Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date	**03/07/2025**
Time	**9:30 AM - 11:30 AM**
Location	**Microsoft Teams Meeting/ Ystwyth Boardroom; Ystwyth Board Room Avocor (Hywel Dda UHB - Generic Account)**

Health & Safety Committee Meeting

HDD_Health and Safety Committee

NHS Wales

Agenda - 3 July 2025

1 Governance

9:30 AM, 0 min

1.1 Welcome and Apologies

9:30 AM, 2 min
Ann Murphy (Hywel Dda UHB - RCN Trade Union Rep - Independent Board Member)

1.2 Declarations of Interest

9:32 AM, 2 min
All

1.3 Minutes of the Previous Meeting held on 6 May 2025

9:34 AM, 2 min
Ann Murphy (Hywel Dda UHB - RCN Trade Union Rep - Independent Board Member)

1.4 Matters Arising and Table of Actions from Meeting held on 6 May 2025

9:36 AM, 5 min
Ann Murphy (Hywel Dda UHB - RCN Trade Union Rep - Independent Board Member)

1.5 Health and Safety Sub Committee Update

9:41 AM, 10 min
Jonathan Arthur (Hywel Dda UHB - Deputy Director of Health Sciences)

1.6 Corporate Risks Assigned to HSC

9:51 AM, 10 min
James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)

2 Health and Safety Updates

10:01 AM, 0 min

2.1 Staff/Patient Story

10:01 AM, 10 min

2.2 **Internal Audit Update Report and Associated Actions**

10:11 AM, 10 min
Tim Harrison (Hywel Dda UHB - Head of Health, Safety and Security)

2.3 **Monitoring of H&S Annual Work Plan**

10:21 AM, 10 min
Tim Harrison (Hywel Dda UHB - Head of Health, Safety and Security)

2.4 **Compliance with Health and Safety, Fire, and Security Training**

10:31 AM, 10 min
Tim Harrison (Hywel Dda UHB - Head of Health, Safety and Security)

3 **Emergency Planning**

10:41 AM, 0 min

3.1 **Major Incident Annual Plan: 2025/26**

10:41 AM, 10 min
Sam Hussell (Head of Health Emergency Planning)

4 **Policies to be Approved**

10:51 AM, 0 min

4.1 **Business Continuity & Planning Policy**

10:51 AM, 10 min
Sam Hussell (Head of Health Emergency Planning)

5 **For Information**

11:01 AM, 0 min

5.1 **HSC Workplan**

11:01 AM, 2 min
Ann Murphy (Hywel Dda UHB - RCN Trade Union Rep - Independent Board Member)

6 **Any Other Business**

11:03 AM, 2 min
All

7 Matters for Escalation to Board

11:05 AM, 2 min
Ann Murphy (Hywel Dda UHB - RCN Trade Union Rep - Independent Board Member)

8 Date and Time of Next Meeting

11:07 AM, 0 min

Table of contents

03/07/2025 9:30 AM - 11:30 AM

1 - Governance 8

1.1 - Welcome and Apologies 9

1.2 - Declarations of Interest 10

1.3 - Minutes of the Previous Meeting held on 6 May 2025 11

Attachments

2025-05-06 - Health _ Safety Committee Meeting - Minutes 12

1.4 - Matters Arising and Table of Actions from Meeting held on 6 May 2025 19

Attachments

HSC Table of Actions 6 May 2025 20

1.5 - Health and Safety Sub Committee Update 21

Attachments

HSSC 3As report 3_6_25 22

Appendix 1 HSSC Terms of Reference July 2025 26

1.6 - Corporate Risks Assigned to HSC 31

Attachments

HSC Corporate Risk Report July 2025 FINAL Clean 32

Appendix 2 - Health and Safety Committee Corporate Risks- June 2025 43

2 - Health and Safety Updates 63

2.1 - Staff/Patient Story 64

2.2 - Internal Audit Update Report and Associated Actions 65

Attachments

SBAR H_S Internal Audit Paper - July 25 V1.1 66

2.3 - Monitoring of H&S Annual Work Plan 74

Attachments

SBAR H_S Workplan Update Paper - July 25 V1.1 75

2.4 - Compliance with Health and Safety, Fire, and Security Training 79

Attachments

SBAR HS Training Paper - July 25 V1.2 80

3 - Emergency Planning 87

3.1 - Major Incident Annual Plan: 2025/26 88

Attachments

Major Incident Plan July 2025 89

Appendix 1 HDUHB MIP 2025-26 93

Appendix 2 Ex Tendley Exercise Report 169

4 - Policies to be Approved 179

4.1 - Business Continuity & Planning Policy 180

Attachments

Health and Safety SBAR BC Planning Policy June 2025 181

Appendix 1 186 Business Continuity Planning Policy FOR APPROVAL 184

5 - For Information 201

5.1 - HSC Workplan 202

Attachments

HSCommittee Work Programme 2025-26 203

6 - Any Other Business 206

7 - Matters for Escalation to Board 207

8 - Date and Time of Next Meeting 208

1

9:30 AM, 0 Mins

1 - Governance

1.1 **9:30 AM, 2 Mins**

1.1 - Welcome and Apologies

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

1.2 **9:32 AM, 2 Mins**

1.2 - Declarations of Interest

All

1.3

9:34 AM, 2 Mins

1.3 - Minutes of the Previous Meeting held on 6 May 2025

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

For approval

Attachments

2025-05-06 - Health Safety Committee Meeting - Minutes.pdf

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

MINUTES OF THE Health and Safety Committee MEETING

Date of Meeting:	**9:30 AM, Tuesday 06 May 2025**
Venue:	**Ystwyth Board Room Avocor (Hywel Dda UHB - Generic Account)**

Present:	Ann Murphy	Independent Board Member (*Chair*)
	Chantal Patel	Independent Board Member
	Michael Imperato	Independent Board Member
In Attendance:	Joanne Wilson	Director of Corporate Governance/Board Secretary
	Karen Ryan	Head of Occupational Health
	Simon Chiffi	Head of Operations
	Adam Springthorpe	Health & Safety Manager
	James Severs	Executive Director of Allied Health Professions and Health Science
	Jonathan Arthur	Deputy Director of Health Sciences
	Tim Harrison	Head of Health, Safety and Security
	Simon Day	Head of Maintenance & Engineering
	Anthony Dean	Estates
	Ardiana Gjini	Executive Director of Public Health
	Sharon Daniel	Executive Director of Nursing, Quality & Patient Experience
	Ruth Poynting	Committee Services Officer (minutes)
Apologies:	Rob Elliott	Director of Estates, Facilities and Capital Management
	Andrew Carruthers	Chief Operating Officer
	Iwan Thomas	Independent Board Member
	Amanda Glanville	Assistant Director of People Development

Minutes Ref.	Item	Action
HSC(25)001	**Welcome and Apologies** Ms. Ann Murphy welcomed everyone to the meeting and announced that a new Independent Member (IM) for Community will be joining the Committee starting in July 2025, following the conclusion of the previous IM's term. Mr Michael Imperato was introduced as a new member as an IM representing the legal sector.	
HSC(25)002	**Declarations of Interest** There were no declarations of interest.	

HSC(25)003 **Minutes of the Previous Meeting held on 4 March 2025**

Changes were requested as follows:

- Corrections to Dr Jonathan Arthur's title throughout.

The Committee approved the minutes of the previous meeting provided the above changes are made.

Decision:
The Health and Safety Group APPROVED the minutes of the previous meeting.

HSC(25)004 **Matters Arising and Table of Actions from Meeting held on 4 March 2025**

An update was provided on the Table of Actions from the meeting held on 4 March 2025 and confirmation received those outstanding actions had been progressed. In terms of matters arising:
HSC(24)131: Dr Arthur informed the group that a paper is being developed for the Violence and Aggression Management Plan and the challenges with the portering role. An update will be presented to the next HSC meeting on 3 July 2025.

HSC(24)111 Members discussed the presentation of Risk 1745 (Estate Condition) and agreed that this will be presented to the next HSC meeting on 3 July 2025.

HSC(24)136 Mr. Severs stated that the challenge regarding traffic flow outside Prince Philip Hospital (PPH) has been escalated, however this remains unresolved. Ms Joanne Wilson agreed to discuss further with the Chief Executive Officer (CEO). JW

Decision:
The Health and Safety Group DISCUSSED the Table of Actions.

HSC(25)005 **Health and Safety Committee Annual Report 2024/25**

The Health and Safety Committee approved the Annual Report as an accurate record of the work undertaken in 2024/25.

Ms Chantal Patel queried whether a similar report is produced for In Committee meetings. Ms Wilson stated that currently there is no such report, however this could be considered for the next cycle of meetings.

Ms Wilson and Ms Murphy thanked Charlotte Wilmshurst and Ruth Poynting for supporting the Committee and producing this report.
Members were assured by the HSC Annual Report for 2024/25 that the Committee operates effectively and in line with the Terms of Reference and issues have been escalated to Board as appropriate.

Decision:
The Health and Safety Committee **ENDORSED** the Health and Safety Committee Annual Report 2024/25

HSC(25)006 **Health and Safety Sub Committee Update**

Dr Arthur introduced the report from the Health and Safety Sub-Committee (HSSC), highlighting concerns around Level 2 Fire Safety Training, which could potentially be classified as an alert. Current compliance stands at 61%, significantly below the 85% threshold agreed upon with Mid and West Wales Fire and Rescue Service (MAWWFRS). A work plan has been initiated to improve compliance, including further communication with Clinical Care Groups to stress the importance of completing the training. Additionally, an urgent position paper has been requested. An update on progress is expected shortly.

