Health, Safety & Fire Sub Committee

Fri 24 January 2025, 09:30 - 11:30

Microsoft Teams

Agenda

09:30 - 09:35
5 min

1. PRELIMINARY MATTERS

1.1. Welcome and 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*

09:35 - 09:40
5 min

2. CONSENT AGENDA BUSINESS

The Sub Committee Chair will ask 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

09:40 - 09:45
5 min

3. COMMITTEE GOVERNANCE ARRANGEMENTS

3.1. Action Log

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

3.1 HSFSC Action Log HSFSC 24 January 2025.pdf (3 pages)

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

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

3.3. Sub Committee Annual Cycle of Business 2025

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

3.3 CTMUHB HSFSC Cycle of Business HSFSC 24 January 2025.pdf (2 pages)

09:45 - 10:00
15 min

4. STAFF AND SERVICE USER EXPERIENCE

4.1. Shared Listening & Learning Story - Violence & Aggression

Discussion *Emyr Jones, Personal Safety Advisor & Sophie Bow, Practice Development Nurse ITU*

4.1 Staff Story - Delirium (final) (002).pdf (12 pages)

10:00 - 10:55
55 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*

- 5.1a Assistant Director for Health Safety and Fire HSFSC 24 January 2025.pdf (14 pages)
- 5.1b Appendix 3 - Risks for Health Safety Sub Committee.pdf (12 pages)

5.2. Fire Safety Report

Discussion *Carl Edwards, Senior Fire Officer*

- 5.2a Fire Safety Report (HSFSC) 3 DEC 24 HSFSC 24 January 2025.docx (12 pages)
- 5.2b Appendix 1 extreme risks HSFSC 224 January 2025.xlsx (77 pages)
- 5.2c Appendix 2 - Copy of Fire Strategy 2024 - 2027 HSFSC 24 January 2025.xlsx (8 pages)

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

Discussion *Sarah James, Deputy Chief Operating Officer*

- 5.3 Final Highlight Report -COO Overarching Report HSFSC 24 January 2025.pdf (9 pages)

5.3.1. Primary Care & Community Care Group - Health, Safety & Fire Highlight Report

Discussion *Sarah James, Deputy Chief Operating Officer*

- 5.3.1 PCC HSF Highlight Report January 2025 HSFSC 24 January 2025.pdf (6 pages)

5.3.2. Mental Health & Learning Disabilities Care Group - Health, Safety & Fire Highlight Report

Discussion *Julie Denley, Deputy Chief Operating Officer*

- 5.3.2 MHLD HS+F Sub Committee Highlight Report HSFSC 24 January 2025.pdf (7 pages)

5.4. Estate Safety & Compliance Report – Annual Report Medical Gasses

Information *Alan Martin, Head of Operational Estates*

This item has been deferred and will be presented to a future meeting

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10:55 - 11:05
10 min

6. DELIVERING OUR PLAN

6.1. Health, Safety & Fire Performance Report

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

- 6.1a Performance Report HSFSC 24 January 2025.pdf (11 pages)
- 6.1b Appendix 1 - Copy of HS Performance Report Q2 2024-2025.pdf (21 pages)
- 6.1c Appendix 2 - Core Learning Compliance Summary HSFSC 24 January 2025.pdf (22 pages)

11:05 - 11:15
10 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 Org RR Cover Report - Jan 25 - HS&FSC.docx (6 pages)
- 7.1b Appendix 1 - Org RR - Jan 25 - HSFSC.xlsx (4 pages)

11:15 - 11:20

8. CONSENT AGENDA

5 min

8.1. FOR APPROVAL

8.1.1. Unconfirmed Minutes of the meeting held on 5th September 2024

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

8.1.1 Unconfirmed Minutes Health, Safety & Fire 5th September 2024 HSFSC 24 Jan 2025.pdf (6 pages)

11:20 - 11:25
5 min

9. CLOSE OUT BUSINESS

9.1. Sub Committee Highlight Report to the Quality, Safety & Experience Committee

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

Consider as a Sub Committee the areas of Escalation, Assurance, Advise & Inform

9.2. Meeting Feedback

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

Is there anything we should do more or less of?
Have we managed our time and allowed open and balanced discussion?
Have we considered our values and acted in a way that supports embedding our values across CTM?
Have we maintained a Strategic Focus?
Have we received sufficient assurance from a range of sources?
Has our discussion allowed us to better understand the risks that we are managing that may affect the achievement of our strategic goals?

11:25 - 11:25
0 min

10. Private / Closed Session Business

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

There have been no items identified that will require an In Committee discussion

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11:25 - 11:30
5 min

11. Date & Time of the Next Meeting

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

Tuesday 1 April 2025 at 2:00pm

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Sub Committee Action Log

ittee
mber, Third Sector

the action originated from	reference	Reference Page Number	m Title / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
13-sep-21			Organisational Risk Register	Review of the Merthyr & Cynon ILG Emergency Department risks to be undertaken by Major Projects Team colleagues as this relates to Phase 2 Redevelopment of Prince Charles Hospital	Head of Operational Estates	Executive Director of Finance	Ongoing	Open	**Propose for Closure** Risk ID 3562 - closed in December 2021 as risk mitigated. Further detail on closure available on request as captured in Datix. Risk ID 4684 - closed in September 2024 as risk mitigated. Further detail on closure available on request as captured in Datix.
30-nov-21	3,4		Health & Safety Performance Report – Themes and Trends	Further interrogation to be undertaken of the data being reported in relation to incidents to determine the incident rate and reporting culture and the reasons behind this.	Assistant Director of Health, Safety & Fire	Executive Director for People	Ongoing	Open	**Proposed for Closure** The All Wales Datix Coding Workstream continues to meet monthly to address issues with the current coding structure. Given that these issues will take some time to address on a national basis, it is proposed that this action is closed on the action log and annual updates on progress will be included in the Assistant Director for Health Safety & Fire Report
19-jun-24	3,4	Page 5	Fire Safety Report	Escalate issues to the Quality and Safety Committee regarding the concerns experienced with items blocking all central core landings at Prince Charles Hospital.	Deputy Chief Operating Officer	Chief Operating Officer	sep-24	Open	**Proposed for Closure** This matter was included in the alert/escalate section of the Highlight Report presented to the Quality & Safety Committee at its meeting on the 23 July 2024.

19-jun-24	3,5	Page 5	Estates, Safety & Compliance Report	Escalate the issues in relation to workforce sustainability issues within the Fire Safety Team and within specialist areas within the Estate Teams.	Deputy Chief Operating Officer	Chief Operating Officer	Ongoing	Open	**Proposed for Closure** The risks associated with the future recruitment of competent Fire Officers has been added to the Health Board's risk register. Discussions are underway to explore the use of apprenticeships. This is being proposed for closure as the position will be monitored via the Risk Register. In relation to workforce sustainability within Estates, both Senior Operational Estates Manager posts have now been filled and staff will commence in post over the new few weeks.
05-sep-24	3,2	Page 2	Assistant Director of Health, Safety & Fire Report	Future report on risks to only include the most recent update on progress within the progress to ensure the report was easier to navigate for Members.	Assistant Director of Health, Safety & Fire	Executive Director for People	des-24	Open	**Proposed for Closure** This has now been completed and latest report only includes most recent update on actions being taken
05-sep-24	3,4	Page 3 and 4	Fire Safety Report	Discussion to be held with the Hospital General Manager in relation to concerns raised regarding issues being experienced with equipment blocking landings at Prince Charles Hospital. Update to be provided at the next meeting.	Deputy Chief Operating Officer	Chief Operating Officer	des-24	Open	**In progress** Update to be provided by the Deputy Chief Operating Officer at the 24 January 2025 meeting regarding issues being experienced with equipment blocking landings at Prince Charles Hospital.
05.09.2024	4,1	Page 5 and 6	Highlight Report to the Quality & Safety Committee	Escalate blocked stairways and PCH issues to the Quality & Safety Committee and ensure it remains a live risk.	Head of Corporate Governance & Board Business	Director of Corporate Governance/Board Secretary	sep-24	Open	**Proposed for Closure** This matter was included in the alert/escalate section of the Highlight Report to the Quality & Safety Committee which was presented to the meeting held on 18 September 2024

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Sub Committee Action Log

the action originated from	reference	Reference Page Number	m Title / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
19-jun-24	3,2		Assistant Director of Health, Safety & Fire Report	The Chief Operating Officer agreed to investigate the allocation of funds for battery replacement, as it was not recommended to use Charitable Funds for the purpose.	Chief Operating Officer	Chief Operating Officer	30-sep-24	Closed	**COMPLETED** Following a meeting with the COO, appropriate funding was identified to resolve this risk. All batteries have now been delivered and have been replaced across the Health Board.
09-nov-23	3,5		Fire Safety Report	Executive Director for People to explore alternative solutions in relation to awarding competencies on ESR.	Executive Director for People	Executive Director for People	18 September 2024/19 November 2024	Closed	**COMPLETED** Following a restructure of the Health, Safety and Fire Admin Team provision, the Team have agreed to add all Fire competencies to ESR following training. This was on a 3 month trial basis to ensure the team can manage this additional capacity. It can be reported this issue is now resolved and can be closed.

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	⚑

Listening and Learning Story – Violence and Aggression

Emyr Jones Personal Safety Advisor CTMUHB

The Intensive Care Unit at Prince Charles Hospital reported an incident of violence where several nursing staff were assaulted. It appears from investigation similar incidents had occurred.

Incident Intensive Care Unit PCH April 30th 2024 incident number 56538

Reported Incident Examples

Patient in ITU receiving haemofiltration.

Becoming verbally and increasingly physical through night with staff.

Times where pt was violent and confused but also frequent periods where patient was lucid and violent

Required 3 nurses at bedside for multiple hours to maintain patients safety as trying to climb from bed and pull out all indwelling lines and monitoring

Staff nurse (1) Kicked in breast and punched in left arm. Attempting to crush staff members fingers with his fist and poke her in the eye.

Staff nurse (2) grabbed by the neck, and also hit multiple times on her arms.

Patient threatening staff with violence that he would get them when they came back in tonight.

Following the incidents, the Health and Safety Personal Safety team made initial contact with the handler offering support. Discussions took place where possible actions could be taken to mitigate the risks of future incidents.

Following these discussions a Multi-disciplinary meeting was arranged with Senior Nurses and Medical staff within Critical Care to identify a series of actions to reduce the likelihood and severity of future Incidents.

The Following actions were agreed

- The Personal Safety Advisor would showcase a range of clinical holding techniques to a forum of Senior Nurses in order to develop a bespoke training session.

- The Personal Safety Advisor demonstrated several clinical holding and breakaway techniques. Through discussion and analysis with the Senior Nurses a training programme was devised. It was also agreed to devise a technique training manual exclusive to Critical Care.

A policy would be developed to incorporate not only physical restraint, but also mechanical and chemical restraint. A policy was devised within Critical Care the and the Personal Safety Advisor contributed by supplying key legislation, national guidance and sections of the Policy related to physical restraint.

Training sessions were developed in awareness raising and management of acute Delirium. The Multi-Disciplinary team arranged for psychology practitioners to deliver training on Acute Delirium. This training would form part of a full study day alongside the violence and aggression training within Critical Care.

August 2024

Training for Critical Care Staff was rolled out for violence and aggression, clinical holding and Breakaway. To date 8 courses have been delivered from the scheduled 10.

Training in awareness and management of Acute Delirium was also rolled out to all critical care staff.

The Training department were contacted to set the training module on the ESR system. The module has been named *Maintaining a safe Environment for the Critical Care Patient.*

September 2024

A draft policy namely *The use of Restraint in the Critical Care Unit* is near compilation. Further work is required on the techniques manual. It is envisaged this document will be completed in early December

Conclusion

Following a severe incidents of physical assault, collaborative work with the Clinical area resulted in a number of actions which will reduce the severity and likelihood and future incidents. Training in acute delirium and clinical holding will effectively reduce violent incidents within Critical care.

The violence and aggression training also covered the importance of incident reporting. As a consequence, Critical Care are now reporting restrictive practice incidents.

The training will be rolled out across all Critical care units within Cwm Taf Morgannwg University Health Board.

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Find us on

Agenda Item
5.1

Health, Safety & Fire Sub Committee

Assistant Director for Health, Safety and Fire
- Update Report

Dyddiad y Cyfarfod / Date of Meeting	24/01/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Chris Beadle – Assistant Director for Health, Safety and Fire
Cyflwynydd yr Adroddiad / Report Presenter	Chris Beadle – Assistant Director for Health, Safety and Fire
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**
Health and Safety Coordinators Group	18/09/2024	Discussion and Noted

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 The purpose of this report is to update the Health, Safety and Fire Sub Committee of the main issues associated with the management of Health, Safety and Fire risks within the Health Board.

2. Specific Matters for Consideration

2.1 This report will cover the following areas:

- Health and Safety Executive involvement
- Health & Safety Audit 2024 – Status Review
- CTM Face-fit team
- End of the "7 minute briefing" on-line training
- Bridgend – POW Roof issues
- Health surveillance Occupational Health / Health & Safety Team working
- Safety & Fire Alerts
- Health & Safety Podcasts
- Manual Handling
- Violence and Aggression
- Organisational Health, Safety & Fire Risks

3. Key Risks / Matters for Escalation

3.1 Health and Safety Executive Involvement

Since the last report, there are currently no active Health and Safety Executive investigations in place in the Health Board.

It is worth noting that the HSE are conducting structured inspections of the NHS in the UK. The HSE have set out to inspect 30 NHS bodies annually and their focus is compliance with the management of Manual Handling and Violence and Aggression risks. Several Health Boards in Wales have been subject to these inspections and Cardiff and Vale University Health Board have just had theirs completed. Cwm Taf Morgannwg University Health Board has not received confirmation to when it is likely to be inspected to date.

3.2 Health & Safety Audits 2024 – Status Review

Following a very successful year of compact "Flash" Health & Safety audits, the year is brought to completion within the Health Board with one final audit exercise.

The topic to be considered is "*Medical sharps*". All of the background planning is now complete for the task and the subject has an agreed question set in place. Completion of this audit, including a final report based on the actual findings is the first week of December 2024.

It is expected that there will be fewer "*Flash*" audits in 2025, however these will make way for a far more substantial "*General*" Health & Safety Audit planned for mid-year so there is no deficit as such. All summary reports are available upon request in respect of the findings of previous and future audit projects.

3.3 CTM Face-fit team

The Sub Committee is asked to note that the three staff member "*Face-Fit*" Team are now fully operational to provide a mask fitting service for our staff. At the time of writing, they have "*Face fit tested*" more than 1200 of our staff which should be applauded as they were effectively starting from scratch, being the first team of its kind within the organisation.

A review of their goals will take place at the end of 2024 and revised accordingly if necessary.

3.4 End of the "7 minute briefing" on-line training

Each month during 2024, the Health & Safety Co-ordinating team has provided the organisation with what has been commonly known as a "*7-minute briefing*" which in effect are mini on-line training sessions. These have been topic themed training sessions, delivered via SharePoint, that are chopped into seven manageable chunks (hence the name) to assist with their delivery.

The sessions however, usually take more than seven minutes to deliver depending on the feedback and interaction that takes place at the time by the person delivering the session with their staff.

On the back of the very successful "*Toolbox talk*" programme of 2023, the "*7-minute briefings*" have proven to be just as popular this year with our managers using the information within their respective areas. The briefings not only provide their staff with awareness on a particular subject, but also a personal update for these managers on the topic also. The plan for a similar training format for 2025 is still under discussion within the Health and Safety Coordinators Team and subject to full agreement.

3.5 Bridgend – POW Roof issues

For awareness, the Health & Safety team have been active in supporting the moving of staff and related activities following the major roof incident problems experienced at the Princess of Wales Hospital. The 2 Health and Safety Coordinators based in Glanrhyd have been more active than the rest of the co-ordinators due to locality. They have provided valuable advice and assistance as the moves were planned and took place as well as providing continual support around any ongoing related issues.

3.6 **Health surveillance Occupational Health / Health & Safety Team working**

During the course of recent months both the Occupational Health and Health & Safety team have been working together. The goal for this work is to improve standards of Health Surveillance for our staff across the Health Board and thereby helping us meet our associated legal obligations.

Progress has been steady and positive to date, however recent staff sickness and team changes have disrupted progress a little toward the end of the year. It is anticipated that the goals will be back on track and set to plan at the start of 2025.

3.7 **Safety & Fire alerts**

There were no "*New*" internal Safety or Fire alerts since the previous report, however a supplementary document was issued via SharePoint in respect of ***Safety alert 036 – Office chairs used on smooth and hard surfaces***. Some of the information provided in the original alert had been a little misleading and required further explanation. This clarity has now been resolved as a consequence of the supplementary document's circulation.

3.8 **Health & Safety Podcasts**

Over the last few months the Health and Safety Team have been exploring the use of "*Podcasts*". The team has come up with a series of topics that have been shared within the organisation. Initially the use of the technology proved to be a little challenging to use, however after some practice it is now being used more easily and less time consuming than at the start with podcasts now being recorded and edited appropriately.

It is hoped this new format for supporting Health & Safety training can be expanded by the Health & Safety team going into 2025. This is an exciting new way to share important messages, giving the work a more "*Personal*" touch recognising that Health & Safety may occasionally be a dry topic.

3.9 **Manual Handling**

3.9.1 Following the implementation of the recently approved business case to increase manual handling training provision across the Health Board, we are now fully established to meet our objectives of providing a legally compliant programme and to be able to support our staff as and when it is required.

Currently the biggest risk to our projected timings and targets for training provision is the maintenance of the training rooms within the Bridgend area

which has caused the Glanrhyd Training Rooms (Block 1) to be in a state of disrepair including being damp and mouldy. The conditions pose a risk to those with respiratory conditions and those who are immunosuppressed.

Attached as Appendix 1 is an update on the work now being undertaken following the additional resources provided to support and improve Manual Handling Training Provision.

3.9.2 Staff Non Attendances at Training (DNA's)

Manual Handling Training Courses	Apr - June 2023 (Q1)	July - Sept 2023 (Q2)	Oct - Dec 2023 (Q3)	Jan - March 2024 (Q4)	April - June 2024 (Q1)	July - Sept 2024 (Q2)
2 Day Foundation Patient Handling Courses Provided	**6**	**11**	**11**	**16**	**17**	**31**
Number of Available Spaces on 2 Day FPH	50	96	96	129	187	248
Number of staff that attended and completed training	39	83	82	92	136	153
Number of DNA's on 2 Day Foundation Patient Handling (Locations below)	11	13	19	37	51	45
Bank Staff	0	5	6	11	21	10
Localities & Primary Care	3	1	3	2	0	15
Mental Health	0	0	0	4	5	5
POW	3	2	5	6	6	4
PCH	0	2	2	2	15	4
RGH	4	1	0	8	4	6
YCC	1	1	1	2	0	1
YCR	0	1	2	2	0	0
1 Day Foundation Patient Handling Courses Provided	**4**	**4**	**8**	**17**	**15**	**19**
Number of Available Spaces on 1 Day FPH	32	32	64	155	132	152
Number of staff that attended and completed training	21	23	35	130	107	91

Number of DNA's on 1 Day Foundation Patient Handling (Locations below)	7	6	6	25	25	38
Localities & Primary Care	5	1	2	5	4	16
Bank Staff	0	0	0	1	1	0
POW	0	2	1	2	3	6
Mental Health	1	0	2	5	12	10
Obs & Gynae	0	0	0	0	0	0
Pathology	0	0	0	0	0	0
PCH	1	1	0	2	2	3
RGH	0	1	1	10	3	3
Patient Handling Update Day Courses Provided	**2**	**4**	**3**	**3**	**3**	**7**
Number of Available Spaces on Updates	16	32	24	24	24	56
Number of staff that attended and completed training	10	16	4	0	20	7
Number of DNA's on Patient Handling Update Day (Locations below)	1	5	1	0	3	1
Localities & Primary Care	0	0	0	0	0	1
POW	0	2	0	0	0	0
Porters	0	0	0	0	0	0
PCH	1	2	0	0	3	0
Radiology	0	0	0	0	0	0
RGH	0	0	0	0	0	0
YCC	0	1	1	0	0	0
YCR	0	0	0	0	0	0
Inanimate Load Handling Courses Provided	**37**	**36**	**30**	**22**	**21**	**55**
Number of Available Spaces on ILH	480	470	420	320	398	660
Number of staff that attended and	347	280	191	242	303	187

completed training						
Number of DNA's on Inanimate Load Handling (Locations below)	115	91	62	78	95	111
Bank Staff	0	0	3	2	2	8
CAMHS	8	5	1	2	9	19
Children and Young People	2	1	0	6	0	8
Corporate Services	4	2	0	3	1	3
Facilities	2	3	1	2	9	5
IT	2	2	1	0	0	2
Localities & Primary Care	38	29	28	42	24	28
Mental Health	27	22	7	6	14	16
Obs & Gynae	1	2	1	1	0	2
PCH	6	7	8	2	8	7
POW	13	6	2	4	21	9
RGH	8	11	7	8	6	4
Therapies	4	1	3	0	1	0
YCR	0	0	0	0	0	0

Total Attendees on Manual Handling Training	**417**	**402**	**312**	**464**	**566**	**438**
Total DNA's on Manual Handling Training	**134**	**115**	**88**	**140**	**174**	**195**

3.9.3 **Manual Handling Incidents**

Incidents by Sub Subtype and Incident date (Financial quarter)	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	24/25 Q1	24/25 Q2	24/25 Q3	Total
Bed mobility patient/service user	3	3	2	1	0	2	1	12
Bending +/or twisting	1	3	1	2	4	1	1	13
Carrying/supporting a load	1	2	1	1	2	1	1	9
Hoisting patient/service user	5	3	1	1	3	2	1	16
Injured during a manual handling manoeuvre	6	8	10	5	6	5	5	45
Injured whilst being moved with manual handling equipment	1	2	1	1	1	1	0	7
Lifting/lowering a load	3	0	4	1	3	2	0	13
Management of the falling patient/service user	3	2	0	2	2	1	3	13
Manual handling aid / equipment required but unavailable	4	5	11	7	2	3	1	33
Other	10	6	8	6	4	7	2	43
Pushing/pulling a load	1	0	0	2	3	3	0	9
Reaching +/or stretching	0	1	0	1	0	0	0	2
Sitting/standing/walking patient/service user	2	2	2	0	3	1	1	11
Toileting patient/service user	3	2	0	0	0	0	0	5
Using manual handling equipment	2	0	1	0	0	0	0	3
Total	45	39	42	30	33	29	16	234

3.10 **Violence and Aggression**

3.10.1 Violent Incidents

During July 2024 – September 2024, 14% of the incidents reported can be classified as non-gratuitous and can be attributed to the patient's medical or physical condition. Further analysis reveals that 48% of the physical assaults reported can be attributed as non-gratuitous. This may be a reporting issue where staff are not reporting incidents within the correct category. In order to address this issue reporting guidance has been issued to all clinical areas.

The vast majority of violent incidents reported within are in the following areas:

- Mental Health inpatient services,
- Accident and Emergency Departments,
- Medical and Surgical wards,
- Children`s Mental Health Services (CAMHS)
- Community Hospitals

Appendix 2 provides detailed Security and Management of Violence Key Performance Indicator Dashboard, for July –September 2024 and the three previous quarters.

3.10.2 Specific Risks

The main violence and aggression risk continues to be the management of clinically challenging behaviour where the patient lacks capacity. These incidents have occurred regularly with confused patients being nursed on our medical wards and community Hospitals. This effects both patients and staff. This type of patient to staff physical assault is the highest reported non-patient safety incident reported within the Health Board. There has been a concerted effort to increase training courses to meet the training need. Training has commenced within the Community Hospitals in the management of clinically challenging behaviour which will continue throughout the year. The Health and Safety, personal safety department are experiencing an increased demand for training and support from our community hospitals in the management of patients with behaviours that challenge.

3.10.3 Security and Violence Strategy 2025-2027

The current Strategy is to be reviewed and revised to identify the delivery plan goals over the next 3 years. The violence and aggression management sections will cover the higher risk areas and identify control measures to reduce the risk of violence. The strategy delivery plan will be reviewed on

a 3 monthly basis by the Security and Violence Operational group. The higher risk areas include Emergency Departments, Mental Health inpatient wards, and the Community Hospitals.

3.10.4Violence and Aggression Case Management

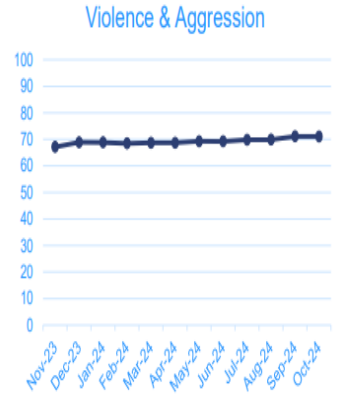
Please see appendix 2 KPI case management Dashboard

3.10.5Hate Crime Awareness

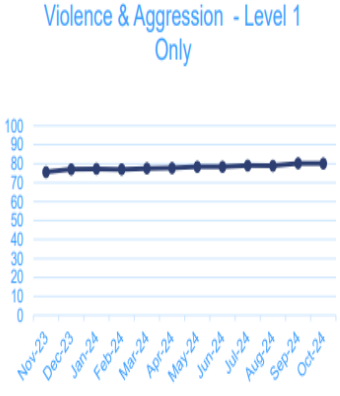
The Violence and Aggression Case Manager relaunched the Hate Crime Awareness sessions in conjunction with South Wales Police commencing at POW. This relaunch in October coincided with hate crime awareness week.

3.10.6Violence and Aggression training

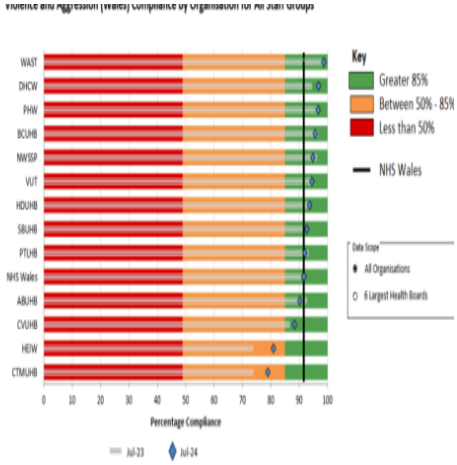
The Dashboard in Appendix 2 demonstrates training numbers have increased over the past year and the table below shows overall training compliance is at 71%. Overall training staff figures have increased significantly from the last quarter 390 to 584. This can be attributed to the introduction of a further Risk and Safety advisor delivering training. Further training and resource however is still required to deliver training to our high-risk staff in particular the management of clinically challenging patients.



Compliance for all levels of training is currently **71.07%** which is **-0.07%** on the previous month and **-13.93%** on the 85% target.



Compliance for Level 1 training is currently **80.11%** which is **-0.09%** on the previous month and **-4.89%** on the 85% target.



CTM is currently 13th from an All Wales perspective

The Table below shows the numbers of non-attendance for July to September 2024.

Training Module:	Number of staff attended:	Number of DNA's
Modules A&B (Theory)	312	131
Module C (Breakaway)	122	14
Module D (Lower Level)	12	0
Module D (Higher Level)	43	2
Safe Management	150	35

3.11 Organisational Health, Safety & Fire Risks

Please see Appendix 3 for a list of the Health, Safety and Fire risks managed by the Health, Safety and Fire Team. All risks are updated in line with their review dates.

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 Healthier 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))*	Whole-systems Perspective If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /*	Safe If more than one applies please list below:

Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	
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 *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Update Report
Cyfreithiol / Legal	Yes (Include further detail below)	
	Prosecution for non-compliance. Civil litigation	
Enw da / Reputational	Yes (Include further detail below)	
	Failure to comply with legislation	
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

5.9 The Sub Committee are asked to note this update report.

6 Next Steps

6.9 A further update report from the Assistant Director for Health, Safety and Fire will be provided to the Sub Committee at the next meeting.

