Designated Hospital to allow for a larger number of casualties to be accepted.

HOSPITAL CONTROL TEAM
The Team, led by the Hospital/On-Call Manager and including the Medical Controller and Nurse Controller, that manages the Hospital's response to a major incident. The Hospital Control Team will be based in the Hospital Co-ordination Centre.

HOSPITAL CO-ORDINATION CENTRE
A centre set up at a Receiving Hospital to collate details of casualties received, their condition and location, hospital bed status, theatre availability, and all necessary information to assist the hospital's response to the incident.

TRIAGE OFFICER
The Doctor who receives and assesses all casualties as soon as they enter the hospital and then decides priority for treatment.

AMBULANCE LIAISON OFFICER
An Ambulance Officer at a Receiving Hospital who is responsible for the provision of mobile radio communications between the hospital and Ambulance Services; for the supervision of Ambulance Service activity and for liaison at the Receiving Hospital.

MEDICAL CONTROLLER
The Doctor responsible for co-ordinating all hospital medical arrangements relating to the major incident.

NURSE CONTROLLER
The Senior Nurse responsible for co-ordinating all hospital nursing arrangements relating to the major incident.

RELATIVES RECEPTION AREA
An area allocated to relatives or friends involved in the major incident, which will be attended by the appropriate specialist personnel, Counsellors, Hospital Chaplain etc.

INCIDENT RESPONSE TEAM
A team of Senior Representatives from Hywel Dda University Health Board, Public Health Wales and other nominated agencies which will usually only be activated in certain circumstances, i.e. communicable disease, radiation incidents, chemical incidents, flu pandemic or other unforeseen circumstances.

TRAUMA NETWORK
A network of hospitals, emergency services and rehabilitation services across the region, working together to ensure patients with life-threatening or life-changing injuries receive the best possible treatment and care.

LOGGIST
Person responsible for recording decisions made, and the time/date and rationale behind the decision.

GLOSSARY

A&C	Acute and Community
AIC	Ambulance Incident Commander
ALO	Ambulance Liaison Officer
AMAU	Acute Medical Assessment Unit
BGH	Bronglais General Hospital
BIRT	Burns Incident Response Team
BSCT	Burns Specialist Care Team
CBRN	Chemical, Biological, Radiational and Nuclear
CCS	Casualty Clearing Station
ChaPD	Chemical Incident Hotline
CIMSU	Chemical Incidents Management Support Unit
CNC	Clinical Night Co-ordinator
COMAH	Control of Major Accident Hazards Regulations
DH	Department of Health
DI	Designated Individual
DoTH	Director of Therapies and Health Science
DPH	Director of Public Health
DSU	Day Surgery unit
DVI	Disaster Victim Identification
ED	Emergency Department
EMRTS	Emergency Medical Retrieval and Transfer Service
EPRR	Emergency Preparedness, Resilience & Response
EU	Emergency Unit
GGH	Glangwili General Hospital
EUCC	Emergency & Unscheduled Care Centre
GP	General Practitioner
HALO	Hospital Ambulance Liaison Officer
HCC	Hospital Co-ordination Centre
HDU	High Dependency Unit
ID	Identification
IP&C	Infection Prevention & Control
ITU	Intensive Therapy Unit
JDM	Joint Decision Model
LRF	Local Resilience Forum
MIO	Medical Incident Officer
MIP	Major Incident Plan
MIU	Minor Injuries Unit
MOU	Memorandum of Understanding
NAIR	National Arrangements for Incidents involving Radioactivity
NBBB	National Burns Bed Bureau
NEMA	National Emergency Mortuary Arrangements
NHS	National Health Service
NNP	Night Nurse Practitioner
NWSSP	NHS Wales Shared Services Partnership
OCM	On Call Manager
OPD	Outpatients Department
PPE	Personal Protective Equipment
PPH	Prince Phillip Hospital
RMU	Radiation Monitoring Unit
RTC	Road Traffic Collision

SAR	Surgery, Anaesthetics & Radiology
SCG	Strategic Co-ordination Group
SPH & HSCRC	South Pembrokeshire Hospital and Health & Social Resource Centre
STAC	Scientific and Technical Advisory Cell
SWTN	South Wales Trauma Network
TCG	Tactical Co-ordination Group
VIP	Very Important Person
WAST	Welsh Ambulance Services NHS Trust
Wd	Ward
WG	Welsh Government
WGH	Withybush General Hospital

5

11:20 AM, 0 Mins

5 - FOR INFORMATION

5.1

11:20 AM, 0 Mins

5.1 - 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 / 6 Month Update	Assurance	Chair	JW	✓			✓		
Health & Safety Committee Annual Report 2026/27	Assurance	Chair	JS	✓					✓
Assurance and Risk Report (3.1.11)	Assurance	JS	RW	✓	✓	✓	✓	✓	✓
H&SC Governance Review	Assurance	Chair	JW					✓	
HEALTH AND SAFETY UPDATES									
Health and Safety Assurance Report (3.1.1)	Assurance	JS	DE&F	✓	✓	✓	✓	✓	✓
Methodology for Site Visits	Assurance	JS	AS	✓					
Review of efficacy of the health, safety, fire and security training programmes (3.1.8)	Assurance	JS	AS		✓				
Health and Safety Annual Report for Board (3.1.15)	Approval	JS	HHSS					✓ draft	✓ final
COMPLIANCE AGAINST INDIVIDUAL REGULATIONS ASSURANCE REPORTS (3.1.2)									
Health & Safety (Part 1) – covering the following regulations:	Assurance	JS	HHSS	✓				✓	

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

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

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

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

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
Major Incident Plan (3.1.13) (Review Date July 2026)	Approval	AG	SH		✓				
Administration									
Agenda setting meeting with Chair & Exec Lead (at least 6 weeks before the meeting)	N/A	CSO	N/A	✓	✓	✓	✓	✓	✓
Draft agenda to go to Executive Team	N/A	CSO	N/A	✓	✓	✓	✓	✓	✓
Call for papers (at least 6 weeks before the meeting to receive papers at least 14 days before the meeting	N/A	CSO	N/A	✓	✓	✓	✓	✓	✓
Disseminate agenda/papers 7 days prior to meeting	N/A	CSO	N/A	✓	✓	✓	✓	✓	✓
Issue a draft TOA within two days of the meeting	N/A	CSO	N/A	✓	✓	✓	✓	✓	✓
Circulate minutes and TOA to the Lead Director within 7 days of meeting	N/A	CSO	N/A	✓	✓	✓	✓	✓	✓
Issue minutes and TOA to Members (including the Committee Chair) following Lead Director review	N/A	CSO	N/A	✓	✓	✓	✓	✓	✓

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

JS	James Severs	**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

6

11:20 AM, 5 Mins

6 - ANY OTHER BUSINESS

All

7

11:25 AM, 5 Mins

7 - MATTERS FOR ESCALATION TO BOARD

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

8

11:30 AM, 0 Mins

8 - DATE AND TIME OF NEXT MEETING

Thursday 10 September 2026, 9.30am-11.30am