Health, Safety & Fire Sub Committee Meeting

Thu 05 June 2025, 09:30 - 11:30

Agenda

09:30 - 09:30
0 min

1. PRELIMINARY MATTERS

Information *Dilys Jouvenat*

1.1. Welcome & Introductions

Information *Dilys Jouvenat, Independent Member /Sub Committee Chair*

1.2. Apologies for Absence

Information *Dilys Jouvenat, Independent Member /Sub Committee Chair*

1.3. Declarations of Interest

Information *Dilys Jouvenat, Independent Member /Sub Committee Chair*

09:30 - 09:30
0 min

2. CONSENT AGENDA BUSINESS

The Sub Committee Chair will ask if there are any items from the Consent agenda (Section 8) that the Sub committee Members wish to bring forward to the main agenda.

09:30 - 09:30
0 min

3. COMMITTEE GOVERNANCE ARRANGEMENTS

3.1. Action Log

Information *Dilys Jouvenat, Independent Member /Sub Committee Chair*

3.2. Action Log and Matters Arising not considered within the Action Log

Infromation *Dilys Jouvenat, Independent Member /Sub Committee Chair*

3.3. Outcome of Sub Committee Self-Assessment

Information *Emma Walters, Head of Corporate Governance & Board Business*

3.3. Outcome of Committee Self Effectiveness Survey HSFSC June 25.pdf (6 pages)

09:30 - 09:30
0 min

4. STAFF AND SERVICE USER EXPERIENCE

4.1. Shared Listening & Learning Story - Manual Handling - Deferred to next Committee Meeting

09:30 - 09:30
0 min

5. SETTING THE SCENE - SERVICE DELIVERY

5.1. Assistant Director of Health, Safety & Fire Report

Discussion *Chris Beadle, Assistant Director of Health, Safety & Fire*

5.2. Fire Safety Report

Discussion *Carl Edwards, Senior Fire Officer*

- 5.2. Fire Safety Report - Health, Safety & Fire 5 June 2025.pdf (13 pages)
- 5.2.a. Apprendix 1 - Extreme Fire Risks June 2025.pdf (3 pages)
- 5.2.b. Apprendix 2 - Fire Strategy.pdf (1 pages)

5.3. Overarching Care Group - Health, Safety & Fire Highlight Report

Discussion *Sarah James, Deputy Chief Operating Officer*

- 5.3. Overarching Care Group - Health Safety Fire Highlight Report 5 June 2025 SL amends.pdf (13 pages)

5.3.1. Children & Families Care Group - Health, Safety & Fire Highlight Report

Discussion *Carl Verrecchia, Care Group Service Director*

- 5.3.1. Children Families Care Group - Health Safety Fire Highlight Report 5 June 2025 SL amends.pdf (7 pages)

5.3.2. Diagnostics, Therapies, Pharmacy & Sciences Care Group - Health, Safety & Fire Highlight Report

Discussion *Carl Verrecchia, Care Group Service Director*

- 5.3.2 DTPS Care Group Highlight Report 5 june 2025 SL amends.pdf (7 pages)

5.3.3. Facilities - Health, Safety & Fire Higlight Report

Discussion *Stephen Gardiner, Facilities Service Director*

- 5.3.3. Facilities - Health Safety Fire Highlight Report 5 June 2025 SL amends.pdf (10 pages)

5.4. Ventilation System Compliance Report

Discussion *Tim Burns, Assistant Director of Planning & Alan Martin, Head of Operational Estates &*

- 5.4 Ventilation System Compliance- HSFSC 5th June 2025.pdf (11 pages)

09:30 - 09:30
0 min

6. DELIVERING OUR PLAN

6.1. Health, Safety & Fire Performance Report - Deferred to next Committee Meeting

Discussion *Chris Beadle, Assistant Director of Health, Safety & Fire*

09:30 - 09:30
0 min

7. GOVERNANCE, RISK AND ASSURANCE

7.1. Organisational Risk Register - Risks assigned to Health, Safety & Fire Sub Committee

Discussion *Emma Walters, Head of Corporate Governance & Board Business*

- 7.1a Organisational Risk Register - May 2025 HSF CP.pdf (5 pages)
- 7.1b Appendix 1 - Org RR May 2025 - HSFC.xlsx (3 pages)

09:30 - 09:30
0 min

8. CONSENT AGENDA

8.1. FOR APPROVAL

8.1.1. Health, Safety & Fire Sub Committee Annual Report

Endorse for Approval *Emma Walters, Head of Corporate Governance & Board Business*

8.1.1. HSFSC Annual Report - Cover Report 5 June 2025.pdf (3 pages)
8.1.1.a. Appendix 1 HS&F Sub-CMt Annual Report HSFSC June 25.pdf (7 pages)

8.1.2. Unconfirmed Minutes of the meeting held on 1st April 2025

Decision *Dilys Jouvenat, Independent Member / Sub Committee Chair*

8.1.2. Unconfirmed Minutes HSFSC 3 April 2025 v3 Approved by Dilys.pdf (8 pages)

8.2. FOR NOTING

8.2.1. Sub Committee Annual Cycle of Business 2025

Information *Emma Walters, Head of Corporate Governance & Board Business*

8.2.1. CTMUHB HSFSC Cycle of Business - 5 June 2025.pdf (2 pages)

09:30 - 09:30
0 min

9. CLOSE OUT BUSINESS

Agenda Item
3.3

Health, Safety & Fire Sub Committee

Committee Annual Self Effectiveness Survey Outcome 2024-2025 & Improvement Plan

Dyddiad y Cyfarfod / Date of Meeting	05/06/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Tyler Lewis, Corporate Governance Officer
Cyflwynydd yr Adroddiad / Report Presenter	Dilys Jouvenat, Independent Member / Sub Committee Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Hywel Daniel, Executive Director for People

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**

Acronyms / Glossary of Terms	
Nil	

1. PURPOSE

1.1 The Chair of the Health, Safety & Fire Sub Committee is required to present an annual report to the Board outlining the Committee's business through the financial year to provide an assurance. As part of this process, The Committee are required to undertake an annual self-assessment questionnaire.

1.2 Members of the Committee are asked to discuss and review the feedback set out in this report which relate to its activities and performance during 2024-2025

1.3 Members should note that 5 responses were received out of a total of 9 which equated to 55.5%

2. SUMMARY REPORT

Positive Assurance	All respondents confirmed that the Committee Annual Report was produced and presented to the Quality, Safety & Experience Committee to ensure alignment with its remit. 100% of Members/Attendees unanimously agreed that the Committee met frequently enough to address planned matters adequately and that sufficient time was allocated for questions and discussions during the meetings. All respondents agreed that all Members and Attendees of the Committee were courteous and professional. Most respondents agreed that Subcommittee meetings were scheduled before important decisions. 80% of respondents believed private meetings were appropriately held for sensitive items. All respondents unanimously agreed that their experience with holding meetings remotely or virtually was positive. The survey indicated that members and attendees concurred that the committee meetings were chaired efficiently, with clear objectives and outcomes. 100% of respondents indicated that the chair provided clear updates on activities and areas of escalation through the highlight report to the Board.

Areas of Note	Whilst most responders were satisfied there were some responders who felt that the Sub Committee may need a review regarding its function Whilst many responders felt they were adequately trained for their role, some responders indicated that they would welcome further training Eighty percent of respondents agreed that the Committee possessed sufficient authority and resources to perform its role effectively. One respondent suggested that a review of the Committee's purpose might be necessary, considering whether assurance could be provided in an alternative manner. It was also noted that there is currently insufficient operational representation, and that estates health, safety, and facilities risks are not being adequately addressed. 67% of respondents agreed that the Committee Meetings facilitate open and productive discussions. 33% stated that the committee often focuses too much on operational details, and strategic issues such as estates risks receive insufficient attention. Further comments indicated that debates can sometimes become more operational rather than focusing on strategic oversight and assurance. The survey indicated that 80% of respondents did not perceive a need for the use of the Welsh language within the Committee, whereas 20% expressed support for its use. 40% of respondents indicated that the Committee receives adequate support from the Executive Leads in areas such as attendance, the quality of papers, and responses to challenges and scrutiny. However, 40% suggested that further exploration is needed regarding the involvement of the Executive Leads for Estates and Facilities, with a focus on preventing duplication. The remaining 20% did not provide any comments.
Areas Requiring Further Consideration	**Committee Effectiveness - Areas for action/improvement** were identified as follows: 80% of members/attendees who responded were aware that there are approved Terms of Reference (TOR) in place, defining the role of the Committee and reviewed annually. However, one respondent noted that they did not remember reading or seeing a TOR document and could not find any email with the TOR attached or a document easily accessible on Admincontrol or the Intranet. 40% of respondents believe more involvement from Executive Leads for Estates and Facilities should be explored. 20% of respondents suggested reviewing the Sub Committee's role to avoid overlapping responsibilities in Estates and Facilities.

	More operational input is needed, and risks related to estates, health, safety, and facilities are not being properly addressed.

Action Plan	In response to the areas of improvement identified the following actions are proposed:
	
	• Place the Terms of Reference on the main agenda when due for their next review to increase visibility and awareness
	
	• Further discussion to be held between the Executive Lead and Senior Corporate Governance Team regarding:
	  ○ undertaking a review of the Sub Committees role and purpose;
	  ○ reviewing the membership of the Sub Committee to ensure adequate Executive Director representation is in place and that there is adequate operational representation from Estates and Facilities teams
	  ○ ensuring that future meetings are more strategically focussed as opposed to operationally focussed

Appendices	

3. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Not Applicable If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research If more than one applies please list below:

Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not Required
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not Required
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

3. RECOMMENDATION

3.1 The Sub Committee is asked to **NOTE** the report.

Agenda Item
5.2

Health, Safety & Fire Sub Committee

Fire Safety Report

Dyddiad y Cyfarfod / Date of Meeting	05/06/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Carl Edwards – Senior Fire Officer
Cyflwynydd yr Adroddiad / Report Presenter	Carl Edwards – Senior Fire Officer
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Hywel Daniel, Executive Director for People

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
SFO	Senior Fire Officer
FO	Fire Officer
FRA	Fire Risk Assessment(s)
SWFRS	South Wales Fire & Rescue Service
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital

POWH	Princess of Wales Hospital
GRH	Glanrhyd Hospital
UPS	Uninterrupted Power Supply
PPM	Preventative Planned Maintenance
SB UHB	Swansea Bay University Health Board
MCP	Manual Call Point
AFA	Automation Fire Alarm

1. Situation /Background

1.1 The purpose of this report is to inform and update the Health, Safety & Fire Sub Committee of the current situation and main issues with Fire Safety within the Health Board.

1.2 The Health Board is duty bound to comply with the current Fire legislation (Regulatory Reform Fire Safety Order 2005 (RRFSO) and WHTM 05 Fire code). Basically:

- Prevention as opposed to intervention (Prevent the fires from occurring).
- Good management of fire safety (Ensuring everyone is aware of what good fire safety management is).
- Responsibilities (Self-Explanatory who is responsible for what).

2. Specific Matters for Consideration

2.1 **Enforcements**. Currently the Health Board has ONE active fire enforcement notice from SWFRS.

- ACTIVE - Prince Charles Hospital Ground & First floors Merthyr block. One of its kind due to the extent of work and timescale. Each year the Health Board must apply for an extension of time and funding. *Ongoing Estimated completion 2026. The Health Board* is progressing with the works in line with the recently granted extension. Concentrated efforts have been placed upon completion to main Theatres and ensuring all compartmentation works are compliant. SWFRS have requested an update meeting in July 2025 at PCH.

- NON-ACTIVE - POW theatres, enforcement notice was lifted on 01.01.2025 following disclosure around the condition of the roof and the proposal of works, the proposed work encompasses the enforcement notice issued for compartmentation within the plant space above theatres.

2.2 **SWFRS Activity.**

Since the last report there has been one audit carried out by SWFRS.

- RGH – 06.05.2025 – Estates (PPM Paperwork and contracts)

IN01 notice to be issued for this audit, not received at time of writing this report. These are information notices that require actions to be carried out

in a reasonable time frame, agreed with RGH and SWFRS through action plans.

Automatic Fire Alarm Exemptions

Following the changes to AFA procedures implemented by SWFRS on 07th April 2025 numerous exemption requests have been submitted.

Rejected Exemptions:	Royal Glamorgan Hospital Princess of Wales Hospital Prince Charles Hospital Glanrhyd Hospital Ysbyty Cwm Cynon Ysbyty Cwm Rhondda Ysbyty George Thomas
Granted Exemptions:	PCH Residences RGH Residences POW Residences Dewi Sant Health Park Kier Hardy Health Park

3. Key Risks / Matters for Escalation

3.1 **Prince Charles Hospital –** Remains a significant risk across all centre core landings within the main H block, the areas have become increasingly cluttered with:

- Beds, mattresses, wheelchairs, walking aids etc.
- Clinical stores not being put away, left on pallets in the lift area, this is subject to fire, theft and potential accidents.

The current risk associated has been added to the Health Board's Organisational Risk Register.
(ID: 5545).

This risk continues to be unmanageable with more obstructions being placed in common walkways and more concerning the continual blocking of the evacuation routes to the evacuation lifts.
Environment Tours have been organised by the Hospital General Manager at PCH to look at the continuing problem with the ideal to identify and rectify the perpetrators.
This continues to pose a risk with control measures in place.

3.2 **Glanrhyd Hospital Fire Alarm –** This programme of works is now complete, with new fire zone plans indicating all changes, and the emphasis is now on Fire Door Replacements.

Further works have taken place following the recent re-occupation of Ward 3 Angleton Ward.

Taith Newydd – Cedar Ward remains unoccupied following the serious fire on 22.11.2024. Numerous meetings have been held with SB UHB and CTM UHB to discuss next steps.

3.3 **Princess of Wales Hospital Theatre Enforcement –** Lifted on 01.01.2025 - Following recent developments at POWH, identification of the damaged roof, the location of the enforcement notice is directly under a section of damaged roof, therefore this area has been decanted of staff, as this area is now vacant there is no longer a risk to life.

The breeches identified under the enforcement notice will be addressed as part of the extensive roof repairs taking place.

Continuous communication is a key factor with SWFRS, to engage with them the understanding of the programme of works.

Due to the decant of patients from POWH, the following areas have been reopened or repurposed for patient use:

Ysbyty George Thomas – Fernhill and Dinas wards
Glanrhyd – Angleton Ward 3
Royal Glamorgan Hospital – Ward 23(MHU) now Pre-Assessment unit, Children's wards condensed to one template and adults now occupy adjacent template.

Fire Officers have been involved in updating Fire Risk Assessments, Fire Evacuation Plans, Ward Training and ensuring all staff are confident in the fire safety of their new homes.

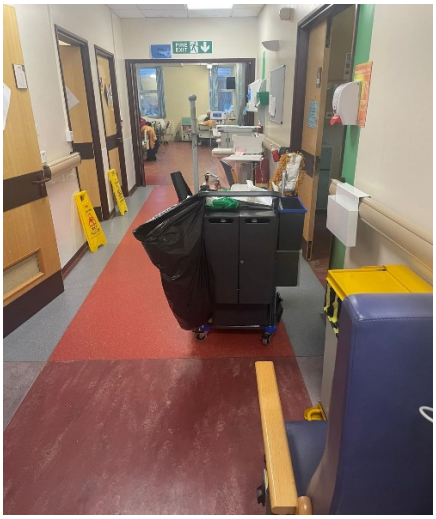
3.4 **Royal Glamorgan Hospital** – Vanguard Modular Theatres / Endoscopy units.

The project is complete at RGH to create more clinical space to address increased waiting lists for minor procedures.

Endoscopy unit consist of 2 modular buildings, with 2 treatment rooms and six recovery bays, this unit saw its first patient on 04/03/25. The building is well protected from fire with its own inbuilt automatic fire alarm and water suppression system, evacuation training has commenced with staff including a trolley evacuation back into the main hospital.

Theatres consists of 4 theatre modules with associated recovery bays and administration facilities, these saw the first procedures completed on 10/04/25. These buildings are also protected by a water suppression system and have been inspected by SWFRS for suitability – no issues raised.

RGH has now become a significant risk following the increased numbers of patients and staff decanted from POWH. This has impacted on how wards / departments are occupied and used, resulting in corridors being heavily loaded with equipment. Fire doors being wedged open or on the reverse fire doors/routes blocked and unable to sustain our progressive horizontal fire evacuation strategy.



This is now being addressed with the RGH Site Manager.

These areas have been addressed and there are now weekly walk arounds to ensure continuity.

3.5 **Fire Safety Team Resource** - The Fire Safety Team has and continues to struggle to meet the needs of the Health Board due to reduced levels of experienced Health Board Fire Officers. However, the service provided has been complimented on by SWFRS as one of the highest professionalisms.

The Health Board currently has 4 full time Fire Officers and 1 x Senior Fire Officer, compared to 2020 when there was 6 full time Fire Officers and an SFO. These staff have been relocated across the Health Board to provide basic fire safety provisions. Fire Officers are located at PCH, RGH, POWH and GRH, whilst the SFO is now located centrally at Dewi Sant. Every effort is being made to supply all the sites with equal access and support.

This resource concern was highlighted by the NHS Wales Shared Services Partnership: Governance and Assurance audit carried out in July 2021, this concern is replicated across all Wales, and recruitment of Health Board FO's is proving problematic.

This resource concern lends itself to the potential for a FO Apprenticeship scheme. A meeting was carried out on 15/05/2025 with actions taken by the Health Board's Authorised Engineer in NWSSP Shared Services to investigate potential avenues for this training.

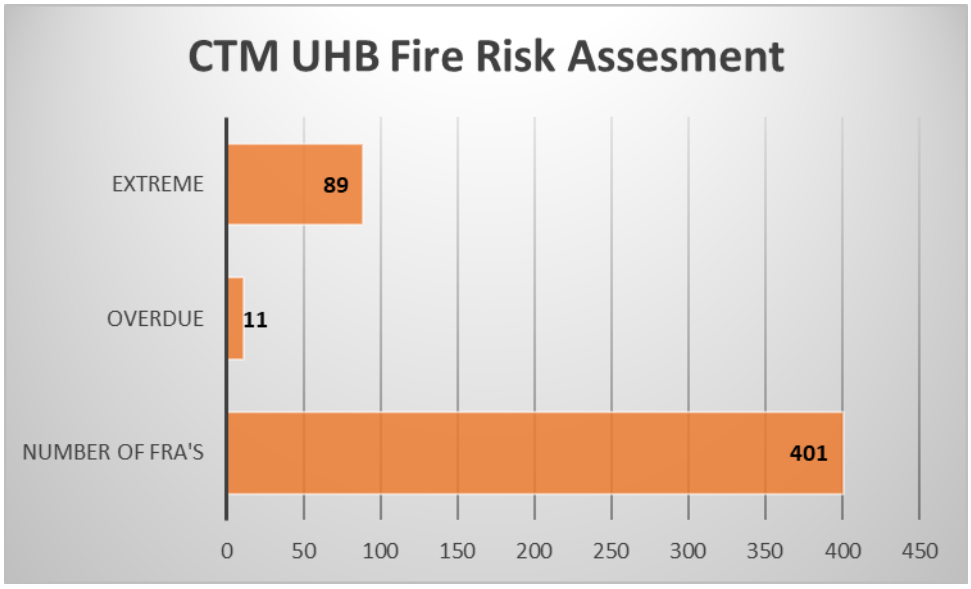
It is noticeable at CTM UHB we have an aging workforce within the fire safety team and without future investment and training our own FO's, there will be a significant gap in years to come.

The current risk associated with competent FO Provision has been added to the Health Board's Organisational Risk Register. (ID: 4356).

3.5 **Fire Risk Assessments (FRA) –** NWSSP introduced a new Fire Risk Assessment portal (FARS) in July 2024, with a 3 to 5-year transition period. As current FRA's come up for review, they will be reviewed against the new FARS.
Improvements have been made across all sites in relation to updating/reviewing FRAs. However due to continual changes of areas, FRAs will never be 100% up to date. Every effort is made to

ensure FRAs across the Health Board are reviewed in the required times. The Fire Team resource issues and increased operational requirements on the Fire Officers that are available will undoubtedly have an impact on keeping FRAs up to date.

Copies of FRAs are sent to Care Group leads to ensure they are aware of the issues on their sites. Care Groups review and monitor progress against the FRA's presented. Any significant risks are discussed at their relevant meetings and solutions found to reduce these risks. Care Groups escalate any significant risks that cannot be addressed.