Appendix 2 Cwm Taf Morgannwg UHB - Violence & Aggression and Security Compliance Key Performance Dashboard

VIOLENCE & AGGRESSION KPIs	Oct - Dec 2023 (Q3)	Jan - Mar 2024 (Q4)	Apr- June 2024 (Q1)	July - Sept 2024 (Q2)
1. Incidents Attributed to Clinically Challenging Behaviour by Category	**10**	**6**	**27**	**57**
Physical Assault	7	4	20	50
Aggressive behaviour	0	0	0	0
Verbal Assault	4	2	6	6
Sexual Inappropriate Behaviour	0	0	11	1
2. Incidents Attributed to Gratuitous Behaviour Total by Category	**257**	**266**	**301**	**340**
Physical Assault	62	82	83	63
Aggressive behaviour	174	174	202	201
Verbal Assault	16	9	25	67
Sexual Inappropriate Behaviour	5	1	1	9
3. Incidents Attributed to Clinically Challenging Behaviour by Department	**10**	**6**	**27**	**57**
Acute Sites	4	2	9	5
Community Sites	0	0	2	9
A&E	2	0	3	5
Mental Health	5	4	13	42
4. Incidents Attributed to Gratuitous behaviour by Department	**257**	**266**	**301**	**340**
Acute Sites	117	50	33	12
Community Sites	1	12	12	30
A&E	15	28	31	16
Mental Health	124	180	225	272
5. Severity of Physical Assaults				
No Harm	12	8	30	10
Low	44	67	46	81
Moderate	10	9	9	19
Major/Severe	3	2	1	0
Death	0	0	0	0
6. Number of RIDDOR Reported Incidents	**1**	**1**	**3**	**1**
7. Total Number of Reported Violent & Aggression Incidents Overall	**257**	**272**	**328**	**397**
STAFF TRAINING KPIs	**Oct - Dec 2023 (Q3)**	**Jan - Mar 2024 (Q4)**	**Apr- June 2024 (Q1)**	**July - Sept 2024 (Q2)**
1. Total Number of Staff Trained	**345**	**320**	**390**	**584**
Module A&B	226	222	265	312
Module C	82	90	75	122
Module Safe Management	37	8	50	150
CASE MANAGEMENT KPIs	**Oct - Dec 2023 (Q3)**	**Jan - Mar 2024 (Q4)**	**Apr- June 2024 (Q1)**	**July - Sept 2024 (Q2)**
1. Total Number of Cases being Managed	**13**	**32**	**8**	**21**
Cases this quarter	13	32	8	21

Violent Patient Markers Applied	0	2	1	2
Code of Conduct Letters Issued	7	11	2	7
Cases with police involvement	1	2	3	5
Cases awaiting trial / verdicts	2	0	4	2
Anti Social Behaviour Referrals	3	16	5	3
Police actions - Police cautions	0	2	0	1
Fixed Penalty Noticed Issued	0	1	0	0
Other Police Actions	1	1	0	1
Repeat Offenders	9	0	5	6
Number of incidents repeat offenders responsible	2	0	0	6
Prosecution and sentencing	0	0	0	0
Incidents that involved physical assault	2	4	0	2
Incidents that involved verbal assault	13	0	0	1
Hate Crime/Racial	3	0	0	8
Harrassment	0	0	0	4
Threatening behaviour	15	19	1	20
Other Incidents	0	0	0	0
SECURITY KPIs	**Oct - Dec 2023 (Q3)**	**Jan - Mar 2024 (Q4)**	**Apr- June 2024 (Q1)**	**July - Sept 2024 (Q2)**
1. Total Number Of Reported Security Incidents by Acute Hospital	**11**	**12**	**39**	**38**
RGH	3	5	19	19
PCH	0	0	8	9
POW	3	2	8	6
Community/Localities	5	5	4	5
2. Total Number Of Reported Security Incidents by Category	**11**	**12**	**39**	**38**
Auto Crime Theft of Vehicle	0	1	0	0
Auto Crime Damage to Vehicle	0	2	0	0
Auto Crime Theft from Vehicle	0	0	0	0
Anti-Social Behaviour	0	0	22	15
Theft of Property UHB	1	4	0	0
Theft/Loss of Property Person	4	1	8	8
Security Major Incidents	0	0	1	0
Security of Premises/Alarms/Access etc	6	4	7	15

Risks for Health, Safety and Fire Team

There are 37 risks on the system for Health, Safety and Fire

11 have been approved
25 have been closed/archived
1 rejected as a duplicate

June 2024 –October 2024
1 risk has been closed/archived

Below is a chart of open risks for Health, Safety and Fire

Health, Safety & Fire Risk Report for the Health, Safety & Fire Sub Committee December 2024

ID	Handler	Title	Description	Controls in place	Rating current	Rating Target	Opened	Review date	Action ID	Description	Progress	Due date	Done date
2787	Beadle, Mr Chris	Absence of a robust health Surveillance programme for employees	If: No monitoring in place for staff who work in areas of the organisation where known health risks could develop e.g. Hand, Arm Vibration (HAVs), noise, skin conditions such as contact dermatitis, respiratory etc. Then: Should a reportable incident occur the UHB will be liable to criminal repercussions by the HSE Resulting in: Criminal Actions by the HSE	OH linking with H&S to re-establish the skin surveillance programme. Plan to submit a briefing to execs in relation to the associated risks due to the absence of a health surveillance programme. Report provided to the Health, Safety and Fire Committee outlining the work undertaken in developing SOPs for Respiratory, HAVs, Noise and Skin Surveillance. Noise and HAVs assessments are now underway across the UHB.	12	8	26/06/2017	31/12/2024	6807	Scoping Exercise for Health Surveillance	October 2024 - FRA system in now live and the Health Board is not using it as it is currently identified as not fit for purpose. It only allows you to allocate the FRA to a single person. Work is underway to rectify this issue.	31/12/2024	

4549	Beadle, Mr Chris	Breach of Statutory Legislation RRFSO (2005) Fire Safety - Enforcement GF/FF Merthyr Block	If the organisation fails to comply with the enforcement, then there could be further increased levels of enforcement action against the Health Board. Resulting in possible restriction of use of the areas concerned, legal action against the Health Board or prosecution. Main issues were lack of compartmentation. HB utilising the fire works to modernise the services covered in these areas. Enforcement is a long term risk.	HB has submitted a business case for funding to WG. Funding is applied for each year. Works and phasing have been agreed and is on a phased approach. Works are progressing and each year the HB (CEO) has to apply to extend the enforcement timescale as per enforcement requirements. The HB applies for funding to WG for each phase of works via the PCH ground & first floor capital project team.	12	6	16/02/2021	31/07/2025	4583	Enforcement extension and funding application.	Update October 2024 - Application for extension of the Enforcement Notice approved by Fire Service for a further 12 months.	31/08/2024	
5269	Beadle, Mr Chris	Development of Appropriate Systems to Allow the Production of Basic Management Information in Relation to Risk Assessments	If there is no control over the All Wales Fire Management System. Then the Health Board will be unable to provide accurate management information. Resulting in non-compliance and limited assurance	Very old All Wales IT system in place that only records information and does not provide management reports. FRAs are therefore sent to Relevant Managers, ILG Leads and Estates Team. Managers are asked to enter high risks on to Datix should they not be easily remedied.	12	4	25/10/2022	31/03/2025	6985	Support NWSSP Estates to develop new package	October 2024 - FRA system in now live and the Health Board is not using it as it is currently identified as not fit for purpose. It only allows you to allocate the FRA to a single person. Work is underway to rectify this issue.	31/03/2025	

4584	Beadle, Mr Chris	Failure to Act Upon Fire Risk Assessments (FRA) Significant Findings	If wards/department managers fail to address the significant findings made known to them through the FRA process, then risks will remain unaddressed resulting in risks to life, increased risks of fire and possible enforcement.	FRAs are being undertaken by the HB competent persons (HB Fire Officers) and completed FRAs are provided to the relevant area manager, and the ILG leads.	9	9	24/03/2021	31/10/2025	5265	Monitor and address Fire Risk Assessments (Bridgend)	Email request to FRO to advise on progress. Will be discussed through ILG Health, Safety and Fire group on 7th October. Findings are reviewed as they are received and through the bi monthly ILG Health Safety and Fire Committee meetings. Robust process in place	08/10/2021	04/01/2022
									5268	Monitor and address Fire Risk Assessments (RTE)	review FRA as they arrive and action as necessary. Review again in 1 month. This is now in place in RTE ILG and forms part of the work of their Health, Safety and Fore Group	30/09/2021	25/11/2021
									5269	Monitor and address Fire Risk Assessments (Merthyr & Cynon)	Findings are reviewed as they are received and through the bi monthly ILG Health Safety and Fire Committee meetings. Robust process in place	30/09/2021	29/10/2021
									5534	FRAs to be provided to ILG Directors	This is being currently undertaken.	05/07/2021	05/07/2021

4824	Beadle, Mr Chris	Inadequate provision for noise assessment across the organisation	If specialist noise training skills are not updated with appointed competent person(s). Then the organisation is open to prosecution as a result of non-compliance with current regulation and legislation. This could result in long-term hearing loss for members of staff, and as a consequence the organisation is open to future personal injury claims / complaints.	At the time of writing, all competent noise assessor's licenses have expired but update training is planned for the first quarter of 2022. 01/11/2022 - 2 x H&S Coordinators are now trained to conduct noise assessments and the noise equipment is in the process of being calibrated. Both trainers are now competent to undertake noise assessments and equipment has been calibrated for use.	9	6	16/09/2021	31/12/2024	5968	Training	01/08/2022 - As with Action 5969 the training has been completed x2 staff and noise equipment is currently being calibrated. Noise assessments will commence once equipment is returned calibrated.	31/10/2022	03/10/2022
									5969	Identification of areas of concern	June 2023 - The month of June was designated as noise awareness month to help support the identification of high risk noise areas across the UHB. Action will be completed by end of July 2023.	31/08/2023	19/09/2023
4809	Beadle, Mr Chris	Non-Compliance with Mandatory Violence and Aggression Training	A training review was undertaken to identify HB violence and aggression training requirements. Following review, the HB is unable to achieve full compliance on any training module. This is due to a lack of training resource within the Health Safety and Fire Team. If the training is not delivered, then the organisation will not	Personal Safety Advisor delivers training modules with some support from part time trainers within Mental Health and CAMHS. However, there is insufficient resource to ensure compliance within the entire organisation. Trained tutors available from clinical areas. The PSA regularly has to support training due	16	9	31/08/2021	31/12/2024	6301	Review of V&A Training Programme	17.12.21 PMVA report completed, sent to Chris Beadle and added to the documents section of the risk.	24/12/2021	17/12/2021

			be compliant with mandatory Violence and Aggression Training. Restraint training is mandatory for inpatient acute services for Mental Health and CAMHS. Training is delivered by inpatient staff and the Health Safety and Fire Personal Safety Advisor. If there is insufficient training resource available then the organisation will be unable to maintain compliance on annual refreshers. If the PSA is unable to deliver key aspects of their role due to the high demand for violence and aggression training delivery then advice to clinical areas is greatly reduced. Resulting in non-compliance of mandatory training and a risk of injuries to both staff and patients and possible claims.	to ward-based trainers unable to be released to deliver. This role is not currently included in their job description which has resulted in some trainers resigning from delivering, hence compounding the lack of training resource. The availability of the PSA to offer personal advice to clinical areas is greatly reduced due to the excessive training requirement.					6372	Module D PMVA Training Provision / Programme Delivery	The Health and Safety Committee has requested a further options paper. EJ met with MA Service Improvement Manager and LG Head of Nursing to discuss training options. Options discussed employing dedicated team or buying in training both options involve a significant financial commitment. Further meeting arranged for September 2nd. In the meantime, PMVA training will be delivered up until December 24. MA Service Improvement Manager is currently re writing the PMVA options seeking funding for 3 full time trainers within Mental Health to deliver training.	20/12/2024	
									6374	Addition Training Resource Required	26/06/2024 - A series of meetings have been set up with the V&A Team and Mental Health Service Group to look at means to ensure a suitable training provision form their Care Group. A paper highlighting the risks along with recommendations to ensure a separate contract is provided to the part time trainers is being considered.	30/09/2024	
4392	Beadle, Mr Chris	Site Specific documents require updating on some sites	Site specific documents on a number of sites have outdated information. We have a duty under the RR(FS) 2005 to provide site specific information for oncoming fire crews.	There are site specific documents available on a number of our sites throughout CTMUHB, however where changes to our sites have occurred it should be ensured the site-specific documents are	8	8	30/10/2020	31/12/2024	4224	Update Site Specific Documentation	Fire Officer Appointed on 1st September 2021 on a 12-month fixed term contract.	06/09/2021	01/09/2021

			Hospital and other healthcare estates are constantly evolving environments that must be flexible enough to accommodate new layouts and changes of use as and when required. It is important to provide up to date site specific information for attending fire crews to highlight hazards etc, and for the crews to make informed decisions, failure to do so could put persons at risk and the possibility of enforcement action from the Enforcing Authority. IF Site Specific information is not provided THEN The Health Board does not meet its legal duties RESULTING IN the Fire Service being unclear on their firefighting plans which could result in loss of life, damage to buildings and possible prosecution.	updated to reflect the change. There are several site-specific documents out of date still due to losing one fire officer post and the retirement of the Senior Fire Officer. A plan is being devised by the Fire Team to complete this work. 01/11/2022 - New Senior Fire Officer appointed and due to start on 07/11/2022. Priority will be given to ensuring these documents are up to date.					7063	Site Specific Documentation	August 2024 - Work is progressing to ensure these documents are updated and available for Fire incident Coordinators and the Fire Service. It is anticipated that all these documents will be update by end 2024.	31/12/2024	
4826	Beadle, Mr Chris	Vibration at Work	If HB fails to properly manage the risk of vibration, then the HB is failing its duties under various Acts and Regulations. Resulting in members of staff continue to be	Vibration Information Page available on H&S Handbook via SharePoint. Member of the H&S Team is trained as a competent assessor.	12	9	16/09/2021	31/12/2024	5971	Development of Self-Assessment / Benchmark Assessment	26/06/2024 - Meetings continue with colleagues in Occ Health. A programme of work has been agreed between both departments and an SOP is in place in Occ Health for the management of HAVS. The H&S Team are currently considering	31/12/2024	

			exposed to potentially dangerous levels of vibration causing conditions such as Hand Arm Vibration Syndrome. Currently no competent person within organisation.								the use of equipment to measure vibration. Options include purchase, hire or loan from C&V UHB. Current plans are for this work to commence in Quarter 3 of 2024.		
									5972	Development of Vibration Information Page	Available on SharePoint, H&S Manual Section	31/12/2021	08/12/2021

Additional Open Approved Risks

ID	Handler	Title	Description	Controls in place	Rating (current)	Rating (Target)	Opened	Review date	ID	Description	Progress	Due date	Done date
5270	Jason Williams	Update Drawings in Respect of Compartmentation for all Sites	If management is unable to confirm an appropriate timeline to update drawings in respect of compartmentation for all sites. Then the Health Board will be unaware of fire risks in relation to fire compartmentation. Resulting in non-compliance with audit findings and potential Enforcement Action by the Fire Service.	Some Health Board Sites already have compartmentation surveys in place. Capital and Estates employing additional support to undertake this exercise.	8	4	25/10/2022	31/07/2024	6987	All Sites to have full compartmentation surveys	26/06/2024 - following a review, this risk and action has been transferred to Jason Williams in Capital and Estates	31/07/2024	

2987	Foley, Mr Robert	Fire Enforcement Order ground and first floor for compatentation ground and first floor PCH Estates Fire Scorecard point 14	IF: the Health Board fails to meet fire standards required in this area. Then: the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. Resulting in: potential harm, risk of fire.	Fire Enforcement Order. An action plan and target dates for the 1st and ground floor areas at PCH is available and is subject to available finance for completion. 12/10/20 Phase 1 on track with restaurant and pharmacy opening 2021, awaiting outcome of meeting I Oct 2020 with WG with regards to further funding for Phase 2, estimated timescale for 5-6years 02/02/20 - Phase 1b of the wider programme has progressed to the point that the UHB has now achieved remediation for physical fire issues identified in the FEN in the majority of the new Pharmacy, Dining Room and Kitchen areas at PCH which opened in January 2021. This has tackled the higher risk for fire areas of the old kitchens and improved the fire stopping below ITU as well as reducing the overall volume of area remaining in the FEN to be remediated. In addition, the UHB secured Welsh Government approval in October 2020 for the Phase 2 FBC, in the sum of £220m, which will see progressive improvement of the majority of the remaining G&FF areas to be remediated for fire over the next 5 and a half years. As a reminder these works are progressive due to the need	12	6	29/11/2017	01/01/2026	2170	Fire enforcement order PCH for fire compartments	26/10/21 (Chris Beadle)- Programme has been agreed for five and a half years from today. A review will take place 6 months prior to action completion date. An extension of a further 12 months has been granted by the Fire Service and will now expire on 31/07/2022.	01/01/2026	

				to balance them against maintaining service delivery as best as we are able and are intended to be supplemented (to run concurrently with final years of the Phase 2) by a final Phase 3 business case intended to address the final physical accommodation areas included within the FEN. 06/06/2022 The need for capital investment is recognised and is recognised on the Health Board list of schemes. The plans have been drawn up so the project can be progressed when the funding becomes available. The capital funding challenges, in NHS Wales, however, are recognised and so in the meantime to ensure safe respiratory and non respiratory pathways fracture clinic has been moved to Ysbyty Cwm Cynon to allow the PCH ED to move into the vacated space. 01/11/2022 - This risk has been transferred from Catherine Roberts to Neil Cooper. See Communication and Feedback. 04/07/2023 - Updated by C Beadle. Risk scoring has been amended appropriately as this risk is in the process of reducing as further works on the site are completed.								

4417	Ms Julie Denley	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	clinical areas across the Health Board should have in place local arrangements/procedures to prevent patients from absconding. 29/09/2022 - RTE ILG has recently undertaken a review of all their clinical areas and assessed the risks from patients absconding. An action plan is being developed.	16	8	30/09/2020	31/12/2024	4230	Management of Security Doors in All Hospital Settings in Bridgend	02.09.24 Access control report now submitted to Julie Denley highlighting the areas of risk and to support SON to enhance measures as listed within the report.	31/12/2024	
								4280	Identification	Evidence provided to Chris Beadle for Health and Safety Executive Improvement notice.	31/12/2020	15/02/2021
								6376	Management of Security Doors in All Hospital Settings in RTE	02.09.24 Access control report now submitted to Julie Denley highlighting the areas of risk and to support SON to enhance measures as listed within the report.	31/12/2024	
								6377	Management of Security Doors in All Hospital Setting in M&C ILG	There has bene an on-going piece of work regarding this issue where each CSG in MH assessed the access and egress points on wards. A M&C risk assessment and action plan is available. • From a M&C point of view we identified one action from the risk assessments and that is in relation to a CCTV camera that is not working at Cefn Yr Afon. It is on order	07/02/2022	25/02/2022

			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.							We will monitor this action through our H&S meeting and report progress or issues through the ILG H&S meeting		

Agenda Item
5.2

Health, Safety & Fire Sub Committee

Fire Safety Report

Dyddiad y Cyfarfod / Date of Meeting	24/01/2025
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

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 TWO fire enforcement notices from SWFRS.

- First is 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 has to apply for extension of time and funding. *Ongoing Estimated completion 2025. 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.

- Second is the POW theatres, which was granted a continual extension that is applied for annually from SWFRS. Progress has been slow with minor steps being agreed as to how to facilitate the need to maintain a theatre service across the HB for Enforcement works to commence. Any further decision making sits with the POW Fire Enforcement Project Board in conjunction with SWFRS. Following recent meetings a draft fire strategy has been drawn up with the HB and the architects, this is awaiting approval of the HB and NWSSP. However with recent developments, the damaged roof, this has a potential to impact upon the enforcement notice (see 3.3).

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

Scheduled fire audits:

- Prince Charles Hospital – Residences, Blocks 1 - 5 & 7. Audit carried out by Watch Manager with the Fire Officer for PCH), the Assistant Director of Facilities and the Senior Facilities Manager in attendance.
- All residence blocks were issued an IN01 (Information Notice) for the following discrepancies:
    - Fire doors required on all COSHH cupboards – 6 in total. Costings received and doors ordered (6-8 weeks delivery)
    - Store/Meter cupboards require clasp and lock – 12 in total. Materials ordered and locks to be fitted by estates team.
    - All entrance doors to have Self Closing devices serviced. Completed.
    - General rubbish in escape corridors. Completed.
- Full reports available upon request.

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, wheel chairs, 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.

More recently, 29th & 30th October, this has been raised by the Hospital's Equipment Coordinator to the Hospital General Manger with an ever growing amount of uncleaned beds and mattresses being placed in corridors blocking escape routes.

This has been raised by the hospital management team through the safe to start meetings including the Infection Prevention and Control team.

3.2 **Glanrhyd Hospital Fire Alarm –** It had been identified that numerous devices throughout the hospital required upgrading, this included fire alarm panels and detection devices. 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.

3.3 **Princess of Wales Hospital Theatre Enforcement -** Due to the restriction on Capital funding from Welsh Government, the Health Board is having to review its proposals and look at alternatives to address the fire enforcement notice. This has been asked by Welsh Government to be done as a priority. At the time of compiling this report, steps are being agreed as to how to facilitate the need to maintain a theatre service across the HB for Enforcement works to commence. The next step is to take this back to Welsh Government.

Regular meetings are taking place with the POWH Fire Enforcement Notice Project Board and SWFRS to ensure sufficient communication is maintained.

The Health Board is required to continue to progress the issue towards a solution as a matter of priority, and provide feedback to the SWFRS.

Fire Risk Assessments are reviewed every 6 months to ensure control of the risk is maintained.

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.

Initial contact has been made with SWFRS to discuss the enforcement notice and its now lack of impact, awaiting a response.

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 **Fire Safety Team Resource** - The Fire Safety Team has struggled 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 professionalism.

The Health Board currently has 4 full time Fire Officers and 1 x Senior Fire Officer. 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, to be discussed further with NHS Wales Shared Services Partnership - Specialist Estates Services.

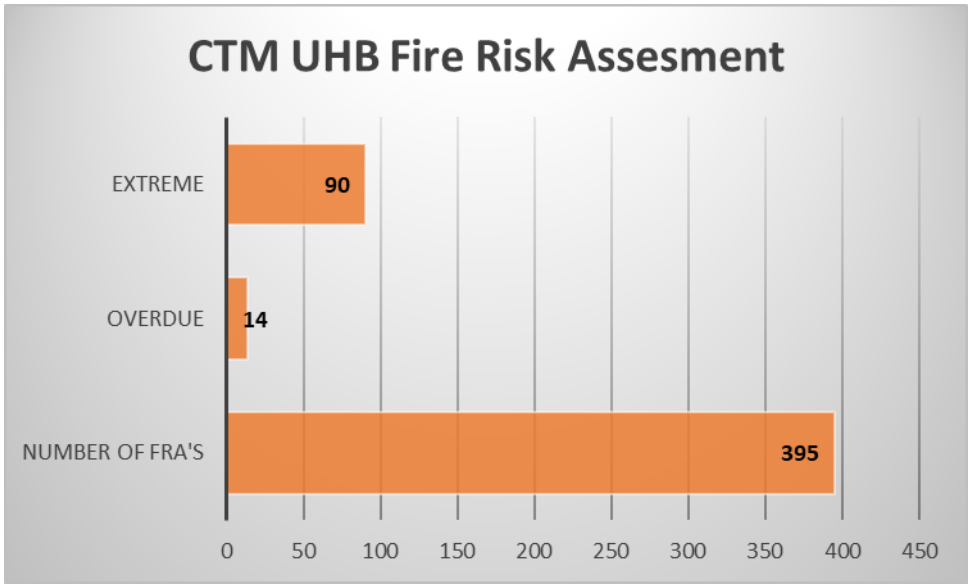
It is noticeable at CTM UHB we have an aging workforce within the fire safety team and without future investment, training our own FO's, there will be a significant gap in years to come.

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 the out of date 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.

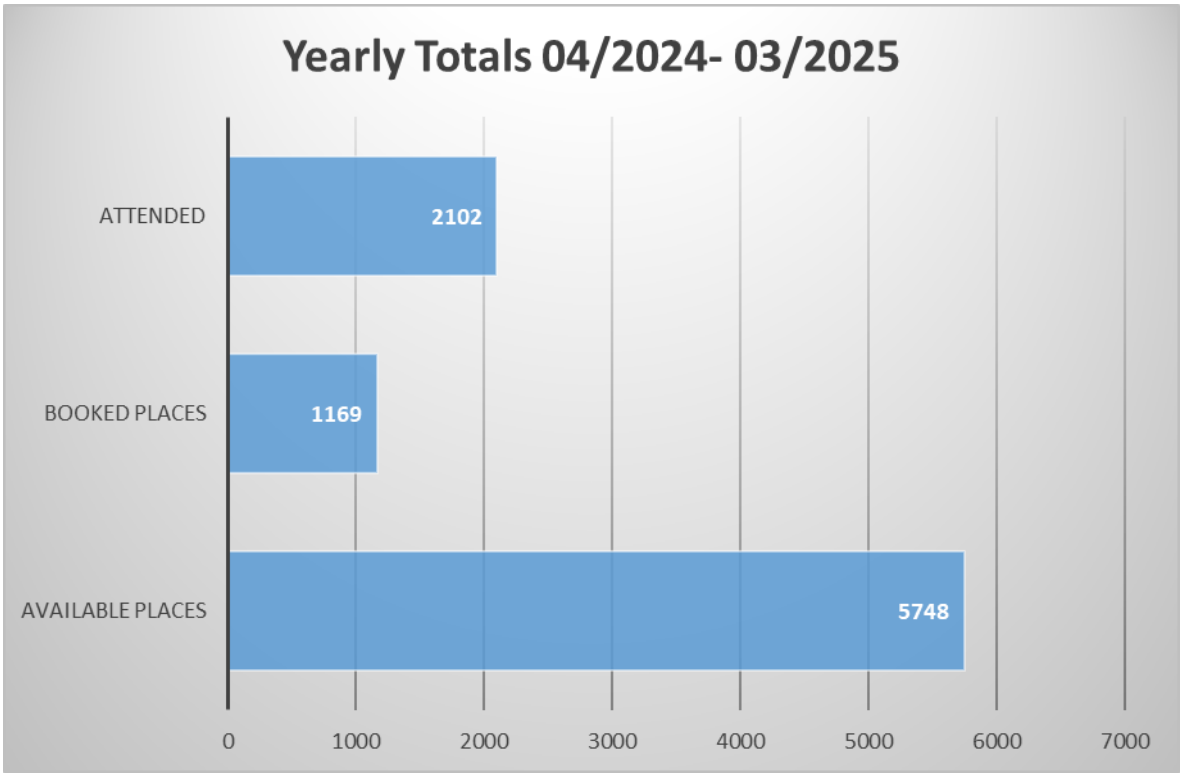


- Total number of FRA's across all sites is 395, increased following decants from POWH.
- As of 11.11.2024, overdue FRA's is 14,(Evidenced in NWSSP FRA Reporting System).
- Of the 395 FRA's there are 90 extreme risks, an increase of 2 risks since the last report.

Please see Appendix 1 for a list of all 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 Fire Admin Support person.

Throughout April 2024 and May 2024, as shown in the graph below more attendees were as "drop ins" and not booked through ESR.



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.

Compliance for all levels of training is currently **65.02%** which is **+0.32%**on the previous month and **-19.98%** on the 85% target.

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

08/2024	POWH	56 attendees
09/2024	PCH	47 attendees
10/2024	RGH	62 attendees

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. This is still a major concern and breach of both statutory legislation and WHTM Fire code. Any new starters who have not received face to face training with a Fire Officer are being advised to attend these sessions as a priority.

3.7 **Fire Incidents & False Alarms 06/08/2024 – 11/11/2024.**

Fire and false Alarms continue to roller coaster 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 06/08/2024 and 11/11/2024 inclusive

53 incidents found.

Site	Fire	UwFS
Caswell Clinic, Tondu Road	0	7
Glanrhyd Hospital, Tondu Road	0	4
PCH - Staff Residences, Prince Charles Hospital	0	2
POW - Staff Residences, Coity Road	0	3
Prince Charles Hospital, Gurnos Estate	0	7
Princess of Wales Hospital, Coity Road	0	11
Royal Glamorgan Hospital, Ynysmaerdy	1	10
Treorchy (Central Processing) Cook Chill Unit, Cae Mawr Industrial Estate	0	3
Ysbyty Cwm Cynon, New Road	0	1
Ysbyty Cwm Rhondda, Partridge Road	1	3

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 no change in Fires, and would attribute this to the change in patient locations.

28/05/2024 – 05/08/2024		06/08/2024 – 11/11/2024	
Fire	Fire	Fire	UwFS
2	43	2	51

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 –**

15/08/2024 @ 12:00 RGH Main Entrance.
Informed by member of staff of an external fire incident which occurred within a waste bin, at the bus stop adjacent to hospital entrance.
Fire appeared to be the result of a discarded cigarette being placed in bin, setting fire to waste material.
Fire was extinguished by member of staff using 6 litre foam extinguisher obtained from Porters Lodge.
Fire service was not called. No evacuation was necessary. Only waste materials in bin was damaged.
Incident was reported directly to HB Fire Officer.

19/10/2024 @ 09:10 YCR Plant Room.
Automatic fire alarm (AFD) activation, YCR Boiler Zone – Area EC 11. Fire Service called.
Further AFD alarm activations in Mortuary & Pharmacy Depts.
On investigation incident confirmed to be within Boiler room area, only smoke entering into Mortuary & Pharmacy Depts. due to being located nearby.
Fire service attended incident and reported 2 breathing apparatus sets and one jet line were used.
On further investigation, damp wood chips that were being conveyed via BIOMASS system into Boiler
Unit produced large volumes of smoke which ventilated naturally. Conveyer system was shut down.
No report of fire being seen, Fire service left.

