Public Digital & Infrastructure Committee

Agenda

Tuesday 04th August 2026 at 9:00am

1 **9:00**	**Standing Items**	
1.1	Welcome, Apologies & Introductions	Rhian Thomas
1.2	Declarations of Interest	Rhian Thomas
1.3	Minutes of the Committee Meeting held on 05th May 2026	Rhian Thomas
1.4	Action Log following the Committee Meeting held on 05th May 2026	Rhian Thomas
1.5	Committee's Chairs Actions	Rhian Thomas
2 **09:05**	**Infrastructure** (09:05 – 09:40)	
2.1 *20 mins*	BAF and Organisation Response (Risk Register)	Geoff Walsh
2.2 *10 Mins*	Board Assurance Framework – Capital & Estates	Geoff Walsh
2.3 *5 Mins*	Operation POET	Geoff Walsh
3 **09:40**	**Health & Safety**	
3.1 *10 mins*	Health & Safety Update and Annual Report	Robert Warren
4 **09:50**	**Digital**	
4.1 20 Mins	Digital Roadmap and work programme update	David Thomas
4.2 *10 mins*	Corporate Digital Risk Register	David Thomas
4.3 *10 mins*	IG Data Compliance	James Webb
4.4 *15 Mins*	Medical Records Report	Sarah Lloyd
5 **10:45**	**Items for Approval / Ratification**	
5.1	No Items	

6 **10:45**	**Items for Noting and Information**	
6.1 *0 mins*	Minutes: Digital Directors Peer Group	David Thomas
6.2 0 Mins	CEF Regulatory inspections (Food Hygiene/Natural Resources Wales/Welsh Water)	Geoff Walsh
6.3 0 Mins	Authorising Engineers Report Ventilation	Geoff Walsh
6.4 0 Mins	Authorising Engineers Report Medical Gas Pipeline Systems	Geoff Walsh
6.5 0 Mins	EHO Inspection Report	Geoff Walsh
6 **10:45**	**Agenda for Private Digital & Infrastructure Committee Meeting**	
	• *Minutes from previous meeting* • *Cyber Security* • *Caldicott Guardian*	
7	**Review of the Meeting**	Rhian Thomas
	Date & Time of next Meeting: Tuesday 24th November 2026 at 9am via MS Teams	Rhian Thomas

Draft Minutes of the Public Digital & Health Intelligence Committee Meeting Held On 05 May 2026 Via MS Teams

To view a recording of the meeting click here.

Chair:		
Rhian Thomas	RT	Committee Chair / Independent Member – Capital & Estates
Present:		
David Edwards	DE	Independent Member – ICT
In Attendance:		
David Thomas	DT	Director of Digital & Health Intelligence
James Webb	JW	Head of Information Governance & Cyber Security
Geoff Walsh	GW	Director of Capital, Estates & Facilities
Robert Warren	RW	Assistant Director of Health, Safety & Fire
Frankie Ogden	FO	Head of Corporate Governance
Rachel Gidman	RG	Executive Director of People & Culture
Angela Parratt	AP	Director of Digital Transformation
Mark Wardle	MW	Consultant Neuroscientist
David Fluck	DF	Executive Medical Director
Secretariat		
Nikki Regan	NR	Corporate Governance Officer
Apologies		
Suzanne Rankin	SR	Chief Executive
Kirsty Williams	KW	CAV UHB Chair
Susan Lloyd-Selby	SLS	Independent Member – Local Authority
Steve Riley	SR	Independent Member - University
Rachna Upadhya	RU	Independent Member – General
Catherine Phillips	CP	Executive Director of Finance
Richard Skone	RS	Deputy Medical Director
Lorna McCourt	LM	Independent Member – Trade Union

Item No	Agenda Item	Action
D&IC 05/05/1.1	**Welcomes Introductions & Apologies** The Committee Chair – Rhian Thomas (RT) welcomed everyone to the public meeting and confirmed the meeting was quorate.	
D&IC 05/05/1.2	**Declarations of Interest** **The Committee resolved that:** a) No Declaration of Interest were noted.	
D&IC 05/05/1.3	**Minutes of the Meeting Held 10.02.2026** The Committee accepted the minutes from 10th February 2026 as a true and accurate record.	

	The Committee Resolved that: a) The Minutes of the Meeting held on the 10th February 2026 were confirmed as a true and accurate record.	
D&IC 05/05/1.4	**Action Log – Following the Meeting held on 10.02.2026** One action on the action log was noted as complete. **The Committee Resolved that:** a) The Action Log was discussed and noted.	
D&IC 05/05/1.5	**Chair's Action taken since the last Committee Meeting** No chairs actions taken since the previous meeting. **The Committee Resolved that:** a) There were no Chair's Actions taken since the last meeting.	
	Items for Review and Assurance - Infrastructure	
D&IC 05/05/2.1	**Estates Briefing – Condition Survey** The Director of Capital, Estates & Facilities – Geoff Walsh (GW) highlighted the following points on the Estates Briefing – Condition Survey: • A significant increase in the reported backlog position to £753m, up from £173m previously. • 85% of the estate was in condition C (not optimal), with 10% in condition D/DX, which represents imminent risk of failure. • The D/DX rating was based on a surveyor opinion and plant condition, and while C-rated items were high risk, D/DX items were considered at imminent risk. • The 10% D/DX equated to £45m for CAVUHB alone, and the team was analysing which areas were affected, focusing on critical services like ITU, wards, and operating theatres versus admin areas. • Specific risks, such as the high voltage generator (no backup, manual intervention sometimes required) and the boiler house distribution board (failure would result in loss of heating, hot water, and mains water to ward blocks, with no local backup). • The catastrophic impact was emphasised if these systems fail, especially for hospital operations, and noted that the boiler house generator need was included in this year's capital funding request. • Ongoing work was highlighted, including a sensitivity check in ITU to trace dependencies (medical gases, electricity, UPS, pipework, cabling) and identify components needing attention. • The team was in dialogue with Welsh Government (WG) and was developing both immediate and longer-term schemes for resilience, such as a new 11kV substation and generator. The Executive Director of People & Culture – Rachel Gidman (RG) asked GW if he links in with the fire officers and whether they are part of the discussion or would be involved in the future. She also questioned if there was enough funding highlighted for the fire element of the agenda.	

	GW stated that he talked frequently with the Health, Safety & Fire team. He acknowledged fire was an issue and recognised as such, mentioning discussions about additional funding for compartmentation from the capital programme. He emphasised that the hospital had one of the most extensive fire alarm systems, which was constantly being upgraded, providing significant early warning capability. The independent Member – ICT – David Edwards (DE) noted that the report was a snapshot in time and observed that the backlog had increased significantly as a result of the survey, which exposed issues that may not have been previously known or fully understood. He asked how CAVUHB can keep this information current without having to conduct a full survey every year, expressing concern about maintaining up-to-date data as infrastructure ages and risks change. He was interested in the reaction received from WG when presented with the information about the £753m backlog, especially given that 10% of it was critical and could impact staff and patients. GW explained that he liaised with his counterpart in the civil service and confirmed that CAVUHB receives a fair share of funding from WG. He stated that even if WG provided the necessary funds immediately, services must continue running, and it would not be possible to spend all the money in a single year to address the issues. The current approach was to focus on the 10% of the estate at imminent risk and assess how these impact critical services such as theatres, ITU, and other essential areas. He noted that this work was taking longer than anticipated due to the depth and complexity of the information. He identified that the ward blocks were the areas most affected within the 10% D and DX risk category. WG asked for a plan, and GW confirmed that they were working on this plan as part of their ongoing work. DE noted that the civil servants GW is talking to in WG have a good understanding of how serious the situation is as a result of the survey and the extent of the challenge facing any incoming government. GW explained that they were undertaking some actions because they receive targeted Estates funding from WG, and they use their Estates risk register to identify and submit funding requests for those risks. He highlighted the need to strike a balance, as increasing targeted Estates funding reduces the discretionary capital available for other priorities like digital and clinical services. GW acknowledged that they have not yet ensured the risk register fully reflects the new condition survey, but the Estates team reviews the risk register every two months to monitor and update it. The CC asked GW if there was an expected timeline for when the team would have absorbed all the information from the surveys and updated the risk register accordingly. GW stated that asbestos will be an element in all the work, so costs have been estimated to include this factor. He mentioned that as the construction market changes, they will adjust their cost index accordingly as they move forward. GW noted that WG officials were not overly surprised by the figures from the survey, though the amount may have shocked some. He added that he would expect more senior people in WG to acknowledge the findings but focus on what actions will be taken in response.	

	The CC asked when the risk registers would be fully populated. GW confirmed the teams were learning how to use the registers, training was required for staff, and they need to work with the supplier to extract information efficiently. He stated it would be several months before the registers were fully populated. **The Committee Resolved that:** a) **T**he content of the report was noted. b) The intention to continue with the operation 'POET' 2026/27 testing programme within the original autumn period to provide assurance that the electrical systems function as they are expected to prior to entering the winter period was supported. c) The development of a project mandate to install a second 11KV generator at the UHW site to provide further resilience (N+1) for critical services was supported.	
D&IC 05/05/2.2	**Capital & Estates Risk Register** GW highlighted the following points on the capital & estates risk register: • The paper is a monthly update on risk status, now almost fully transferred to the AMAT system. • There are still significant numbers of risks rated over 20 and many over 16, which are reviewed bi-monthly. • The risk register is used as the basis for investment requests, both for targeted Estates funding and discretionary capital, and for preparing schemes for slippage funding from WG. • Progress was made on replacing electrical infrastructure, specifically non-essential raising busbars, with final connections happening soon and essential busbars installation to follow. • Operation Poet at UHL was completed successfully, with lessons learned but no major issues. • The need for a new 11kV substation and generator at UHW and boiler house upgrades had already been discussed. • The targeted Estates funding was in its second year, with schemes moving forward, and there was hope for continued support from WG. • WG civil servants reviewed the appetite for targeted Estates Fund, and consensus is to continue it. • Recent schemes include roof replacement for a ward block, mental health projects, and the Wellbeing Hub Park in Ely, which WAs approved and starting soon. • A vision document team was appointed for phased redevelopment of the UHW site, funded by WG, to align with clinical service plans. • A business case for ITU refurbishment was being developed as a medium-term plan, with more discretionary capital available this year. RG asked GW how he would get clinical engagement around the infrastructure build, emphasising the importance of clinicians helping to scope the project and questioning whether they had been involved yet or would be involved further down the line.	

	GW responded that clinical engagement would be further down the line, clarifying that the infrastructure build must be led by the Clinical Services plan, not by Estates alone. He stated that certain services (e.g., EU, Critical Care, operating theatres) are known to remain on the UHW site, and the current focus was on developing a vision document to guide redevelopment. He emphasised that detailed planning would require the help and advice of clinical leads as the process progresses. RG noted the refresh of the People and Culture Plan, highlighting the need to link it with the clinical service plan and to motivate and involve people. She mentioned that the People and Culture Plan would include the people safety aspect in one document, rather than having H&S separate, and suggested joining this up with GW's work. The CC asked GW about about the UHB's approach for articulating requirements to WG, specifically whether it involves stressing the urgency and acuity of the projects, and requested an update on the Haematology project and insight into the narrative used to obtain more funding beyond the discretionary allocation. GW explained that for the Haematology scheme, they had gone back to the drawing board, recognising the need for ongoing dialogue and relationship with WG regarding the UHW redevelopment. He emphasised that they cannot stand still for the next 10–15 years, so for ITU, they were pursuing refurbishment as an interim solution, which is a significant investment (around £30m). WG was supportive and awaiting the business case. For Haematology, they plan to submit a strategic outline case with a high-level budget cost by the July deadline, aiming to demonstrate to WG that they have a clear direction of travel and secure their support for the funding required. **The Committee Resolved that:** a) The content of the report was noted and the level of investment required to address the assets identified as imminent risk of failure b) The appendices were noted and detailed data and findings which support the information included in the report c) The proposed schemes were noted and exercises to be undertaken to mitigate the risks	
	Items for Review & Assurance – Health & Safety	
D&IC 05/05/3.1	**Health & Safety Update and Health & Safety Tracker** The Assistant Director of Health, Safety & Fire – Robert Warren (RW) highlighted the following points: • No outstanding enforcement or improvement notices; recent South Wales Fire and Rescue Service (SWFRS) inspection of Lakeside building was positive, with no expected formal issues. • Health & Safety Culture Plan was 80% complete, now focused on embedding systems and habits across clinical boards, with a shift towards measuring outcomes rather than just action completion. • RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrence Regulations) submissions: 77 last year (lowest recorded), but 90% were due to staff absence over 7 days, which is higher than the national average (70%). Working to reduce this through engagement with Clinical Board leaders and People & Culture.	

	• Training compliance trends: ongoing review of VBA and manual handling training assignments, with some improvements and corrections; fire training compliance dropped but was being addressed with more online and Teams-based courses. • Lone worker system messaging campaign launched to improve awareness and usage, treating the device as essential PPE. • No fire incidents year-to-date at time of writing, except for a recent electrical fault at CRI under investigation. • 14 overdue risk assessments, all in low-risk areas; no inpatient areas overdue. • Significant capital investment in fire alarm systems at UHW, with ongoing upgrades expected to reduce unwanted fire signals. • Last year saw 14 fire incidents (double previous year), mainly due to smoking-related bin fires and unattended cooking; working with clinical boards to address behavioural causes. The CC noted that this was the first time Health and Safety (H&S) was incorporated into the committee and invited the team to suggest any deep dives they would like to present over the next year, emphasising the importance of making H&S a proper component of the committee. RG highlighted RIDDOR's educational importance for staff and the impact of long sickness absences. She stated that statutory fire training compliance should be at 85%, but CAVUHB was just over 70%. She was explicit and directive at executive reviews about the need to improve compliance, emphasising that people must complete their training and that more courses were being offered to address this. DE thanked RW for the report and noted that visitors and patients also fall under RIDDOR if incidents were work-related. He asked about the proportion of such cases out of the 77 reported and suggested that future reports should include trends and breakdowns (serious injuries, near misses, occupational diseases) to help the committee better understand the numbers and be more educated on the details. RW stated the 90% figure for over-seven-day absence reporting had been constant for years, and the 70% figure was directly from the HSE. He noted that dangerous occurrences and specified injuries (like fractures) were rare, which was positive. He was working with trade unions to support and empower staff to return to work after injury, including offering light duties if needed. He clarified that returning on light duties does not prevent incidents from being reported to RIDDOR, as full duties must be fulfilled for reporting to stop. The CC asked RW about the current status of the relationship between the organisation and partners such as the HSE and SWFRS, seeking his impression of those relationships. RW noted the relationship with HSE was good, mentioning they do not have a specific inspector assigned. He described the relationship with SWFRS as excellent, led by Ryan Paxford, and mentioned that Brecknock House was provided for their fire drills and practice.	

	The Committee Resolved that: a) The findings of the report were noted.	
D&IC 05/05/3.2	**Fire Alarm Response** RW highlighted that the paper was for noting. He confirmed the site teams will take over the fire alarm response from next Monday, following a review that found this approach better than the previous arrangement. RG highlighted that fire officers were previously taken away from training and risk assessment duties due to unwarranted fire alarms and noted the positive action of site teams supporting this, allowing fire officers to focus on their skill set. The CC tweaked the recommendation slightly to note and support the content of the paper. **The Committee Resolved that:** a) The contents of the paper were noted and supported.	
	Items for Review & Assurance – Digital	
D&IC 05/05/4.1	**Digital Roadmap and Work Programme Update** The Director of Digital – David Thomas (DT) highlighted the following points on the Digital Roadmap and Work Programme Update: • The Digital Foundations programme business case had undergone changes and would be discussed in detail in the private session due to commercial considerations. • The paper was progressing through internal governance and would go to May Board if cleared, emphasising the challenge of realising benefits and cashable savings. • Changes were being made to the digital roadmap, with rationale provided, and stressed reliance on external funding due to a zero-investment position. • National programme schemes were highlighted, including the business case for replacing the Mental Health and community system Paris, which has an end-of-life date in three years, requiring a decision during 26-27. • The Welsh Intensive Care Information System implementation, showing red status pending WG communication, and clarified the go-live date was scheduled for the 1st of June. • Tactical service delivery updates were noted, such as better access to data via Power BI, guardrails, and ongoing work on data cataloguing and platform support. The CC thanked DT for the overview and mentioned that, after reviewing the papers with green, amber, and red blocks, it might be worthwhile for the committee to have more insight or a deep dive into national programmes with additional context, possibly later in the year. DE stated that the topic would be discussed in greater detail in the private session, but in public session, it would be worthwhile to spend time on the challenge of achieving cashable savings. He acknowledged it was a challenge, noting that while certain things would deliver savings and benefits, achieving cashable savings	

	requires a disciplined and systematic approach that links across many areas. He asked if something could be said about the work being done to achieve these savings. DT agreed that the transformation needed was essentially a large change management programme. He acknowledged the work that the Director of Digital Transformation - Angela Parratt (AP) was doing by engaging with individual clinical boards, explaining the digital perspective and encouraging them to consider how their workforce will change. AP highlighted the following points on the Digital Roadmap and Work Programme Update: • Main challenge was that all clinical boards agree efficiency will be found and realised, but until the system was implemented, it's unclear where the savings or efficiencies would appear. • There was no "as is" mapping currently; both "as is" and "to be" mapping were needed to understand how workflows will change, which leads to service redesign. • The release of efficiency, productivity, and cash needs to be owned and driven by the clinical boards, as they manage, design, and deliver the services. • Digital Foundations was discussed as digital capabilities coming in as an enterprise process that spans all clinical boards, not just one niche area. Efficiency may manifest in different places, not necessarily within a single clinical board. • A very detailed benefits statement was shared with all clinical boards and this committee back in November. • All clinical boards and their finance business partners agree there will be efficiency and productivity gain, but it's difficult to know exactly what the route to cash will be. DE asked how, as part of the business case, CAVUHB can ensure there is a mechanism to effectively take money out of the UHB, turning efficiency savings into actual financial savings. He noted that extracting money out is more than just saving time; it required turning those savings into the money side of things, especially since CAVUHB is currently spending money that wasn't allocated. He stated the need for assurance about how this will be dealt with, acknowledging it wasn't something that can be answered immediately in committee. He expressed that he would want to see a mechanism where, for example, if a system achieves a £500k saving in a clinical board, that money is taken out of the clinical board's budget, with the board possibly making a case for spending it elsewhere. He added the need for grip and control, noting this is a whole-organisation digital transformation, not just a clinical board transformation. DT stated that implementing digital solutions will standardise and reduce variation, having a huge impact, especially in terms of time saved or time released to care. He mentioned that efficiency gains can be pushed further into back-office functions, and automating or changing processes will create efficiency. He highlighted the importance of describing and tracking these changes to show benefits being realised, initially through back-office, and eventually	

	through the Clinical Services plan and changing pathways, all supported by digital and data. He noted that future plans were predicated on digital and data as core enablers but emphasised the need to capture and measure the "so what" of these changes. He suggested learning from others who have gone through similar implementations and confirmed ongoing liaison with other organisations in NHS Wales and beyond to understand steps taken to improve efficiency and reduce resource needs. He concluded that it is a journey, but it is right to challenge how CAVUHB will capture these benefits. RG noted the importance of not seeing culture change initiatives in isolation, emphasising that the clinical services plan and digital foundation plan should be integrated as one. She stated that AI needs to be considered as part of the workforce plan, and that CAVUHB must look after AI agents as well as employees, reflecting a new concept for workforce planning. She highlighted the need to link staff capability with digital literacy and system changes, showing hope for the future and stressing that capability development should be included as part of the overall strategy. **The Committee Resolved that:** a) The progress and updates contained in the report were noted.	
D&IC 05/05/4.2	**Board Assurance Framework – Digital** DT highlighted the following: • The key aspects of the digital BAF were summarised, noting it was a first draft and appended the latest version for committee review. • The BAF would be updated for the May Board and asked committee members to consider whether they were getting sufficient oversight and detail. • The need to embed digital and cyber risk ownership consistently across clinical boards was addressed, explaining that digital deep dives are now part of Clinical Board Executive reviews and that James is engaging with clinical boards on cyber risk. • Referenced an audit report highlighting the need for consistent management of cyber risks and confirmed steps are being taken to address this, with progress to be reflected in the risk register. The CC noted that some controls in the digital BAF were outdated and sought assurance from DT that it would be updated before the next board meeting. She challenged the need to embed digital and cyber risk ownership consistently across clinical boards, asking how this was being tackled. DT confirmed there is a digital deep dive slot at Clinical Board Executive reviews every three months. He stated the need for an overview of all information assets, noting not all are known to corporate services and clinical boards are being asked to engage. He explained that consistent application is being pursued,	

	referencing an audit report and ongoing engagement with clinical boards to ensure cyber risk management is embedded. **The committee resolved that:** a) The director-led actions in place to manage and mitigate digital risk were noted and supported.	
D&IC 05/05/4.3	**Corporate Digital Risk Register** DT highlighted the following points on the Corporate Digital Risk Register: • All risks were now on AMaT and future reports will be more succinct, explaining the current format is due to temporary data loss in AMAT. • Cyber security remains the top risk, insufficient resources is a risk, and the risk rating for non-compliance with data protection legislation has increased due to resource backlogs. • Two data quality risks were amalgamated, and future presentations will include AMAT summaries with red/green/amber tracking. The Head of Corporate Governance – Frankie Ogden (FO) reported positive feedback, noting that all risks are now joined up centrally, whereas previously clinical boards worked in isolation with their own local risk registers. She explained that clinical boards can now engage with capital and estates, see linked risks, and work collaboratively, which was not possible before. She stated that as they start moderating risks within clinical boards, ownership of digital and cyber risks will be driven, working collaboratively with subject matter experts. **The Committee resolved that:** a) The progress and updated to the Risk Register report was noted.	
D&IC 05/05/4.4	**Information Governance (IG) Data Compliance** JW highlighted the following points on the data compliance: • Confirmed CAVUHB remains broadly compliant with IG requirements and no regulatory action has been taken to date. • Noted ongoing capacity pressures are impacting Freedom of Information and subject access performance, requiring senior management attention. RG mentioned that fire training, along with consent and information governance, was strongly pushed at executive board level, emphasising their importance. She stated she is supporting this agenda through the executive reviews. **The Committee resolved that:** a) The series of updates relating to significant IG issues were received and noted.	
	Items for Approval / Ratification	
D&IC 05/05/5.1	**Annual Committee Report**	

	DE expressed gratitude for the support provided by the corporate governance team throughout his tenure as committee member and chair, specifically in producing the annual committee report. **The Committee resolved that:** a) The annual committee report was noted.	
	Items for Noting and Information	
D&IC 05/05/6.1	**Minutes: Digital Directors Peer Group** Item for noting. . **The Committee Resolved that:** a) The minutes of the Digital Directors Peer Group were noted.	
D&IC 05/05/6.2	AE (LV) Annual Report CVUHB 2025 & Authorised Engineers Report Item for noting. **The Committee Resolved that:** a) The report was noted.	
	Any Other Business	
D&IC 05/05/7.1	The CC thanked everyone for an engaging meeting during her first time as chair of the committee and stated she is open to any changes or suggestions from committee members, inviting them to email or message her with feedback or ideas for evolving the committee.	
	Items to bring to the attention of the Committee	
D&IC 05/05/8.1	**Date & Time of next Meeting:** *Tuesday 04th August 2026 at 9am via MS Teams*	

Report Title:	BAF & Organisational Response – Capital Estates & Facilities				Agenda Item No:	2.1
Meeting:	Digital & Infrastructure Committee	Public	√		Meeting Date:	4 August 2026
		Private				
Status **(please only tick one)**	Assurance		Approval	√	Information/Noting	
Lead Executive Title:	Director of Finance					
Report Author Title:	Director of Capital, Estates and Facilities					

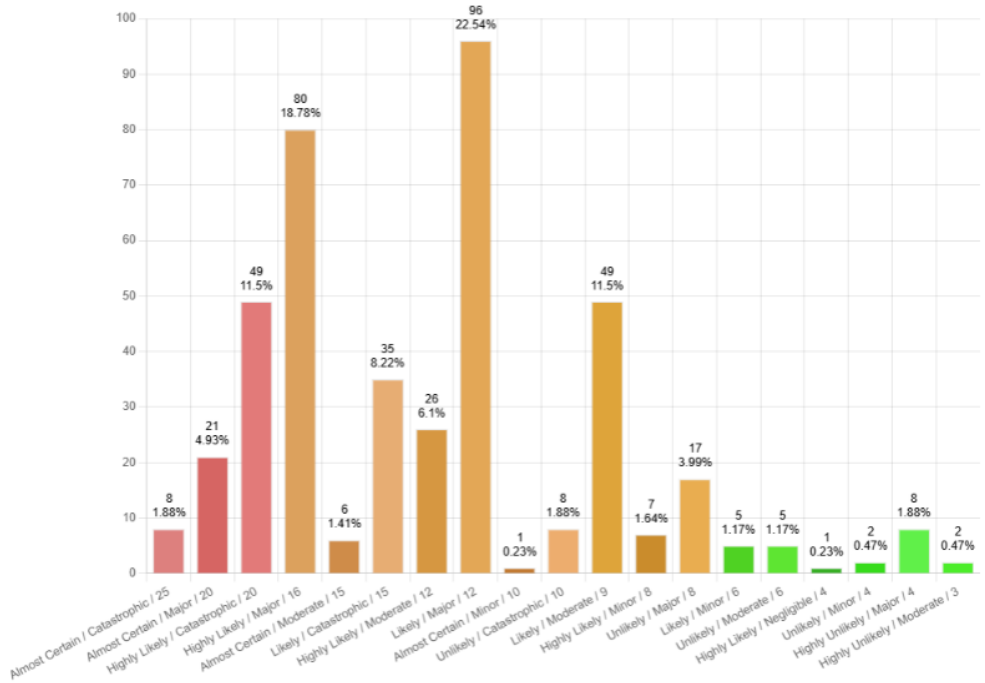
Main Report
Background and Current Situation:

The purpose of this report is to provide the Digital & Infrastructure Committee with an overview progress and status of the actions identified within the Health Board Business Assurance Framework and in particular relating to the Strategic Risk in relation to the Estate Infrastructure.

It has been well reported that the age of the HB estate and the lack of sufficient capital funding over a prolonged period has resulted delays to many of the HB capital investment programmes which are designed to improve the patient, staff and visitor environments and reduce the backlog maintenance liability, thereby eliminating or mitigating the level of risk, reducing service disruption minimising the HB's opportunities to modernise clinical services.

Risk Management & Current Status

- Capital, Estates & Facilities are currently managing 426 risks (at all levels)
- During the reporting period:-
  13 new risks have been added, 1 scoring 25
  2 risks have been removed



Of the 426 risks identified on the Capital, Estates & Facilities risk register 63 are considered high risk associated with the estate infrastructure or operational estate systems of which 8 score 25 and are shown in the table below, with the remainder of the high risks included in Appendix 1.

The risks are identified by individuals who are considered specialist in their field. For example, the Authorised Person for Medical Gases would identify any risks associated with the medical gas installation and likewise the Authorised person for ventilation would include any plant or system risks with the are of expertise. To sensitivity check the risks they would be discussed with other Authorised or competent persons within the particular are of expertise along with consideration by the working group, ventilation, water safety, electrical safety etc. the risks are issued to the Assurance & Compliance team before inclusion on the risk register.

Quarterly risk review meetings are held which is attended by all risk owners, the Assurance and Compliance Team and Corporate Health & Safety Representatives, where the scoring is agreed, the rationale for the scoring and what mitigating actions are required to reduce or remediate the risk.

Risk scoring across estates considers the impact of infrastructure, plant or equipment failure on our patients and our ability to continue to deliver the clinical services. For example, a pipe or motor failure on the mezzanine floor level within the University Hospital of Wales boiler house, may not be considered a high risk. However, the fact that work to affect a repair in a timely manner could not progress until asbestos is removed has the potential to leave the site without heating, steam etc. The risk therefore is greater because of the presence of asbestos.

	Title	Initial rating	Current rating	Target rating	Response (Status)
1	E18 - UHW LGF Switch Room 4	25	25	5	Tolerate
2	UHW Main Boiler House Asbestos Risk on Mezzanine Floor Level when Carrying out Engineering Work and Repairs	25	25	5	Tolerate
3	Energy Cost Pressures - instability within the energy markets.	25	25	5	Tolerate
4	Potential end term payment	25	25	5	Tolerate
5	Main Steam Header and Valves - UHW	25	25	5	Tolerate
6	Plant Room Roofs - UHW. Profiled steal sheeting	25	25	10	Tolerate
7	M36 - UHW & UHL Medical Gas Pressure Reducing Sets.	25	25	5	Tolerate
8	UHW High Voltage Load Shedding Equipment	25	25	5	Tolerate

Whilst it may be considered that Capital Estates & Facilities are satisfied with tolerating the top risks shown in the table above, members of the committee can be assured that, with the exception of the, Energy Cost Pressure and end term payment risks, schemes for each of the remaining risk are in progress to mitigate or eliminate the risk.

Risk 1 – scheme in design which will be tendered to establish robust cost with possible option to seek funding via WG slippage during the current financial year

Risk 2- a tender for the removal of asbestos has been received and is more than £1m. This would require a re-prioritisation of discretionary capital funding, or an option would be to seek WG funding via a Business Justification Case. There is also the possibility of combining it with risk 5 and submitting one business case for the boiler house works, which would be more than £1.6m.

Risk 5 – a design and tender process has been undertaken, and the proposal is to develop a Business Justification Case for consideration by Welsh Government and seeking funding support of circa £1.6m to complete the works. This, however, would require the completion of Risk 2either as enabling works or a combined project.

Risk 6 – schedule of roof replacement schemes has been collated and is being progressed on a phased basis. Much of the funding over recent years has been secured via end of year slippage.

Risk 7 – A scope and specification for the replacement of the medical gas equipment is being produced to proceed to tender and delivery within the financial year and funded from the backlog maintenance budget allocation

Risk 8 – Funding for this project has been secured via the Welsh Government Targeted Estate Fund (TEF) and the specification is being progressed with the programme of work to be delivered with the financial year 2026/27

The Condition Survey undertaken across the estate continues to be reviewed to bring forward a comprehensive plan to identify the capital investment required to address the D & Dx risks in the first instance, which are considered as almost certain and/or catastrophic. The proposal is for the plan to be submitted to Welsh Government in Quarter 3 2026/27. As part of the review being undertaken, the information presented is being cross referenced to the risk register to ensure that any issues not currently captured within the register is identified and assessed.