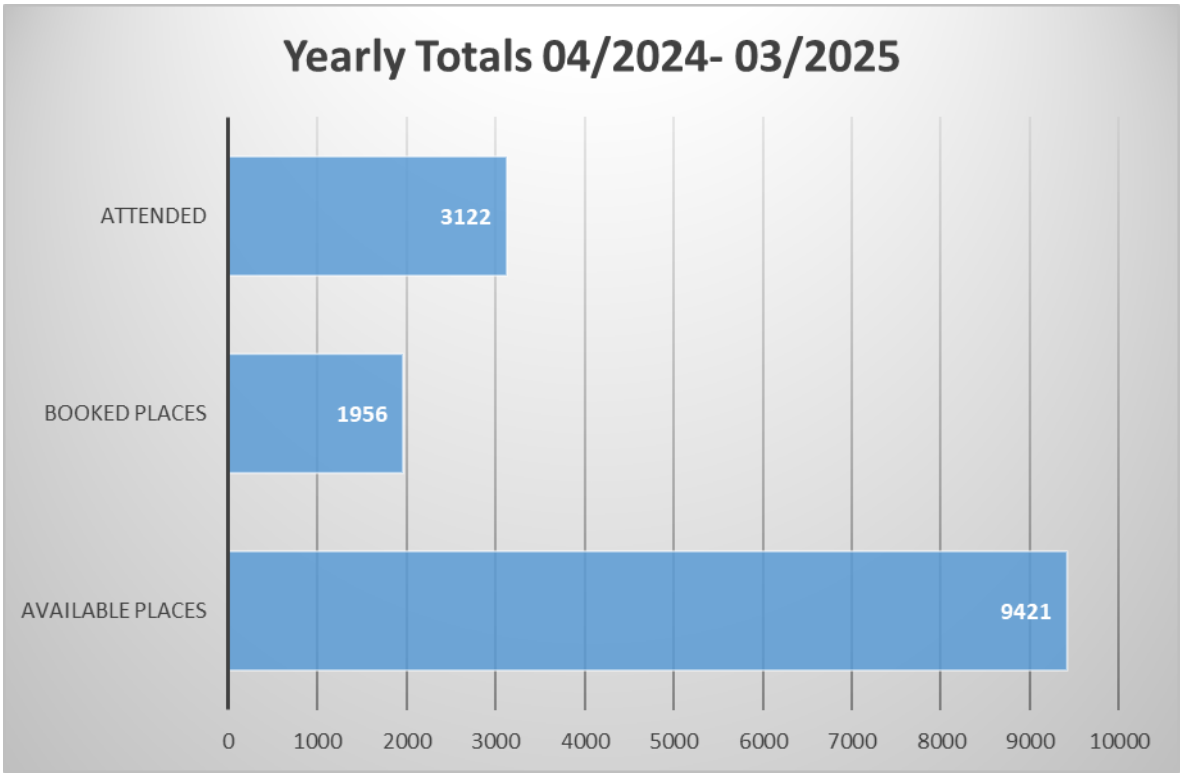


- Total number of FRA's across all sites is 401.
- As of 21.05.2025, overdue FRA's is 11, (Evidenced in NWSSP FRA Reporting System).
- Of the 401 FRA's there are 89 extreme risks, this is 23% of the total risks, and range from risks such as:
    - Training – noncompliant staff
    - Fire doors – damaged
    - Room changes of use
    - Non authorised equipment in high risk areas
- These extreme risks are being addressed by CTM UHB Estates management team. See Appendix 1 for the list of extreme fire risks

3.6 **Training -** Face to face training is being carried out at PCH, RGH and POW with a minimum of 3 session per month per site. Dates are advertised on the Fire Safety Intranet Page, and through ESR with

the Admin Function now being carried out by the Health Safety and Fire Team.

Adhoc sessions are also delivered at satellite sites when requested.



Compliance for fire training is the responsibility of the manager and the staff member and they must undertake the face to face training where provided.

Compliance is now awarded though the Health Safety and Fire Admin Support person on completion of the training register.

At 05.03.2025 compliance for all levels of training is currently **65.45%** which is **+1.04%** on the previous month and **-19.55%** on the 85% target.

The "Fire Management" face to face training continues, with monthly sessions held at PCH, then the next at RGH and then at POWH, these dates will continue every month at each location in succession.

The "Senior Management" Fire E learning package is still available for those holding above band 8b and is available to access and complete for those members of management.

Due to changes to Health Board induction there is no fire training provided for new starters. Any new starters are being advised to attend face to face training with a Fire Officer as a priority.

3.7 **Fire Incidents & False Alarms 05/03/2025 – 21/05/2025.**

Fire and false Alarms continue to fluctuate within the Health Board, with peaks and troughs. Common causes continue to be:

- Cooking left unattended or cooking and leaving the door open to kitchens allowing smoke to leave the kitchen activating corridor detection.
- Increased activations in Mental Health Departments; including deliberate activation of Manual Call points, deliberate acts of smoking and deliberate acts of setting fires.
- Steam from showers. Excessive steam due to poor ventilation and patients showering for a considerable time allowing excessive steam build up. When opening door from ensuite, steam shocking the detector.
- Accidental / Deliberate activation by patients exiting a ward or department.

Below is a summary of incidents, this does not include near misses as these are not recorded nationally. Near misses are classed by the Health Board as incidents that were avoided due to staff interaction such as staff isolating electrics or discovering what could have been a possible start of a fire and preventing it by addressing the cause.

Comparison of fire incidents and UwFS on a site-by-site basis
Between 05/03/2025 and 21/05/2025 inclusive

62 incidents found.

Site	Fire	UwFS
Caswell Clinic, Tondu Road	0	2
Glanrhyd Hospital, Tondu Road	0	9
Maesteg Community Hospital, Neath Road	1	0
PCH - Staff Residences, Prince Charles Hospital	0	2
POW - Staff Residences, Coity Road	0	1
Prince Charles Hospital, Gurnos Estate	0	9
Princess of Wales Hospital, Coity Road	0	15
Royal Glamorgan Hospital, Ynysmaerdy	1	17
Tonteg Medical Records, Tonteg Hospital	0	1
Treorchy (Central Processing) Cook Chill Unit, Cae Mawr Industrial Estate	0	1

Ysbyty Cwm Rhondda, Partridge Road	**0**	**2**
Ysbyty George Thomas, Cwmparc Road	**0**	**1**

Whilst every effort to reduce these have been made by the Health Board Fire Officers, it is the responsibility of site management to act upon reports provided by the Fire Officers for each incident.

The table below demonstrates an increase in the UwFS and a decrease in Fires, and I would attribute this to increased training sessions at specific locations.

11/11/2024 – 05/03/2025		**05/03/2025 – 21/05/2025**	
Fire	Fire	Fire	UwFS
5	58	1	61

The Fire Officers provide a report for every incident as they occur to the Care Groups. Advice and guidance to address each incident is also provided, but as the Fire Officers have no enforcing powers, they can only escalate to Care Group management to address non-compliance. Each Care Group is requested to provide feedback at their Health Safety and Fire Group meetings of any significant issues that cannot be addressed.

3.8 **Major Incidents –**

23/03/2025 @ 14:38 RGH – Plantroom.
MCP was activated by an Estates electrician, having been alerted by a mains power failure alarm. Having gone to investigate the cause within the External Standby Generator 1 cabin and having smelt burning from within generator cabin, operated an MCP in Estates Yard.
The External Generator cabin was unoccupied, and no other evacuation was necessary.
Fire service attended incident.
Fire appeared to have self-extinguished.
Information received from site Estates manager indicates that a possible loose electrical connection, within a distribution board controlling systems within generator cabin, shorted, causing a small electrical fire which was contained within distribution board. This however tripped out electrical control services resulting in the mains gas supply being isolated, therefore disabling kitchen equipment, Boilers, steam equipment and heating systems.

Estates site Manager was able to have new distribution board purchased and fitted by electrical contractor in short period of time, enabling all disabled systems to become operational.
No further damage caused. No injuries reported. Approx. incident cost £2,000.

Full incident reports are available upon request.

3.9 **Fire Strategic Plan.**
As part of an Internal Fire Safety Management Audit conducted by NWSSP Audit and Assurance services it was highlighted the lack of a Mid-Term (3 year) Fire Strategy Plan.
A 3-year Fire Strategy Plan has been developed and is attached for the board's information.
The plan is very dependent upon capital investment to ensure completion of significant risks. Lack of this investment will not see completion of this plan.
Achievable risks have been highlighted and are either completed or currently under review. Please see Appendix 2 for copy of the Fire Strategy.

4 Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Not Applicable
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below:

Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Update Report
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?* / **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: Update Report
Cyfreithiol / Legal	Yes (Include further detail below)	
	Civil or Criminal Prosecution	
Enw da / Reputational	Yes (Include further detail below)	
	Following Civil or Criminal Prosecution	
Effaith Adnoddau *(Pobl /Ariannol)* / **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Ongoing Fire Safety Maintenance	

5 Recommendation

5.1 The Sub Committee is asked to note the Fire Safety Update Report

6 Next Steps

6.1 Further update reports will be provided to future Sub Committee meetings.

Action plan findings
All sites, all areas, risk levels: Extreme, all questions, all responsibilities

Introduction

The Regulatory Reform (Fire Safety) Order, that came into force on 1st October 2006, requires 'general fire precautions' to be put in place 'where necessary and to the extent that is reasonable and practical' for the protection of the 'relevant persons'.
Article 9 of the Fire Safety Order imposes a duty upon the 'responsible person' to make a suitable and sufficient assessment of the risks. Therefore, it is through the fire risk assessment process that the necessary measures are identified.
Responsibility for complying with the Fire Safety Order rests with the responsible person. Broadly, in a workplace this would be the employer or any person who has control of any part of the premises (for example the occupier or owner). Where there is more than one responsible person such as in multi-occupied premises, all must take reasonable steps to co-operate and coordinate with each other.
In support of the Fire Safety Order the Department for Communities and Local Government published a series of premise specific guidance documents on undertaking risk assessments, one of which refers to healthcare (the Green Guide).
These guidance documents all adopt the 'five-step' risk assessment process as illustrated.
Due to the complex nature of 'healthcare' premises, the Department for Health, in conjunction with CFOA representatives, published HTM05 03 Part K Fire Risk Assessment in Complex Healthcare Premises as part of the Firecode suite of documents.
This Organisation undertakes fire risk assessments following the recognised guidance adopting a standardised approach for the healthcare organisations in Wales.
Risk assessments should only be conducted by competent persons and all fire risk assessments should be maintained up-to-date, furthermore prioritised action plans should be implemented to address any significant findings identified.

Ref.	Question	Assessment name	Findings	Variation/justification or action required	Risk rating	Anticipated completion	Action taken	Signed	Dat
A1.1	Are processes such as cooking, welding or frictional heat present in the assessment area?	DSHP, Estates Building & Boiler Room	At the time of assessment, room EST 413C was in use as the designated kitchen for the building. It contained a microwave. The microwave displayed signs of damage to its outer casing.	It is highly recommended that the microwave is removed due to the damage displayed and the uncertainty of its serviceability.	16	Immediately			
A1.1	Are processes such as cooking, welding or frictional heat present in the assessment area?	Template 161 Ambulatory Emergency Care Unit (AECU)	At the time of assessment room TM 37, (DU 38) currently identified as a Treatment Room, was in use as a kitchen. It contained a microwave, toaster, heated sandwich maker, large fridge freezer unit, fridge and kettle. This room does not meet the standards required for a kitchen. This was identified in previous FRA. FB1 upgrade request submitted 10/06/21. No further action undertaken to upgrade room.	It is highly recommended that until such time as the room is upgraded to the standard required, (WHTM 05-02 Hazard room) the microwave, toaster and sandwich maker are removed from this room. The assessment area is now in use as an inpatient area.	16	Immediately			
A1.1	Are processes such as cooking, welding or frictional heat present in the assessment area?	Ward C3	At the time of assessment, room C319 was identified as a Quiet room. This room was i use as a staff kitchen and equipped with a microwave. Although the room is identifiable as a hazard room, it is equipped with piped medical gas outlets and as such cooking appliances are not permitted in this room.	It is highly recommended that the microwave be removed from this room immediately.	16	Immediately			
A1.1	Are processes such as cooking, welding or frictional heat present in the assessment area?	Template 203 Ward 8,9 & Common Areas	At the time of assessment room OEA 52 was in use as a departmental secretaries office. Previous 2 FRA's indicated that the microwave must be removed and that the room is in use as an office or kitchen not both.	It is highly recommended that the microwave is removed from this office as does not comply to current fire safety/departmental guidlines. This room is not a designated kitchen.	16	Immediately			
A1.2	Are ignition sources controlled/managed?	Mental Health Rehabilitation Unit	At the time of assessment and from information recieved matches and lighters are confiscated from the service users and staff monitor smokers when lighting their cigarettes, staff also carry out environmental checks hourly/weekly unannounced room checks which includes checking for illicit smoking and checking the kitchen areas. If/when necessary an individual 'care plan' is carried for the needs of the service user known to be a particular risk.	Staff have robust measures in place attempting to control ignition sources, however these measures are made more challenging as the majority of service users have open access to the nearby town where they are able to purchase/obtain matches lighters and possibly share these with fellow service users.	16	continue to manage			
A1.2	Are ignition sources controlled/managed?	Template 202 - Ward 10, Ward 11 & Common Areas	At the time of assessment, room 7 (ward 10) was in use by Pharmacy. . It was equipped with a Zebra electronic labelling device, which is subject to a Fire Alert notification (attached to FRA).	It is highly recommended that the ward manager brings this to the attention of Pharmacy staff in order to ascertain from ICT the status of the device.	16	Immediately			
A1.2	Are ignition sources controlled/managed?	Pharmacy Department	At the time of assessment, area ST 8, was in use as a storage area and charging area for electric floor cleaning equipment. Adhesive tape was wrapped around a power cable.	It is highly recommended that this is addressed and if cable is damaged, it must be replaced by authorized Estates staff or maintenance contractor.	16	Immediately			
A1.2	Are ignition sources controlled/managed?	Catering Department & Reception Offices.	At the time of assessment, room SUP 13 is in use as the General Office. An IT server unit, cables and extension leads are located underneath desks within the office. Above is a make shift water leak drainage system terminating in a bucket. Information received indicated that water from the ceiling had previously made contact with the electrical sources on the floor resulting in a burning smell.	It is highly recommended that this finding is addressed. Cabling should be more suitably managed. Measures must be taken to remove electrical equipment from below the makeshift leak drainage system in order to prevent further incidents involving water making contact with the power sources on the floor possibly causing an electrical safety hazard/fire hazard and prevent communication disruption due to water ingress on the server unit on the floor.	16	Immediately			
A1.4	Are permanent and temporary electrical sources suitably managed?	Pharmacy Department	At the time of assessment, an electrical cable reel was i use within the distribution and receipt area of the department. The use of this equipment is not permitted within the HB.	It is highly recommended that measures are taken to remove this equipment and an alternative mains power source be obtained.	16	Immediately			
A1.4	Are permanent and temporary electrical sources suitably managed?	Day Hospital, Gastro & Vaccination Areas	At the time of assessment, the vaccination centre store room had a 4 way drum extension lead plugged into the mains, into the drum were plugged 4 extension leads to power 5 fridges.	Estates should be requested to provide additional sockets	16	Within 28 days of this assessment			
A1.6	Is the risk of arson addressed within the assessment area (including patient ignition)?	Mental Health Rehabilitation Unit	Although staff monitor the ignition sources and carry out hourly/weekly checks there will always be the opportunity for service users to obtain ignition sources, therefore there is always risk of the service users starting a fire.	Continue to manage the risk of arson to a level as low as reasonably practicable and report any suspected arson incidents.	16	continue to manage			
A1.7	Is smoking permitted or are smoking materials present?	Mental Health Rehabilitation Unit	At the time of assessment smoking was allowed in the smoking shelter situated in the enclosed garded area, there is a wall mounted 'ciglow' cigarette lighter available in the garden area.	Staff would provide the matches/lighters, monitor service users lighting their cigarettes and remove the ignition sources when finished. As from 01st October 2024, smoking will not be permitted with the foot print of Pinewood house.	16	continue to manage			
A1.7	Is smoking permitted or are smoking materials present?	Template 272 MHU Ward 22 (Taff Ely)	At the time of assessment, the designated smoking area, which is used by patients from 3 MH wards, was an enclosed external patio area within ward 21. Several patients were smoking within this area, with the access door open, patients entering corridor with cigarettes while being supervised by 2 student nurses on their first day	It is highly recommended that appropriate staff supervise this area while in use and the door remains closed, restricting patients from entering the corridor while smoking and activating the fire alarm system.	16	Immediately			
A1.7	Is smoking permitted or are smoking materials present?	Template 271 MHU Ward 21 (Rhondda Unit)	At the time of assessment, the designated smoking area, which is used by patients from 3 MH wards, was an enclosed external patio area within ward 21. Several patients were smoking within this area, with the access door open, patients entering corridor with cigarettes while being supervised by 2 student nurses on their first day.	It is highly recommended that appropriate staff supervise this area while in use and the door remains closed, restricting patients from entering the corridor while smoking and activating the fire alarm system.	16	Immediately			
A1.7	Is smoking permitted or are smoking materials present?	Ward B2	At the time of assessment, smoking was not permitted within the assessment area. Information has been received indicating that a ward patient has been smoking and vaping within the assessment area. This failing to comply to the HB Ignition Control Policy and HB Fire/Smoking Policy.	It is highly recommended that all patients admitted to wards are informed of the No Smoking Policy and Control Of Ignition Source policy and of future enforcement action.	16	Immediately			
A1.7	Is smoking permitted or are smoking materials present?	Template 270 MHU Admissions Unit	At the time of assessment, the designated smoking area was an enclosed external patio area within ward 21. Several patients were smoking within this area, with the access door open, patients entering corridor with cigarettes while being supervised by 2 student nurses on their first day.	It is highly recommended that appropriate staff supervise this area while in use and the door remains closed, restricted patients from entering the corridor while smoking and activating the fire alarm system.	16	Immediately			
A2.1	Are flammable/highly flammable materials managed/stored correctly?	Unit 2 - Gwaun Elai (The Hub)	At the time of assessment room FF02 (Innovation Team) was equipped with a Flam Locker, with various types of flammable substances stored within. Containers within the locker appear to be leaking resulting in soiled packaging and and the lockers sump reservoir containing fluid.	It is highly recommended that this finding is addressed and measures taken to remove damaged items/leaked fluid from the flam locker, ensuring there are no heat/ignition sources operating at the time. Staff must display contents of Flammable substances on locker door and comply with COSHH guidelines regarding use and storage.	16	Immediately			
C4.19	Is the organisation's arson policy being effectively managed on this site?	Quarella Road Health Clinic	At he time of assessment the cover for the external gas meter had been removed allowing persons access to the meter and the valve.	The cover should be re-instated.	16	Within 7 days of this assessment			
A2.2	Are combustible materials adequately managed?	Template 213.Multi Occupancy Offices	At the time of assessment, combustible materials were located/stored within the Means of Esacpe. This has been highlighted in previous FRA'S. Departmental staff were requested to remove such items at the time of assessment. This has also been highlighted by the Fire Service attending an incident within assessment area.	It is highly recommended staff/departmental managers ensure no equipment/ furnishings/ christmas decorations, are stored / located within the Means of Escape. These areas must remain clear at all times.	16	Immediately			
A2.3	Is combustible waste allowed to accumulate?	T174 Mental Health Crisis Management Team, Reception, ECT & Administration .	At the time of assessment, large quantities of combustible waste was located within the ECT department areas. Some of which obstructed doors restricting access to rooms within this area.(Rooms ECT 02, 03 & 04). This waste is mainly contractors waste and dept.equipment.	It is highly recommended that all waste is removed from this area and disposed of in external waste disposal area. Waste/items obstructing doors may impede emergency access if required.	16	Immediately			
A3.1	Is there piped oxygen in use?	Ward C3	At the time of assessment. piped medical gas outlets were located within room C319, currently in use as staff room/kitchen which is equipped with a microwave.	It is highly recommended that the microwave be removed from this room, due to the presence of medical gas outlets.	16	Immediately			
C5.5	Is the fire alarm system linked to an alarm receiving centre?	Hirwaun Medical Centre	At the time of assessment the fire alarm system was not linked to an alarm receiving station. From information received the link for fire and security provided by 'Cintrix' was in previously in place however the contract had expired and not been renewed.	It is recommended the contract to link the fire alarm system to an alarm receiving centre is renewed as soon as reasonably practicable to provide property protection and business continuity especially when the premises is unoccupied.	16	as soon as reasonably practicable			
A4.1	Are identified risk measures and controls being implemented?	Template 211 Intensive Therapy Unit , High Dependency Units, Ward 7 & Anaesthetic Offices	At the time of assessment, identified risk control measures were identified within departmental fire folders. Not all were being implemented. (Ref Finding A6.2 & A6.6)	It is highly recommended that all risk control measures documented within departmental fire folders and within this FRA are implemented.	16	Immediately			
A4.1	Are identified risk measures and controls being implemented?	Template 272 MHU Ward 22 (Taff Ely)	At the time of assessment identified risk and control measures were documented within the departmental Fire Folder, not all were being implemented. (See finding A1.2 & A1.7(2).	It is highly recommended that all risk control measures documented within Departmental Fire Folders and within this FRA are implemented.	16	Immediately			
A4.1	Are identified risk measures and controls being implemented?	Template 202 - Ward 10, Ward 11 & Common Areas	At the time of assessment, identified risk control measures were documented within the departmental Fire Folders. Not all risk control measures were being implemented.	It is highly recommended that all risk control measures documented within the departmental Fire Folders and within this FRA are implemented.	16	Immediately			
A4.1	Are identified risk measures and controls being implemented?	Template 209 Wards 3 & 4	At the time of assessment, identified risk risk control measures were documented within both wards departmental fire folders Not all risk control measures were being implemented. These risk control measures involved the obstruction of fire exit doors and escape routes.This was previously investigated by Fire Service.	It is highly recommended that all risk control measures documented within departmental fire folders and within this FRA are implemented.	16	Immediately			
A4.1	Are identified risk measures and controls being implemented?	Template T116 Wards 19 & 20.	At the time of assessment, identified risk control measures were documented within the departmental fire folders, not all of the control measures were being implemented. (Score rating high - Ref Finding A6.6).	It is highly recommended that all identified risk control measures documented within the Departmental Fire Folders and within this FRA are implemented.	16	Immediately			
A4.1	Are identified risk measures and controls being implemented?	T174 Mental Health Crisis Management Team, Reception, ECT & Administration .	At the time of assessment, the departmental fire folder available within the CMT Dept. provide information regarding risk control measures. Within CMT these were being appropriately managed. Risk control measures within the ECT and adjoining areas were not being implemented and are identified in findings in this FRA.	It is highly recommended that those staff responsible for these areas ensure all risk control measures identified within departmental fire folder(s) and within this FRA are implemented. Contractors should be given guidelines to ensure compliance.	16	Immediately			
A4.1	Are identified risk measures and controls being implemented?	Template 270 MHU Admissions Unit	At the time of assessment, identified risk control measures were documented within the departmental fire folder. Not all were being implemented. (See finding A1.2 & A1.7(2)	It is highly recommended that all risk control measures documented within Departmental Fire Folders and within this FRA are implemented.	16	Immediately			
A4.1	Are identified risk measures and controls being implemented?	Template 271 MHU Ward 21 (Rhondda Unit)	At the time of assessment identified risk and control measures were documented within the departmental Fire Folder, not all were being implemented. (See finding A1.2 & A1.7(2).	It is highly recommended that all risk control measures documented within Departmental Fire Folders and within this FRA are implemented.	16	Immediately			
A4.1	Are identified risk measures and controls being implemented?	Template 161 Ambulatory Emergency Care Unit (AECU)	At the time of assessment, identified risk control measures were documented within the departmental Fire Folder, however not all risk controls were being implemented.	It is highly recommended that all risk control measures identified within the departmental Fire Folder and within this FRA are implemented.	16	Immediately			
A4.5	If so, are staff trained in their use in accordance with the manufacturers' recommendations and are training records maintained?	Unit 4 Gwaun Elai (Snowdrop-Breast Unit).	At the time of assessment, information received indicated that as the Evac Chairs had not been placed on the HB Asset list, theye were not subject of maintenance contract.	It is highly recommended that all Evac Chairs are placed on the HB Assett list and are maintained in line with current maintenance contract. This in order that staff can be trained in their use and to meet current DDA/Equality Act legislation.	16	Immediately			
A4.6	Are there clearly defined departmental fire action and emergency evacuation procedures?	Unit 4 Gwaun Elai (Snowdrop-Breast Unit).	At the time of assessment, was unable to ascertain the serviceability status of Evac chairs within building as to whether they met current maintenace guidlines.	It is highly recommended that this is addressed, Evac Chairs are documented and maintenace records obtained. In order they meet the standards required to evacuate patients staff/in absence of lift. If this cannot be achieved consideration must be given to ensure mobility impaired patients /staff are treated/located on ground floor.	16	Immediately			
A4.8	Does the evacuation strategy cater for visitors including those at special risk (e.g. disabled or special needs)?	Unit 4 Gwaun Elai (Snowdrop-Breast Unit).	At the time of assessment, as indicated in findings A4.5 & A4.6(2), was unable to ascertain if Evac Chairs were in compliance with current legislation and met standards required to evacuate mobility impaired staff/patients from first floor.	It is recommended that this finding is addressed in order to ensure compliance with DDA/Equality Act.	16	Immediately			
A4.9	Are staff numbers sufficient to meet the fire evacuation strategy?	Template 203 Ward 8,9 & Common Areas	At the time of assessment, information received indicated that although staff numbers were sufficient, an effective evacuation would be dependent on staff attending from other departments as existing staff would be engaged in clearing/preparing escape routes. due to equipment stored in corridors/doorways. Information regarding staffing levels are provided on the front page of this document	It is highly recommended that a review of the assessment area be conducted by management ensuring that sufficient staff would be immediately available to ensure that a prompt and effective evacuation can be conducted.(WHTM 05-02 Chapter 2)	16	Immediately			