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 was developed and approved by the Sub Committee. Attached as Appendix 2 is an update on actions from the Strategy.

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.

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:
	Not Applicable

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)*	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)	
	Prosecution by Fire Authority or Health and Safety Executive	
Enw da / Reputational	Yes (Include further detail below)	

	Poor Publicity following legal action
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)
	Replacement and additional fire officers and capital investment to meet legal obligations

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.

Introduction

The Regulatory Reform (Fire Safety) Order, that came into force on 1st October 2006, requires 'general fire precautions' to b
Article 9 of the Fire Safety Order imposes a duty upon the 'responsible person' to make a suitable and sufficient assessment

Responsibility for complying with the Fire Safety Order rests with the responsible person. Broadly, in a workplace this would
In support of the Fire Safety Order the Department for Communities and Local Government published a series of premise sp
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, pu
This Organisation undertakes fire risk assessments following the recognised guidance adopting a standardised approach for
Risk assessments should only be conducted by competent persons and all fire risk assessments should be maintained up-to

Ref.	Question	Assessment name
A1.1	Are processes such as cooking, welding or frictional heat present in the assessment area?	Template 203 Ward 8,9 & Common Areas
A1.1	Are processes such as cooking, welding or frictional heat present in the assessment area?	DSHP, Estates Building & Boiler Room
A1.1	Are processes such as cooking, welding or frictional heat present in the assessment area?	Template 161 Ambulatory Emergency Care Unit (AECU)
A1.1	Are processes such as cooking, welding or frictional heat present in the assessment area?	Ward C3

A1.2	Are ignition sources controlled/managed?	Mental Health Rehabilitation Unit
A1.2	Are ignition sources controlled/managed?	Pharmacy Department
A1.2	Are ignition sources controlled/managed?	Template 203 Ward 8,9 & Common Areas
A1.2	Are ignition sources controlled/managed?	Catering Department & Reception Offices.
A1.2	Are ignition sources controlled/managed?	Template 202 - Ward 10, Ward 11 & Common Areas
A1.4	Are permanent and temporary electrical sources suitably managed?	Pharmacy Department

A1.4	Are permanent and temporary electrical sources suitably managed?	Template 203 Ward 8,9 & Common Areas
A1.4	Are permanent and temporary electrical sources suitably managed?	Day Hospital, Gastro & Vaccination Areas
A1.6	Is the risk of arson addressed within the assessment area (including patient ignition)?	Mental Health Rehabilitation Unit
A1.7	Is smoking permitted or are smoking materials present?	Mental Health Rehabilitation Unit
A1.7	Is smoking permitted or are smoking materials present?	Template 270 MHU Admissions Unit
A1.7	Is smoking permitted or are smoking materials present?	Template 272 MHU Ward 22 (Taff Ely)

Is smoking permitted or are smoking materials present?	Ward B2

A1.7

Is smoking permitted or are smoking materials present?	Template 271 MHU Ward 21 (Rhondda Unit)

A1.7

Are flammable/highly flammable materials managed/stored correctly?	Unit 2 - Gwaun Elai (The Hub)

A2.1

Is combustible waste allowed to accumulate?	T174 Mental Health Crisis Management Team, Reception, ECT & Administration .

A2.3

Is there piped oxygen in use?	Ward C3

A3.1

C5.5	Is the fire alarm system linked to an alarm receiving centre?	Hirwaun Medical Centre
A3.4	Are compressed cylinders/gases used in accordance with the appropriate HSE guidance?	Administration Block (2)
A4.1	Are identified risk measures and controls being implemented?	Template 203 Ward 8,9 & Common Areas
A4.1	Are identified risk measures and controls being implemented?	T174 Mental Health Crisis Management Team, Reception, ECT & Administration .
A4.1	Are identified risk measures and controls being implemented?	Template 271 MHU Ward 21 (Rhondda Unit)
A4.1	Are identified risk measures and controls being implemented?	Template 211 Intensive Therapy Unit , High Dependency Units, Ward 7 & Anaesthetic Offices

A4.1	Are identified risk measures and controls being implemented?	Template 209 Wards 3 & 4
A4.1	Are identified risk measures and controls being implemented?	Template T116 Wards 19 & 20.
A4.1	Are identified risk measures and controls being implemented?	Template 272 MHU Ward 22 (Taff Ely)
A4.1	Are identified risk measures and controls being implemented?	Template 270 MHU Admissions Unit
A4.1	Are identified risk measures and controls being implemented?	Template 161 Ambulatory Emergency Care Unit (AECU)
A4.1	Are identified risk measures and controls being implemented?	Template 202 - Ward 10, Ward 11 & Common Areas

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

A4.9

Are staff numbers sufficient to meet the fire evacuation strategy?	Template 215 Ward 12, 14, Cardiac Rehabilitation Offices & Common Areas

A4.9

Are staff numbers sufficient to meet the fire evacuation strategy?	Template 203 Ward 8,9 & Common Areas

A4.9

	Are fire drawings for this assessment area available and up to date?	DSHP, Health Centre, Second Floor.
A4.12		
	Is the fire detection system within the assessment area adequate?	T115A - Y BWTHYN Macmillan, Specialist Palliative Care Unit.
A5.1		
	Are all fire doors within the assessment area to the correct standard and functioning correctly?	DSHP, Health Centre, Second Floor.
A6.1		
	Are all fire doors within the assessment area to the correct standard and functioning correctly?	Template 271 MHU Ward 21 (Rhondda Unit)
A6.1		

	Are all fire doors within the assessment area to the correct standard and functioning correctly?	Template 204 The Clinical Education Department
A6.1		

	Are all fire doors within the assessment area to the correct standard and functioning correctly?	Tenby Ward Caswell Clinic
A6.1		

	Are all fire doors within the assessment area to the correct standard and functioning correctly?	DSHP, Health Centre,Ground Floor.
A6.1		

	Are all fire doors within the assessment area to the correct standard and functioning correctly?	Unit 2 - Gwaun Elai (The Hub)
A6.1		

A6.1	Are all fire doors within the assessment area to the correct standard and functioning correctly?	Penarth Ward
A6.1	Are all fire doors within the assessment area to the correct standard and functioning correctly?	Template 161 Ambulatory Emergency Care Unit (AECU)
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.
A6.2	Are fire doors wedged open?	Template 211 Intensive Therapy Unit , High Dependency Units, Ward 7 & Anaesthetic Offices
A6.2	Are fire doors wedged open?	Template 161 Ambulatory Emergency Care Unit (AECU)

	Are fire doors wedged open?	Pharmacy Department
A6.2		
	Are all doors fitted with security devices easily opened in the event of an emergency?	Template 271 MHU Ward 21 (Rhondda Unit)
A6.3		
	Are all doors fitted with security devices easily opened in the event of an emergency?	Template 270 MHU Admissions Unit
A6.3		
	Are all doors fitted with security devices easily opened in the event of an emergency?	Unit 2 - Gwaun Elai (The Hub)
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.
A6.3		
	Are all doors fitted with security devices easily opened in the event of an emergency?	North Road Stores UNIT 32
C6.3		

	Are suitable and sufficient escape routes provided within the assessment area?	Out Patients Department.
A6.4		
	Are suitable and sufficient escape routes provided within the assessment area?	Discharge Lounge
A6.4		
	Are suitable and sufficient escape routes provided within the assessment area?	Discharge Lounge
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.
A6.4		
	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.
A6.6		

A6.6	Are escape routes free from obstruction, combustible materials that would assist fire spread or anything that may impede an evacuation?	Administration Block (2)
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
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
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.
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 .

	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
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)
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)
A6.6		
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)

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.
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
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

Are hazard rooms adequately protected?	Merthyr Block - 1st Floor - Main Operating Theatres.

A6.7

Are hazard rooms adequately protected?	Unit 2 - Gwaun Elai (The Hub)

A6.7

Are hazard rooms adequately protected?	Template 204 The Clinical Education Department

A6.7

Are hazard rooms adequately protected?	Template 271 MHU Ward 21 (Rhondda Unit)

A6.7

	Are hazard rooms adequately protected?	Estates Workshops & Compound. Offices. Clinical Engineering Workshop. Technical Services Team Admin Offices.
A6.7		
	Is compartmentation/ (sub)compartmentation integrity adequately maintained?	Templates 331 - 338. (Plant Rooms 1 - 8) & Roof Spaces.
A6.8		
	Is compartmentation/ (sub)compartmentation integrity adequately maintained?	Merthyr Block - 1st Floor - Main Operating Theatres.
A6.8		

Is compartmentation/ (sub)compartmentation integrity adequately maintained?	Template 161 Ambulatory Emergency Care Unit (AECU)

A6.8

Is compartmentation/ (sub)compartmentation integrity adequately maintained?	Unit 2 - Gwaun Elai (The Hub)

A6.8

Is compartmentation/ (sub)compartmentation integrity adequately maintained?	DSHP, Health Centre,Ground Floor.

A6.8

Is compartmentation/ (sub)compartmentation integrity adequately maintained?	DSHP, Health Centre, Second Floor.

A6.8

Is compartmentation/ (sub)compartmentation integrity adequately maintained?	DSHP, Health Centre, First Floor.

A6.8

Is compartmentation/ (sub)compartmentation integrity adequately maintained?	DSHP, Health Centre, 3rd Floor, 4th floor & Roof.

A6.8

Is compartmentation/ (sub)compartmentation integrity adequately maintained?	DSHP,Health Centre, Basement.(Crawl-ways/Walkways).

A6.8

Is compartmentation/ (sub)compartmentation integrity adequately maintained?	Template 214 First Floor Pathology

A6.8

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

be put in place 'where necessary and to the extent that is reasonable and practical' for the protection of the 'relevant persons'.
t of the risks. Therefore, it is through the fire risk assessment process that the necessary measures are identified.

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 th
pecific guidance documents on undertaking risk assessments, one of which refers to healthcare (the Green Guide).

ublished HTM05 03 Part K Fire Risk Assessment in Complex Healthcare Premises as part of the Firecode suite of documents.
r the healthcare organisations in Wales.
o-date, furthermore prioritised action plans should be implemented to address any significant findings identified.

Findings	Variation/justification or action required	Risk rating
At the time of assessment room OEA 52 was in use as a departmental secretaries office. A Microwave was located within this office and was in use at the time of assessment. Previous 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.	16
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
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
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

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
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
At the time of assessment room OEA 52 was in use as a departmental secretaries office. A electronic printer was located on the window ledge behind curtains.	It is highly recommended that this finding is addressed and the printer is relocated to a more suitable location within the office.	16
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
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
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

At the time of assessment, rooms GOA 14 & GOA 15 (Ward 9) were in use as 6 bed patient sleeping areas. Each entrance door had electric cabling tied to the door handle.	It is highly recommended that staff ensure cabling is not attached in any way to doors within the assessment area. This will obstruct immediate use of the door, it may also cause damage to equipment or present an electrical hazard/ignition source.	16
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
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
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
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
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

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
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
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
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
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

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
At the time of assessment it was noted there were CD size oxygen cylinders free standing in the corridor, an oxygen cylinder in the 'grab bag' and 3 Entonox cylinders stored on the floor in the escape corridor.	Escape corridors should be maintained free of obstructions and combustible materials. CTM's fire policy is for cylinders to be stored in cabinets and in rooms that can be provided with ventilation. Staff carrying cylinders in their cars should ensure that they are covered by their vehicle insurance.	16
At the time of assessment, identified risk control measures were documented within departmental fire folders, not all risk control measures were being implemented.	It is highly recommended that staff ensure all risk control measures documented within the departmental fire folder and this FRA are implemented.	16
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
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
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

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
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
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
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
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
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

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
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
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. 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

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
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
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
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

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
At the time of assessment it was not possible to 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
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
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

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
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
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
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
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

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
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
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
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
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
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

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
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
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
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
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

At the time of assessment there were cardboard boxes oxygen cylinders and Entonox cylinders stored in the escape corridor.	The corridor should be maintained free of any type of obstruction.	16
At the time of assessment, an additional bed was located within room MAA25 (ward 20) as a result of the HB's Bed Boarding procedure. Due to the additional bed located in the rooms, and as a consequence, items of equipment previously stored within the bed spaces were being relocated in the corridors, resulting in the means of escape being obstructed.	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
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
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
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

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
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
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
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

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
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
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

At the time of assessment hazard rooms (store rooms, rest rooms, electrical switch rooms, IT Hub room, medical gas store, waste rooms) were not adequately protected by the requisite standard of fire resisting materials. Despite the Health Board's extensive interim fire precautionary works to comply with EN79/10, manager(s) of the area/department must ensure staff are made aware of the risks associated in their working area and a robust level of Fire Safety Management is applied until full compliance can be achieved through the major refurbishment project.	All fire hazard rooms must be segregated by at least half hour standard of fire resistance with fire doors fitted with hot & cold smoke seals. Air transfer grilles should not be fitted on fire doors unless accompanied by a test certificate provided by the manufacturer. Full compliance to the standards cannot be achieved until completion of the major projects refurbishment programme.	15
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
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
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

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
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
At the time of assessment the sub-compartmentation was inadequate throughout the department.	The integrity of sub compartmentation, and walls to fire hazard rooms above ceiling is crucial to the safety of the occupants. However full compliance to the standards cannot be achieved within this area until completion of the major refurbishment. To ensure fire risks are as low as reasonably practical a high level of fire management is required to be maintained within this area. All staff and users of the department must be made aware of the risks that currently exist due to the lack of building protection.	15

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
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
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
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

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
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
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
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

onsibilities

han one responsible person such as in multi-occupied premises, all must take reasonable steps to co-operate and coordinate with each

Responsibility	Anticipated completion	Action taken
Administration Manager,Acute Services General Manager.	Immediately	
Head of Nosocomial Investigation Team,Senior Nurse – District Nursing Team,Team Leader - District Nursing Team,Capital Planning Manager.	Immediately	
AECU – Manager,Senior Nurse – ED.	Immediately	
Senior Nurse,Ward Manager – Ward C3.	Immediately	

Ward Manager	continue to manage
Regional Facilities Manager.	Immediately
Administration ManagerAcute Services General Manager.	Immediately
Head of Estates,Operational Support Manager.	Immediately
Ward Manager – ward 10.	Immediately
Head of Pharmacy- YCR,Team Leader Pharmacy.	Immediately

Senior Nurse,Sister – Ward 9.	Immediately
Vaccination Ctr Manager to Consult with Estates	Within 28 days of this assessment
Ward Manager	continue to manage
Ward Manager	continue to manage
MHU-Adult Directorate Manager,Ward Manager – MH Admissions Ward.	Immediately
MHU-Adult Directorate Manager,Ward Manager – Ward 22.	Immediately

Senior Nurse,Ward Manager – Ward B2).	Immediately
MHU-Adult Directorate Manager,Ward Manager – Ward 21.	Immediately
Business Support Manager-The Hub.	Immediately
MH Service Director.	Immediately
Senior Nurse,Ward Manager – Ward C3.	Immediately

Primary Care Lead	as soon as reasonably practicable
Department Manager	Immediately
Administration Manager,Senior Nurse,Sister – Ward 8,Sister – Ward 9.	Immediately
MH Service Director.	Immediately
MHU-Adult Directorate Manager,Ward manager – Ward 21.	Immediately
Senior Nurse,Ward Manager – ITU,Team Manager – ITU Psychology Service,Administration Manager - Anaesthetics,Facilities Site Manager.	Immediately

Ward Manager – ward 4Ward Manager – Ward 3.	Immediately
Ward Manager-Ward 20.	Immediately
Ward Manager - Ward 22,MHU-Adult Directorate Manager.	Immediately
MHU-Adult Directorate Manager,Ward Manager – MH Admissions Ward.	Immediately
AECU – Manager,Senior Nurse – ED.	Immediately
Ophthalmic Manager – Ward 11,Ward Manager-ward 11,Ward Manager – ward 10.	Immediately

Ward Manager – Ward 6,Head of Nursing,Acute Services General Manager.	Immediately
Dep. Ward Manager- Ward 14,Ward Manager - Ward 12.	Immediately
Senior Nurse,Sister – Ward 8,Sister – Ward 9.	Immediately

Head of Estates,OSM.	Immediately
Head of Estates.	Immediately
Head of Estates.	Immediately
Head of Estates.	Immediately

Head of Estates.	Immediately
Operational Estates Manager/ Senior Estates Officer allocated responsibility for the site.	Within 7 days of this assessment
Head of Estates.	Immediately
Head of Estates,Senior Project Officer.	Immediately

Managers to liaise with Operational Estates Manager/ Senior Estates Officer allocated responsibility for the site	as soon as reasonably practicable
Head of Estates.	Immediately
Head of Estates,RGH Estates Manager.	Immediately
Facilities Site Manager,Senior Nurse,Ward Manager – ITU,Team Manager – ITU Psychology Service,Administration Manager - Anaesthetics.	Immediately
AECU – Manager,Senior Nurse – ED.	Immediately

Head of Pharmacy- YCR,Team Leader Pharmacy.	Immediately
Head of Estates.	Immediately
MHU-Adult Directorate Manager,Ward Manager – MH Admissions Ward.	Immediately
Head of Estates.	Immediately
Head of Estates,RGH Estates Manager.	Immediately
Estates Manager	Within 7 days of this assessment

Head of Estates.	Immediately
Senior Management team to liaise with Estates and Capitol	Immediately
Senior Management team to liaise with estates and Capitol	Immediately
Management - Estates and Technical Services.	Within 28 days of this assessment
Management - Estates and Technical Services.	Within 90 days of this assessment

Department Manager	Immediately
Head of Nursing,Acute Services General Manager,Senior Nurse,Sister – Ward 8,Sister – Ward 9.	Immediately
Dep. Ward Manager- Ward 14,Ward Manager - Ward 12.	Immediately
Head of Estates.	Immediately
MH Service Director.	Immediately

Ward Manager – Ward 6,Head of Nursing,Acute Services General Manager.	Immediately
Head of Estates.	Immediately
Head of Estates,Senior Facilities Manager.	Immediately
Head of Estates.	Immediately

Ward Manager-Ward 20,Lead Nurse – ward 20.	Immediately
Ward Manager – ward 4,Ward Manager – Ward 3,Senior Nurse – Wards 3 & 4.	Immediately
Facilities Site Manager,Senior Nurse,Ward Manager – ITU,Team Manager – ITU Psychology Service,Administration Manager - Anaesthetics.	Immediately

Director of Strategic & Capital Planning/Management.	continue to manage
Head of Estates,Senior Project Officer.	Immediately
Head of Estates.	Immediately
Alan Martin (Head of Estates)	Immediately

Management - Estates and Technical Services.	Within 28 days of this assessment
Head of Estates,RGH Estates Manager.	Immediately
Director of Capital & Strategic Planning.	continue to manage

Head of Estates.	Immediately
Head of Estates,Senior Project Officer.	Immediately
Head of Estates	Immediately
Head of Estates,OSM.	Immediately

Head of Estates,OSM.	Immediately
Head of Estates	Immediately
Head of Estates	Immediately
Head of Estates	Immediately

other.

Signed Date

FIRE SAFETY 3 YEAR STRATEGIC PLAN (2024 – 2(

Aspects of this medium term fire plan will require cap

Fire Risk Assessment – FRA (Initial)

Ref	Stratgic Requirement
	High (Red) Sleeping Risk Areas
	Medium (Amber) Day Patient Risk Areas
	Low (Green) Community Risk Areas

Training (Statutory Update)

Ref	Stratgic Requirement
	Provide annual ongoing training to meet a 50% audience (approximately 6,000 staff).
	Training sessions will be pre-booked 3 months in advance.
	Develop an On-Line Fire Manager package to suit, April 2024,

Training (Evacuation) It is proposed to undertake 2 hospital e

Ref	Stratgic Requirement
	Prince Charles Hospital (outbuilding)
	Ysbyty George Thomas
	Prince Charles Hospital (ward)
	Dewi Sant Health Park
	Princess of Wales Hospital (ward)
	Glanrhyd - Angleton Clinic
	Royal Glamorgan Hospital (ward)
	Kier Hardy Health Park

Site Specific Fire Information.

Ref	Stratgic Requirement
	Dewi Sant Health Park
	Glanrhyd Hospital
	Pinewood House
	Royal Glamorgan Hospital
	Princess of Wales Hospital
	Prince Charles Hospital
	Ysbyty George Thomas
	Ysbyty Cwm Cynon
	Ysbyty Cwm Rhondda
	Kier Hardy Health Park
	Maesteg Hospital
	CAMHS - Ty Llidiard

Site Fire Compartmentation Surveys

Ref	Stratgic Requirement

Site Fire Orientation Drawings

Ref	Stratgic Requirement
	All Sites
	All Sites
	Prince Charles Hospital

Fire Doors/Fire Alarms Two pronged approach to upg

Ref	Stratgic Requirement
1	
2	

Cause And Effect Testing

Ref	Stratgic Requirement
	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

Fire Service Audits

Audits are undertaken annually, amounts/frequency defined by Sou

Operational and Strategic Planning Directorat

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 s
PCH - Major refurbishment of building under EN79/10 Grounc
POWH - Major refurbishment of theatres under enforcement
DSHP - Compartmentation upgrade (fire doors) within the nex
KHHP - Fire alarm cause and effect and upgrade from C&A resu

Note all above upgrade priorities may vary du

)27 inclusive).

›ital investment to ensure completion of significant risks. Lack of t

Description of Actions	Completion Date
Initial FRA to be completed or reviewed for all areas by April 2024	apr-24
Initial FRA to be completed or reviewed for all areas by April 2025	apr-25
Initial FRA to be completed or reviewed for all areas by April 2026	apr-26

Description of Actions	Completion Date
Each Fire Officer will arrange training locality and feed the organisations training calendar accordingly.	
Each Fire Officer will arrange training locality and feed the organisations training calendar accordingly.	
commence delivering August /September 2024.	

›vacuations per year

Description of Actions	Completion Date
	2024
	2024
	2025
	2025
	2026
	2026
	2027
	2027

Description of Actions	Completion Date
Compilation of site specific fire safety folders	2024
Compilation of site specific fire safety folders	2024
Compilation of site specific fire safety folders	2024
Compilation of site specific fire safety folders	2025
Compilation of site specific fire safety folders	2025
Compilation of site specific fire safety folders	2025
Compilation of site specific fire safety folders	2026
Compilation of site specific fire safety folders	2026
Compilation of site specific fire safety folders	2026
Compilation of site specific fire safety folders	2027
Compilation of site specific fire safety folders	2027
Compilation of site specific fire safety folders	2027

Description of Actions	Completion Date
Complete identification of Health Board sites that have had a fire compartmentation survey, identifying risks and completing action plans.	2024

From above survey complete fire compartmentation surveys as required	2025
Complete actions identified from surveys	2026/27

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

grading the fire alarm systems and fire door protection

Description of Actions	Completion Date
Highlighted through Fire Risk Assesments	
EFAB project for Fire Door Replacement	2025-2027

Description of Actions	Completion Date

uth Wales Fire and Rescue

e

urveying all patient high risk areas to be achieved within the next 3 years. Following that
d and First Floor H Block, wards first plan already submitted for next 5 years with long ter
.

t 2 years

ults, within next 2 years. Compartmentation upgrade (fire doors) within the next 2 years.

e to Fire Risk Assessment findings, or a fire related incident.

this investment will not see completion of this plan.

Responsible Manager	Current Update on Actions
All Fire Officers	Initial FRA's completed, Reviews ongoing.
All Fire Officers	Initial FRA's completed, Reviews ongoing.
All Fire Officers	Initial FRA's completed, Reviews ongoing.

Responsible Manager	Current Update on Actions
SFO	
SFO	
SFO	

Responsible Manager	Current Update on Actions
FO	
SFO	
FO	
FO	
FO	
FO	
FO	
FO	

Responsible Manager	Current Update on Actions
SFO	
SFO	
SFO	Completed.
SFO	Completed.
SFO	Completed.
SFO	
SFO	Completed.
SFO	Completed.
SFO	Completed.
SFO	
SFO	
SFO	

Responsible Manager	Current Update on Actions

Responsible Manager	Current Update on Actions

Responsible Manager	Current Update on Actions

Responsible Manager	Current Update on Actions

all the adjacent, above and below areas in the following 5 years with long term plans of upgrades
m plans of upgrades changing annually

changing annually.

Agenda Item
5.3

Health, Safety & Fire Sub Committee

Overarching Highlight Report - Chief Operating Office

Dyddiad y Cyfarfod / Date of Meeting	24/01/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Gemma Cummings – Business Support Manager- Chief Operating Office
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**
Operational Management Board	27/11/2024	Nothing to note

Acronyms / Glossary of Terms	
COTE	Care of the Elderly
C&VUHB	Cardiff and Vale University Health Board
CTM	Cwm Taf Morgannwg
DSH	Dewi Sant Hospital
DTPS	Diagnostics, Therapies, Pharmacy and Sciences
HGM	Hospital General Manager
ITU	Intensive Care Unit
JCF	Junior Clinical Fellow
MHLD	Mental Health & Learning Disabilities
NPTH	Neath Port Talbot Hospital
O&G	Obstetrics & Gynaecology

OMFS	Oral Maxillofacial Service
OOH	Out of Hours
OPD	Outpatients Department
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
QIA	Quality Impact Assessment
RCT	Rhondda Cynon Taff
RGH	Royal Glamorgan Hospital
SEHS	School Entry Hearing Screening
SLA	Service Level Agreement
STAMP	Strategic Transformation of Acute Medicine Programme
YCC:	Ysbyty Cwm Cynon
YCR	Ysbyty Cwm Rhondda
YGT:	Ysbyty George Thomas

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 Chief Operating Office at its Operational Management Board Meeting in October 2024.

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

2. Purpose of this Meeting

2.1 The purpose of this report is to provide an update to the Health, Safety and Fire Committee and provide assurances of any actions and mitigations against health, safety and fire matters, that has the potential to impact staff, patients and assets. To provide assurance to the committee of any risks escalated to the Organisational Risk Register and consider whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks.

3. Highlight Report

Alert / Escalate	**Health Board Critical Incident due to water ingress in Princes of Wales Hospital (PoW)** Following the Structural Survey report on 9 October 2024 that identified serious concerns with the roof at the Princess of Wales Hospital. A decision was taken through the health board's gold command structure to decant services from the first floor of POWH Phase 1 due to the identified safety concerns.

A comprehensive programme of work has been taking place, at pace, involving the most senior clinical staff in the Health Board, to develop safe plans to move patients. All patients were successfully moved to alternative settings, with each patient being individually clinically assessed before they moved to ensure they were transferred to the most appropriate for their needs. Patients who were well enough to be discharged were transported home, or to another setting in the community that was more suitable for meeting their needs. This has included into care homes or community hospital beds.

The final ward move took place and was completed on 01 November 2024.

Further to this phase 1 works have now been completed and handed back to CTM with plans for ITU to move back week commencing 19/01/25.

Work is underway to start planning for the return of other clinical services, including Neo Natal, Labour ward and ward 12, to the POW site.

Children and Families Care Group drew attention to the following:

Maternity/Neonatal Temporary Closure
Significant activity continues at Prince Charles Hospital and maternal and neonatal safety has been maintained. The planned work has progressed well at POW and the Care Group is now planning the return to POW over the next few weeks.

O&G services at NPTH
Outpatient activity has ceased at NPTH and we have now repatriated the CTM and currently Swansea Bay activity back to POW and Maesteg Hospitals. Agreement awaited on date to change health board flows but likely to be March 2025.