Mr Simon Chiffi added that Hywel Dda University Health Board (HDdUHB) is compliant in level 1 and 3 training but not in level 2. Level 2 training is delivered face-to-face as mandated by the Welsh Health Technical Memorandum (WHTM). As part of the project works and the agreed scope reduction on phase 2 fire projects in Withybush Hospital (WGH) and Glangwili Hospital (GGH) MAWWFRS has agreed that HDdUHB can temporarily put an Electronic Staff Record (ESR) training module in place to achieve the necessary compliance. The Health Board has committed to achieving this by the end of June 2025.

The Fire Safety Group is well attended, and work is taking place to improve communication through Clinical Governance Groups and Directorate leads. Mr Chiffi provided assurance that there is sufficient capacity in the Fire Team to facilitate face-to-face training.

In response to a query from Ms Patel, Mr Chiffi explained that each Service Director, for understanding the training needs of their respective teams. Whilst this responsibility rests with them, the Fire Team is available to provide support, if needed. Adding that Mr Andrew Carruthers is the Chief Officer for this risk.

An Estates and Clinical Care Group has been established with the first meeting taking place today (6 May 2025), which reports to the Integrated Quality, Financial Performance and Delivery Group (IQFPD)

The Committee agreed to advise the Board on the status of Level 2 Fire Safety training and were assured by the other items on the sub-committee update.

Decision:
The Health and Safety Committee were ASSURED of the management processes in place to manage Health and Safety through the HSSC, however they were NOT ASSURED of Health Board compliance with level 2 Fire Safety Training.

HSC(25)007 **Staff/Patient Story**

This item was deferred. A story has been arranged for HSC on 3 July 2025.

HSC(25)008 **Health and Safety Update Report**

Mr Adam Springthorpe provided an update on the redevelopment of the Health and Safety dashboard which will be pivotal in managing risks and reporting compliance. The expected completion date for this work is the end of September 2025. It is expected that there will be a period of adaptation to the new system however this will be a good resource in the long term.

An application has been made to the Mandatory Training Group for Manager Health and Safety training to be compulsory. This would comply with the findings from of the Internal Audit due to be completed by the end of July 2025.

Ms Murphy queried the lack of medical teams listed under the training proposal. In response, Mr Springthorpe advised that this training is not directly applicable for doctors. Aligning the course with individual roles would prove a challenge as this would entail looking at individual job descriptions.
Mr Springthorpe added that level 2 Manual Handling is delivered face-to-face and often has poor attendance as staff book the course, and do not attend.

Mr Severs noted that the detail for addressing the operational challenges for delivering this training will be discussed at the HSSC.

In response to some discussion about writing reports for HSC, Ms Wilson offered to provide guidance on reporting at Committee level for assurance as opposed to managing work in the more operational sub-committee.

Ms. Wilson commented that HDdUHB has the highest number of mandatory training courses among all health boards in Wales and questioned whether it is necessary for this particular course to be mandatory. Although this was a recommendation in an internal audit, the final decision ultimately rests with HDdUHB. It was agreed that this required further discussion outside of the meeting. AS, JS

Mr Springthorpe reported that the Health and Safety Executive (HSE) provided very positive feedback on the training. However, a specific compliance figure is not currently available. Mr Springthorpe suggested that making the training mandatory would be the most effective way to obtain accurate compliance data.

Ms Patel noted that the report lacks sufficient detail for the Committee to understand why compliance targets are not being met and the reasons for non-attendance; which would be helpful to provide assurance at Committee level.

Mr Imperato expressed interest in the number of reported incidents and suggested a comparison with figures from previous years would help demonstrate trends and trajectory.

Incident figures for members of the public are very low and as such are not included in the dashboard plan. Mr Springthorpe suggested that data from Datix could be drawn on a periodic basis rather than being presented at every meeting.

Discussion around Health and Safety training will take place in the HSSC and at the Clinical Care Group before being presented to HSC for assurance.

Given the need for further assurance the Committee agreed to advise the Board. However, should there be no progress in forthcoming meetings, the Board may need to be alerted to the concerns raised.

The Committee were assured in all other aspects of the report.

Decision:
The Health and Safety Committee were ASSURED that the Health and Safety Dashboard is in development and that at least the first phase will be in place by the end of Q2 2025/26. However NOT ASSURED of Health Board compliance with level 2 Manual Handling training.

HSC(25)009 **H&S Annual Work Plan 2025/26**

Mr Harrison introduced the Health and Safety Annual Work Plan for 2025/26, noting that this report brings together various themes across health and safety and aims to provide assurance that a workplan is in place for the coming year.

In response to concerns raised by Mr Imperato about stress being a leading cause of staff sickness, Mr Springthorpe and Mr Harrison explained that this is primarily managed by the Staff Psychological Wellbeing Group, who may be able to provide further assurance. The Health Board does have a Mental Wellness Policy in place.

Ms Karen Ryan highlighted the proactive work being done in staff psychological wellbeing and noted that Occupational Health provides advice on managing affected staff. Stress management is included in mandatory training for managers, and significant work is ongoing in this area, however current training focuses on managing stress after it occurs.

Mr Severs confirmed that the topic of stress does fall under the HSE and the committee's remit, suggesting the need for greater oversight. A report was requested with input from Mr Harrison, Ms Ryan and the Psychological Wellbeing Group for the HSSC before presenting this topic to the HSC in September 2025. TH, KR

The Committee were assured by the Annual Health and Safety Work Plan for 2025/26.

Decision: The Health and Safety Committee were ASSURED that the Health and Safety and Security Team have a work plan in place and that progress will be monitored by the Health and Safety Sub-Committee during 2025/26.

HSC(25)010 **Electrical Infrastructure Risks**

Mr Simon Day introduced the report which outlines the need to modernise electrical infrastructure across all hospital sites.

Mr Severs queried what impact the remedial work would have on frontline services, staff and patients. Mr Day answered that circuit breaker replacement would have a relatively low impact on services, however upgrades to the Low Voltage (LV) switchgear would have a significant effect on services.

For any work that may cause an interruption to power on hospital sites there are a series of measures to ensure limited impact on services including creating a schedule of work and communicating with the affected wards in advance of the work. The Estates Team has Certified Persons (CPs) that manage electrical risk and issue permits for the work, while Authorised Persons (APs) lead on the work even in electrical projects raised by the Capital Team. Additionally, action plans are created to respond to any potential trips.

Mr Day confirmed that funding has been secured for the installation of generators across all sites. This initiative, combined with ongoing High Voltage (HV) and LV electrical works, represents significant progress toward enhancing the overall electrical infrastructure.

A correction was made to page 2 of the report. The second point to advise the committee should read:

Electrical Safety Group meet regularly, in line with the defined requirements of the WHTM. The group is well attended, and the required quorum as defined by the TOR is always met. There are also Electrical Safety sub-groups that regularly meet between the Electrical Safety Group to resolve issues at a working group level.

Mr Day provided assurance that a robust system of Subgroups and Safety Groups are in place to manage Estate risk.

Mr Chiffi added that there is a new Estates Clinical Governance Group which will be focusing on reprofiling risks to support this structure.

The Committee were assured of the risk management process employed to manage electrical risk across all sites.

Decision:
The Health and Safety Committee were ASSURED by the risk management process employed to manage electrical risk.

HSC(25)011 **Risk 1745 - Estates Condition**

Deferred to July meeting.

HSC(25)012 **RAAC Assurance Report**

The Committee were assured by the report of the current position of Reinforced Autoclaved Aerated Concrete across all HDdUHB sites.

Decision:
The Health and Safety Committee were ASSURED by the current position on the outcome of the reinspection surveys to date and the ongoing controls established by the Operational teams to safely manage the risk.

HSC(25)013 **HSC Workplan**

No comments were made on the content of the workplan.

Decision: HSC Workplan
The Health and Safety Committee NOTED the workplan for 2025/26.

HSC(25)014 **Any Other Business**

There was no other business.

HSC(25)015 **Matters for Escalation to Board**

The Committee wish to ADVISE the Board of the following:

- The percentage of staff completing Level 2 Fire Safety training is below the minimum threshold.
- The percentage of staff completing Level 2 Manual Handling training is below the minimum threshold.

HSC(25)016 **Date and Time of Next Meeting**

Thursday 3 July 2025, 9:30-11:30

1.4

9:36 AM, 5 Mins

1.4 - Matters Arising and Table of Actions from Meeting held on 6 May 2025

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

For information

Attachments

HSC Table of Actions 6 May 2025.pdf

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

HEALTH & SAFETY COMMITTEE (HSC)/ PWYLLGOR IECHYD A DIOGELWCH
6 MAY 2025
TABLE OF ACTIONS/TABL GWEITHREDOEDD

MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
HSC(24)131	**Health and Safety Sub Committee Update** • To report back to the Committee after a discussion with JS on the timeline for the Violence and Aggression Management Plan and the issue with the Portering Role	**JA**	**May 2025**	**In progress** Paper is being developed
HSC(24)138	**Bariatric Report** • Further update report to be brought to either HSC or HSSC	**JB**	**Nov 2025**	**In progress:** Added to the workplan for November 2025
HSC(25)008	**Health and Safety Update Report** • To review the mandatory training proposal for Manager Health and Safety and feedback whether this course will be made mandatory.	**AS**	**June 2025**	**Closed** Proposal for training tabled for Mandatory Training Group 17 June.
HSC(25)009	**H&S Annual Work Plan 2025/26** • To provide assurance to HSSC around the management of stress in the workforce in collaboration with the Psychological Wellbeing Group and report back to HSC.	**TH, KR**	**September2025**	**In progress:** Added to the workplan for September 2025.