A4 .9	Are staff numbers sufficient to meet the fire evacuation strategy?	Template 215 Ward 12, 14, Cardiac Rehabilitation Offices & Common Areas	At the time of assessment, information received indicated that an effective evacuation would be dependent on staff attending from other departments as existing staff would be engaged in clearing/preparing escape routes. This as a consequence of bedboarding and items being stored/located within the escape routes . Information regarding staffing levels are provided on the front page of this document	It is highly recommended that a review of the assessment area be conducted by management ensuring that sufficient trained staff would be immediately available to ensure that a prompt and effective evacuation can be conducted.(WHTM 05-02 Chapter 2) score - 16	16	Immediately
A4 .9	Are staff numbers sufficient to meet the fire evacuation strategy?	Template T210 - Cardiac Monitoring Unit (C.M.U.), Cath Lab, Ward 6, Bed Management & HOOH Offices	At the time of assessment, room MAA 25, was in use as a 4 bed bay within ward 6. A fifth bed had been introduced to the bay in line with the HB Bed Loading situation. As a consequence of the bed boarding policy, additional electrical equipment is located in this area and a large quantity of equipment had been relocated into the MOE (escape route causing obstruction) Unable to ascertain whether current staff levels were sufficient to evacuate bay/department areas.	It is highly recommended that departmental managers review the requirement of bed loading ensuring sufficient staff are on duty to effectively compensate for additional equipment and patients and conduct a prompt and effective evacuation.	16	Immediately
A4 .12	Are fire drawings for this assessment area available and up to date?	DSHP, Health Centre, Second Floor.	At the time of assessment, the Fire plans displayed at departmental entrance doors within the accommodation stairwell did not provide correct information reflective of what is in place and in relation to the Plan Key. All rooms identified on the current plans currently indicate there is no automatic fire detection devices fitted in either A or B wing. Compartmentation lines were not reflective of FR protection in place. This was highlighted in previous FRA's as a result of project works.(see finding A6.8)	It is highly recommended that these findings are addressed. A survey should be conducted to ensure fire plans provide the required information, in line with the plan key and reflective of what's located in the assessment area. (see actions A6.1, & A6.8(1)	16	Immediately
A5 .1	Is the fire detection system within the assessment area adequate?	T115A - Y BWTHYN Macmillan, Specialist Palliative Care Unit.	At the time of assessment, the fire damper panel/air transfer grill panel indicated that none of the air transfer grills numbered 71-80 were serviceable. All indicated Red Lights on panel. The checking of such devices is a requirement of the Cause & Effect testing of fire alarm system and to maintain the Fire Integrity of Hazard rooms. This has been reported in previous FRA's.	It is highly recommended that this finding is addressed in order to ascertain the level of fire integrity provided by each device and to ensure each hazard room meets the FR standard required.	16	Immediately
A6 .1	Are all fire doors within the assessment area to the correct standard and functioning correctly?	DSHP, Health Centre, Second Floor.	At the time of assessment, the following doors were identified on Fire Plans as forming sub/compartmentation lines but do not meet the standard required.(FD30(S). 1. Doors SF 68 & SF 09 (A-Wing, GP Surgery area). 2. Link door between corridors SF14 & SF51. 3. Link door between corridors SF 14 & SF 17. 4. Access door to room SF 16.	It is highly recommended that these findings are addressed and doors forming part of subcompartmetation lines/walls as indicated on the Fire Plans are fitted with FD30(S) doors. (Please also refer to Finding A6.8(1) & A4.12)	16	Immediately
A6 .1	Are all fire doors within the assessment area to the correct standard and functioning correctly?	DSHP, Health Centre,Ground Floor.	At the time of assessment, the following Fire Doors were not to the correct standard or functioning correctly. 1. Fire Door GF 60 - Failed to close fully on release of hold open device. 2. Fire Exit door - in corridor GF34, (Sexual Health Dept.) is out of alignment causing door to jam closed due to lock. Previous Job No. 88606.	It is highly recommended that these findings are addressed and the doors upgraded to the required standard.	16	Immediately
A6 .1	Are all fire doors within the assessment area to the correct standard and functioning correctly?	Template 204 The Clinical Education Department	At the time of assessment, room PG 204 was in use as a staff kitchen. It could be accessed via two doors. One within the reception office the other within the corridor. Neither door was a fire door (FD30(S) Due to the kitchen being equipped with a fire suppression system this was not required, however neither door was equipped with self closing devices as requested in previous FRA's.	It is highly recommended that both doors are equipped with self closing devices in order to maintain the fire integrity of the kitchen. Should the doors remain open, fire/smoke could spread in either direction into the Means of Escape, obstructing any attempt to escape.	16	Immediately
A6 .1	Are all fire doors within the assessment area to the correct standard and functioning correctly?	Template 271 MHU Ward 21 (Rhondda Unit)	At the time of assessment, information received and observations made indicated that the self closing devices on patients bedroom doors (FD30 S) were ineffective and failed to function correctly.	It is highly recommended that this finding is addressed in order to maintain the fire integrity of the fire doors on patients bedrooms.	16	Immediately
A6 .1	Are all fire doors within the assessment area to the correct standard and functioning correctly?	Template 161 Ambulatory Emergency Care Unit (AECU)	At the time of assessment, the Emergency Exit door, within the ward is jamming and operated by a thumb turn device.	It is highly recommended that this finding be addressed to enable the door to function without delay.	16	Immediately
A6 .1	Are all fire doors within the assessment area to the correct standard and functioning correctly?	Unit 2 - Gwaun Elai (The Hub)	At the time of assessment, Fire Doors within the stairwell/emergency exit route on the ground floor & first floor, were not to the required standard, that being FD30(S). This due to each door being fitted with a vent. This was reported in previous FRA, requesting doors were replaced for new FD30(S) Doors. Current doors have since had vents covered (internally) with unknown material. Unable to confirm fire integrity of door.	It is highly recommended that as doors form part of the fire compartmentation of building and ensuring the integrity of main means of escape, the current doors are replaced with new, meeting the standards required.(FD30(S).	16	Immediately
A6 .1	Are all fire doors within the assessment area to the correct standard and functioning correctly?	Penarth Ward	At the time of assessment there were no self closing devices fitted to the corridor doors leading to the bedrooms and access corridor. no Self closing devices fitted to the kitchen door or the adjacent dinning room door.	Whilst it is understood that a self closing devices are a ligature risk this is an area monitored by staff, the consequences could be severe should a fire occur in the central area or a bedroom and the fire doors are open. Subsequently it is advised that low level self closing devices are fitted and if observation is required magnetic hold open devices are installed.	15	as soon as reasonably practicable
A6 .1	Are all fire doors within the assessment area to the correct standard and functioning correctly?	Templates 331 - 338. (Plant Rooms 1 - 8) & Roof Spaces.	At the time of assessment, the following fire doors do not reach the required standard; 1. FD T337-3, Door leaf fails to close on SCD. 2.FD T338-1A, Plant Access door via emergency stairwell. One door leaf stuck closed. 3.FD T336-1, Plant room 6. Fire door leaf's fail to align. 4.FD T338-3, Entrance to plant room 8. On opening, door makes contact with cabling gantry. (Future damage likely). 5.FD T336-3, Intumescent strip coming loose on leaf where doors meet. All Fire Doors indicated have recently been installed under Phase 1 of the Fire door instalation project by R. Lewis.	It is highly recommended that these findings are addressed and doors upgraded to the required standard.	16	Immediately
A6 .1	Are all fire doors within the assessment area to the correct standard and functioning correctly?	Template 213.Multi Occupancy Offices	At the time of assessment the following Fire Door required attention. 1. Fire Door - ST213-1 - Newly fitted FD displaying FD30, should be FD60(s) as forms part of fire compartmentation as indicated on fire plan. This door fitted recently by R-Lewis.	It is highly recommended that assurances are provided regarding FD ST213-1, Meets the FD60(S) standard required.	16	Immediately
A6 .1	Are all fire doors within the assessment area to the correct standard and functioning correctly?	Tenby Ward Caswell Clinic	At the time of assessment it was not possible to easily open the exit door into the garden at the end of the corridor by door number 5.30. This has been reported as being difficult to open during previous fire risk assessments.	The door should be adjusted so that staff can open it easily with a key.	16	Within 7 days of this assessment
A6 .2	Are fire doors wedged open?	Template 211 Intensive Therapy Unit , High Dependency Units, Ward 7 & Anaesthetic Offices	At the time of assessment, room UAA 11, was in use as a Cleaners room, (Hazard room). The door to this room, was found to be open and wedged in the frame of the fire compartmentation door accessing clinical areas. As a result the Fire compartmentation doors were obstructed from closing automatically on activation of the Fire Alarm System.	It is highly recommended that the use of such methods to obstruct doors closing are stopped immediately in order to maintain the fire integrity of the assessment area and prevent fire growth by contents within open rooms.	16	Immediately
A6 .2	Are fire doors wedged open?	Template 161 Ambulatory Emergency Care Unit (AECU)	At the time of assessment, several doors within the assessment area were being wedged/held open, including the door to room TM 37, currently in use as a Kitchen.	It is highly recommended that any device used which allows the fire door to be held open is removed to allow the door to function correctly and close by means of the self-closing device fitted.	16	Immediately
A6 .2	Are fire doors wedged open?	Pharmacy Department	At the time of assessment, information received indicated that several doors within the assessment area were wedged/held open to allow for adequate ventilation, to reduce the build up of heat in certain areas which are temperature controlled and the resulting rise in temperature may result in activation of warning device.	It is highly recommended that should there be an operational requirement to have "Fire Doors" held open, this can be achieved by an electronic hold open device being fitted to the relevant doors, which will release on activation of the fire alarm. Any other method that restricts the fire door from closing is not permitted.	16	Immediately
A6 .3	Are all doors fitted with security devices easily opened in the event of an emergency?	Template 271 MHU Ward 21 (Rhondda Unit)	At the time of assessment, the Emergency Door Release device (Green box) attached to the main access door to the department (lift lobby) was unserviceable, due to the key barrel being missing.	It is highly recommended that staff report any such incident to Estates in order that Estates can repair/replace the device in order to allow persons within the assessment area to evacuate.	16	Immediately
A6 .3	Are all doors fitted with security devices easily opened in the event of an emergency?	Template 270 MHU Admissions Unit	At the time of assessment, the Emergency Door Release device (Green box) attached to the main access door to the department (lift lobby) was unserviceable, due to the key barrel being missing.	It is highly recommended that staff report any such incident to Estates in order that Estates can repair/replace the device in order to allow persons within the assessment area to evacuate.	16	Immediately
A6 .3	Are all doors fitted with security devices easily opened in the event of an emergency?	Templates 331 - 338. (Plant Rooms 1 - 8) & Roof Spaces.	At the time of assessment, as indicated in finding A6.1, FD T338-1A, Plant Access door via emergency stairwell. One door leaf stuck closed.	It is highly recommended this finding is addressed in order that the door meets the required standard, ensuring both door leaf's open and do not obstruct the MOE.	16	Immediately
A6 .3	Are all doors fitted with security devices easily opened in the event of an emergency?	Unit 2 - Gwaun Elai (The Hub)	At the time of assessment, the main entrance door appeared to be linked to a number of security devices/door release devices internally and externally. These including a push button door release device and Emergency Door Override device. Information received indicated none of the devices were operational and the door could only be operated by a key externally with an internal thumb turn device.	It is highly recommended that this finding is addressed and those electronic door opening devices devices not operational are removed and more suitable door control/locking device is fitted, in line with the the equality act/DDA compliant. This in order to avoid any unnecessary confusion for occupants trying to escape from building, as has previously been reported.	16	Immediately
C6 .3	Are all doors fitted with security devices easily opened in the event of an emergency?	North Road Stores UNIT 32	The fire exit door on the right hand side of the building could not be opened using the push bar at the time of assessment. Without the use of this door as a fire exit the travel distances are excessive.	The door should be serviced and maintained so that it is easily opened using the push bar.	16	Within 7 days of this assessment
A6 .3	Are all doors fitted with security devices easily opened in the event of an emergency?	Tenby Ward Caswell Clinic	As detailed in A6.1 it was not possible to easily open the exit door into the garden at the end of the corridor by door number 5.30.	This door needs urgent attention as detailed in 6.1	16	Within 7 days of this assessment
A6 .4	Are suitable and sufficient escape routes provided within the assessment area?	Out Patients Department.	At the time of assessment, there were 2 fire exit doors, both providing escape towards the car park area. Both doors had limited external hard standing, neither meeting the standards required in compliance with the Equality act. Contractors are also carrying out works in the area outside the doors.	It is highly recommended that this finding be reviewed, with a view to provide an adjoining pathway from both doors to allow mobility impaired staff/patients to escape safely from the building to the designated assembly area. This in order to comply with DDA/Equality Act.	16	Immediately
A6 .4	Are suitable and sufficient escape routes provided within the assessment area?	Discharge Lounge	At the time of assessment, the fire exits located at the side of the lounge Was found not to be suitable. The one to the side had no means of exiting the building safely and then being able to travel along to the hard surface of the outside of the building (image001/002/003)	On the fire orientation plans for the lounge these are designated fire escape routes. Given the variable mobility of the patients using this area. It is highly recommended that works are completed to ensure that they can be used to evacuate the lounge if required.At the time of assessment progressive horizontal evacuation cannot be carried out from this area	15	Immediately
A6 .4	Are suitable and sufficient escape routes provided within the assessment area?	Discharge Lounge	At the time of assessment, it was found that the rear fire exit in the kitchen area was not suitable as it leads onto a loading bay with steps to the road level. The wooden ramp that had been provided at the exit was damaged and presented a trip hazard	On the fire orientation plans for the lounge these are designated fire escape routes. Given the variable mobility of the patients using this area. It is highly recommended that works are completed to ensure that they can be used to evacuate the lounge if required.At the time of assessment progressive horizontal evacuation cannot be carried out from this area	15	Immediately
A6 .4	Are suitable and sufficient escape routes provided within the assessment area?	Estates Workshops & Compound. Offices. Clinical Engineering Workshop. Technical Services Team Admin Offices.	At the time of assessment the escape route from the rear back office did not provide the requisite standard of fire protection. In the event of a fire the means of escape would seriously be compromised.	(a) Remove/relocate cooking items. relocate photocopier or (b) Enclose beverage room which provides the requisite standard of fire protection. (30 minutes). No ignition sources should be placed on the escape route.	16	Within 28 days of this assessment
A6 .6	Are escape routes free from obstruction, combustible materials that would assist fire spread or anything that may impede an evacuation?	Estates Workshops & Compound. Offices. Clinical Engineering Workshop. Technical Services Team Admin Offices.	At the time of assessment escape routes were not free from ignition sources. The rear facilities offices must be provided with a protected fire escape route due to a single direction of escape due to no hazard room protection. Cooking facilities & photocopying machines should not be placed along escape routes with only a single means of escape.	Protect the means of escape by providing the requisite standard of fire protection along the escape route. Provide 30 minutes standard of fire protection to all risk rooms. (beverage room/photocopier room) or remove all cooking & electrical items. An alternative approach to the single escape would be to provide a secondary fire exit in the Technical Services Support office.	16	Within 90 days of this assessment
A6 .6	Are escape routes free from obstruction, combustible materials that would assist fire spread or anything that may impede an evacuation?	DSHP, Health Centre,Ground Floor.	At the time of assessment, Fire Exit door - in corridor GF34, (Sexual Health Dept.) is out of alignment causing door to jam closed due to lock. Previous Job No. 88606.	It is highly recommended that this finding is addressed and the door alignment/locking mechanism is repaired to prevent obstruction to a Means of Escape.	16	Immediately
A6 .6	Are escape routes free from obstruction, combustible materials that would assist fire spread or anything that may impede an evacuation?	T174 Mental Health Crisis Management Team, Reception, ECT & Administration .	At the time of assessment, combustible materials and other items within the ECT Dept. obstructed doors from opening, restricted access within areas which would impede an evaluation or fire service access in the event of an emergency.	It is highly recommended that any items that may impede or obstruct an evacuation or restrict access to emergency services must be removed. All methods of Means Of Escape, doors and routes, must remain clear at all times.	16	Immediately
A6 .6	Are escape routes free from obstruction, combustible materials that would assist fire spread or anything that may impede an evacuation?	Template 215 Ward 12, 14, Cardiac Rehabilitation Offices & Common Areas	At the time of assessment, it was noted that as a consequence of an additional bed being located within rooms GAA27 & MAA28 as a result of the HB Bed boarding requirement, items of equipment/storage were located within the Means of escape corridors/ doorways. (See finding A4.9).	It is highly recommended that staff ensure all means of escape are unobstructed in order that a prompt and effective evacuation can take place.	16	Immediately
A6 .6	Are escape routes free from obstruction, combustible materials that would assist fire spread or anything that may impede an evacuation?	Template 161 Ambulatory Emergency Care Unit (AECU)	At the time of assessment, the Emergency Exit door, within the ward is jamming and operated by a thumb turn device.	It is highly recommended that this finding be addressed to enable the door to function without delay.	16	Immediately