The Health Board have written to the Joint Accreditation Committee (JACIE) following the inspection of the Haematology/BMT facilities confirming submission of a Strategic Outline Case for the development of compliant in patient and Stem cell laboratory accommodation to meet the current standards. WG have issued scrutiny questions associated with the Strategic Outline Case .

The construction works for the development of the Hub at Park View is due to commence in September 2026 which has been in planning since 2018 when the Park View Health Centre was closed, following a serious flood. Clinical services have been located out of the area that they serve reducing the attendance at several clinics.

The 'vision document' for the redevelopment of University Hospital of Wales is progressing well with completion scheduled for the autumn 2026 for consideration by the appropriate internal forums prior to issue to WG, who have commissioned the exercise.

The HB estate rationalisation plan continues to make progress with tenders for the next phase of demolition planned for Q4 2026/27 and the plans to relocate services from Glamorgan and Monmouth houses in progress. The Health Board continue to work with the Local Authorities on several joint project which will reduce our poor estate and benefit patients as it aligns with the Health Board model to take services closer to home.

The disposal of 2 HB properties is proposed and will be considered by the Board at their July 2026 meeting.

Executive Director Opinion & Key Issues to bring to the attention of the Committee

- Infrastructure risks continue to be monitored and managed by Capital, Estates & Facilities on a frequent basis which are recorded on the Amat system
- Risk scoring across estates considers the impact of infrastructure, plant or equipment failure on our patients and delivery of clinical services.
- Capital, Estates and Facilities identify schemes which require capital investment using the risk register to prioritise any investment with the aim to reduce risk and backlog maintenance
- The number of reactive maintenance requests resulting from a lack of capital investment restrict the ability to be undertaking a comprehensive planned maintenance approach

Appendices (please list any appendices that will accompany this report. Do **not** embed)

BAF CEF Risk Register

Recommendations:

The Committee is requested to:

a) NOTE: the content of the paper and the approach taken to score the risks identified

b) NOTE: the availability of capital funding across NHS Wales is impacting on the HB's ability to reduce backlog liability and increases the risk profile for the Health Board

Link to Strategic Objectives of Shaping our Future Wellbeing: Please place an "x" in the below boxes where relevant – *Click each item for further information.*			
1. Putting People First	√	2. Providing Outstanding Quality	√
3. Delivering in the Right Places	√	4. Acting for the Future	√

Five Ways of Working (Sustainable Development Principles) considered: Please place an "x" in the below boxes where relevant									
Prevention	√	Long Term	√	Integration		Collaboration	√	Involvement	

Quality Impact Assessment Completed? Please place an "x" in the below boxes where relevant				
Yes *(please include the complete QIA document)*		No *(please provide reasoning e.g. not required*	x	

Impact Assessment Please place an "x" in the below boxes where relevant
Risk: Yes
Limited capital funding to address the infrastructure risks which have an implication on clinical service delivery
Safety: No
Financial: Yes
As above. The UHB will continue engagement with Welsh Government to determine and potential additional funding available
Workforce: No
Legal: Yes
Statutory obligations require investment and the lack thereof can lead to exposure to risk and legal challenge
Reputational: Yes
Any impact to clinical services as a result of the aging infrastructure and non-compliance could be reputational to the UHB
Socio Economic: No -
Equality & Health: No
Decarbonisation: No
Although not specifically mentioned, new equipment installed will be more energy efficient
Welsh Language: No

Approval/Scrutiny Route ***(please list all other Committees/Groups this report has been to)***	
Name of Committee/Group/Exec	Date:

APPENDIX 1 – BAF CEF Risk Register

Operational Risks (14)

Risk ID	Date raised	Service	Title	Initial rating	Current rating	Target rating	Response (Status)									Manage
CEF - Estates/2026-27/13	09/06/2026	Speciality: CEF - Estates	UHW Main Boiler House Asbestos Risk on Mezzanine Floor Level when Carrying out Engineering Work and Repairs	R 25	R 25	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2022-2301	31/12/2022	Speciality: CEF - Estates	Medical Gas Safety PRV Equipment	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Mechanical/2021-2208	01/06/2021	Speciality: CEF - Mechanical	M29 - Ventilation verification of critical systems has identified UHW ITU A3N does not comply with HTM's for ventilation.	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Mechanical/2019-2005	01/12/2019	Speciality: CEF - Mechanical	M38- Ventilation AHU serving HDU AT UHL does not comply to WHTM's.	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Compliance/2023-2405	11/10/2023	Speciality: CEF - Compliance	Fume Cabinet Inspections	R 20	R 20	G 5	Treat	0	0	0	0	0	0	0	0	Manage
CEF - Compliance/2023-2404	01/12/2023	Speciality: CEF - Compliance	Ventilation Smoke/Fire Dampers Dental Hospital UHW	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Compliance/2023-2402	01/12/2023	Speciality: CEF - Compliance	Verification Smoke/Fire Dampers	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2023-2405	04/08/2023	Speciality: CEF - Estates	2 Unservicable Boilers (from 6)	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2024-2503	16/04/2024	Speciality: CEF - Estates	Leaking Flue - CRI Main plant room	R 20	R 20	G 4	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Catering CFPU/2024-2502	23/04/2024	Speciality: CEF - Catering CFPU	Potential Goods Lift Failure Service Impact	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Catering CFPU/2024-2501	01/02/2024	Speciality: CEF - Catering CFPU	Electrical Distribution - Potential Loss of Power	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2026-27/05	06/05/2026	Speciality: CEF - Estates	Nurse Call System in CAVOC (UHL)	A 16	R 20	A 8	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Mechanical/2025-2617	21/11/2025	Speciality: CEF - Mechanical	M67 - Ro Water system no longer supported by Manufacturer from 2027	A 16	R 20	G 4	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2024-2510	08/04/2024	Speciality: CEF - Estates	Gas Shutdown and Installation of Gas Shutoff Solenoid (UHL)	R 20	R 20	A 12	Tolerate	0	0	0	0	0	0	0	0	Manage

Infrastructure Risks (49)

Risk ID	Date raised	Service	Title	Initial rating	Current rating	Target rating	Response (Status)									Manage
CEF - Critical Risk Project/2024-2567	29/11/2024	Speciality: CEF - Critical Risk Project	Main Steam Header and Valves - UHW	R 25	R 25	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Building/2021-2201	02/08/2021	Speciality: CEF - Building	Plant Room Roofs - UHW. Profiled steal sheeting	R 25	R 25	A 10	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Electrical/2025-2607	09/06/2025	Speciality: CEF - Electrical	E18 - UHW LGF Switch Room 4	R 25	R 25	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Mechanical/2021-2210	01/01/2021	Speciality: CEF - Mechanical	M36 - UHW & UHL Medical Gas Pressure Reducing Sets.	R 25	R 25	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Critical Risk Project/2023-2403	20/11/2023	Speciality: CEF - Critical Risk Project	UHW High Voltage Load Shedding Equipment	R 25	R 25	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Critical Risk Project/2024-2502	04/12/2024	Speciality: CEF - Critical Risk Project	Cast Iron Above Ground Drainage Pipes	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Critical Risk Project/2024-2503	01/12/2024	Speciality: CEF - Critical Risk Project	2 Cold/ Hot Water Storage Tanks - CHFW	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Critical Risk Project/2024-2501	04/12/2024	Speciality: CEF - Critical Risk Project	UHW Day Surgery Medical Air Compressors	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Mechanical/2021-2207	01/06/2021	Speciality: CEF - Mechanical	M9 - UHW ITU A3N Non Compliance	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Mechanical/2021-2212	01/06/2021	Speciality: CEF - Mechanical	M30 - UHW ITU B3N Non Compliance	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Mechanical/2021-2213	01/06/2021	Speciality: CEF - Mechanical	M31 - UHW ITU C3 Link Non Compliance	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Mechanical/2023-2414	02/10/2023	Speciality: CEF - Mechanical	M46 - UHW Main Recovery	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Electrical/2024-2504	02/12/2024	Speciality: CEF - Electrical	E17 - Reliance on High Voltage generation for critical services.	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Energy & Environment/2025-2603	15/08/2025	Speciality: CEF - Energy & Environment	IT Connectivity	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Energy & Environment/2025-2605	28/02/2025	Speciality: CEF - Energy & Environment	Combined Heating and Power Plant (CHP)	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2025-2613	24/03/2025	Speciality: CEF - Estates	CHFW Ph 2 MRI Unit Scaleformation, Corrosion, Biological Growth	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2025-2615	13/02/2025	Speciality: CEF - Estates	CHFW P2 Main Chiller Scale Formation, Corrosion, Biological Growth,	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2025-2616	24/03/2025	Speciality: CEF - Estates	Radiology Plantroom Main Chillers	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2025-2619	26/03/2025	Speciality: CEF - Estates	Fire Fighting Lift Control	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Compliance/2024-2502	08/04/2024	Speciality: CEF - Compliance	Fire Compartmentation	R 20	R 20	A 10	Treat	0	0	0	0	0	0	0	0	Manage
CEF - Asbestos/2025-2605	02/01/2025	Speciality: CEF - Asbestos	Regulation 18 Areas - Dental Hospital	R 20	R 20	A 10	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Electrical/2026-2702	16/01/2026	Speciality: CEF - Electrical	E19 - UHW - No Backup Electricity Supply to Boilerhouse if HV Generator Fails During Powercut	R 20	R 20	A 10	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Critical Risk Project/2024-2568	29/11/2024	Speciality: CEF - Critical Risk Project	Steam Plate Heat Exchanger - UHL	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Critical Risk Project/2024-2569	18/12/2024	Speciality: CEF - Critical Risk Project	Modular Heating Boilers -CHFW	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Asbestos/2025-2618	22/12/2025	Speciality: CEF - Asbestos	Regulation 18 Area - UHW Boiler House	R 20	R 20	G 5	Treat	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2023-2408	14/10/2023	Speciality: CEF - Estates	Safe Access Cold Water Storage Tank (CWST) (B58)	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2024-2501	02/12/2024	Speciality: CEF - Estates	Cold water supply to theatres (CAVOC, Spinal)	R 20	R 20	G 4	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2025-2609	16/01/2025	Speciality: CEF - Estates	Working at Height lack of edge protection	R 20	R 20	G 4	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2025-2605	01/05/2025	Speciality: CEF - Estates	Roof Lifeline/Mansafe covered & obstructed	R 20	R 20	G 4	Tolerate	0	0	0	0	0	0	0	0	Manage

CEF - Estates/2025-2604	01/05/2025	Speciality: CEF - Estates	Roof parapet wall not to regulation height.	R 20	R 20	G 4	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Mechanical/2023-2410	02/10/2023	Speciality: CEF - Mechanical	M61 - Hamadryad Centre Boiler 1 & 2	R 20	R 20	G 4	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Mechanical/2023-2415	02/10/2023	Speciality: CEF - Mechanical	M49 - UHW Maternity suites	R 20	R 20	G 4	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2024-2505	02/12/2024	Speciality: CEF - Estates	CRI Main Boiler Plant - High Levels of Corrosion	R 20	R 20	G 4	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2025-2620	03/09/2025	Speciality: CEF - Estates	Non WHTM compliant AGSS Pump set	R 20	R 20	A 8	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2025-2611	07/04/2025	Speciality: CEF - Estates	Fire Doors Require Replacing	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2023-2410	04/07/2023	Speciality: CEF - Estates	Main CIAT Chiller, replacement X6 EBM Papst fan assemblies units on chiller circuit No2.	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2023-2406	09/09/2023	Speciality: CEF - Estates	Both DSS4 Maternity HV substation double doors and LV switchroom single door	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2022-2302	14/12/2022	Speciality: CEF - Estates	Community Barry Drainage issue	R 20	R 20	G 4	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2025-2610	05/06/2025	Speciality: CEF - Estates	Roofing Sheets Rusted Through	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2022-2304	14/12/2022	Speciality: CEF - Estates	General Issues With I.T. Ports - BEMS	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2022-2303	14/12/2022	Speciality: CEF - Estates	UHW Mains water services risk of failure	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2023-2404	18/01/2023	Speciality: CEF - Estates	Satchwell Sigma BMS Control Cards	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2023-2403	18/10/2023	Speciality: CEF - Estates	VIE underground piped oxygen - From estates.	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2025-2602	23/06/2025	Speciality: CEF - Estates	Issues to control Legionella bacteria.	R 20	R 20	A 8	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Estates/2025-2603	12/06/2025	Speciality: CEF - Estates	MRC plant room condition.	A 16	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Critical Risk Project/2023-2402	22/11/2023	Speciality: CEF - Critical Risk Project	UHW Pumped Cold Water Mains to Roof Tanks	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Critical Risk Project/2023-2401	01/12/2023	Speciality: CEF - Critical Risk Project	UHW Blowdown vessel of main steam boilers	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Critical Risk Project/2024-2505	01/12/2024	Speciality: CEF - Critical Risk Project	UHW 11KV Mains Distribution Board - Site Network	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage
CEF - Critical Risk Project/2024-2504	01/12/2024	Speciality: CEF - Critical Risk Project	Main 415v Distribution Panel - UHW	R 20	R 20	G 5	Tolerate	0	0	0	0	0	0	0	0	Manage

Report Title:	Operation 'POET' Update				Agenda Item No:	2.3	
Meeting:	Digital & Infrastructure Committee		Public Private	√	Meeting Date:	4th August 2026	
Status **(please only tick one)**	Assurance	√	Approval		Information/Noting		√
Lead Executive Title:	Director of Finance						
Report Author Title:	Director of Capital, Estates & Facilities						

Main Report

Background and Current Situation:

The purpose of this report is to request that the Digital & Infrastructure Committee note the actions generated from the Operation 'POET' lessons learnt exercises and the progress made by the project team to mitigate any associated risks in the event of an unplanned electrical outage.

The UHB, annually, undertake the planned exercise at the University Hospital of Wales (UHW) and University Hospital of Llandough (UHL) which is designed to test the resilience of the electrical infrastructure in the event of a Total Shutdown of the National Electricity Transmission System (NETS) which would cause an extensive loss of supplies to the sites.

Following the main events, the project team operational leads for the Clinical Boards, Digital & Health Intelligence, Clinical Engineering and Capital, Estates and Facilities consider a number of key areas including;

- Planning stages – the team have seen a considerable improvement with the familiarisation of the planning requirements to ensure that sufficient information is available of the electrical systems, improved communication strategy with the departments and wider organisation and governance arrangements. There is a perception that the clinical teams are also becoming familiar with the event, however, the project team are ensuring that the areas are prepared for an unexpected loss of power.
- Phased testing arrangements – the team are continuing to work with the clinical teams to undertake the 'on load' local generator tests, as part of the planning stages to prove the systems, prior to the planned main event.
- The main event – Reflecting on arrangements of the day, communication and re-instatement process are improving, however, the age of the system remains an overall risk
- Post Event – hot debrief, reflection and lessons learned that require addressing, which continue to reduce year on year.

The review culminated in the development of a post project action and recommendations log, attached Appendix 1 which details the key elements that required addressing, the progress of the item and update on the anticipated completion date, providing assurance that mitigation is in place.

Significant improvements with the signal of the two way radio's across the sites has been achieved, albeit, further investigations of the tunnels at UHW & UHL and the identified Major Incident Rooms are scheduled for further improvement prior to the 2026/27 Operation 'POET' exercise.

Routine on-load generator tests have not been formally established yet due to the volume of electrical infrastructure works being undertaken, including the replacement of Substation 2A and the changeover of Tower Block 2 non- essential risers and essential risers, scheduled to complete in August 2026, which has required the availability of teams both clinically and from estates. However, during these infrastructure works, generator tests have been undertaken in support of planned maintenance and testing, providing confidence of the infrastructure to the clinical teams.

Executive Director Opinion & Key Issues to bring to the attention of the Board/Committee/SLT (delete as appropriate)

- The Capital & Estates team and operational leads for the clinical boards, DH&I, Clinical Engineering, Emergency Preparedness and Planning have improved confidence in the Operation 'POET' planning stages and annual exercises
- The 2026/27 planned exercises are scheduled to be undertaken at UHW on Tuesday 15th September 2026 and UHL on Wednesday 14th October 2026
- The actions raised from the lessons learnt exercises are reducing year on year.

Appendices (please list any appendices that will accompany this report. Do **not** embed)

Combined Operation 'POET' recommendations & action log

Recommendations:

a) **NOTE:** the content of the paper
b) **NOTE:** the progress made with addressing the actions from the annual Operation 'POET' exercises
c) **NOTE:** the dates scheduled for the 2026/27 financial year Operation 'POET' exercises which are aligned with clinical audit days.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please place an "x" in the below boxes where relevant – *Click each item for further information.*

1. Putting People First	√	2. Providing Outstanding Quality	√
3. Delivering in the Right Places		4. Acting for the Future	√

Five Ways of Working (Sustainable Development Principles) considered:
Please place an "x" in the below boxes where relevant

Prevention	√	Long Term	√	Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?
Please place an "x" in the below boxes where relevant

Yes *(please include the complete QIA document)*	x	No *(please provide reasoning e.g. not required*		

Impact Assessment
Please place an "x" in the below boxes where relevant

Risk: Yes

Whilst many of the actions have been addressed from the previous Operation 'POET' exercises, the age of the infrastructure remains a risk

Safety: Yes

Improving the resilience of the electrical infrastructure

Financial: No

Workforce: No
Legal: Yes
If there was a system failure there could be potential litigation
Reputational: Yes
Failure of systems impacting on patient care and safety
Socio Economic: No -
Equality & Health: No
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:

APPENDIX 1 2023-24 Operation POET Actions / Recommendations

No.	Issue Identified	Recommendation / Action to be undertaken	Status	Owner	Anticipated completion	Comments (Constraints for delivery)	Completion Comments
01	Tertiary Tower back up supply. The generator supporting the Tertiary Tower could not support the full load of this building.	Whilst this will be addressed within the delivery of the Tertiary Tower Electrical Infrastructure Upgrade Scheme which has received All Wales Capital Funding, there is a requirement to ***develop a Clinical Business Continuity Plan for this building in the interim.***	In Construction	Head of Discretionary Capital	Dec - 2026	The installation of a new generator to feed tertiary tower is ongoing and is due for completion in December 2026 Clinical Business Continuity Plans are in place, and a number of tests have been undertaken since the action was raised with no further significant issues reported from the clinical services.	
02	Reliance on HV generator for critical services – radiology, pharmacy, critical care, CCU, Respiratory Ward, Dialysis Units.	Consider options to provide generator back-up in addition to the HV generator for critical services currently support by HV only.	In design	Head of Discretionary Capital	Q4 2026/27	Detailed electrical design works are required to provide emergency connections points on the LV network to support the system in the event of a main HV failure. Due to the current limitations and location of the existing low voltage services feeding these areas, emergency connections are not suitable. There are currently two Capital Schemes being considered in support of this action. CCU is being designed with a dedicated emergency back up generator, the other is the long term capital project to provide N+1 to the whole site via a new dedicated incoming supply and HV generator.	

03	Maternity - Limited essential supply sockets for medical equipment devices such as monitoring machines.	Increase essential power supply to maternity services.	**Completed**	Head of Discretionary Capital	Q2 2025/26	Detailed electrical design works are required to ensure there is sufficient capacity on the network not to risk overloading the current system. To be added to the electrical design programme for 2025.	Works have been undertaken to increase the scope of UPS cover, with installation of additional essential sockets within areas considered higher risk. Further generator testing has been undertaken with successful feedback from the clinical teams.
04	Dialysis services water supply not supported by UPS resulting in temporary loss of water supply	One or both ROs should be support by UPS.	**Completed**	Head of Discretionary Capital	Q4 2024/25	Scheme has been tendered, confirmation of funding source required, £96k inc. of VAT.	A full UPS system has been installed to provide suitable support in the event of a loss of power within the area, allowing sufficient time to move across to generator supply. This has been successfully tested following further generator tests with no disruption to the dialysis machines.
05	Tower Block 2 Labs - Option to provide either a local device-based UPS or CEF to supply and maintain UPS for the area.	Agreement of approach to UPS for Tower Block 2	In Construction	Head of Discretionary Capital	Q3 2026/27	Critical Labs have been identified through the Clinical Boards, such as, Blood Bank and Biochemistry. UPS have been installed and changeover of circuits is currently being planned with clinical teams and estates.	
06	Loss of neutral circuit within the BMS controls impacted on the load shedding and re-energising power at the Ward Blocks and Tower Block 1	Review and upgrade the Building Management System to ensure reliability as the current system failed and required manual intervention	Design	Head of Discretionary Capital	Q4 2026/27	Detailed electrical design works are currently being undertaken by Schnieder to provide a replacement High Voltage load shedding and switching system.	

APPENDIX 1 2024-25 Operation POET Actions / Recommendations

Ref.	Issue Identified	Recommendation / Action to be undertaken	Status	Owner	Anticipated completion	Comments (Constraints for delivery)	Completion Comments
01	TDSI across sites, 'fail open' however, will require to be 'fail shut' in critical areas / areas that have a legal requirement to secure	Exercise to be undertaken with CEF & Ops to review the maintenance contract and battery replacement for specifically agreed areas.	Ongoing	Operational Lead UHW /UHL Head of Disc. Capital (DC)	Q3 2025/26	Ops to confirm areas which require continuity of operation. CEF to identify doors within the areas to establish scope of work required and potential solutions.	
02	Identification of any service location changes since the latest main event to ensure that they are familiarised with what to expect during a power outage in that area.	Existing exploded diagram of UHW to be issued to Director of Operational Planning (DoP) to review / update if required Exploded diagrams of the sites to be centralised for the planning preparatory works and a review of any service location changes across both hospital sites.	**Completed**	Head of Estates	Q1 2025/26		Detailed floor plans and exploded diagrams given to Head of Operations to support planning. These are to be used in preparation for 2026 testing.
03	Comms / Two-way radio's	Improved system to be identified with the Head of Security and EPRR	**Closed / Duplication**	Head of Security	Q2 2026/27	EPRR and Security to identified areas of poor coverage. Repair works have been undertaken to several areas within the UHL site which improved coverage overall. Head of Security currently reviewing areas of poor coverage across UHW & UHL with the suppliers.	

04	Sensor operated WC's and Scrub sinks will not operate without electricity	Sensor operated WC's to be added on essential supply	**Completed**	Head of Estates	Q4 2024/25	Manual taps to be fitted as an alternative to sensor taps in theatres etc. WC's to be connected to essential circuits.	Individual circuits that support the WC's have now been transferred to the essential supply which is supported by the emergency backup generator.
05	RO Plant – Dialysis Water became available; however, issues were identified with the indicator light which impacted on patient activity	CEF to contact 'Baxter' to attend site and investigate	**Completed**	Head of Estates	Q4 2024/25		A full UPS system has been installed to provide suitable support in the event of a loss of power within the area, allowing sufficient time to move across to generator supply. This has been successfully tested following further generator tests with no disruption to the dialysis machines.
06	RO Plant requires UPS	UPS to RO Plant to be prioritised	**Completed**	Head of DC	Q4 2024/25	Scheme has been tendered, confirmation of funding source required, £96k inc. of VAT.	A full UPS system has been installed to provide suitable support in the event of a loss of power within the area, allowing sufficient time to move across to generator supply. This has been successfully tested following further generator tests with no disruption to the dialysis machines.
07	IT issues identified with Maternity equipment which is supported by Hub-41	UPS for Hub41 required due to the criticality of the 'Omniview' machines	**Completed**	Head of DC	Q1 2025/26	Design, tender and funding to be included in the draft capital programme 2025/26.	
08	Potential for UPS to be added to hubs that support critical clinical system to mitigate loss	Identification of critical clinical systems that require IT and Estate response	Ongoing	Head of Digital Operations	TBC	RK to confirm with Ops leads the requirements.	

10	Differences identified in 'change over' to HV generator and 'change back' to mains power	Load shedding control	**Duplication**	Head of Discretionary Capital	Q2 2025/26	Detailed electrical design works are required to provide a replacement High Voltage load shedding and switching system. To be added to the electrical design programme for 2025	**Removed due to duplication in 2023/24 06.**
11	Main switch board breakers did not operate as expected	Review to be undertaken to establish the potential cause	**Completed**	Head of Estates	Q4 2024/25	Specialist contractors to review the switch	Contractors have undertaken post inspection and full service to ensure correct operation.
12	Essential equipment on non-essential supply	Undertake a comprehensive survey at UHL of the areas with Ops, Estates, Clinical Engineering and IT	**Completed**	Head of Estates	Q1 2025/26	Detailed site inspection of all areas to identify equipment and supplies	Full operational review of areas undertaken in readiness for on load generator testing.
12	Site wide communication channels	Improved communications strategy prior to any shutdown	**Completed**	Director of Comms	Q1 2025/26	Improved and targeted communications to ensure maximum awareness across all areas.	Communications have improved significantly with a dedicated Operations Director and the ongoing use of Clinical Walkarounds with staff in dedicated areas of concern.
13	Requirement to undertake routine tests of the generators at UHW	Establish a plan for the routine testing of generators, on load.	Ongoing	Head of Estates	Q4 2026/27	The routine generator tests are not yet fully established due to the infrastructure works being undertaken, such as the replacement of Substation 2A and the transfer of supplies for the Tower Block 1 essential and non-essential risers, which require significant electrical engineer and clinical support. However, during these works generator tests have been undertaken to prove the systems, in addition to on load generator tests during the planning stages of the annual Operation 'POET' exercises.	

APPENDIX 1 2025-26 Operation POET Actions / Recommendations UHL

Ref.	Issue Identified	Recommendation / Action to be undertaken	Status	Owner	Anticipated completion	Comments (Constraints for delivery)	Completion Comments
01	West Side Generators now switching, manual switching requirement.	Undertake further ACB servicing, however this has in the past still failed following servicing.	**Completed**	Head of Estates	Q1 2026/27	Does this require further capital investment for replacement.	Service undertaken and emergency generator tests completed across site.
02	Communications – radio reception has been poor across the site.	Better coverage for this POET however does this need further consideration.	Ongoing	Head of Security	Q1 2026/27	Engaged with EPRR and Security identify areas of poor coverage. Repair works have been undertaken to several areas within the UHL site which improved coverage overall. Head of Security currently reviewing areas of poor coverage further with the suppliers.	
03	No Emergency Lighting within Labs (PHW).		Ongoing	Head of DC	Q3 2026/27	Review has been undertaken remedial actions are ongoing to meet the current standards This will be addressed under the emergency lighting scheme	
04	Continued network/IT issues.		**Completed**	Head of Digital Operations	Q1 2026/27	Survey to be undertaken by the digital team to confirm which areas require additional support.	Survey undertaken and works to support have been undertaken for known issues.

Report Title:	Health and Safety Annual Report April 2025 – March 2026			Agenda Item no.	3.1
Meeting:	Digital and Infrastructure Committee	Public	X	Meeting Date:	04/08/2026
		Private			
Status *(please tick one only):*	Assurance		Approval		Information X
Lead Executive Title:	Executive Director of People and Culture				
Report Author (Title):	Assistant Director of Health, Safety and Fire				

Main Report

Background and current situation:

A Health and Safety annual report has been produced to provide assurance to the Board regarding the effectiveness of the Health Board's health, safety and fire safety arrangements.

Executive Summary

The Annual Health and Safety Report demonstrates continued progress in strengthening the Health Board's health, safety and fire safety arrangements during 2025/26. Significant progress has been made in embedding the Health and Safety Culture Plan, local health and safety planning processes and the Health and Safety Management System, with delivery of the Culture Plan reaching 89%. The reporting period saw improvements in incident management, violence prevention, risk management and governance arrangements. The transfer of the corporate Health and Safety and Fire Safety risk registers into AMaT has strengthened organisational oversight and assurance, and no health and safety or fire safety risks remained at a score of 20 or above on the corporate risk registers at year end.

A significant achievement during the year was the sustained reduction in RIDDOR-reportable incidents, which remained approximately 20% below historical levels for a second consecutive year. This provides increasing assurance that improvements in incident review, investigation and preventative interventions are becoming embedded across the organisation.

Further progress was made in managing workplace violence and aggression and manual handling risks through enhanced partnership working with criminal justice agencies, improved outcomes for staff affected by violence and aggression, the introduction of a UHB-wide patient handling audit programme, expanded bariatric equipment provision and service improvements supporting community-based care.
The Department also continued to provide assurance and specialist support across fire safety, environmental monitoring, occupational health, contractor management, emergency preparedness and regulatory compliance, whilst supporting continued investment in fire safety governance and infrastructure.

Whilst opportunities for further improvement remain in relation to training compliance, unwanted fire signals and work-related absence, the overall position demonstrates continued progress towards a more mature, proactive and integrated approach to the management of health, safety and fire risks across Cardiff and Vale University Health Board.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The Health and Safety department continue to work with the Clinical/Service Boards to drive improvements in all elements of Health, Safety and Fire.

Recommendation:

The Committee is requested to:

a) Note the content of the H&S Annual Report.
b) Take assurance from the progress made during the reporting period.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please place an "X" in the below boxes as relevant.*			
1. Putting People First **Click the objective above to view more detail.**		2. Providing Outstanding Quality **Click the objective above to view more detail.**	
3. Delivering in the Right Places **Click the objective above to view more detail.**		4. Acting for the Future **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered *Please place an "**X**" in the below boxes as relevant*									
Prevention		Long term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?: *Please place an "**X**" in the below boxes as relevant. Any queries, please contact Alexandra.scott3@wales.nhs.uk*				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		*Comment here*

Impact Assessment: *Please state **yes** or **no** for each category. **If yes please provide further details.***
Risk: No
The report is an appraisal of previous year's performance for noting only
Safety: No
The report is an appraisal of previous year's performance for noting only
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:
Digital & Infrastructure Committee	04.08.2026

2025 – 2026 Annual
Health and Safety Report

Health & Safety Team

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

Contents

IMS-01: Responsibilities and Accountability

The Health and Safety annual report has been produced to provide an overview of the breadth of work undertaken by the health and safety team and the overarching performance of the many facets of health and safety throughout the Health Board.

The department has continued to support the clinical/service boards, supporting functions, relevant stakeholders and interested parties throughout the reporting period.

1.1 Health and Safety Culture Plan

The department has continued to deliver the Health and Safety Culture Plan through ongoing collaboration with Clinical and Service Boards across the Health Board. Progress against the six themes has continued throughout the reporting period, with closure of specific actions monitored and reported quarterly to the People and Culture Committee.