Royal Glamorgan Hospital (RGH)
Loss of the paediatric ward to accommodate adult patients due to PoW roof repairs. Quality Impact Assessments and risk mitigations have been undertaken

Advise	**Facilities** advise the following: **Winter 2024-2025 - Adverse Weather Plan** The winter adverse weather plan is now in operation and Facilities have been supporting all sites with the plan during December and into January. **Essential Changes to Car Parking at RGH** Essential changes to car parking at RGH are being implemented to provide additional capacity for theatres and endoscopy. Additional parking has been provided for staff at Llantrisant Health Park to free up space for patients. **Pest Control (Rodents) Updated Summary:** Significant pest control intervention at PoW, RGH and Glanrhyd sites has reduced rodent activity. Further actions are planned for 2025. **Security Management and Systems**: Upgrades to CCTV and access control systems are planned or in progress across multiple sites **Estate Tree Management** Essential tree surgery to remove diseased trees and manage at-risk trees has been carried out across CTMUHB sites in 2024, with work continuing in 2025. **Planned Care, Care Group** advise the following: Two significant risks have been identified: management of sterile services store for theatres and safely drying and lubricating robotic instrumentation **Diagnostics, Therapies, Pharmacy and Specialities Care Group** advise the following: **Therapies** Bed reconfiguration across RGH/POW means we are working through right sizing our workforce and skill mix. Datix incidents are being submitted for stroke, patients not receiving optimal therapy care due to ward move from POW to RGH. Lack of rehabilitation space remains a significant concern. **Medicines management** Medicines management staff moves complete following POW decant. MM SMT are introducing a suite of metrics to monitor

	impact of staff moves and will review weekly to determine if experiencing reduced quality service. **Radiology** **(Risk ID 5730)** The MRI Pacemaker service has commenced at PCH, and the risk score has been reduced. Radiopharmaceutical provision remains a concern **(Risk ID 5590)** **Pathology** Issues with accreditation and sustainability on PM service at RGH. Extreme fragility in microbiology and biochemistry teams due to vacancies and sickness **Healthcare Science – Datix Risks** No DTPS access to Health Science risks through Datix, and further plans are needed to enable the movement of legacy risk into the DTPS structure
Assure	**<u>Withdrawal of the enforcement Notice at POW:</u>** Following a review of the audit of the fire safety arrangements at the above premises by an authorised inspector on 25 November 2024, the Enforcement Notice, dated 05 April 2019 and numbered EN4/19 now been withdrawn. **<u>Planned Care, Care Group</u>** <u>assure the following:</u> **HSDU** • Returned to full establishment • Negative result from smoke test **<u>Children and Families Care Group</u>** <u>assure the following:</u> <u>Risk Register</u> There is currently one risk risk scoring 'high' with 15 or more.

Risk ID	Description	Score
5763	Lack of special school nurses – unfulfilled SLA	16

Inform	**Facilities** inform of the following: **Materials Recycling World (MRW) National Recycling Awards** Facilities environment waste team have been shortlisted with elite paper Solutions and pulse Plastics for their social value commitments in the current SBRI Welsh Government supported plastic repurposing projects. **Children and Families Care Group** inform of the following: • 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 **Diagnostics, Therapies, Pharmacy and Specialities Care Group** inform of the following: **Pathology High Risk updates** **ID5554, CL3 facility (Microbiology lab) at RGH: Risk reduced to score 15** • Regular audits and safety checks in place. Assurance that fumigation can be undertaken if required and Statement of need submitted to update and repair. At present the department has done all it can to continue use as safely as possible. A bid has been submitted to Welsh Government and this has been identified as a priority scheme for this year and scoping work has taken place and a design consultant is being progressed. **ID3567, Cellular pathology lab space constraining any further cell path work being brought back to CTM. Risk score 20 but with mitigations 16** • Workflows and controls in place but there is no further space to undertake additional work now that breast sampling has been brought in house from SBU since 1st April. No further mitigations are available without consideration of additional space. Options Paper has been discussed and CTM team are reassessing what a temporary facility could deliver on RGH site. With impending SLA repatriation this is becoming more urgent. **ID5276, Risk of LIMS 2.0 delivery by Summer of 2025** • This remains a high organisational risk at a score of 20. Internal issues have improved now that IT posts have

	been recruited but there are still ongoing delays to the programme and user acceptance testing(UAT) has commenced but due to a large proportion of functionality not being available is generating a significant amount of work and leading to a new risk being identified as below. **New Risk ID5299** • Pathology wide Laboratory Resource constraints to support validation and implementation of LIMS 2.0. **RISK Score of 15. Mitigating actions are being considered.** **New Risk ID 5792 score of 20 at present** • Demand for Haematology care is outstripping funded capacity. Escalated in the last week due to consultant sickness and recent cessation of high-cost agency doctor. Currently a shortfall in new patient capacity due to job planning issues and short notice but medium to long term sickness has warranted use of an agency locum to hold the position from further deterioration. This has been approved by COO and Medical Director whilst longer term plans are worked on. **Updated Risk ID 3410 score 15** • Microbiology Staffing levels are critical (3 staff leaving) meaning all 9 benches in RGH are at risk of not being staffed impacting on test turnaround. Urgent conversation is underway with PHW to see if they can support. PCH and POW continue as PHW run hot labs. • 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.
Appendices	None identified.

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 Globally Responsible 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:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language**	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: The report is an overarching report and

Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	any equality and Welsh language requirements will be considered by the care group responsible.
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)*	Yes (Include further detail below)	
	Some areas of the report do require resource, E.g. pest control activity and CCTV, this will be considered and escalated in accordance with financial procedure as required, and the necessary consideration of funding with the appropriate officers/budget holder. POW roof replacement will have not been forecast into existing budget, however, Executives have escalated and reported costs incurred to WG, and approval has been sought for the repairs including other areas of work to bring the roof and identified areas to the required standards, including Fire compliance.	

5. Recommendation

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

Agenda Item
5.3.1

Health, Safety & Fire Sub Committee

Primary Care & Community Care Group - Health, Safety & Fire Highlight Report

Dyddiad y Cyfarfod / Date of Meeting	24/01/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Gemma Cummings – Business Support Manager- Chief Operating Office
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**
Operational Management Board	30/10/2024	Nothing to note

Acronyms / Glossary of Terms	
POW	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
YCR	Ysbwty Cwm Rhondda
YCC	Ysbwty Cwm Cynon
YGT	Ysbwty George Thomas

DSH	Dewi Sant Hospital
OOH	Out of Hours
OPD	Outpatients Department
JCF	Junior Clinical Fellow
COTE	Care of The Elderly
RCT	Rhondda Cynon Taff
C&VUHB	Cardiff & Vale University Health Board
CTM	Cwm Taf Morgannwg
MHLD	Mental Health & Learning Disabilities
NPTH	Neath Port talbot Hospital
O&G	Obstetrics & Gynaecology
SLA	Service Level Agreement
QIA	Quality Impact Assessment
HGM	Hospital General Manager
STAMP	Strategic Transformation of Acute Medicine Programme
DTPS	Diagnostics, Therapies, Pharmacy and Sciences
SEHS	School Entry Hearing Screening
ITU	Intensive Care Unit
OMFS	Oral Maxillofacial Service

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 Chief Operating Office at its Operational Management Board Meeting in October 2024.

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

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2.1 The purpose of this report is to provide an update to the Health, Safety and Fire Committee and provide assurances of any actions and mitigations against health, safety and fire matters, that has the potential to impact staff, patients and assets. To provide assurance to the committee of any risks escalated to the Organisational Risk Register and consider whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks.

3. Highlight Report

Alert / Escalate	**Primary & Community Care Group** **Drainage Problem in YCC** A drainage issue has been reported in YCC which has led to some Out Patient Clinics having to be relocated. An approved contractor was commissioned to undertake a jet clean of the internal drain runs, followed by a CCTV Survey of all the runs, they then produced a report on the condition of the drains highlighting those needing immediate attention. A number of those have been identified for action and the work is scheduled to start on the 7th January 2025. **Critical Incident due to Water Ingress at the POW site – impact for PCC** Alternative accommodation needs to be found for the Vaccination and Immunisation Service delivering from YGT since the additional 2 wards (Fernhill and Dinas) have been opened. An option has been identified and will be finalised by the end of January 2025 in order to facilitate the reinstatement of the dining room on site.
Advise	**<u>Primary & Community Care</u>** **Hazards Health Protection Service** • Final planning stages of the Mpox vaccination for the OOH on-call rota. Vaccination (in hours and OOH) will at present be on site at Dewi Sant Health Park. • The Maternal RSV programme is now embedded and the CVC's are successfully seeing daily (small) numbers of pregnant ladies coming through for vaccination. Mop up sessions for children's flu has also been taking place over weekend to support the need to increase uptake rates

Assure	**<u>Primary Care & Community Care Group</u>** The Care Group continues to receive Fire Risk Assessments for sites under its responsibility, which includes community facilities and also primary care buildings where head leases are in place. Actions are identified and appropriate monitoring is undertaken in the Care Groups Health, Safety and Estates meetings.
Inform	**<u>Primary & Community Care Group</u>** **Use of Masks** Following the communication within the Health Board with regard to the use of masks in clinical areas, all independent practices have also been advised to follow the same precaution to limit the risk of Covid and Flue this winter.
Appendices	

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 *<u>150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)</u>*	A Globally Responsible 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:
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: The report is an overarching report and any equality and Welsh language requirements will be considered by the care group responsible.
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)*	Yes (Include further detail below)	
	Some areas of the report do require resource, E.g. pest control activity and CCTV, this will be considered and escalated in accordance with financial procedure as required, and the necessary consideration of funding with	

	the appropriate officers/budget holder. POW roof replacement will have not been forecast into existing budget, however, Executives have escalated and reported costs incurred to WG, and approval has been sought for the repairs including other areas of work to bring the roof and identified areas to the required standards, including Fire compliance.

5. Recommendation

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

Agenda Item

Health, Safety & Fire Sub Committee

Highlight Report from the Mental Health & Learning Disabilities Care Group

Dyddiad y Cyfarfod / Date of Meeting	24/01/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Business Sensitive
Awdur yr Adroddiad / Report Author	Aaron Jones Directorate Manager Older Adult Mental Health
Cyflwynydd yr Adroddiad / Report Presenter	TBC
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 and Capital Care Group Meeting	12/11/2024	Directorate Operational Managers presented their reports for discussion

Acronyms / Glossary of Terms	
AU	Assessment Unit
FRA	Fire Risk Assessment
MCP	Manual Call Panel
MH&LD	Mental Health & Learning Disabilities
POWH	Princess of Wales Hospital
RCTCBC	Rhondda Cynon Taf County Borough Council
RGH	Royal Glamorgan Hospital
SMT	Senior Management Team

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

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	**CAMHS Ty Llidiard Security Doors (Fob Access):** • Challenges with internal door security continue, and Estates is actively seeking a timely response from the contractor regarding repair requests for the main doors on Enfys Ward. Additional doors, including those in the sports hall and admin wing, are also impacted. The existing system is outdated, making parts difficult to source, and an immediate solution has not yet been identified. The operational management team is considering alternative options, and a risk management plan has been implemented in areas with door failures. Estates continues to engage with contractors to source the necessary parts, and external airlocks remain unaffected.
Advise	**Door Issues** • The care group is currently addressing multiple door failures and other wider estates challenges. To ensure thorough oversight, an internal process has been implemented to systematically collate, document, and escalate estates-related risks. Due to delays in door replacements, interim risk management measures include increased environmental checks and, where necessary, the deployment of additional staff to support enhanced engagement and observation. • Improvement works on anti-ligature doors in Ty Llidiard are scheduled to begin on 18th November 2024, to be conducted by Safe Hinge. This upgrade will ensure that the doors meet the required specifications, supporting the establishment of an SLA to prevent future issues. **Smoking Policy Implementation** • In line with government legislation, mental health inpatient settings became smoke-free on 1st October 2024. This represents a transition from the prior approach, where smoking was being managed in designated areas with measures in place to manage and reduce smoking-related incidents.

- Despite the policy shift, incidents of patients smoking, or vaping have continued, particularly during adverse weather when patients gather in sheltered areas.
- Recent incidents on Ward 21 and the Assessment Unit (AU) involved patients refusing to surrender vaping devices, and similar issues in the PICU underscore the need for clear communication with both patients and staff regarding smoking and vaping regulations.
- To support adherence to the smoke-free policy, the Operational Teams at the Mental Health Unit, Royal Glamorgan Hospital, are installing a tannoy system outside the main entrance. This system can be activated by reception staff to remind patients and visitors that it is a non-smoking area.

Fire Safety

- As outlined in the Fire Safety Report presented to the MH&LD Care Group Health, Safety, Fire & Capital Group, the following fire activations/false alarms were recorded for the reporting period 7th August 2024 to 7th November 2024:X1 RGH Mental Health Unit – Smoking Related
  - **RGH Mental Health Unit:** 1 activation related to smoking.
  - **POW Ward 14/PICU:** 3 activations caused by steam in the bathroom.
  - **Glanrhyd Angleton Clinic:** 2 activations due to an aerosol and MCP fault (now repaired).
- Since the reintroduction of a smoke-free policy within MH&LD as of 1st October 2024, fire activations will be closely monitored. Additional mitigation measures will be implemented if there is an observed increase in smoking-related activations.

Security & Violence

- For the period 1st April 2024 to 31st October 2024, a total of 218 incidents categorised as Violence and Aggression (V&A) were reported on Datix.
  - In the most recent reporting month (October 2024), 24 V&A incidents were recorded, marking the lowest monthly total for the 2024/25 financial year to date.
  - Across the 10 sub-categories of incidents, no specific trends were identified that would necessitate targeted intervention.
- The Care Group will continue to monitor V&A incidents closely through local governance forums, ensuring appropriate escalation where necessary.

Assure	**Fire Safety** • All outstanding Fire Risk Assessment actions are regularly reviewed, tracked, and escalated as necessary through the Care Group and Directorate governance structures. • Two recent Fire Risk Assessments were conducted on Seren and St David's Wards at RGH. No actions were identified for either ward, with the recommendation to "Continue to Manage" in line with the audit findings. **Risk Management** • All identified risks are being reviewed and updated as necessary, with escalated risks highlighted for further consideration. • Due to current limitations in Datix configuration, not all managers have access to their respective risks. The Head of Nursing has been working with the corporate Datix team to address this issue. While an initial target date of 1st October was set for reconfiguration, progress has been delayed due to national-level data migration challenges. ○ This matter has been escalated to the Assistant Director of Nursing for Quality and Safety for resolution.
Inform	**Fire Safety Update** • No fire enforcement notices have been issued, and no outstanding actions remain. • All Mental Health areas have up-to-date fire risk assessments, with no further assessments currently scheduled. **Health & Safety – Ty Llidiard** • Due to ongoing contractor works across the POW site, a risk assessment has been implemented restricting young people from grounds leave unless accompanied by staff. • Where appropriate, off-site outings are being facilitated to ensure young people can safely access outdoor activities.
Appendices	

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 /	Not Applicable
	If more than one applies please list below:

Link to CTMUHB Strategic Areas	
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*	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:

Impact Assessment Screening?		
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
6.1

Health, Safety & Fire Sub Committee

HEALTH, SAFETY AND FIRE PERFORMANCE REPORT

Dyddiad y Cyfarfod / Date of Meeting	24/01/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Chris Beadle – Assistant Director for Health, Safety and Fire
Cyflwynydd yr Adroddiad / Report Presenter	Chris Beadle – Assistant Director for Health, Safety and Fire
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**
Health and Safety Coordinators Group	18/09/2024	Discussion and Noted

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 The purpose of this report is to inform the Health, Safety & Fire Sub Committee of the main issues identified from the current Health, Safety and Fire Dashboard for the recent period 1st July 2024 to 30th September 2024. As a result of changes to the Dashboard, the data is now provided on a month by month basis. The Dashboard is attached as Appendix 1.

2. Specific Matters for Consideration

1.2 The Health Safety and Fire Team have been developing a matrix containing information on health and safety incidents, risk assessments, training compliance and personal injury claims to aid the Health Board to understand and make changes where non-compliance is identified or standards need improving. The attached spreadsheet contains quarterly information on the following areas:

- Non-Patient Safety Incidents
- Manual Handling Incidents
- Violence and Aggression Incidents
- Number of RIDDOR Reports
- Risk Assessments
- Personal Injury Claims
- Training Compliance (information from Electronic Staff Records)

This information is provided from live Dashboards in the Health Board's Risk Management System (Datix) and Electronic Staff Record to allow Wards, Directorates, Care Groups and the Board to have consistent and comparable data. Due to major changes in the new Datix Cymru coding structure compared to the Health Board's previous coding structure, the granularity of information in the Dashboard is far less than previously reported. Work is underway within the Health Board's Datix Team to address this shortfall as well as Nationally by the Welsh Risk Pool.

3. Key Risks / Matters for Escalation

3.1 The data is captured from the Incident, Risk and Claims Modules from the Health Boards Risk Management System (Datix) as well as the Electronic Staff Record and analysed by the Health, Safety and Fire Team. Any issues identified from the data are investigated to support better compliance or improvement.

3.2 The information captured is from the newly installed Datix Cymru system (a recently implemented All Wales Datix System) and is in its early stages of development. Information from the Dashboard is being used to populate the Organisational Health, Safety and Fire Action Plan where improvement or assurance is required. As with the Dashboard, the action plan will also

mature in time. Detailed below are some headline issues from this quarters Dashboard.

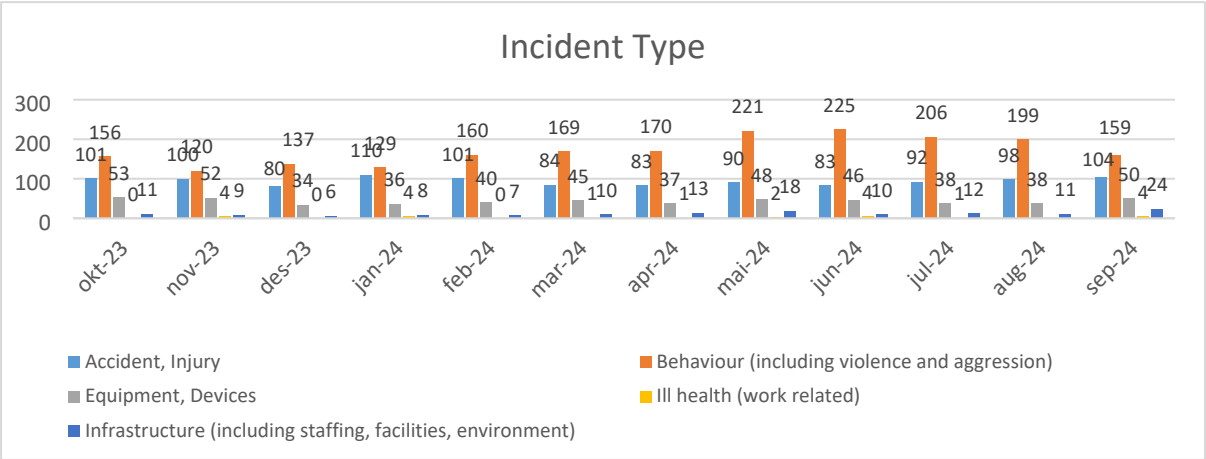
3.2.1 Non Patient Safety Incidents

Highlights from the high-level data confirms that there is a reduction with the category 'Personal Incident - Personal injury attributed to clinically related challenging behaviour of patient.' This previously has been the Health Board's highest reported incident but since the introduction of the new system has reduced in number. It appears that staff are now reporting this pervious category as Aggressive/Threaten Behaviour instead, but work continues with Service Groups for them to understand the appropriate reporting codes.

Aggressive/Threatening Behaviour incidents remain the highest reported on the system over the last 12 months. Although the numbers have fluctuated significantly month on month.

The incident type of Accident/Injury is still causing some issues with confusion for reporters and work is underway with the Datix Cymru to review the whole coding structure within the system. A task and finish group has been set up by the Welsh Risk Pool with Health Boards/Trusts which meets on a monthly basis to address these coding issues. A meeting took place on the 18th November where the Category Accident/Injury has been removed and more appropriate codes added to replace it.

Listed in the chart below are the current top 5 incidents reported in the Datix system's Type Category in the Health Board:



Breakdown of Manual Handling Incidents

Incidents by Sub Subtype and Incident date (Financial quarter)	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	24/25 Q1	24/25 Q2	24/25 Q3	Total
Bed mobility patient/service user	3	3	2	1	0	2	1	12
Bending +/or twisting	1	3	1	2	4	1	1	13
Carrying/supporting a load	1	2	1	1	2	1	1	9
Hoisting patient/service user	5	3	1	1	3	2	1	16
Injured during a manual handling manoeuvre	6	8	10	5	6	5	5	45
Injured whilst being moved with manual handling equipment	1	2	1	1	1	1	0	7
Lifting/lowering a load	3	0	4	1	3	2	0	13
Management of the falling patient/service user	3	2	0	2	2	1	3	13
Manual handling aid / equipment required but unavailable	4	5	11	7	2	3	1	33
Other	10	6	8	6	4	7	2	43
Pushing/pulling a load	1	0	0	2	3	3	0	9
Reaching +/or stretching	0	1	0	1	0	0	0	2
Sitting/standing/walking patient/service user	2	2	2	0	3	1	1	11
Toileting patient/service user	3	2	0	0	0	0	0	5
Using manual handling equipment	2	0	1	0	0	0	0	3
Total	45	39	42	30	33	29	16	234

Breakdown of Violent Incidents

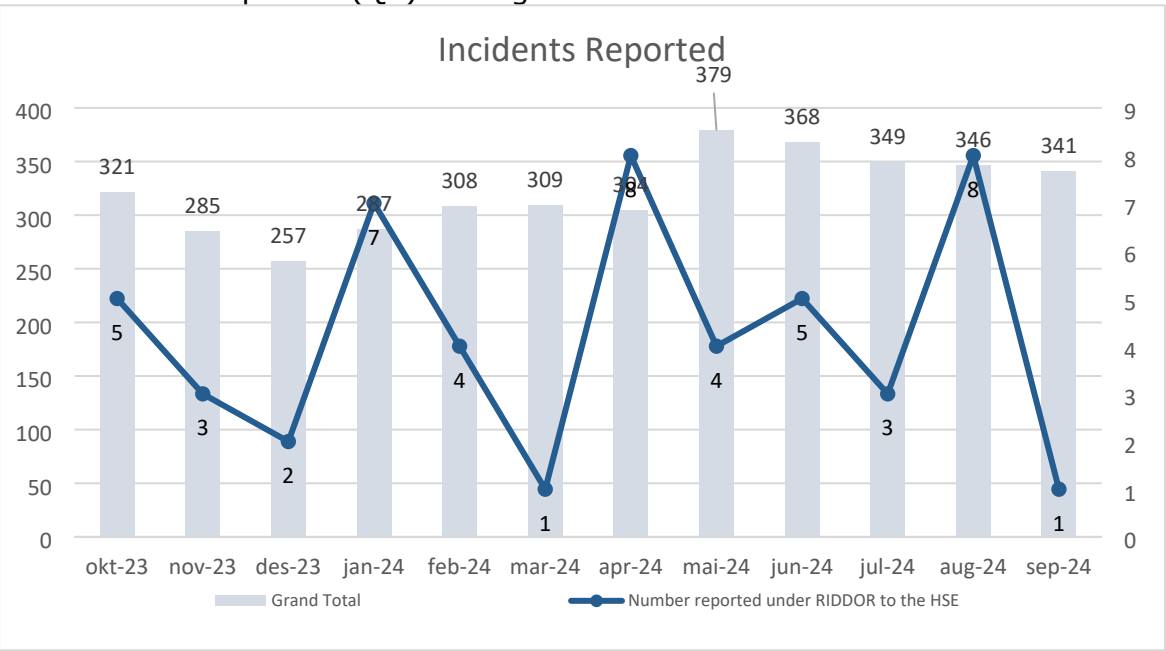
During July 2024 – September 2024, 14% of the incidents reported can be classified as non-gratuitous and can be attributed to the patient's medical or physical condition. Further analysis reveals that 48% of the physical assaults reported can be attributed as non-gratuitous. This may be a reporting issue where staff are not reporting incidents within the correct category. In order to address this issue reporting guidance has been issued to all clinical areas.

The vast majority of violent incidents reported within are in the following areas:

- Mental Health inpatient services,
- Accident and Emergency Departments,
- Medical and Surgical wards,
- Children`s Mental Health Services (CAMHS)
- Community Hospitals

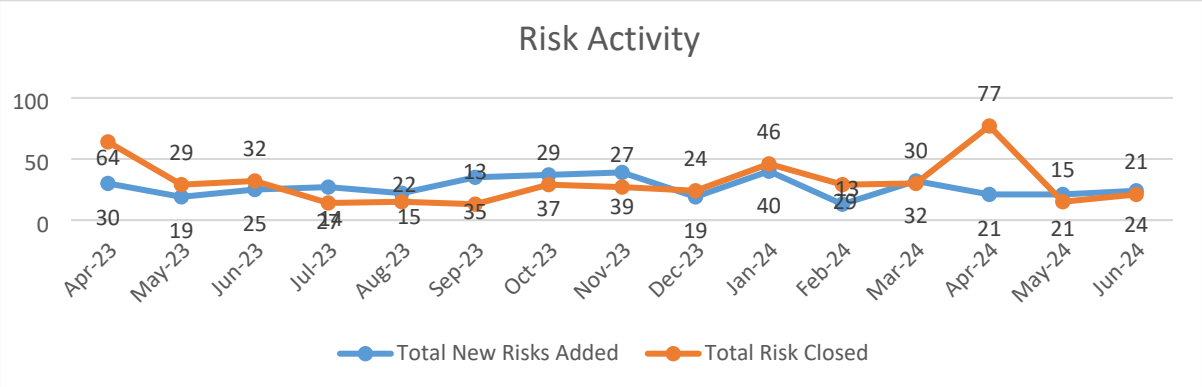
3.2.2 **Number of RIDDOR Reports**

In relation to the Health Board's responsibilities to report certain accident/incidents to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), there was a slight fluctuation in the numbers reported in quarter 1 comparable to the preceding 4 quarters. For Quarter 2, the figures are now more in line with other quarters. Slip, Trip and Fall incidents and Manual Handling incidents remain the highest cause reported. 1.32% of reported incidents throughout the year resulted in a RIDDOR submission to the HSE. For the current quarter (Q2) this figure is 1.12%.

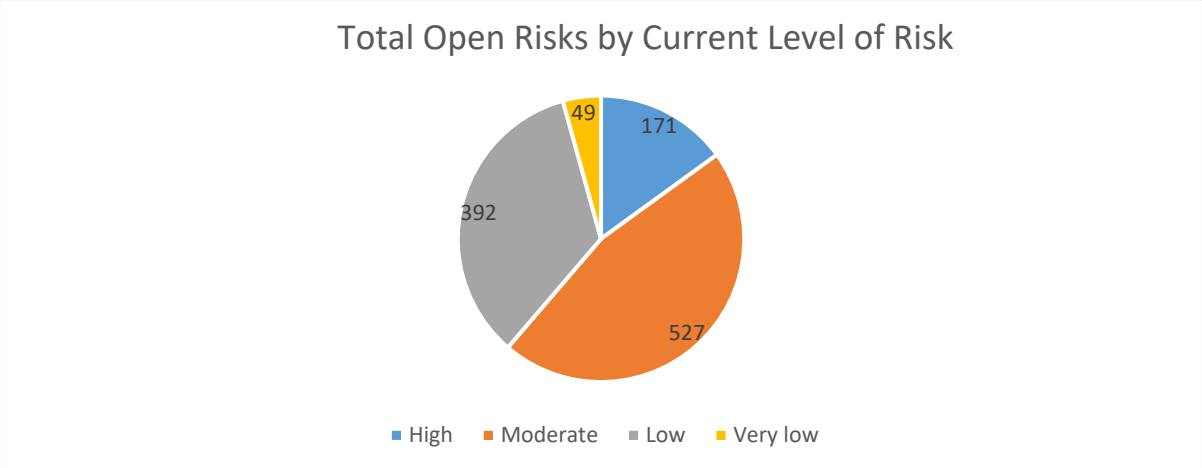


3.2.4 **Risk Assessments**

The information presented in the Dashboard attached presents the number of new risks that have been entered on the Health Board system (Datix) over the past year. The data is a snapshot in time and is constantly changing. Amendments have been made recently to the Risk functionality on the system to allow better reporting going forward. Each current risk is in the process of being updated with the new information which will allow the Health Board further information on the profile of these risks. Like incidents, this data is now presented in line with the Health Board's New Operating Model.



There are 1317 open risks as at 13.11.24. Of these, 525 are overdue for review. 14 have no Care or Service Group allocated.

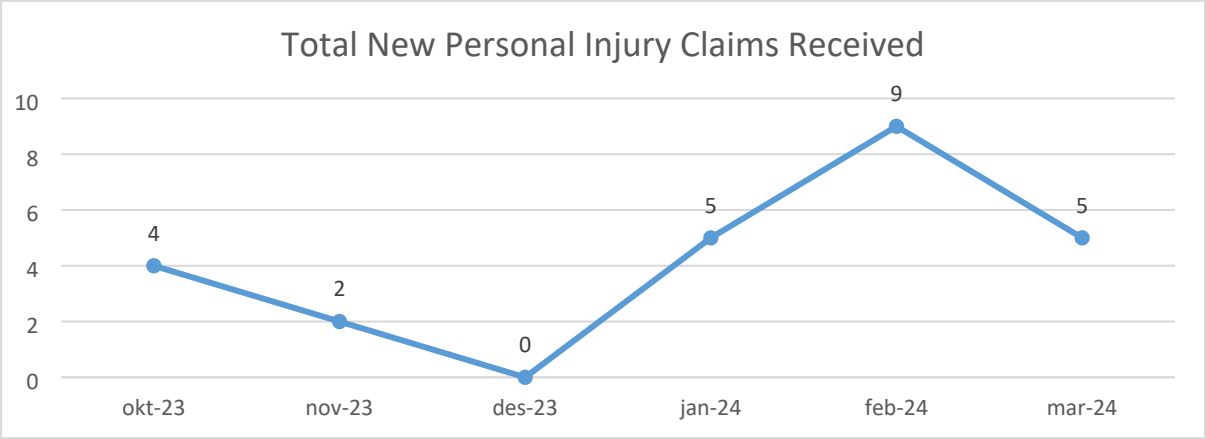


Total Open Risks by Care Group	Awaiting Review	Risk Approved	Total
Corporate Function / Operations	57	564	621
Diagnositcs, Therapies and Specialist Care	18	135	153
Families and Children	12	45	57
Mental Health	15	48	63
Planned Care	48	117	165
Primary & Community	9	35	44
Unscheduled Care	51	103	154
Total	210	1047	1257

More detailed information on these risks is provided in the accompanying Performance Dashboard (Appendix 1).