A6.6	Are escape routes free from obstruction, combustible materials that would assist fire spread or anything that may impede an evacuation?	Unit 2 - Gwaun Elai (The Hub)	At the time of assessment, the main entrance door appeared to be linked to a number of security devices/door release devices internally and externally. These including a push button door release device and Emergency Door Override device. Information received indicated none of the devices were operational and the door could only be operated by a key externally with an internal thumb turn device.	It is highly recommended that this finding is addressed and those electronic door opening devices devices not operational are removed and a more suitable door locking device fitted. This in order to avoid any unnecessary confusion for occupants trying to escape from building, as has previously been reported.	16	Immediately
A6.6	Are escape routes free from obstruction, combustible materials that would assist fire spread or anything that may impede an evacuation?	Unit 2 - Gwaun Elai (The Hub)	At the time of assessment, the fire exit door on the ground floor presents an obstruction when opened, as the doors direction of opening obstructs access to the pathway (Door hinges on wrong side). The external escape path has vegetation over the pathway which would obstruct anyone with mobility impairment using walking devices or wheelchairs.	It is highly recommended that these findings are addressed. The fire exit door should open to the right and all vegetation should be removed from escape route. This to comply with ADB and Equality/DDA guidelines.	16	Immediately
A6.6	Are escape routes free from obstruction, combustible materials that would assist fire spread or anything that may impede an evacuation?	Template 211 Intensive Therapy Unit , High Dependency Units, Ward 7 & Anaesthetic Offices	At the time of assessment, room UAA 11, was in use as a Cleaners room, (Hazard room). The door to this room, was found to be open and wedged in the frame of the fire compartmentation door accessing clinical areas. As a result the Fire compartmentation doors were obstructed from closing automatically on activation of the Fire Alarm System.	It is highly recommended that the use of such methods to obstruct doors closing are stopped immediately in order to maintain the fire integrity of the assessment area and prevent fire growth by contents within open rooms.	16	Immediately
A6.6	Are escape routes free from obstruction, combustible materials that would assist fire spread or anything that may impede an evacuation?	Template T210 - Cardiac Monitoring Unit (C.M.U.), Cath Lab, Ward 6, Bed Management & HOOH Offices	At the time of assessment, room MAA 25, was in use as a 4 bed bay within ward 6. A fifth bed had been introduced to the bay in line with the HB Bed Boarding situation. As a consequence of the bed boarding policy, additional electrical equipment is located in this area along with other equipment associated with the additional patient. A large quantity of equipment, previously stored within this area had been relocated into the MOE (escape route causing obstruction) Unable to ascertain whether current staff levels were sufficient to evacuate bay/department areas.	It is highly recommended that departmental managers review the requirement of bed boarding ensuring the MOE (escape routes) are not obstructed as a consequence and staff can carry out a prompt and effective evacuation when required.	16	Immediately
A6.6	Are escape routes free from obstruction, combustible materials that would assist fire spread or anything that may impede an evacuation?	Template T116 Wards 19 & 20.	At the time of assessment, furnishings were obstructing the link doors within room MAA 11(Linked to template 115) and within room MAA 25 (linked to ward 19) Both Ward 20. This concern has previously resulted in the attendance of South Wales Fire Service as a result of complaints from patients, visitors and staff.	It is highly recommended that staff ensure all means of escape, doors and routes remain clear in order to ensure a prompt and effective evacuation can be carried out.	16	Immediately
A6.6	Are escape routes free from obstruction, combustible materials that would assist fire spread or anything that may impede an evacuation?	Template 209 Wards 3 & 4	At the time of assessment, it was noted that as a consequence of the introduction of additional beds,(Boarded beds) escape routes & fire doors were blocked, by equipment used to accommodate patient needs and that equipment previously located where additional bed has been introduced. These concerns have previously resulted in the Fire Service Safety Team attending the hospital to investigate complaints from staff and members of the public. These findings were also reported in previous FRA. (Note- Link doors between ward 3 & ward 4)	It is highly recommended that this finding be addressed and that any item obstructing fire doors/automatic fire doors from functioning or obstructing fire escape routes must be removed.	16	Immediately
A6.6	Are escape routes free from obstruction, combustible materials that would assist fire spread or anything that may impede an evacuation?	Template 203 Ward 8,9 & Common Areas	At the time of assessment, several corridors/doorways were obstructed by equipment stored, which would delay/impede an evacuation.	It is highly recommended that all doorways, corridors, escape routes forming part of the means of escape (MOE) are kept clear at all times in order to ensure a prompt and effective evacuation can be conducted.	16	Immediately
A6.7	Are hazard rooms adequately protected?	Template 213.Multi Occupancy Offices	At the time of assessment, room CS 01, was in use as a Telephone Exchange. It was identified as a Hazard room. There was a large penetration in the ceiling due to cabling. There was also several insecure floor panals forming openings in the floor surface exposing electric cabling and gaps inti the void below.	It is highly recommended that the cable penetration is appropriately Fire Stopped in order to maintain the rooms FR integrity.(FR30). A reveiw of the floor surface must be carried out to ensure its FR integrity and avoid falls into void below surface resulting in injury during searches identifying location of fire.	16	Immediately
A6.7	Are hazard rooms adequately protected?	Unit 2 - Gwaun Elai (The Hub)	At the time of assessment, Fire Doors within the stairwell/emergency exit route on the ground floor & first floor, were not to the required standard, that being FD30(S). This due to each door being fitted with a vent. This was reported in previous FRA, requesting doors were replaced for new FD30(S) Doors. Current doors have since have vents covered (internally) with unknown material. Unable to confirm fire integrity of door.	It is highly recommended that as these doors are fitted to hazard rooms accessed via the stairwell and the doors also form part of the fire compartmentation of building and ensuring the integrity of main means of escape, the current doors are replaced with new, meeting the standards required.	16	Immediately
A6.7	Are hazard rooms adequately protected?	Template 271 MHU Ward 21 (Rhondda Unit)	At the time of assessment, as per finding A6.1, patients bedrooms within the assessment area are defined as Hazard rooms of which the fire doors FD30(S) are not functioning correctly.	It is highly recommended that this finding is addressed in order to maintain the fire integrity of the fire doors on patients bedrooms.	16	Immediately
A6.7	Are hazard rooms adequately protected?	Template 204 The Clinical Education Department	At the time of assessment, room PG 204 was in use as a staff kitchen. It could be accessed via two doors. One within the reception office the other within the corridor. Neither door was a fire door (FD30(S) Due to the kitchen being equipped with a fire suppression system this was not required, however neither door was equipped with self closing devices as requested in previous FRA's.	It is highly recommended that both doors are equipped with self closing devices in order to maintain the fire integrity of the kitchen. Should the doors remain open, fire/smoke could spread in either direction into the Means of Escape, obstructing any attempt to escape.	16	Immediately
A6.7	Are hazard rooms adequately protected?	Estates Workshops & Compound. Offices. Clinical Engineering Workshop. Technical Services Team Admin Offices.	At the time of assessment hazard rooms were not adequately protected.	Any form of cooking whether microwave or toaster must be in the recognised purpose built room or designated cooking area only. Under no circumstances should cooking be undertaken in any room other than the accepted designated rooms for cooking. The photocopier and beverage room must provide a half hour standard of fire resistance including glazing and fitted with hot & cold smoke seals & a positive self closing device. Recommendation: (a) remove cooking appliances & photocopier or (b) enclose rooms with a minimum of 30 minutes standard of fire protection.	16	Within 28 days of this assessment
A6.8	Is compartmentation/ (sub)compartmentation integrity adequately maintained?	Template 213.Multi Occupancy Offices	At the time of assessment, Fire Door - ST213-1 - Newly fitted FD displaying FD30, should be FD60(s) as forms part of the fire compartmentation line within hospital street, as indicated on Fire Plan.	It is highly recommended that assurances are provided ensuring FD ST213-1, Meets the FD60(S) standard required.	16	Immediately
A6.8	Is compartmentation/ (sub)compartmentation integrity adequately maintained?	DSHP, Health Centre, 3rd Floor, 4th floor & Roof.	At the time of assessment, records indicated that on completion of a major refurbishment project,including compartmentation, a request was made by the HB for a sign of document regarding works carried out. This is currently under review due to insufficient information being available.	It is highly recommended that the HB addresses the availability of all documents in relation to the various phases of projects involving this building in order that any compliance concerns / safety concerns can be addressed.	16	Immediately
A6.8	Is compartmentation/ (sub)compartmentation integrity adequately maintained?	DSHP,Health Centre, Basement.(Crawl-ways/Walkways).	At the time of assessment, information on record indicated that there were breaches in compartmentation within the basement area, this due to Conveyance/distribution pipework for heating,domestic hot and cold water service pipework. Data/communication service cables.this included service pipeline areas and crawlways. This was reported by the fire service during a previous audit.	It is highly recommended that a fire compartmetation survey be conducted, with a veiw to ensure upgrade works are conducted meeting the required standard of compartmentation/sub compartmentation within the basement /passage way/crawlways meet the required standard.	16	Immediately
A6.8	Is compartmentation/ (sub)compartmentation integrity adequately maintained?	Template 214 First Floor Pathology	At the time of assessment, the lobbied area (PA 201B) forms part of the compartmentation wall beside the main entrance door. There is currently no door to this area. Above ceiling check conducted, confirming compartmentation of main corridor MOE compromised. This has been reported in previous FRA's.	It is highly recommended that a fire door meeting standard FD30(S) is fitted to lobby entrance PA201 B, in order to maintain the fire entegrity of the 30 min fire wall and the MOE/main exit door for the department.	16	Immediately
A6.8	Is compartmentation/ (sub)compartmentation integrity adequately maintained?	Templates 331 - 338. (Plant Rooms 1 - 8) & Roof Spaces.	At the time of assessment several fire doors within the assessment area did not meet the required standard as indicated in finding A6.1, therefore compromising compartmentation.	It is highly recommended that the findings indicated in Finding A6.1 are addressed in order that compartmentation/ (sub)compartmentation integrity can be adequately maintained.	16	Immediately
A6.8	Is compartmentation/ (sub)compartmentation integrity adequately maintained?	Unit 2 - Gwaun Elai (The Hub)	At the time of assessment, the building incorporates 3 compartment areas, ground floor, first floor and accommodation /emergency stairwell. Due to the standard of fire doors fitted within the stairwell, was unable to determine whether the fire integrity is maintained.	It is highly recommended that as doors form part of the fire compartmentation of building and ensuring the integrity of main means of escape, the current doors are replaced with new, meeting the standards required.	16	Immediately
A6.8	Is compartmentation/ (sub)compartmentation integrity adequately maintained?	Template 161 Ambulatory Emergency Care Unit (AECU)	At the time of assessment, enquiries confirmed that the compartmentation was based on Building code ADB (Non-inpatient area) and not WHTM(Firecode) as required for inpatient facilities. As a result of the introduction of an inpatient area being a 6 bed ward (TM 10) a further review will be required to ensure compliance with WHTM requirements. This includes compartmentation meeting FR30, between Inpatient & OPD and firestopping around services passing through compartmentation.	It is highly recommended that a review be conducted ensuring building meets WHTM requirements.	16	Immediately
A6.8	Is compartmentation/ (sub)compartmentation integrity adequately maintained?	DSHP, Health Centre,Ground Floor.	Prior to assessment being conducted, information received indicated that the "Building Sign Off" document required from the Building Control Officer on completion of previous project works had yet to be obtained confirming building compliance. This concern was raised by the Fire Service in relation to compartmentation in accommodation stairwell/Bar barista area. (And other compartmentation concerns within the building).	It is highly recommended that the HB obtains this document in order that any compliance concerns/safety concerns can be addressed.	16	Immediately
A6.8	Is compartmentation/ (sub)compartmentation integrity adequately maintained?	DSHP, Health Centre, Second Floor.	Prior to assessment being conducted, information received indicated that the "Building Sign Off" document required from the Building Control Officer on completion of previous project works had yet to be obtained confirming building compliance. This concern was raised by the Fire Service in relation to compartmentation in accommodation stairwell /Bar barista area. (And other compartmentation concerns within the building).	It is highly recommended that the HB obtains this document in order that any compliance concerns / safety concerns can be addressed. (Please also refer to Finding A6.1 & A4.12)	16	Immediately
A6.8	Is compartmentation/ (sub)compartmentation integrity adequately maintained?	DSHP, Health Centre, First Floor.	Prior to assessment being conducted, information received indicated that the "Building Sign Off" document required from the Building Control Officer on completion of previous project works had yet to be obtained confirming building compliance. This concern was raised by the Fire Service in relation to compartmentation in accommodation stairwell /Bar barista area. (And other compartmentation concerns within the building).	It is highly recommended that the HB obtains this document in order that any compliance concerns / safety concerns can be addressed.	16	Immediately

FIRE SAFETY 3 YEAR STRATEGIC PLAN (2024 – 2027 inclusive).

Aspects of this medium term fire plan will require capital investment to ensure completion of significant risks. Lack of this investment will not see completion of this plan.

Fire Risk Assessment – FRA (Initial)

Ref	Stratgic Requirement	Description of Actions	Completion Date	Responsible Manager	Current Update on Actions
	High (Red) Sleeping Risk Areas	Initial FRA to be completed or reviewed for all areas by April 2024	apr-24	All Fire Officers	Initial FRA's completed, Reviews ongoing.
	Medium (Amber) Day Patient Risk Areas	Initial FRA to be completed or reviewed for all areas by April 2025	apr-25	All Fire Officers	Initial FRA's completed, Reviews ongoing.
	Low (Green) Community Risk Areas	Initial FRA to be completed or reviewed for all areas by April 2026	apr-26	All Fire Officers	Initial FRA's completed, Reviews ongoing.

Training (Statutory Update)

Ref	Stratgic Requirement	Description of Actions	Completion Date	Responsible Manager	Current Update on Actions
	Provide annual ongoing training to meet a 50% audience (approximately 6,000 staff).	Each Fire Officer will arrange training locality and feed the organisations training calendar accordingly.	Continuous	SFO	Each FO contiues to delevier weekly tarining sessions at each DGH.
	Training sessions will be pre-booked 3 months in advance.	Each Fire Officer will arrange training locality and feed the organisations training calendar accordingly.	Continuous	SFO	Bookings are made by each FO and then posted to ESR / SharePoint.
	Develop an On-Line Fire Manager package to suit, April 2024,	Commence delivering August /September 2024.		SFO	Package has been developed and erviewd, cahnges to be maded by CTM IT Team before a trail relaese commences, no date confirmed.

Training (Evacuation) It is proposed to undertake 2 hospital evacuations per year

Ref	Stratgic Requirement	Description of Actions	Completion Date	Responsible Manager	Current Update on Actions
	Prince Charles Hospital (outbuilding)		2024	FO	Completed 09/2024
	Ysbyty George Thomas		2024	SFO	Desktop completed 10/2024
	Prince Charles Hospital (ward)		2025	FO	
	Dewi Sant Health Park		2025	FO	
	Princess of Wales Hospital (ward)		2026	FO	
	Glanrhyd - Angleton Clinic		2026	FO	Planned for 04/2025
	Royal Glamorgan Hospital (ward)		2027	FO	
	Kier Hardy Health Park		2027	FO	

Site Specific Fire Information.

Ref	Stratgic Requirement	Description of Actions	Completion Date	Responsible Manager	Current Update on Actions
	Dewi Sant Health Park	Compilation of site specific fire safety folders	2024	SFO	
	Glanrhyd Hospital	Compilation of site specific fire safety folders	2024	SFO	Completed.
	Pinewood House	Compilation of site specific fire safety folders	2024	SFO	Completed.
	Royal Glamorgan Hospital	Compilation of site specific fire safety folders	2025	SFO	Completed.
	Princess of Wales Hospital	Compilation of site specific fire safety folders	2025	SFO	Completed.
	Prince Charles Hospital	Compilation of site specific fire safety folders	2025	SFO	75% complete with changes.
	Ysbyty George Thomas	Compilation of site specific fire safety folders	2026	SFO	Completed.
	Ysbyty Cwm Cynon	Compilation of site specific fire safety folders	2026	SFO	Completed.
	Ysbyty Cwm Rhondda	Compilation of site specific fire safety folders	2026	SFO	Completed.
	Kier Hardy Health Park	Compilation of site specific fire safety folders	2027	SFO	
	Maesteg Hospital	Compilation of site specific fire safety folders	2027	SFO	
	CAMHS - Ty Llidiard	Compilation of site specific fire safety folders			

Site Fire Compartmentation Surveys

Ref	Stratgic Requirement	Description of Actions	Completion Date	Responsible Manager	Current Update on Actions
	All Sites	Complete identification of Health Board sites that have had a fire compartmentation survey, identifying risks and completing action plans.	2024	SFO	
	All Sites	From above survey complete fire compartmentation surveys as required	2025	SFO	
	All Sites	Complete actions identified from surveys	2026/27	SFO	

Site Fire Orientation Drawings

Ref	Stratgic Requirement	Description of Actions	Completion Date	Responsible Manager	Current Update on Actions
	All Sites	Complete identification of Health Board status, identifying site standards	2024	SFO	
	All Sites	Update site requirements to ensure standardisation across the Health Board	2025/26	SFO	
	Prince Charles Hospital	Prince Charles Hospital - Enforcement works nearing completion. All efforts will be concentrated at PCH as highlighted in EN79/10 Sec1.7 Fire Plans	2027	FO	

Fire Doors/Fire Alarms Two pronged approach to upgrading the fire alarm systems and fire door protection

Ref	Stratgic Requirement	Description of Actions	Completion Date	Responsible Manager	Current Update on Actions
1	All Sites	Highlighted through Fire Risk Assesments	2025-2027		
2	All Sites	EFAB project for Fire Door Replacement			

Cause And Effect Testing

Ref	Stratgic Requirement	Description of Actions	Completion Date	Responsible Manager	Current Update on Actions
	All Sites	In conjunction with the Health Board Estates Team, Fire Alarm incumbent engineer and site fire officers ensure a standardised approach to cause and effect testing across Wales	2025 - 2027	SFO / FO	C&E testing is carried out across all sites weekly. A standardised report document is under trial at 2 sites.

Fire Service Audits

Audits are undertaken annually, amounts/frequency defined by South Wales Fire and Rescue

Operational and Strategic Planning Directorate

As required

Welsh Health Estates Audit

Audit completed annually (End of March)

Upgrades/Work required - Hospital sites

RGH - site upgrade to all fire doors identified under fire door surveying all patient high risk areas to be achieved within the next 3 years. Following that all the adjacent, above and below areas in the following 5 years with long term plans of upgrades changing annually.

PCH - Major refurbishment of building under EN79/10 Ground and First Floor H Block, wards first plan already submitted for next 5 years with long term plans of upgrades changing annually

POWH - Major refurbishment of theatres under enforcement .

DSHP - Compartmentation upgrade (fire doors) within the next 2 years

KHHP - Fire alarm cause and effect and upgrade from C&A results, within next 2 years. Compartmentation upgrade (fire doors) within the next 2 years.

Note all above upgrade priorities may vary due to Fire Risk Assessment findings, or a fire related incident.

Agenda Item
5.3

Health, Safety & Fire Sub Committee

Overarching Highlight Report- Chief Operating Officer Care Groups

Dyddiad y Cyfarfod / Date of Meeting	05/06/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Gemma Cummings- Business Support Manager
Cyflwynydd yr Adroddiad / Report Presenter	Sarah James- Deputy Chief Operating Officer
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gethin Hughes, Chief Operating Officer

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
MH&LD Health, Safety & Fire Care group meeting	15/05/2025	Attended and reports received and discussed from, Fire, H&S, Facilities, x3 Directorates within MH&LD Care Group

Acronyms / Glossary of Terms
MH&LD: Mental Health and Learning Disabilities
RGH: Royal Glamorgan Hospital
POWH: Princess of Wales Hospital
IPC: Infection Prevention and Control
RIDDOR: Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
CAMHS: Child and Adolescent Mental Health Services
SVA: Security Vulnerability Assessment
DSHP: Dewi Sant Health Park
FIC: Fire Incident Co-ordinator

1. Introduction

1.1 This report had been prepared to provide the Health, Safety and Fire subcommittee with details of the key issues considered by the Mental Health , Urgent and Emergency Care, Planned Care and the Primary and Community Care Groups.

1.2 Key highlights from the meeting are reported in section 3.

2. Purpose of this Meeting

2.1 As a minimum Care Groups are asked to cover the following areas of activity within the Highlight Report to the Health, Safety & Fire Sub Committee (Sub Committee of the Board). If any of these areas are not applicable, please indicate this in the report.

- Fire enforcement Notice issued and actions status
- Health and Safety Executive Improvement Notices
- Fire alarm system activations and false alarms (data)
- Health, Safety and fire Risk Assessments
- New Risk Assessments or significant changes
- RIDDOR reportable incidents – any themes / spikes
- High incidence of needle stick injuries
- Security & Violence - significant issues
- Mandatory training performance – % compliance and improvement trajectory where necessary
- Health Safety & Welfare Training
- Fire Safety

- Moving and Handling
- Violence and aggression

3. Highlight Report

Alert / Escalate	**Unscheduled Care Group** drew alert/ escalation to the following: **Stroke Unit, RGH:** Following a request for a Quality and Assurance review, Ward 20 (Stroke Unit) RGH was provided with a red rating primarily due to the results of the Environmental and Infection Control audit and immediate feedback obtained during the visit. Several critical areas require urgent improvement, notably infection control and audit compliance. A robust improvement plan has been implemented across the Stroke Unit to address the issues identified and immediate infection control measures have been completed to improve the cleanliness of the ward. **Planned Care Group** drew alert/ escalation to the following: **Manual Handling:** Lack of training provision in POWH of Manual Handling and Violence & Aggression - staff are working for long periods of time out of compliance **Primary Care and Community Care Group** drew alert/ escalate to the following: **South Wales Fire and Rescue Service withdrawal of responder services to Automated Fire Signals** in April this year has significant impact upon the hospital services. As services are seized on site after 4pm and throughout the night, weekends and bank holidays not all premises will have staff present on site. Consideration is being given to how to proceed. A risk assessment is being undertaken and will be escalated in due course. There is also implications for primary care head lease sites and a review of keyholder and fire and intruder alarm responder provision. This work is ongoing and arrangements are to be confirmed as soon as practicable.

	Mental Health and Learning Disabilities Care Group drew alert/ escalation to the following: **Health & Safety – Violence & Aggression (Angelton Wards 1 and 2):** A recent audit identified concerns about vulnerability during incidents at Angelton Wards 1 and 2. The care group have identified contributing factors and mitigation has been considered, this includes the following. : • Designated leads for all MH&LD premises will develop a Security Risk/Threat Action Card to support out-of-hours decision-making. • Service Managers will engage with Security Management to carry out security audits where required. **Health & Safety – Maritime Resource Centre:** Following complaints from local residents about alarms sounding overnight and at weekends, a review identified the need for an upgraded system. Estates have placed an order for the replacement, with installation still pending. This was followed up with Estates on 08/05/2025. Older Adult Mental Health Directorate Management will continue to work with estates to expedite installation of new alarm system. **DTPS Care Group-** Submitting focus report **Children and Families Care Group**- Submitting a focus report **Facilities-** Submitting a focus report
Advise	**Unscheduled Care Group** have no matters to Advise. **Planned Care Group** Advise the Following: **IPC:** Ward 8, PCH has received praise from the IPC team for isolating patients quickly and preventing an outbreak of Noro Virus. **Primary Care and Community Care Group** Advise the following. **Fire Risk Assessments:** The RAG schedule of Fire Risk Assessments and outstanding actions is actively reviewed. We have worked with the Fire

Officers to develop plans indicating the necessary actions for turning outstanding red and amber issues to green.