At the end of the reporting period, delivery of the current plan is 89% complete. In parallel, the department has commenced development of the next planning and strategic cycle, aligned to the wider People and Culture Plan, to ensure continued improvement and organisational focus on health, safety and wellbeing priorities.

Table1.1

Tracker sets							
Title	Total Group	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5	Theme 6
Actions Not Started	4	0	2	2	0	0	0
Actions In Progress	8	2	2	2	2	0	0
Actions Completed	100	28	17	8	11	7	29

Theme 1: Training
Theme 2: Risk and Incident Management
Theme 3: Communication
Theme 4: Performance and Review
Theme 5: Audit
Theme 6: Fire

1.2 Annual Departmental Health and Safety Plan

As well as the overarching Health and Safety Culture Plan, the organisation has continued to embed localised annual health and safety plans as part of its commitment to continual improvement. Now in its second year of implementation, this approach is becoming increasingly established across departments.
The plans were originally introduced following the Health and Safety Executive (HSE) Manual Handling and Violence and Aggression intervention in November 2023. They replaced the previous Health and Safety Priority Improvement Plan (PIP), providing clearer differentiation between proactive planning activities and the risk register, and setting out how organisational health and safety policy requirements are delivered at a local level.

The plans utilise a structured, scorable format, with actions aligned to the following key themes:

- Safety
- Health
- Fire
- Quality

In the first year of implementation, overall departmental completion was 59%. During this reporting period, performance has improved, with the Health and Safety Department achieving a year-end completion rate of 86% against a KPI of 85%. This demonstrates positive progress in embedding the planning framework and strengthening delivery against defined health and safety objectives.

IMS-02: Management System

The department has continued to develop and embed the health and safety management system established in 2022/2023. Now in its second year of implementation, the programme of Annual Health and Safety Management System Reviews is providing an increasingly robust framework for assurance and continuous improvement across clinical and service boards.

During the reporting period, 8 out of 9 planned reviews were completed, representing strong delivery against the agreed programme and demonstrating continued progress in embedding systematic review processes. This builds on the initial implementation phase and reflects growing organisational maturity in the application of the management system.

The purpose of the review is to:

- Assess the suitability, adequacy and effectiveness of the health and safety management system, and identify and address any gaps
- Evaluate the extent to which the management system (or equivalent local arrangements) is being effectively implemented
- Provide assurance to the Operational Health and Safety Group and Executive Board that health and safety risks are being appropriately managed across CAVUHB

The outcomes of the reviews have supported improved visibility of system performance, informed targeted improvement actions, and strengthened assurance arrangements at both operational and strategic levels. While one review was not completed within the reporting period, overall performance demonstrates a sustained commitment to embedding effective health and safety governance and continuous improvement.

2.1 Policies and Procedures Approved by the People and Culture Committee/Executive Director of People and Culture and Operational H&S Group

The following procedures were written or reviewed and approved:

- IMS-06-02-CRI: Fire Safety Procedure – Cardiff Royal Infirmary (CRI) – UHB 517
- IMS-06-02-BCH: Fire Safety Procedure – Barry Hospital – UHB 569
- IMS-06-02-Communities: Fire Safety Procedure - GP Surgeries, Clinics, Health Centre's & Community Buildings – UHB 570
- IMS-06-02-SDH: Fire Safety Procedure – St David's Hospital – UHB 571
- IMS-06-02-UHL: Fire Safety Procedure – University Hospital Llandough (UHL) – UHB 572.
- IMS-07-02-CAV: Risk Assessment Procedure
- IMS-08-04-CAV: Serious Incident Review Procedure
- IMS-09-01-CAV: Personal Protective Equipment Procedure
- IMS-10-04-CAV: Noise Procedure
- IMS-10-10-CAV: Display Screen Equipment [DSE] and Eye Test Procedure
- IMS-10-12-CAV: First Aid at Work Procedure
- IMS-11-01-CAV: Violence and Aggression [Personal Safety] Procedure

IMS-03: Document and Data Control

CAVUHB maintains a formal process for the control of documents and data under the ownership of the Corporate Governance department. This process ensures that all key policies, procedures, and records are appropriately managed, version-controlled, and accessible to staff as required.

During the reporting period, there were no updates or changes to the document and data control process. The continued maintenance of this system supports organisational compliance, ensures the integrity of key information, and provides ongoing assurance that documents and data are managed consistently in line with governance requirements.

IMS-04: Testing and Calibration

The department continued to support the wider UHB in terms of environmental monitoring; this included the purchase of new vibration monitoring equipment.

Equipment registers are held by the department to ensure all in-scope items are tested and calibrated as per manufacturer's requirements.

IMS-05: Audits

5.1: Internal Audits

The department has previously provided reasonable assurance to NWSSP Audit and Assurance Services, and as such, no internal audits were conducted by the H&S Department during the reporting period.

5.2: Management System Audits

The department continued the management system audit programme, with five conducted during the reporting year within various clinical boards.

Additionally, focused audits were conducted for Control of Substances Hazardous to Health (COSHH), manual handling and Safe Intervention for the Management of Aggression (SIMA) training.

Audits conducted by the health and safety department are captured and tracked using web-based i-Auditor software.

IMS-06: Fire Safety Management

Fire Safety Management is a key priority for Cardiff and Vale UHB both in terms of achieving statutory compliance and ensuring the safety of staff, patients and all other stakeholders. It is widely recognised that fire safety management in healthcare is a complex and challenging discipline with risks being identified, prioritised and mitigated.

6.1 Welsh Assembly Government Annual Fire Safety Audits

The annual fire safety audits carried out by the Senior Fire Safety Officer on behalf of the Welsh Government (WG) were completed and submitted in 2025 for the previous reporting period using the on-line web-based reporting system administered by NHS Wales Shared Services Partnership - Specialist Estates Services who prepare an All-Wales UHB report submitted to WG.

6.2 Fire Risk Assessments

The principal fire safety legislation applicable to all Health Board premises is the Regulatory Reform (Fire Safety) Order 2005 (FSO) enforced by the Local Fire Authority. Part of this compliance requires a fire risk assessment to be completed for every building, ward or department, currently there are 414 risk assessment reports that are being regularly assessed and reviewed by members of the fire safety management team either annually, bi or tri-annually or they may be amended whenever material alterations or significant changes in use take place in terms of service or staff.

6.3 Enforcing Authority Audits and Notices

This is covered in IMS-16: Communication

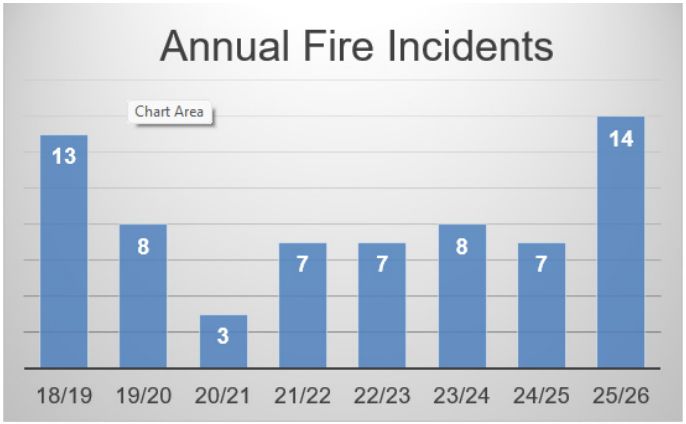
6.4 Fires and Unwanted Fire Signals

Fire Incidents for the period – 1st April 2025 to 31st March 2026

Table 6.4.1

No	Date	Fire Incident Location	Cause	How Extinguished
1	07/04/2025	Pharmacy roof UHW	Contractor hot works	Extinguished by contractor.
2	08/04/2025	TB3 5F - UHW	Electrical equipment failure	No visible flame, electric fan was isolated and removed from the area.
3	09/04/2025	Alder Ward - HYC	Unattended cooking process	Extinguished by UHB staff.
4	17/07/2025	UHL - Specialist Spinal and Neuro Rehab Therapies outpatients	Unattended cooking process	No fire present, large quantities of smoke produced overcooked food.
5	04/08/2025	Outside the main entrance to HYC.	Discarded Smoking materials place within waste bin	Extinguished by UHB staff.
6	07/08/2025	On steps outside Y-Gegin restaurant UHW	Discarded Smoking materials place within waste bin	Extinguished by UHB staff.
7	08/08/2025	External side of wooden fence outside Ash ward in HYC	Evidence of discarded smoking materials were the likely cause.	Extinguished by UHB staff.
8	09/08/2025	External area of the UHW concourse	Discarded Smoking materials place within waste bin with a lighter to a mattress	Extinguished by UHB staff.
9	23/08/2025	Island Ward UHW	Electric breast pump placed into a steriliser and then into the microwave	Staff removed the steriliser to an external area.
10	12/10/2025	Cedar Ward HYC	Patient snapped mobile phone causing battery thermal runaway	Extinguished by UHB staff.
11	03/11/2025	Roath Clinic	Deliberately set in an area known to be occasionally used by individuals experiencing homelessness	Self-extinguished.
12	18/12/2025	Cystic Fibrosis Unit - UHL	Overheating of the backup batteries within the emergency lighting system.	Estates isolated and locked off the system, batteries then removed to a safe location.
13	07/01/2026	Ward East 1 (MEAU) - UHL	Unattended cooking process, waste bin subsequently caught fire when food was discarded.	Extinguished by UHB staff.
14	12/02/2026	Ward East 12 MHSOP - UHL	Unattended cooking process.	Extinguished by UHB staff.

Graph 6.4.1



In 2025/26, fire incidents increased to 14, returning to levels last seen in 2018/19. Analysis of incident data identifies that the majority of fires during the reporting period were attributable to smoking-related activity and cooking processes, rather than failures of fire safety systems or infrastructure.

This indicates that the primary risk remains behavioral rather than systemic, with existing fire detection, alarm, and containment measures continuing to function as intended. However, the increase in incidents highlights the need for renewed focus on risk reduction interventions targeting smoking and cooking practices, including staff awareness, patient engagement, and local control measures. Overall, while fire safety systems remain effective, the data demonstrates that sustained improvement will depend on influencing behaviours and strengthening preventative controls in higher-risk areas.

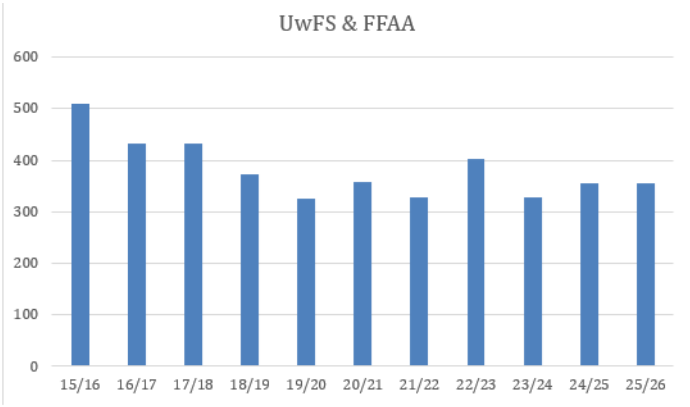
UwFS 1 April 2025 – 31 March 2026 (SWFRS attended/unattended)

Table 6.4.2

Site	UwFS/FFAA	Grade
Barry Hospital	1	A
Cardiff Edge (Genomics)	5	N/A
Cardiff Royal Infirmary	5	A
Dental Hospital (University Hospital of Wales)	2	N/A
Hafan Y Coed	14	B - 10% reduction in UwFS
Llandough Hospital	46	A
Rookwood Hospital	1	N/A
St David's Hospital (Cardiff)	0	A
UHW	281	B - 10% reduction in UwFS
Total	**355**	

Unwanted Fire Signals and False Fire Alarm Actuations by Financial Year

Graph 6.4.2



Performance in unwanted fire signals has almost mirrored the previous reporting period, from 356 to 355. The Fire Safety Team has carried out trend analysis and identified several recurring causes, including unattended cooking, contractor related activations, and system faults. It is recognised that false fire alarm activations are extremely challenging to prevent, particularly at UHW, due to the size and complexity of the fire alarm and detection system. Other contributing factors include challenging patient categories with a wide range of abilities, many of whom will be unfamiliar with our sites with some being mobility impaired.

UHW remains the primary source of UwFS, and targeted estates funding (TEF) has been secured to support system upgrades across the site. These improvements are aimed at reducing activations caused by system faults and enhancing overall reliability. A reduction of at least 10% is required across UHW and Hafan-Y-Coed respectively to improve performance grades at both sites.

6.5 Fire Safety Policy, Procedures and Permits

The reviewed or implemented procedures are listed in IMS-02.

At the commencement of this financial year, 2025/2026, SWFRS implemented a new call challenge procedure to automatic fire alarms (AFA'S). Given this change, fire management processes were implemented across both of our acute hospital sites (UHW and UHL), and evidence shows they are operating effectively. In addition, all eight business cases submitted to SWFRS requesting exemptions for our critical community sites, where applying their AFA procedure would have created significant societal risk, were approved by the service.

Since the SWFRS changes to the AFA response procedure were introduced, the service has recorded a 43% reduction in AFA callouts and an 89% reduction in hospital-related responses across the service area.

6.6 Provision of Fire Safety Advice on Capital Projects

During the preceding 12 months the fire safety management team have completed technical reviews and reports for all major capital and minor discretionary capital projects undertaken PAN Estate. These include:

- UHW ITU Scheme, including 8th floor plant room scope.
- UHW Ward C1.
- Woodland House Mass Vaccination rooms.
- UHW Emergency Generator.
- Park View Health and Wellbeing Centre.
- Pentyrch Health Centre
- UHL Fire Alarm system zoning including Cause and effect.
- UHW Main Theatres, including recovery room and external UPS.
- Jungle Ward Ph1 CHfW.
- HYC seclusion room and reception refurbishment.

6.7 Capital Investment in Fire Safety Precautions and Service

- The fire safety team continues to work with capital planning in the bid process for Targeted Estates Funding (TEF). This provides a significant investment vehicle for the estate fire safety infrastructure.

Projects have included.

- Ongoing fire stopping project - An expanded annual budget has been requested via SBAR to support the continuing fire stopping works PAN Estate.
- Fire alarm and detection system upgrade project at UHW and UHL.

6.8 Other Notable Fire Related Workstreams

- Deputy Fire Safety Managers and Fire Safety Group continues to operate.
- The new Shared Services fire risk assessment system, implemented across NHS Wales to capture all FRAs, is giving the organisation stronger assurance that fire safety is being managed effectively by enabling the tracking of outstanding risks through to resolution.
- Fire safety training for UHB staff remains ongoing, covering in person fire training, fire warden courses, and evacuation chair instruction. To broaden accessibility, virtual face to face training was launched through Teams in January 2026.
- Practical evacuation drills have been completed in some areas across the estate.
- Fire Risk Assessment schedule 95% up to date.

IMS-07: Risk Management

During the reporting period, the Health and Safety Team continued to support the clinical and service boards in the identification, assessment and management of high-risk and complex activities across the full range of departmental functions. This included the provision of specialist advice, guidance and assurance in relation to general health and safety, fire safety, manual handling, and violence and aggression. Support was provided through collaborative risk assessment processes, incident review, development of safe systems of work, and targeted engagement with operational teams to ensure that risks were appropriately controlled and managed in line with statutory requirements and organisational policy.

7.1 Risk Registers

In line with the organisational strategy to strengthen governance, oversight and reporting arrangements, the corporate Health and Safety and Fire Safety risk registers were successfully transferred to the Auditing Management and Tracking (AMaT) system during the year. The transition has improved visibility, consistency and monitoring of risks, enabling enhanced tracking of mitigating actions and supporting a more streamlined approach to assurance reporting across the organisation.

The corporate Health and Safety and Fire Safety risk registers continued to be formally submitted to, and reviewed by, the People and Culture Committee on a six-monthly basis. This ensured continued executive oversight of key risks, mitigation measures and areas requiring further action or assurance.
At the end of the reporting period, there were no Health and Safety or Fire Safety risks assessed at a score of 20 or above on the corporate risk registers, reflecting the continued focus on proactive risk management, governance and organisational assurance arrangements.

IMS-08: Incident Management

During 2025/2026, continued emphasis has been placed on maintaining a robust and effective incident management framework, with a particular focus on incidents that meet Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) thresholds, as well as those with the potential to cause significant harm. Strong governance arrangements remain in place to ensure that incidents are appropriately reviewed and investigated. Monthly Serious Incident Reviews (SIRs) are undertaken in collaboration with clinical and service boards, providing structured oversight of significant events and ensuring that appropriate corrective and preventative actions are implemented. Key themes and outcomes are shared through established forums, including the monthly health and safety dashboard, clinical and service board meetings, and the Operational Health and Safety Group.
During the reporting period, 77 incidents were reported to the Health and Safety Executive (HSE) under RIDDOR. This represents a sustained reduction compared to historical levels and demonstrates continued improvement in this key performance indicator.

As in previous years, approximately 90% of staff-related RIDDOR submissions relate to incidents resulting in absences exceeding seven days. This remains notably higher than the wider UK workplace profile, where figures are typically closer to 70%.
The Health and Safety Department continues to contribute to a wider organisational sickness reduction programme led by People Services. This collaborative approach is focused on better understanding the causes of work-related absence, strengthening preventative measures, and supporting staff wellbeing, with the aim of further reducing both incident frequency and associated lost time. Overall, the organisation continues to demonstrate a mature and proactive approach to incident management, underpinned by strong governance and a clear commitment to continuous improvement.

8.1 Incident reporting and data

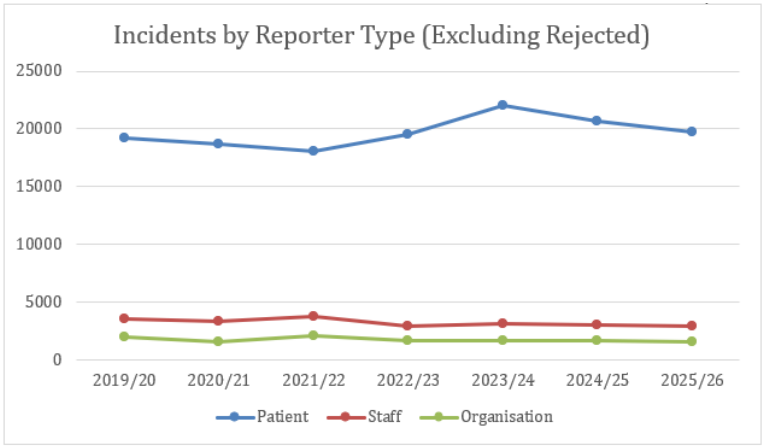
Table 8.1 shows the total number of incidents reported over the last 6 years.

Incidents reported by date reported excluding rejected	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Patient	18671	18046	19506	21988	20719	19719
Staff	3361	3785	2925	3130	2997	2905
Organisation	1513	2036	1653	1684	1681	1595
Public/Visitor	81	68	86	79	107	114
Totals:	23626	23935	24170	26877	25504	24333

Overall, the 2025/26 position demonstrates a modest reduction across most categories over the previous two years, with patient incidents continuing to account for the majority of reported events.

Graphical representation of 5-year incident trend of incidents reported by patients, staff and organisation. The organisational entries are UHB wide and include infrastructure and estate issues.

Graph 8.1



Staff Incidents by reported date

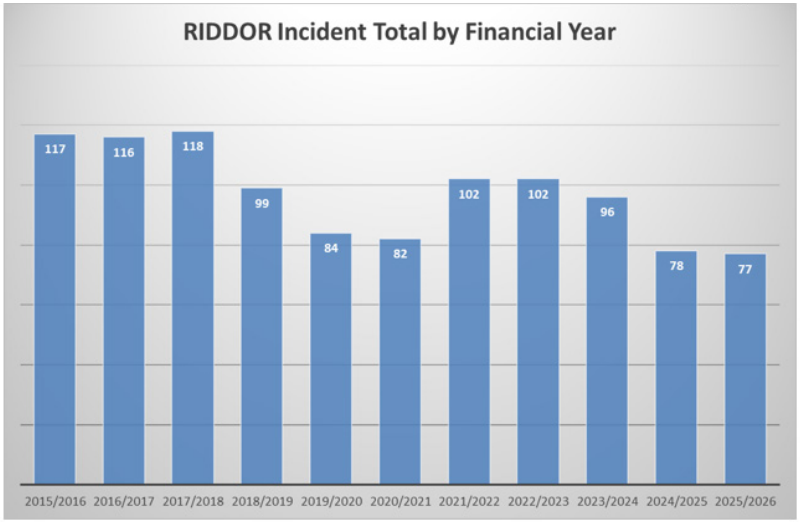
Table 8.2

Staff incidents by Classification	Total
Behaviour (including violence and aggression)	2045*
Accident, Injury	828
Infrastructure (including staffing, facilities, environment)	237
Communication	81
Ill health (work related)	41
Equipment, Devices	80
Information Governance, Confidentiality	19
Information Technology	12
Records, Information	17
Safeguarding	13
Transfer, Discharge	15
Total	3388

**Behaviour incidents also include incidents reported as patient affected where the subcategory identifies that the behaviour was directed towards a member of staff.*

Histogram of RIDDORS by year from 2018/19 to 2025/26

Graph 8.2



Reported RIDDOR incidents by Clinical/Service Board

Table 8.3

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	KPI
AWMGS	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CEF	3	0	4	3	0	0	2	2	3	5	1	1	24	17
Mental Health	2	0	1	0	2	1	0	0	1	1	0	5	13	13
Specialist	1	2	1	0	2	2	0	0	0	2	3	0	13	13
CD&T	0	0	0	0	0	0	0	0	0	0	1	1	2	3
Medicine	1	3	2	4	0	3	0	0	0	0	2	1	16	10
Surgical	0	2	2	0	0	0	1	0	0	0	0	1	6	8
PCIC	0	1	0	0	0	0	0	0	0	0	0	0	1	0
Children and Women	0	0	0	0	0	2	0	0	0	0	0	0	2	5
Total	7	8	10	7	4	8	3	2	4	8	7	9	**77**	**69**

Reported RIDDOR incidents by incident category

Table 8.4

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Accident, Injury	Burns or scalds	1	0	0	1	0	0	0	1	1	1	0	0	5
	Contact with needles or medical sharps	0	0	0	0	0	0	0	0	0	0	0	1	1
	Contact with object or animal	0	1	1	0	0	0	1	0	0	0	0	0	3
	Manual Handling - Non patient/service user handling	1	0	1	0	1	Close	1	0	1	2	0	1	9
	Manual Handling - Patient/service user handling	1	3	1	1	1	3	1	1	0	0	1	0	13
	Slip, trip or fall	1	2	3	3	1	2	0	0	0	3	1	1	17
	Struck against or by an object	0	0	1	0	0	1	0	0	1	1	1	1	6
	Total	4	6	7	5	3	7	3	2	3	7	3	4	54
Behaviour (including violence and aggression)	Aggressive/threatening behaviour	0	0	1	1	0	0	0	0	0	0	0	0	2
	Patient clinically challenging behaviour	1	0	0	0	0	0	0	0	0	0	0	2	3
	Physical assault (physical contact)	2	2	2	1	1	1	0	0	1	1	4	3	18
	Total	3	2	3	2	1	1	0	0	1	1	4	5	23
Total		7	8	10	7	4	8	3	2	4	8	7	9	**77**

Table 8.5

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Injury > 7 days	6	6	8	6	4	8	2	2	4	5	7	8	66
Injury to a member of the public, taken directly to the hospital or injured on hospital grounds	0	1	1	1	0	0	0	0	Close	1	0	0	4
Specified Injury	1	1	1	0	0	0	1	0	0	2	0	1	7
Total	7	8	10	7	4	8	3	2	4	8	7	9	77

IMS-09: Personal Protective Equipment

9.1 Face Fitting and Respiratory Protective Equipment

Personal Protective Equipment (PPE) encompasses a wide range of control measures; however, within the UHB the predominant focus continues to be on Respiratory Protective Equipment (RPE), reflecting the nature of clinical risks and the ongoing requirement for effective respiratory protection across services. The Health and Safety Department has continued to deliver a comprehensive face fit testing programme across the UHB and partner organisations. This has included both direct face fit testing of staff and the development of local capability through structured training.

The department has continued to train fit testers across clinical and service boards, strengthening local capacity and supporting timely access to compliant RPE provision. This approach supports a sustainable and responsive model, enabling services to maintain compliance with legislative requirements while retaining flexibility to meet operational demands. Ongoing focus has been placed on maintaining standards of competence, consistency in testing methodologies, and alignment with current guidance, ensuring that RPE provision remains effective in protecting staff.

9.2 General Personal Protective Equipment

In addition to RPE, the Health and Safety Department continues to provide advice and support on the selection, use, and management of general PPE across the UHB.

This support is largely delivered through responsive engagement with services, including guidance on risk assessment, equipment suitability, and compliance with relevant standards. While this represents a smaller proportion of activity compared to RPE, it remains an important aspect of ensuring appropriate protective measures are in place across a broad range of operational environments.

IMS-10: Health and Hygiene

10.1 Control of Substances Hazardous to Health (COSHH)

During the year, the UHB continued its programme of retraining COSHH Coordinators and Leads in the use of the approved management system for COSHH risk assessments. This work supports compliance with the COSHH Regulations and ensures those with COSHH responsibilities can effectively access, manage and maintain assessments within their areas.

Table 10.1

Count of Email	Column Labels		
Row Labels	Editor	Viewer	Grand Total
AWMGS	12		12
CDT	19	3	22
CW	7	3	10
EXECUTIVE	2		2
MEDICINE	1	1	2
MH	5		5
PCIC	3	1	4
SPECIALIST	1		1
SURGERY	7	10	17
Grand Total	**91**	**34**	**125**

As part of this review process, existing COSHH risk assessments are being systematically scrutinised, with redundant or obsolete assessments archived where they are no longer required. This has supported a reduction in assessment volume and improved clarity around current, in-use controls.

The Health and Safety Team continues to encourage all COSHH Leads and Coordinators to engage in training to ensure roles are clearly understood and applied consistently across the organisation.

10.2 Environmental Monitoring

The Health and Safety department continues to respond to the needs of the organisation to provide suitable and sufficient monitoring to cover a varied spectrum of environmental and occupational health-related risks. These include vibration, thermal comfort, noise, and monitoring of hazardous substances.

As part of the UHB's long-term environmental monitoring programme, a structured approach is maintained to identify, assess, and manage potential risks arising from workplace exposures. This includes a rolling 10-year monitoring programme for radon in accordance with regulatory expectations and established good practice.

During the current reporting period, elevated radon levels were identified within a defined section of the tunnel infrastructure. Subsequent monitoring was undertaken to validate the initial findings, which confirmed the presence of elevated concentrations within this specific area. A comprehensive risk assessment has been completed, incorporating both qualitative and quantitative analysis. This assessment concluded that the overall risk of exposure is low. The area in question was not designated as a work location and has historically only been used as a transient route, further limiting potential exposure duration.

In response to these findings, proportionate control measures have been implemented. The affected section of the tunnel has been isolated, and access is now strictly controlled through a permit-to-work system. This ensures that any entry is subject to appropriate oversight and risk control measures. Following risk assessment, the monitoring regime within this location has been revised from the standard 10-year cycle to an annual programme. This targeted approach ensures continued oversight of radon levels while remaining proportionate to the level of risk identified.

The Health and Safety Department will continue to review monitoring data and control measures alongside the UHB Radiation Protection Advisor to ensure that risks remain effectively managed and aligned with current guidance and best practice.

10.3 Occupational Health Monitoring

The Health and Safety department continues to work collaboratively with Occupational Health in the provision of UHB health surveillance. Over the past year, progress has been made in key areas including noise, vibration, and COSHH health surveillance. Looking ahead, the focus will remain on strengthening information sharing and coordination between services to further enhance assurance and support the UHB's overall health surveillance arrangements.

IMS-11: Violence Prevention Case Management

11.1 Violence Prevention Case Management

The Violence Prevention Case Management Team has continued to focus on reducing violence and aggression across the Health Board, providing practical support to affected staff and signposting individuals to appropriate formal support services. The Team has also worked closely with Clinical Boards to support the management of complex cases, providing specialist advice on risk assessment, risk management measures, and the implementation of appropriate interventions to safeguard staff.

The Team continues to work closely with South Wales Police, including the designated UHB Police Liaison Officer, as well as the Crown Prosecution Service and Witness Care, to support investigations and ensure that offences against staff are progressed appropriately through the criminal justice system.

Compared with 2024/25, the number of incidents referred to the Police increased by 15%, rising from 255 to 294 (+39 reports).

Positive outcomes continued to increase during 2025/26. Successful prosecutions and other criminal justice outcomes rose by 7%, from 55 to 59, while other sanctions and ASB related outcomes increased by 40%, rising from 50 to 70. In addition, the number of custodial sentences increased by 57%, from 7 in 2024/25 to 11 in 2025/26. These results demonstrate continued success in securing positive outcomes for offences committed against UHB staff and reinforce the organisation's commitment to supporting staff through the criminal justice process and pursuing appropriate action against those responsible for violence and abuse.

Outcome Table

Table 11.1

Year	No. referred to Police- verbal warnings or no further action	Successful Prosecutions/ Outcomes	Other Sanction ASB
2019/20	183	58	16
2020/21	213	77	65
2021/22	152	47	27
2022/23	58	16	183
2023/24	126	38	67
2024/25	255	55	50
2025/26	294	59	70

11.2 All Wales Anti Violence Collaborative (AVC)

The Health Board has continued to work with and support the All Wales AVC in its ongoing violence reduction work and promotion of the Obligatory Responses to Violence (ORV), which sets out the responsibilities of AVC partners when managing incidents of violence and aggression within the NHS. To further raise awareness of the support available, the Team and the UHB Police Liaison Officer jointly deliver presentations on the ORV process, highlighting the partnership approach between the Health Board

and South Wales Police and the support available to staff following incidents of violence and aggression.

11.3 Violent Warning Markers

The team continues to manage the violent warning marker system by reviewing alerts and adding or removing markers. These markers alert staff to potential violent risks, whether intentional or unintentional, without implying criminal responsibility.

Compared with 2024/25, the number of alerts raised by staff and subsequently reviewed and managed by the Team increased by 28%, rising from 224 to 287 (+63 alerts). During the same period, the number of violent warning markers placed increased by 30%, from 89 to 116 (+27 markers). These increases represent the highest annual figures recorded during the reporting period and reflect enhanced identification, reporting, and management of violence and aggression risks across the Health Board.