Key: JB-Jeni Bryant, JS- James Severs, AC-Andrew Carruthers, CSO- Committee Services Officer, GC – Gareth Cottrell, JB – Jeni Bryant, JA – Jonathan Arthur, JW – Jo Wilson

1.5

9:41 AM, 10 Mins

1.5 - Health and Safety Sub Committee Update

Jonathan Arthur (Hywel Dda UHB - Deputy Director of Health Sciences)

For approval

Attachments

HSSC 3As report 3_6_25.pdf

Appendix 1 HSSC Terms of Reference July 2025.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

COMMITTEE UPDATE REPORT/ ADRODDIAD DIWEDDARU'R HEALTH & SAFETY SUB COMMITTEE

Date of last meeting/ Dyddiad y cyfarfod diwethaf: **3 June 2025**

Quoracy/ Cworwm: Met **Report by/ Adroddiad gan**: Dr Jonathan Arthur, Vice Chair

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KEY DISCUSSION POINTS AND MATTERS FROM THE DISCUSSION AT THE MEETING/ PWYNTIAU TRAFOD ALLWEDDOL A MATERION I'W HUWCHGYFEIRIO O'R DRAFODAETH YN Y CYFARFOD:

Alert[1] (may require discussion)/ **Rhybuddio** (efallai y bydd angen trafodaeth)

The Health & Safety Sub-Committee (HSSC) wish to **alert** members of the The Health & Safety Committee (HSC) that:

Fire Safety Group - There is significant concern regarding compliance with Level 2 fire safety training across the Health Board. As of the end of May 2025, only 69% of staff have completed the training, with Glangwili Hospital (GGH) identified as a significant area of concern. This falls below the 85% compliance target threshold required by the Mid and West Wales Fire and Rescue Service (MAWWFRS). Continued non-compliance poses a risk of enforcement action or prosecution.

To address this urgently, a targeted communication strategy will be implemented, focusing on the Clinical Care Groups (CCG). A SMART (Specific, Measurable, Achievable, Relevant, Timely) action plan to rapidly improve the position has been requested from the Fire Safety Group, which must include:

- Ensuring CCGs are fully informed of their current training compliance status and the available training provision.
- Confirmation of the "go live date" for the Electronic Staff Record (ESR) level 2 training module to support timely communication and uptake.
- Integration of fire safety training compliance reporting into monthly CCG, Quality, Health & Safety meetings.

In addition to improving training compliance, the action plan must also:

- Provide clear reporting on the status and mitigation of high, medium and low risk actions, including the number of fire risk assessments and a plan to address them.
- Clarify ownership and oversight, particularly of outstanding actions under the responsibility of Estates and Hospital Managers and establish a clear process to ensure responsible leads are actively progressing and closing these outstanding actions.
- Ensure the completion of all overdue risk assessments by the end of July 2025.

[1] *There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.*

- **Security Management Group** – There was low member attendance at the last meeting and low compliance with annual restraint training. A report outlining the cause of non-compliance for training and a trajectory for improvement, has been requested.

- **Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) –** A reduction in RIDDOR incidents has been observed in this year's figures. However, concerns remain regarding the timeliness of reporting across the organisation. The HSSC has requested a position update to provide assurance on current processes and outline a clear trajectory for improvement.

Advise[2] (to monitor)/ **Cynghori** (i fonitro)

The Health & Safety Sub-Committee wish to **advise** members of the Health & Safety Committee that:

- Members of the HSSC were reminded to prioritise completion of outstanding actions from the sub-committee's action log, ensuring progress is made between meetings.
- **Security Management Group -** A training needs analysis confirmed the requirement for staff to attend Violence and Aggression Management training. Operational support is essential to release staff from their duties to attend.
- The Body worn video devices trial project has stalled due to a lack of dedicated security personnel. The Health and Safety (H&S) Team will continue to investigate and explore solutions.
- **Electrical infrastructure Group** – All identified risks relating to electrical infrastructure improvements have been appropriately recorded on the organisational risk register.
- A Targeted Efficiency Fund (TEF) programme has commenced, and a major infrastructure plan has been submitted to Welsh Government (WG) to address high and low voltage switchgear over the next three years. All acute sites now have secondary generator connection points. A detailed mitigation and contingency plan will be presented at the next meeting.
- **Security Management Group** – A security management report including improvements to the ID badge process is due to be presented to the Executive Team. Engagement with workforce colleagues is critical to progress.
- **Medical Gas Pipeline Systems Safety Group** – Two unresolved risks were highlighted. Further clarity is required regarding risk visibility, potential impact of failure, robustness of contingency plans and the organisation's risk tolerance in the context of funding constraints.
- **Compliance and Site Operations Group** – A training needs analysis was presented, and two new risk entries were discussed. An update will be provided at the next HSSC including progress on risk mitigation, training compliance and control measures effectiveness. This will also be reviewed by the Estates and Facilities Integrated Governance Group for development and thereafter presented to the HSSC.
- **Radiation Protection Group** – A Radiology team member exceeded the local action level for whole body radiation dose during a specific period. The Radiation

[2] *There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.*

Protection Group will investigate whether a formal incident report should have been completed.

An environmental survey identified elevated radiation levels at the Computed Tomography (CT) scanner roof edge. A permit to work system has been implemented. The risk to contractors and estates staff is considered extremely low due to limited occupancy.

- **Trade Union Health and Safety Group –**
  - The Royal College of Nursing (RCN) has completed audits across all four acute sites. Findings will be discussed with the Executive Director of Nursing, Quality and Patient Experience
  - The Society of Radiographers (SOR) completed an inspection in Radiology in Bronglais Hospital (BGH). Results will be shared with the HSSC
  - Trade Union colleagues have been asked to support the development of SMART action plans.

- **Health & Safety Update Report –** Over 120 site inspections have been completed. The department has been asked to explore how outcomes are tracked using the Audit Management and Tracking (AMAT) and Board Operational Risk Information System (BORIS) platforms.
- Manual Handling training attendance remains challenging. The CCG's will be asked to support staff release for training.
  Health and Safety (First Aid) Regulations – The Health and Safety Department has been asked to provide assurance that the organisation is compliant, and the processes align with the policy

Assure[3] (to note)/ Sicrhau (i nodi)

The Health & Safety Sub-Committee wish to **assure** members of the Health & Safety Committee that:

- **Medical Gas Pipeline Group** – has addressed identified risks and implemented mitigation measures through established CCG governance processes

- **The Water Safety, Ventilation, and Environmental Hygiene Groups** will now report directly to the Infection Protection Steering Group (IPSSG), rather than the HSSC, as agreed at the previous meeting.

- **Welsh Health Technical Memorandum (WHTM)–** Audits are now tracked through the AMAT system, enhancing visibility and accountability of compliance actions.

- **Anti-Violence Collaborative Wales Data Analysis** – Confirmation that letter received and response provided.

[3] *There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.*

- The **HSSC Terms of Reference** have been updated and approved by the HSSC and are presented for final approval by the HSC.