3.2.5 **PI Claims**

Total Number of Personal Injury Claims as at 11.11.24 is 130. Robust detail in relation to current stage and incident classification is currently not available.



26 Claims were closed during the 12 month period 01.10.23 to 30.09.24. 13 of which have triggered a learning from events report following a decision to settle.

Below is the current list of claims that have been categorised.

Classification of Open Personal Injury Claims	
Accident, Injury	106
Assessment, Investigation, Diagnosis	6
Behaviour (including violence and aggression)	4
Consent, Mental Capacity Act (including DoLS)	1
Equipment, Devices	1
Ill health (work related)	5
Infection Prevention and Control	1
Information Governance, Confidentiality	1
Patient/service user death	1
Records, Information	1
Treatment, Procedure	3
Total	130

Further detail is unable to be provided at the current time due to incomplete information and system functionality in some areas. Work will be undertaken to address the gaps in data and system functionality issues will be escalated to the National Team.

3.2.5 **Health and Safety Training Delivery**

The Health, Safety and Fire Team have been working closely with the Health Board's Learning and Development Team to review all staff health, safety and fire competencies required for their posts and this information has been uploaded to their Electronic Staff Record (ESR).

Each subject matter expert within the Health, Safety and Fire Team are working with the Care Groups and Learning and Development Team to support improvement in these areas. Items being considered range from establishing different means to deliver training, to more robust local competency assessments to prevent the requirement for unnecessary repeated training.

Attached as Appendix 2 is the current compliance levels across the Health Board for Health, Safety & Fire Training at the various competency levels i.e. Health and Safety, Fire Safety, Manual Handling and Violence and Aggression.

Health, Safety and Welfare Training – whilst the overall compliance with all levels of this training sits at 74.05%, it should be noted that compliance with level 1 is currently at 84.70%. Work is ongoing with the development

of an interactive e-learning package for level 2. Monthly Face to Face Managing Safely Training has been scheduled for 2024.

Fire Safety Training – overall compliance with all levels of training for this competency currently stands at 65.02%. For level 1 training, compliance is currently 79.03%. Fire Management Training resumed in February 2024 and will also be accompanied by an e-learning package. Take up of this training has been very positive and is reflected in the Fire Safety Report attached to this meeting's agenda.

Moving and Handling Training – overall compliance for all levels of this training is currently 65.02%. Whilst compliance with level 1 of this training is at 83.00% it should be noted that patient handling training which includes the practical training in the use of all patient handling equipment is currently very poor. A combination of lack of training resource and non-attendance at these courses has seen the significant reduction in compliance. This figure is expected to rise over the coming 3 years following the approval of a business case to provide more training staff to deliver this training.

Violence and Aggression – overall compliance with all levels of this training is currently 71.07%. Compliance with level 1 is currently 80.11%, although improvement to the higher risk areas and breakaway training is required. The Health Board's Personal Safety Adviser has been working closely with the Mental Health Care Group to address this and additional training has now been agreed to make up this shortfall. The training programme for this competency relies on staff from the Mental Health Care Group to release trainers to support the training programme. Their release has been problematic in the past and without this commitment, improvement will be hard to be achieved.

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	Not Applicable
	If more than one applies please list below:

150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	
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 on Topics
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 on Topics
Cyfreithiol / Legal	Yes (Include further detail below)	
	Civil or Criminal sanctions	
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 and Fire Sub Committee are asked to NOTE the Health and Safety Performance Report.

6. Next Steps

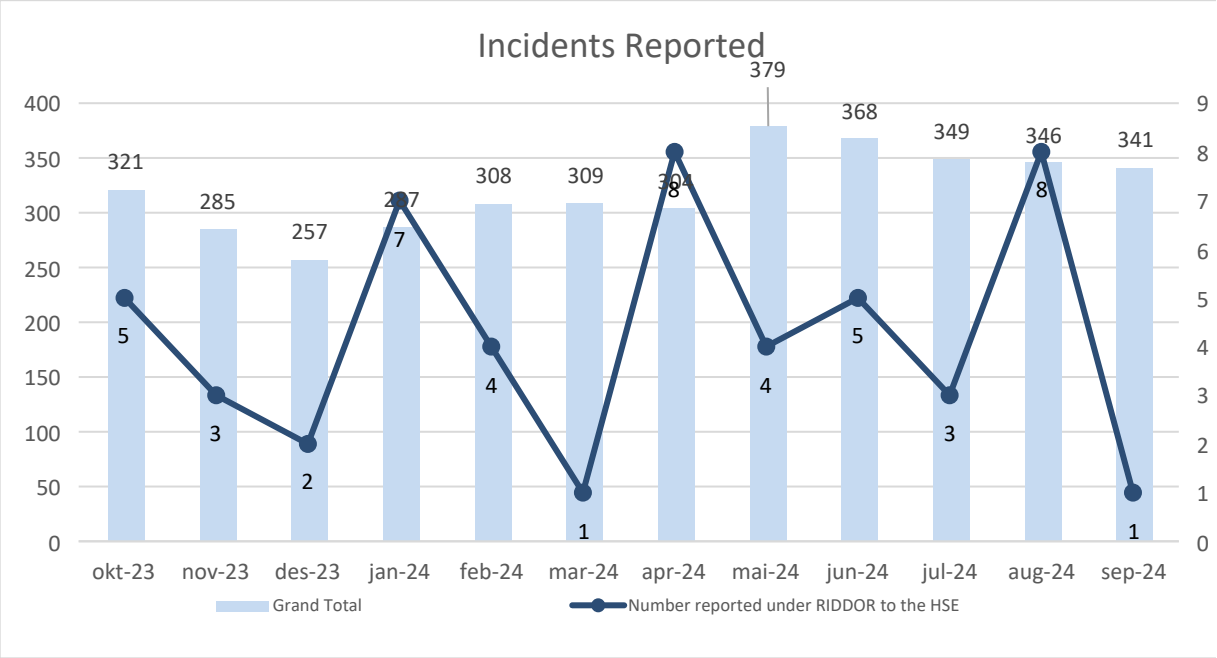
6.1 More work is to be undertaken locally and nationally to improve the quality and granulation of the information contained within the Health Board's Risk Management System (Datix Cymru). The report highlights these areas for improvement going forwards.

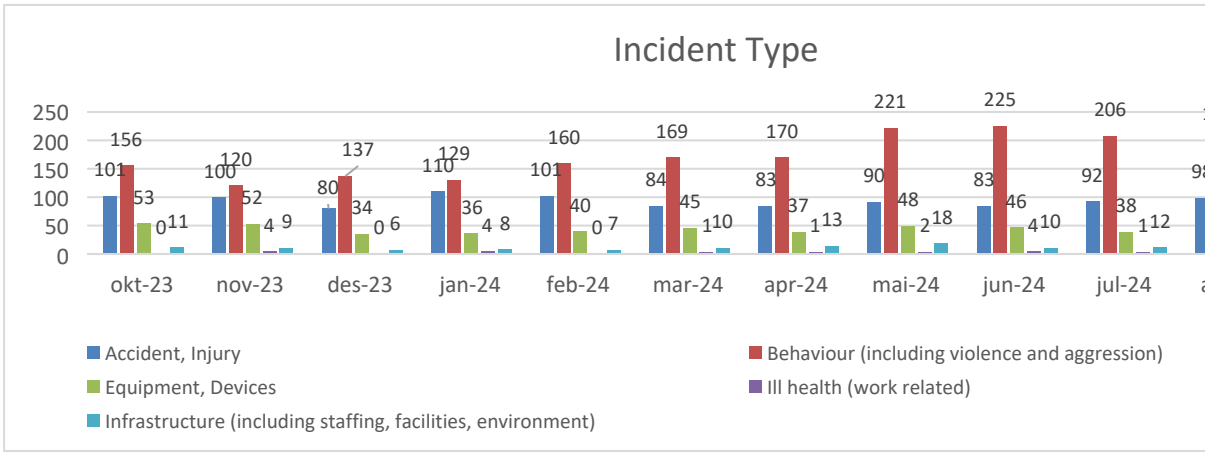
Person Affected	okt-23	nov-23	des-23	jan-24
Organisation	27	24	14	28
Patient/Service User	163	156	139	135
Public/Visitor	4	6	3	5
Staff/Contractor	127	99	101	119
Grand Total	321	285	257	287
Of the total number of incidents reported,				
Number reported under RIDDOR to the HSE	5	3	2	7
% of incidents reported as RIDDOR	1,56	1,05	0,78	2,44
Incident Classification	**okt-23**	**nov-23**	**des-23**	**jan-24**
Accident, Injury	101	100	80	110
Behaviour (including violence and aggression)	156	120	137	129
Equipment, Devices	53	52	34	36
Ill health (work related)	0	4	0	4
Infrastructure (including staffing, facilities, environment)	11	9	6	8
Grand Total	321	285	257	287
Incident Category	**okt-23**	**nov-23**	**des-23**	**jan-24**
Grand Total	321	285	257	287
Aggressive/threatening behaviour	68	45	62	56
Restrictive practices	28	14	15	14
Patient injury	39	48	34	44
Physical assault (physical contact)	19	16	25	23
Inappropriate behaviour / attitude	18	27	26	19
Medical devices	29	27	18	14
Non-medical equipment	19	17	13	19
Contact with needles or medical sharps	17	14	10	20
Patient clinically challenging behaviour	6	4	0	3
Environmental hazards / issues	7	8	5	5
Slip, trip or fall	11	9	4	11
Contact with object or animal	6	7	6	12
Anti social behaviour	1	5	3	8
Manual Handling - Patient/service user handling	7	12	6	6
Verbal assault (swearing etc.)	8	4	2	2
Struck against or by an object	6	5	3	8
Burns or scalds	6	3	9	4
Manual Handling - Non patient/service user handling	3	1	3	2
Smoking	3	0	0	3
Choking	0	0	0	1
Contact with or exposure to hazardous substance	3	3	6	3
Fire safety	2	0	0	2
Ill health	0	4	0	3
Verbal assault (racial abuse)	1	0	1	0
Clinical waste disposal	1	0	0	0
Temperature levels	0	0	0	0
Manual Handling - Equipment	5	5	1	2
Road traffic collision	1	1	1	0
Entrapment / Drawn in	1	0	0	0
Clinical waste disposal - Sharps	0	0	1	1
Indecent exposure	0	1	0	0

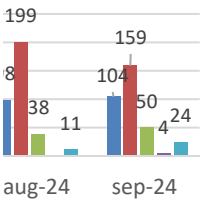
Verbal assault (gender/sexual orientation)	0	0	0	0
Sexual (inappropriate) behaviour	3	3	0	0
Musculoskeletal disorder (MSD)	0	0	0	1
Inappropriate use of social media	0	1	1	0
Sexual assault	0	0	2	0
Harassment	1	0	0	1
Contact or exposure to electricity (electric shock)	1	0	0	0
Noise Level	0	0	0	0
Traffic Management	1	1	0	0
Equipment Safety	0	0	0	0
Protest	0	0	0	0
Other	0	0	0	0
Care / Sevice Group	**okt-23**	**nov-23**	**des-23**	**jan-24**
Community	28	30	22	21
Corporate Services	1	2	1	0
Diagnostics, Therapies & Specialist Care	15	14	10	18
Emergency Ambulance Services Committee	1	0	0	0
Facilities	11	8	9	5
Facilities Hub	8	2	2	4
Families & Children	28	18	7	28
Finance	0	1	0	1
Health, Safety & Fire	0	0	0	0
Mental Health	94	70	83	75
Patient Care & Safety	1	3	1	1
Pharmacy & Medicines Management	2	3	1	3
Planned Care (Surgery)	44	39	42	41
Planning & Partnerships	8	3	4	4
Primary Care	0	1	0	0
Primary Care - Bridgend	0	7	1	1
Primary Care - Merthyr & Cynon	1	3	0	0
Primary Care - Prison Service	2	1	0	3
Primary Care - Rhondda & Taff	2	3	1	1
Research and Development	0	0	0	0
Unscheduled Care (Medicine)	70	71	72	81
Welsh Health Specialised Services Committee	0	1	0	0
Workforce & Organisational Development	2	2	0	0
Not Reported at Care Group Level	3	3	1	0
Grand Total	321	285	257	287

feb-24	mar-24	apr-24	mai-24	jun-24	jul-24	aug-24	sep-24	Grand Total
22	21	18	23	34	25	24	34	294
145	161	160	202	208	193	188	158	2008
8	6	4	3	3	5	3	5	55
133	121	122	151	123	126	131	144	1497
308	309	304	379	368	349	346	341	3854
								0
4	1	8	4	5	3	8	1	51
1,30	0,32	2,63	1,06	1,36	0,86	2,31	0,29	1,32
feb-24	mar-24	apr-24	mai-24	jun-24	jul-24	aug-24	sep-24	Grand Total
101	84	83	90	83	92	98	104	1126
160	169	170	221	225	206	199	159	2051
40	45	37	48	46	38	38	50	517
0	1	1	2	4	1		4	21
7	10	13	18	10	12	11	24	139
308	309	304	379	368	349	346	341	3854
feb-24	mar-24	apr-24	mai-24	jun-24	jul-24	aug-24	sep-24	Grand Total
308	309	304	379	368	349	346	341	3854
58	61	65	63	74	74	74	46	746
44	35	39	47	76	55	52	33	452
33	36	29	37	27	42	39	27	435
26	33	29	36	18	22	27	15	289
22	27	22	31	19	13	17	18	259
14	23	19	26	22	22	26	21	261
22	19	14	20	22	15	12	24	216
17	10	10	15	13	8	17	15	166
1	2	2	21	11	23	13	27	113
2	5	12	9	6	9	5	22	95
20	15	6	10	10	10	8	9	123
10	4	7	8	11	7	7	12	97
7	1	3	6	13	7	4	4	62
5	3	8	6	5	3	4	10	75
0	6	5	4	9	4	6	5	55
5	6	8	7	2	10	8	11	79
5	3	4	2	7	5	8	11	67
3	2	8	0	4	1	5	3	35
0	0	2	7	1	2	2	0	20
0	0	4	1	2	0	0	1	9
2	1	1	3	2	3	2	6	35
2	1	0	5	1	3	4	0	20
0	0	1	2	3	1	0	4	18
0	1	0	3	1	2	0	2	11
0	2	0	1	2	0	0	1	7
0	0	0	2	1	0	1	1	5
3	2	1	1	0	1	0	2	23
0	2	1	0	1	1	0	2	10
2	1	0	2	0	2	0	0	8
2	2	1	1	0	0	1	0	9
1	2	0	1	1	0	0	3	9

0	0	0	1	1	0	0	0	2
1	0	1	0	0	1	2	2	13
0	1	0	0	1	0	0	0	3
0	0	1	0	0	0	0	0	3
0	0	0	0	1	0	1	0	4
0	1	0	0	0	2	1	4	10
0	2	0	0	0	0	0	0	3
1	0	0	0	0	0	0	0	1
0	0	0	0	0	0	0	0	2
0	0	0	0	0	0	0	0	0
0	0	0	0	0	1	0	0	1
0	0	1	1	1	0	0	0	3
feb-24	**mar-24**	**apr-24**	**mai-24**	**jun-24**	**jul-24**	**aug-24**	**sep-24**	**Grand Total**
20	23	23	24	34	30	22	32	309
0	0	1	1	1	1	0	1	9
11	7	11	11	10	9	7	17	140
1	1	0	0	0	1	0	0	4
6	10	4	9	10	9	16	10	107
2	2	1	5	6	5	1	1	39
24	19	24	14	22	24	19	21	248
1	0	0	1	1	0	1	0	6
0	0	0	0	1	1	1	2	5
86	88	83	113	138	125	125	82	1162
0	3	1	1	4	0	3	1	19
3	1	1	5	0	1	1	0	21
31	41	37	45	39	42	38	50	489
5	6	3	7	5	2	2	8	57
1	3	1	0	1	0	1	0	8
1	0	1	0	0	1	0	0	12
1	1	0	3	1	0	1	1	12
4	6	5	10	7	3	4	4	49
2	2	4	1	2	0	1	1	20
0	0	0	0	0	0	0	0	0
98	92	103	117	80	92	98	105	1079
3	1	0	8	0	0	1	1	15
1	0	0	1	3	1	1	2	13
7	3	1	3	3	2	3	2	31
308	309	304	379	368	349	346	341	3854


Incidents Reported
400
350
300
250
200
150
100
50
0
9
8
7
6
5
4
3
2
1
0
321
285
257
308
309
379
368
349
346
341
5
3
2
4
1
4
5
3
1
okt-23
nov-23
des-23
jan-24
feb-24
mar-24
apr-24
mai-24
jun-24
jul-24
aug-24
sep-24
Grand Total
Number reported under RIDDOR to the HSE


Incident Type
250
200
150
100
50
0
okt-23
nov-23
des-23
jan-24
feb-24
mar-24
apr-24
mai-24
jun-24
jul-24
Accident, Injury
Behaviour (including violence and aggression)
Equipment, Devices
Ill health (work related)
Infrastructure (including staffing, facilities, environment)


199
159
104
38
50
11
4
24
aug-24
sep-24

Incident Category	apr-23	mai-23	jun-23	jul-23	aug-23	sep-23
Aggressive/threatening behaviour	56	65	67	56	71	39
Restrictive practices	23	18	13	6	9	18
Patient injury	49	30	36	40	27	50
Physical assault (physical contact)	22	36	22	15	23	14
Inappropriate behaviour / attitude	42	24	25	17	19	29
Medical devices	19	27	25	26	27	17
Non-medical equipment	11	17	12	19	8	29
Contact with needles or medical sharps	17	13	16	16	10	19
Patient clinically challenging behaviour	3	6	9	10	17	9
Environmental hazards / issues	2	6	4	5	5	7
Top Ten Total	244	242	229	210	216	231
Total Number	310	323	304	277	285	284
Top 10 % of Total Incidents	78,71	74,92	75,33	75,81	75,79	81,34

okt-23	nov-23	des-23	jan-24	feb-24	mar-24	apr-24	mai-24	jun-24
68	45	62	56	58	61	65	63	74
28	14	15	14	44	35	39	47	76
39	48	34	44	33	36	29	37	27
19	16	25	23	26	33	29	36	18
18	27	26	19	22	27	22	31	19
29	27	18	14	14	23	19	26	22
19	17	13	19	22	19	14	20	22
17	14	10	20	17	10	10	15	13
6	4	0	3	1	2	2	21	11
7	8	5	5	2	5	12	9	6
250	220	208	217	239	251	241	305	288
321	285	257	287	308	309	304	379	368
77,88	77,19	80,93	75,61	77,60	81,23	79,28	80,47	78,26

jul-24	aug-24	sep-24
74	74	46
55	52	33
42	39	27
22	27	15
13	17	18
22	26	21
15	12	24
8	17	15
23	13	27
9	5	22
283	282	248
349	346	341
81,09	81,50	72,73

New Risks Opened

	Apr-23	May-23	Jun-23
Organisational risk	12	4	9
Locality risk	1	2	1
Service Group risk	9	6	3
Specialty risk	3	3	6
Sub specialty risk	0	2	0
Site risk	0	1	1
Ward/Department risk	5	1	5
Total	30	19	25

New Risks Opened where Care Group has been assigned

	Apr-23	May-23	Jun-23
Corporate Function / Operations	1	0	4
Diagnositcs, Therapies and Specialist Care	10	4	5
Families and Children	1	3	4
Mental Health	0	0	1
Planned Care	0	3	2
Primary & Community	8	2	3
Unscheduled Care	0	2	0
Care Group not allocated	10	5	6
Total	30	19	25

Open Risks @ 13.11.24

Total Open Risks	Awaiting Review	Risk Approved	Total
Corporate Function / Operations	57	564	621
Diagnositcs, Therapies and Specialist Care	18	135	153
Families and Children	12	45	57
Mental Health	15	48	63
Planned Care	48	117	165
Primary & Community	9	35	44
Unscheduled Care	51	103	154
Total	210	1047	1257

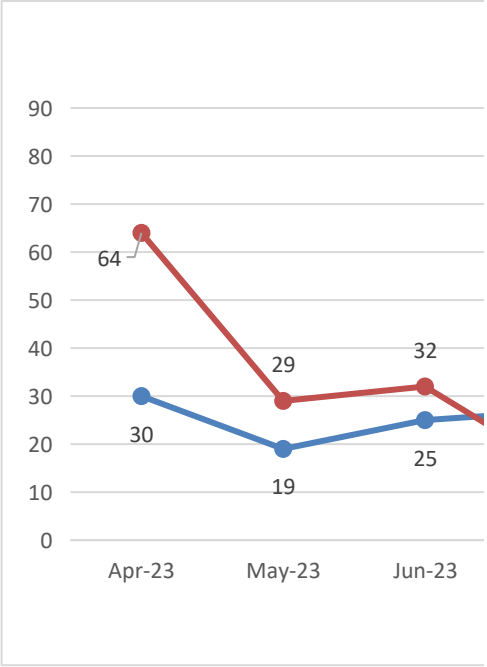
Overdue Risks	Awaiting Review	Risk Approved	Total
Corporate Function / Operations	31	213	244
Diagnositcs, Therapies and Specialist Care	1	34	35
Families and Children	2	26	28
Mental Health	3	29	32
Planned Care	8	62	70
Primary & Community	1	21	22
Unscheduled Care	6	74	80
Total	52	459	511

Open Risks by Current level of risk

NB 178 Risks do not contain current level of risk

	Awaiting Review	Risk Approved	Total
High	17	154	171
Moderate	43	484	527
Low	9	383	392
Very low	2	47	49
Total	71	1068	1139

	Apr-23	May-23	Jun-23
Total New Risks Added	30	19	25
Total Risk Closed	64	29	32



Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
4	3	4	4	10	3
0	0	0	0	1	0
11	9	10	11	14	10
0	4	2	9	4	3
0	0	7	0	1	0
2	0	9	0	0	0
10	6	3	13	9	3
27	22	35	37	39	19

Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
1	2	1	2	4	0
12	5	3	5	4	3
4	2	3	14	7	2
1	0	0	1	1	3
1	4	12	9	12	0
0	4	12	2	3	3
5	4	1	1	4	6
3	1	3	3	4	2
27	22	35	37	39	19

Total open risks: 1317

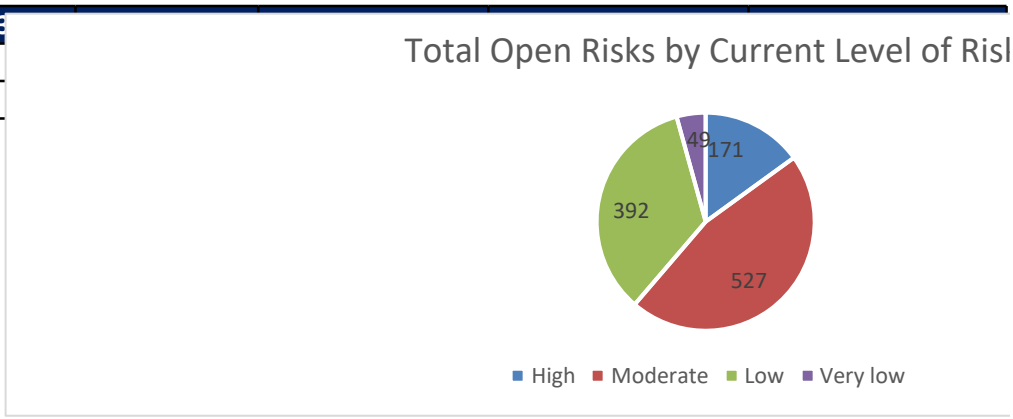
Please note: The overall number of risks awaiting review is 249 - therefore 39 have no care or se

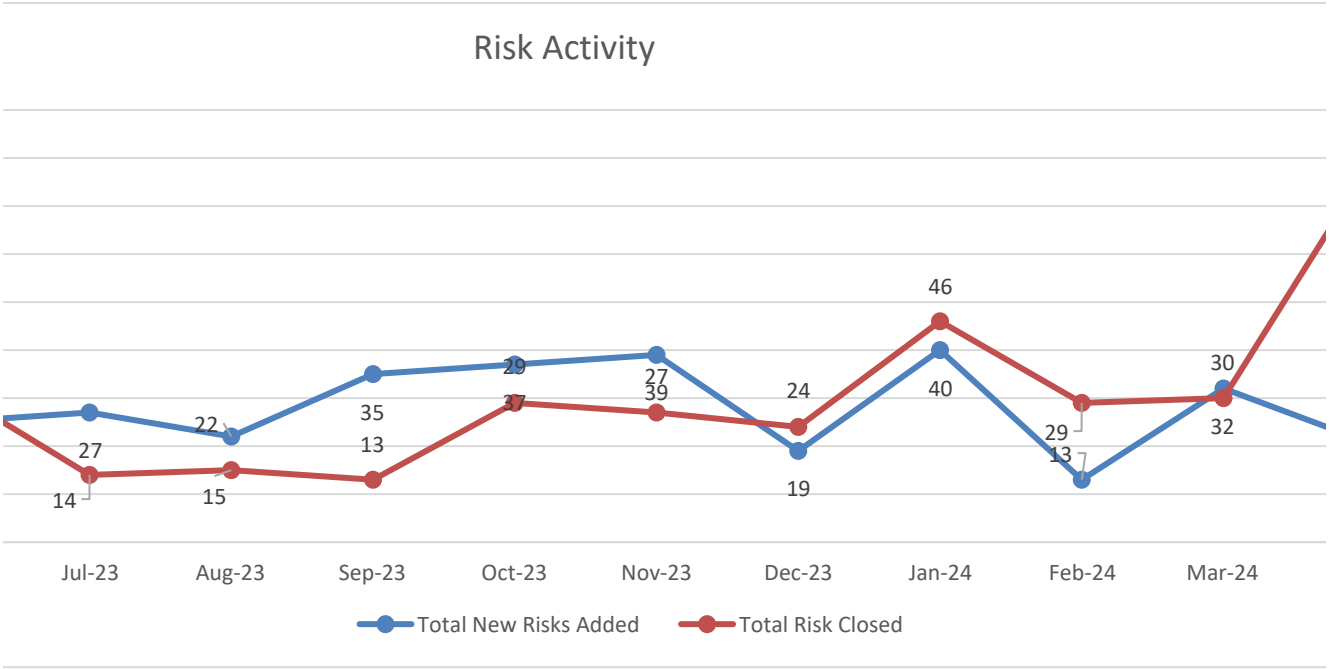
Please note: The overall number of approved risks is 1068 - therefore 21 have no care or service

% of risks overdue for review
39,29
22,88
49,12
50,79
42,42
50,00
51,95
40,65

There are 1317 open risks as at 13.11.24. Of these, 525 are ov

Jul-23	Aug-23
27	22
14	15





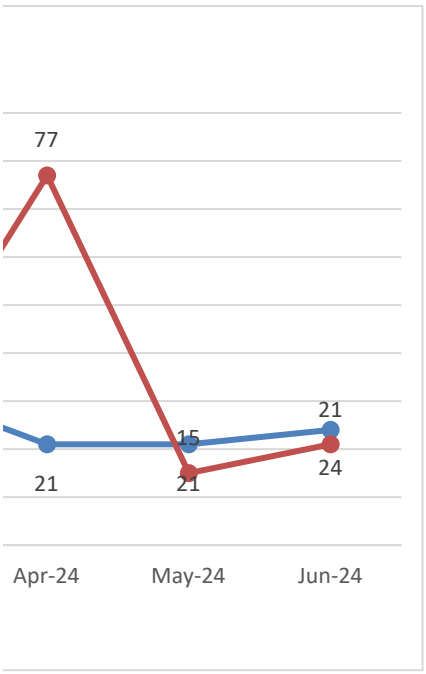
Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
15	1	12	5	4	4	8
0	0	0	1	1	0	0
13	1	13	8	4	4	4
0	5	2	2	7	3	8
1	0	0	0	1	1	6
2	0	0	0	0	4	6
9	6	5	5	4	8	10
40	13	32	21	21	24	42

Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
13	1	3	3	3	8	8
7	4	10	2	9	2	4
5	1	3	4	2	5	0
1	2	2	2	0	4	1
5	1	2	1	3	1	13
6	1	0	5	0	1	2
1	3	9	1	2	1	7
2	0	3	3	2	2	7
40	13	32	21	21	24	42

ervice group allocated
e group allocated

verdue for review.14 have no Care or Service Group allocated.