The outcome of the FRAs are discussed by exception as part of the three Environmental Site Meetings.

Following a suite of surveys completed by a specialist Fire Consultant, Fire Resilience works are progressing across the Primary Care Headleased Estate initially at Ferndale and Ynyshir Medical Centres, but other sites are to follow once scope and funding has been agreed.

Fire Evacuation Chair:
Training needs to be reviewed and renewed across the Primary Care headleased estate.

Fire evacuation at DSHP:
Thought is being given to the appropriate action to resolve the issue of staff membership of the Fire Incident Co-ordinator (FIC) at DSHP, including the operating of the lifts. A meeting is planned for 23 May 2025 to discuss this and related matters across the Directorate.

Mental Health and Learning Disabilities Care Group Advise the Following:

Fire - Activations
Between 07/11/2024 and 01/05/2025, there were 22 fire activations across MH&LD premises:
- 12 at RGH Mental Health Unit
- 6 at Ward 14/PICU, Princess of Wales Hospital
- 4 at Angelton Clinic, Glanrhyd

There were no consistent patterns. Causes included faulty sensors, steam from bathrooms, vaping/smoking related, and occasional malicious activations.

To support local mitigation, future fire reports to the MH&LD Health, Safety & Fire Group will detail activations by ward and cause. This will enable Service Managers to target interventions and reduce further incidents.

Fire Audit – RGH Mental Health Unit:
South Wales Fire & Rescue conducted a fire audit at RGH MHU between 03/02/2025 and 06/02/2025, resulting in an IN-01 being issued. Key findings included:
- Damaged or held-open fire doors

- Missing fire signage
- Blocked evacuation routes
- Missing ceiling tiles
- Charging of equipment in corridors
- Evidence of smoking/vaping

Immediate remedial actions were taken where possible. The IN-01 will be owned by the MH&LD directorates within the MHU, with progress tracked via an action plan governed through the MH&LD Health, Safety & Fire Group.

Health & Safety - **Anti-Barricade Doors – Ward 7, Ysbyty Cwm Cynon**
A recent Door and Security Audit identified that Ward 7 has no anti-barricade doors on patient bedroom doors. The Directorate is in the process of obtaining a quote, with plans to progress the work through the Organisational Capital Group approval process.

This upgrade will be incorporated into the broader Older Adult Inpatient Redesign, which includes a review of the environment and Health & Safety standards, with a focus on anti-ligature measures, safe ward environments, and therapeutic improvements.

Health & Safety – Anti-Ligature and Anti-Barricade Doors, Ty Llidiard (CAMHS Inpatient Unit)
Ongoing issues with door safety, including anti-ligature and anti-barricade concerns, have been identified. Directorate Management is working with Estates to trial a new door function to determine whether full replacement is required.

Health & Safety – Fob Access, Ty Llidiard (CAMHS Inpatient Unit)

Directorate to undertaken SVA in first instance to inform the need for new security fob system. This will be progressed via the Care Group Operational Capital Group process.

DTPS Care Group- Submitting focus report

Children and Families Care Group- Submitting a focus report

Facilities- Submitting a focus report

Assure	**<u>Unscheduled Care Group</u>** <u>no matters to Assure.</u> **<u>Planned Care Group</u>** <u>Assure the following:</u> **Current Compliance Rate in Care Group for Mandatory Training**: • Health, Safety and Welfare – 60% • Fire Training – 52% • Manual Handling – 54% Numbers increased since last report **<u>Primary Care and Community Care Group</u>** <u>Assure the following:</u> Updated High Level review of statutory compliance checks is attached to this report. **Water Risk Assessments** – a new suite of assessments has been completed across the Primary Care Headleased Estate and a three point action plan to address the recommendations set out is being progressed: 1. Address physical works (via procurement), 2. Agree mandation of training, 3. Identify Responsible Person allocation within the Health Board. There has been an **incident of an outbreak of Legionella within Maesteg Community Hospital**. All measures have been taken to remove immediate risk and a programme of testing is underway. Significant work has been undertaken by Estates to modernise and repair plant and pipework. The matter remains ongoing and further updates will be available at the next meeting – staff are being kept updated on progress. Colleagues within Community Hospitals remain concerned about the lack of official security on site – it is anticipated that the assent given to Martyn's Law will clarify the matter. Martyn's Law, officially known as the Terrorism (Protection of Premises) Act 2025, aims to enhance public safety by requiring certain venues and events in the UK to implement measures against the threat of terrorism. Background

Martyn's Law is named in memory of Martyn Hett, who was tragically killed in the 2017 Manchester Arena bombing. The law was championed by his mother, Figen Murray, whose advocacy played a crucial role in its development. The Act received Royal Assent on April 3, 2025, and reflects the government's commitment to improving security measures at public venues and events.

'Martyn's Law' introduced in Parliament to better protect the public from terrorism - GOV.UK

Mental Health and Learning Disabilities Care Group Assure the following:

Fire - Automatic Fire Alarm (AFA) Response – Process Change

The revised AFA response process has been shared across the Care Group for awareness. There have been no reported near misses or incidents linked to this change within the MH&LD Care Group.

Summary - Fire Risk assessment – Adult Mental Health

AREA	TOTAL ACTIONS	COMPLETED	IN-PROGRESS
RGH PICU	12	11	1
RGH WARD 21	26	25	1
RGH WARD 22	17	17	0
RGH AMU	20	17	3
POW WARD 14 & PICU	19	8	11

All actions being monitored and progress by Service Manager for Acute Adult Mental Health

Summary – Fire Risk Assessments – Older Adult Mental Health

	WARD/SITE ACTIONS	
	COMPLETED ACTIONS	**OUTSTANDING ACTIONS**
WARD 1 ANGELTON	**0**	**7**

	WARD 2 ANGLETON	**11**	**3**
	ANGLETON CLINIC MAIN OFFICES	**8**	**7**
	ANGLETON CLINIC OFFICES, MAIN KITCHEN AND DELIVERY AREA	**1**	**5**
	PONTYPRIDD MENTAL HEALTH CLINICAL DAY SERVICES	**4**	**5**
	LEWIS MERTHYR DAY UNIT	**4**	**1**
	TONTEG DAY UNIT	**2**	**1**
	KEIR HARDIE DAY UNIT	**4**	**1**
	YCC OLDER PERSONS	**6**	**0**

All actions being monitored and progress by Service Manager for Older Adult Mental Health

DTPS Care Group- Submitting focus report

Children and Families Care Group- Submitting a focus report

Facilities- Submitting a focus report

Inform

Unscheduled Care Group no matters to Inform for update.

Planned Care Group Inform the following:

Risk raised for POWH – Ward 7 Flooring, initial score of 20. Risk ID 5929. Floor needs repair and therefore present a risk for IPC and trip hazard.

Primary Care and Community Care Group Inform the following:

- No Fire Enforcement Notices or Health & Safety Executive Improvement Notices have been received for the qualifying period.
- No Fire Alarm System Activations or False Alarms have occurred in the qualifying period.

- No RIDDOR reportable incidents in the qualifying period.
- Fire and Intruder Alarm action cards have been agreed with the Fire Officer team and the proposed Responder service contractor.

Mental Health and Learning Disabilities Care Group Inform the following:

Portering & Security
Portering and Security are now included in the attendance for the MH&LD Care Group Health, Safety & Fire Group. A consolidated report covering all CTM sites will be provided going forward.

Incidents Overview
Between 1st April 2024 and 30th April 2025, 322 incidents were reported in Mental Health services:

- 89% related to violence and aggression
- 2% manual handling
- 2% needlestick/sharps

Directorate teams continue to work with Health & Safety colleagues to maintain staff training compliance, ensuring staff have the necessary skills to manage incidents. Compliance is monitored through Care Group governance via Integrated Performance Meetings.

Risk Overview

Between 01/04/2024 and 30/04/2025, 40 new risks were recorded:

- 7 awaiting review
- 25 approved
- 2 closed/archived
- 6 rejected

There are currently 65 open risks:

- 7 awaiting review
- 58 approved

Risk Scoring Breakdown:

	• Low risk: 10 • Moderate: 44 • High: 5 **H&S Executive Improvement Notices** None received. **RIDDOR Overview** No RIDDOR-reportable incidents have been recorded for Q4 2024/25 or Q1 2025/26 to date. **Estates Reporting System Pilot Update** As part of the inpatient environmental safety workstream, a new MH&LD Estates reporting system designed and built within MH&LD utilising MS Teams technology was trialled to improve job tracking and resolution. Strengths: • User-friendly, well-received by staff. • Allows efficient tracking and reporting of jobs by urgency, site, and type. • Introduces automation around estate job escalation and report closures. • Reduces duplicate of reporting, saving both estates and Care Group staff time • Supports structured monthly/bi-monthly reviews. Next Steps: • Finalise Standard Operating Procedure • Introduce to all inpatient areas (Scheduled for 16th May 2025) • Roll-out to all remaining sites (June 2025) **DTPS Care Group-** Submitting focus report **Children and Families Care Group**- Submitting a focus report **Facilities-** Submitting a focus report
Appendices	**Primary Care and Community Care Group** High Level Statutory Maintenance & Testing Matrix by Property - Primary Care very 9 12052025

4. Assessment

Objectives / Strategy

Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Creating Health If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:

Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Health, Safety & Fire sub-committee is asked to **NOTE** the highlights outlined in section 3 of this report.

Agenda Item
5.3.1

Health, Safety & Fire Sub Committee

HIGHLIGHT REPORT Children and Families CARE GROUP HEALTH, SAFETY & FIRE MEETING

Dyddiad y Cyfarfod / Date of Meeting	22/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	(Carl Verrecchia, Care Group Service Director)
Cyflwynydd yr Adroddiad / Report Presenter	(Carl Verrecchia, Care Group Service Director)
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gethin Hughes, Chief Operating Officer

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
NNU	Neo Natal Unit
PAU	Paediatric Assessment Unit
SMTL	Surgical Materials Testing Laboratory
CCN	Childrens Community Nursing

1. Introduction

1.1 This report had been prepared to provide the Health, Safety and Fire Sub Committee with details of the key issues considered by the Children and Families Care Group through its meetings.

1.2 Key highlights from the meeting are reported in section 3.

2. Highlight Report

2.1 As a minimum Care Groups are asked to cover the following areas of activity within the Highlight Report to the Health, Safety & Fire Sub Committee (Sub Committee of the Board). If any of these areas are not applicable please indicate this in the report.

- Fire enforcement Notice issued and actions status
- Health and Safety Executive Improvement Notices
- Fire alarm system activations and false alarms (data)
- Health, Safety and fire Risk Assessments
- New Risk Assessments or significant changes
- RIDDOR reportable incidents – any themes / spikes
- High incidence of needle stick injuries
- Security & Violence - significant issues
- Mandatory training performance – % compliance and improvement trajectory where necessary
- Health Safety & Welfare Training
- Fire Safety
- Moving and Handling
- Violence and aggression

Alert / Escalate	• Fire extinguishers are out of date in Princess Of Wales children's outpatients – estates contacted 06/05/2025- FIRE RISK • Royal Glamorgan Hospital temporary ward move linked to Princess of Wales (PoW) critical incident still has some outstanding safeguarding work to be concluded. This is installation of Magnetic locks in the expanded PAU and the commencement of converting an unused pool into a safeguarding medical assessment area. Both have been approved on capital programme and awaiting start date. All necessary make safes are in place whilst the work is pending.

Advise	• Electrical and air handling unit resilience in POW Labour ward and NNU previously scoring a 20 on the risk register has been concluded and the risk removed the staff sickness associated with the stressors of the moves is now returning to normal levels. • Health & Safety identified there are no first aiders on each site and that we should have trained first aid staff, however, there has been no funded training available - this used to be undertaken by the resus dept but was discontinued. The Care group is following up on how we can address this. • Emergency call bell issues in Prince Charles Hospital paediatric wards (Octopus and Turtle) were previously reported as not functioning. The call bells have been renewed and childrens outpatients are also going to have the same system to interlink. • Previously reported Rat sightings in paediatric areas reported by clinical staff at POW through last year. Issue escalated and estates and facilities have resolved this. No further sightings have been raised. • The Royal Glamorgan Hospital Womens unit in regard to the air changes within the colposcopy / hysteroscopy suite is being progressed. The business case has been approved to convert the parentcraft rooms at the end of the unit to enable a hysteroscopy suite that will be fully compliant with air changes. Feasibility study and architect stages are now progressing. • SMTL have been asked to support a review of areas within maternity that use Entonox/ Pethrox and ventilation requirement to ensure we are keeping our staff safe. We expect some initial reports in early June. • Temperature control issues in medication room on paediatric ward at POW. Has been approved through Capital but awaiting start date. • Ceiling tiles missing in childrens ward requires electrician as around Wi-Fi box, fire exit lights, and alarm lights. - 134860-FIRE

Assure	• Childrens clinic digital lock at the rear of POW childrens centre was defective. Reported to estates and escalated to Care Group service Director. Lock changed and functioning effectively now. • Dewi Sant Health Park security for women's clinic area has been assessed. We have CCTV running in the waiting area but are looking at some further safety measures such as a door call system with locked doors or some element of site security improvements. • CCN Office Glanrhyd – access to store room problematic due to location in bank area (alarm), on risk register, estates working to look for solution, risk currently mitigated as able to use old CCN office for storage, this is problematic as up a flight of stairs with no lift access. • CCN Office KHHP (Day Unit 3) damaged ceiling tiles following flood, reviewed by estates, tiles ordered, still awaiting delivery.
Inform	• There are no Fire enforcement notices specifically for Children families. • There are no Health and Safety executive actions specifically for Children and Families. • No concerning trends on needle stick injuries. • No concerning trends on fire alarm activations • No concerning trends on violoence and aggression incidents but 2 recent verbal aggression incidents noted at RGH paediatric / Emergency department relating to safeguarding concerns so being monitored. • Mandatory training compliance is slightly improved in April at 74.2% there is still further improvement needed in the small group of AHP's and medical and dental which the Care Group is working on. The service director has sent a strong message to medical colleagues with the expectation that by end of June all will have achieved at least 75% as they have time in their job plans. We have queried whether students should be included in our care group mandatory training compliance and will remove from the overall compliance if appropriate.

	The gauge below provides an overall compliance % for all staff in the Care Group covering all 10 CSTF subjects.  The Table below provides an overview of Care Group compliance by staff group.

Staff Group	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
Add Prof Scientific and Technic	1	16	9	56.25%	0	56.25%
Additional Clinical Services	263	3388	2504	74.39%	85	71.87%
Administrative and Clerical	176	2164	1788	82.67%	41	80.78%
Allied Health Professionals	5	71	41	57.75%	0	57.75%
Medical and Dental	136	1813	952	52.51%	17	51.57%
Nursing and Midwifery Registered	834	11479	8745	76.18%	283	73.72%
Students	1	15	7	46.67%	0	46.67%

Appendices	•

3. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /*	Learning, Improvement & Research
	If more than one applies please list below:

Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: The report provides an update to Committee, no decisions or changes resulting in an impact is being sought.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?* / **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	Yes (Include further detail below)	
	Statutory responsibility under health and safety law. This has potential for legal implications due to the nature of the report, if not managed and sufficient action taken and monitored appropriately.	
Enw da / Reputational	Yes (Include further detail below)	
	Reputation can be at risk due to the nature of this report and failure to manage appropriately.	
Effaith Adnoddau *(Pobl /Ariannol)* / **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Existing budget will be considered for any costs incurred.	

4. Recommendation

4.1 The Health Safety and Fire Sub Committee is asked to **NOTE** the highlights outlined in section 3 of this report.

Agenda Item
5.3.2.

Health, Safety & Fire Sub Committee

HIGHLIGHT REPORT Diagnostic, Therapies, Pharmacy and Sciences CARE GROUP
HEALTH, SAFETY & FIRE MEETING

Dyddiad y Cyfarfod / Date of Meeting	22/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	(Carl Verrecchia, Care Group Service Director)
Cyflwynydd yr Adroddiad / Report Presenter	(Carl Verrecchia, Care Group Service Director)
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gethin Hughes, Chief Operating Officer

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
RSI	Repetitive Strain Injury
YMH	Ynysmeurig House
YCR	Ysbyty Cwm Rhondda

1. Introduction

1.1 This report had been prepared to provide the Health, Safety and Fire Sub Committee with details of the key issues considered by the Diagnostics, Therapies, Pharmacy and Sciences Care Group through its meetings.

1.2 Key highlights from the meeting are reported in section 3.

2. Highlight Report

2.1 As a minimum Care Groups are asked to cover the following areas of activity within the Highlight Report to the Health, Safety & Fire Sub Committee (Sub Committee of the Board). If any of these areas are not applicable please indicate this in the report.

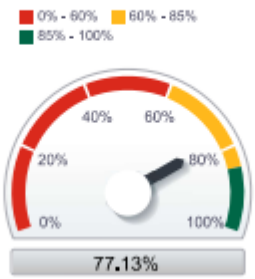
- Fire enforcement Notice issued and actions status
- Health and Safety Executive Improvement Notices
- Fire alarm system activations and false alarms (data)
- Health, Safety and fire Risk Assessments
- New Risk Assessments or significant changes
- RIDDOR reportable incidents – any themes / spikes
- High incidence of needle stick injuries
- Security & Violence - significant issues
- Mandatory training performance – % compliance and improvement trajectory where necessary
- Health Safety & Welfare Training
- Fire Safety
- Moving and Handling
- Violence and aggression

Alert / Escalate	• Radiology team are supporting staff with ongoing RSI. A new risk assessment is being undertaken as we have new equipment being introduced as part of a planned replacement. The demand on clinics for antenatal scanning has increased and it is this scanning that is having the impact on staff. A meeting was held on 21st May to discuss a realistic cap to the amount of scans expected per clinic at Ysbyty Cwm Rhondda. Locums have been brought in and we are looking to alternate duties so that sonographers are not solely scanning pregnant mothers. This sickness is having an impact on staff then not being available for Non Obstetric Ultrasound scanning.

Advise	• Air handling issues in Royal Glamorgan Hospital (RGH) cellular pathology previously reported that resulted in a higher than normal level of formalin detected in office spaces near the laboratory have been resolved. Longer term the plan is to consider additional lab space that will be future proofed and ventilated to modern standards. • Concern flagged to Estates regarding Contractors on site within Pathology RGH moving fire extinguishers to hold open fire doors. Escalated and resolved via Estates team. • One autoclave within Microbiology Pathology RGH requiring repairs. NHS Wales Shared Services Partnership (NWSSP) and Estates aware and resolving as quickly as possible. Risk will increase if another autoclave goes down. • Pathology RGH templates outstanding PAT testing from 2024 – escalated via Helpdesk and RGH Site Forum • Therapy staff are moving from Pontypridd Cottage by the end of June 2025. Options for some staff to relocate to Ynysmeurig House have been provided. • Site issues at Princess Of Wales Radiology (ultrasound rooms) where ceiling tiles and roof space was left exposed have been resolved but we did receive comments from patients who were curious about whether that was normal. Site General Manager and estates resolved quickly once alerted. • Prince Charles Hospital (PCH) new radiology reception opened recently. Reception staff have raised their concern about the height of the desk and the fact there is no screen to help protect them. Service Director visited 21.5.25 and has asked for a screen to be costed and installed on the grounds of staff safety as per other sites. **Medical Illustration** Two issues that both have been resolved. • Hole in the ceiling of the studio, repaired when studio was updated • Main office Fire door would not completely close (by itself) following installation of new door. Rectified by estates. • Last fire review for Cardiopulmonary diagnostics in RGH was 29/03/23 and all actions related to our template and for us to action were completed. Annual Extinguisher checks due July 25 • Review PCH (Cardiac Physiology)last fire safety review July 2024 all management actions for our area completed promptly post review. Annual fire extinguisher checks due March / April 2025, site Fire Officer has been contacted.

	Estates are aware, however they are awaiting confirmation from Procurement on the renewal contract from 'Proderm'.
Assure	• Following Display Screen Equipment assessment and some Musculoskeletal concerns raised height adjustable desks are being installed for pathologists who require them in RGH and this will remove a high staff risk from the risk register. • Issue of storage of beds and items in PCH corridors which Clinical engineering is supporting on and this requires a whole site procedure which is being worked on by the Hospital General Manager. • Plans to address further improvements in mandatory training in DTPS. • Equipment replacement for DTPS has been well supported and a large amount of capital has been given to replacing and updating imaging equipment and patient bed stock. The Capital team continue to work with the Care Groups priorities to address equipment and environment improvements
Inform	• There are no Fire enforcement notices specifically for DTPS, • There are no Health and Safety executive actions specifically for DTPS. • No concerning trends on needle stick injuries. • No concerning trends on fire alarm activations • No concerning trends on violence and aggression incidents although still some isolated incidents in therapies. • Mandatory training compliance is slightly deteriorated since last report in August 2024 for DTPS at 77.13% from 78.11% there is now a drive on further improvements needed in the small group of medical and dental which the Care Group is working on and there is a headcount on estates and ancillary in the DTPS figures which is being queried as this is also below 52%. • Fire training compliance is at 67.3% (slight deterioration) and Health, Safety and Welfare is at 79.9% (improved)

The gauge below provides an overall compliance % for all staff in the Care Group covering all 10 CSTF subjects.



The Table below provides an overview of Care Group compliance by staff group.