Review of Risks/ Adolygiad o Risgiau

Discussed within the body of the AAA report

Sharing of learning/ Rhannu dysgu

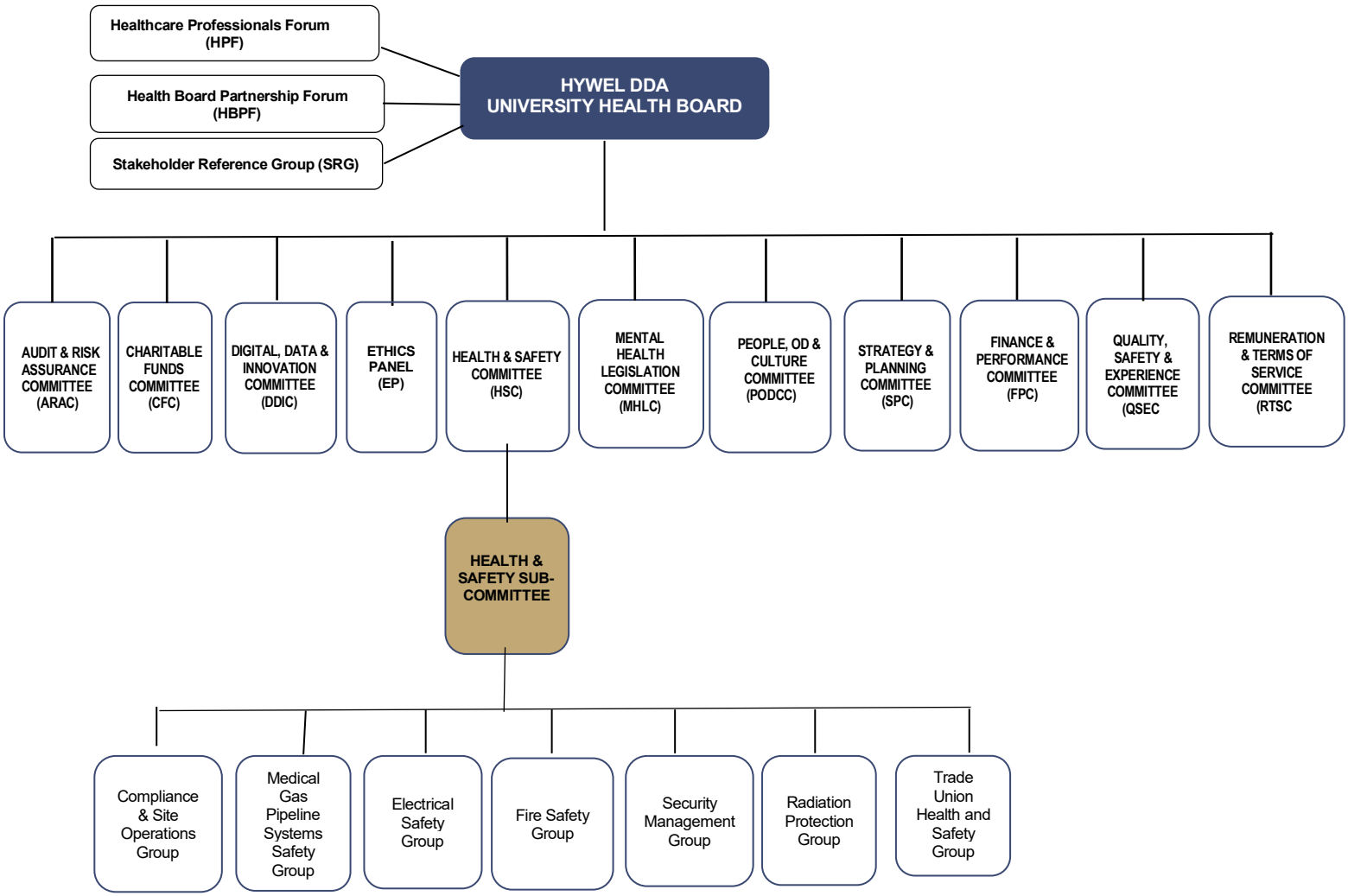
Not Applicable

Recommendation/ Argymhelliad

The Board/Committee is asked to:

- Approve the revised Terms of Reference for the sub committee
- Respond to the items that they are being alerted to
- Note the items the Committee is advising them of
- Be assured on the items that the Committee is providing assurance on

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board



HEALTH AND SAFETY SUB-COMMITTEE

TERMS OF REFERENCE

1. Constitution

Version	Issued to:	Date	Comments
V.01	Health & Safety Committee	10.09.2024	For Discussion
V.02	Health & Safety Committee	12.11.2024	For Approval
V.03	Health & Safety Sub-Committee	06.12.2024	For Adoption
V.04	Health & Safety Committee	14.01.2025	Approved
V.05	Health & Safety Sub-Committee	06.02.2025	For Discussion
V.06	Health & Safety Committee	04.03.2025	Approved
V.07	Health & Safety Sub-Committee	03.06.2025	Approved
V.07	Health & Safety Committee	03.07.25	For Approval

1.1 The Health and Safety Sub-Committee has been established as a Sub-Committee of the Health & Safety Committee and constituted from 12 November 2024.

2. Purpose

2.1 The purpose of the Health and Safety Sub-Committee is to ensure that the health and safety and security arrangements across the Health Board are driven by and focused on the requirements involved in each area, together with Hywel Dda University Health Board's (HDdUHB's) compliance or performance against these.

2.2 The Sub-Committee will monitor, scrutinise and receive assurance from its constituent parts that the various actions undertaken to ensure health and safety and security are effective and well managed.

2.3 The Sub-Committee will oversee the arrangements in place for the identification, assessment and prioritisation of risks related to health and safety and security.

2.4 The Sub-Committee will act as a forum for technical advisors to discuss health and safety and security issues across the Health Board.

2.5 The Sub-Committee will also provide opportunity for communication between the Health and Safety Sub-Committee and other health and safety and security related groups.

3. Key Responsibilities

3.1 The Health & Safety Sub-Committee will oversee levels of compliance with national guidance and subsequent legislation and standards in respect of health and safety and security.

3.2 Monitor progress against agreed performance indicators related to health and safety and security within the Health & Safety Dashboard to be developed.

3.3 Approve organisational health and safety policies, procedures, guidelines and codes of practices (policies within the scope of the Sub-Committee).

3.4 Review the Health Board's Health and Safety Policy prior to approval by Health & Safety Committee.

3.5 Seek assurance on the management of operational risks that have been aligned to the Health & Safety Sub-Committee, where the risk tolerance is exceeded or where there is a lack of timely action. Lack of assurance and resolution to be escalated to the Health & Safety Committee.

3.6 Request a deep dive report when action/contingency plans to address incidents and alerts that HDdUHB receives in relation to health and safety and security breach the agreed timescales.

3.7 Ensure actions are completed in a robust and timely manner and seek assurance that learning in regard to health and safety is disseminated and embedded across all the Health Board's activities as appropriate.

3.8 Receive assurance from the Groups reporting to the Sub-Committee and consider how escalated issues are addressed/resolved.

3.9 Provide the necessary assurances to the Health & Safety Committee, escalating any matters of immediate concern with recommendations for action.

3.10 Develop an annual work plan, responding to operational service priorities, consistent with the strategic direction for the organisation, for approval by the Health & Safety Committee.

3.11 Inform the work plans for reporting Groups and vice versa.

3.12 Receive and consider any relevant Health & Safety issues from the Infection Prevention Strategic Steering Group.

3.13 Address any other requirements stipulated by the Health & Safety Committee.

4. Membership

4.1 The membership of the Health and Safety Sub-Committee shall comprise:

Title
Executive Director of Allied Health Professions & Health Science (Chair)
Deputy Director of Health Science (Vice-Chair)
Deputy Chief Operating Officer
Chair/Vice Chair, Compliance & Site Operations Group
Chair/Vice Chair, Medical Gas and Pipeline Systems Safety Group
Chair/Vice Chair, Electrical Safety Group
Chair/Vice Chair, Fire Safety Group
Chair/Vice Chair, Security Management Group
Chair/Vice Chair, Radiation Protection Group
Chair/Vice Chair, Trade Union Health and Safety Group
Head of Health, Safety & Security (covering Violence & Aggression, Moving & Handling)
Health & Safety Manager
Head of Operations
Head of Occupational Health (or deputy)
Head of Infection Prevention and Control
Head of Fire Safety
Assistant Director of Assurance & Risk
Head of Estates, Risk and Compliance
Assistant Director of Nursing, Patient Safety, Quality & Experience (Community & Integrated Medicine)

4.2 The membership of the Sub-Committee will be reviewed on an annual basis.

5. Quorum and Attendance

5.1 A quorum shall consist of either the Chair or Vice-Chair and no less than a third of the membership of the Health and Safety Sub-Committee.

5.2 Any senior officer of HDdUHB or partner organisation (e.g. NHS Wales Shared Services Partnership NWSSP Legal and Risk Services and NWSSP - SES Specialist Estates Services staff) may, where appropriate, be invited to attend, for either all or part of a meeting, to assist with discussions on a particular matter.

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

5.4 Should any member be unavailable to attend, they may nominate a fully briefed deputy to attend in their place, subject to the agreement of the Chair.

6. Agenda and Papers

6.1 The Health and Safety Sub-Committee Secretary is to hold an agenda setting meeting with the Chair and/or the Vice Chair, at least **six** weeks before the meeting date.

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

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

6.4 The minutes and Table of Actions will be circulated to the Chair within seven days to check the accuracy, prior to sending to Members to review within the next seven days.

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

7. Frequency of Meetings

7.1 The Health and Safety Sub-Committee will meet bi-monthly and shall agree an annual schedule of meetings. Any additional meetings will be arranged as determined by the Chair of the Sub-Committee.

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

8. Accountability, Responsibility and Authority

8.1 The Health and Safety Sub-Committee will be accountable to the Health & Safety Committee for its performance in exercising the functions set out in these terms of reference.

9. Reporting

9.1 The Health and Safety Sub-Committee may, subject to the approval of the Health & Safety Committee, establish groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business. The Sub-Committee will receive an update following each group's meeting, detailing the business undertaken on its behalf. The following groups have been established:

9.1.1 Compliance & Site Operations Group
9.1.2 Medical Gas Pipeline Systems Safety Group
9.1.3 Electrical Safety Group

9.1.4 Fire Safety Group
9.1.5 Security Management
9.1.6 Radiation Protection Group
9.1.7 Trade Union Health and Safety Group

9.2 The Sub-Committee, supported by the Sub-Committee Secretary, shall:

9.2.1 Report formally, regularly and on a timely basis to the Health & Safety Committee on the Sub-Committee's activities. This includes the submission of a Sub-Committee update report, as well as the presentation of an annual report within 6 weeks of the end of the financial year.

9.2.2 Bring to the Health & Safety Committee's specific attention any significant matters under consideration by the Sub-Committee.