Violent Warning Marker Movements.

Table 11.2

Year	Alerts	Violent Marker Placed	Alternative Treatment Scheme (ATS) Markers	Violent Markers Removed
2019/20	112	24	10	77
2020/21	157	66	7	115
2021/22	242	101	7	77
2022/23	180	85	13	121
2023/24	186	75	10	71
2024/25	224	89	24	82
2025/26	287	116	18	94

11.4 Lone Worker Devices

Lone worker device usage compliance showed an improvement during 2025/26 when compared with the previous reporting period. Monthly compliance rates increased from an average of 45% in 2024/25 to 53% in 2025/26 and compliance exceeded 50% in 11 of the 12 months during 2025/26, peaking at 57% in May 2025, compared to a peak of 51% in March 2025 during the previous year. This demonstrates a sustained improvement in device usage and staff engagement with the lone worker system.

Several measures have been implemented to support improved compliance. From March 2025, scheduled monthly non-usage reports were introduced and shared directly with line managers to enable local monitoring and intervention. In addition, targeted text message campaigns have been delivered directly to device users to reinforce their responsibilities when lone working and the importance of using the system consistently. Device usage reports

are also now routinely reported through Clinical Board Health and Safety Meetings, providing greater oversight and accountability at a Clinical Board level. The Team continues to work closely with managers to address compliance issues through bespoke training and local support.

The Health Board continues to maintain ten dedicated lone worker devices to support colleagues identified as being at higher risk due to stalking, domestic abuse, or other personal safety concerns. These devices have been utilised by a number of staff during the reporting period, providing an additional layer of protection and reassurance while at work. The lone worker system remains a critical component of the Health Board's violence and aggression risk management arrangements, helping to enhance staff safety and wellbeing across the organisation.

11.5 Behaviour (Including Violence and Aggression) Incidents

Behaviour-related incidents, including violence and aggression towards staff, remained the most significant staff safety issue reported across Cardiff and Vale University Health Board during 2025/26. A total of 2,045 incidents were recorded within this classification, accounting for 60.4% of all staff incidents reported (2,045 of 3,388 incidents).

Of the 2,045 behaviour-related incidents reported, 23 were reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), representing 1.12% of all violence and aggression incidents.

IMS-12: Manual Handling

12.1 Advisors Report

The team has continued to proactively provide specialist support and advice to the wider UHB clinical/service boards.

In addition to the specialist support and advice, notable points during the reporting period are;

- A joint project was undertaken with the Senior Nurse for Professional Standards to introduce a UHB-wide Patient Handling Audit on Tendable. This audit has now been incorporated into the Care Specifics audit schedule across the UHB, supporting greater assurance, consistency, and monitoring of patient handling practices
- A comprehensive UHB-wide audit of Manual Handling equipment was completed to identify obsolete and end-of-life equipment, as well as gaps in equipment provision. The findings will support future procurement and replacement programmes, ensuring equipment availability aligns with current patient demographics and service needs.
- Identified and secured funding for an innovative solution to improve the efficiency of bed and mattress transfers for patients in the community. The initiative is expected to reduce equipment-related costs, minimise delays in patient care, and enhance service delivery. A comprehensive training programme was successfully delivered to all community staff who will be using the equipment, ensuring its safe and effective implementation.
- Continued further expansion of bariatric equipment provision for the UHB in conjunction with equipment provider to facilitate

rehabilitation of plus sized patients to include extra-large transfer/transport devices.

The department has also provided continued ongoing support work for all clinical/service boards across the UHB including;

- Complex community and hospital visits, this provides support to staff whilst being in line with the 6 goals for urgent and emergency care and home first approach to reduce the likelihood of readmission.
- Continuation of joint working with Local Authority therapy staff to ensure a seamless transfer of care for plus size patients on admission or discharge from hospital in relation to access to equipment.

12.2 Manual Handling Incidents

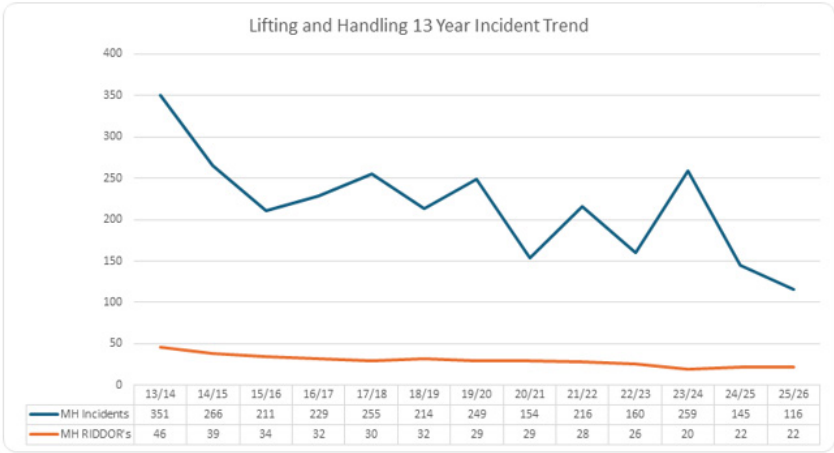
Staff manual Handling Incidents

Table 12.1

2025-2026 Staff Manual Handling Incidents	Total
Manual Handling - Equipment	2
Manual Handling - Non patient/service user handling	50
Manual Handling - Patient/service user handling	64
Total	116

The number of recorded manual handling incidents decreased during the reporting period compared with 2024/25. However, the number of RIDDOR-reportable incidents remained at 22; accounting for 19% of all reported manual handling incidents

Graph 12.1



IMS-13: Training

13.1 Training Compliance Health and Safety Training Compliance 1st April 2025

UHB Training Compliance

Table 13.1

	Moving and Handling - Level 1	Moving and Handling - Level 1b	Moving and Handling - Level 2	V&A - Module A	V&A - Module B	V&A - Module C	V&A - Module C+	V&A - Module D	Fire Safety	Health, Safety and Welfare
001 Cardiff and Vale University LHB	89.95%	62.60%	58.32%	91.33%	77.35%	41.71%	39.68%	52.34%	77.07%	86.68%

Clinical Board Training Compliance

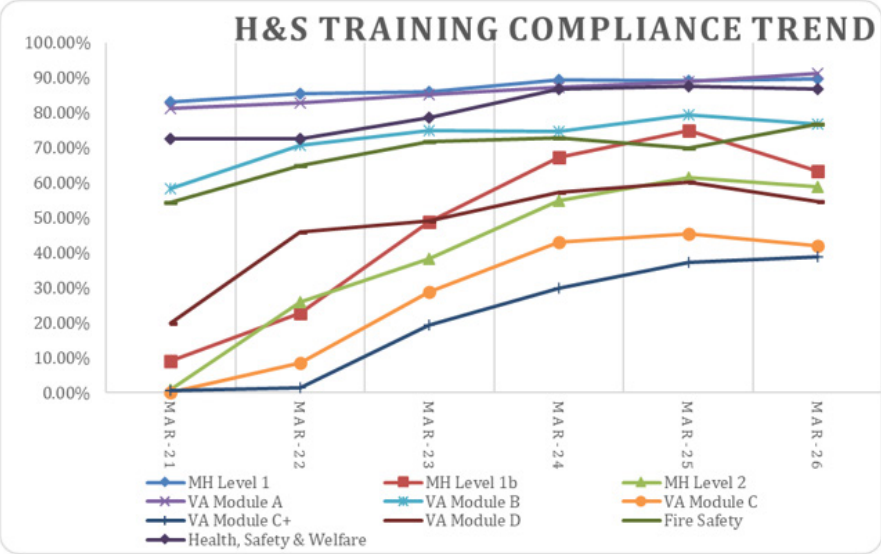
Table 13.2

CB	Moving and Handling - Level 1	Moving and Handling - Level 1b	Moving and Handling - Level 2	V&A - Module A	V&A - Module B	V&A - Module C	V&A - Module C+	V&A - Module D	Fire Safety	Health, Safety and Welfare
AWMGS	94.67%	85.64%		97.60%	82.91%	61.69%			84.53%	94.93%
CEF	95.82%	78.85%	95.18%	96.53%	92.00%	9.09%		28.21%	84.22%	91.37%
C&W	90.24%	39.39%	38.79%	91.96%	71.69%	38.60%	36.75%		78.51%	87.43%
CD&T	93.89%	62.57%	78.53%	94.73%	86.13%	53.78%			79.32%	88.62%
Executives	90.11%	40.00%	54.17%	93.13%	84.72%	53.57%			80.13%	88.42%
Medicine	86.76%	26.39%	58.80%	87.84%	68.11%	33.02%	38.59%		71.51%	84.06%
Mental Health	89.18%	50.00%	45.22%	94.05%	78.53%	32.73%		55.25%	76.31%	87.13%
PCIC	90.87%	49.46%	65.99%	92.85%	81.43%	51.23%			79.67%	87.42%
Specialist	88.62%	18.10%	62.55%	89.43%	73.37%	40.38%	41.94%		73.46%	85.16%
Surgical	84.95%	54.17%	61.66%	84.38%	73.60%	34.96%	80.00%		73.87%	82.11%

Course description

Moving and Handling Level 1	Awareness of manual handling theory	eLearning – core module of mandatory training for all staff
Moving and Handling Level 1b	Inanimate (object) load handling	Classroom
Moving and Handling Level 2	Patient handling	Classroom
Violence & Aggression (V&A) Module A	Awareness	eLearning – core module of mandatory training for all staff
Violence & Aggression (V&A) Module B	Theory & de-escalation	eLearning (included in classroom delivery for Module C+ courses)
Violence & Aggression (V&A) Module C	Communication skills and break & escape techniques	Classroom
Violence & Aggression (V&A) Module C+	Care control – restrictive physical intervention/safe hold techniques	Classroom
Violence & Aggression (V&A) Module D	Safe Intervention for the Management of Aggression (SIMA) techniques	Classroom – delivered by the Mental Health SIMA training team for Mental Health staff
Fire Safety	• Clinical staff - face to face annually. • Patient facing non-clinical staff - face to face every 2 years. Online training in alternate years. • Non patient facing, non-clinical staff - face to face every 3 years. Online training in other years.	eLearning, MS Teams & classroom – core module of mandatory training for all staff
Health, Safety & Welfare	Awareness	eLearning – core module of mandatory training for all staff

CAVUHB 4 Year Compliance Trend
Graph 13.1



A collaborative review commenced with ECOD to assess Manual Handling training requirements for all staff across the UHB. The review aims to ensure that the appropriate training levels are assigned to staff roles, resulting in a more accurate Training Needs Analysis (TNA). This will enable managers to monitor compliance more effectively and ensure that all staff who require Manual Handling training are appropriately allocated.

The reduction in Manual Handling Level 1b and the V&A courses is attributed to the commencement of this systematic review of these competencies assigned to staff. Whilst some staff had assigned training that was not required as part of their job role, a number of other staff members required training that had not been assigned to them. This short-term reduction was expected as the training matrix continues to be realigned. Despite this, overall compliance trends remain positive, with sustained improvements seen across most health and safety competencies over recent years. Compliance with manual handling and V&A eLearning showed improvement.

Fire Safety compliance showed a small reduction during 2024/25 and whilst it finished the reporting year below the 85% KPI, it continues to demonstrate continued improvement. The temporary decline is attributable to staffing challenges and the impact of changes to South Wales Fire and Rescue Service attendance arrangements for automatic fire alarm signals, which required significant organisational effort to review alarm response procedures. Both matters have now been addressed and are no longer considered to be significant factors affecting performance, providing a stronger foundation for further improvement in compliance during 2026/27

Training compliance therefore continues to strengthen overall, whilst the review process provides a more accurate reflection of actual training requirements across the workforce.

The Health and Safety department continues to offer the Manual Handling Workplace Competency Assessor (MHWCA) training course which enables staff to complete a manual handling competency assessment in the workplace with their local assessor. The programme continues to be positively evaluated.

There continues to be increasing uptake for the managing safely and risk assessment courses that the department offer. These are actioned through incident investigation and management system audits.

IMS-14 Contractor Management

The department continues to provide oversight and support to Clinical Boards in managing contractor activities that fall outside the scope of Capital, Estates and Facilities.

Key areas of activity during the reporting period have included:

- Roof works at University Hospital of Wales (UHW) for Teenage Cancer Trust
- Development of the Well Child Therapy Garden at University Hospital Llandough (UHL)
- Support to Haematology and Blood Transfusion Laboratory (BTL) for the new analysers, lab layout and associated works
- Ongoing transition and onboarding of contractor companies onto the Work Wallet system

In addition, the department has continued contractor management compliance audits using iAuditor. This enables routine monitoring of compliance standards, identification of areas for improvement, and supports a consistent approach to contractor governance across the organisation.

IMS-15 Emergency Planning

Monthly Health and Safety, Security, and Strategic Planning meetings continue to be held, attended by Heads of Department or nominated deputies. These meetings provide an opportunity to support partnership working, discuss future initiatives, and maintain alignment of strategic priorities.

The Assistant Director of Health, Safety and Fire continues to represent the function at the Strategic Operational Emergency Preparedness, Resilience and Response (EPRR) Group, supporting the integration of health and safety considerations within wider organisational emergency planning arrangements.

External Agency Fire Safety Training and Preparedness

South Wales Fire and Rescue Service (SWFRS) has commenced a new tactical phase of high-rise training to support both tactical and strategic officers. This is currently being delivered at Carmarthen House, following the planned demolition of Brecknock House.

Site-Specific Risk Information (SSRI) visits have continued across the organisation, including University Hospital of Wales (UHW), University Hospital Llandough (UHL), and Barry Hospital, ensuring that operational crews remain familiar with site layouts and associated risks.

Localised fire evacuation drills have been completed in collaboration with the EPRR team at West 8 and the Teddy Bear Nursery within UHL. Planning is also underway to deliver practical evacuation exercises within Haematology, the Intensive Care Unit (ICU), and Main Theatres at UHW. The ICU exercise will include coordinated input from EPRR colleagues and SWFRS to test multi-agency response arrangements.

Legislative Preparedness

Work has commenced, led by the Emergency Preparedness, Resilience and Response (EPRR) team, to develop documentation in response to the Terrorism (Protection of Premises) Act 2025. Health and Safety input is supporting consideration of the interface between enhanced security measures and existing fire safety arrangements to ensure both are effectively balanced.

Training and Capability Development

Staff across the UHB continue to receive training in civil contingencies, ranging from incident logging through to Gold (strategic) command. This programme is delivered by the EPRR team within the Chief Operating Officer's Directorate, supporting the development of organisational resilience and response capability.

IMS-16 Communications

16.1 Enforcement Agencies actioned during the period

Table 16.1

Date	Description	Type	Status
Health and Safety Executive			
27.01.2022	Local Extract Ventilation	Request for information from the HSE in relation to the maintenance and testing of local exhaust ventilation systems in JBIOS area in tower block 2, floors 2 and 3 at University Hospital Wales. Facility is operated by a third party, but detailed response sent to the HSE in February 2023 including voluntary statements from the Head of Health and Safety and Head of Facilities and Estates. As yet the health board have not received a reply to formally close.	Open
South Wales Fire and Rescue Service			
April 2025 – March 2026		One regulatory fire safety audit following a Site-Specific Risk Information (SSRI) visit to the Lakeside building. No formal notices were issued.	

South Wales Fire and Rescue Service

The only Enforcement Notice remaining open at the commencement of the reporting period was EN3/21, relating to a prosecution matter that the University Health Board (UHB) had initially intended to defend. Subsequently, the prosecution indicated that it was prepared to withdraw the four counts contained within the indictment, subject to the UHB entering a guilty plea to a single charge relating to inadequate record keeping. This proposal was accepted by the UHB, and the plea hearing took place on 18 September 2025.

The Court imposed a fine of £25,000 together with costs of £70,000. The matter has now been concluded.

16.2 Health and Safety Dashboard

The Department has continued to develop, compile and distribute the Health and Safety Dashboard monthly throughout the reporting period. The dashboard remains a key assurance and performance management tool, providing clinical and service boards with timely, accessible and meaningful information to support effective oversight of health and safety arrangements across their areas of responsibility.

The dashboard presents a range of key performance indicators and quantitative data relating to health and safety activity, compliance and risk management. This includes information relating to incidents, training compliance, fire safety, manual handling, violence and aggression, and other relevant assurance measures. The availability of consistent and standardised data has enabled boards to monitor trends, identify areas requiring improvement, and support informed decision-making at both operational and strategic levels.

16.3 Meetings

The Operational Health and Fire Safety Groups continued to meet quarterly providing the platforms to cascade relevant information to and from the People and Culture Committee and to ensure the necessary assurance that health, safety and fire safety are being suitably and sufficiently managed.

Clinical/Service Board Health and Safety Meetings

Table 16.2

Health & Safety Group	Agreed Frequency	Meeting per year	Actual
All Wales Medical Genetics	3 monthly	4	4
Capital, Estates & Facilities	3 monthly	4	6
Medicine	3 monthly	4	4
Specialist	3 monthly	4	4
Surgery	Bimonthly	4	4
C&W	3 monthly	4	4
PCIC	3 monthly	4	4
CD&T	3 monthly	4	6
Mental Health	Bimonthly	4	5

These continue to be supported by health and safety advisors, along with several other specific operational forums for topics such as medical gas, electrical safety and asbestos management.

As with previous years, the Clinical/Service Board Health and Safety meetings are well-established forums that meet regularly throughout the reporting period.

IMS-17 Change Management

A range of change management processes are applied across the UHB, proportionate to the scale and risk of the proposed change. These processes bring together relevant stakeholders through structured change forums or committees to ensure appropriate oversight, governance, and risk management. Significant organisational changes continue to be managed through the Organisation Change Procedure (OCP). During the reporting period,

this included several ward moves, which were subject to formal assessment and coordination to ensure risks were appropriately identified and controlled.

There were no significant health and safety departmental changes arising from organisational change during the reporting period.

IMS-18 Safe System of Work

Permit-to-work arrangements continue to be applied across a range of higher-risk activities, including hot works (e.g. welding and cutting), work at height, excavation and ground disturbance, and asbestos-related intrusive works managed through “authorisation to proceed” processes.

The Health and Safety Team has continued to support the development and implementation of safe systems of work for these activities, ensuring that control measures are clearly defined, effectively communicated, and consistently applied. This has included advising on permit-to-work requirements, reviewing risk assessments and method statements, and undertaking targeted monitoring to verify compliance in practice.

Assurance arrangements have been further strengthened through close collaboration with Estates, contractors, and Clinical and Service Boards, ensuring that controls remain aligned with organisational standards and informed by audit findings.

IMS-19 Hiring and Placement

Table 19.1

Position	WTE	WTE In-post
Assistant Director Health, Safety & Fire	1	1
Assistant Head of Health and Safety	2	2
Assistant Head of Fire Safety	1	1
Health & Safety Advisors	2	2
Manual Handling Advisor	1	1
Assistant Health, Safety & Manual Handling Advisor	1	1
Violence Prevention Case Manager	1	1
Case Management Officers	1.2	0.8
Senior Trainer	1	1
Health & Safety Trainers	4	4.6*
Fire Safety Advisors	4	4
Administrator Lead	1	1
Administration	1.2	1.2
Total	21.4	21.6

**Seconded position to provide maternity cover*

During the reporting period, departmental vacancies were successfully filled including administration however, staffing shortfalls remain within the case management function. In addition, two members of the Training Team commenced 12-month maternity leave during the year. One of these positions has been temporarily backfilled through an internal secondment arrangement to support continuity of service delivery.

19.1 Competence

In addition to widely recognised externally certified Health and Safety qualifications, such as NEBOSH courses, clearly defined competence pathways have now been established for both the Training and Fire Teams. These pathways incorporate a combination of external accreditations and practical on-the-job experience, further enhancing professional competence and supporting the long-term resilience and future development of the department.

IMS-20 Loss Prevention Inspections

The health and safety department continue to work closely with trade union leads in improving the planned workplace inspection process. The process is managed using the I-Auditor software.

20.1 Ligature Assessments in Mental Health

Annual ligature reviews were completed for all mental health inpatient settings during the period.

In January 2026, NHS Wales Performance and Improvement launched the All Wales Policy for the Assessment and Management of Ligature Anchor Points in Mental Health Wards, the All Wales Ligature Reduction Procedure for Mantal Health Wards, a Ligature Point Recording Template Workbook, and an accompanying ESR eLearning package that were approved by the Strategic Programme for Mental Health Programme Board. With support from the Health & Safety Team, the Mental Health Clinical Board are implementing these standards and updating local procedures. This work forms part of the national Anti-Ligature Project, supporting consistent, robust ligature risk assessment across inpatient clinical environments while balancing safety with therapeutic care.

Conclusion

During 2025/26, the Health Board has continued to strengthen and mature its health and safety arrangements, with further progress made in embedding the Health and Safety Culture Plan, local health and safety planning processes and the corporate Health and Safety Management System.

Delivery of the current Health and Safety Culture Plan has reached 89%, whilst departmental annual health and safety plans have become increasingly established, demonstrating improved ownership of health and safety objectives at a local level. The Health and Safety Management System review programme has also continued to provide increased assurance that health, safety and

fire safety arrangements are being effectively implemented across Clinical and Service Boards.

The reporting period has seen continued improvements in several key areas, including incident management, violence prevention case management outcomes, risk management arrangements and the overall governance framework supporting health, safety and fire safety across the organisation. The successful transfer of the corporate Health and Safety and Fire Safety risk registers into AMaT has further strengthened organisational risk oversight and assurance arrangements.

Particularly noteworthy has been the sustained improvement in RIDDOR performance. Following the significant reduction achieved during 2024/25, the organisation maintained this improvement throughout 2025/26, with reportable incidents remaining approximately 20% below historical levels. Maintaining this reduction for a second consecutive year represents a significant achievement and provides increasing confidence that the improvements achieved through enhanced incident review, investigation, governance and preventative interventions are becoming embedded across the organisation.

The reporting period has also seen significant progress in the management of workplace violence and aggression and manual handling risks. The Violence Prevention Case Management Team has continued to strengthen partnership working with South Wales Police and criminal justice agencies. During the reporting period this was accompanied by increased referrals, improved positive outcomes and enhanced support for staff affected by violence and aggression.

In parallel, the manual handling service has delivered several strategic improvements, including the introduction of a UHB-wide patient handling audit programme, review of training requirements, expansion of bariatric equipment provision, and implementation of innovative solutions to support community-based patient care. Collectively, these initiatives demonstrate the Health Board's commitment to addressing two of its most significant occupational health and safety risks through a combination of preventative, operational and assurance-based approaches.

The department has also maintained a strong focus on specialist areas including fire safety, environmental monitoring, occupational health, contractor management, emergency preparedness and regulatory compliance, whilst continuing to provide practical support and specialist advice to Clinical and Service Boards and supporting functions. Significant work has also been undertaken to strengthen fire safety governance, support investment in fire safety infrastructure and maintain compliance across the Health Board estate.

Whilst opportunities for further improvement remain, particularly in relation to training compliance, unwanted fire signals and reducing work-related absence, the overall position demonstrates continued progress towards a more mature, proactive and integrated approach to health, safety and fire risk management across Cardiff and Vale University Health Board.

Digital & Infrastructure Committee Meeting

Health & Safety Update

Date: 4th August 2026

Health & Safety Team

Annual Report

- IMS-01: Responsibilities and Accountability - Continued driving H&S across the UHB with take up in Annual H&S plans, H&S management system reviews and RACI.

- IMS-06: Fire Safety - Disappointing rise in fire events to 14
  - 4 Unattended cooking processes
  - 4 Smoking related
  - 1 Deliberate fire setting

- IMS-08 Incident Management - Sustained 20% reduction in RIDDOR submissions against historical levels for a second consecutive year.

- IMS-10: Health and Hygiene - Continued the environmental monitoring programme. Elevated Radon levels identified in parts of UHW tunnel infrastructure. Overall risk of exposure is low.

Annual Report

- IMS-11: Violence Prevention Case Management - Successful prosecutions and other criminal justice outcomes rose along with other sanctions and anti-social behaviour related outcomes. In addition, the number of custodial sentences increased from 7 in 2024/25 to 11 in 2025/26.

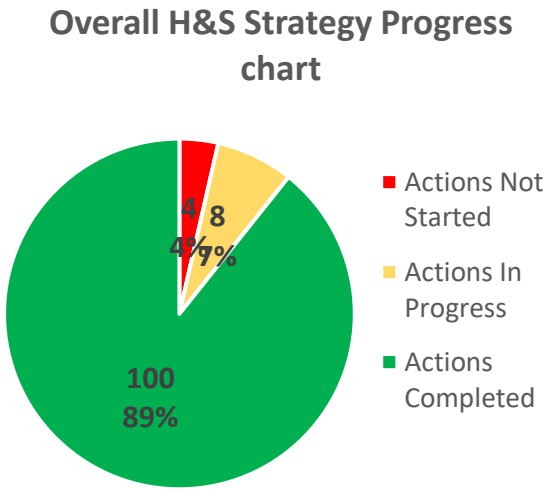
- IMS-12: Manual Handling - The number of recorded manual handling incidents decreased during the reporting period compared with 2024/25. However, the number of RIDDOR-reportable incidents remained at 22; accounting for 19% of all reported manual handling incidents.

- IMS-13: The reduction in Manual Handling Level 1b and the V&A courses is attributed to the commencement of a review of training competencies assigned to staff.

H&S Culture Plan Update

- Theme 1 – Training
- Theme 2 – Risk & Incident Management
- Theme 3 – Communication
- Theme 4 – Measuring Performance
- Theme 5 – Audit & Review
- Theme 6 – Fire

Tracker sets							
Title	Total Group	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5	Theme 6
Actions Not Started	4	0	2	2	0	0	0
Actions In Progress	8	2	2	2	2	0	0
Actions Completed	100	28	17	8	11	7	29



Completion rate from 80% to 89% from last meeting. Work on the new combined People & Culture plan ongoing.

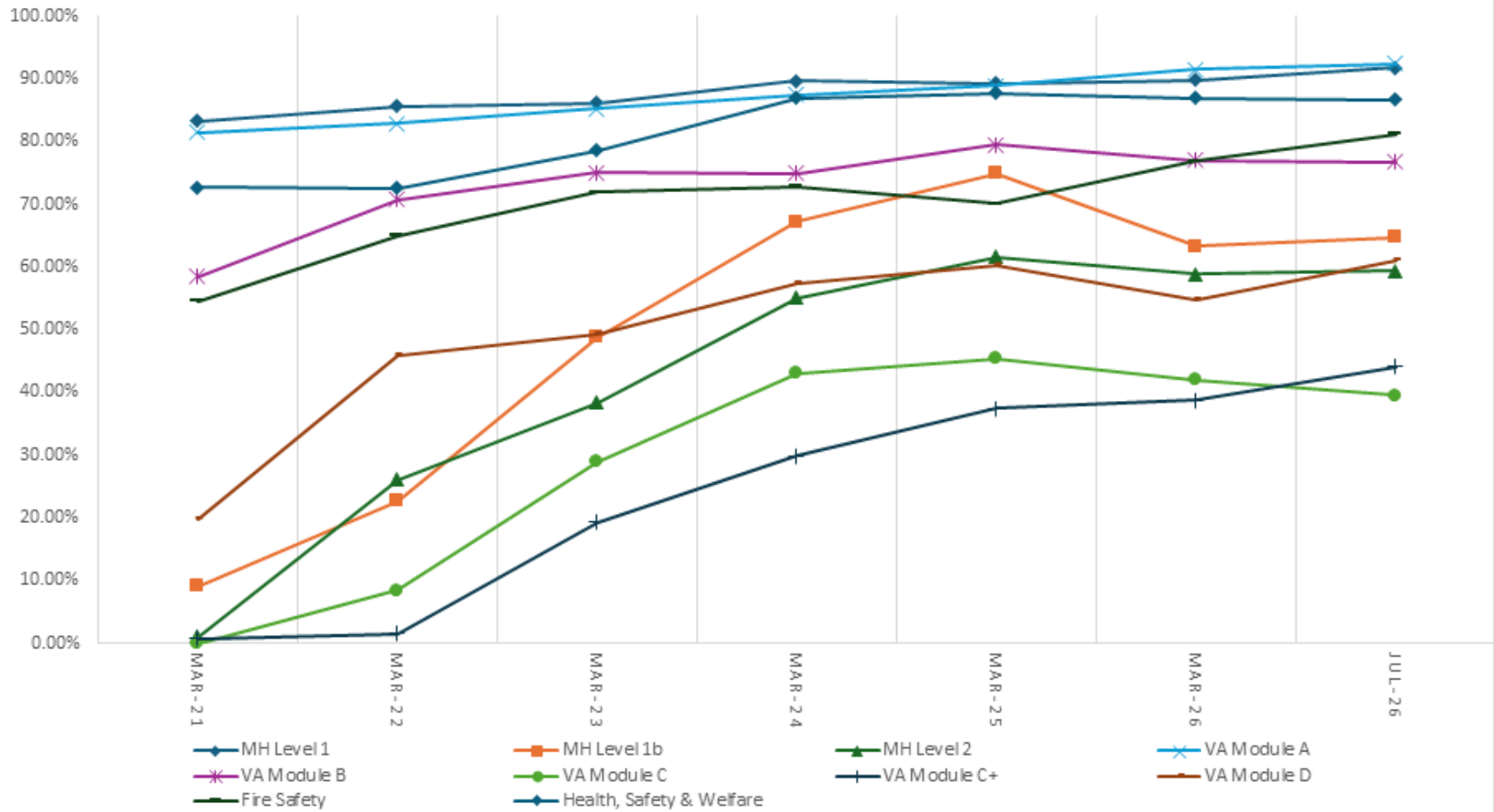
RIDDOR Performance FYTD

- Currently 26 RIDDOR's FYTD
- Maintaining this performance will result in ~78 for the year
- The annual KPI for 2026/2027 is 61
- 96% are due to >7 day injury
- UK figure is 70%

	Apr	May	Jun	Jul	Total
CEF	3	0	0	0	3
CD&T	1	0	0	1	2
Medicine	1	2	0	0	3
Specialist	1	0	4	3	8
Surgical	1	0	0	1	2
Mental Health	0	4	2	1	7
C&W	0	0	1	0	1
Total	7	6	7	6	26

	Apr	May	Jun	Jul	Total
Injury > 7 days	7	6	6	6	25
Specified Injury	0	0	1	0	1
Total	7	6	7	6	26

UHB Training Compliance



Training

- The systematic review of Violence & Aggression and Manual Handling competencies assigned to staff continues.