Staff Group	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
Add Prof Scientific and Technic	236	3105	2183	70.31%	69	68.08%
Additional Clinical Services	422	5018	4052	80.75%	94	78.88%
Administrative and Clerical	202	2387	2025	84.83%	44	82.99%
Allied Health Professionals	655	8416	6630	78.78%	151	76.98%
Estates and Ancillary	5	60	31	51.67%	0	51.67%
Healthcare Scientists	217	2408	1782	74.00%	64	71.35%
Medical and Dental	52	668	307	45.96%	2	45.66%
Nursing and Midwifery Registered	30	427	335	78.45%	4	77.52%

Appendices	• None

3. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
	Learning, Improvement & Research

Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not applicable in overarching report
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	Yes (Include further detail below)	
	Statutory responsibility under Health and Safety Law	
Enw da / Reputational	Yes (Include further detail below)	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	There will be some capital / revenue requirements to deal with all issues but these will be stratified	

4. Recommendation

4.1 The Health, Safety and Fire sub committee is asked to **NOTE** the highlights outlined in section 3 of this report.

Agenda Item
5.3.3.

Health, Safety & Fire Sub Committee

Highlight Report from the Facilities Directorate

Dyddiad y Cyfarfod / Date of Meeting	05/12/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Claire Masters, Performance and Governance Lead
Cyflwynydd yr Adroddiad / Report Presenter	Stephen Gardiner, Facilities Service Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gethin Hughes, Chief Operating Officer

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Facilities Senior Leadership Team (SLT)	30/04/2025	Noted
Facilities Risk Management Group	07/05/2025	Noted

Acronyms / Glossary of Terms	
RGH	Royal Glamorgan Hospital

PMVA	Prevention and Management of Violence and Aggression
OMB	Operational Management Board
SWFRS	South Wales Fire and Rescue Service
AFA	Automatic Fire Alarm
UwFS	Unwanted Fire Signal
FRMG	Facilities Risk Management Group
HAVS	Hand Arm Vibrations
SVRA	Security Vulnerability Risk Assessments

1. Introduction

1.1 This report had been prepared to provide the Health, Safety and Fire subcommittee with details of the key issues considered by the Facilities Directorate.

1.2 Key highlights from the meeting are reported in section 3.

2. Purpose of this Meeting

2.1 As a minimum Care Groups are asked to cover the following areas of activity within the Highlight Report to the Health, Safety & Fire Sub Committee (Sub Committee of the Board). If any of these areas are not applicable, please indicate this in the report.

- Fire enforcement Notice issued and actions status
- Health and Safety Executive Improvement Notices
- Fire alarm system activations and false alarms (data)
- Health, Safety and fire Risk Assessments
- New Risk Assessments or significant changes
- RIDDOR reportable incidents – any themes / spikes
- High incidence of needle stick injuries
- Security & Violence - significant issues
- Mandatory training performance – % compliance and improvement trajectory where necessary
- Health Safety & Welfare Training
- Fire Safety
- Moving and Handling
- Violence and aggression

3. Highlight Report

Alert / Escalate	**Security & Violence - significant issues** At present the Directorate are managing the following security and violence issues: <u>RGH Car Park</u> Due to the extreme pressures within the car parking facilities in RGH, the team are sadly being subjected to frequent verbal assault as staff and visitors express their anger and frustration at not being able to find a space. Whilst long term solutions are being identified, staff are reminded to be respectful towards the Car parking attendants and this is being supported by our Staff side and Trade Union colleagues. Quality Impact Assessments have been completed and the car parking risk assessment for RGH updated.
Advise	**RIDDOR reportable incidents** The table below provides a summary of the RIDDOR reportable incidents that have occurred within Facilities over the last 12 months. Only four of the above DATIX remain open; 2 relating to push pull incidents 1 Contact with a hot liquid 1 slip, trip and fall

		24/25 Q2	24/25 Q3	24/25 Q4	25/26 Q1	Total
Accident, Injury	Burns or scalds	1	0	0	0	1
	Contact with object or animal	0	0	0	1	1
	Manual Handling - Non patient/service user handling	0	0	2	2	4
	Slip, trip or fall	1	1	0	1	3
	Struck against or by an object	0	0	1	0	1
	Total	2	1	3	4	10

Directorate Risk Register Profile Approved Risks (as at 31st March 2025)

Service	Low Risks	Moderate Risks	High Risks	TOTAL
Catering Services	85	8	1	94
CPU/Maith	31	4	2	37
Housekeeping	43	13	2	58
Porter Services	19	12	1	32
Tech Services	56	24	4	84
Transport & Waste	1	4	0	5
Facilities Directorate	**235**	**65**	**10**	**310**

Risks are reviewed regularly by the Directorate team.

Only one of the High risks has been escalated to Operational Management Board, that is the Security risk, all others are operational high risks that are being managed within the service and, as of yet, do not need to be escalated.

DATIX Incidents

Below is a summary of Q4 2024/25;

Service	New Incident	Management Review	Under Investigation	Awaiting Closure	Closed	TOTAL
Facilities Hub	4			1	1	6
CPU/Maith						
Porter Services	4	2	1	1	11	19
Security	3			2		5
Operational Facilities	2	1			3	6
Catering	6	2		1	7	16
Housekeeping	4			1	7	12
TOTAL	23	5	1	6	29	64
QUARTER 4 TOTAL	21	5	1	3	24	54

Incident Category (Top 5) and Service area

	Porter Services	Housekeeping	Catering	Facilities Hub	Security
Non-medical equipment	11	1	4	5	2
Slip, trip or fall	5	7	4	5	0
Burns or scalds	0	1	15	1	0
Struck against or by an object	7	7	2	0	0
Manual Handling - Non patient/service user handling	6	4	2	0	0

Mandatory training performance

The section below provides an overview of the directorate compliance to the Core Skills Training modules relevant to Health, Safety and Fire. It includes the overall compliance total and a breakdown of compliance by module. An action plan to improve compliance to UHB target is being developed and trend analysis will be included in future reports to illustrate the effectiveness of these plans.

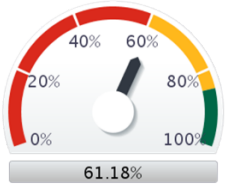
Fire Safety

Competence Full Name	Competencies Required	Compliance %
110|LOCAL|Emergency Evacuation Equipment - 2 years|	142	3.52%
110|LOCAL|Fire Safety Management Training - 2 years|	30	60.00%
110|LOCAL|Senior Managers Fire Safety Awareness - 2 Years|	1	0.00%
110|LOCAL|Ward/Departmental Fire Safety Training - 2 Years|	1123	70.53%
NHS|CSTF|Fire Safety - 2 Years|	1123	65.81%

Health Safety & Welfare Training

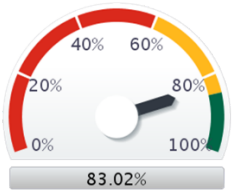
Competence Full Name	Competencies Required	Compliance %
110|LOCAL|Health, Safety and Welfare - Managing Risk Safely - No Specific Renewal|	1	100.00%
110|LOCAL|Health, Safety and Welfare - Managing Safely - No Specific Renewal|	32	46.88%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	1123	69.19%

Moving and Handling



Competence Full Name	Competencies Required	Compliance %
110|LOCAL|Moving & Handling Level 2a (Modules B, C & E Only) - 2 Years|	21	33.33%
110|LOCAL|Moving & Handling Non-Patient Handling Level 1b - 2 Year|	920	61.09%
NHS|CSTF|Moving and Handling - Level 1 - 3 Years|	1123	66.96%
NHS|CSTF|Moving and Handling - Level 2 - 2 Years|	182	29.12%

Violence and aggression



Competence Full Name	Competencies Required	Compliance %
110|LOCAL|Violence & Aggression Module B (Higher Risk Areas) - 3 Years|	37	13.51%
110|LOCAL|Violence & Aggression Module B (Low Risk Areas) - 3 Years|	156	61.54%
110|LOCAL|Violence & Aggression Module D - PMVA - Combined Services Training (Higher Risk Areas) - 18 months|	49	61.22%
110|LOCAL|Violence and Aggression (Wales) - Module C (2 years)|	37	16.22%
NHS|CSTF|Violence and Aggression (Wales) - Module A - No Specified Renewal|	1046	92.07%

Assure

Changes to South Wales Fire and Rescue Services, Automatic Fire Alarm responses.

The implementation of new Fire Service responses to Automatic Fire Alarms within CTM UHB commenced on 07th April 2025.
New procedures have been developed by Facilities teams that were implemented within each switchboard.
Staff to be aware that South Wales Fire and Rescue Services will not automatically send a response to all Automatic Fire Alarms, we have to investigate first.

Prevention and Management of Violence and Aggression Support and Training

Facilities is currently working with procurement to upgrade the Security contract specification to provide PMVA trained relief security officers to cover acute site rotas where required to support the CTM security teams.

Facilities is also working with procurement, MHLD and ED's to produce a contract specification for an accredited and suitable

	PMVA training provider to support initial and refresher training for MHLD, ED's and Facilities staff. **<u>Security Systems and Site Risk Management</u>** To address site security system risks, security vulnerability risk assessments (SVRA) have been carried out at relevant sites and upgrades to CCTV and access control systems are planned subject to appropriate funding being received and delivery programmes accepted.
Inform	**Security Management** <u>The Terrorism (Protection of Premises) Act 2025</u> The Terrorism (Protection of Premises) Act 2025, also known as Martyn's law, received Royal Assent on <u>Thursday 3 April 2025</u>. Now that the legislation has received Royal Assent, we expect the implementation phase will be at least 24 months. This will include establishing the regulator function within the Security Industry Authority (SIA), as well as ensuring there is time for businesses, premises, and events to prepare for the legislation coming into force. <u>Next Steps</u> Facilities have been working on plans and taking forward work in anticipation of this announcement and the implementation phase. For example; • Carrying out site security vulnerability risk assessments (SVRA). • Reviewing site access control and CCTV compliance and new and system upgrading requirements • Putting forward capital investment requirements to support access control and CCTV based on the SVRA risk and priority outcomes. • Reviewing resource implications and Facilities and CTM training requirements. • Working with South Wales Police and Local Authority colleagues.

	Enforcement Notices There is currently no active Health & Safety or Fire Enforcement Notices for the Facilities Team **Hand Arm Vibrations (HAVS)** The level of HAVS risk associated with the use of hand tools within the grounds and Gardens team is currently being investigated with support from the Bridgend locality Health & Safety Coordinator. To date, a full list of equipment used has been compiled along with estimated usage times and HAVS exposure (based on HSE or manufacturers Vib Mag m/s$^{2)}$. Next steps include: • Label all equipment • Record exact usage times for each piece of equipment over a sample study • Calculate HAVS exposure using HSE or manufacturers Vib Mag m/s^2 • If warranted based on initial calculations, conduct a further exercise to calculate Vib Mag m/s^2 for each tool Colleagues in Occupation Health will be included in this work stream when required.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Creating Health
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable
	If more than one applies please list below:
	Not Applicable

Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /*	There is no direct impact on resources as a result of the activity outlined in this report.	

Resource Impact *(People / Financial)*	

5. Recommendation

5.1 The Health, Safety & Fire sub-committee is asked to **NOTE** the highlights outlined in section 3 of this report.

Agenda Item
5.4

Health, Safety & Fire Sub Committee

VENTILATION SYSTEM COMPLIANCE

Dyddiad y Cyfarfod / Date of Meeting	05/06/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Alan Martin, Head of Operational Estates
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Alan Martin, Head of Operational Estates
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board

NWSSP	NHS Wales Shared Services Partnership
SES	Specialist Estate Services
WHTM	Welsh Health Technical Memorandum
AP	Approved Person
CP	Competent Person
AE	Authorised Engineer
V	Ventilation
RGH	Royal Glamorgan Hospital
POW	Princess of Wales Hospital
PCH	Prince Charles Hospital

1. SITUATION/BACKGROUND

To provide the Health Board with the assurance that its Ventilation systems are adequately managed an independent review is undertaken annually by NHS Wales Shared Services Partnership Authorising engineers (AE). The review findings are presented in an annual report to the designated person who for this issue is the Executive Director of Finance and lead for estates.

The key objective of the review is to assess the organisation's compliance with the requirements of ***Welsh Health Technical Memorandum (WHTM) 03-01, parts A & B: Specialist Ventilation in Healthcare Premises***, which promotes good practice in the design, installation, commissioning, operation and maintenance of ventilation services in healthcare premises.

A key requirement of ***WHTM 03-01 parts A & B*** for managing ventilation safety is to formally appoint an independent authorising engineer, responsible persons, deputy responsible persons and competent persons. The AE appointed for Ventilation systems is a Senior Performance Standards Engineer who is employed by NHS Wales Shared Services Partnership. The current appointments for Cwm Taf Morgannwg University Health Board staff are shown at **appendix 1.**

The appointments are reviewed on a quarterly basis at the Ventilation Safety Group and at the Estates and Capital Governance Board to ensure appointments are extant.

SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

CTMUHB's annual report for Ventilation systems was issued in March 2025; the review was undertaken to determine the adequacy of, and operational compliance with the systems and procedures of the Health Board.

The review evaluated the systems and controls in place within the Health Board to determine and provide reasonable assurance that risks associated with ventilation systems were appropriately managed. The scope of the review covered the following areas:-

- **Governance**- The Health Board has reasonable assurance in place to support the management of the ***Welsh Health Technical Memorandum (WHTM) 03-01, parts A & B: Specialist Ventilation in Healthcare Premises*** and the Health and Safety Executive, Approved Code of Practice.

Also that an appropriate policy has been updated to address ventilation safety issues, but is currently going through Health Board governance process for final approval, there are defined allocation of responsibilities, clear lines of communication and reporting and approval processes.

- **Monitoring and reporting –** To ensure that the estate is appropriately monitored and that the Board has effective procedures in place e.g. the establishment of an appropriate Ventilation Safety Group.

- **Procedures-** To ensure that management are implementing applicable procedures, both with internal and external requirements**.**

- **Management –** Assurance that relevant staff have received appropriate training, adequate resources are allocated and an appropriate inspection regime is operated.

- **Risk Management –** Assurance that the Health Board has performed a suitable and sufficient assessment of risk and that risks are appropriately managed.

2. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

Ventilation

Following the annual review the independent Authorising Engineer determined that generally the condition and management of the ventilation systems within the organisation are satisfactory and deemed the overall compliance rating of yellow **(reasonable assurance)** as shown in Figure 1.

The Health Board has made significant capital investments at the Princess of Wales Hospital with ventilation systems within the roof works, and upgrades of air handling units, and Royal Glamorgan Hospital in the replacement of numerous ventilation systems, including additional specialist ventilation within the mobile theatre complex. Work with specialist AE's continues at Prince Charles Hospital with the major redevelopment of the theatres, and Llantrisant health park design. The Health Board have also secured additional Welsh Government funding via the Targeted Estates Funding circa £2.4m to upgrade Theatres 1 – 4 air

handling infrastructure at RGH, and Circa £2.3m for Negative pressure isolation rooms at RGH and POW over the coming 2 years.

Fig. 1

Overall Compliance Rating in 2023 compared to the assessment in 2022

May 2023	April 2025
	
Additional APs appointed but more required CPs are being appointed Policy updates complete and signed off by the board of directors Governance largely in place Procedures are being implemented Risks identified Action plans pending funding, with progress where possible	Appoint additional AP(V)s All CP(V)s to be appointed Ratify updated policy and obtain board of director sign off Ensure all critical ventilation systems are verified Procedures are being implemented Complete annual verifications Action plans created to progress actions from AE(V) Tirennial audits.
Yellow	Yellow

A number of recommendations/observations have been included in the AE report which are shown in **table 1**.

Table 1

LV AE 2023 recommendations/observations	CTMUHB comments – June 2024
Appoint additional AP(V)s	Positions at Band 6 have been identified for training and appointment, with cross site working to support instigated. Current recruitment issues have left a number of positions vacant which are out to advert, but rely on suitably qualified applicants in a mechanical field applying as Estates

	Officer roles care electrical, mechanical or building with no trade specification. To note appointments of AP roles can take up to a year to become competent to be assessed as suitable to take on the appointments by AE's, so are not automatically appointed as soon as the vacancy has been filled.
All CP's to be appointed	Additional staff were appointed as CP (Competent Person) in line with the recommendations of WHTM 03-01. Unfortunately a number of staff have since left the organisation. Following the appointment of new staff an assessment period is required for site/ system familiarisation, once this is concluded the appointment of Competent Person can be made. Training programs to increase the number of CP's has been identified for 24-25.
Ratify updated policy and obtain board of director sign off,	The policy has been completed some months ago when due, and has gone through a number of Health board governance processes, some which have requested additional information thus delaying the formal sign off. The policy has been resubmitted, and is in the final stages of Health Board governance approval.
Procedures are being implemented.	Procedures relating to WHTM03-01 are ongoing and scrutinized by Ventilation AP and CP's, with update to procedures such as risk assessments carried out through handheld technology.
Complete Annual Verifications	A number of identified assets require annual verification. An asset list is in place that identifies when these are to be carried out, and are programmed in with the AE who completes these within the calendar year. Verifications are often dependent on the availability of the AE to complete.
Action plans created to progress actions from AE(V) triennial reports	Actions are captured from the reports through the Estates Head of Governance and recorded within the estates data base and reviewed at ventilation safety meetings and various estates levels. Action are closed off through AP's, and

	any high or significant risks are escalated through governance groups. Assets that are deemed beyond life, or risk of future replacement are recorded with the backlog maintenance risk register, and identified for additional funding through various funding routes when this becomes available, such as the Targeted Estates Funding from Welsh Government.

The Health Board will continue to prioritize and address the recommendations/observations of the AE.

Triennial Compliance Audits

In addition to the organisation's annual review the Authorising engineer undertakes detailed triennial audits of the ventilation systems and safe systems of work in accordance with WHTM 03-01:

Audits have been carried out at Princess of Wales Hospital, and the Royal Glamorgan Hospital in the reporting period by Authorising Engineer of NWSSP-SES and his findings are shown in table 2.

Table 2

Hospital	Compliance Rating	Resilience Rating
Princess of Wales Hospital	Reasonable assurance	Limited Assurance
Royal Glamorgan Hospital	Reasonable assurance	Limited Assurance

Princess of Wales Hospital and Royal Glamorgan Hospital.

The AE has deemed the overall compliance rating of the safe system of work as detailed in HTM 03-01 for the site as reasonable assurance, in addition a rating on the level of resilience inherent in the system design is assessed (in line with HTM 03-01) considering the age and condition of the

equipment and has assessed the overall resilience rating as limited assurance.

3. Safe systems of work

The Health Board has established management processes in place for managing ventilation systems which is reinforced with the following:-

Authorised Persons

For acute hospitals the AE recommends a minimum of three permanently site based Authorised Persons Ventilation (APV).

Authorised Person coverage is limited with typically one/two appointed for each main hospital and community sites. The AE recommends an additional Authorised Person for the Princess of Wales, Prince Charles and the Royal Glamorgan Hospitals to assist the limited numbers currently appointed.

Unfortunately, due to recruitment issues, and staffing numbers at band 6, this leaves all sites with limited Authorised Person Ventilation (APV) permanently based and appointed for each site. The Health Board have advertised positions for estates vacancies at band 6 on numerous occasions. Due to a shortage of suitable applicants, not all positions have been successfully filled. In addition, appointment to AP status is a time consuming process, and can take in excess of a year to complete. Within this timeframe, training has to be undertaken at specialist educational facilities with final examination pass a criteria for certification of achievement. The person has to, on completion of educational training, undertake site familiarisation of all systems at their dedicated place of employment, and prove equipment competency through the management of the system, including maintenance and repair activities. Final assessment is based on all 3 aspects of, training, site and equipment familiarisation, and competency to undertake the requirements of WHTM 03-01. This final assessment is carried out by the Shared Services AE (V). Only then once the nominated persons for AP status has achieved the required level of AE assessment is any recommendations to appoint as an AP (V) given.

Ventilation Safety Group (VSG)

Welsh Health Technical Memorandum WHTM 03-01 ventilation services introduced the concept of the Ventilation Safety Group (VSG)) in healthcare organisations. This is a multidisciplinary group responsible for ensuring

that ventilation safety issues are monitored, recorded and acted on in line with the relevant legislation and guidance.

The WHTM recommends that the VSG is led and chaired by a person who has appropriate management responsibility, knowledge, competence and experience. This is in keeping with the recommendations in Welsh Health Technical Memorandum 00 – 'Policies and principles of healthcare engineering.

CTMUHB have formed an ESG which meets on a quarterly basis. It is generally well attended and includes the AE (V).

1. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment

Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Update report
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Update report
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

2. Recommendation

The Committee is asked to note the contents of the report.

3. Next Steps

3.1 No further action required.

Hospital	Authorised person Ventilation	Date Assessed	Appointment expires
Prince Charles	Estates Officer 1	17/02/2021	Expired in process of reappointment
Princess of Wales	Estates Officer 2	19/12/2024	19/12/2027
Royal Glamorgan	Estates Officer 3	20/11/2024	20/11/2027
Royal Glamorgan	Estates Officer 4	12/09/2022	12/09/2025
Cwm Cynon	Estates Officer 1	17/02/2021	Expired in process of reappointment
Cwm Rhondda	Estates Officer 2	20/11/2024	20/11/2027
Cwm Rhondda	Estates Officer 4	12/09/2022	12/09/2025

All appointed AP(V) have undertaken an approved AP(V) training course.

Agenda Item
7.1

Health, Safety & Fire Sub Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	5 June 2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Emma Walters, Head of Corporate Governance & Board Business
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Service, Function and Executive Formal Review	April / May 2025	RISKS REVIEWED
Operational Management Board / COO approval	April 2025	ENDORSED RISKS FOR ESCALATION WHERE APPLICABLE
Executive Leadership Group	6th May to the 9th May via email	MANAGEMENT SIGN OFF RECEIVED
Quality, Safety and Experience Committee	20th May 2025	ASSIGNED RISKS REVIEWED
Audit, Risk & Assurance Committee	22nd May 2025	RISKS REVIEWED

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 The purpose of this report is for the Sub Committee to review and discuss the organisational risk register and consider whether the assigned risks have been appropriately assessed.