10. Secretarial Support

10.1 The Health and Safety Sub-Committee Secretary shall be determined by the Director of Allied Health Professions and Health Science.

11. Review Date

11.1 These terms of reference shall be reviewed initially on a 6 monthly basis, and thereafter on at least an annual basis, by the Health and Safety Sub-Committee for approval by the Health & Safety Committee.

1.6

9:51 AM, 10 Mins

1.6 - Corporate Risks Assigned to HSC

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

For assurance

Attachments

HSC Corporate Risk Report July 2025 FINAL Clean.pdf

Appendix 2 - Health and Safety Committee Corporate Risks- June 2025.pdf

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

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	03 July 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Corporate Risks Assigned to Health and Safety Committee (HSC)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	James Severs, Executive Director of Allied Health Professionals and Health Sciences Ardiana Gjini, Executive Director of Public Health
SWYDDOG ADRODD: **REPORTING OFFICER:**	Charlotte Wilmshurst, Assistant Director of Assurance and Risk

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

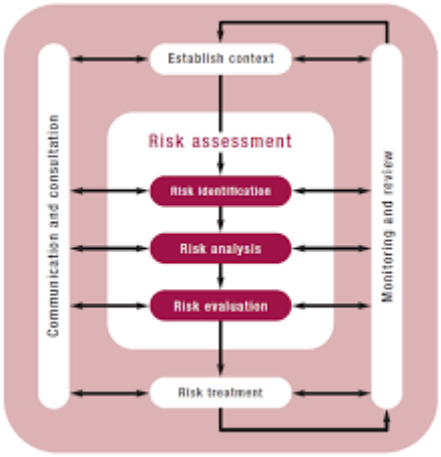
ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Health and Safety Committee (HSC) is asked to request assurance from the Lead Executive Directors that the corporate risks in the attached report are being managed effectively.

Cefndir / Background

Effective risk management requires a 'monitoring and review' structure to be in place to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place.



(Risk Management Process, ISO 31000)

The Board's Committees are responsible for the monitoring and scrutiny of corporate level risks within their remit. They are responsible for:

- Seeking assurance on the management of risks on the Corporate Risk Register (CRR) and providing assurance to the Board that risks are being managed effectively and report areas of significant concern, for example, where risk appetite is exceeded, lack of action, etc.
- Reviewing corporate and operational risks over tolerance and, where appropriate, recommend the 'acceptance' of risks that cannot be brought within Hywel Dda University Health Board's (HDdUHB) risk appetite/tolerance to the Board.
- Identity through discussions any new/emerging risks and ensure these are assessed by management.
- Signpost any risks outside of its remit to the appropriate HDdUHB Committee.
- Use risk registers to inform meeting agendas.

A revised approach to risk tolerance was agreed by the Board at its meeting in March 2025 to reflect the organisation's readiness to bear the risk after risk treatment, in order to achieve its objectives. This supersedes the previous approach agreed in September 2018 which set the tolerance levels for risk aligned to risk impact domains.

The revised approach utilises the target risk score (TRS) of risks in order to demonstrate the lowest level of risk exposure that the Health Board is willing to tolerate, following the completion of all planned actions aligned to each risk. The TRS represents the ultimate level of risk achievable given the available means and resource. Once the TRS is achieved, if the risk continues to exist, it should then be tolerated / accepted unless further actions are identified or made possible (e.g., additional resources). If achieving the TRS is deemed unacceptable (i.e., the TRS is too high), further discussion or escalation is required. The TRS should be quantified, and where possible aligned to performance targets (including quality metrics), with a set timescale for achieving the reduction of the Current Risk Score to the TRS.

Risks will be 'treated' until a discussion to 'tolerate' a risk is triggered – this would be when the Executive Risk Owner for corporate risks does not support the TRS. The Board will be asked to accept any risks where the Health Board is unable to treat within its available means.

These risks have been identified by individual Directors via a top-down and bottom-up approach, and are either:

- Associated with the delivery of the Health Board objectives; or
- Significant escalated operational risks that are of significant concern and require corporate oversight and management.

Each risk on the CRR has been mapped to a Board level Committee to ensure that these risks are being managed appropriately, taking into account the gaps, planned actions and agreed tolerances, and to provide assurance to the Board through Committee Update Reports regarding the management of these risks.

The Board has delegated a proportion of its role of scrutiny of assurances to its Committees to make the most appropriate and efficient use of expertise. Therefore, Committees should also ensure that assurance reports relevant to the principal risks are received and scrutinised, and an assessment made as to the level of assurance it provides, taking into account the validity and reliability i.e. source, timeliness, methodology behind its generation and its compatibility with other assurances. This will enable the Board to place greater reliance on assurances, if they are confident that they have been robustly scrutinised by one of its Committees; and provide them with greater confidence regarding the likely achievement of strategic objectives, as well as providing a sound basis for decision-making. It is the role of Committees to challenge where assurances in respect of any component are missing or inadequate. Any gaps should be escalated to the Board.

The process for risk reporting and monitoring within HDdUHB is outlined at Appendix 1.

Asesiad / Assessment

The HSC Terms of Reference reflect the Committee's role in providing assurance to the Board that principal risks are being managed effectively by the risk owners (Executive Leads).

The Terms of Reference state that the Committee will:

> 3.15 Provide assurance that risks relating to health, safety, security, fire and service/ business interruption/ disruption are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate) and provide assurance that effective risk assessments are undertaken and addressed.

There are 5 corporate risks aligned to HSC from the 20 risks currently identified on the CRR, as the potential impacts of these risks relate to the health and safety of patients, staff and visitors.

The 5 corporate risks have been entered onto a '*risk on a page'* template, which includes information relating to the strategic objective, controls, assurances, performance indicators, and action plans to address any gaps in controls and assurances. Due to the sensitive nature of risks 1860 – *There is a risk of serious harm to staff due to violence & aggression in the workplace* and 1861 - *Risk of harm to staff, patients public and critical assets due to insufficient physical security measures and systems,* the detail is reported to in-committee to provide discussion and assurance.

Details on the 3 remaining risks assigned to HSC are included in Appendix 2.

Changes since the previous report presented to HSC at its meeting on 14 January 2025:

Total Number of Risks	5	
New risks	0	
Risks that are no longer included in the report	0	
Increase in risk score ↑	0	
No change in risk score →	5	*Note 1*
Reduction in risk score ↓	0	
Extreme (red) risks (based on 'Current Risk Score')	4	
High (Amber) risks (based on 'Current Risk Score')	1	

Note 1 – No change in risk score

Since the previous report, there has been no change in the following risk scores:

Risk Reference & Title	Date risk identified	Lead Director	Current Risk Score	Update	Target Risk Score
1861 - Risk of harm to staff, patients public and critical assets due to insufficient physical	01/05/24	Executive Director of Allied Health Professions and Health Sciences	**4x4=16** (Reviewed 09/06/25)	Detail provided to HSC In-Committee	**3x3=9** (Date expected to reach TRS 31/12/25)

security measures and systems					
1860 - Risk of serious harm to staff due to violence & aggression in the workplace	01/05/24	Executive Director of Allied Health Professions and Health Sciences	**3x5=15** (Reviewed 03/06/25)	Detail provided to HSC In-Committee	**3x3=9** (Date expected to reach TRS: TBC)
1745 – Risk of not being able to safely deliver services due to ageing estate and infrastructure across the Health Board	02/08/23	Executive Director of Allied Health Professions and Health Sciences	**5x3=15** (Reviewed 10/06/25)	The current risk score is based upon the level of detailed information the Estates department has for its buildings, plant and infrastructure, including external reports, risk information and Estates and Facilities Performance Management System (EFPMS) data submitted to Welsh Government (WG), clearly articulating the scale of backlog and deficiencies across the Health Board. The programme business case (PBC) has been under development with WG since 2018/19. NHS Wales Shared Services Partnership (NWSSP) has supported a three-year investment programme for major infrastructure. WG are in support of this plan (with a £5m capital expenditure limit per year). The Major Infrastructure project is included as a WG Priority Project for Hywel Dda UHB. Negotiations are ongoing with WG to secure funding for the development of business cases for the implementation of these projects. These negotiations will be aided	**5x2=10** (Date expected to reach TRS: TBC)

				by a piece of work which seeks to ascertain approximate costs, timescales and deliverability of the priorities across the acute sites. Minimal funding has been received to date (circa £1.5m) for lift shaft improvements at Bronglais Hospital (BGH) and electrical infrastructure at Glangwili Hospital (GGH), with fees for the first year of plan secured. A report has been developed by the Major Infrastructure Team and NHS Wales Shared Services Partnership (NWSSP) Estates detailing the consequences of infrastructure failure in relation to patient services and its impact on patient care. This report was presented to Strategy & Planning Committee in April 2025.	
813 - Risk of non-compliance with the Regulatory Reform (Fire Safety) Order 2005 due to ageing infrastructure	01/10/19	Executive Director of Allied Health Professions and Health Sciences	**5x3=15** (Reviewed 04/06/25)	Phased Fire Safety Improvement works are ongoing across sites, with significant investments being made to address the recommendations in the Mid and West Wales Fire and Rescue Service (MWWFRS) letters and Enforcement Notices (EN). All programme dates have been agreed with the Health Board, WG and MWWFRS senior inspecting officers, with completed actions reviewed to determine the	**5x1=5** (Date expected to reach TRS TBC)