All CB's completed apart from:

- CD&T and CEF are reviewing
- Mental Health and Execs not yet started

Violence Prevention

- 2 perpetrators received custodial sentences since the last meeting
  - Charge with offence of Outraging Public Decency – 160 days
  - Assault and Racially aggravated abuse – 30 weeks

- An aggressive male received a fine of £162, Surcharge £65 and Costs £250

Fire Update

- 5 Fire incidents FYTD date

- 01/05/2026 – CRI – A homeless individual gained access to an unused part of the building via scaffolding. The individual was believed to have brought an electrical heater, which subsequently generated smoke and activated the fire alarm. The incident was minor in nature, with no evidence of significant fire-related activity. However, some procedural shortfalls were identified and subsequently reinforced with staff, particularly those responsible for fire response duties.

- 13/05/2026 – UHL – Bin fire outside the main hospital entrance caused by a discarded cigarette.

Fire Update

- 07/07/2026 – HYC – Patient burnt the side of a wooden planter box using a lighter causing minor, localised scorching/fire. It was extinguished immediately using approximately 2 litres of water.

- 12/07/2026 – UHW - Failed bearing in an Air Handling Unit fan serving Radiology. The overheating bearing generated products of thermal degradation (smoke and combustion by-products), which were distributed through the ventilation system. A safe evacuation ensued. South Wales Fire and Rescue Service (SWFRS) attended the incident and subsequently undertook a site visit. Actions arising from the incident were identified by the UHB, added to the regulatory tracker and are being managed with the same level of oversight as a regulatory notice.

Fire Update

- 21/07/2026 – UHW – A smell of fire was reported to Switchboard outside the flammable waste store at University Hospital of Wales Tower Block 2. Whilst there was minimal damage to the grass area and no fire spread there were multiple seats of fire, suggesting the incident was deliberately set. The fire was out on the arrival of the Fire Response Team, and no attendance from SWFRS was required. Additional measures are now being considered to enhance monitoring and security of the area to reduce the risk of similar incidents occurring in the future.

Report Title:	Digital Roadmap and work programme update			Agenda Item no.	4.1	
Meeting:	Digital & Infrastructure Committee	Public Meeting	X	Meeting Date:	4th August 2026	
		Private Meeting				
Status:	Assurance	X	Approval		Information	
Lead Executive:	Director of Digital & Health Intelligence					
Report Author:	Director of Digital Transformation					

Background and current situation:

Shaping our Future Digital Services

1 Digital Foundations Programme Business Case

The Digital Foundations (DF) Programme Business Case (PBC) completed its scrutiny through internal governance was approved by CAVUHB Board on 28th May 2026. It has since been submitted to Welsh Government Infrastructure Investment Board (IIB) for consideration and funding.

The PBC is understood to be going through a Welsh Government scrutiny process. This is likely to mean a series of questions and / or additional clarifications after the various departments have had opportunity to consider the PBC and associated documents. This process can take a number of weeks. CAVUHB awaits a response.

1.1 Internal Governance

The PBC went to the following for a in Private session as the content is commercially sensitive.

CAVUHB Governance route	Meeting date
Capital management group	Monday 18/05/026
Value & Benefits Realisation Group	Wednesday 06/05/2026
Strategic Leadership Team	Thursday 07/05/2026
Public Finance & Performance Committee	Wednesday 20/05/2026
Digital and Infrastructure Committee	Tuesday 05/05/2026
Public Board	Thursday 28/05/2026

2 Key Benefits of investing

A reminder at high level of the expected key benefits of the PBC is as follows.

- **Reduction in clinical/administrative staff time:** Automation, digital workflows, and streamlined processes reduce the burden of repetitive administrative tasks. Clinicians and staff can spend more time on direct patient care, improving efficiency and job satisfaction.
- **Improved outpatient efficiency:** Streamlined referral pathways shorten waiting times, reduce Did Not Attend (DNA) rates, and improve overall clinic productivity.

- **Reduction in costs associated with paper use and storage:** Transitioning to digital records eliminates printing, scanning, and physical storage costs. It also reduces risks linked to lost or incomplete paper files.
- **Improved clinical coding:** Structured, interoperable digital documentation supports accurate and timely coding, ensuring compliance and optimising reimbursement and reporting.
- **Reduction in bank and agency spend:** Better workforce planning, supported by real-time data, reduces reliance on costly temporary staffing. Improved efficiency also decreases the demand for additional cover.
- **Reduction of duplicate and unnecessary tests:** Integrated systems and shared records provide clinicians with full visibility of patient history, preventing duplication of diagnostic tests and reducing unnecessary expenditure.
- **Reduction in costs associated with legal procedures:** Accurate, complete, and accessible digital records reduce medico-legal risks. Strong audit trails and improved documentation safeguard against litigation and compensation claims.
- **Reduction in Length of Stay (LOS):** Better care coordination, real-time flow data, and decision support tools e.g. spot the deteriorating patient sooner before more expensive escalation, enable faster diagnosis, treatment, and discharge planning, reducing unnecessary bed days.
- **Quality & Safety:** Digital tools such as clinical decision support, alerts, and standardised workflows improve patient safety, reduce errors, and support delivery of high-quality care.
- **Patient/Staff Experiences:** Improved access to information, self-service tools, and streamlined processes enhance patient empowerment and satisfaction. Staff benefit from reduced workload pressures and more intuitive digital systems.
- **IT/Infrastructure:** Begin the journey towards more modern, scalable, and resilient IT infrastructure underpinning service delivery, ensuring interoperability, cybersecurity, and long-term sustainability. Investment in infrastructure creates a foundation for innovation and continuous improvement.

2.1 Benefits CAVUHB loses if it doesn't invest

The benefits of the PBC are extensive and meaningful in the context of what CAV is here to deliver. They include:

Improving Patient Safety and Clinical Effectiveness:
By facilitating electronic data capture and enabling interoperability, clinicians will have timely access to critical patient information. This is expected to reduce errors by up to 30%, shorten time-to-treatment in urgent pathways, and release significant clinical time—with estimates of 5–10% of clinician time saved through reduced duplication, fewer delays, and streamlined documentation. Faster, safer decisions directly translate to improved quality outcomes and enhanced patient safety.

Reducing Variation and Inequality in Care:
Modern digital tools will support standardised, equitable pathways and enable improved coordination across CAVUHB and NHS Wales. Evidence from comparable digital implementations shows reductions in unwarranted variation of 10–15%, improved adherence to best practice, and measurable gains in equity of access across deprived populations.

Enhancing Operational Efficiency to Support Frontline Care:

Digitising core processes and replacing outdated infrastructure is projected to release up to 5–10% of clinical time, equating to thousands of hours redirected to direct patient care annually. Streamlined digital workflows can reduce LoS by 0.5–1.0 days per admission, with knock-on reductions in overall bed days and avoidable delays.

Improving Value for Money and Long-Term Sustainability:
Investment in modern infrastructure is expected to reduce unplanned downtime and costly "fix on fail" responses by 20–25%, while improving energy efficiency and system resilience. This will create recurrent savings and free resources for reinvestment into frontline services.

Enabling Future-Ready, Data-Driven Care Models:
A digitally mature foundation will allow adoption of modular EHRs, predictive analytics, and AI-driven decision support. This unlocks the ability to forecast demand, optimise resource utilisation, and deliver proactive interventions driving measurable improvements in safety, quality, and patient experience over the long term.

3 Welsh Emergency Care Dataset (WECDS) compliance and Emergency Unit workstation (EUWS) replacement

CAV is required to satisfy compliance with WECDS however at the moment it has no route to do so. Compliance is dependent upon a new UEC software solution. Funding support has been requested from 3 WG departments but thus far remains unresolved.

4 Update on IMTP priorities with status

Appendix 1 contains the digital priorities shared at the last meeting updated to show the main IMTP (Annual Plan) priorities and their current status.

5 Tactical Service Delivery Activity Update

This is shared at Appendix 2.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Progressing the digital maturity of the organisation is fundamental to delivering our strategy (delivering in the right places) and is a key enabler to all our future plans and ambitions.

Appendices *(Please list any appendices that will accompany this report, please do **not** embed)*

N/A

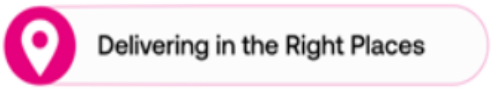
Recommendation:

The Board / Committee is requested to:

a) Note the progress and updates contained within this report.

Link to Strategic Objectives of Shaping our Future Wellbeing:
https://shapingourfuturewellbeing.com/

1. Putting People First **Click the objective above to view more detail.**	2. Providing Outstanding Quality **Click the objective above to view more detail.**

3.  **Click the objective above to view more detail.** Digital Foundations and the digital roadmap are core to the achievement of this strategic objective		4.  **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered:									
Prevention		Long term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		

Impact Assessment:

Risk: Yes/No (delete as appropriate)

Please include the detail of any Risk Assessments undertaken when preparing and considering the content of this report and, where appropriate, the nature of any risks identified. (If this has been addressed in the main body of the report, please confirm)

Safety: Yes/No

Are there any Staff or Patient safety implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Financial: Yes/No

Are there any financial implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Workforce: Yes/No

Are there any Workforce implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Legal: Yes/No

Are there any legal implications that arise from the content and proposals contained within this report? If so, has advice been sought and what was the outcome? (If this has been addressed in the main body of the report, please confirm)

Reputational: Yes/No

Are there any reputational risks associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Socio Economic: Yes/No - ***Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: [The Socio-economic Duty: guidance | GOV.WALES]***

The Socio-Economic Duty is to designed to encourage better decision making, ensuring more equal outcomes. Do the proposals within this report contain strategic decisions, such as setting objectives and the development of services. If so has consideration been given to how the proposals can improve inequality of outcome for people who suffer socio-economic disadvantage? Please include detail. (If this has been addressed in the main body of the report, please confirm)

Equality and Health: Yes/No

Equality Health Impact Assessments (EHIA) are typically undertaking when developing or reviewing Health Board strategies, policies, plans, procedures or services. Do the proposals contained within the report necessitate the requirement for an EHIA to be undertaken? If so, please include the detail of any EHIA undertaken or the plans are in place to do so. (If this has been addressed in the main body of the report, please confirm)

Decarbonisation: Yes/No

There are a number of ways by which carbon emissions can be avoided through the operations of CVUHB.
These include:

- *A focus upon preventing ill health in our population*
- *Saving energy or increasing throughput.*
- *Value based healthcare. Being prudent by not over-treating/intervening. Avoid delivering low-value interventions*
- *Patients empowered to manage their conditions, utilising See on Symptoms and Patient Initiated follow ups to reduce unnecessary outpatient appointments.*
- *Service delivery in the most appropriate setting, e.g. in a community setting rather than an acute setting.*
- *Reducing waste – for example use non-sterile gloves only when needed, manage use-by dates to avoid throwing out good products, recycle and reuse.*

Does the subject matter of your paper risk any of the above not being achieved?

Welsh Language: Yes/No

Consideration should be given to potential impact on the Welsh language, including the following key aspects:
• More than just words: Does the report align with the More than just words strategy, ensuring Welsh-speaking patients can access services in their preferred language, and supporting active offer and bilingual care?
• Accessibility and compliance: Ensure key information is bilingual and that the report meets the Welsh Language Standards for communication, signage, and patient materials.
• Patient understanding and safety: Could English-only content impact Welsh speakers' comprehension in critical areas like consent and medication instructions, potentially affecting safety?
• Staffing and resources: Does the report address the need for Welsh-speaking staff or bilingual resources to deliver equitable care?
Does the subject matter of your paper risk any of the above not being achieved?

Approval/Scrutiny Route (***please note anywhere else this paper has been before***):	
Committee/Group/Exec	Date:

APPENDIX 1 Local update on National Programme implementations

Key	CAV perspective on local implementation
Red	Off track
Amber	Going or slightly off track
Green	On track
Blue	National programme

Project/programme	Description	Update	May 2025	Aug 2025	Oct 2025	Feb 2026	May 2026	July 2026
Regional shared care record (for the purposes of direct care)	A regional partnership board programme To support the delivery of integrated care in integrated multi-agency teams between Cardiff and The Vale Councils and CAVUHB. Relevant information shared via a summary care view	• Won RPB Innovation Award 2026 • User base swollen from 150 to over 400 users in the period. • Agreement from GP DPO (Data Protection Officer) to the I.G proposal for GP record sharing. Next steps are to engage with General Practice Leads. • Future Care planning (making use of BlackPear common care-planning facilities used extensively in England) on track for July'26 launch. • Core Team funding in place and contracts extended through 26/27. • Risk exists with the ongoing lack of clarity on the National ICR programme. The CaV region may have progressed a significant suite of sharing solutions, to have to decommission them in 2027/28						
Connecting Care (previously WCCIS2)	A national programme managed by DHCW In relation to community and mental health services. This national DHCW led programme has submitted a revised business case for	• CAV remains fully supportive of the intention for all HB's to procure new systems with W.G support. • MHCS governance board determined (May 2026) to procure a single solution to solve the challenge of replacing PARIS. • National funding support is pending decision from W.G in 2026/27. The uHB will not be able to fund a PARIS replacement without WG funding, leading						

	Welsh Government. CAV with all other UHB has contributed to this work	to a risk of dropping back to paper in 2028 when the PARIS contract terminates • DPIF funding for Connecting Care is in National dispute.						
WRAPPER (Welsh referral, activity and patient pathway enterprise repository) MDT management	A joint CAV and DHCW project as part of the Canisc replacement programme. This project delivers functionality to WRAPPER that enables cross-organisational booking and data sharing between health Boards for Cancer MDT management purposes	No change to previous update Phase 2 (outbound) – work continues in partnership with DHCW. Completion expected Q4 following re-prioritisation						
Scan4Safety	A national NWSSP patient safety initiative that supports inventory and stock management as well as compliance with the medical device bill for implantable devices It will trace NHS patients and their treatments, manage medical devices and monitor products used in procedures	Temporary pause as new uHB governance and leadership is established, including consideration of this as part of our quality improvement programme						
PROMS (patient reported outcome measures)	PROMs are part of the CAV and National Value in Health Programmes. PROMs support improved quality, safety and experience of care for patients and promote health equality to patients by reducing unwarranted variation in care.	• Onboarded 29 services to date - c88 services awaiting onboarding 2026/2027 + • 57,405 patients onboarded • 283,332 PROMs completed • 5,422 PREMs completed • 47.5% PROMS completeness rate T&O Hip Arthroplasty and Knee Arthroplasty live on Promptly platform for new patients. Pilot data migrated from Amplitude to Promptly with no concerns and ongoing migration scheduled completion end of July. Work conducted to ensure that primary and revision patients are collected along with their laterality.						

Electronic prescribing and medicine administration	This programme is in collaboration with NerveCentre (supplier) and DHCW for use in all patient settings across the UHB and will improve patient safety. Business case agreed by Welsh Government in Q1 2024	ePMA inpatient rollout is now 100% complete. Scoping for implementation across non-inpatient wards is underway, with a pilot phase and subsequent rollout targeted for Q3 2026/27						
NHS Wales app (DSPP)	A national programme, all development goes through the National Digital Services to patients and public (DSPP) programme managed by DHCW. CAV is live with the NHS App in all GP practices with feature sets varying by practice.	After the successful roll out of the initial Priority Patient Pathways features (new waiting list entries and new first appointments) work has been undertaken by DHCW to implement further continuous improvements to these whilst engaging Health Boards and other key stakeholders to scope out future state of solution.						
Welsh Intensive Care Information System (WICIS)	A national programme managed by DHCW, to be implemented locally Introduces electronic observations at the bedside in intensive care	National strategy and funding is unclear in 2026/27. DPIF bids have been submitted by DHCW, news is awaited on success.						
National laboratory systems replacement (LIMS)	A national programme managed by DHCW, implemented locally	Cellular Pathology discipline live with new TCLe solution. Planned Deployment for Microbiology (PHW) on August 10th, Blood Sciences on 28th September (date to be confirmed by National Programme Board). There is a four-week deployment window starting on 21st September and current direction of travel is that CAV will be going live in the second week.						
National radiology system replacement (RISP)	A national programme managed by DHCW, implemented locally	This solution has now been deployed into live on the 1st June. There are still some work packages being delivered that were agreed to be post-go-live activities. Data migration also progressing well for historic data.						

	Go Live for CAV is planned 2026							
Digital Cellular Pathology	A national programme to fully digitise and improve laboratory workflow, creating digital slides	No change to previous update Tender specification has been received by the Health Board, and returned to the national programme. For Digital, the project has passed through project brief stage and is awaiting detailed requirements gathering pending approval to proceed from service. A national business case is in the process of being considered by individual health boards.						
Eyecare Digitisation	A programme to deploy OpenEyes EPR has been led by CAVUHB on an all-Wales basis.	Most Health Boards in Wales have now deployed OpenEyes EPR system to some extent. CAVUHB, SBUHB and ABUHB now have widespread use of the system.						

Appendix 2 – Tactical Service Delivery Activity Update

Business Intelligence (BI) Information

- Completed the new secondary uses data feed from Aqua to the Data Warehouse. Theatre dashboards and the national theatre dataset submission are being updated and put back on-line. The teams have also released three new Power BI dashboards – EU and 6 Goals to replace Lightfoot viewers, and a new Productivity & Performance dashboard commissioned by the Director of Operational Planning and Performance.

Digital Eye Care

- Hosted by CAVUHB, most Health Boards in Wales have now deployed OpenEyes EPR system to some extent. CAVUHB, SBUHB and ABUHB now have widespread use of the system.
- OpenEyes is being actively promoted as an use care for SE Wales Regional working as processes are in place and we need to ensure these early activities align appropriately with wider regional practices.
- Welsh Government DPIF award offer received, providing 50% of the required funds for 2026-27 services. I formal response if being developed to align delivery potential against the restricted funding that has been made available.
- Any requested integration between OpenEyes EPR and the “Operal” Electronic Referral System will require additional funding to be achievable.

AWS Secure Landing Zone – Update

- The CAVUHB AWS Steering Group has secured a “Go” decision for Parallel Running of workloads in AWS.
- AWMGS Genomic Sequencing workloads are being run in parallel with the legacy WREN High Performance Compute platform.
- A strategic PSBA Cloud Connection is in the process of being procured to improve resilience and performance of data transit between CAVUHB locations and AWS.
- The Go/No Go process will evolve until a Go Decision can be secured for an official launch of the CAVUHB AWS platform.

Digital Operations

Over the past few months, CAV Digital Operations across Telecoms, Networks, Server and Support has remained broadly stable, with core services performing well despite sustained demand. Network and telecoms services have maintained good availability, with only minor disruption, while server infrastructure continues to be closely managed with a focus on resilience and addressing legacy risks. Several projects have been successfully delivered, including RISP (Radiology Project), which has been two years in planning, and a number of Estates-led power distribution works in Tower Block A and Substation 2A. Legacy production servers and storage have been decommissioned, and planning is now underway for the implementation of a new file server storage solution.

Support services remain under pressure with consistently high demand, however performance has been maintained overall with priority incidents responded to within agreed thresholds. Ongoing work continues to improve user experience and reduce repeat demand, alongside efforts to stabilise key platforms and reduce technical debt across the estate. Windows 11 deployment is now at over 95% and on target for completion of active devices by Oct 2026, this correlates with the end of extended support purchased last year.

Across all areas, there remains a strong focus on maintaining safe and reliable services while progressing incremental improvements. Capacity continues to be a constraint, but this is being actively managed. A new Change and Support Systems Manager has been recruited and starts in July, this role will strengthen leadership/management capacity in Digital Operations and support further improvement in change, support processes and service delivery.

Windows 11 Project:

- 92% of devices now running Windows 11
- Focus for next month - continue to replace incompatible devices (450 remaining) and update the compatible devices that are still running Windows 10 (500 remaining)
- 250 devices remain on exclusion list as they are running software incompatible with Windows 11
- These 250 devices will require Windows 10 ESU for 2026-27

WiFi Update

- Focus of project has moved to 'non-inpatient ePMA areas' (outpatient areas).

- A list has been provided by ePMA of pilot 'priority non-inpatient areas' - to be scheduled first that includes:
    - TB3 UGF/TB3 FF
    - Glamorgan house
    - Service that continues down haem day unit corridor

- The Wi-Fi team is in the process of preparing surveys, fire, asbestos checks and quotes for the above before we can schedule in.

- We have also been informed that the uHB has been told it has to stop work on all UHW jobs, pending feedback from our fire team regarding The Building (Higher-Risk Buildings Procedures) (Wales) Regulations which came into effect on 01/07/2026 and impacts works at UHW. The updated guidelines have put a stop to us scheduling UHW areas and we are chasing an update on a daily basis. Long-term this may affect the scheduling in of the ePMA pilot areas above. Elaine from ePMA has been made aware of this.

- We are currently investigating wider Wi-Fi areas to be scheduled in Llandough to keep the project moving until the fire team report back that we can continue in UHW.

Digital Service Management Team Update

- RISP went live on 1st June 2026.
- DPIF (funding) - Management of CaV bids. BadgerNet (Maternity EPR) and Digital Eyecare (OpenEyes) have been funded.
- Digital Care Region - Now available to over 400 Social Care and Healthcare staff. Programme won the RPB Innovation award 2026.
- 200 further community access laptops rolled out in support of a mobile non acute workforce
- WCP upgraded to latest National version in early July'26
- Amazon Web Services now Live, dual running the All-Wales Medical Genomics workload.
- Integrated Performance Reporting - Launches in July'26 following a tightly performance managed phase 1 project.

Report Title:	Corporate Digital Risk Register				Agenda Item no.	4.2	
Meeting:	Digital & Infrastructure Committee Meeting		Public	X	Meeting Date:	4th August 2026	
			Private				
Status:	Assurance	X	Approval		Information		X
Lead Executive:	**Director of Digital and Health Intelligence**						
Report Author:	**Director of Digital and Health Intelligence**						

Background and current situation:

The joint IMT Risk register is a combined register consisting of digital / Information Governance and Information / Performance risks.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The Corporate Risk Register has now been entered on to the Audit Management and Tracking system (AMAT).

There are currently 6 joint IMT/IG risks identified on the report:

1 x Risk remains in red status with a score of 20 which is:

- Cyber Security

4 x Risks remain in Amber status

- Insufficient Resource – Capital & Revenue
- Data Quality
- Clinical Records
- Non-Compliance with data protection legislation

1 x Risk is green with a score of 6:

- WCCIS replacement procurement programme

Recommendation:

The Board/Committee are requested to:

NOTE progress and updates to the Risk Register report.

Link to Strategic Objectives of Shaping our Future Wellbeing:

https://shapingourfuturewellbeing.com/

 Putting People First 1. **Click the objective above to view more detail.**		 Providing Outstanding Quality 2. **Click the objective above to view more detail.**	
 Delivering in the Right Places 3. **Click the objective above to view more detail.**		 Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered									
Prevention	x	Long term		Integration		Collaboration	x	Involvement	

Quality Impact Assessment Completed?				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		

Impact Assessment:
Risk: Yes
Safety: Yes
Financial: Yes
Workforce: Yes
Legal: Yes
Compliance with regulatory requirements
Reputational: Yes
Equality and Health: Yes/No
Decarbonisation: Yes
Green UT and digital solution that support greater virtual working
Welsh Language: Yes/No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

Risk ID	Risk title	Date raised	Risk event	Risk cause	Risk effect	Risk category	Reported group (Committee)	Risk owner	Initial rating score	Initial impact rating	Initial likelihood rating	Initial RAG	Initial rationale	Key controls	Assurance on controls	Treatment plan
Digital and Health Intelligence/2022-2301	Cyber Security	06/08/2022	IT infrastructure could be compromised resulting in prolonged service interruption and potential impacts on the safety of patients due to an inability to access electronically stored data.	As an OES we are susceptible to national and international Cyber Security threats	The effect of such a compromise would lead to CAV UHB could lose control over confidential and sensitive clinical data.	Operational risks	Digital Health Intelligence	James Webb	20	Catastrophic	Highly Likely	Red	IT infrastructure could be compromised resulting in prolonged service interruption and potential impacts on the safety of patients due to an inability to access electronically stored data.	Vulnerability scanning on non-critical servers been started by the cyber security team, with plans to address critical and more sensitive servers in the near future. This will work towards identifying known vulnerabilities in our key architecture and This should improve our security posture as a whole and reduce the risk of down	The UHB has in place a number of Cyber security precautions. These include the following: - The implementation of additional VLAN's and/or firewalls/ACL's - Segmenting and an increased level of device patching.	Y
Digital and Health Intelligence/2026-27/01	Insufficient Resource	22/04/2026	The delivery of the IM&T Strategic Work plan is based on the UHB being able to ensure that the IM&T Department is appropriately resourced to manage infrastructure and deliver projects. All benchmarking information indicates that the UHB is significantly under resourced.	This is caused by lack of resource	Consequence is inability to support operational and strategic delivery at pace required, reliance in outsourcing at cost	Operational risks	Digital Health Intelligence	David Thomas	9	Moderate	Likely	Amber	Insufficient recourse	The UHB continues to address priority areas Has document: No Della Ashton 22/04/2026 15:17	The UHB continues to address priority areas Has document: No Della Ashton 22/04/2026 15:18	N
Digital and Health Intelligence/2026-27/02	Data Quality, Accessibility and Data Processing	01/05/2026	There is no Standard Operating Procedures (SOPs) administer patient Activity. No ISO 27001 certification. No accountabilities for how data is handled and to meet the organisations strategy obligations	This is caused by lack of training.	Which could lead to an impact on poorer patient outcomes, flawed analysis which leads top poorer decision making introducing patient to possible harm	Quality risks	Digital Health Intelligence	Della Ashton	9	Moderate	Likely	Amber	Moderate	LDR Programme Board over sees the LDR Audit Action Plan Has document: No Della Ashton 01/05/2026 15:31		N
Digital and Health Intelligence/2026-2704	Clinical Records Risk	27/02/2026	Clinical records are not joined up across the disciplines.	The can cause incomplete data/out of date patient information	Which could lead to an impact on clinical decision-making, introducing patient harm and /or disadvantage and failure to meet NHS Wales digital strategy	Operational risks	Directorate Meeting	David Thomas	9	Moderate	Likely	Amber	moderate	LDR Programme reviews progess Has document: No Della Ashton 30/04/2026 15:02	UHB architectural design to be reviewed to consider local data repository for bringing together in a useable way Has document: No Della Ashton 30/04/2026 14:45	Y
Digital and Health Intelligence/2026-27/03	Non-compliance with Data Protection & Confidentiality Legislation	01/05/2026	the UHB's progress in taking forward the action plan to reduce the risk of non compliance following the ICO's assessment of our 'reasonable assurance' with the GDPR/ DPA is not sufficient to mitigate the risk of non compliance with Data Protection Legislation	Lack of skilled resource	Which could lead to Mistrust of our population and other stakeholders resulting in their unwillingness to share / divulge essential information, Significantly financial penalties - and increasing post BA case	Quality risks	Digital Health Intelligence	James Webb	9	Moderate	Likely	Amber	Moderate	as a result of running with a vacancy for the last Q, a number of regulatory functions have slipped and there is significant pressure on the team to support full IG requirements and support function. Has document: No Della Ashton 01/05/2026 16:55		Y
Digital and Health Intelligence/2026-2702	WCCIS2 (Connected Care)	27/02/2026	The National procurement has now splintered into Social Care, Mental Health and Community Health. The PARIS solution from MH and Community is now entering its' last 36 months of support. It will take the PARIS team 24 months to do the migration.	Delay would mean CaV UHB services returning to pre 2004 days of paper across the UHB	Delay would mean CaV UHB services returning to pre 2004 days of paper across the UHB	Quality risks	Digital Health Intelligence	Mark Cahalane	6	Moderate	Unlikely	Green	Moderate	A business case has been raised to replace the current PARIS system developed for submission to WG for consideration under the 'Connecting Care' programme Has document: No Della Ashton 01/05/2026 11:17		Y

Service	Business unit
Business unit	Digital and Health Intelligence

Report Title:	Information Governance Data Compliance			Agenda Item no.	4.3	
Meeting:	Digital & Infrastructure Committee	Public	×	Meeting Date:	4th August 2026	
		Private				
Status:	Assurance	×	Approval		Information	
Lead Executive:	Director of Digital & Health Intelligence					
Report Author:	Head of Information Governance & Cyber Security					

Background and current situation:

This report considers key information governance issues considered by the responsible Executive Director, Senior Information Risk Owner (SIRO) and Data Protection Officer (DPO). Specifically, it provides information on the following areas of Information Governance within Cardiff and Vale University Health Board (the UHB).

- Information Governance (IG) Staffing levels and capacity
- Data Protection Act - Serious Incident Summary and Report
- Freedom of Information Act - Activity and Compliance
- Data Protection Act (DPA) - Subject access requests (SAR)
- Compliance monitoring/National Integrated Intelligent Auditing Solution (NIIAS)

Each individual report contains specific details relevant to the subject area, and includes updated information since the previous report to the Digital & Infrastructure Committee (D&IC) on how the UHB has complied with the obligations of each piece of legislation that satisfy the information governance requirements.

The UHB is required to ensure that it complies with all the legislative requirements placed upon it. In respect of Information Governance, the relevant legislation which largely impacts on this work are the Data Protection Act 2018 (DPA), UK General Data Protection Regulation (UK GDPR) and the Freedom of Information Act 2000 (FOIA).

Quarterly reports are produced for the D&IC to receive assurance that the UHB continues to monitor and action breaches of the UK GDPR/DPA 2018, FOI requests and that subject access requests (SAR) are actively processed within the legislative time frame that applies and, that any areas causing concern or issues are identified and addressed.

ASSESSMENT

1. **Information Governance Staffing Levels and Capacity**

The Information Governance Department experienced a vacancy following the departure of a team member in January 2026. In response, the department has undertaken a review of its staffing structure to ensure it remains appropriately resourced to meet current and anticipated demand. As a result, a new substantive position is currently being prepared for advertisement. In the interim, additional capacity is being provided through a Welsh Government-supported work placement.

Whilst staffing pressures have continued to impact departmental capacity, particularly in relation to the processing of Freedom of Information (FOI) requests and Subject Access Requests (SARs), a range of mitigations remain in place, including workload prioritisation,

cross-cover arrangements and revised working practices. These measures, together with the planned recruitment and temporary placement support, are intended to strengthen resilience and support the continued delivery of core Information Governance functions.