2. Specific Matters for Consideration

Risk Review

2.1 Care Groups and Central leads are continuing to review and update their assigned risks considering feedback received from Members in relation to scoring, actions with associated timeframes and ensuring timely reviews.

2.2 The Operational Management Board / Chief Operating Officer approves escalation of Care Group risks to the Organisational Risk Register.

2.3 The Executive Lead approves escalation of central/core function risks to the Organisational Risk Register.

2.4 Risks on the organisational risk register have been updated as indicated in red in Appendix 1.

2.5 Please note that the risk updates are captured at the time the Organisational Risk Register being finalised for submission, which on this occasion was the 2 May 2025.

Training

2.6 Risk training, although not a core training requirement under the statutory and mandatory framework, has been added to the Electronic Staff Record (ESR) to support staff in registering for training and to support ease of reporting. This is managed by the Quality Assurance and Compliance Team. Interest in the course continues with positive uptake.

2.7 The sessions are run by the Assistant Director of Governance & Risk and Heads of Quality and Safety. The session is held virtually via Teams on a monthly basis for a duration of 1 hour and covers the following areas:

- Risk Management Approach
- Practical Approach to Managing Risk
- Risk Assessment and Scoring
- Datix Risk Management Module

2.8 To date **773** members of staff trained to date since training commenced in 2021. Based on the Risk Management Awareness Training Needs Analysis all attendees completed Training Profile 2.

2.9 Focussed sessions to discuss risk have also been undertaken with Care Group Leads and other departments/directorates as required.

2.10 109 attendees have provided formal feedback (using the URL Code for the Evaluation Form, which was introduced in November 2023). The average rating for the course is 4.80 out of a maximum score of 5.

2.11 100% of the 109 attendees providing formal feedback found that:
- The session provided the right amount of information.
- They gained more confidence and knowledge in risk management having attended.
- They would recommend this training to a colleague.

2.12 98% of the 109 attendees providing formal feedback said they felt more confident to escalate a risk through the organisation.

2.13 Some of the recent comments from the session, received through evaluation, have been included below:
- *"Delivered well and clear".*
- *"training, well rounded, concise and very informative"*

3. Key Risks / Matters for Escalation

3.1 NEW RISKS

None as assigned to this Sub Committee.

3.2 CHANGES TO RISKS

Risk Score Increased

None as assigned to this Sub Committee.

Risk Score Decreased

None as assigned to this Sub Committee.

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

None as assigned to this Sub Committee.

3.4 ORGANISATIONAL RISK REGISTER – VISUAL HEAT MAP BY DATIX RISK ID (RISK RATED 15 AND ABOVE)

Consequence						
	5				5932	
	4				4417 5691 5961	
	3					
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

3.5 EMERGING RISKS

Nil as assigned to this Sub Committee.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Not Applicable If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant /Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Resilient Wales If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required for the Organisational Risk Register. Individual risks may have been subject to QIA.
Cydraddoldeb a'r Gymraeg	Yes: ☐	No: ☒

Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not required for the organisational Risk Register. Individual risks may have been subject to an Impact Assessment.
Cyfreithiol / Legal	Yes (Include further detail below)	
	See detail captured for each risk	
Enw da / Reputational	Yes (Include further detail below)	
	See detail captured for each risk	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	See detail captured for each risk	

5. Recommendation

5.1 The Sub Committee are asked to:

- **Review** the risks escalated to the Organisational Risk Register at Appendix 1.
- **Consider** whether the Sub Committee can seek assurance from the report that all that can be done is being done to mitigate the risks

5. Next Steps

6.1 The Organisational Risk Register will be submitted to the relevant Board and Committees.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
6	5932	Executive Director of Finance Executive Lead for Estates	Central Corporate - Estates	Assistant Director of Planning - (Capital and Estates), Strategic and Operational Planning	Sustaining Our Future	Environmental / Estate / Infrastructure	Roof covering replacement works to resolve identified roof integrity issue and consequent risk of tiles falling internally and externally from weakened roof at POWH Phase 1.	IF: the Health Board fails to act upon the recommendations of the findings of the report from the appointed Structural Engineers in relation to the roof area at the POWH. Then: there is a risk of collapse of the roof coverings which could result in the roof coverings falling through the roof void into occupied clinical/non clinical areas and externally from the edges of Phase 1. This risk increases in adverse weather with additional loading on the roof. Resulting in: significant impact/harm to patient, staff and public safety. Healthcare facilities which are not fit for purpose or sustainable for the future. Service delays impacting the patient experience and service performance of the Health Board. Potential legislative challenge and reputational damage. Loss of confidence in the Health Board estate infrastructure across CTM.	Command structure established to manage the critical incident following identification of roof structure failings. Immediate mitigations being considered under 4 key Cells: 1) Discharge Cell - Objectives: The safe but rapid discharge of patients and services from top floor phase 1 POW site and to maintain quality of care and patient safety 2) Decant Cell - Objectives are the safe but rapid decant of patients and services from top floor phase 1 POW site, to maintain quality of care and patient safety and to maintain staff safety and the deployment of the right staff to the right place. 3) Redirect Take - Objective - Reduce demand for inpatient beds on the POW site 4) Estates - focusing on ensuring decant areas are fit for purpose as well as overseeing the plans for the works on the roof. Enabling Support Cells Established: Patient Transport Workforce Digital Facilities Patient Safety Communication In addition barriers are in place around the footpaths to keep pedestrians away from the edge of Phase 1 roofs.	Update April 2025: Removal of Roof Coverings at the Princess of Wales Hospital site in accordance with the recommendations in the structural engineering report of 9th October 2024. Contractor started the roof replacement programme on Monday 11th November. Phase 1 prioritised Maternity and Special Care Baby Unit, these areas are complete and were handed back 13th January, services returned to site in Feb. Contractors have replaced the old tiles above Main Theatres and Wards 9, 10, ITU and Endoscopy are almost complete so risk of falling tiles has reduced considerably with the large area of roof where the old tiles have been removed. Remaining Wards 5, 6, 7 and 8 roof works have started. Full programme including Theatre FEN works and fire compartmentation above vacated wards and depts due to be completed mid August 2025.	Operational Delivery Committee Quality, Safety & Experience Committee Health, Safety & Fire Sub Committee	20	C5xL4	10 (C5xL2)	↔	23.09.2024	06.05.2025	30.06.2025
23	5961	Executive Director of Finance Executive Lead for Estates	Central Corporate - Estates	Estates Directorate	Sustaining Our Future	Environmental / Estate / Infrastructure	Remedial roof works to resolve the water ingress at POWH.	IF: the Health Board fails to act upon the recommendations of the findings of the report from the appointed Structural Engineers in relation to the roof areas at the POWH Then: water ingress will continue to be a problem. Resulting in: significant impact/harm to patient, staff and public safety. Healthcare facilities which are not fit for purpose or sustainable for the future. Service delays impacting the patient experience and service performance of the Health Board. Potential legislative challenge and reputational damage. Loss of confidence in the Health Board estate infrastructure across CTM.	Command structure established to manage the critical incident following identification of roof structure failings. Immediate mitigations to vacate 1st floor wards & depts. of Phase 1 being managed under 4 key Cells: 1) Discharge Cell - Objectives: The safe but rapid discharge of patients and services from top floor phase 1 POW site and to maintain quality of care and patient safety 2) Decant Cell - Objectives are the safe but rapid decant of patients and services from top floor phase 1 POW site, to maintain quality of care and patient safety and to maintain staff safety and the deployment of the right staff to the right place. Decant plan agreed 15th Oct. 3) Redirect Take - Objective - Reduce demand for inpatient beds on the POW site 4) Estates - focusing on ensuring decant areas are fit for purpose as well as overseeing the plans for the works on the roof. Enabling Support Cells Established: Patient Transport, Workforce, Digital, Facilities, Patient Safety, Communication In addition barriers are in place around the footpaths to keep pedestrians away from the edge of Phase 1 roofs.	Update April 2025: Removal of Roof Coverings at the Princess of Wales Hospital site in accordance with the recommendations in the structural engineering report of 9th October 2024. Contractor has been appointed. Welsh Government funding £26,524m was approved Friday 8th November, contractor started the roof replacement programme on Monday 11th November. Phase 1 has prioritised Maternity and Special Care Baby Unit, roof replaced and handed over on Monday 13th January, services returned to site mid Feb. Full programme including Theatre FEN works and fire compartmentation above vacated wards and depts due to be completed mid August 2025. Water ingress on the Phase 1 areas of the roof is only a risk on areas yet to be completed i.e. ITU, Endoscopy, Wards 5, 6, 7 and 8 but all are vacant and roof works progressing.	Quality, Safety & Experience Committee Operational Delivery Committee Health, Safety & Fire Sub Committee	16	C4xL4	8 (C4xL2)	↔	21.10.2024	06.05.2025	30.06.2025
25	5691 Closed Session due to business sensitivities	Chief Operating Officer	Facilities Directorate	Assistant Director Facilities	Sustaining Our Future	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	The detail of this risk is included in the Closed Session of the Sub Committee due to business sensitivities.											
32	4417 (Linked to Risk IDs 4706 and 4703)	Chief Operating Officer	All Care Groups	Deputy COO (Acute Services & Primary, Community & Mental Health)	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Management of Security Doors in All Hospital Settings	Following several serious incidents following patients absconding from clinical areas, the HSE have issue an Improvement Notice on Bridgend Integrated Locality Group (see Documents) outlining the following actions: In consultation with employees and involving competent persons: 1. Identify the units, wards and premises where in-patients may be at risk from wandering, absconding or escaping. 2. For each of these, undertake a suitable and sufficient risk assessment of physical and procedural measures to prevent in-patients from wandering, absconding or escaping. 3. Identify the measures needed to protect patients at risk 4. Record the significant findings. Any lessons learned from the above should be formally shared with the other 2 Integrated Locality Groups for action. IF: the Health Board do not comply with the notice. THEN: the Health Board may be subject to prosecution by the HSE RESULTING IN: Large Fines and poor publicity.	Clinical areas across the Health Board should have in place local arrangements/procedures to prevent patients from absconding. A document has been circulated from Estates which outlines procedures around how and where staff should be reporting failures in doors.	Update May 2025 - Princess of Wales (POW) Hospital - An allocation of funding has been approved. Security Vulnerability Risk Assessments (SVRA's) have been carried out. Technical system surveys have been carried at some of the high risk Ward areas and at adjacent areas. Stakeholders updated on the plans. The planned further work and commencement dates have been affected by the Princess of Wales Hospital roof issues in particular gaining access to the areas to be surveyed. Because of this there are several phases to the site plan in FY 2025/26 namely 1a and 1b. Phase 1a estimated costs have been provided as of 28/4/25 waiting for cost for Phase 1b. The work plan schedule for FY 2025/26 will be prioritised based on risk, the cost within budget allocated. Capital team will schedule the work once costs are in. Work will then be planned in FY 2025/26. This work will continue in FY2026/27 with plans for a Phase 2 scheme to address other sites access and CCTV site risks at Princess of Wales Hospital.	Health Safety & Fire Sub Committee	16	C4 x L4	8 C4xL2	↔	30.09.2020	06.05.2025	30.06.2025

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	De-escalation Rationale
5226	Director of Digital	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Risk of damage to records and equipment due to leaking roof in the Williamstown Records Hub	**If:** the paper records stored at Williamstown Records Hub are damaged due to the recurrent water leaks in the roof. **Then:** then they may be damaged beyond repair. **Resulting in:** records not being available for patient care or for legal purposes.	The Estates Directorate have arranged for checks and repairs but roof continues to leak in Library Record Store and above workstations in Library Office. Staff are vigilant and containers are placed to catch known leaks. However, new leaks can occur and unavoidable water damage could occur at any hour during wet weather. Leaks could also cause slips/falls in hard-floor areas.	Update March 2025 - As at 10.2.2025- Repairs have commenced on the southern end of the roof. However, since 6/1/25, 6 new areas of leakage have occurred. On 4 of these occasions, patient records have been water-damaged. @300 records have been affected in total so far, including maternity records which have a 25-year retention period. Work to repair the northern end of the roof is awaited with urgency. Plastic sheeting has been utilised in an attempt to protect notes but it is only possible to do this in small areas. approximately 40% of the Library remains at significant risk. Update May 2025 - Repairs completed mid- April 2025. To date, no further leaks have been observed; however, there has not yet been sustained rain to enable confirmation that all leaks have been stopped. The situation is being monitored on an ongoing basis. The likelihood has been reduced to 2 and it is hoped to reduce this further, if no leaks occur during sustained wet weather.	Quality, Safety & Experience Committee Operational Delivery Committee	8 Risk reduced from a 20 in May 2025	4 (C4xL1)	Update May 2025 - Repairs completed mid- April 2025. To date, no further leaks have been observed; however, there has not yet been sustained rain to enable confirmation that all leaks have been stopped. The situation is being monitored on an ongoing basis. The likelihood has been reduced to 2 and it is hoped to reduce this further, if no leaks occur during sustained wet weather. Risk will continue to be monitored by the Digital Directorate Function.

	A	B	C	D	E	F	G	H	I	J	K
1	Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
2	5765	Executive Director of Finance	Finance Directorate	Financial Risk	Failure to reduce the £19.4m recurrent deficit at the start of 24/25 down to the planned £2.1m recurrent surplus at the end of 24/25	IF: The Health Board is not able to plan and deliver recurrent expenditure run rates that align with the available recurrent funding for 2024/25. THEN: The Health Board may not be able to deliver a break-even financial position for 2025/26. RESULTING IN : • The Health Board not being able to increase investments in services and/or reduce savings targets from current levels. • Potential short term unsustainable cost reductions with associated risks and potential Welsh Government regulatory action. • WG not supporting the Health Board's plan for 25/26 • Failure to meet the statutory financial duty to break even over a 3 year period resulting in qualification of the Annual Accounts in 25/26. • Potential cash shortfalls in 25/26.	• Financial Accountability letters from CEO to Executive Leadership Group. • Monthly monitoring arrangements and meetings in place with Care Groups and directorates. • Regular reporting to the Executive leadership Group, the Planning, Performance & Finance Committee and the Board.	Update at end of March 2025 - Month 12 update: The forecast underlying deficit at the end of 2024/25 is £7.9m (M10: £10.7m). The deterioration in the underlying position is mainly attributed to under achievement of savings delivery. The forecast recurrent deficit also excludes any ongoing costs of the Princess of Wales Hospital critical incident, which will represent an additional non recurrent cost pressure in 25/26. Our latest estimate is that these costs will be circa £10.0m. The main action is to develop a more project and programmatic approach to planning and delivery of efficiency savings schemes, with a focus on pipeline schemes for 25/26 as well as schemes in delivery for 24/25.	Operational Delivery Committee	May 25	Risk can now be closed as CTMUHB have reported 2024/25 financial year and achieved a break even position overall. Two new risks being developmed for the 2025/26 financial year and will be captured in the July Organisational Risk Register.

Agenda Item
8.1.1.

Health, Safety & Fire Sub Committee

Health, Safety & Fire Sub Committee Annual Report 2024-2025

Dyddiad y Cyfarfod / Date of Meeting	05/06/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Tyler Lewis, Corporate Governance Officer
Cyflwynydd yr Adroddiad / Report Presenter	Emma Walters, Head of Corporate Governance & Board Business
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Hywel Daniels, Executive Director for People

Pwrpas yr Adroddiad / Report Purpose	ENDORSE FOR QUALITY AND SAFETY COMMITTEE APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 This Annual Report from the Health, Safety & Fire Sub Committee details the activities and performance for the Sub Committee for the reporting period 2024-2025

2. Specific Matters for Consideration

2.1. The Sub Committee Annual Report at Appendix 1, summarises the key areas of business activity undertaken by the Sub Committee from April 2024 – March 2025 and highlights some of the key issues which the Sub Committee intend to give further consideration to over the next 12 months.

3. Key Risks / Matters for Escalation

3.1. Please refer to Appendix 1 for the full detail contained within the report.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Efficient If more than one applies please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not Required
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1. The Health, Safety & Fire Sub Committee is asked to **ENDORSE** for Quality & Safety Committee **APPROVAL** the Committee Annual Report for 2024-2025

6. Next Steps

6.1. If ENDORSED by the Sub Committee the Annual Committee Report will be received by the Quality, Safety & Experience Committee for Approval at the next available meeting.

Appendix 1

Cwm Taf Morgannwg University Health Board

Annual Report 2024-2025

Health, Safety and Fire Sub Committee

Date:

June 2025

HEALTH, SAFETY & FIRE SUB COMMITTEE
ANNUAL REPORT 2024-2025

1. FOREWORD

As Chair of the Health, Safety and Fire Sub Committee, I am pleased to present our Annual Report for 2024-2025. This report highlights the significant progress and achievements we have made in ensuring the health, safety, and fire compliance within our organisation.

Over the past year, our Sub Committee has worked diligently to advise and assure the Board and the Quality, Safety & Experience Committee on the effectiveness of our health and safety arrangements.

The Sub Committee has met quarterly, providing robust scrutiny on behalf of the Quality & Safety Committee on all matters relating to health, safety, and fire 4. Our membership, comprising four independent members, has ensured that we provide thorough scrutiny and assurances to the Board.

As we move forward, we remain committed to enhancing our health, safety, and fire management practices. We will continue to collaborate closely with other Committees of the Board, particularly the Quality, Safety & Experience, to share risks and support each other's work

Dilys Jouvenat,
Chair of the Health, Safety & Fire Sub Committee
Cwm Taf Morgannwg University Health Board (CTMUHB)

2. INTRODUCTION

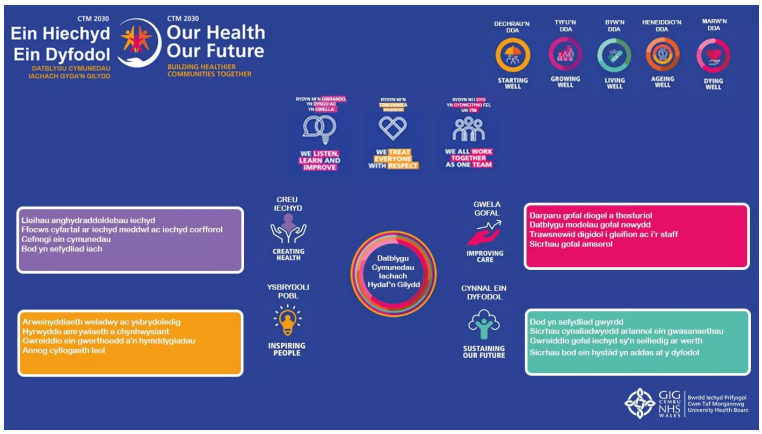
The purpose of the Health, Safety & Fire Sub Committee "the Sub Committee" is to:

- Advise and assure the Board and the accountable officer on whether effective arrangements are in place to ensure organisational wide compliance of the health Board's health and safety policy, approve and monitor delivery against the health and Safety priority action plan and ensure compliance with the relevant standards for Health Services in Wales.

- Encourage strong leadership in health, safety and fire, championing the importance of a common-sense approach to motivate focus on core aims distinguishing between real and trivial issues.

Where appropriate, the sub-committee will advise the Board and the accountable officer on where and how its health, safety and fire management may be strengthened and developed further.

The Sub-Committee has embraced the new Strategic Goals in how it manages its agenda to ensure that its activity supports the **'CTM2030: Our Health, Our Future'** Strategy and the **Values and Behaviours** of the Health Board.



The Sub-Committee meets quarterly, with the key function to provide scrutiny on behalf of the Quality, Safety & Experience Committee on all matters relating to Health, Safety and Fire.

3. ROLE, MEMBERSHIP, ATTENDEES AND COMMITTEE ATTENDANCES

3.1 ROLE

The role of the Sub-Committee is to support the Board through the Quality, Safety & Experience Committee with regard to its responsibilities for health, safety and fire:

- approve and monitor implementation of the annual health, safety and fire action

plan.

- review the comprehensiveness of assurances in meeting the Board and accountable officers' assurance needs across the whole of the health Board's activities, both clinical and non-clinical.
- the consideration of relevant CTMUHB policies for approval by the Quality, Safety & Experience Committee.

3.2 MEMBERSHIP

The membership of the Health, Safety & Fire Sub-Committee comprises of four independent members, enabling the Sub-Committee to provide robust scrutiny and assurances to the Board as appropriate through the Quality, Safety & Experience Committee.

A summary of the independent membership during 2024-2025 is outlined in table 1 below:

Table 1 – Composition & Membership of the Health, Safety & Fire Sub- Committee April 2024-March 2025

Name	Period
Members	
Dilys Jouvenat	April 2023 –
Geraint Hopkins	November 2023 -
Helen Lentle	March 2024 – January 2025
Carolyn Donoghue	September 2024 -
Hayley Proctor	January 2025 -
Nicola Milligan	April 2023 – June 2024

3.3 ATTENDANCE AT HEALTH, SAFETY & FIRE COMMITTEE 2024-2025

During the year, the Sub-Committee met on three occasions. All meetings held during 2024-2025 were quorate as shown in Table 2 below:

Table 2 - Meetings and Member Attendance 2023-2024

	19th June 2024	5 September 2024	January 2025
Dilys Jouvenat	✓	✓	✓ (Chair)
Geraint Hopkins	✓	✓ (Chair)	✓
Helen Lentle	✓	X	
Carolyn Donoghue		✓ (Additional Attendee)	✓
Hayley Proctor			X
Nicola Milligan	✓		

3.4 ATTENDEES

The Sub-Committee's work is informed by reports provided by leads within CTMUHB, colleagues from these areas are invited to attend each meeting of the Health, Safety & Fire Sub-Committee. Invitations to attend the Sub-Committee meetings are also extended, where appropriate and on an 'ad-hoc' basis, to specific staff when reports which relate to their specific area of responsibility are being discussed.