				risk score as works are progressed. Extensions of time, particularly for EN schemes, have been fully agreed by MWWFRS. The BORIS system is in place and all fire risk assessments have been transferred across. Currently, the risk remains extreme until further progress is made on the above Fire safety improvement works. This will be reviewed regularly. A further EN was served (19 March 2025) on the Health Board for the Cwm Seren Site, for which we are seeking additional funding. The scheme is now out to tender and we are awaiting full costs. Based on the planned works for completion (November 2025), it is expected that the current risk score could be reduced to 10. It is anticipated that when training attendance levels specifically for Level 2 training have reached over 85% targets and are sustained at this level continuously, the Health Board will then be in an informed position to look at the further reduction of the risk score. This decision will be reviewed regularly.	
1433 - Risk to the ability to maintain routine and emergency	01/05/22	Executive Director of Public Health	**4x3=12** (Reviewed 04/06/25)	The national security and risk assessment was reviewed and republished in November 2022 and	**4x2=8** (Date expected to reach TRS 31/08/25)

services in the event of a severe pandemic				remains unaltered. The previous pandemic influenza risk has been changed into 2 new risks, one generic pandemic event and one on emerging infectious diseases. Current likelihood is scored at a 3 to reflect the risk of the Health Board being unable to respond to the scale and severity of the pandemic - not the likelihood of the pandemic actually occurring. The expected date to reach the Target Risk Score is August 2025. A Cabinet Review of Influenza Preparedness was due just prior to COVID-19 which delayed publication. This workstream has now recommenced and together with outcomes and learning points from COVID-19 will inform our future planning approach for pandemic response. The Government Respiratory Pandemic Guidance was due late Summer 2024, but final draft for consultation is now expected end of September 2025. It is hoped to reduce either the likelihood and/or impact score following consideration and implementation of these reviews/recommendations and subsequent review of internal planning arrangements.	

The heat map below includes the risks currently aligned to HSC:

HYWEL DDA RISK HEAT MAP					
	LIKELIHOOD →				
IMPACT ↓	RARE 1	UNLIKELY 2	POSSIBLE 3	LIKELY 4	ALMOST CERTAIN 5
CATASTROPHIC 5			813 (→) 1745 (→)		
MAJOR 4			1433 (→)	1861 (→)	
MODERATE 3					1860 (→)
MINOR 2					
NEGLIGIBLE 1					

Argymhelliad / Recommendation

The HSC is requested to:

- **RECEIVE ASSURANCE** that all identified controls are in place and working effectively.
- **RECEIVE ASSURANCE** that all planned actions will be implemented within stated timescales and will reduce the risk further and/or mitigate the impact if the risk materialises.
- Challenge where assurances are inadequate.

This in turn will enable the Committee to provide the necessary assurance to the Board, through its Committee Update Report, that HDdUHB is managing these risks effectively.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.15 Provide assurance that risks relating to health, safety, security, fire and service/ business interruption/ disruption are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate) and provide assurance that effective risk assessments are undertaken and addressed.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Contained within the report
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply

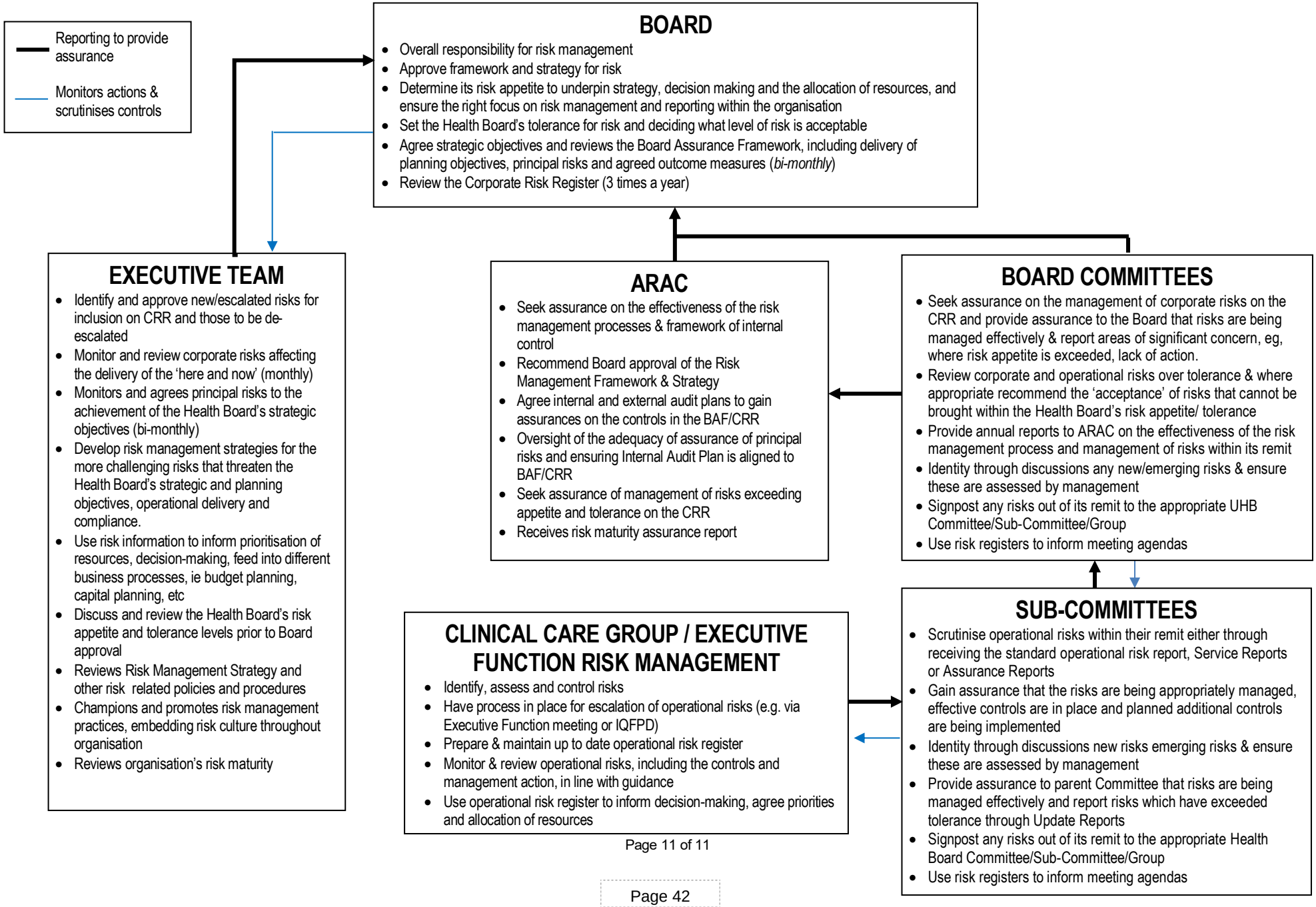
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Underpinning risk on the Datix Risk Module from across HDdUHB's services reviewed by risk leads/owners.
Rhestr Termau: Glossary of Terms:	Current Risk Score - Existing level of risk taking into account controls in place. Target Risk Score - The ultimate level of risk that is desired by the organisation when planned controls (or actions) have been implemented.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd Iechyd a Diogelwch: Parties / Committees consulted prior to Health and Safety Committee:	Not applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts from report, however, impacts of each risk are outlined in risk description.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from report, however, impacts of each risk are outlined in risk description.
Gweithlu: Workforce:	No direct impacts from report, however, impacts of each risk are outlined in risk description.
Risg: Risk:	No direct impacts from report, however, organisations are expected to have effective risk management systems in place.
Cyfreithiol: Legal:	No direct impacts from report, however, proactive risk management including learning from incidents and events contributes towards reducing/eliminating recurrence of risk materialising and mitigates against any possible legal claim with a financial impact.

Enw Da: **Reputational:**	Poor management of risks can lead to loss of stakeholder confidence. Organisations are expected to have effective risk management systems in place and take steps to reduce/mitigate risks.
Gyfrinachedd: **Privacy:**	No direct impacts.
Cydraddoldeb: **Equality:**	Has EqIA screening been undertaken? No Has a full EqIA been undertaken? No

Appendix 1 – Committee Reporting Structure



Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Jun-25	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score	Risk on page no…
813	Risk of non-compliance with the Regulatory Reform (Fire Safety) Order 2005 due to ageing infrastructure	Severs, James	Statutory duty/inspections	3×5=15	3×5=15	→	1×5=5		6
1745	Risk of not being able to safely deliver services due to ageing estate and infrastructure across the Health Board	Severs, James	Safety - Patient, Staff or Public	3×5=15	3×5=15	→	2×5=10		14
1433	Risk to the ability to maintain routine and emergency services in the event of a severe pandemic	Gjini, Ardiana	Service/Business interruption/disruption	3×4=12	3×4=12	→	2×4=8	31/08/2025	18

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Management	Tends to be detailed assurance but lack independence
2nd Line	Corporate Oversight	Less detailed but slightly more independent
3rd Line	Independent Assurance	Often less detail but truly independent

Key - Assurance Required	
Detailed review of relevant information	*NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you*
Medium level review	
Cursory or narrow scope of review	

Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective and in proportion to the risk
INSUFFICIENT	Insufficient information at present to judge the adequacy/effectiveness of the controls

RISK SCORING MATRIX

Likelihood x Impact = Risk Score					
Likelihood	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	**This will probably never happen/recur (except in very exceptional circumstances).**	**Do not expect it to happen/recur but it is possible that it may do so.**	**It might happen or recur occasionally.**	**It might happen or recur occasionally.**	**It will undoubtedly happen/recur, possibly frequently.**
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least weekly.*	Expected to occur at least daily.*
	* time-framed descriptors of frequency				
Probability - Will it happen or not? (what is the chance the adverse consequence will occur in a given reference period?)	**(0-5%*)**	**(5-25%*)**	**(25-75%*)**	**(75-95%*)**	**(>95%*)**
	*used to assign a probability score for risks related to time-limited or one off projects or business objectives.				
Risk Impact Domains	**Negligible - 1**	**Minor - 2**	**Moderate - 3**	**Major - 4**	**Catastrophic - 5**
Safety of Patients, Staff or Public	**Minimal injury requiring no/minimal intervention or treatment.**	**Minor injury or illness, requiring minor intervention.**	**Moderate injury requiring professional intervention.**	**Major injury leading to long-term incapacity/disability.**	**Incident leading to death.**
	No time off work.	**Requiring time off work for >3 days**	**Requiring time off work for 4-14 days.**	**Requiring time off work for >14 days.**	**Multiple permanent injuries or irreversible health effects.**
		Increase in length of hospital stay by 1-3 days.	**Increase in length of hospital stay by 4-15 days.**	**Increase in length of hospital stay by >15 days.**	**An event which impacts on a large number of patients.**
			Agency reportable incident.	**Mismanagement of patient care with long-term effects.**	
			An event which impacts on a small number of patients.		
Quality, Complaints or Audit	**Peripheral element of treatment or service suboptimal.**	**Overall treatment or service suboptimal.**	**Treatment or service has significantly reduced effectiveness.**	**Non-compliance with national standards with significant risk to patients if unresolved.**	**Totally unacceptable level or quality of treatment/service.**
	Informal complaint/inquiry.	**Formal complaint.**	**Formal complaint -**	**Multiple complaints/ independent review.**	**Gross failure of patient safety if findings not acted on.**
		Local resolution.	**Escalation.**	**Low achievement of performance/delivery requirements.**	**Inquest/ombudsman inquiry.**
		Single failure to meet internal standards.	**Repeated failure to meet internal standards.**	**Critical report.**	**Gross failure to meet national standards/performance requirements.**
		Minor implications for patient safety if unresolved.	**Major patient safety implications if findings are not acted on.**		
		Reduced performance if unresolved.			

Workforce & OD	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff.	Uncertain delivery of key objective/service due to lack of staff.	Non-delivery of key objective/service due to lack of staff.
			Unsafe staffing level or competence (>1 day).	Unsafe staffing level or competence (>5 days).	Ongoing unsafe staffing levels or competence.
			Low staff morale.	Loss of key staff.	Loss of several key staff.
			Poor staff attendance for mandatory/key training.	Very low staff morale. No staff attending mandatory/ key training.	No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
		Reduced performance levels if unresolved.	Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty.	Prosecution.
				Improvement notices.	Complete systems change required.
				Low achievement of performance/delivery requirements.	Low achievement of performance/delivery requirements.
				Critical report.	Severely critical report.
Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage
					Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.
Health Equity	Minimal or no impact on our attempts to improve health equity	Minor impact on our attempts to improve health equity or low level of certainty on the impact we are having on health equity	Moderate impact on our attempts to improve health equity or a lack of sufficient information that would demonstrate this. Indications that we are not having a positive impact on health improvement or health equity	Major impact on our attempts to improve health equity. Validated data suggesting that we are not improving the health of the most disadvantaged in our population whilst clearly supporting the least disadvantaged. Validated data suggesting we are having no impact on health improvement or health equity.	Validated data clearly demonstrating a disproportionate widening of health inequalities or a negative impact on health improvement and/or health equity.

RISK MATRIX

IMPACT ↓	LIKELIHOOD →				
	RARE	UNLIKELY	POSSIBLE	LIKELY	ALMOST CERTAIN
	1	2	3	4	5
CATASTROPHIC 5	5	10	15	20	25
MAJOR 4	4	8	12	16	20
MODERATE 3	3	6	9	12	15
MINOR 2	2	4	6	8	10
NEGLIGIBLE 1	1	2	3	4	5

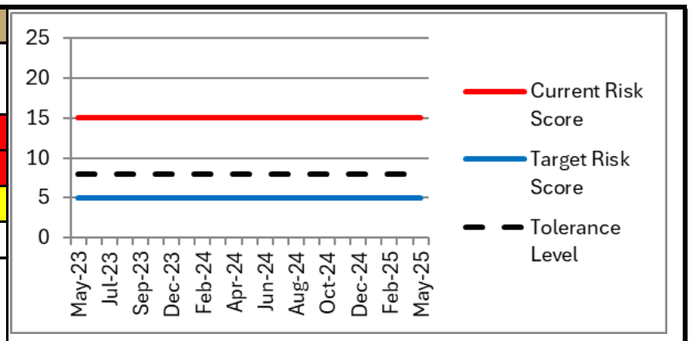
RISK ASSESSMENT - FREQUENCY OF REVIEW

RISK SCORED	DEFINITION	ACTION REQUIRED (GUIDE ONLY)	MINIMUM REVIEW FREQUENCY
15-25	Extreme	Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have an effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required.	This type of risk is considered extreme and should be reviewed and progress on actions updated, at least monthly.
8-12	High	Very unlikely to be acceptable. Significant resources may have to be allocated to reduce the risk. Urgent action should be taken. A number of control measures may be required.	This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly.
4-6	Moderate	Not normally acceptable. Efforts should be made to reduce risk, providing this is not disproportionate. Establish more precisely the likelihood & harm as a basis for determining the need for improved measures.	This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months.
1-3	Low	Risks at this level may be acceptable. If not acceptable, existing controls should be monitored & reviewed. No further action or additional controls are required.	This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually.

Date Risk Identified:	Oct-19	**Executive Director Owner:**	Severs, James	**Date of Review:**	Jun-25
Strategic Objective:	3. Striving to deliver and develop excellent services	**Lead Committee:**	Health and Safety Committee	**Date of Next Review:**	Jul-25

Risk ID:	**813**	**Corporate Risk Description:**	There is a risk of failing to fully comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO). This is caused by 1: The age, condition and scale of physical backlog, circa £20m (+) relating to fire safety (i.e. non compliant fire doors, compartmentation defects and general fire safety management issues) across our estate significantly affects our ability to comply with the requirements of the RRO in every respect. 2:Difficulties managing the actions within the current fire safety risk assessment system - to enable complete transparency and ongoing management of actions assigned to responsible persons. The new Boris system will help address this issue. 3: Management responsibilities for fire safety not fully understood by all responsible managers. 4: Fire safety training attendance figures are not reaching HB agreed targets. This could lead to an impact/affect on the safety of patients, staff and general public, HSE investigations and further fire brigade enforcement (already served on Withybush and Glangwili General Hospitals), fines and/or custodial sentences, adverse publicity/reduction in stakeholder confidence.
Does this risk link to any Directorate (operational) risks?		708, 951, 503	

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



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
Phased fire safety improvement works are ongoing across our sites, with significant investments being made to address the recommendations in the Mid and West Wales Fire and Rescue Service (MWWFRS) letters and Enforcement Notices. All programme dates have been agreed with the Health Board, Welsh Government (WG) and MWWFRS senior inspecting officers. We intend to review the progress of our completed actions to determine the risk score as we progress with these works. Extensions of time particularly for EN schemes have been fully agreed by MWWFRS. The BORIS system is now in place and all fire risk assessments have been transferred across. A paper was submitted to the HSC in September 2024 indicating this achievement and a high level summary of the Estates and Hospital Management Risks. Currently, the risk is felt to still be extreme until further progress is made on the above Fire safety improvement works. This will be reviewed regularly. Further EN served (19th March 2025) on the HB for the Cwm Seren Site which we are seeking additional funding for. Scheme already out to tender and we are awaiting full costs.	Further improvements in culture and ownership for fire safety. It is the scale of physical backlog for fire safety compliance (additional surveys) that will remain until appropriate measures are put in place to address the deficit. Despite annual investment from statutory capital for fire safety components (circa £200k), the scale of current investment is clearly not adequate to address the true scale of backlog the UHB has. Based on the planned works for completion (November 2025), it is expected that the current risk score could be reduced to 10. It is anticipated that when training attendance levels specifically for L2 training have reached > 85% targets and are sustained at this level continuously, the HB will then be in an informed position to look at the further reduction of risk score. This decision will be reviewed regularly.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Pre Planned Maintenance (PPM) checks are carried out across the UHB on fire safety components. A detailed physical estates backlog system is in place that identifies the scale (£) and risk of backlog for UHB. Data used to manage backlog maintenance & statutory decision making also regularly reported to WG. Extensive fire safety improvement works are being undertaken at WBH, GGH and at BGH from WG agreed funding (EFAB bids for BGH and funding and From submitted business cases), with phased timelines fully agreed with MWWFRS. Regular communications and dialogue is taking place between HB and MWWFRS. Individual Fire Risk Assessments (FRA's) in place for all sites across the UHB identifying fire related risks. Boris fire safety system implemented across the UHB, giving the ability to review all risks from fire risk assessments via a dashboard and risk ownership. Training Needs Analysis (TNA) for fire safety training in place, as defined in Fire Policy.	Despite significant investments already in place following enforcement notices and letters of fire safety matters, additional investment is required to address fire safety defects at other sites within the UHB, which are being inspected by MWWFRS. We have firm plans in place to address a range of fire safety projects over the coming years and these are all fully identified as actions within this risk with anticipated timelines. Not all managers who are assigned actions on Boris are regularly accessing the system to close off their actions. Despite recent invitations for staff to attend training sessions. Fire safety training performance (for L2) is currently below the agreed level at	Implementation of a new software system to manage the content of the HB's fire risk assessments. Boris software has now been purchased and is currently being implemented. Date agreed as part of internal fire safety governance review.	Evans, Paul	Completed	Boris software now purchased Dec 2020, initial implementation planned for March 2021. Implementation of risk assessments will now be planned for July 2021. System now supports the use of mobile technology therefore risk assessments can be completed live on the system. System now being tested on site, fully operational by Jan (now Feb) 2022
		Additional fire surveys are required across various sites to obtain costs for all fire compartmentation defects, doors, fire alarm systems and other associated items.	Evans, Paul	Completed	fire safety team and compliance team are working with site operations to determine what the gaps are and to agree what surveys will be required.