The staffing structure is as follows:

- David Thomas, Director of Digital and Health Intelligence is the Senior Information Risk Owner
- Dr Richard Skone is the Caldicott Guardian
- James Webb is the Data Protection Officer
- The Information Governance Department is currently resourced at 4 WTE.

2. Data Protection Act – Serious Incident Report

Date reported: April 2026 to June 2026

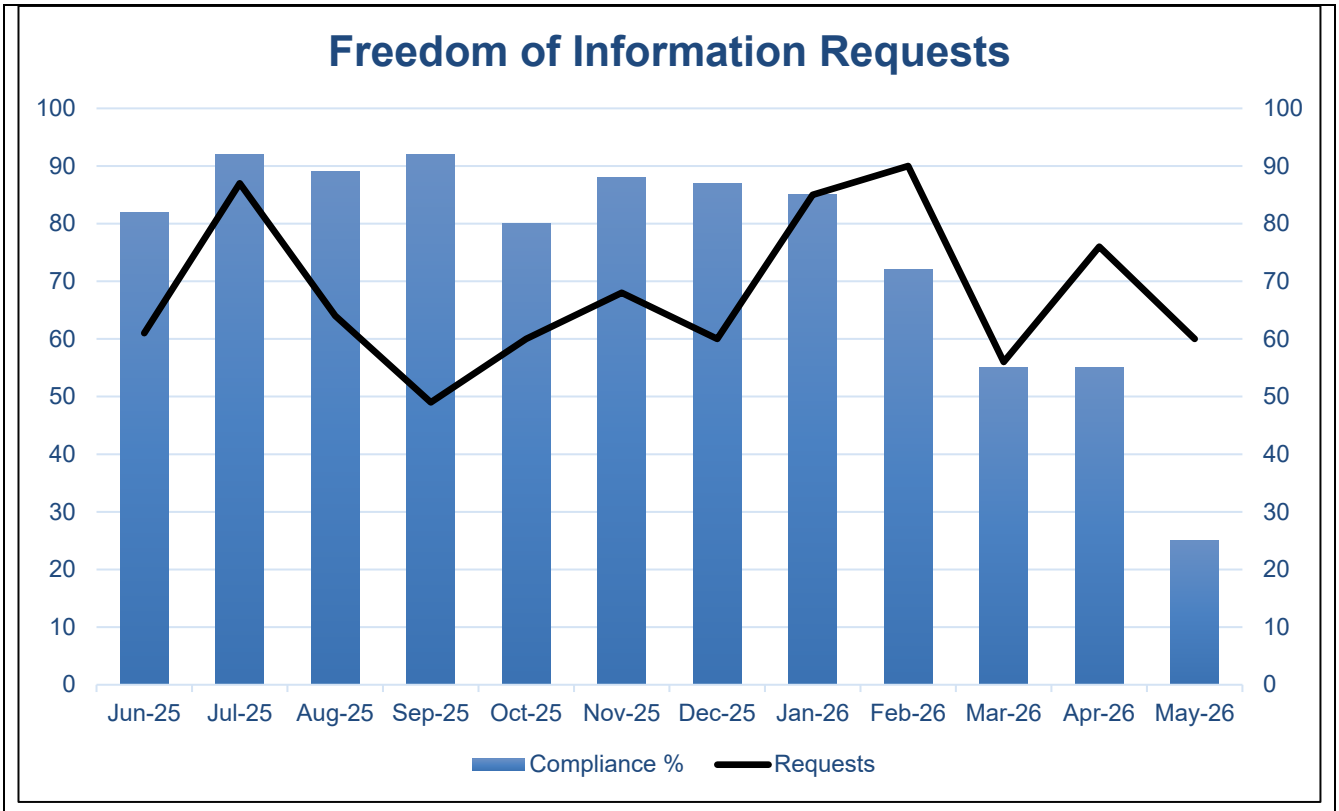
Between April 2026 to June 2026, the Information Governance Department have reviewed a total of 147 (49 per month) information governance related incidents, which were reported via the UHB's Datix reporting solution. On average, for the last 12 months, the Information Governance Department has reviewed approximately 49 incidents per month, which is unchanged from the previous report.

Of these breaches reviewed during this recent period, two breaches met the threshold to be reported to the Information Commissioner's Office (ICO). The two incidents reported to the ICO were assessed as required under UK GDPR and were notified within statutory timescales.

The number of ICO-reportable incidents remains consistent with previous reporting periods and does not indicate any emerging systemic concerns.

3. Freedom of Information Act

FOI compliance percentage for the last rolling 12 months against the 20-working day deadline is demonstrated as follows:



The average number of FOIs received during the last 12 months remains at 68 requests per month, and average compliance has further dropped to 76% from 86%. The continued reduction in FOI compliance is largely driven by a lack of capacity within the team.

There are currently 106 overdue requests which are being managed alongside the regular new requests.

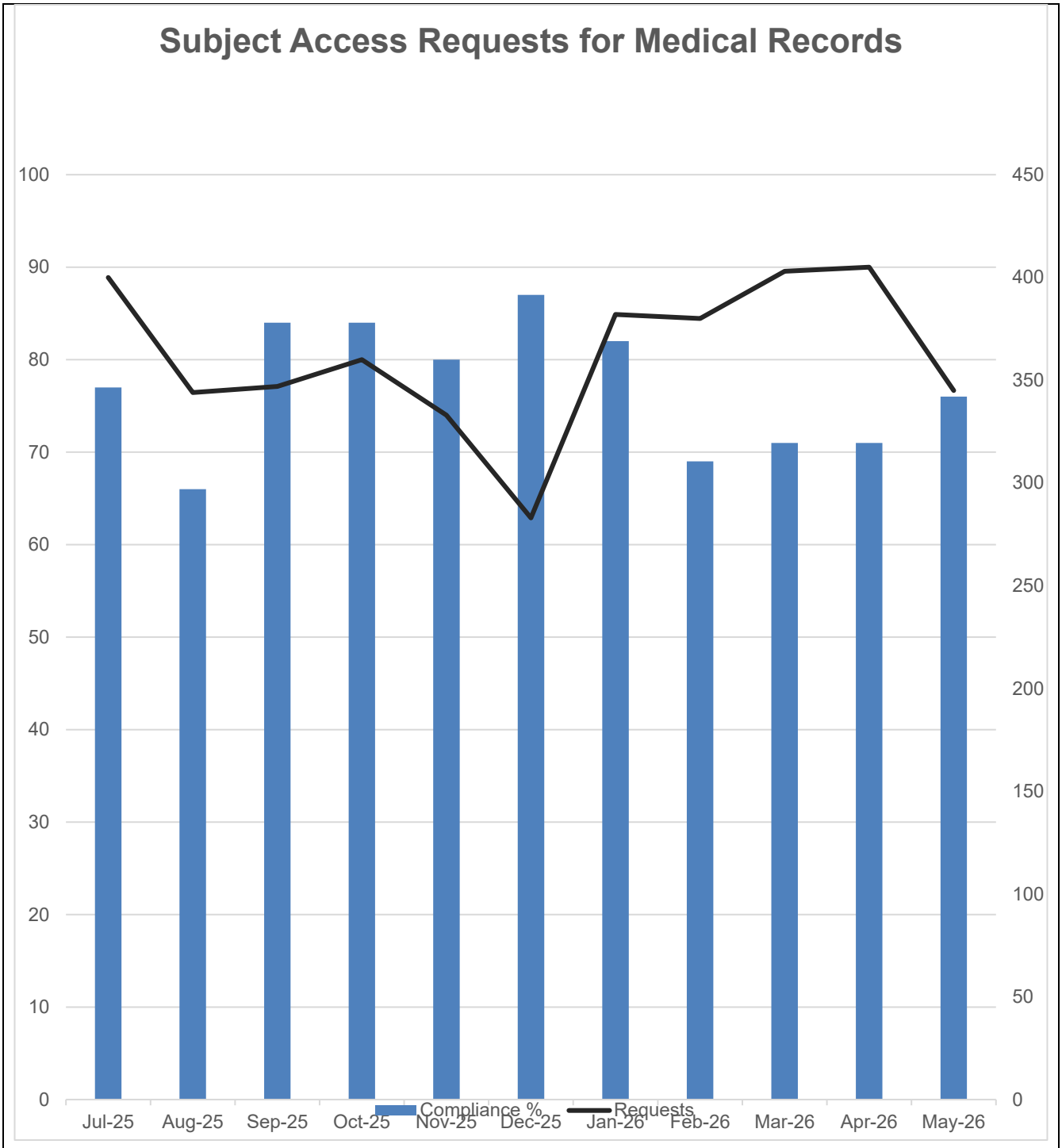
A link to the UHBs FOI disclosure log can be found below. This provides a link to every FOI the UHB publishes online. In the event that requests are made for the same information, the UHB is able to signpost requestors to this log.

https://cavuhb.nhs.wales/about-us/governance-and-assurance/freedom-of-information/disclosure-log/

4. Subject Access Requests Processed

4.1 Health Records requests

Medical Records SAR compliance percentage for the last rolling 12 months against the one-month deadline is demonstrated as follows:



The ongoing improvements seen over the last 12 months, continue to be made with average compliance now averaging 76% per month (an increase from 75% since the last committee). During this time, an average of 361 requests have been submitted each month, up from 339.

Additionally, the average request continues to be responded to within 24 days, against a deadline of 28 days. Only 28 requests remain open for March 2026 to May 2026.

4 .2 Non-Health Records requests

A total of 55 subject access requests submitted for non-health records were received between March 2026 to May 2026. 46 requests (84%) have been complied with within the legislated timeframe, which is an increase from 78% as last reported.

5. Compliance Monitoring/NIIAS

Since January 2022, the UHB has sent out a total of 1414 letters to staff who have been identified by the UHB's instance of the National Intelligent Integrated Audit Solution (NIIAS), based on a process approved by Management Executive.

The NIIAS process operates under an approved governance framework, with a proportionate and educational focus.

NIIAS continues to provide assurance regarding the monitoring of access to health records, with investigations demonstrating ongoing effectiveness as both a deterrent and educational control.

Further comms reflecting widely reported high profile data breaches in NHS England have been drafted and due to be disseminated across the organisation. This guidance reiterates to staff their data protection responsibilities and the seriousness of inappropriate access.

6. Information Governance Mandatory Training

Overall UHB Information Governance training compliance is currently 77% and is broken down by Clinical Boards as follows.

Clinical Board	Assignment Count	Achieved	Compliance
All Wales Genomics Service	371	334	90%
Capital, Estates & Facilities	1414	1211	86%
Children & Women Clinical Board	2281	1801	79%
Clinical Diagnostics & Therapeutics Clinical Board	2753	2174	79%
Corporate Executives	1069	846	79%
Medicine Clinical Board	1801	1280	71%
Mental Health Clinical Board	1565	1280	71%
Primary, Community Intermediate Care Clinical Board	1300	1006	77%
Specialist Services Clinical Board	2325	1755	75%
Surgical Services Clinical Board	2465	1776	72%
UHB	**17344**	**13302**	**77%**

The figure represents an increase from 76% to 77% since figures were provided to the last Committee.

Whilst organisational compliance has slightly increased, a number of Clinical Boards remain below the Health Board target and targeted management action continues.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

- Information Governance resource is still 4 WTE.
- 147 information governance related incidents reviewed between April 2026 to June 2026.
- 2 data breaches since the last committee have been reported to the Information Commissioner's Office.
- Freedom of Information compliance has dropped to 76% for last 12 rolling months.
- Access to Health Records compliance continues to increases to 76%. The number of requests over the last 12 months has increased to 361 per month.
- Letters to staff regarding inappropriate access to clinical systems remain in place.
- Information Governance mandatory training across the UHB has increased to 77%.

Whilst the Information Governance function continues to maintain delivery of core statutory activities, workforce capacity constraints are having a direct impact on performance, particularly in relation to Freedom of Information compliance.

Without substantive recruitment to fill existing capacity gaps, there is a risk of further deterioration in performance and increasing difficulty in meeting statutory obligations. Recruitment activity is underway, however sustained improvement is unlikely until additional resources are in place.

Recommendation:

The Board/Committee are requested to:

a) RECEIVE and NOTE a series of updates relating to significant Information Governance issues

Link to Strategic Objectives of Shaping our Future Wellbeing:

https://shapingourfuturewellbeing.com/

Putting People First 1. **Click the objective above to view more detail.**		Providing Outstanding Quality 2. **Click the objective above to view more detail.**	
Delivering in the Right Places 3. **Click the objective above to view more detail.**		Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered

Prevention		Long term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?

Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		

Impact Assessment:
Risk: Yes/No (delete as appropriate)
Please include the detail of any Risk Assessments undertaken when preparing and considering the content of this report and, where appropriate, the nature of any risks identified. (If this has been addressed in the main body of the report, please confirm)
Safety: Yes/No
Are there any Staff or Patient safety implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)
Financial: Yes/No
Are there any financial implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)
Workforce: Yes/No
Are there any Workforce implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)
Legal: Yes/No
Are there any legal implications that arise from the content and proposals contained within this report? If so, has advice been sought and what was the outcome? (If this has been addressed in the main body of the report, please confirm)
Reputational: Yes/No
Are there any reputational risks associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)
Socio Economic: Yes/No - ***Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES***
The Socio-Economic Duty is to designed to encourage better decision making, ensuring more equal outcomes. Do the proposals within this report contain strategic decisions, such as setting objectives and the development of services. If so has consideration been given to how the proposals can improve inequality of outcome for people who suffer socio-economic disadvantage? Please include detail. (If this has been addressed in the main body of the report, please confirm)
Equality and Health: Yes/No
Equality Health Impact Assessments (EHIA) are typically undertaking when developing or reviewing Health Board strategies, policies, plans, procedures or services. Do the proposals contained within the report necessitate the requirement for an EHIA to be undertaken? If so, please include the detail of any EHIA undertaken or the plans are in place to do so. (If this has been addressed in the main body of the report, please confirm)

Decarbonisation: Yes/No

There are a number of ways by which carbon emissions can be avoided through the operations of CVUHB.
These include:

- *A focus upon preventing ill health in our population*
- *Saving energy or increasing throughput.*
- *Value based healthcare. Being prudent by not over-treating/intervening. Avoid delivering low-value interventions*
- *Patients empowered to manage their conditions, utilising See on Symptoms and Patient Initiated follow ups to reduce unnecessary outpatient appointments.*
- *Service delivery in the most appropriate setting, e.g. in a community setting rather than an acute setting.*
- *Reducing waste – for example use non-sterile gloves only when needed, manage use-by dates to avoid throwing out good products, recycle and reuse.*

Does the subject matter of your paper risk any of the above not being achieved?

Welsh Language: Yes/No

Consideration should be given to potential impact on the Welsh language, including the following key aspects:
• More than just words: Does the report align with the More than just words strategy, ensuring Welsh-speaking patients can access services in their preferred language, and supporting active offer and bilingual care?
• Accessibility and compliance: Ensure key information is bilingual and that the report meets the Welsh Language Standards for communication, signage, and patient materials.
• Patient understanding and safety: Could English-only content impact Welsh speakers' comprehension in critical areas like consent and medication instructions, potentially affecting safety?
• Staffing and resources: Does the report address the need for Welsh-speaking staff or bilingual resources to deliver equitable care?
Does the subject matter of your paper risk any of the above not being achieved?

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*

Committee/Group/Exec	Date:

Report Title:	**Digital Directors' Peer Group**			Agenda Item no.	6.1	
Meeting:	Digital & Infrastructure Committee Meeting	Public	X	Meeting Date:	4th August 2026	
		Private				
Status:	Assurance		Approval		Information	x
Lead Executive:	Director of Digital & Health Intelligence					
Report Author:	Director of Digital & Health Intelligence					

Background and current situation:

The creation of the Digital Directors' peer group in 2021 replaced the previous Digital Delivery Leadership Group meeting which came into existence in 2020 following the dissolution of the National Information Management Board which had been focused on providing an overview of information and IM&T issues nationally.

The establishment of the peer group brings Digital in line with other professions in the NHS in Wales (eg Directors of Finance peer group, Directors of Planning peer group) and is a welcome development.

Assurance is provided by the discussion and exchange of views and updates on a wide range of digital related issues via the regular monthly meetings compromising board-level leads for digital from across all NHS Wales organisations, including Welsh Government's Chief Digital Officer and members of DHCW's executive team.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The attached minutes of the last two meetings held in February and March 2026 provide an update on the scope and range of discussions on digital matters impacting on all NHS Wales organisations.

CAV UHB is represented by the Director of Digital and Health Intelligence (the Director of Digital Transformation acts as deputy when necessary).

Recommendation:

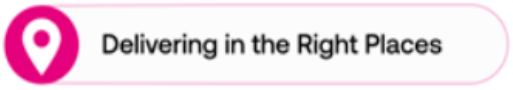
The Committee are requested to NOTE the minutes of the last meetings as follows:

a) Minutes of Meeting – 5th May 2026 (Appendix 1)
b) Minutes of Meeting – 2nd June 2026 (Appendix 2)

Link to Strategic Objectives of Shaping our Future Wellbeing:

https://shapingourfuturewellbeing.com/

Putting People First		Providing Outstanding Quality	
1.		2.	
Click the objective above to view more detail.		**Click the objective above to view more detail.**	

 3. **Click the objective above to view more detail.**		 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered									
Prevention		Long term	x	Integration	x	Collaboration	x	Involvement	x

Quality Impact Assessment Completed?				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		

Impact Assessment:
Risk: No
Safety: Yes
Financial: No
Workforce: Yes
Legal: No
Reputational: Yes
Socio Economic: Yes
Equality and Health: Yes
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

Welsh NHS Confederation
Conffederasiwn GIG Cymru

NHS WALES Digital Directors Peer Group
Collaboration • Innovation • Leadership

Attendance

Name of meeting: Directors of Digital Peer Group
Date: 2nd June 2026
Time: 09:30am – 1:30pm
Venue: Microsoft Teams

Digital Directors Present	
Initials	**Name**
AT	Anthony Tracey (HDUHB)
BH	Bryn Harries (NWSSP)
CB	Christopher Brown (NHS P&I)
CT	Carl Taylor (VUNHST)
DJ	Dafydd James (PHW) – deputising for IB
DT	David Thomas (CVUHB)
IR	Ian Rawlings (NHS P&I)
JP	Justine Parry (BCUHB)
MJ	Matt John (SBUHB)
PS	Paul Solloway (ABUHB)
SL	Sam Lloyd (DHCW)
SR	Sian Richards (HEIW) - Chair
VC	Vicki Cooper (PTHB)

External Speakers	
Initials	**Name**
AM	Alison Maguire (DHCW)
CLJ	Carwyn Lloyd-Jones (DHCW)
DO	David Owen (PTHB)
ME	Mark Edwards (DHCW)
SM	Sarah Murphy (DHCW)

Digital Directors Apologies	
Initials	**Name**
CM	Chris Moreton (DHCW)
IB	Iain Bell (PHW)
IE	Ifan Evans (DHCW)
SM	Stuart Morris (CTMUHB)

Minutes

Name of meeting:	Directors of Digital Peer Group
Date:	2nd June 2026
Time:	09:30am – 1:30pm
Venue:	Microsoft Teams

1.3	**Previous notes and Action Log** Notes from the meeting held on Tuesday 5th May 2026 were approved and action log updated (see May 2026 action log).

1.5	**Good news and Achievements**
	The group noted strong progress across priority digital transformation programmes, with several strategic developments supporting continued momentum and system alignment.
	• MJ – Maternity services across all units went live with BadgerNet on 18 May, representing a significant operational change requiring focused support to manage early implementation issues and service impact.
	• DT -
	  ○ Successful go-live with RISP
	  ○ Regional digital planning continues to strengthen referral and record access between health boards, supporting core digital infrastructure and a major capital bid to Welsh Government.
	  ○ Alongside CTMUHB and ABUHB, DT presented a regional digital plan to the South East Wales Regional Committee to improve referrals and records access across different systems, with further work planned over the coming months.
	• CT –
	  ○ The new Velindre Cancer Centre opens in 45 weeks, with network procurement completed and modern HPE Aruba cloud-based infrastructure being implemented.
	  ○ RISP live on 20th April and running at stable operations.
	• SL – Reported completion of the GP systems migration, moving almost 200 practices across Wales to a single supplier and resolving a previously critical programme issue.
	• VC – Shared positive NHS staff survey results for digital teams, including an 80% response rate and strong feedback on support, work-life balance and team culture.
	• BH – Confirmed the LIMS programme for the surgical materials testing laboratory has progressed through UAT, marking an important milestone after significant delivery challenges.
	• JP –
	  ○ BCUHB was runner-up for an HSJ award for a digital clinical service form.
	  ○ The ICT helpdesk achieved SEI 4 Star accreditation, reflecting improved service quality and staff culture.
	  ○ Staff survey results also highlighted strong teamwork, flexible working, kindness and respect within the digital team.
	  ○ Director of Digital post will be going to advert in June.
	• IR – working alongside the Musculoskeletal Clinical Network, an early engagement session has been held with potential suppliers who can provide an accredited digital solution for people needing physiotherapy remotely.
	• DJ – WEDINOS website review and rebuild allowed PHW to remove some legacy servers.

	• CB – Noted increased use of remote patient monitoring and requested that this be brought to a future meeting for further discussion.
	• AT –
	  ○ Announced the imminent award of the electronic document and media management service tender.
	  ○ Highlighted a Director of Finance-requested workforce transformation review of administrative roles over the next 5–10 years.
	  ○ The first electronic observations ward is due to go live within eight days, with full board-wide rollout targeted by the end of summer.
	• SR – The digital skills programme is developing into an integrated workforce transformation model aligned to local and national workstreams, with potential for wider rollout.
	
	Actions
	• **001 - MJ** to consolidate maternity go-live impact analyses into a single summary for wider sharing with IMS and stakeholders.
	• **002 - CT** to present the new HPE Aruba cloud-based infrastructure at a future meeting.
	• **003 - IR** to bring a briefing for digital and operational colleagues on Musculoskeletal Clinical Network supplier engagement for remote physiotherapy solutions.
	• **004 - DJ/IB** share learning from website migration
	• **005 – CB** – remote patient monitoring added to future meeting
	• **006 - AT** to bring back the administrative workforce transformation paper covering the next 5–10 years.
	• **007 – SR** digital skills programme update

1.6	**Chair's Report** • **DPIF update** SR will provide feedback on the DPIF process to Leon Wong and Alex Slade. • **NHS Peer Group Event, 9th June** • **Feedback Digital Conference, 21st May** The Blueprint written output is expected in June. • **Feedback from CEMT Chair, Paul Mears** • **Meeting with Chair Digital IM Group, Mynard Davies** SR will share a summary of good news and progress, alongside the new government statement, with Mynard Davies, following prior discussions with Leon Wong and Alex Slade. • **Strategy preparation for Delivery Board / DAG** No DAG June meeting scheduled. • **National Clinical Plan Board** The terms of reference are included in the papers, with the first meeting expected in early July; SR and MJ will attend. • **Benchmarking response** The DDoDs Group will lead the benchmarking response for future planning, with AT and MJ to consider any regional implications. • **New Government statement** SR will share the new government statement with Paul Mears and Mynard Davies and arrange an informal pre-meet with Leon Wong and Alex Slade to gather their views; the statement will also inform the Peer Group forward work plan after 9 June.
Strategic Matters	
2.1	**Cloud Transition Programme – CLJ/SM**

	The cloud transition programme is moving into active migration with KPMG as migration partner, supported by defined governance, risk management and cost optimisation arrangements. CLJ requested a single organisational contact for migration communications and volunteers to join the Cloud Transition Programme Board. Clear risk assessment and communication of operational impacts, including clinical safety considerations, were emphasised; CLJ confirmed application functionality will not change, but resilience and security will improve. Concerns were raised about alignment with ongoing product requests, with assurance that standard communication and product board routes will remain; CLJ confirmed implementation will be delivered in three-month waves with quarterly steering and tailored plans for larger systems. The discussion highlighted opportunities for shared learning and blueprinting to reduce duplicated effort across national services and health boards. DHCW is establishing a community of practice to share progress and support other organisations. DHCW is currently focused on its own migration due to contract expiry pressure, with future potential to support other organisations once resources and funding allow. VC welcomed stronger emphasis on the collective NHS Wales position, including shared ownership, shared risks and shared benefits. **Actions** • **008 - DoDs** to provide point of contact to SM to facilitate communications and coordination during migration • **009 - DoDs** to confirm DoD on Cloud Transition Programme Board.
2.2	**Cyber Group Report Update, 3rd Party Supply Chain Security - Risk Ledger, NCSC Project SPARTAN – ME** **Cyber Group Report Update** Cyber security remains a high priority, with the threat landscape becoming more complex and national collaboration strengthening detection and response capability. Increasingly sophisticated threats are extending remediation times and increasing operational pressure across NHS Wales security teams. A recent NHS alert relating to a ransomware precursor was identified and remediated within hours, demonstrating the effectiveness of current monitoring and response arrangements. A forthcoming major vendor patching wave linked to vulnerabilities associated with the Mythos AI model may require rapid deployment of significant patch volumes, creating material operational risk. ME emphasised the importance of operational awareness and advance notice of patching schedules in order to minimise service disruption. National coordination through task and finish groups is supporting improved remediation of weak passwords and dormant accounts. Since May, almost 20,000 dormant accounts have been enabled, supported by ongoing work on tagging and reporting standards to manage valid exceptions such as maternity leave. Weak passwords have reduced by approximately 8,000 accounts to 21,000, with continued focus on reducing the overall risk surface. SL and ME thanked Directors of Digital for reinforcing this work within their organisations and acknowledged the progress achieved through the National Weak Password Remediation Task and Finish Group.

	Action: • **010** - SR requested National Cyber group ToR to be drafted and shared. ME confirmed ToR is available in draft and will share. **3rd Party Supply Chain Security - Risk Ledger** Risk Ledger offers a federated third-party supply chain risk management solution at reduced cost if adopted across multiple organisations, supporting a potential national approach to NIS and ISO 27001 compliance. **NCSC Project SPARTAN** Project SPARTAN, in collaboration with the National Cyber Security Centre (NCSC), will strengthen threat detection and response through telemetry sharing and expert analysis. SL confirmed the intention to sign authority on behalf of NHS Wales to enable NCSC access while maintaining appropriate data privacy safeguards. A governance mechanism, including a national cyber security board, is being developed to align local risks and provide national oversight. A request was made for the proposed national cyber KPI data and reporting set out in slide 11 of the presentation to be shared with Directors of Digital in advance of the DDaT Leadership Board, to support full understanding and review. **Action:** • **011** - SL to share NCSC letter with DoDs and DoDs to share their approval
2.3	**Digital Maternity - AT** The digital maternity programme highlighted delivery complexity, constrained funding, leadership transition and the need for stronger clinical ownership of future business cases. Phase two and three funding submissions received limited support, with Welsh Government indicating restricted revenue for continued digital midwifery provision. AT emphasised the need for a consolidated, midwifery-led business case, supported by digital teams, to present a unified national position. Phase three estimated costs are approximately £2 million across NHS Wales, requiring strategic advocacy for funding approval The delivery model combined formal governance with rapid digital director intervention to unblock clinical teams and maintain pace. The approach was welcomed by midwifery teams but received mixed Welsh Government feedback, prompting a planned lessons-learned document. Strong project management and clinical leadership were critical success factors recognised by all participants. Effective local digital programme and project managers were praised for deep business process understanding and delivery facilitation. Digital directors emphasised the importance of driving transformation while supporting clinical ownership of business cases and operational change. Future business case development will be clinician-led with digital teams providing technical and transformation support.

	This model aims to enhance ownership and alignment with clinical needs, improving chances of successful funding and implementation AT to speak with Chief Nursing Officer in coming weeks. The group thanked AT and all teams involved for their contribution to the programme's success. **Action:** • **0012** - AT to share lessons learnt paper
2.4	**<u>Deputy Directors of Digital – VC/DO</u>** A new Deputy Directors of Digital group is being established to strengthen operational leadership, share best practice and operate within terms of reference aligned to existing governance. Draft terms of reference have been developed, with a strong emphasis on measurable outcomes and cross-organisational change management. The group is intended to reduce the operational burden on Directors of Digital by addressing technical leadership and delivery challenges collaboratively. Overlap with existing cyber and national programme leads groups creates an opportunity to consolidate structures and reduce duplication; DO confirmed this is being considered as part of a wider structural review. Initial meetings are expected to take place after the CEO peer group session on 9 June, ensuring alignment with wider system expectations and programmes of work. Membership should be limited to one representative per organisation at each meeting to maintain focus and avoid over-representation. The seniority of attendees, together with appropriate preparation in advance of meetings, was highlighted as essential to productive discussion and effective decision-making. The seniority and preparation of attendees were identified as critical to productive discussion and effective decision-making. The DDoDs group is also expected to coordinate activity across specialist forums, including health records, information governance, and performance leads. A priority will be to map and rationalise these groups in order to provide greater clarity on roles, responsibilities, and decision-making authority. DO shared the draft terms of reference for review, with particular emphasis on the exchange of best practice and effective ways of working. The all-peer-group session on 9 June is expected to provide further clarity on respective programmes of work. VC requested that an update from the DDoDs group become a standing item on the Directors of Digital agenda to support communication and the effective flow of information between groups. **Action:** **013** – VC/DO discuss work programme in July meeting following the peer group session on 9th June
Delivery and Performance Matters	
3.1	**<u>LIMS/RISP</u> – AM** **LIMS**

	The LIMS programme faces critical legacy data access challenges that affect PHW go-live readiness and require urgent decisions on funding, risk and scope. Legacy data access requirements emerged late, with PHW and other health boards requesting real-time, 24/7 access beyond the original project scope. Current ODBC access does not meet operational requirements, leading to a proposal for a read-only cloud-based copy of the TCL 2016 database. The proposed solution includes a one-off Intersystems cost plus ongoing hosting and licensing charges, with total costs estimated at approximately £900,000 and allocated via SLA. Project scope and governance issues include a significant delay in recognising these needs, with formal requests only arising in February 2025. AM explained that the original project scope, agreed in July 2023, did not anticipate this level of legacy data access. PHW's 20 July go-live is at risk unless legacy data access is resolved, with tranche sequencing adding further scheduling complexity. To avoid delay and additional cost, tranche four is proposed for July go-live, with PHW potentially deferred to August or September, which would affect blood transfusion timelines. The project board will review these trade-offs on 9th June, with ongoing discussions on defect resolution and system readiness Lessons learned highlight the complexity of transforming digital systems alongside workforce and process changes. Many reported "defects" are required changes to workflows and configurations, not system faults, emphasising the need for dedicated UAT teams and better change management Many reported "defects" reflect workflow and configuration changes rather than system faults, reinforcing the need for dedicated UAT teams and stronger change management. **LIMS legacy data** MJ requested formal letter to be sent to health boards outlining the reasons, options and break down of all costs included. AM confirmed the Programme Board are aware of the requests and costings. Action: • **014** - SR requested risk assessment for not having access to legacy data, AM happy to provide this. **Summary:** Directors of Digital should review local requirements, functionality needs and associated costs to ensure clear organisational positions, clinical support and confirmation of essential elements. Attendees should be prepared to support decision-making on next steps. PHW will be a key consideration, as they have confirmed that access to legacy data is required for go-live. Without this access, PHW cannot proceed with the LIMS 2 go-live currently scheduled for 20th July. Awareness should be raised of the revised go-live dates and the importance of maintaining a strong approach to delivery within Q2. Chief Executives are expected to seek Directors of Digital advice on next steps; focused discussion is therefore required to support alignment and provide a clear professional view on the proposed way forward. Directors of Digital thanked AM for her hard work. **RISP** ABUHB is the final organisation scheduled to go live on 22 June.