	Mar-24	Apr-24	May-24	Jun-24	
	32	21	21	24	42
k	30	77	15	21	29



Aug-24	Sep-24	Total
18	14	134
0	0	7
16	10	156
2	4	67
0	0	19
2	3	30
9	14	125
47	45	538

Aug-24	Sep-24	Total
4	7	65
12	6	107
3	4	67
4	6	29
6	6	81
3	3	58
1	6	54
14	7	77
47	45	538

		Total
47	45	538
15	23	532

New Claims Received

	okt-23	nov-23	des-23	jan-24	feb-24
Total New Personal Injury Claims Received	4	2	0	5	9

Care Group Information is not available for 8 cases

Care Group	okt-23	nov-23	des-23	jan-24	feb-24
Community	0	0	0	0	0
Corporate Services	0	0	0	0	0
Diagnostics, Therapies & Specialist Care	0	0	0	2	1
Facilities	1	1	0	1	2
Facilities Hub	1	0	0	0	2
Mental Health	0	0	0	1	0
Planned Care (Surgery)	0	1	0	0	1
Planning & Partnerships	0	0	0	0	0
Unscheduled Care (Medicine)	1	0	0	1	0
Families and Children	1	0	0	0	0
Care Group Not assigned	0	0	0	0	3
Total	4	2	0	5	9

New Claims Received by Incident Type

	okt-23	nov-23	des-23	jan-24	feb-24
Accident, Injury	3	2	0	3	7
Assessment, Investigation, Diagnosis	0	0	0	0	0
Behaviour (including violence and aggression)	0	0	0	0	0
Equipment, Devices	0	0	0	0	0
Ill health (work related)	0	0	0	2	1
Treatment, Procedure	1	0	0	0	1
Total	4	2	0	5	9

Total Number of Personal Injury Claims as at 11.11.24 is 130. Robust detail in relation to current stage and

Classification of Open Personal Injury Claims	
Accident, Injury	106
Assessment, Investigation, Diagnosis	6
Behaviour (including violence and aggression)	4
Consent, Mental Capacity Act (including DoLS)	1
Equipment, Devices	1
Ill health (work related)	5
Infection Prevention and Control	1
Information Governance, Confidentiality	1
Patient/service user death	1
Records, Information	1
Treatment, Procedure	3
Total	130

26 Claims were closed during the 12 month period 01.10.23 to 30.09.24. 13 of which have triggered a lear
Further detail is unable to be provided at the current time due to incomplete information and system fun
Work will be undertaken to address the gaps in data and system functionality issues will be escalated to t

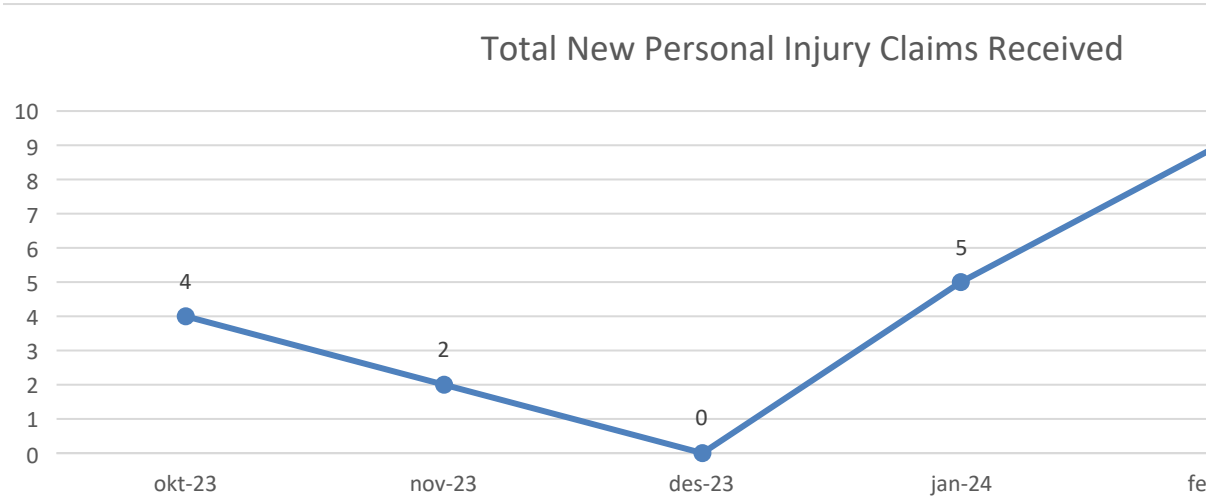
mar-24	apr-24	mai-24	jun-24	jul-24	aug-24	sep-24	Total
5	3	0	1	2	1	0	32

mar-24	apr-24	mai-24	jun-24	jul-24	aug-24	sep-24	Total
0	1	0	0	0	0	0	1
0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	3
2	2	0	1	0	0	0	10
0	0	0	0	1	0	0	4
1	0	0	0	0	0	0	2
0	0	0	0	0	0	0	2
0	0	0	0	0	1	0	1
1	0	0	0	0	0	0	3
0	0	0	0	1	0	0	2
1	0	0	0	0	0	0	4
5	3	0	1	2	1	0	32

mar-24	apr-24	mai-24	jun-24	jul-24	aug-24	sep-24	Total
4	3	0	0	2	1	0	25
0	0	0	0	0	0	0	0
1	0	0	0	0	0	0	1
0	0	0	0	0	0	0	0
0	0	0	1	0	0	0	4
0	0	0	0	0	0	0	2
5	3	0	1	2	1	0	32

d incident classification is currently not available.

rning from events report following a decision to settle.
ıctionality in some areas.
:he National Team.


Total New Personal Injury Claims Received
10
9
8
7
6
5
4
3
2
1
0
4
2
0
5
okt-23
nov-23
des-23
jan-24
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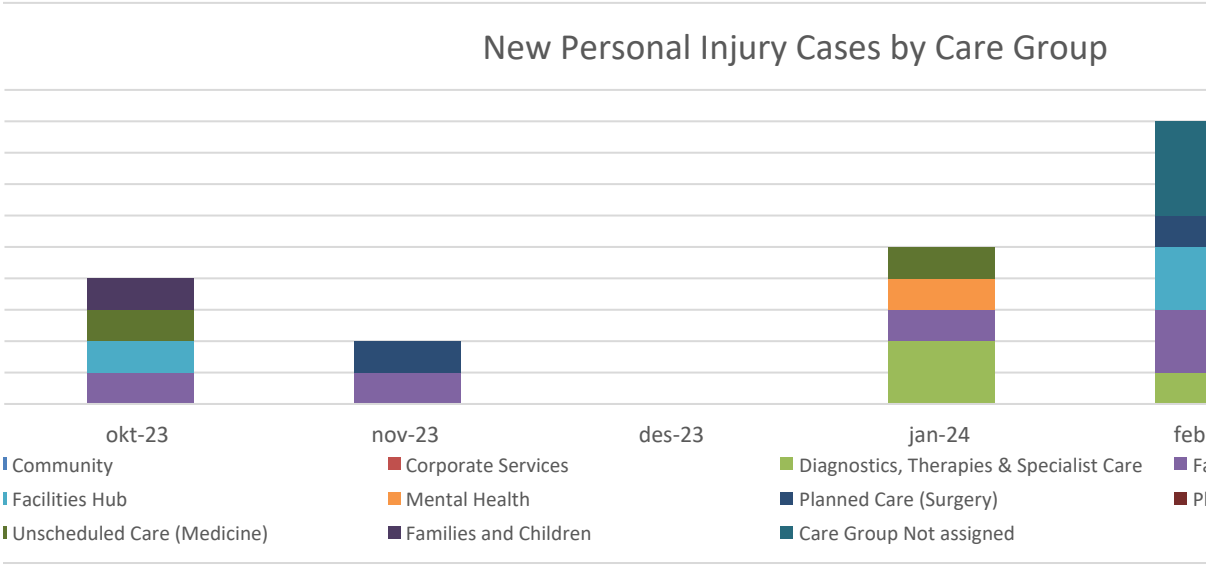
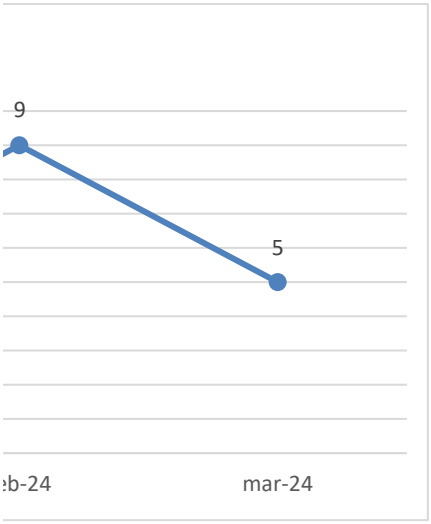

New Personal Injury Cases by Care Group
okt-23
nov-23
des-23
jan-24
feb
Community
Corporate Services
Diagnostics, Therapies & Specialist Care
Facilities Hub
Mental Health
Planned Care (Surgery)
Unscheduled Care (Medicine)
Families and Children
Care Group Not assigned


9
5
eb-24
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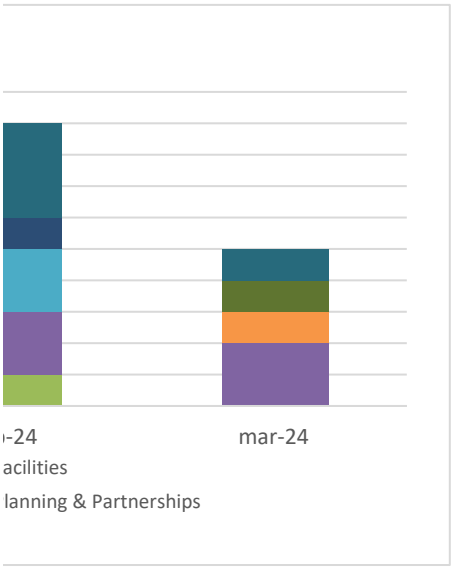

ı-24
mar-24
acilities
lanning & Partnerships

DYSGU CRAIDD
CORE LEARNING
Cwm Taf Morgannwg

CORE LEARNING UPDATE

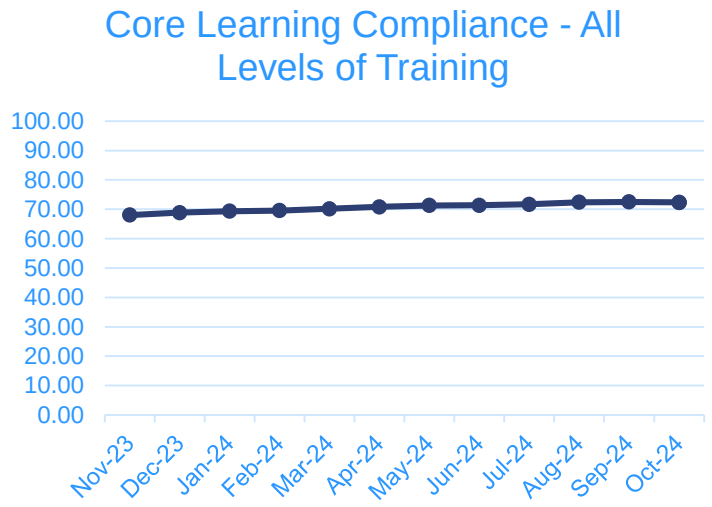
Compliance data as at 2.10.24

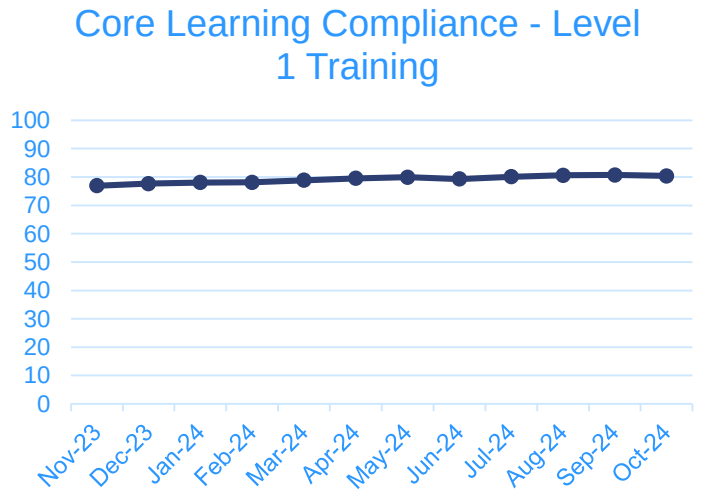
DYSGU CRAIDD
CORE LEARNING
Cwm Taf Morgannwg

CSTF Subjects

Health Board Compliance

Overall Health Board compliance for all levels of training currently sits at **72.33%**. This is **-0.19%** on the previous month and **+4.27%** year on year. Compliance for level 1 currently sits at **80.39%**. This is **-0.34%** on the previous month and **+3.45%** year on year.





Subjects Overview

* Subject Compliance Reports available *here*.

Combined Core Mandatory (all levels):

Subject	Current	MoM	YoY
Equality, Diversity & Human Rights	83.38	-0.70	-0.91
Fire Training	65.02	0.32	2.71
Health, Safety & Welfare	74.05	0.10	3.62
Infection Prevention & Control	75.83	-0.83	4.25
Information Governance	82.44	-0.47	6.45
Moving & Handling	65.02	-0.44	3.35
Resuscitation	63.05	-0.67	11.76
Safeguarding Adults	76.04	0.37	5.78
Safeguarding Children	84.88	-0.21	2.81
Violence & Aggression	71.07	-0.07	3.92

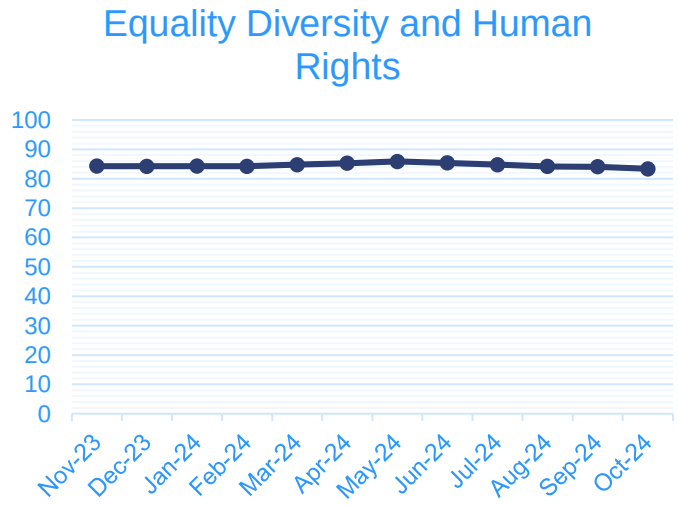
Level 1 Core Mandatory:

Subject	Current	MoM	YoY
Equality, Diversity & Human Rights	83.38	-0.70	-0.91
Fire Training	79.03	-0.36	4.39
Health, Safety & Welfare	84.70	-0.01	2.25
Infection Prevention & Control	75.83	-0.83	0.76
Information Governance	82.44	-0.47	6.45
Moving & Handling	83.00	-0.09	0.35
Resuscitation	66.53	-0.40	11.15
Safeguarding Adults	83.73	-0.42	1.98
Safeguarding Children	84.88	-0.21	2.81
Violence & Aggression	80.11	-0.09	4.54

Level 1 Compliance for Safeguarding Children is the highest at **84.88%** followed closely by Health, Safety and Welfare at **84.70%** and Safeguarding Adults at **83.73%**. All subjects (apart from Resuscitation) are now above 76%. Focus across the HB needs to be provided to improve Resuscitation Training which is at **66.53%**.

Equality, Diversity and Human Rights

There is only one level of training within Equality, Diversity and Human Rights



Compliance for all levels of training is currently **83.38%** which is **-0.70%** on the previous month and **-1.62%** on the 85% target.

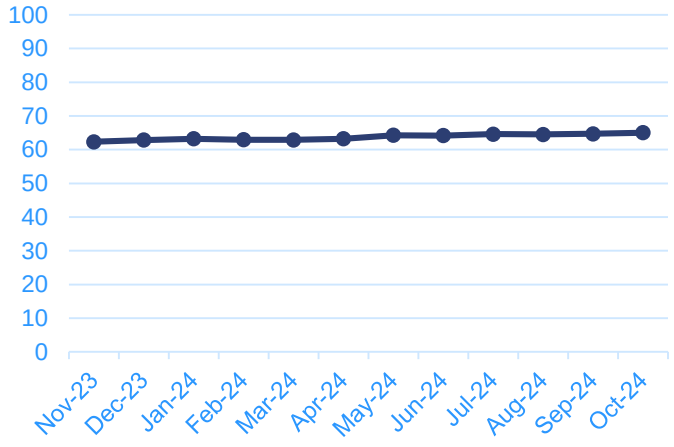
Level 1 Compliance across Wales as at 31.7.24

CTM is currently 12th from an All Wales perspective

Fire Safety

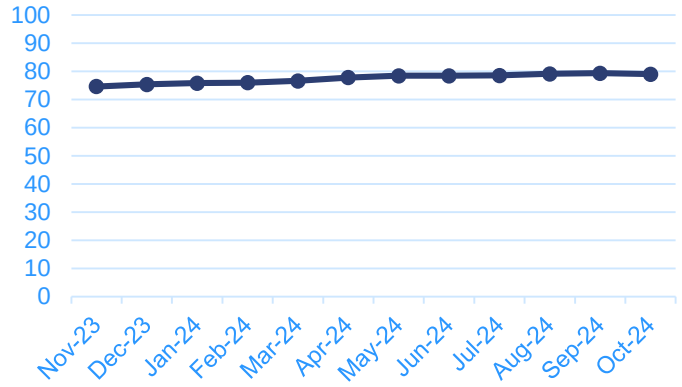
There are 5 levels of training within Fire Safety

Fire Training



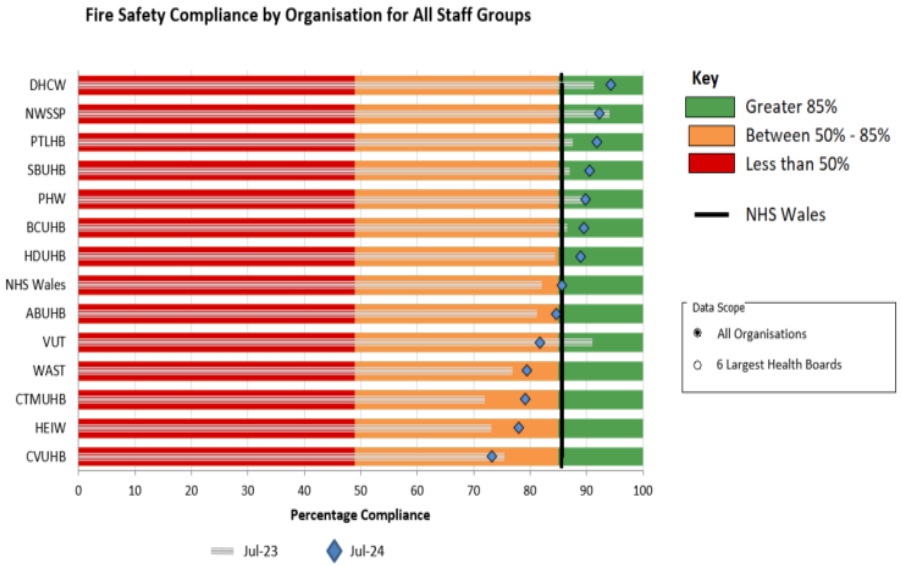
Compliance for all levels of training is currently **65.02%** which is **+0.32%** on the previous month and **-19.98%** on the 85% target.

Fire Safety - Level 1 Only



Compliance for Level 1 training is currently **79.03%** which is **-0.36%** on the previous month and **-5.97%** on the 85% target.

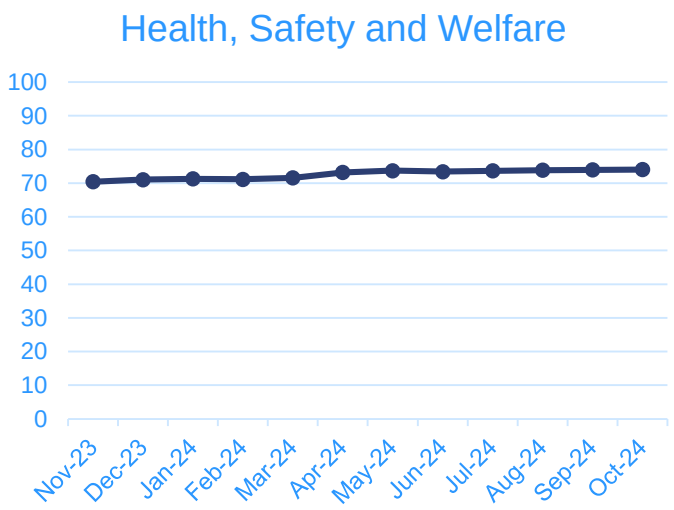
Level 1 Compliance across Wales as at 31.7.24



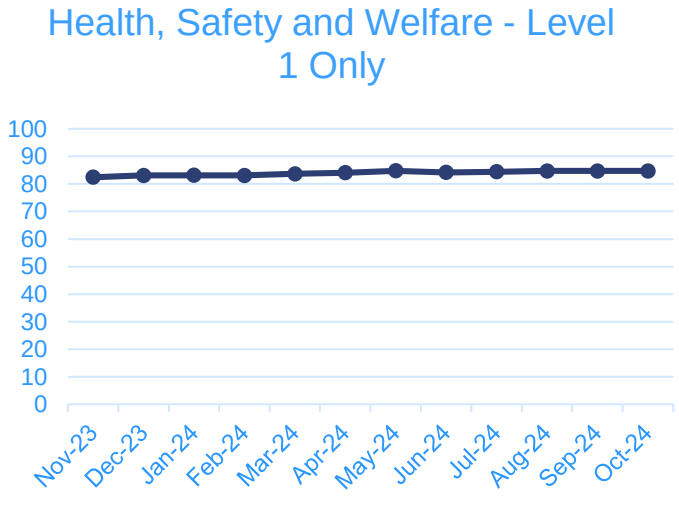
CTM is currently 11th from an All Wales perspective

Health, Safety and Welfare

There are 4 levels of training within Health, Safety and Welfare

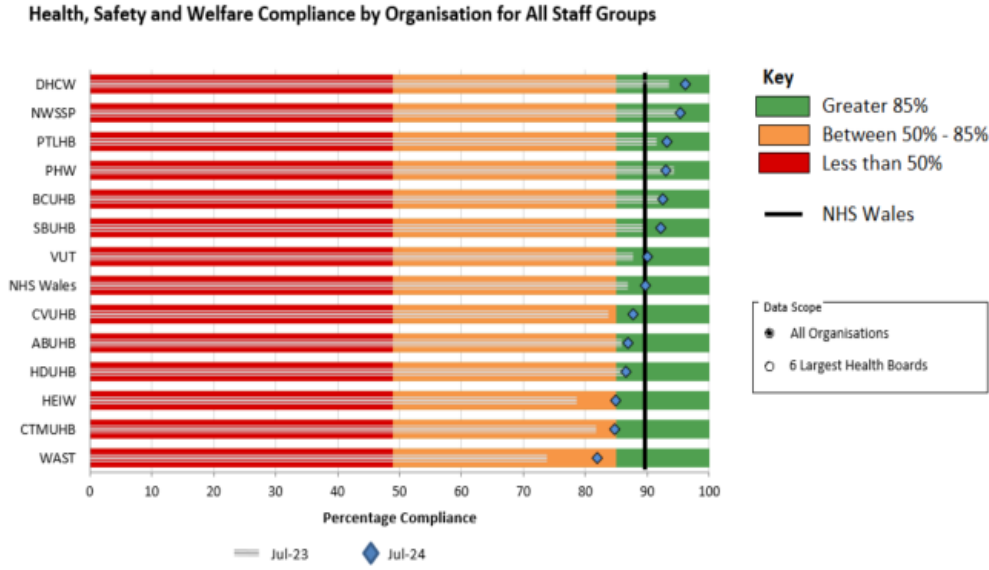


Compliance for all levels of training is currently **74.05%** which is **+0.10%** on the previous month and -**10.95%** on the 85% target.



Compliance for Level 1 training is currently **84.70%** which is **-0.01%** on the previous month and **-0.30%** on the 85% target.

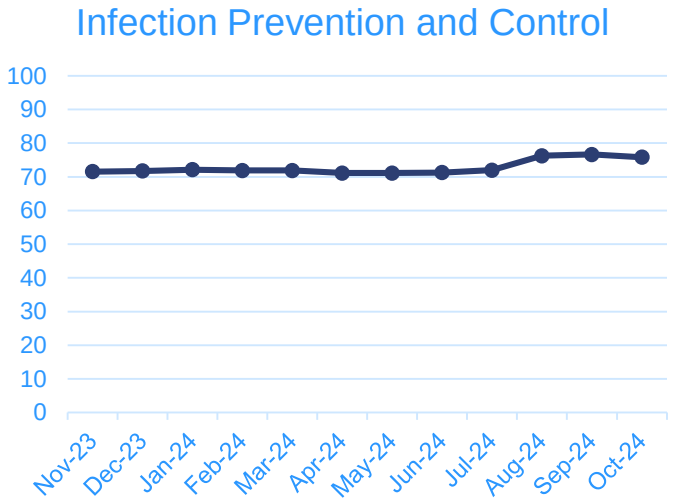
Level 1 Compliance across Wales as at 31.7.24



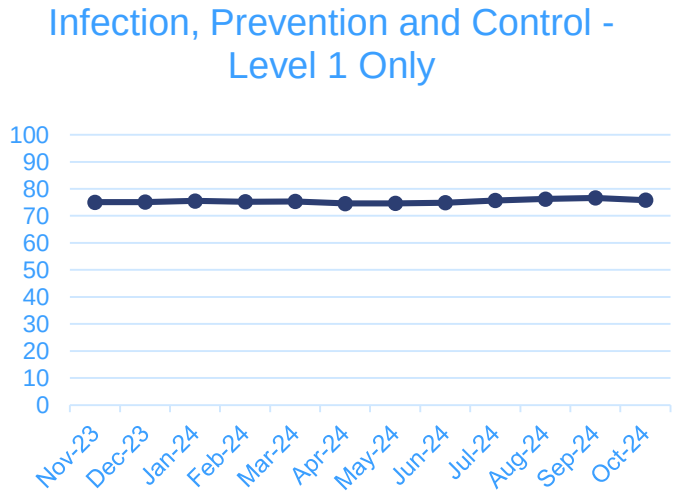
CTM is currently 12^{h} from an All Wales perspective

Infection, Prevention and Control

There are 3 levels of training within Infection, Prevention and Control

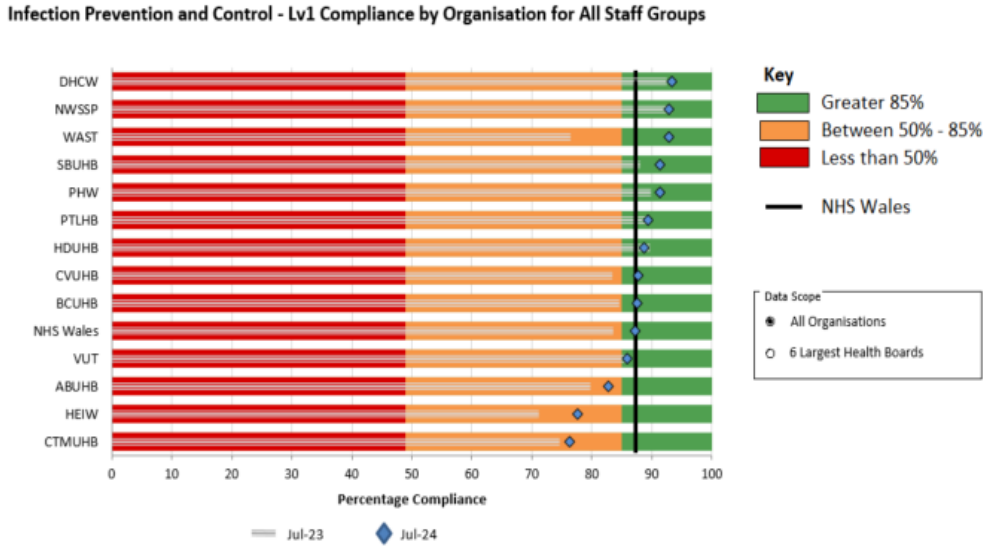


Compliance for all levels of training is currently **75.83%** which is **-0.83%** on the previous month and **-9.17%** on the 85% target.