4. HEALTH, SAFETY & FIRE SUB COMMITTEE BUSINESS

The Health, Safety & Fire Sub-Committee provides an essential element of the Health Board's overall assurance framework.

Any items included on the consent agenda were considered by Members prior to each meeting, with Members provided with the opportunity to raise questions prior to the meetings regarding the reports.

All reports included on the Main Agenda were discussed during each meeting. The Health, Safety & Fire Sub Committee agenda broadly follows a standard format, comprising of specific sections, and the activity of the Committee during 2024/2025 is outlined in Appendix 1 of this report.

Links with Other Committees/Boards

Key risk areas from the Health, Safety & Fire Sub-Committee are highlighted at the Quality, Safety & Experience Committee by the Sub-Committee Chair via a highlight report.

At each meeting, if any Committee referrals are identified, the Chair of the Sub-Committee or the Corporate Governance Lead will ensure that the following questions are captured to ensure a referral is managed effectively:

- What are you referring?
- Why are you referring?
- What is the outcome you are anticipating from this referral?

5. ACTION LOG

In order to monitor progress and any necessary follow up action, the Sub-Committee has developed an Action Log that captures all agreed actions. This has provided an essential element of assurance both to the Sub-Committee and from the Sub-Committee to the Board.

6. GOVERNANCE

The effectiveness of the Committee is monitored through the following key governance activity:

- Annual Review of the Terms of Reference;
- Committee Annual Report;
- Highlight Reports from the Sub-Committee to the Quality, Safety & Experience Committee meetings;
- Forward Work Programme.

The Corporate Governance Team maintain a "Committee Effectiveness Tracker" to ensure the above activity is undertaken at the appropriate times during the year.

7. ASSURANCE TO THE BOARD/QUALITY, SAFETY & EXPERIENCE COMMITTEE

The Health, Safety & Fire Sub Committee considers, that on the basis of the work completed by the Sub-Committee during 2024 - 2025, there are effective measures in place that have delivered against its agreed Terms of Reference.

The forward work programme for 2024-2025 and beyond ensures that the Sub Committee retains scrutiny on key areas of activity.

The Forward Work Programme has continued to be presented to each meeting of the Sub-Committee during 2024/2025. This supports and helps identify the key areas of focus for the Sub-Committee and is one of the key components in ensuring that the Sub-Committee is effectively carrying out its role. It also facilitates the management of agendas and Sub-Committee business.

8. LINKS WITH OTHER COMMITTEES

The Health, Safety & Fire Sub-Committee will continue to have close links, and share risks with other Committees of the Board, particularly the Quality, Safety & Experience Committee and Audit & Risk Committee.

As a Sub Committee of the Quality, Safety & Experience Committee, regular highlight reports are presented to the Quality, Safety & Experience Committee.

Through either specific meetings or the regular Independent Member meetings there is an opportunity for Committee Chairs to support the work of each of the Committees they Chair, share learning and avoid duplication. All Committee Chairs have access to Committee Highlight Reports to the Board.

APPENDIX 1

1. Preliminary Matters

This included the apologies for absence, welcome and introductions and declarations of interest.

2. Consent Agenda

During 2024 – 2025 the following items were received on the Consent Agenda for Approval/Endorsement:

- Unconfirmed minutes;
- Sub Committee Terms of Reference.
- Sub committee Annual Report

During 2024-2025 the following items were received on the Consent Agenda for Noting/Information

- Forward Work Programme.

3. Main Agenda

During 2024-2025 the following items were received on the Main Agenda:

- Action Log & Matters Arising not Contained within the Action Log
- Shared Listening & Learning Story – Violence & Aggression
- Assistant Director of Health, Safety & Fire Report
- Health, Safety & Fire Performance Report
- Fire Safety Report
- Estate Safety & Compliance Reports
  - Low Voltage Electrical system compliance
  - Annual Report High Voltage Electricity
  - Annual Report Medical Gasses
- Organisational Risk Register
- Overarching Care Group Health, Safety & Fire Highlight Reports
  - Planned Care & Unscheduled Care Health, Safety & Fire Reports
  - Children & Families and Diagnostics Therapies, Pharmacy and Sciences Health, Safety & Fire Reports
  - Primary Care & Community Group and Mental Health & Learning Disabilities Care Group, Health Safety & Fire Report

Agenda Item	8.1.2.

Unapproved Minutes of the Health, Safety & Fire Sub Committee

Date and Time of Meeting	Tuesday 01 April 2025 14:00-16:00pm
Venue	Virtual via Microsoft Teams

Members Present	Dilys Jouvenat	Independent Member (Committee Chair)
	Carolyn Donoghue	Independent Member
	Hayley Proctor	Independent Member
In Attendance	Hywel Daniel	Executive Director of People
	Chris Beadle	Assistant Director of Health Safety and Fire
	Carl Edwards	Senior Fire officer
	Joanne Trewartha	Health & Safety Rep
	Stephen Gardiner	Facilities Service Director
	Alan Martin	Head of operational estates
	Deborah Matthews	Assistant Nurse Director for PCH, RGH and AGM(In part)
	Sarah James	Deputy Chief Operating Officer
	Emma Walters	Head of Corporate Governance & Board Business
	Tyler Lewis	Corporate Governance Officer (Committee Secretary)

Agenda Item	Meeting Business
1.	**PRELIMINARY MATTERS**
1.1	**Welcome and Introductions**
	In opening the meeting, the Chair **welcomed** all those present. The format of the proceedings in its virtual form were also noted by the Chair.
1.2	**Apologies for Absence**
	Apologies received: • Geraint Hopkins, Independent Member
1.3	**Declarations of Interest**
	No declarations of interest were received.
2.	**CONSENT AGENDA BUSINESS**
	The Sub Committee Chair asked if there are any items from the Consent Agenda (Section 8) that Sub Committee Members wish to bring forward to the main agenda for discussion. Members did not have any items to bring forward and agreed to approve and note all items within the Consent Agenda.

3.	**COMMITTEE GOVERNANCE ARRANGMENTS**
3.1	**Action Log and Matters Arising not considered within the action log**
	The chair asked the committee if they were in agreement with closing the actions listed in the action log. The committee consented to close the actions that had been proposed for closure.
4.	**STAFF AND SERVICE USER EXPERIENCE**
4.1	**Shared Listening & Learning Story – Spotlight On Health, Safety & Fire Issues At The Royal Glamorgan Hospital**
	D Matthews delivered a presentation and highlighted the following key matters for consideration. • Key issues were identified during a walkthrough at Royal Glamorgan Hospital and reported to fire safety officers and the Operational Management Board. • She discussed the guidance and mitigation measures, noting new site leadership was in place and that a meeting was held with the Director of Facilities in February 2025 to review risks. • Regular monitoring was identified as crucial to foster best practices and ensure continued compliance. Discussions among team members highlighted the need to maintain standards and sustain ongoing improvements at the site. A Martin queried whether departments had previously raised concerns directly with the estates helpdesk, noting that this approach might have caused delays or resulted in certain issues being overlooked due to duplicate submissions. D Matthews noted that she had previously assumed the departments were responsible for addressing the issues, as she had been unaware that the estates helpdesk had received the concerns following audits. A Martin noted that the helpdesk had received issues prior to submission by departments and emphasised the importance of collaboration in addressing these concerns. C Donoghue reported that she had recently visited Prince Charles Hospital (PCH) and had discussed various issues, including broken equipment and storage concerns. She noted that the meeting had focused on identifying potential long-term solutions to address these challenges effectively. D Mathews emphasised that the plan for Prince Charles Hospital needed to be sustainable and clearly understood as a shared responsibility. She reiterated that the plan should have been integrated into daily operations, with standards and individual roles clearly defined. J Trewartha advised that it would be helpful if she could be included in future meetings to ensure she could effectively communicate outcomes to individuals who had raised concerns.

	H Daniel raised several points, particularly concerning issues highlighted in a letter from South Wales Fire & Rescue Service. He inquired about the measures taken to mitigate the risks mentioned in the correspondence and sought assurance that appropriate actions had been implemented. He also acknowledged the critical role played by trade union partners in addressing these concerns, expressing gratitude for their continued involvement in resolving ongoing issues. S James shared comments and concerns around the importance of sustaining the plan. She agreed that a standardised approach across the three sites would be developed, with collaboration between Hospital Managers and the Facilities Service Director, noting the focus on ensuring safety and preparing a unified plan to be periodically shared with the committee. She further mentioned that a meeting was held to address feedback and identify solutions, including recruiting additional members of staff to manage corridor stock effectively. S James advised that she was aiming to create a more cohesive strategy and planned to present updated progress to the committee for review in the coming weeks. The Chair thanked D. Mathews for the detailed presentation and for highlighting these issues to the Committee. D Mathews asked H. Proctor about the Zimmer frames appearing across sites, as it seems to be a growing issue. H. Proctor inquired about their origin and requested they be returned to their respective departments; however, she mentioned they were not always returned. H Proctor emphasised the need to inform staff to return Zimmer frames to the correct department once used. H Daniel raised a question about the operational escalation of ongoing issues and inquired whether the Chief Operating Officer had successfully established a sub-group within the Operational Management Board to address these concerns. C Beadle informed the Committee that a meeting had taken place with the COO Business Manager, during which they had agreed to include an item on the Operational Management Board agenda in regards to Health, Safety & Fire matters. This item was intended to address ongoing issues, and any outcomes from that meeting were to be reiterated to the Committee to provide assurance.
Resolution	The Committee **NOTED** the report
Action	Develop a standardised safety plan that can be applied across all CTMUHB sites, and share it with the Committee for review once it's completed.
5.	**SETTING THE SCENE – SERVICE DELIVERY**
5.1	**Assistant Director of Health, Safety & Fire Report**
	C Beadle provided the Committee with an update regarding the primary challenges in managing Health, Safety & Fire risks within the Health Board.

	During the meeting, C Donoghue expressed appreciation for the detailed report and acknowledged the extensive efforts that were reflected in it. She asked if the outcomes of assessments had been measured effectively, as stated in the report. She also raised concerns about the Did Not Attend (DNA) rates for manual handling training sessions and suggested that a review of the current approach and consideration of alternative methods could improve delivery. C Beadle noted that it is challenging to manage people who booked but did not actually attend, as indicated by the figures in the report. C Donoghue inquired about potential solutions for addressing this issue across all mandatory training sessions. H Daniel emphasised the need to reinforce expectations for mandatory training sessions. He noted that vacant positions had an impact on attendance and highlighted issues with courses scheduled but not attended, which was impacting on time and resources. He suggested discussing Did Not Attend (DNA) rates at the Operational Management Board (OMB) to address the issue seriously. H Daniel highlighted the theme regarding the expectation around statutory training and communicated it to everyone. Additionally, he noted the importance of completing these tasks. Considering this, he advised that he would provide the Deputy Chief Operating Officer with data on training in order for the information to be shared with care groups and provide clarity on expectations. D Jouvenat sought clarity as to whether the new safety newsletter it was only available on SharePoint. C Beadle explained that the newsletter was currently available only on SharePoint, however, the Communications team intended to distribute it more widely across the board. D Jouvenat expressed her willingness to receive the newsletter. Following this discussion, C Beadle committed to distributing the newsletter to the Committee and ensuring that it would be included in future reports for the Committee.
Resolution	The Committee **NOTED** the report.
Action	• Distribute the new safety newsletter more widely across the board and ensure it is included in future reports for the Committee. • Review manual handling training methods to reduce DNA rates and share data with the Deputy Chief Operating Officer. • Raise a query regarding statutory training within the Health Board due to the high number of missed mandatory training sessions. The Executive Director for People will send the figures to the Chief Operating Officer to share information and concerns about the lack of training completion.

5.2	**FIRE SAFETY REPORT**
	C Edwards presented the report and highlighted several key points contained within it. C Donoghue raised concerns that fire safety training was no longer included in the induction process for new staff members. C Edwards reported that fire awareness training had been revised to fall under departmental responsibility and advised that this would involve assigning specific personnel to deliver the training tailored to the needs of their respective departments. C Donoghue referred to a paragraph within the report, which indicated that Cwm Taf Morgannwg had breached code and legislation regarding fire training and sought assurance on whether this was accurate, expressing the belief that this was not the case, and requested the report to be reviewed and amended accordingly. H Daniel clarified that the belief concerning the breach of statutory requirements was inaccurate, as no such obligation was present. He advised that the report be reviewed and revised accordingly by the Fire Safety Officer
Resolution	The Committee **NOTED** the report and considered the issues raised.
Action	The Committee raised a query regarding a paragraph that incorrectly stated CTMUHB was in breach due to training standards. They requested the author of the report to revisit and reword the paragraph before republishing.
5.3	**OVERARCHING CARE GROUP – Health, Safety & Fire Report**
	S James presented the report and updated Members on key areas. During the meeting, H. Proctor discussed parking issues at various sites, with heightened concerns raised about problems affecting both staff and patients. Further. H Proctor queried whether the communication improvements regarding parking would address staff, patients, or a mixture of both. S Gardiner clarified that the improvements would apply to both groups. S James acknowledged that the car park issues had become significantly problematic and emphasised the importance of maintaining close monitoring to address these concerns effectively.
Resolution	The Committee **NOTED** the report.
5.3.1.	**PLANNED CARE - Care Group - Health, Safety & Fire Report**
	S. James presented the report, which detailed the key issues that had been reviewed by the Planned Care Group during the meeting.

	No queries were raised, and the Committee expressed its satisfaction in receiving and noting the report.
Resolution	The Committee **NOTED** the report
5.3.2	**UNSCHEDULED CARE – Care Group – Health, Safety & Fire Report**
	S James presented the report and updated Members on key areas. C Donoghue raised a query regarding double and triple boarding to wards and how frequently this issue arose. S James explained that triple boarding had been implemented for some time following the rollout of the stamp system and was part of the surge plan, and intended to balance patient safety at the door. She advised the balance of risk in areas likely to triple board was considered when making such decisions. C Donoghue asked if the situation varied across sites and was becoming more of an issue once more. S James clarified that triple boarding had occurred Prince Charles Hospital only and noted the decision to implement triple boarding had been made instead of opening another ward to better manage the balance of risk. J Trewartha raised concerns regarding triple boarding, noting that some patients should not have been placed in such situations. Issues across CTM were highlighted, where nurse managers were reportedly not conducting risk assessments, as they were instructed not to perform these evaluations. She emphasised that risk assessments should always be conducted to ensure patient safety. S James expressed appreciation to J Trewartha for highlighting the issue and further emphasised that such decisions should be made in consultation with patients who are capable of managing these circumstances. H Daniel observed that the practice of triple boarding had become more prevalent following the COVID-19 pandemic and was now integrated into the escalation protocol. He acknowledged the difficulties in managing this process and expressed concerns regarding the clarity of escalation routes. Additionally, H Daniel emphasised the necessity of reassessing and updating risk assessments, highlighting their critical role in maintaining patient safety. J Trewartha reported her collaboration with colleagues to develop a comprehensive risk assessment intended for distribution to the wards. She indicated that this had been shared with the Assistant Director of Quality & Safety and noted the need to follow up with him on the matter. She further highlighted the importance of completing these risk assessments, noting that they serve as an effective foundation for raising concerns. S James advised that collaboration with D. Matthews and other hospital managers was crucial to ensure the escalation of risk assessment information to the care groups.

Resolution	The Committee **NOTED** the report.
5.4	**ESTATE SAFETY & COMPLIANCE REPORT – ANNUAL REPORT MEDICAL GASSES**
	The audit report was not received in time for the estates team to produce their report. It was agreed with the Chair to defer this item to the June Committee meeting.
Action	The Estates Team committed to ensuring that reports would be presented at future meetings.
6.	**DELIVERING OUR PLAN**
6.1	**HEALTH, SAFETY & FIRE PERFORMANCE REPORT**
	C Beadle presented the report, which informed the Health, Safety & Fire Sub Committee of the main issues identified from the Health, Safety and Fire Dashboard for the period of 1st October 2024 to 31st December 2024. C Beadle informed the Committee that the team had reviewed several items within the Health Board's organisational system, risks, and ongoing mitigation steps. He explained that the data presented covered up to December 2024 and assured the Committee that updated data for the subsequent quarters would be provided at the next meeting. The Committee did not raise any queries regarding the report and expressed satisfaction with the outlined next steps.
Resolution	The Committee **NOTED** the performance report.
Action	The Assistant Director of Health, Safety & Fire to provide an update on training data at the next Committee meeting.
7.	**GOVERNANCE, RISK AND ASSURANCE**
7.1	**ORGANISATIONAL RISK REGISTER**
	E. Walters presented the Organisational Risk to the Committee and highlighted key areas for Members. C Donoghue referred to the statement included against risk 4417, noting that in relation to security doors, no works had been planned at Royal Glamorgan Hospital. S Gardiner advised that although no works had been planned at Royal Glamorgan Hospital, the site had not yet been surveyed to determine the required works and associated costs.
8.	**CONSENT AGENDA**
8.1	**FOR APPROVAL**
8.1.1.	**Unconfirmed Minutes of the meeting held on 24 January 2025** The Minutes were **APPROVED**.
8.2.	**FOR NOTING**
8.2.1.	**Sub Committee Annual Cycle of Business 2025** The Cycle was **NOTED**.
9.	**CLOSE OUT BUSINESS**
9.1	**ANY OTHER BUSINESS**

9.2	**Highlight Report to Quality & Safety Committee**
	E. Walters made reference to the items that she had captured for inclusion within the alert/escalate section and advised that she would share the draft report with Members for review outside the meeting.
9.3	**MEETING FEEDBACK** D Jouvenat requested feedback from the Committee Members and attendees on the meeting's evaluation at present or within two weeks of the meeting.
10.	**DATE AND TIME OF NEXT MEETING**
5.1	The next Committee Meeting is being held on Thursday 5th June at 9:30am.

Health, Safety & Fire Sub Committee – Annual Cycle of Sub Committee Business

(1st January 2025 to the 31st December 2025)

The Annual Cycle of Sub Committee Business has been developed to help plan the management of Sub Committee matters and facilitate the management of agendas and sub-committee business. The Annual Cycle of SUB Committee Business will be complemented by a "Non-Routine Sub Committee Business (Forward Plan)" for 'one-off' Adhoc items raised during the course of meetings.

The role of the Sub Committee is set out in CTMUHB's standing orders and the Terms of Reference, both of which are available here: Standing Orders & Standing Financial Instructions - Cwm Taf Morgannwg University Health Board (nhs.wales)

The Health, Safety & Fire Sub Committee meets at **least 4 times per annum**.

Sub Committee Chair:	**Sub Committee Vice Chair**	**Executive Leads for Agenda Planning**
• Dilys Jouvenat, IM Third Sector	• Geraint Hopkins, IM Local Authority	• Hywel Daniel, Executive Director for People

CTMUHB Committee Business:

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda
Sub Committee Governance Arrangements																
1. Action Log	Director of Corporate Governance / Board Secretary	All Regular Meetings	⚑			⚑		⚑			⚑			⚑	⚑ If all actions are complete	⚑ If there are actions in progress / overdue actions
2. Minutes of the previous meeting (Public and Closed Session)	Director of Corporate Governance / Board Secretary	All Regular Meetings	⚑			⚑		⚑			⚑			⚑	⚑	X
3. Non-Routine Sub Committee Business (Forward Plan)	Director of Corporate Governance / Board Secretary	All Regular Meetings	⚑			⚑		⚑			⚑			⚑	⚑	X
4. Annual Cycle of Business	Director of Corporate Governance / Board Secretary	All Regular Meetings	⚑			⚑		⚑			⚑			⚑	⚑ Except for the annual review in January	⚑ Annual Review only
5. Sub Committee Annual Report	Director of Corporate Governance / Board Secretary	Annually						⚑							X	⚑
6. Outcome of Annual Sub Committee Self-Assessment	Director of Corporate Governance / Board Secretary	Annually						⚑							X	⚑
7. Terms of Reference Review	Director of Corporate Governance / Board Secretary	Annually									⚑				X	⚑

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda
Staff and Service User Experience																
8. Shared Listening & Learning Story	Executive Director for People	All Regular Meetings	⚑			⚑		⚑			⚑			⚑	X	⚑
Setting the Scene – Service Delivery																
9. Assistant Director of Health, Safety & Fire Report	Executive Director for People	All Regular Meetings	⚑			⚑		⚑			⚑			⚑	X	⚑
10. Fire Safety Report	Executive Director for People	All Regular Meetings	⚑			⚑		⚑			⚑			⚑	X	⚑
11. Overarching Care Group Highlight Report	Chief Operating Officer	All Regular Meetings	⚑			⚑		⚑			⚑			⚑	X	⚑
12. Specific Care group Highlight Reports (x2 per meeting)	Chief Operating Officer	All Regular Meetings	⚑			⚑		⚑			⚑			⚑	X	⚑
13. Estates Safety & Compliance Report	Executive Director of Finance	All Regular Meetings	⚑			⚑		⚑			⚑			⚑	X	⚑
Delivering our Plan																
14. Health, Safety & Fire Performance Report	Executive Director for People	All Regular Meetings	⚑			⚑		⚑			⚑			⚑	X	⚑
Governance, Risk and Assurance																
15. Organisational Risk Register – Risks Assigned to Health, Safety & Fire Sub Committee	Director of Corporate Governance/Board Secretary	All Regular Meetings	⚑			⚑		⚑			⚑			⚑	X	⚑
16. Internal Audit Reports	Director of Corporate Governance/Board Secretary	All Regular Meetings (as and when applicable)	⚑			⚑		⚑			⚑			⚑	X	⚑