	The programme is expected to close by the end of June, with transition to business as usual over the summer. Programme Board and national meetings also end in June. Any ongoing issues managed by SMB and programme colleagues will continue to work along with them. There will be a paper provided to the Programme Board listing outstanding issues and what's left to be completed. Lessons learnt to be taken forward: ○ Treat programmes as transformation activity, not solely system implementation or delivery. ○ Ensure go-live decisions are led by health boards and suppliers rather than DHCW alone. ○ Establish dedicated UAT capacity. Lessons learned will be reported to the SMB Board, DHCW Programme Board and health boards, with health boards also contributing implementation-specific learning. AM will explore how the DDaT Delivery Board should also be informed.
Risk	
5.1	**Development of Directors of Digital Risk Register** Peer group risk registers were discussed, with Welsh Government not supporting formal registers for peer groups; digital leaders nevertheless emphasised the need for shared risk visibility. National risks, particularly cyber and shared infrastructure, require coordinated management beyond individual organisations. Further discussion is needed to agree mechanisms for collective risk visibility and escalation.
Forward Work Plan (FWP) and AOB	
7.1	**FWP** • July – HEIW Digital Skills workforce transformation programme • NDR • 10mins on WG updates before summer recess • Digital blueprint collective views **AOB** • **8 September visit to Microsoft London** – AI adoption is an emerging priority, with a dedicated September or October session proposed to showcase internal and external innovation and support discussion on clinical and administrative use cases; Welsh Government should also be invited.
Details of the next meeting	
The next Directors of Digital Peer Group meeting will be taking place on **Tuesday 7th July 2026** in **Boardroom, DHCW Cardiff**	

DIRECTORS OF DIGITAL PEER GROUP MEETING

MEETING NOTES

Date: Tuesday, 5th May 2026

Time: 9am – 11pm

Location: The Mail Room, Parkgate Hotel and Microsoft Teams

Attendance

Digital Directors Present	
Initials	**Name**
BH	Bryn Harries (NWSSP)
CM	Chris Moreton (DHCW)
IE	Ifan Evans (DHCW)
IR	Ian Rawlings (NHS P&I)
JP	Justine Parry (BCUHB)
MJ	Matt John (SBUHB)
PS	Paul Solloway (ABUHB)
SL	Sam Lloyd (DHCW)
SM	Stuart Morris (CTMUHB)
SR	Sian Richards (HEIW) – Chair
VC	Vicki Cooper (PTHB)
MC	Mark Cahalane (CVUHB)
AT	Anthony Tracey (HDUHB)
IB	Iain Bell (PHW)
CT	Carl Taylor (VUNHT)
MC	Mark.Cahalane (CVUHB) - Deputising for DT

Apologies	
Initials	**Name**
DT	David Thomas (CVUHB)

External Speakers	
Initials	**Name**
CC	Casey Cucciniello, VodafoneThree
GH	Gareth Hopkins (VodafoneThree)
SE	Sarah Eadie (VodafoneThree)
YM	Yas Mansour (VodafoneThree)
ME	Mark Edwards (DHCW)

OK	Oz Khan (Atos)
GC	Grant Crawley (Atos)
LR	Lyn Rees (Atos)

Agenda Item	Discussion	Action
Preliminary matters		
1.3 Previous Notes Approval	**Previous Notes –** Approved. Add CM to attendees list.	
1.4 Matters Arising	IR - NHS P&I supporting Six Goals with the procurement exercise of Adastra procurement exercise. Aim for a new three year contract to be put in place not an extension. In relation to the wider digital approach to primary and community care, AT suggested a regional approach could be an option in discussions with six goals, with an understanding of local nuances and informing Welsh Government of the regional working health boards are willing to undertake. IR to discuss this with NHS P&I and agreed to provide a paper detailing best point of contact, structure, vision of how Community by Design also feeds into this work and the plan Six Goals envisions for a digital working model. From the notes there was a discussion in relation maximising the use of Copilot discussion, it was agreed that this would be taken as an action in the ATOS presentation and added to the forward work plan (FWP) accordingly. The group agreed to explore Microsoft alternatives cautiously, focusing on a high-level assessment to understand feasible options for the future digital estate. Initial Assessment of alternatives centred on understanding open source, Google, or hybrid options led by SL and the Centre of Excellence, engaging health board stakeholders. Strategic rationale included the recognition of legacy application dependencies on Microsoft platforms and the need to mature web-based solutions over the next few years to disentangle from Microsoft. Implementation approach involves adding this exploration to the forward work plan, working collaboratively with the Centre of Excellence, and balancing partial migration with maintaining critical Microsoft services.	**001 – IR – September** **002 – add to FWP September** **003 – add to FWP**
1.5 Good news and achievements	IE – Met with Welsh Gov regarding AI. Encouraging and positive meeting. Happy to see collaborative working with Welsh Gov and NHS. AT – Maternity delivered and working well. EMPA has gone live and successful. SL – DHCW awarded Cloud migration contracts.	

	JP & CM – DPIF submitted meeting deadline. VC – EMPA went live and successful SM – Pharmacy upgrades, open eyes. Blueprint work session was good for all DoDs. CT – VUNHST went live with RISP IB – New website and one single operating website launching next week. This also ensures PHW are fully Welsh language and accessibility compliant. FWP – look at new supplier and process undertaken. MJ – Neath Port Talbot Hospital has replaced the Wi-Fi network successfully without disruptions. BH – Digital Data Subgroup and engagement sessions for the Digital Strategy successful. MC – Launch of regional Children Safeguarding and Adult Safeguarding which has been well received. Full power down of the Heath Hospital which was18 months in the planning. MC share a paper and further information. IR – Supporting the learning disabilities team in HDUHB for App roll out. Other health boards are picking this up and working with Centre of Excellence for development across. Quick wins: digitalising paper systems currently in place. SR – NHS P&I joint working with HEIW for roll out of virtual care with the skills and capabilities and what understanding what staff need to work in a digital way. • Formal programme underway with HEIW new Head of Digital Skills and work completed by Tektology. Opportunity to understand what staff need to feel confident to work in a digital way. • NHS ConfedExpo – HEIW have a mid-Wednesday afternoon panel for AI in Education, SR will be Chairing the Panel. CM – draft accounts submitted. • Next steps in challenge with the HMRC VAT position. DHCW are acting on behalf of NHS Wales and have served a pre action protocol letter to HMRC. DHCW continue to connect with NHS Scotland and are looking to identify best contact in NHS England.	**004 – add to FWP** **005 - MC**
1.6 Chairs Report	• Feedback from DoD workshop SR has added document to SharePoint. Share feedback to SR via email. Following feedback this will be refined and become the plan for 26/27 • Digital Blueprint	

	Positive event. Interest to explore next steps. Good value and conversation, but progression is needed and clarity of outcomes and next steps. BCUHB has session is arranged and engagement challenges. SR to invite Tektology to DoD peer group to understand aim and outcomes for clarity. IB asked for clarity of Welsh Government role. It was confirmed that the worked had been commissioned by CEOs of NHS Wales IB raised this could be a business transformation challenge to DoPs and Chief Execs. • Digital Conference, 21st May It was discussed that there was opportunity for the agenda could have been more inclusive and incorporate a wider view of the digital activity across NHS Wales. DoD were encouraged to attend and to support any request from DHCW for presentations or stands. IE agreed to check with comms department in DHCW on attendance and promotion activities. • National Digital Data and Technology (DDaT) Workforce Capability Group is meeting as part of the DDaT governance and meeting scheduled for the 6th of May. Agenda shared in the DoD Teams folder for information. • DDaT – Delivery Board – 13th May, paper and agenda received made available in the DoD Teams folder	**006 - SR** **007 – All**
Strategic Matters		
2.1 Wales' Connectivity Investment Programme – VodafoneThree	Colleagues from Vodafone attended the session to present an overview of the Vodafone's merger with Three which commits to an £11 billion UK network investment over eight years, with £605 million earmarked for Wales, focused on 5G standalone rollout and rural connectivity. DoD were asked to engage in the programme to ensure that the investment was maximised. The £605 million investment aims to eradicate 25% of not-spots in the initial year and reach 99% 5G standalone population coverage in Wales by 2034, meeting Ofcom regulatory requirements. Approximately 1,500 sites require upgrades or new builds, with planning delays posing significant barriers to timely deployment. Vodafone emphasised the necessity for a collective Welsh public sector effort to build compelling local narratives to overcome planning hurdles and accelerate infrastructure rollout, especially in rural areas like Powys and Ceredigion. IE added that Regional Partnership Boards (RPB) would be a good mechanism for engagement.VC queried if VodafoneThree are engaging with Council/Local Authority digital teams to assist with working strategically together to produce a compelling case for any planning hurdles. CC confirmed 1:1s with health boards and engaging with councils. Feedback from council regarding barriers are highways and planning.	

	Swansea University's private 5G network illustrates transformative healthcare applications such as remote ultrasound and blood pressure monitoring, signalling significant efficiency and care delivery improvements. Case studies were provided on how VodafoneThree is providing solutions for accessibility, digital skills, personal preference and trust, home ultrasounds, blood pressure monitoring/CVD prevention. IB raised the challenges faced when the mobile coverage significantly impacting screening vans across Wales which are vital to equality of access. Would be keen to discuss opportunities around PHW vans. JP added that Remote Patient Monitoring is starting to come up through Community by Design processes. **Digital Inclusion and NHS Wales App Accessibility** Efforts to increase digital inclusion include piloting solutions to overcome barriers to NHS Wales app adoption, focusing on device accessibility, digital skills, and motivation. Pilots in England test SIM-enabled refurbished devices, multilingual content, retail-based onboarding, and targeted regional campaigns to address accessibility, skills, and motivation barriers. Cross-Regional Learning: Discussions include learning from NHS England's experience in addressing digital exclusion and adapting proven approaches for Welsh contexts. IE raised that digital inclusion has a barrier of connectivity and it would be beneficial sharing Vodafone's knowledge with the NHS Wales App team. YM confirmed customised offers regarding local issues e.g. language barriers etc by looking at why adoption is slow compared to other areas. Japan would be an example of an adopter and is high user of 5GSA. Shift away from Wi-Fi is already happening. Local example can be seen with Swansea University. VodafoneThree is also engaging with number of MS's, keeping in mind the political climate we are in regarding the upcoming Senedd elections. How do VodafoneThree plan to build confidence with organisations? • transparency and investment plans shared/published. Joining up for areas of concern. Sharing the challenges with an end vision included • engagement with councils and DoDs and telling the collective story to build confidence. **Next steps:** VodafoneThree to reach out to individuals for follow up post meeting. Feedback from DoDs would be appreciated to drive positive change.	
2.2 Cyber Workshop	The system faces significant cybersecurity challenges with a consensus to establish a national cyber group to coordinate efforts, prioritise risks, and improve collective resilience	

	Persistent vulnerabilities include dormant accounts and increasing weak password incidents, indicating poor basic hygiene and escalating cyber risk. The lack of formal national cybersecurity program and governance limits progress; agreement reached to set up a Heads of Cyber Security Group with clear terms of reference and reporting lines by June. It was stated that , many basic mitigations require prioritisation and collaboration rather than additional funding, and actions can be taken. National Cybersecurity Program and Metrics: A draft program is underway, focusing on supply chain management, incident response, and emerging threats including AI-enabled attacks with agreed shared metrics and reporting mechanisms to Welsh Government. It was agreed by DoD that until an alternative DDaT cyber meeting has been established that a Cyber Group should be established to report into DoDs with suggestion of ToR for DoDs to endorse at the June meeting. ME agreed to take action to get nominations from organisations and set up the way of working. It was agreed that • Action - ME requested nominated Heads of Cyber to form Head of Cyber Group. Agreed for a Chair, ToR, work plan and formally bring back to DoDs Peer Group meeting In June ME reported back on the progress of the Risk Ledger procurement discussed, with five organisations signed up at £25,000 each, enabling better supply chain visibility and compliance. Further updates and prioritise were discussed and the presentation shared for follow up by DoD. There was agreement to take action on weak passwords and dormant accounts and this will be a focus of the Cyber group. • Action - ME requested nominated Heads of Cyber to form Head of Cyber Group. Agreed for a Chair, ToR, work plan and formally bring back to DoDs Peer Group meeting in June.	**008 – ME** **008 - All**
2.3 DPIF	During this item, IE raised the concerns that DHCW not being invited to the DAG meeting when RISP/LIMS are being discussed. SR agreed to continue to discuss the governance arrangements with WG colleagues. In relation to DPIF, IE raised the concern in the impact of the DPIF Pause and Review and the risk of delay and not understanding the interdependencies, it was therefore. IE agreed to share the requested RAG rating email shared again to get a consistency of impact and risk across programmes of work It was confirmed as a result of the pause and review Programme boards will be asked to look at their commitments and disbursements. The evidence of the impact of the pause and review is being seen in WICIS, where a decision has had to be made to fund from DHCW allocation for Q1, noted this was at risk and not sustainable.	

Delivery and Performance Matters		
3.1 Atos Presentation for M365 Review	The item was a presentation from Atos in their review and finding of the DHCW Centre of Excellence (CoE). The review found that actions was required in relation • Operational: clearer service ownership, prioritisation and delivery focus. • Digital: improved consistency, assurance and adoption of M365 capabilities. • Workforce: clarity of roles, expectations and engagement with organisations. • Financial: use of existing investment more effectively. The Atos presentation was followed by a discussion from Lyn Rees DoD welcomed the report by Atos and found it comprehensive. It was agreed that further work was required on proposed way forward and the draft response by DHCW to address the actions and make improvements DoD were happy to work and be part of the revised mode to plan provide a sound, proportionate approach to strengthening the Microsoft 365 Centre of Excellence, with appropriate governance, clarity of accountability and delivery focus.	**Action – LR to bring back revised improvement plan**
Items for Information and Noting	DoD were asked to note that the Chief Exec all Joint Peer Group event, 9th June where there will be a focus on the work of the peer groups and clarity of ways of working.	
8.	**Actions** • MC share a paper and further information regarding successful full power down. • SR to invite Tektology to DoD peer group to understand aim and outcomes for the Digital Blueprint. • Digital Conference, 21st May feedback • ME formally bring back to DoDs Peer Group meeting in June the Head of Cyber Group ToR and Work Plan. • LR to bring back revised Atos improvement plan FWP – June • Commence work programme (if agreed) • Cloud Transition Programme • Blueprint feedback • Deputy Group • LR to bring back revised Atos improvement plan FWP – September • Digital approach to primary and community care with consideration for Community and Six Goals • Maximising the use of Copilot	
Details of next meeting:		

The next **Directors of Digital Peer Group meeting** will be taking place **Tuesday 2nd June 9:30am – 1pm** on **Microsoft Teams only**

Report Title:	Authorising Engineer Annual Report CVUHB 2026 - Ventilation				Agenda Item No:	6.3	
Meeting:	Digital & Infrastructure Committee		Public	√	Meeting Date:	4th August 2026	
			Private				
Status **(please only tick one)**	Assurance	√	Approval		Information/Noting		
Lead Executive Title:	Director of Finance						
Report Author Title:	Director of Capital, Estates and Facilities						

Main Report

Background and Current Situation:

The purpose of the report is to provide the Committee with assurance that the ventilation systems at Cardiff & Vale UHB are maintained and inspected in accordance with the guidance document Welsh Health Technical Memorandum (WHTM) 03-01 parts A and B to ensure that the systems remain safe.

In accordance with the HTM guidance, Cardiff and Vale UHB have appointed an independent Authorising Engineer (AE) to provide advice and guidance to the UHB. The AE assesses the Approved Persons and undertakes the system audits. The AE service is currently provided by National Wales Shared Services Partnership, Specialist Estate Services (SES).

The 2026 annual audit report, issued by the AE in April 2026, indicates the overall compliance rating as 'reasonable assurance'. There has been no change in assurance since the previous report. Capital, Estates & Facilities have reviewed the findings of the report and produced an action plan (appendix 1), which identifies the management response and current status of the recommendations.

Since the last annual audit, two site operational audits have been completed by the AE(V). Section 13 in these reports summarises the main actions that should be taken to improve the health boards overall ventilation compliance rating. Other items highlighted in the recommendations section of the triennial reports are summarised within section 3.6 of that annual report.

The AE recognised that the Health Board has made progress in a number of areas throughout the site. However, there are still areas that require further improvement.

The Service Board are striving to achieve a 'suitable number' of trained Authorised Persons (APs) for Ventilation Systems at each acute site. The HTM AP establishment is 1 APs at UHW and 1 APs at UHL, along with 2)APS) dedicated to Capital Planning.

A training programme has been established to improve the position which will provide further assurance that the required standards are being met.

Recommendations:

Whilst the Designated Person should note the full content of this report and the attached audit report, it is recommended that particular attention is given to addressing the following:

- Health board to develop an Local Exhaust Ventialtion (LEV) management system to ensure systems are adequately managed.
- Schedule non-accessible fire dampers, liaise with fire officer and ensure these are accounted for in the fire strategy.
- Review risk assessments and method statements for maintenance procedures.
- Ensure that cause & effect and BMS fire damper status indication is adequately tested as part of the damper testing programme.
- Introduce a **"permit to release"** system at C&V UHB.

- Appoint two additional full time AP(V)s at UHW & UHL to improve resilience. Contract manager for external contractor undertaking maintenance to be appointed as AP(V).
- Create annual verification action plan.
- Updates on AE(V) audit recommendations to be included as an agenda item for future VSG meetings.
- Instigate closer engagement between AE(V) and the health board.
- Improve AE(V) access to verification reports.

Executive Director Opinion & Key Issues to bring to the attention of the Board/Committee/SLT (delete as appropriate)

- The overall compliance rating of the annual report issued in April 2026 remains as 'reasonable assurance'
- A training programme has been implemented to achieve the HTM Approved Persons establishment

Appendices (please list any appendices that will accompany this report. Do **not** embed)

Ventilation Annual Report Action plan
AE Ventilation Annual Report 2026

Recommendations:

The committee are requested to:

a) **NOTE** the content of the report and the progress made in addressing the recommendations of the annual audit and recent triennial audit
b) **NOTE** the risk associated with the age and obsolescence of the existing ventilation infrastructure

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please place an "x" in the below boxes where relevant – *Click each item for further information.*

1. Putting People First		2. Providing Outstanding Quality	√
3. Delivering in the Right Places	√	4. Acting for the Future	√

Five Ways of Working (Sustainable Development Principles) considered:
Please place an "x" in the below boxes where relevant

Prevention	√	Long Term	√	Integration		Collaboration		Involvement	√

Quality Impact Assessment Completed?
Please place an "x" in the below boxes where relevant

Yes *(please include the complete QIA document)*	x	No *(please provide reasoning e.g. not required*		

Impact Assessment
Please place an "x" in the below boxes where relevant

Risk: Yes

Associated with the age of equipment which is both non-compliant and becoming obsolete
Safety: Yes
Please include the detail of any Risk Assessments undertaken when preparing and considering the content of this report and, where appropriate, the nature of any risks identified. (If this has been addressed in the main body of the report, please confirm)
Financial: Yes
Parts periodically have to be manufactured specifically for the system and are more costly. To replace the system or parts thereof will be significant and disruptive to the service
Workforce: Yes
Recruitment of competent staff.
Legal: No
Reputational: No
Socio Economic: No
Equality & Health: No
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:

Action Plan: UHB (Ventilation) Annual Report 2026

ID	Site	Status	Action	Comments	Date Raised	Action Owner	Target Completion Date	Actual Completion Date
6.1a	UHB		Health board to develop an LEV management system to ensure systems are adequately managed.	Discussed at Ventilation Safety Group meeting and further works with this action required.	3/2/2026	R Jones/J Garrett	12/31/2026	
6.1b	UHB		Schedule non-accessible fire dampers, liaise with fire officer and ensure these are accounted for in the fire strategy.	Compliance team to devise a plan to complete this action with the fire officers.	3/2/2026	R Jones/J Garrett	12/31/2026	
6.1c	UHB		Review risk assessments and method statements for maintenance procedures.	This will be mainly with the current contractor who carries out AHU system maintenance. Compliance team to check and involve VAPs.	3/2/2026	R Jones/J Garrett	12/31/2026	
6.1d	UHB		Ensure that cause & effect and BMS fire damper status indication is adequately tested as part of the damper testing programme.	Compliance team to confirm this action is carried out as recommended.	3/2/2026	R Jones/J Garrett	31/09/2026	
6.1e	UHB		Introduce a “permit to release” system at C&V UHB.	This has been discussed at the VSG and the urgent requirement to implement the permit to release system. As we use contract labour then may require to be added to the work wallet control of contractor system for this to work correctly.	3/2/2026	Ventilation Safety Group/Owen Davies	12/31/2026	
6.1f	UHB		Appoint two additional full time AP(V)s at UHW & UHL to improve resilience . Contract manager for external contractor undertaking maintenance to be appointed as AP(V).	Requirement for additional VAPs for C&V. Also the requirement for the appointed contractor to be have an appointed VAP and then C&V appoint VCPs to carry out work. Discussed at VSG and requires both Estates and Compliance staff to attend training and become appointed VAPs for the health board. Also an agenda item at the Estates AP meetings.	3/2/2026	Ventilation Safety Group/Estates/Compliance	12/31/2026	
6.1g	UHB		Create annual verification action plan.	There is currently an action plan in place, but the AE has required additional and more clearer the plan/schedule.	3/2/2026	R Jones/J Garrett	12/31/2026	
6.1h	UHB		Updates on AE(V) audit recommendations to be included as an agenda item for future VSG meetings.	This is an agenda item and will be discussed at every VSG meeting. Also an agenda item at the Estates AP meetings.	3/2/2026	P George	6/30/2026	6/30/2026
6.1i	UHB		Instigate closer engagement between AE(V) and the health board.	This action was for any project AHU work to involve the AE for comments and review, this has now been implemented and will engage with AE for other Ventilation matters on all occassions.	3/2/2026	P George	6/30/2026	6/30/2026
6.1j	UHB		Improve AE(V) access to verification reports.	These are currently stored in a C&V shared drive and Compliance team trying to get access.	3/2/2026	R Jones/J Garrett	7/31/2026	

GIG CYMRU NHS WALES

Partneriaeth Cydwasanaethau
Gwasanaethau Ystadau Arbenigol

Shared Services Partnership
Specialist Estates Services

Authorising Engineer (Ventilation)
Annual Report
For
Cardiff and Vale University Health board

Authorising Engineer (Ventilation)
Annual Report
For
Cardiff and Vale University Health board

NWSSP-SES Report Reference: **AE(V)/AR/2025/C&VUHB/01**

Report Date: **April 2026**

AUTHORISING ENGINEER

D Morris B Eng. (Hons), C.Eng, MCIBSE,
Senior performance standards Engineer

COUNTER SIGNED

M. Gapper B.Eng (Hons), C.Eng. MCIBSE
Head of Engineering

CONTENTS

1.0 EXECUTIVE SUMMARY

1.1 Following on from the triennial audit completed in 2025, the assurance in relation to governance and procedures at C&V UHB has reduced since the last annual report. Action plans should be put in place, which, when implemented should result in improvements across the acute sites. Further details on non-conformities can be found in the individual triennial report issued previously under separate cover.

1.2 AE(V) triennial site audits have been completed at University Hospital Wales & University Hospital Llandough during the period with limited assurance for both hospitals.

1.3 The ventilation systems are not being fully managed in accordance with WHTM 03-01 with significant non-compliances including:

- It is understood that capital & estates are not responsible for the management of all LEV systems within C&V UHB. Capital & estates should hold a central register of all LEV systems and should have copies of the relevant test certificates. Testing to be reviewed across the health board, with procedure detailing the testing requirements and legal responsibilities to be developed to inform departments that undertake their own LEV testing of their legal obligations. Certificates to be collated and held by estates as a central register of compliance.
- The non-accessible fire dampers should be scheduled and identified on building layout plans. This information should be reviewed by the fire officer to ensure the fire strategy takes the inaccessible dampers into account. Every effort should be made to reduce the percentage of dampers that are not accessible.
- Review risk assessments and method statements for maintenance procedures (external contractors and internally) and update as necessary to ensure that maintenance activities are undertaken in a safe manner ensuring they do not create a hazard for those who undertake the work or those who could be affected by the work (risk assessments need to be task specific). Consider implementing a risk assessment review ‘gateway’ when jobs are allocated to the craftsmen on the CAFM system to ensure operatives are aware of potential risk and how to work safely.
- Liaise with fire officer to ensure that cause & effect and BMS fire damper status indication is adequately tested as part of the damper testing programme. Consider creating a summary sheet of compliance each year.
- Introduce a “permit to release” system at C&V UHB when undertaking inspections, maintenance, and verifications on critical ventilation systems, as recommended in WHTM 03-01 Part B. The permit should apply to C&V UHB operatives as well as the external contractors that undertake planned cyclic maintenance.
- Appoint two additional full time AP(V)s to improve resilience. One additional appointment at UHW to support Paul George and one at UHL to support Mark Branch is required. Health board should monitor workload of the AP(V)s and allocate additional resources to assist if

necessary. Contract manager for external maintenance contractor should also be trained and formally assessed as an AP(V).

- Develop a system to rationalise maintenance records currently filed 'by block' to a system filed by asset in date order. This will improve accessibility of the records should they need to be reviewed. Consider allocation of additional resource to complete this task.
- An annual verification action plan should be created, this action plan should list all the non-compliance items, the duty holders for rectification, the actions undertaken and if any action items are long term with no immediate resolution i.e. capital bids. Where significant non-compliance issues are noted which can impact patient safety e.g. insufficient air change rates, the health board should have a formal procedure to record risk assessments and mitigation measures put in place if the area is to remain in use.
- Updates on AE(V) audit recommendations to be included as an agenda item for future VSG meetings.
- To ensure that future projects are fully compliant with the current HBN and WHTM guidance, closer engagement is required between the AE(V), the VSG, Capital, and the Estates Departments, to ensure that the MEP services are properly scrutinised at all design stages and fully validated at completion.

1.4 The Authorising Engineer for Ventilation AE(V) currently deems the overall compliance rating as yellow (reasonable assurance) which is comparable with the previous report issued in July 2025, as shown in figure 1 below.

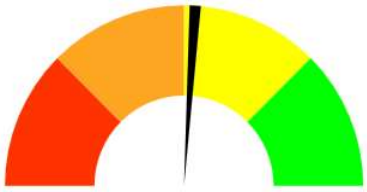
Report Issued July 2025	Report Issued April 2026
	
Triennial AE(V) audit is overdue. **Further APs(V) required** **No CPs(V) appointed** **Unclear whether all critical ventilation systems have been verified** **Unclear whether Critical ventilation system lists have been updated to include LEV systems** **HTM 03-01 Part B non-compliances in the audit report require action**	**LEV management system required** **Liaise with fire officer regarding non-accessible fire dampers** **Review risk assessments** **Ensure cause & effect is tested** **Instigate permit to release system** **Appoint additional AP(V)s** **Report on AE(V) audit action plan progress at VSG meetings.**
Reasonable assurance	**Reasonable assurance**

Figure 1 Overall Compliance Rating

2.0 BACKGROUND

2.1 The following report is a compliance review undertaken by the Authorising Engineer for Ventilation AE(V) appointed by C&VUHB.

2.2 This report is in accordance with the guidance set out in Welsh Health Technical Memorandum 00 - which stipulates the requirement for the Authorising Engineer to produce an annual audit (WHTM 00 Best practice guidance for healthcare engineering paragraph 3.15).

2.3 Healthcare organisations have a duty of care to patients, their workforce and the general public. This is to ensure that a safe and appropriate environment for healthcare is provided, which is a requirement identified in a wide range of legislation.

2.4 The role of the AE(V) is detailed within WHTM 03-01 and details the principal duties undertaken by the AE(V) in relation to the Healthcare organisation's statutory duties with regard to their ventilation installations.

2.5 The AE (V) appointed by C&VUHB is Mr Dylan Morris of NWSSP-SES, and his role as AE (V) includes the following:

- Acting as an independent professional adviser to the Healthcare organisation on ventilation issues.
- Act as an assessor and make recommendations for the appointment of Authorised Persons (Ventilation), AP(V).
- Monitor the performance of the service and provide an annual audit of the Ventilation systems to the Healthcare Designated Persons.
- At intervals not exceeding three years, the AE(V) is to undertake comprehensive audits of the operational procedures, safe systems of work and safety procedures recommended by WHTM 03-01. A written report of the audit should be compiled, listing satisfactory items seen and any deficiencies found, and recommendations made.

3.0 AUDITS OF SYSTEMS AND INSTALLATIONS

Operational management arrangements

3.1 The health board's Authorised Person Ventilation (AP(V)) has the key operational responsibility for this specialist service. Table 1 (below) details the current APs (V) nominated by the health board, assessed by the AE(V) and appointed by the health board.