Compliance for Level 1 training is currently **75.83%** which is **-0.83%** on the previous month and **-9.17%** on the 85% target.

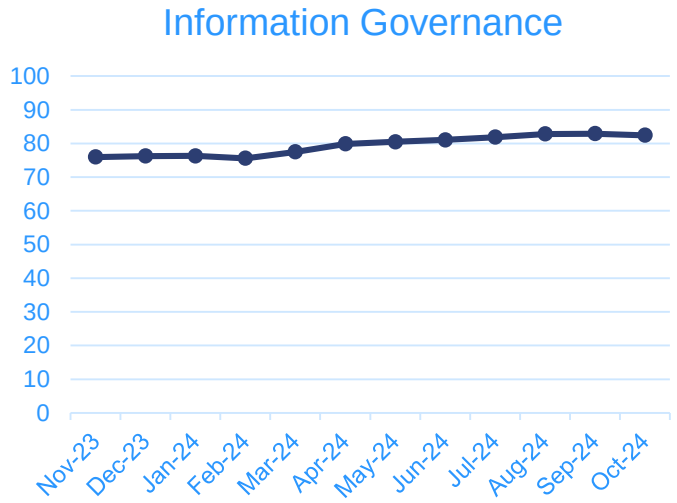
Level 1 Compliance across Wales as at 31.7.24



CTM is currently 13th from an All Wales perspective

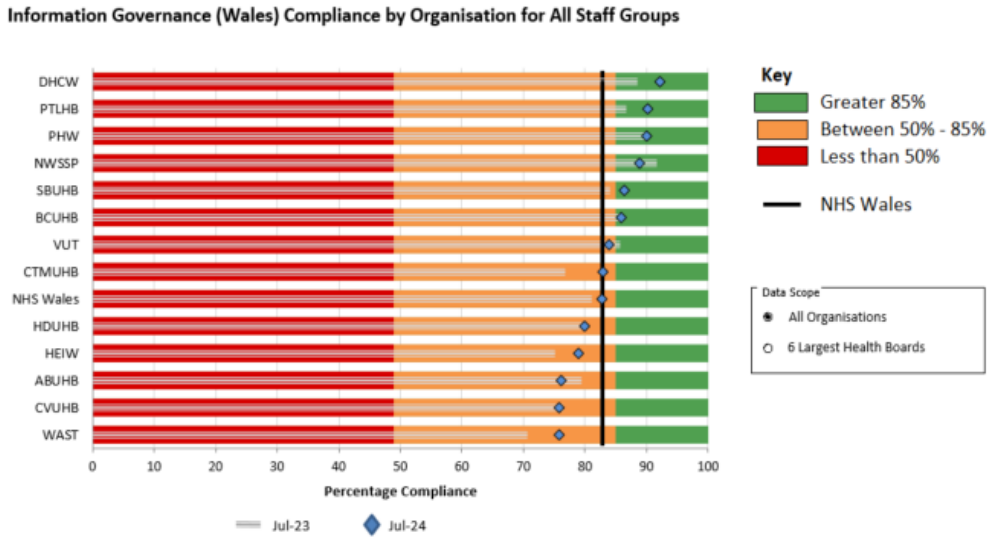
Information Governance

There is 1 level of training within Information Governance



Compliance for all levels of training is currently **82.44%** which is **-0.47%** on the previous month and **-2.56%** on the 85% target.

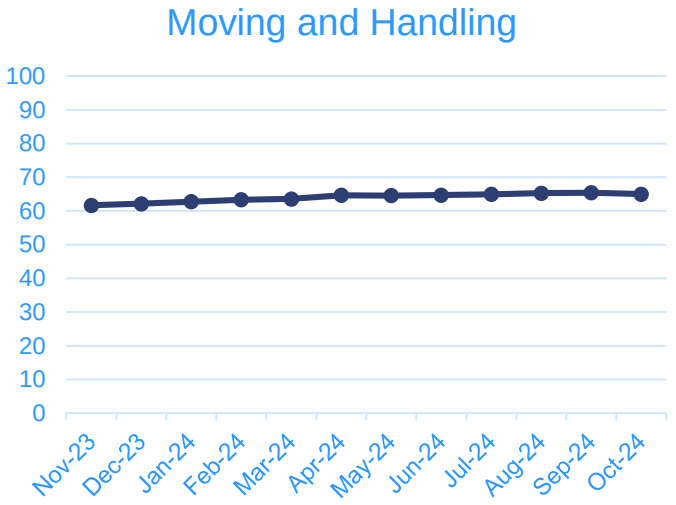
Level 1 Compliance across Wales as at 31.7.24

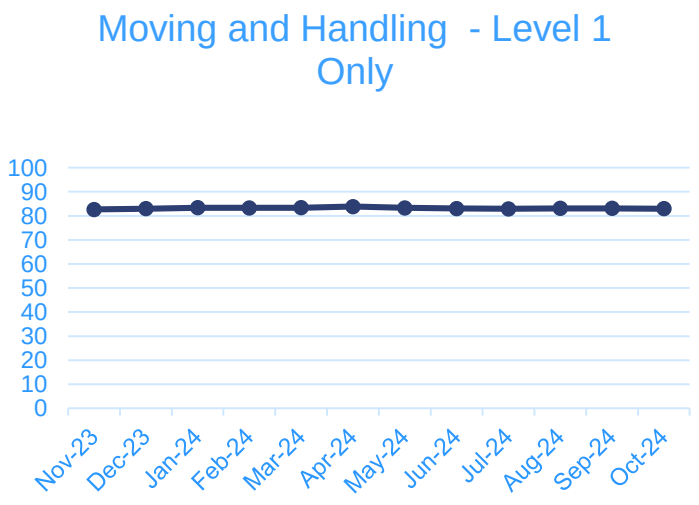


CTM is currently 8th from an All Wales perspective

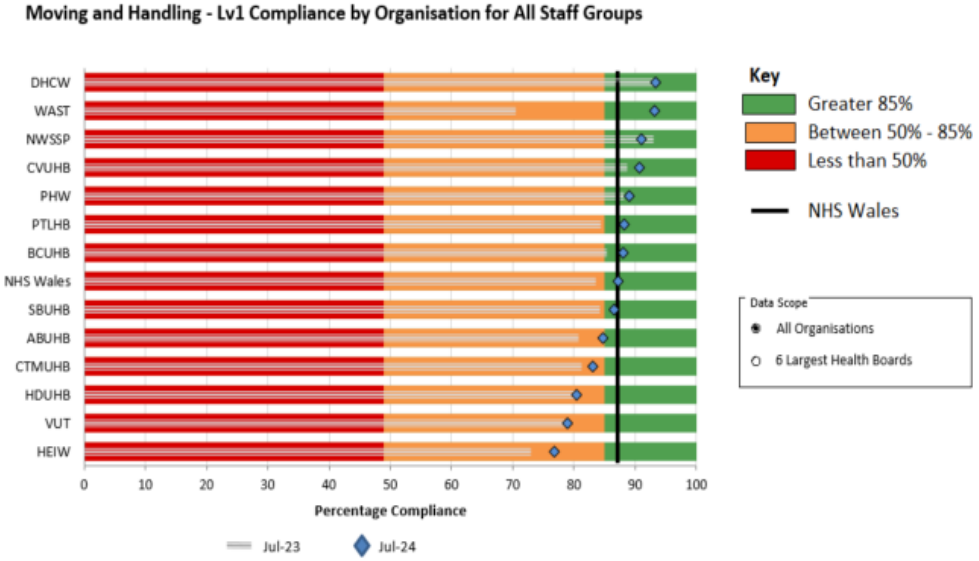
Moving and Handling

There are 4 levels of training within Moving and Handling





Level 1 Compliance across Wales as at 31.7.24



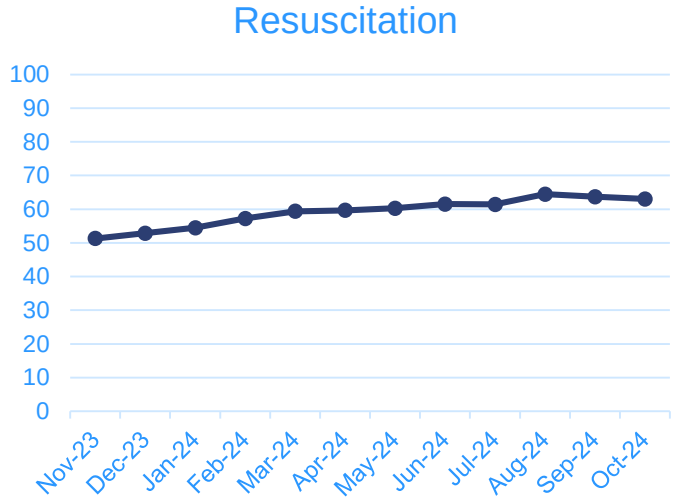
Compliance for all levels of training is currently **65.02%** which is **-0.44%** on the previous month and **–19.98%** on the 85% target.

Compliance for Level 1 training is currently **83.00%** which is **-0.09%** on the previous month and **-2.00%** on the 85% target.

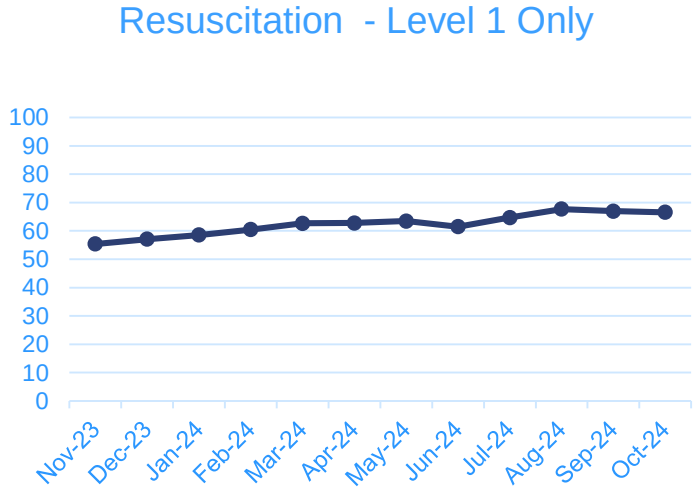
CTM is currently 10th from an All Wales perspective

Resuscitation

There are 10 levels of training within Resuscitation

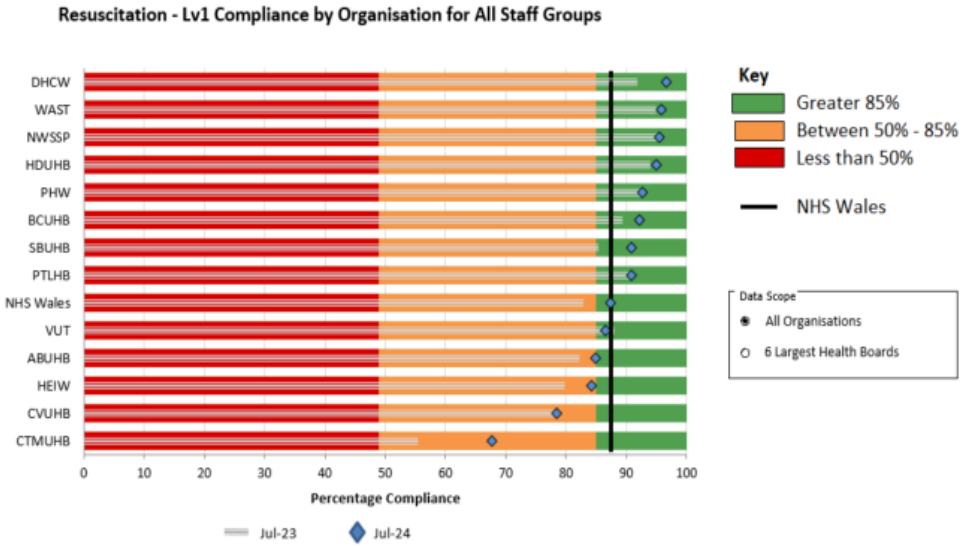


Compliance for all levels of training is currently **63.05%** which is **-0.67%** on the previous month and **-21.95%** on the 85% target.



Compliance for Level 1 training is currently **66.53%** which is **-0.40%** on the previous month and **–18.47%** on the 85% target.

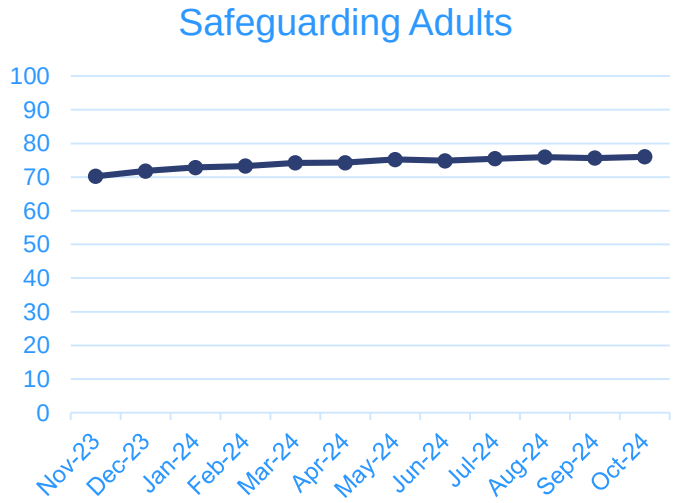
Level 1 Compliance across Wales as at 31.7.24

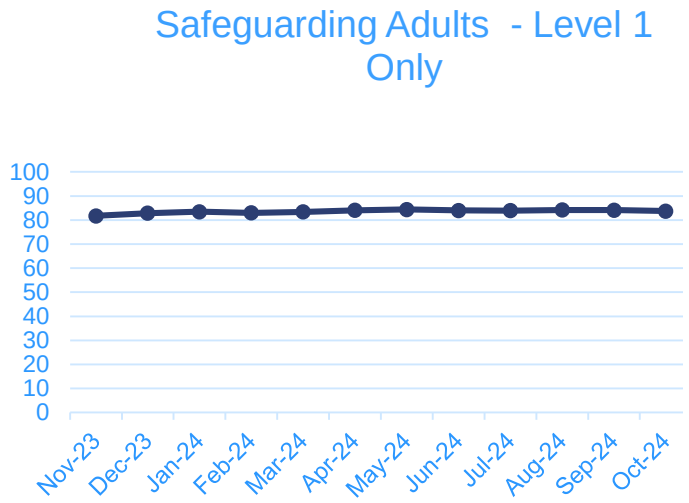


CTM is currently 13th from an All Wales perspective

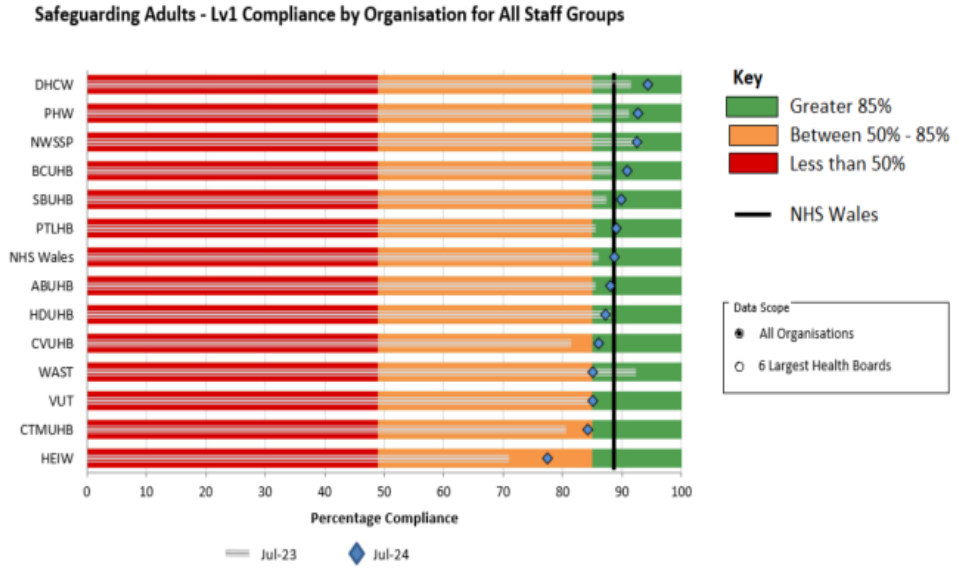
Safeguarding Adults

There are 3 levels of training within Safeguarding Adults





Level 1 Compliance across Wales as at 31.7.24



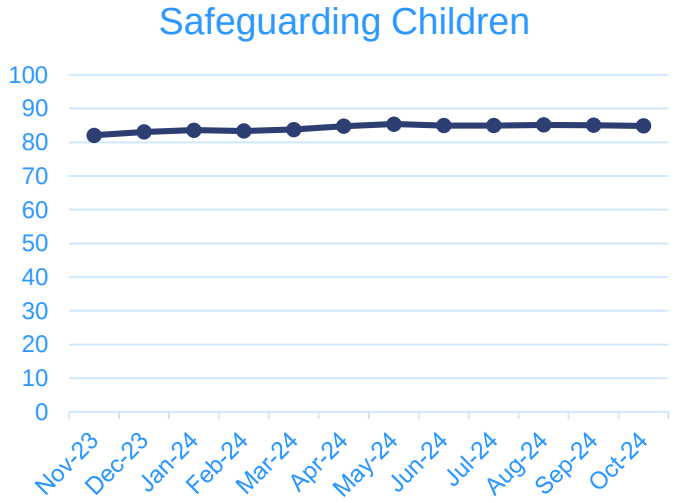
Compliance for all levels of training is currently **76.04%** which is **+0.37%** on the previous month and **–8.96%** on the 85% target.

Compliance for Level 1 training is currently **83.73%** which is **-0.42%** on the previous month and **–1.27%** on the 85% target.

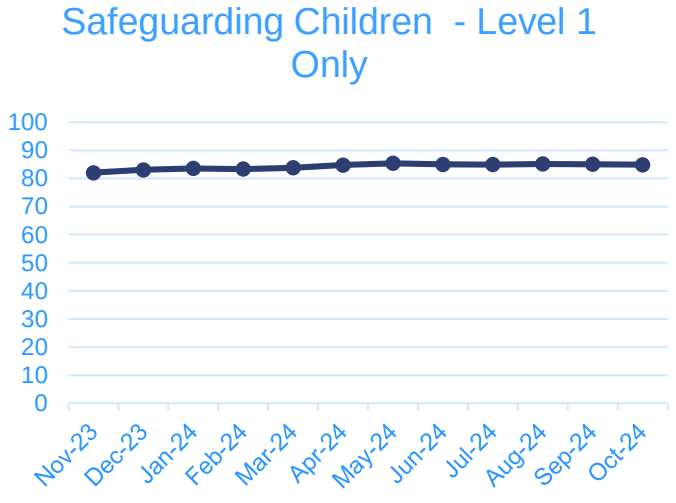
CTM is currently 12th from an All Wales perspective

Safeguarding Children

There are 2 levels of training within Safeguarding Children

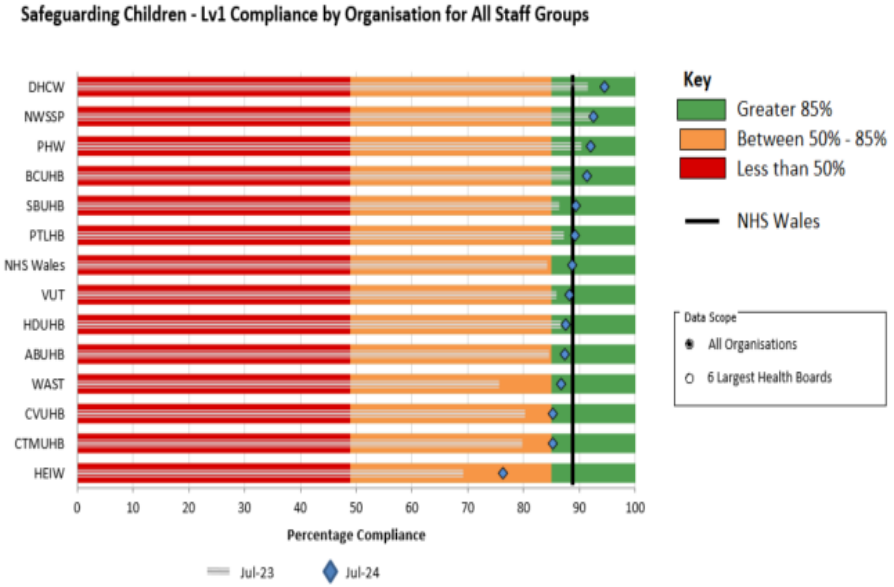


Compliance for all levels of training is currently **84.88%** which is **-0.21%** on the previous month and **-0.12%** on the 85% target.



Compliance for Level 1 training is currently **84.88%** which is **-0.21%** on the previous month and -**0.12%** on the 85% target.

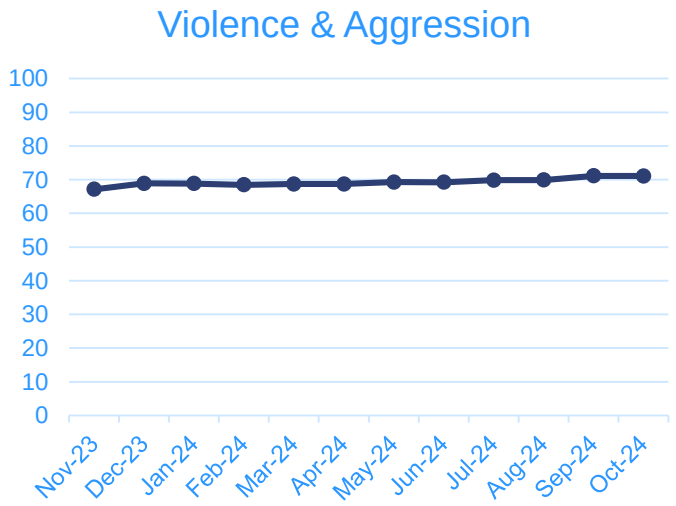
Level 1 Compliance across Wales as at 31.7.24



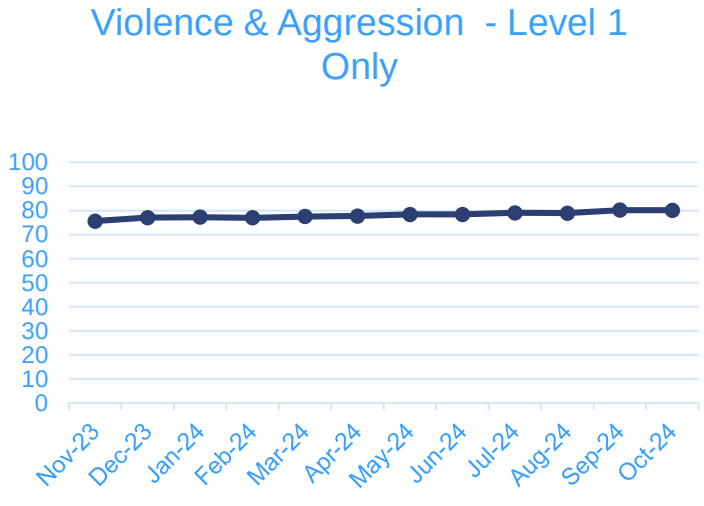
CTM is currently 12th from an All Wales perspective

Violence & Aggression

There are 7 levels of training within Violence & Aggression

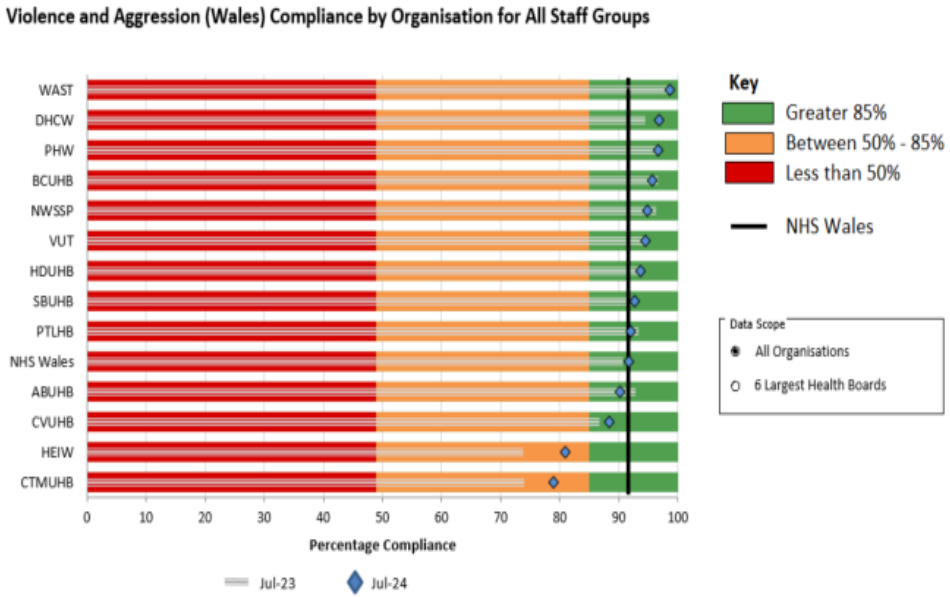


Compliance for all levels of training is currently **71.07%** which is **-0.07%** on the previous month and **-13.93%** on the 85% target.



Compliance for Level 1 training is currently **80.11%** which is -**0.09%** on the previous month and **-4.89%** on the 85% target.

Level 1 Compliance across Wales as at 31.7.24



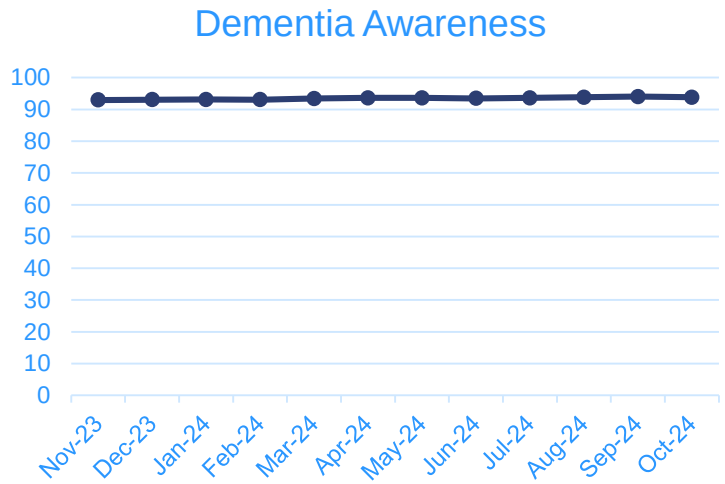
CTM is currently 13th from an All Wales perspective

DYSGU CRAIDD
CORE LEARNING
Cwm Taf Morgannwg

Additional Mandated Subjects

Dementia Awareness

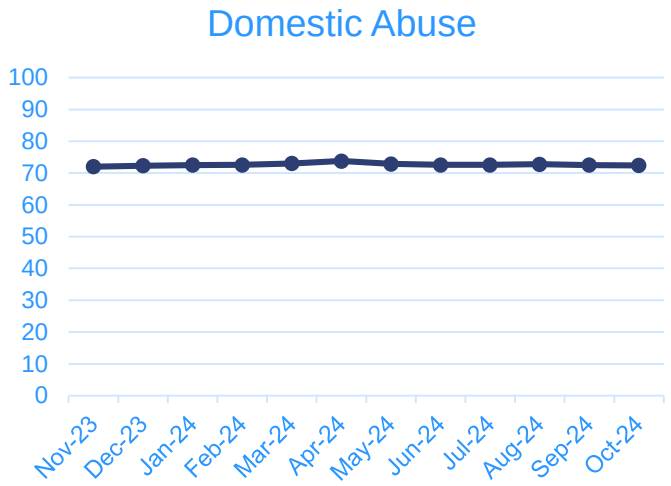
There is 1 levels of training within Dementia



Compliance for level 1 training is currently **93.82%** which is **-0.18%** on the previous month.

Domestic Abuse

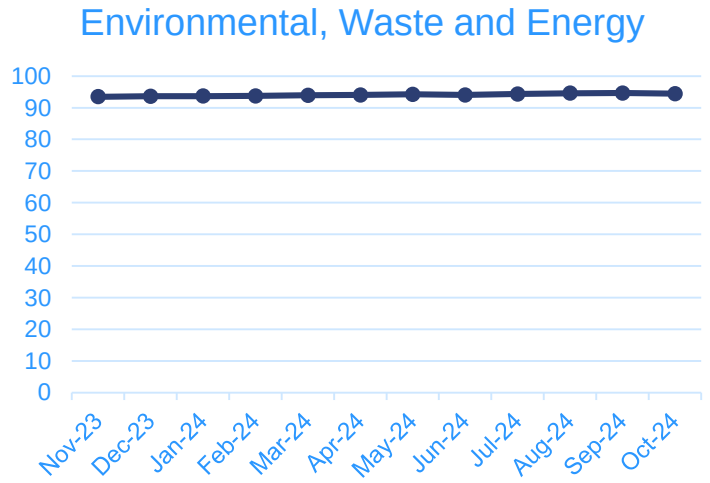
There is 1 levels of training within Domestic Abuse



Compliance for level 1 training is currently **72.44%** which is **-0.10%** on the previous month.