Hospital	Authorised Person (Ventilation)	Date Appointed	Appointment Expires
University Hospital of Wales	Paul George 2nd AP(V) to be appointed	4th August 2025 2nd AP(V) to be appointed	4th August 2028 2nd AP(V) to be appointed
University Hospital Llandough	Paul George 2nd AP(V) to be appointed	5th July 2024 2nd AP(V) to be appointed	5th July 2027 2nd AP(V) to be appointed
Capital & Service Planning	Richard Jones Richard Sheppard	17th December 2024 17th December 2024	17th December 2027 17th December 2027

Table 1 – Details of Authorised Persons (Ventilation)

(AP(V)s names with green text have current AP(V) appointments and are currently performing AP(V) role on a day-to-day basis, AP(V)s identified with amber text are appointed as AP(V)s but do not undertaking day-to-day AP(V) duties, red text denotes estates officers that require re-appointment as AP(V)s)

3.2 A suitable number of APs should be formally appointed for each site to manage the ventilation systems. The overall number of AP(V)s has not changed since the last annual report was issued.

3.3 Additional AP(V)s are still required at UHW & UHL to provide adequate resilience to cover peak times and unforeseen unplanned events such as annual leave and sickness. The minimum number of AP(V)s for UHW & UHL should be two AP(V)s. Most of the planned maintenance work at UHW & UHL is completed by an external contractor, the supervisor for the contractor should be assessed and appointed as an AP(V) with operatives undertaking maintenance assessed and appointed as CP(V)s.

3.4 It is evident that the number of individual AP's appointed to cover multiple services is generally increasing throughout NHS Wales. WHTM 00 does not specifically limit the number of AP duties staff can undertake as this is dependent upon many variables such as site complexity, condition of infrastructure, number of sites covered and existing duties of the individual. However, management should ensure adequate resource is provided to enable the APs to fulfil their duties for each service appointed in accordance with the HTM/WHTM guidance.

Operational management audits

3.5 Table 2 details the hospitals within the health board in which operational management audits were completed since the last AE(V) annual report. The reports associated with these audits will be issued as accompanying documents to this report for reference. Section 13.0 in both reports summarise the main actions that should be taken to improve the health boards overall ventilation compliance rating.

Hospital	Date of audit	Name of auditee
University Hospital of Wales	29th of July 2025	Tony Ward Paul George Richard Sheppard Richard Jones Mark Branch
University Hospital Llandough	29th of July 2025	Tony Ward Paul George Richard Sheppard (1st Day) Richard Jones (1st Day) Mark Branch (1st Day)

Table 2 – Operational Management Audits

3.6 Other items highlighted in the recommendations section of the triennial reports which require action or are in the process of being completed can be summarised as follows:

- It is understood that capital & estates are not responsible for the management of all LEV systems within C&V UHB. Capital & estates should hold a central register of all LEV systems and should have copies of the relevant test certificates. Testing to be reviewed across the health board, with procedure detailing the testing requirements and legal responsibilities to be developed to inform departments that undertake their own LEV testing of their legal obligations. Certificates to be collated and held by estates as a central register of compliance.
- The non-accessible fire dampers should be scheduled and identified on building layout plans. This information should be reviewed by the fire officer to ensure the fire strategy takes the inaccessible dampers into account. Every effort should be made to reduce the percentage of dampers that are not accessible.
- Review risk assessments and method statements for maintenance procedures (external contractors and internally) and update as necessary to ensure that maintenance activities are undertaken in a safe manner ensuring they do not create a hazard for those who undertake the work or those who could be affected by the work (risk assessments need to be task specific).
- Liaise with fire officer to ensure that cause & effect and BMS fire damper status indication is adequately tested as part of the damper testing programme. Consider creating a summary sheet of compliance each year.
- Introduce a ***"permit to release"*** system at C&V UHB when undertaking inspections, maintenance, and verifications on critical ventilation systems, as recommended in WHTM 03-01 Part B. The permit should apply to C&V UHB operatives as well as the external contractors that undertake planned cyclic maintenance.

- Appoint two additional full time AP(V)s to improve resilience. One additional appointment at UHW to support Paul George and one at UHL to support Mark Branch is required. Health board should monitor workload of the AP(V)s and allocate additional resources to assist if necessary. Contract manager for external maintenance contractor should also be trained and formally assessed as an AP(V), operatives undertaking maintenance should also be assessed and appointed as CP(V)s.
- An annual verification action plan should be created, this action plan should list all the non-compliance items, the duty holders for rectification, the actions undertaken and if any action items are long term with no immediate resolution i.e. capital bids. Where significant non-compliance issues are noted which can impact patient safety e.g. insufficient air change rates, the health board should have a formal procedure to record risk assessments and mitigation measures put in place if the area is to remain in use.
- Updates on AE(V) audit recommendations to be included as an agenda item for future VSG meetings.

Annual critical ventilation system verifications

3.7 Advised verbally at VSG meetings that annual verifications are up to date other than areas that are under refurbishment or have not allowed access. The format for reporting verification progress and compliance is not in a format which makes assessing verification progress and compliance simple.

3.8 Reported at a recent VSG meeting that verification records are now stored on a new management system, access to this system should be given to the AE(V) to enable reviews of verification reports to improve assurance. It is hoped the new management system will also improve reporting of progress and compliance at future VSG meetings.

3.9 The current C&V UHB list of critical ventilation systems should be reviewed and updated at least annually, to include for all new critical ventilation systems installed in the previous 12 months, including imaging facilities, dental treatment rooms and local extract ventilation systems (LEVs).

3.10 Once updated, the list of critical ventilation systems should be reviewed and agreed with the AE(V) and the VSG.

3.11 All critical ventilation systems should be inspected at least quarterly and verified annually, as recommended in WHTM 03-01 Part B.

Ventilation Safety Group (VSG)

3.12 The ventilation safety group is a multidisciplinary group responsible for ensuring that all specialist healthcare ventilation systems are operated safely and efficiently, properly maintained, regularly performance tested (verified annually) and routinely monitored and that detailed performance and maintenance records for each system are kept in line with the relevant legislation and guidance.

3.13 The group has met fairly regularly in 2025 (three meetings). Key staff are attending most meetings. Attendance at the VSG is generally good

with representation from Estates, Capital Planning, IP&C, Theatres, HSDU, Clinical / Nursing, Microbiology, Health and Safety, the AP (V)s' and the AE (V).

3.14 The health board should generate an action plan following the following AE(V) site audit, action plan progress should be reported at the VSG meetings and should be included in future agendas.

3.15 The WHTM recommends that the Group report to the responsible person at Board level and be led and chaired by a person who has appropriate management responsibility, knowledge, competence, and experience. This is in keeping with the recommendations in Welsh Health Technical Memorandum 00 – 'Policies and principles of healthcare engineering.

4.0 INDEPENDENT PROFESSIONAL ADVICE

4.1 No requests received from the health board with regards to independent professional advice during the reporting period.

Interaction with the health board with regards to professional advice needs to improve with the AE(V) involved in design scrutiny on projects, derogations and validation/witnessing.

5.0 INVESTIGATIONS OF ADVERSE INCIDENTS

5.1 No adverse incidents on the ventilation systems were reported to the AE (V) by the health board during this period.

6.0 RECOMMENDATIONS

6.1 Whilst the Designated Person should note the full content of this report and the attached audit report, it is recommended that particular attention is given to addressing the following:

- Health board to develop an LEV management system to ensure systems are adequately managed.
- Schedule non-accessible fire dampers, liaise with fire officer and ensure these are accounted for in the fire strategy.
- Review risk assessments and method statements for maintenance procedures.
- Ensure that cause & effect and BMS fire damper status indication is adequately tested as part of the damper testing programme.
- Introduce a ***"permit to release"*** system at C&V UHB.
- Appoint two additional full time AP(V)s at UHW & UHL to improve resilience . Contract manager for external contractor undertaking maintenance to be appointed as AP(V).
- Create annual verification action plan.
- Updates on AE(V) audit recommendations to be included as an agenda item for future VSG meetings.
- Instigate closer engagement between AE(V) and the health board.
- Improve AE(V) access to verification reports.

6.2 If the Designated Person or their representatives would like to discuss this report further, please contact the AE (V) using the details below:

Mr Dylan Morris
Senior Performance Standards Engineer
Alder House
Alder Court
St Asaph Business Park
St Asaph
LL17 0JL

Email: Dylan.Morris2@wales.nhs.uk

☎: 07484 943 640

Report Title:	Authorising Engineer Annual Report CVUHB 2026 – Medical Gas Pipeline Systems				Agenda Item No:	6.4
Meeting:	Digital & Infrastructure Committee		Public	√	Meeting Date:	4th August 2026
			Private			
Status **(please only tick one)**	Assurance	√	Approval		Information/Noting	
Lead Executive Title:	Director of Finance					
Report Author Title:	Director of Capital, Estates and Facilities					

Main Report

Background and Current Situation:

The purpose of the report is to provide the Committee with assurance that the medical gas pipeline systems at Cardiff & Vale UHB, are maintained and inspected in accordance with the guidance document Health Technical Memorandum (HTM) 02-01 parts A and B to ensure that the systems remain safe.

In accordance with the HTM guidance, Cardiff and Vale UHB have appointed an independent Authorising Engineer (AE) to provide advice and guidance to the UHB. The AE assesses the Approved Persons and undertakes the system audits. The AE service is currently provided by National Wales Shared Services Partnership, Specialist Estate Services (SES).

The 2026 annual audit report, issued by the AE in May 2026, indicates the overall compliance rating as 'limited assurance'. There has been a reduction in assurance since the previous report, this is primarily due to a reduction in appointed Authorised Persons (AP's) and Co-ordinating Authorised Peron (CAP). The CAP was initially put in place to mitigate risks until a full complement of APs were appointed. Capital, Estates & Facilities have reviewed the findings of the report and produced an action plan (appendix 1), which identifies the management response and status of the recommendations.

The report outlines that the MGPS systems are not being fully managed in accordance with HTM 02-01 with non-compliances including:

- Lack of sufficient trained, assessed and formally appointed MGPS Aps to cover sites. Confirm the AP operational cover for the St Davids site Liquid Oxygen Room, with lack of 24/7 on-call arrangements.
- Continue training and appointing sufficient Designated Nursing/Medical (DNO/DMO_ officers and formalise the process.
- Once ratified, implement the MGPS Operational Policy at the earliest opportunity.
- Only one health board QC (MGPS) with no formal cover 24/7 on-call arrangements.

Other documentation, such as the continual updating of the operational manual is in progress.

Several actions included in the audit are the responsibility of the Clinical Boards and require no Capital, Estates & Facilities input.

The Service Board are striving to achieve a 'suitable number' of trained Authorised Persons (APs) for Medical Gas Pipeline Systems at each acute site. The HTM AP establishment is 3 APs at UHW and 3 APs at UHL.

At present there are 6 APs in total, albeit there is a requirement for these members to be permanently site based. A training programme has been established to improve the position which will provide further assurance that the required standards are being met.

Recommendations:

Whilst the Designated Person should note the full content of this report and the site reports, it is recommended particular attention is given to addressing the following:

- Once trained and assessed ensure additional MGPS APs are appointed to provide suitable cover.
- Confirm the AP operational cover for the ST Davids site Liquid Oxygen room.
- Continue to develop the MGPS committee, governance procedures, staff training, and ensure relevant personnel are in attendance on a regular basis. Recommend adding an agenda item to cover AE audits for both HB and PFI sites to report on progress and training.
- Once ratified, implement the MGPS Operational Policy at the earliest opportunity.
- Produce procedural documents, including pandemic responses, emergency preparedness should be developed to sit under the policy.
- Continue the asset tagging of all items of physical MGPS plant and equipment.
- Complete a full PPM review for all the identified MGPS assets and complete a full list of maintenance requirements developed for all sites.
- A MGPS safety group risk register should be developed.
- Continue training and appointing sufficient Designated Nursing/Medical (DNO/DMO) officers and formalise the process.

Executive Director Opinion & Key Issues to bring to the attention of the Board/Committee/SLT (delete as appropriate)

- The overall compliance rating of the annual report issued in May 2026 remains as 'limited assurance'
- A training programme has been implemented to achieve the HTM Approved Persons establishment
- An Action Tracker has been implemented to ensure both engineering and clinical actions are addressed with support of the Medical Gas Safety Group.

Appendices (please list any appendices that will accompany this report. Do **not** embed)

Appendix 1-MGPS Annual Audit Action plan
MGPS Annual Audit 2026

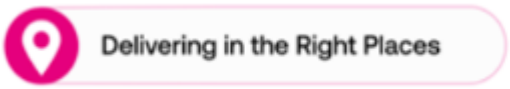
Recommendations:

The committee are requested to:

a) **NOTE:** the content of the report and the progress made in addressing the recommendations of the annual audit
b) **NOTE:** the risk associated with the age and obsolescence of the existing medical gas infrastructure

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please place an "x" in the below boxes where relevant – *Click each item for further information.*

1. Putting People First		2. Providing Outstanding Quality	√

3. 	√	4. 	√

Five Waves of Working (Sustainable Development Principles) considered: Please place an "x" in the below boxes where relevant									
Prevention	√	Long Term	√	Integration		Collaboration		Involvement	√

Quality Impact Assessment Completed? Please place an "x" in the below boxes where relevant				
Yes *(please include the complete QIA document)*	x	No *(please provide reasoning e.g. not required*		

Impact Assessment Please place an "x" in the below boxes where relevant
Risk: Yes
Associated with the age of equipment which is both non-compliant and becoming obsolete
Safety: Yes
Please include the detail of any Risk Assessments undertaken when preparing and considering the content of this report and, where appropriate, the nature of any risks identified. (If this has been addressed in the main body of the report, please confirm)
Financial: Yes
Parts periodically have to be manufactured specifically for the system and are more costly. To replace the system or parts thereof will be significant and disruptive to the service
Workforce: Yes
Recruitment of competent staff.
Legal: No
Reputational: No
Socio Economic: No
Equality & Health: No
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:

GIG CYMRU NHS WALES

Partneriaeth Cydwasanaethau
Gwasanaethau Ystadau Arbenigol

Shared Services Partnership
Specialist Estates Services

Authorising Engineer
(Medical Gas Pipeline Systems) Annual Report
For
Cardiff & Vale University Health Board

Authorising Engineer
(Medical Gas Pipeline Systems) Annual Report
For
Cardiff & Vale University Health Board

NWSSP-SES Job No: WG/AE/002

Report Date: May 2026

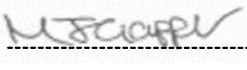
Authorising Engineer: Christopher East BEng (Hons), MIET

Designation: Senior Performance Standards Engineer

Signed: 

Authorised by: M. Gapper BEng (Hons), C.Eng, MCIBSE

Designation: Head of Engineering

Signed: 

CONTENTS

1.0 EXECUTIVE SUMMARY

1.1 Generally, the overarching management of the Medical Gas Pipeline Systems (MGPS) within Cardiff and Vale University Health Board (C&VUHB) provides a limited assurance level which is a reduced level compared with the previous report issued in October 2024 (see figure 1 below). The lower assurance level is primarily due to a reduction in appointed Authorised Persons (APs) and Co-ordinating Authorised Person (CAP). The CAP was initially put in place to mitigate risks until a full complement of APs were appointed.

1.2 The MGPS committee continues to improve with regular attendance from the wider health board (HB) staff groups.

1.3 Excellent progress has been made with capital investment, installing Oxygen ring mains and replacing obsolete MGPS plant.

1.4 One MGPS yearly site audit has been completed for the health board during this report period (refer to table 2).

1.5 The MGPS systems are not being fully managed in accordance with HTM 02-01 with non-compliances including:

- Lack of sufficient trained, assessed and formally appointed MGPS APs to cover sites. Confirm the AP operational cover for the ST Davids site Liquid Oxygen room, with a lack of 24/7 on-call arrangements.
- Continue training and appointing sufficient Designated Nursing/Medical (DNO/DMO) officers and formalise the process.
- Once ratified, implement the MGPS Operational Policy at the earliest opportunity.
- Only one health board QC (MGPS) with no formal cover or 24/7 on-call arrangements.

Please refer to Section 6 within this report for a list of recommendations and further detailed non-conformities can be found in the individual site annual reports issued under separate cover.

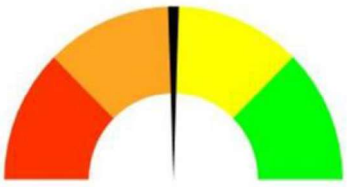
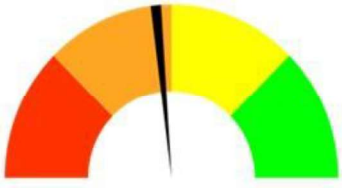
October 24	May26
	
Policy in draft. **Improved numbers of Authorised persons.** **Limited implementation of procedures.** **Limited governance arrangements.** **Risks identified with funding secured to complete, Oxygen ring main, rationalise VIEs & replace medical air plant.**	**Policy submitted for ratification..** **Reduced numbers of Authorised persons. Loss of CAP** **Limited implementation of procedures.** **Limited governance arrangements.** **Some risks identified and completed, Oxygen ring mains, VIE rationalisation & replacement medical air & vacuum plant.**
Amber/Yellow	**Amber**

Figure 1 Overall Compliance Rating

2.0 BACKGROUND

2.1 The following report is a compliance review undertaken by the Authorising Engineer for Medical Gas Pipeline Systems (AE (MGPS)) appointed by the Cardiff & Vale University Health Board (C&VUHB).

2.2 This report is in accordance with the guidance set out in Welsh Health Technical Memorandum 00 - which stipulates the requirement for the Authorising Engineer to produce an annual audit (WHTM 00 Best practice guidance for healthcare engineering paragraph 3.15).

2.3 Healthcare organisations have a duty of care to patients, their workforce and the general public. This is to ensure that a safe and appropriate environment for healthcare is provided, which is a requirement identified in a wide range of legislation.

2.4 The role of the AE (MGPS) is detailed within HTM 02-01, which details the principal duties undertaken by the AE (MGPS) in relation to the Healthcare organisation's statutory duties, and with regard for their Medical Gas Pipeline Systems.

2.5 The AE (MGPS) appointed by Cardiff & Vale University Health Board (CVUHB) is Mr Christopher East of NWSSP-SES, and his role as AE (MGPS) includes the following:

- Acting as an independent professional adviser to the healthcare organisation on medical gas issues.
- Act as an assessor and make recommendations for the appointment of Authorised Persons (AP).
- Monitor the performance of the management arrangements, during yearly site audits, and provide an overall annual report of the medical gas system to the Health Board Designated Person.
- On request of the health board the AE (MGPS) will undertake comprehensive compliance surveys of the MGPS on all sites as recommended by HTM 02-01. A written report of the survey should be complied, listing satisfactory items seen and any deficiencies found and recommendations made.

3.0 AUDITS OF SYSTEMS AND INSTALLATIONS

Authorised Persons Medical Gas Pipeline Systems, AP(MGPS)

3.1 The health board's Authorised Person's (Medical Gas Pipeline Systems) AP (MGPS)) have the key operational responsibilities for this specialist service. Table 1 details the current APs (MGPS) assessed by the AE (MGPS), and whether they have been appointed by the health board.

Authorised Person (MGPS)	Date of assessment	Re-assessment due	Appointed by the Health Board Y/N
University Hospital of Wales (UHW)			
Ian Fitsall*	April 2025	May 2028	Y
Paul George	April 2024	April 2027	Y
Jodi Sheppard	November 2024	November 2027	Y

Llandough & Barry			
Ian Fitsall*	May 2025	May 2028	Y
Karen Doyle	February 2024	February 2027	Y
David Evans**	January 2023	January 2026	N
Anthony Davies**	March 2023	March 2026	N
St David's Liquid Oxygen room			
Paul Sayer	September 2024	September 2027	N

* Indicates Co-ordinating/Senior AP ** Indicates AP with limitations

Table 1 – Details of Authorised Persons (MGPS)

3.2 It can be seen in Table 1 above that there has been no improvement in the numbers of appointed APs (MGPS) within the health board, in addition Ian Fitsall no longer covers his previous Estates function, therefore acting as a coordinating AP is no longer appropriate and reduces not only site AP numbers, but also removes the CAP role. David Evans's appointment has expired; however he is in the process of re-assessment, Anthony Evans has not completed refresher training and is currently not in work.

Gareth Simpson did not complete his assessment and has therefore been removed from the AP table, which leaves UHW with only two active APs, Llandough has one active full AP, and one development role AP. Further individuals were identified for assessment; however, confirmation is required from the health board as to the requirements of the role.

3.3 Paul Sayer M&M medical (MGPS specialist contractor) had been assessed for AP duties (liquid Oxygen room only) at the St David's PFI site on behalf of C&V. However, during assessment, the AP discussed the appointment would only cover planned work, emergency response requirements need to be addressed. Formal appointment by the health board has also not been completed.

3.4 The appointed APs (MGPS) have undertaken Authorised AP (MGPS) training courses and CPR training.

3.5 It is evident that the number of individual APs appointed to cover multiple services is generally increasing throughout NHS Wales. WHTM 00 does not specifically limit the number of AP duties staff can undertake as this is dependent upon many variables such as site complexity, condition of infrastructure, number of sites covered and existing duties of the individual. However, management should ensure adequate resource is provided to enable the APs to fulfil their duties for each service appointed in accordance with HTM/WHTM guidance.

Management arrangements & compliance audits

3.6 Table 2 below provides details of hospitals within the health board in which management arrangement audits have been carried out previously.

The associated site audit reports are issued under separate cover for reference. Section 14.0 in site audit reports summarise the main actions that should be taken to improve the health boards overall Medical Gas Pipeline Systems compliance rating.

Hospital	Date of management audits	Name of auditee
UHW	February 2025	I Fitsall/P George
Llandough & Barry	June 2019	Gareth Thomas

Table 2 – Details of annual audits

3.7 Generally, the site APs management of the Medical Gas Pipeline Systems (MGPS) is reasonable with respect to the number of appointed APs, the overarching management arrangements remain limited.

3.8 The maintenance schedules and associated paperwork for the works being carried out by in house staff and the maintenance contractor during the period, need to be formally reviewed, recorded and linked to the asset database.

3.9 An asset database/specification for contract maintenance purposes has been constructed. Physical asset tagging of all items of MGPS plant & equipment in line with this database should be completed and is recommended. This methodology will help ensure all consumable items of plant are changed in line with manufacturer's guidance, and all items of plant changed in line with pressure regulations and insurance inspector's recommendations.

3.10 Once the asset tagging is completed it is recommended that a full PPM review is carried out for all the MGPS assets, and a full list of maintenance requirements developed for all sites.

3.11 There is limited information on the St David's PFI site available, including copies of their audits. The PFI appear to have a policy in place, however this needs to be reviewed at the MGPS committee. Copies of their audit documents should be tabled at C&V MGPS group with progress on actions.

Medical Gas Group

3.12 Health Technical Memorandum (HTM) 02-01 Medical Gas Pipeline Systems (MGPS) highlights the importance of a functional MGPS committee/group in healthcare organisations. This is a multi-disciplinary group responsible for ensuring that the management of all medical gas systems and safety issues are monitored, recorded and acted on in line with the relevant legislation and guidance. The group should report to the chief executive/designated person.

3.13 The MGPS committee meets on a regular basis and is chaired by the, Clinical Director of Pharmacy & Medicines Management, with varied personnel attending on a regular basis. The AE (MGPS) attends the meetings regularly.

3.14 The management and operational policy has been recently submitted for formal ratification/adoption by the health board. The draft policy was generally in accordance with HTM 02-01.

3.15 Procedural documents, including pandemic responses, emergency preparedness should be developed to sit under the policy. The policy document should ensure references are made to the procedural documents, including pandemic responses, emergency preparedness in line with published documents (e.g. SESN 20/19, WG SES EFA 2020 001 etc).

3.16 Once ratified a yearly review and update the MGPS Operational Policy via the MGPS safety group is recommended.

3.17 Site action plans need to be generated following any AE (MGPS) site audits, with action plan progress reported at the MGPS safety group meetings.

3.18 Training of all staff to comply with HTM 02-01 guidelines is an agenda item, with health board progress on ESR reported on. Training compliance for all elements of MGPS training should be presented at the MGPS safety group.

3.19 There is evidence of DNO training being undertaken, however further work in training sufficient staff and formalising the process is required.

3.20 A MGPS safety group risk register should be developed, capturing all items of risk to the MGPS.

3.21 Health board cylinder management requires continued improvement.

4.0 INDEPENDENT PROFESSIONAL ADVICE

4.1 Independent advice has been provided by the AE (MGPS) to the health board during the period covered by this report. The advice was provided verbally or via e-mail and covered guidance on interpretation of the HTM or involving new medical gas installations on a number of subject matters, including:

- Input into the MGPS committee.
- Oxygen systems.
- Medical air system requirements.
- AP assessments & requirements.

5.0 INVESTIGATIONS OF ADVERSE INCIDENTS, ALERTS & NOTIFICATIONS

5.1 No adverse incidents on the MGPS were reported to the AE during the period covered by this report.

5.2 There have been no alerts or notifications issued by the AE during the period covered by this report.

6.0 RECOMMENDATIONS

6.1 Whilst the Designated Person should note the full content of this report and the site reports, it is recommended particular attention is given to addressing the following:

- Once trained and assessed ensure additional MGPS APs are appointed to provide suitable cover.
- Confirm the AP operational cover for the ST Davids site Liquid Oxygen room.
- Continue to develop the MGPS committee, governance procedures, staff training, and ensure relevant personnel are in attendance on a regular basis. Recommend adding an agenda item to cover AE audits for both HB and PFI sites to report on progress and training.
- Once ratified, implement the MGPS Operational Policy at the earliest opportunity.

- Produce procedural documents, including pandemic responses, emergency preparedness should be developed to sit under the policy.
- Continue the asset tagging of all items of physical MGPS plant and equipment.
- Complete a full PPM review for all the identified MGPS assets and complete a full list of maintenance requirements developed for all sites.
- A MGPS safety group risk register should be developed.
- Determine and review St David's PFI operating & maintenance procedures.
- Continue training and appointing sufficient Designated Nursing/Medical (DNO/DMO) officers and formalise the process.

6.2 If the Designated Person or their representatives would like to discuss this report further, please contact the AE (MGPS) using the details below:

Mr Christopher East

Senior Performance Standards Engineer

4th Floor, Companies House

Crown Way

Cardiff

CF14 3UB

Email: chris.east@wales.nhs.uk

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Action Plan: UHB (MGPS) Annual Report 2026 - Engineering Actions								
ID	**Site**	**Status**	**Action**	**Comments**	**Date Raised**	**Action Owner**	**Target Completion Date**	**Actual Completion Date**
6.1a	UHB		Once trained and assessed ensure additional MGPS APs are appointed to provide suitable cover.	Currently X2 MGPS APs at appointed fr UHW site. Currently X2 MGPS APs appinted fr UHL & Barry community hospital. PG obtaining UHL site familiarisation with a view to be appointed for UHL and Barry sites. Planned training for a further 2 APs for UHW and 2 APs for UHL and Barry sites. Currently the appinted MGPS CAP (Co ordinating AP) is on a secondment role, therefore suggest plans put in place for a replacement CAP rather than wait too long and prempt that the CAP does not return to his Estates role within the department. Also an agenda item at the Estates AP meetings.	5/1/2026	P George	31/04/2027	
6.1e	UHB		Asset tagging of all items of physical MGPS plant and equipment is recommended.	Asset tagging is currently in progress with the implementastion of Zetasafe. Further discussion with MGPS AE to asset equipment or go to component level.	5/1/2026	Jody Shepperd	5/31/2027	
6.1f	UHB		Complete a full PPM review for all the MGPS assets, and a full list of maintenance requirements developed for all sites.	A full review of the PPMs currently set up is in progress with the implementstion of Zetasafe and development of new PPMs to fill any gaps to meet htm and OEM requirements.	5/1/2026	Paul George	5/31/2027	
6.1g	UHB		A MGPS safety group risk register should be developed.	Risk register discussed at MGPS safety group meeting in May and agreed, created. Risks will also become an agenda item to review on future meetings. In addition to this we also report DATIX reports raised specifically for medical gas related issues,	5/1/2026	Paul George	5/31/2026	5/5/2026
6.1h	UHB		Determine and review St David's PFI operating & maintenance procedures.	Will obtain O&M procedures, review and discuss with MGPS AE to ensure adequate and any audit reports to confirm actions have been completed. Currently split responsibilities between C&V and Eqauns the PFI operator. C&V Pharamcy are responible for the liquid Oxygen LC/PCC and Equans are responsible for the gaseuos Oxygen and Medical Air installation.	5/1/2026	Paul George	31/09/2026	

Action Plan: UHB (MGPS) Annual Report 2026 - Clinical Actions								
6.1c	UHB		Ratify and implement an up-to-date MGPS Operational Policy.	MGPS policy developed and in draft format following agreement at MGPS safety group meeting and distrbution to relevant staff. Currently under review and ratification process	5/1/2026	Tim Banner	8/31/2026	
6.1d	UHB		Produce procedural documents, including pandemic responses, emergency preparedness should be developed to sit under the policy.	Further discussion on this action with Authorising Engineer and MGPS safety group. Will require time to develop and implement due to inputs from clinical, pharmacy and estates departments.	5/1/2026	MGPS Safety Group	5/31/2027	
6.1f	UHB		Complete a full PPM review for all the MGPS assets, and a full list of maintenance requirements developed for all sites.	A full review of the PPMs currently set up is in progress with the implementstion of Zetasafe and development of new PPMs to fill any gaps to meet htm and OEM requirements.	5/1/2026	Paul George	5/31/2027	
6.1g	UHB		A MGPS safety group risk register should be developed.	Risk register discussed at MGPS safety group meeting in May and agreed, created. Risks will also become an agenda item to review on future meetings. In addition to this we also report DATIX reports raised specifically for medical gas related issues,	5/1/2026	Paul George	5/31/2026	5/5/2026
6.1h	UHB		Determine and review St David's PFI operating & maintenance procedures.	Will obtain O&M procedures, review and discuss with MGPS AE to ensure adequate and any audit reports to confirm actions have been completed. Currently split responsibilities between C&V and Eqauns the PFI operator. C&V Pharamcy are responible for the liquid Oxygen LC/PCC and Equans are responsible for the gaseuos Oxygen and Medical Air installation.	5/1/2026	Paul George	31/09/2026	

6.1i	UHB		Train and appoint sufficient Designated Nursing/Medical (DNO/DMO) officers, and Designated Porters.	No Porters to change cylinders on manifolds and raised at MGPS safety group meeting to stop this at Barry community hospital. Therefore no requirement for Designated Porters training as discussed with MGPS Authorising Engineer. Will raise at next MGPS meeting to finalise this with head ofPortering in attendance.	5/1/2026	Tim Banner/MGPS Safety Group	12/31/2026	