Environmental Waste and Energy

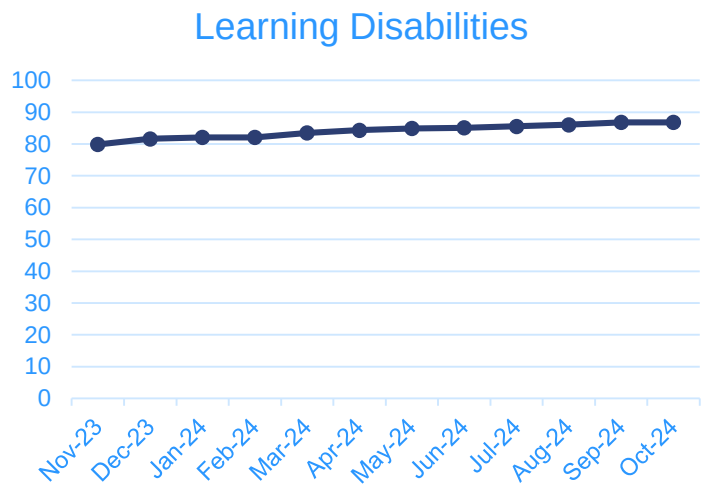
There is 1 levels of training within Domestic Abuse



Compliance for level 1 training is currently **94.42%** which is **-0.23%** on the previous month.

Learning Disabilities

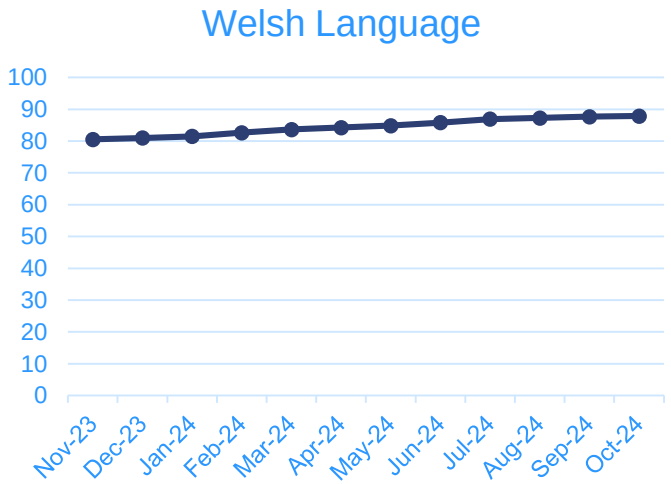
There is 1 levels of training within Learning Disabilities



Compliance for level 1 training is currently **86.81%** which is **-0.01%** on the previous month.

Welsh Language Awareness

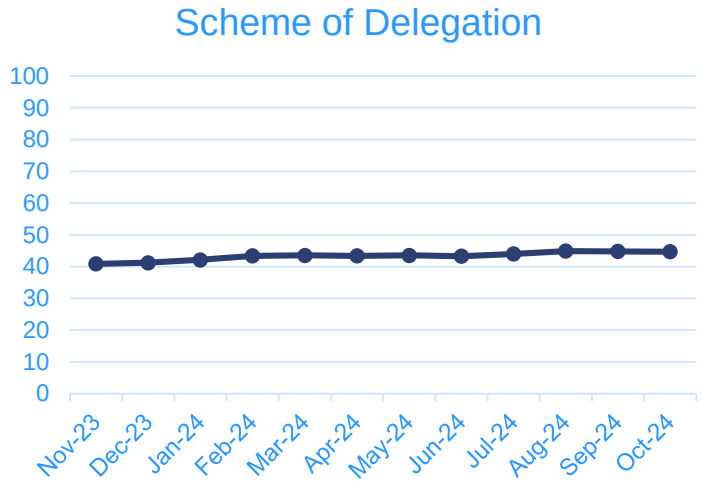
There is 4 levels of training within Welsh Language. This includes the 3 Welsh Skills as well as the E-learning package.



Compliance for all levels of training is currently **87.87%** which is **+0.18%** on the previous month.

Scheme of Delegation

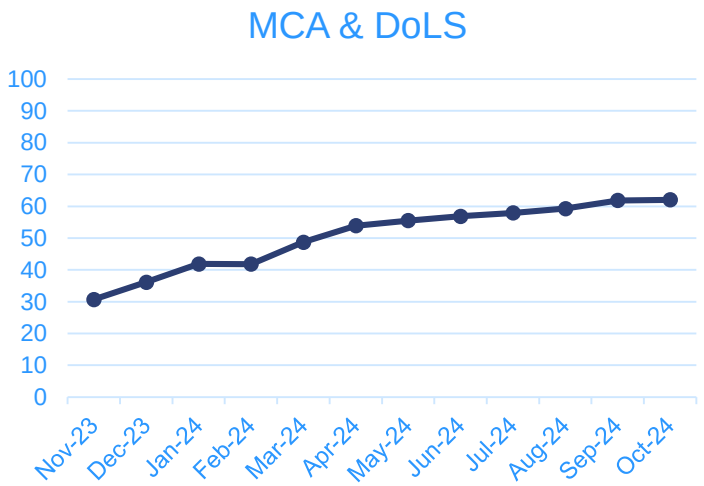
There is 1 levels of training within Scheme of Delegation



Compliance for level 1 training is currently **44.71%** which is **-0.08%** on the previous month.

Mental Capacity Act (MCA) & Deprivation of Liberty Safeguarding (DoLS)

There is 3 levels of training within MCA & DoLS



Compliance for all levels of training is currently **62.06%** which is **+0.24%** on the previous month.

Agenda Item
7.1

Health, Safety & Fire Sub Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	24 January 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	November / December 2024	RISKS REVIEWED
Operational Management Board	November / December 2024	ENDORSED RISKS WHERE APPLICABLE FOR ELG
Executive Leadership Group	Via email 10 January 2025	MANAGEMENT SIGN OFF RECEIVED
Quality, Safety & Experience Committee	21 January 2025	ASSIGNED RISKS REVEIWED

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. This will be a continuous improvement area that Members will hopefully note will evolve and improve over the next 12 months.

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 3 January 2025. Where review dates have passed, and updates were not available these have been followed up and a request to update sent. Reviews received after this date will be reflected in the next iteration.

2.6 The unprecedented demand and operational challenges seen during December 2024 and January 2025 has impacted the Operational Teams capacity to undertake a full review of risks and therefore as noted in Appendix 1 there are three risks that have not been reviewed this period, however, the Care Group Senior Management Team have confirmed that they will endeavour to ensure a review is captured in the next iteration.

2.7 The risks on the Organisational Risk Register have been reassigned to align with the new Committee Structure implemented in January 2025.

Training

2.8 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.

2.9 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

2.10 To date **765** 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. In addition to this number training has also been provided to the Joint Commissioning Committee Senior Leadership Team during this period and their feedback is captured in the evaluations at 2.1.4.

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

2.12 101 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 4.78 out of a maximum score of 5.

2.13 100% of the 101 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.

2.14 99% of the 101 attendees providing formal feedback said they felt more confident to escalate a risk through the organisation.

2.15 Some of the recent comments from the session in June, received through evaluation, have been included below:

- *Easy to follow and enough information to have a clear understanding of the risk escalation process and how to appropriately document risks.*
- *I am new to Risk. I found the session very interesting and informative. The presenter was a great speaker and gave good explanations and examples to follow.*
- *"I'm new to NHS so this session was invaluable*

3. Key Risks / Matters for Escalation

3.1 NEW RISKS

Nil as reported to the Organisational Risk Register in January 2025.

3.2 CHANGES TO RISKS

Risk Score Increased

Nil as reported to the Organisational Risk Register in January 2025.

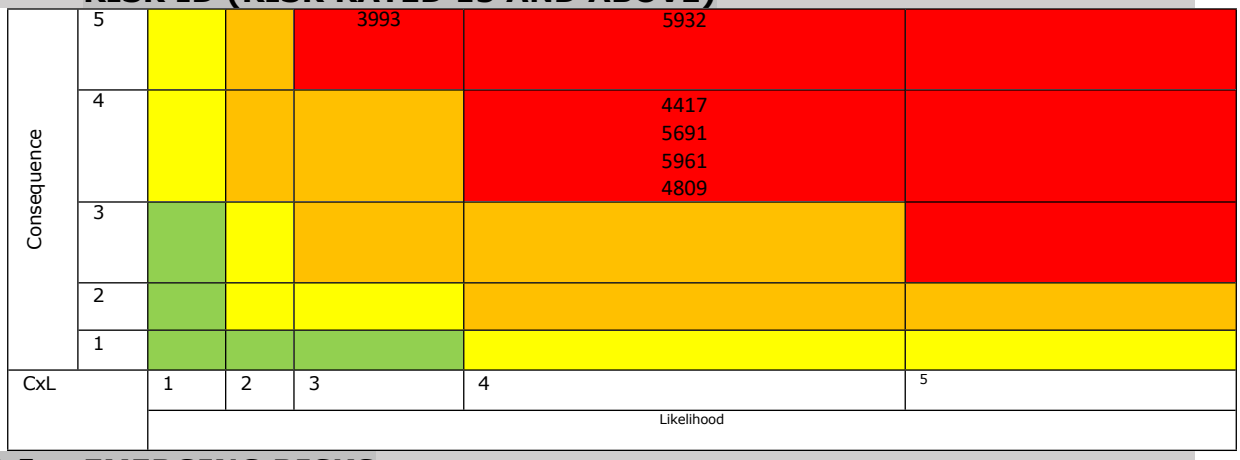
Risk Score Decreased

Nil as assigned to this Sub Committee.

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

There were no risks escalated to the Organisational Risk Register that were closed this period.

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



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	Learning, Improvement & Research

(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 required for the Organisational Risk Register. Individual risks may have been subject to QIA.
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 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

6. 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
2	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 January 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, on target to hand over to the clinical service on Monday 13th January. Contractors and any staff that need to be in any of the first floor areas must wear hard hats and hi-vis vests. 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	06.01.2025	28.02.2025
15	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 January 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, on target to hand over to the clinical service on Monday 13th January. Contractors and any staff that need to be in any of the first floor areas must wear hard hats and hi-vis vests. Full programme including Theatre FEN works and fire compartmentation above vacated wards and depts due to be completed mid August 2025.	Quality, Safety & Experience Committee Operational Delivery Committee Health, Safety & Fire Sub Committee	16	C4xL4	8 (C4xL2)	↔	21.10.2024	06.01.2025	28.02.2025
18	5691	Chief Operating Officer	Facilities Directorate	Assistant Director Facilities	Sustaining Our Future	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	CCTV System Failure in Prince Charles Hospital	**IF:** Major CCTV security management platform (SMP) headend and camera outage at PCH. Unable to live view live data images at the security control centre. NVR recording function is not available to record data images. The outage is also linked with the PCH site refurbishment scheme. The Capital Major Projects team advise that the new (SMP) headend server is not part of the PCH scheme as there is no funding for it. **THEN:** As a consequence this presents a site security with very limited site surveillance available to identify site incidents and provide evidence of criminal activity and crime. **RESULTING IN:** The ground floor, first floor and external site areas require the roll out of (124) new CCTV cameras as part of the PCH refurbishment scheme and the existing old (SMP) headend server does not have the functionality and capacity to accept these additional cameras therefore the contractor TD are unable to roll out the new cameras on site until a new SMP is installed. Risks to the PCH site, patients and staff safety risk. Site risk of theft, property damage and personal injury/assault.	Incident meeting held by Facilities with Digital ICT, Estates, the system contractor and Capital Major Projects team who are managing the PCH site Major project scheme to review the faults and aim to resolve the issue.	Update October 2024 added in red to August update - The Estate CCTV system contractor attended site and identified the root cause of the system failure and restored the PCH security management system headend and power to the majority of existing site cameras. The outcome and recommendation from the system contractor, Capital Major Projects team and TD s is that there is further CCTV system replacement and upgrade of hardware and software work to be undertaken. The existing Security Management Platform (SMP) which is the headend control system is old and not fit for purpose and requires replacement and upgrading. Until the (SMP) headend is replaced, the GF/FF contractor will also be unable to fully install the (124) new site GF/FF scheme CCTV cameras and a 'moderate' risk of future system failure remains until this work is completed. A specification and estimate of cost of a new (SMP) headend has been completed and funding has been approved. Waiting for a contractor to be allocated the work and an installation date to install the SMP system. Following a recent tender process a supplier has been awarded the contract and the work to install the security management platform(headend) is due to commence in November 2024. Security Systems Risk Assessments A rolling programme of security vulnerability risk assessments is being undertaken out at a number of sites that include the suitability, compliance and provision of current CCTV and control of access systems and where systems may require replacing and upgrading or where site system provision is inadequate. Where there is a requirement for replacement/upgrade or additional systems further work is then required with support from Estates and Digital Services to complete the system technical specifications before a statement of need is provided to the Operational Capital Group for replacement or new works and security hardware/software scheme funding. Update January 2025 - It is anticipated that the work to install the new Headend will not take place until January 2025. The review date for this risk has been amended to 31/01.25 so that the action to mitigate the risk can be updated as soon as work commences.	Quality, Safety & Experience Committee Operational Delivery Committee Health, Safety & Fire Sub Committee	16	C4xL4	C3xL4 12	↔	31.01.2024	16.12.2024	31.01.2025
22	4809	Executive Director for People	Central Support Function - Health, Safety & Fire	Assistant Director Health, Safety & Fire	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Non Compliance with Mandatory Violence and Aggression Training	A training review was undertaken to identify HB violence and aggression training requirements. Following review the HB is unable to achieve full compliance on any training module. This is due to a lack of training resource within the Health Safety and Fire Team. **If** the training is not delivered, then the organisation will not be compliant with mandatory Violence and Aggression Training. Restraint training is mandatory for inpatient acute services for Mental Health and CAMHS. Training is delivered by inpatient staff and the Health Safety and Fire Personal Safety Advisor. **If** there is insufficient training resource available then the organisation will be unable to maintain compliance on annual refreshers. **If** the PSA is unable to deliver key aspects of their role due to the high demand for violence and aggression training delivery **then** advice to clinical areas is greatly reduced. **Resulting in** non compliance of mandatory training and a risk of injuries to both staff and patients and possible claims.	Personal Safety Advisor delivers training modules with some support from part time trainers within Mental Health and CAMHS. However there is insufficient resource to ensure compliance within the entire organisation. Trained tutors available from clinical areas. The PSA regularly has to support training due to ward based trainers unable to be released to deliver. This role is not currently included in their job description which has resulted in some trainers resigning from delivering, hence compounding the lack of training resource. The availability of the PSA to offer personal advice to clinical areas is greatly reduced due to the excessive training requirement.	Update August 2024 - The proposal paper was submitted to the Mental Health Care Group Health and Safety meeting with a recommendation which was not accepted. Personal Safety Advisor discussed that the option was not feasible at the latest Mental Health Care Group Health and Safety meeting July 16th. The Health and Safety Committee has requested a further options paper. Further meetings with the Mental Health Care Group underway to discuss training options. Options discussed employing dedicated team or buying in training both options involve a significant financial commitment . Further meeting arranged for September 2nd. In the meantime PMVA training will be delivered up until December 24 Update October 2024 - Mental Health and Learning Disabilities Care Group Service Improvement Manager is currently re- writing the PMVA options seeking funding for 3 full time trainers within Mental Health to deliver. Update January 2025 - This risk has now been transferred to the Mental Health Directorate and not longer sits within the Corporate H&S Team. From 1st April 2025 Mental Health will be contracting with an external provider to deliver this training.	Health Safety & Fire Sub Committee	16	C4 x L4	9 C3xL3	↔	31.08.2021	23.12.2024	30.03.2025
28	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 August 2024 - Report received by Operational Capital Group and recommendations for work will be made to Executive Capital Management Group in September 24. Update November 2024 - following assessment recommended priority POW supported by ECMG Oct. Pre-dated POW Critical Incident so review meeting in W/C 4th Nov to check this is still feasible and right. No change to risk score. Update January 2025 - The unprecedented demand and operational challenges seen during December 2024 and January 2025 has impacted the Operational Teams capacity to undertake a full review of this risk, however, they will endeavour to ensure a review is captured in the next iteration.	Health Safety & Fire Sub Committee	16	C4 x L4	8 C4xL2	↔	30.09.2020	01.11.2024	31.01.2025
30	3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fire Enforcement Notice - POW Theatres.	**IF:** The Health Board fails to meet fire standards required in this area. **Then:** the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. **Resulting in:** potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 2023. A meeting has been arranged with FRS in November with plans with a view to gaining a further extension. Need to plan for drop in theatres to mitigate work commencing	Update January 2025: Following the identification of risks with the hospital roof in Princess Of Wales Hospital, the first floor of the Hospital has had to be vacated to allow the remedial roofing works to take place. As a result, this has emptied the Theatre template and will therefore make the current FEN invalid. Discussions with South Wales Fire & Rescue Service have led to them withdrawing the Fire Enforcement Works in this area due to the area now being unoccupied and the ongoing programme of work to satisfy the issues in the FEN. The Fire Service will continue to monitor the Health Board's progress with these works to ensure the Main Theatres are fully fire safety compliant prior to the Health Board taking back occupancy of this area.	Quality, Safety & Experience Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	06.01.2025	31.03.2025

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
4080	Executive Medical Director Executive Director of People	Nil as assigned to this Committee.									

	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	No risks proposed for closure from the Organisational Risk Register this period.										

Agenda Item	8.1.1

Unapproved Minutes of the Health, Safety & Fire Sub Committee

Date and Time of Meeting	Thursday 5th September 2024
Venue	Virtual via Microsoft Teams

Members Present	Geraint Hopkins	Independent Member (Committee Chair)
	Dilys Jouvenat	Independent Member
	Carolyn Donoghue	Independent Member
In Attendance	Hywel Daniel	Executive Director for People
	Chris Beadle	Assistant Director of Health, Safety & Fire
	Sarah James	Deputy Chief Operating Officer – Acute Services
	Carl Verrecchia	Care Group Service Director, DTPS and Children and Families
	Julie Denley	Deputy Chief Operating Officer – Mental Health, Primary Care and Community Services
	Alan Martin	Head of Operational Estates
	Carl Edwards	Senior Fire Officer
	Sarah Livingstone	Business Manager
	Emma Walters	Head of Corporate Governance & Board Business

Agenda Item	Meeting Business
1.	**PRELIMINARY MATTERS**
1.1	**Welcome and Introductions**
	In opening the meeting, the Chair **welcomed** all those present, particularly C. Donoghue, Independent Member who had agreed to attend the meeting to provide additional Independent Member scrutiny and support. The format of the proceedings in its virtual form were also noted by the Chair.
1.2	**Apologies for Absence**
	Apologies were received from; • Helen Lentle, Independent Member • Gethin Hughes, Chief Operating Officer
1.3	**Declarations of Interest**
	No declarations of interest were received.

2.	**CONSENT AGENDA BUSINESS**
2.1	**ITEMS FOR APPROVAL**
2.1.1	**Unconfirmed minutes of the meeting held on 19th June 2024**
Resolution	The minutes were **APPROVED** as a true and accurate record.
2.2	**ITEMS FOR NOTING**
2.2.1.	**Forward Work Programme**
Resolution	The work programme was **NOTED**.

3.	**MAIN AGENDA**
3.1	**Action Log and Matters Arising not considered within the action log**
	C. Donoghue raised there were a number of action log items that were overdue and needed amending. E. Walters agreed to work with Action Leads to ensure actions were updated and revised timescales identified.
3.2	**Assistant Director of Health, Safety & Fire Report**
	C. Beadle updated the Committee on the main issues associated with managing Health, Safety & Fire risks within the Health Board. He mentioned an expected Health and Safety Executive (HSE) inspection and the current training issues at Glanrhyd Hospital. Additionally, he updated the Committee on the work ongoing in relation to safety alerts being shared through a number of media resources, noting specifically the use of podcasts. He further advised, the battery funding issue had been resolved with funds being provided from the Chief Operating Officer's budget. G. Hopkins expressed satisfaction with the equipment update and sought clarification on whether the funding was from the budget rather than voluntary contributions, to which C. Beadle confirmed it was. Concerns around windows and balconies' safety were raised by G. Hopkins, and C. Beadle assured that all windows are fitted with restrictors and checks were ongoing. D. Jouvenat raised a query in relation to specific risks and sought clarification on their current status. C. Beadle provided an update on fire and noise risk assessments. A discussion between C. Beadle and H. Daniel followed, in relation to improving the clarity of reports for better understanding and it was agreed to streamline future reports by focusing on current actions and omitting redundant historical details.
Resolution	The Committee **NOTED** the report.
Action	Future report on risks to only include the most recent update on progress within the progress to ensure the report was easier to navigate for Members.
3.3	**Health, Safety & Fire Performance Report**

	C Beadle presented the report and highlighted the key matters for Members attention. During the meeting, G. Hopkins highlighted the topic of violence and aggression against staff, and noted that current figures were based on staff reports, potentially missing unreported lower-level aggression incidents. C. Beadle acknowledged the issue, particularly in A&E where verbal abuse is underreported despite its frequency. He advised, to address this, the Health Board had been providing training on violence and aggression to all A&Es over the summer period. C. Donoghue expressed satisfaction with the training progress and stressed the importance of addressing low-level abuse to prevent staff from feeling that this must be tolerated. Additionally, she raised concerns around unallocated risks on the register and the challenge of obtaining robust information for personal injury claims, with a call for solutions to improve data collection. C. Beadle discussed the risks within care groups, highlighting the need to add a field under the new structure arrangements to ensure risks are updated and included within Care groups. He mentioned that the Assistant Director of Governance & Risk had been working to reduce these risks over the past few months. Furthermore, he emphasised the necessity to articulate clearly whether risks are organisational or should be assigned to care groups and assured that this issue was being addressed. Further, he explained that a new Datix All Wales system had been adopted, however, advised it is not robust enough to pull all the desired information. To conclude, C .Beadle noted that improvements are needed in how the claims team reports and records personal injury claims and that ongoing work with the team aims to improve this process. D. Jouvenat noted the significant improvement reported in training compliance.
Resolution	The Committee **NOTED** the report and expressed satisfaction with the increase in training compliance.
3.4	**Fire Safety Report**
	C. Edwards presented the report and highlighted ongoing issues with equipment blocking landings and overdue risks, which are scheduled for completion. Further, he updated the Committee that a new fire risk assessment was in use, and recent training sessions had seen good attendance. C. Edwards also mentioned an upcoming inspection at Prince Charles Hospital by the fire service in September 2024. G. Hopkins raised concerns in relation to equipment obstructions at Prince Charles Hospital, especially in light of the upcoming inspection, and emphasised the importance of resolving these issues. He expressed discomfort with the term "unmanageable" risk and suggested that continued issues might require disciplinary action, and sought clarity on actions to be taken. C. Edwards noted that current conditions could lead to court prosecutions based on the Dame Hackett report, where fire services focus on individuals rather than

	companies. S. James acknowledged the need for progress and prioritised addressing the issue. Further, she agreed to coordinate with the Hospital General Manager and provide an update to the Sub-Committee at the next meeting. H. Daniel suggested that the issue be considered for escalation within the Health Board and emphasised the need for a hierarchy of escalation for issues such as this, and advised that he felt this issues should have been highlighted to the Executive Leadership Group in the first instance prior to being escalated to the Sub-Committee.
Resolution	The Committee **NOTED** the report and considered the issues raised.
Action	Discussion to be held with the Hospital General Manager in relation to concerns raised regarding issues being experienced with equipment blocking landings at Prince Charles Hospital. Update to be provided at the next meeting.
3.5	**Estates Safety & Compliance Report – Low Voltage Electrical System Compliance**
	A. Martin presented the report on high voltage electrical system compliance, and made the Committee aware that it is reviewed under the Welsh Health Technical Memorandum for Electrical Safety and Supply. He advised the outcomes were positive, showing in green and regular High Voltage Authorised Person checks were identified as part of the audits.
Resolution	The Committee **NOTED** the report.
3.6	**Organisational Risk Register**
	E. Walters presented the report, noting that there were no particular matters to raise. She explained that the register was being updated, the version presented was from July, and the report had been updated for submission to the Executive Leadership Group on the following Monday. She offered to take questions, however, mentioned she might refer to colleagues for updates.
Resolution	The organisational risk register was **NOTED**.
3.7	**Overarching Care Group – Health, Safety & Fire Report**
	S. James provided updates on several key areas. She noted there had been no escalated spaces around acute sites for four weeks and a reduction in boarding and triple boarding. She discussed the upcoming no-smoking policy effective 1st October 2024 around Mental Health sites and the establishment of a smoking cessation group. She also reported on the rat infestation at Princess of Wales Hospital, ongoing pest control, demolition plans for temporary buildings, and highlighted the ISO accreditation for environmental system management. G. Hopkins acknowledged the report, expressing concerns and questioning whether any issues were at the escalation stage. S. James confirmed they were not at Board escalation, however, should continue to be monitored by the Sub-Committee.

	C. Donoghue commended the reduction in boarding issues, which had been escalated through the Quality and Safety Committee and discussed at Board level.
Resolution	The Committee **NOTED** the report.
3.7.1	**Children and Families – Care Group - Health, Safety & Fire Report**
	C. Verrecchia highlighted the highest risk areas concerning electrical and air handling resilience at Princess of Wales Hospital (POW), noting there were temporary measures in place to allow for remedial work expected to take around 12 weeks. He mentioned that the risk has been escalated to a score of 16 due to some uncompleted work. An ongoing wastewater issue at Paediatrics in POW was also discussed by C. Verrecchia, with a reminder for proper disposal practices to prevent blockages. Additionally, he updated the committee there was a slight increase in training compliance to 75%. A. Martin reiterated the issue with wastewater blockages caused by paper waste and wipes, emphasising the need for departments to ensure correct disposal.
Resolution	The Committee **NOTED** the report and the issues raised.
3.7.2	**Diagnostics, Therapies, Pharmacy and Sciences – Care Group – Health, Safety & Fire Report**
	C. Verrecchia drew the Sub-Committee's attention to key issues in relation to defective air handling in an office space at Royal Glamorgan Hospital, which led to staff evacuation and close monitoring. Whilst also noting, RSI injuries in sonographers, and suggested staff rotation to prevent focus on one task. Furthermore, he raised there had been an issue with staff accessibility at Keir Hardie Health Park and noted the need for mitigation solutions following an alarm incident. G. Hopkins sought clarification on the dangers of formalin, and C. Verrecchia explained that high doses can cause respiratory illnesses and long-term exposure can be carcinogenic, stressing the need for a quick resolution and frequent space monitoring. H. Daniel acknowledged the extensive reports from Care Groups, whilst, G. Hopkins agreed that the comprehensive reports set the right tone for the new committee structure.
Resolution	The Committee **NOTED** the report.
4.	**OTHER MATTERS**
4.1	**Highlight Report to Quality & Safety Committee**
	G. Hopkins enquired if there were any issues Members wished to escalate to the Quality & Safety Committee, noting that the Quality and Safety Committee had already considered the matter of Boarding into escalation spaces on wards. C. Donoghue expressed confusion around blocked stairways and issues raised in relation to Prince Charles Hospital. She recalled the issues should have been

	escalated at the last meeting. She sought clarification on whether to escalate the issue now or once an action plan to resolve the concerns was in place. E. Walters assured that the issue was escalated to the Quality & Safety Committee at their July 2024 meeting and queried whether Members wished to escalate this once more. H. Daniels noted the issue is still ongoing and advised that he felt this should be presented again at the Quality & Safety Committee, agreeing the risk should remain live until resolved. E. Walters agreed to place the issue on the highlight report for the November Quality & Safety Committee meeting and to provide feedback to the Health, Safety & Fire Committee in December 2024. Further, H. Daniels clarified that the escalation is not for the Quality and Safety Committee to address directly but to provide assurance as a sub-committee. E. Walters suggested that a positive escalation needed to be made regarding the increase in training compliance rates which had been a previous area of concern for Members. The Chair agreed it would be beneficial to highlight this as a positive escalation.
Action	Escalate blocked stairways and PCH issues to the Quality & Safety Committee and ensure it remains a live risk.
4.2	**Any other Business** No further business was raised at the Committee Meeting.
4.3	**How did we do in this meeting** G. Hopkins requested feedback from the Committee Members and Attendees on the meeting's evaluation at present or within two weeks of the meeting.
5.	**DATE AND TIME OF NEXT MEETING**
5.1	The next Committee Meeting is being held on 3rd December 2024 at 15:00pm.