UHB has implemented a governance structure for fire safety reporting. Estate plans with fire zones, fire doors, fire compartmentation, fire infrastructure items (alarm and detection system). UHB assesses its performance in respect of operational maintenance work carried out on fire safety components and presents this information as a formal paper at all UHB wide fire safety meetings. Annual prioritisation of investment against high risk backlog. Internal governance review (2019/20) initiated by the CEO and all action implemented from review. The HB has now embedded a fully resourced fire safety management team, with appropriate reporting arrangements for fire safety and addressing the backlog of out of date fire risk assessments across the UHB. The UHB has improved fire safety management culture and management ownership for fire safety. The fire team will also look to implement a regular training global e-mail as a reminder for staff on when and how to book a session. Works already completed following issue of Enforcement Notices and LoFSM at various sites. For EN sites (WBH and GGH) - Advanced Works to vertical escape routes now completed. Also improvements carried out under LoFSM at Tregaron, Bronglais, Glangwili and Withybush Hospitals. Level 1 & 2 Fire Safety training is delivered via Teams. Level 3 Fire Safety training is provided face to face. Level 4 training (Fire Safety Warden training) is also a face to face session, with an external trainer. Level 5 training is provided on Teams as part of the H&S Managers induction training. There is an improving performance in terms of uptake of training (except for L2).	(85%) as set by MWWFRS for WBH and GGH (sites under enforcement). The Fire Safety Team are now working with L&D staff to modernise the training material to offer a more interactive e-learning experience with questions for each section. Despite making improvements to the culture of fire safety management and ownership, the HB does need to ensure this is organisational wide and embedded within it's workforce and cascaded by management.	Introduce new innovative ways of improving fire training attendance across the HB to increase the percentage figures agreed and set by the HB. As part of the next risk review the fire team intend to split this action into individual sections so we can track and close off action as and when completed.	Evans, Paul	Completed	The fire safety team have been trialing the use of MS teams for L2 Fire training, which has proved to be very successful. We are planning to roll this out to other areas of fire training levels, such as L5/L4 & L3. This will have a positive impact on staff being able to attend the session. We will need to improve communications on this and to ensure staff are made fully aware of the sessions taking place and the dates.
		To introduce ways to help improve the culture and ownership of fire safety across the HB. Although management training is taking place at the "Managers Induction Programme" and this is well received. The HB still needs to do more to avoid areas of poor practice that is sometimes identified.	Evans, Paul	Completed	To look at improving the current training content and programme that's currently on offer for management. Regular global communications of do's and don'ts. Having a fire safety share point system, with links to interesting info on effective fire safety management.
		Now the new Boris fire safety system is being implemented across the HB (training planned for June 22 for staff), fire risk assessment actions from this need to be monitored by those responsible. These actions need to be communicated at all fire safety sub groups and fed to the HB wide FSG for complete transparency.	Evans, Paul	Completed	System now live in the HB and staff training programme in place. From this point all fire risk assessment actions will be closely monitored using this system.

	Regular communications processes in place to advertise L2 fire safety training.		Introduce a system to manage fire risk assessment recommendations more effectively. System to have the ability to assign risks to risk owners, to track/manage risk and to demonstrate progress on the actions.	Evans, Paul	Completed	The fire team are utilising the current system as best as possible. An Excel system is being introduced (completion Jun20) however a more robust automated system is needed by the HB to track the significant number of actions. Progressing this has been delayed due to COVID-19, however quotes have now been obtained and are under discussion with the Director of Facilities. Approval has now been provided to purchase a system. Completion date for system trial on site by July 2021. System now being tested on site on a few Fire Risk Assessments, we plan to go fully live in Nov/Dec 2021.
			Establish a teams training platform to deliver the level 3 and level 4 fire safety training programmes. Although this will also be supported by face to face sessions.	Evans, Paul	Completed	Following a review of level 3 & 4 fire safety training programmes it has been established that these cannot be delivered via Teams. These are now delivered as follows: Level 3 training has been reviewed and requires a face to face practical delivery. Level 4 training (Fire Safety Warden training) is also a face to face session, with an external trainer.
			WBH - Completion of Phase 1 works - For all remaining horizontal escape routes.	Elliott, Rob	Completed	Completed on Dec 15th 2023

			WBH - Completion of Phase 2 works - For all departments, ward areas and risk rooms.	Elliott, Rob	~~30/04/2025~~ ~~30/04/2025~~ 31/07/2027	Full agreement has now been reached with Welsh Government (WG)/NHS Wales Shared Services Partnership - Special Estates Services (NWSSP-SES) to change the procurement approach for Phase 2. This following a wide-ranging lessons learned exercise undertaken jointly with NWSSP-SES. Start date Sept 2024 completion mid 2027. Will be regularly reviewed.
			GGH - Completion of Phase 1 works - For all remaining horizontal escape routes.	Elliott, Rob	Completed	Full agreement has now been reached with Welsh Government (WG)/NHS Wales Shared Services Partnership - Special Estates Services (NWSSP-SES) to change the procurement approach for Phase 2. This following a wide-ranging lessons learned exercise undertaken jointly with NWSSP-SES. Noting the change in procurement and the new appointments the HB will be making we need to consider now formally the future programme for Phase 2. This is currently being reviewed by the full team and will be reported to the next Phase 2 Fire Project Team.

	GGH - Completion of Phase 2 works - For all departments, ward areas and risk rooms.	Elliott, Rob	~~30/04/2024~~ ~~30/08/2024~~ ~~30/06/2025~~ 30/11/2027	Full agreement has now been reached with Welsh Government (WG)/NHS Wales Shared Services Partnership - Special Estates Services (NWSSP-SES) to change the procurement approach for Phase 2. This following a wide-ranging lessons learned exercise undertaken jointly with NWSSP-SES. Start date Sept 2024 completion mid 2027. Will be regularly reviewed.
	Develop a Fire Training information pack for distributing to agency staff across all 4 sites.	Elliott, Rob	Completed	Completed - We have supported the HoN on this recommendation and issued our current training material to all agency companies. We will continue to support the HoN with any new welcome packs they introduce.
	To ensure all fire risk assessments are transferred from NWSSP-SES system to Boris	Evans, Paul	Completed	Boris system transfer now completed, review of data now being undertaken
	To introduce a new interactive e-learning course (to support) Fire Training across the HB, specifically focusing on L2 and L5 staff. Update the TNA fire training. Note: for L2 e-learning cannot be used as the sole means of training Therefore a review of the Fire Training TNA needs to be considered, this will be a separate action added to this risk. Improve marketing and publicity of this new training to encourage greater attendance.	Jupp, Richard	Completed	Full agreement has now been reached with Welsh Government (WG)/NHS Wales Shared Services Partnership - Special Estates Services (NWSSP-SES) to change the procurement approach for Phase 2. This following a wide-ranging lessons learned exercise undertaken jointly with NWSSP-SES. Start date Sept 2024 completion mid 2027. Will be regularly reviewed.

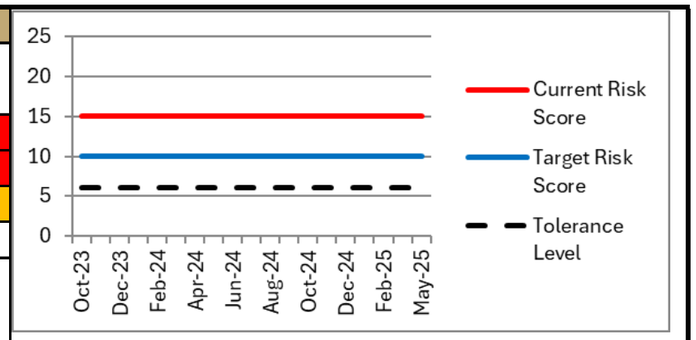
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Maintain a zero or as low as possible number of outstanding fire risk assessments. Monitor the number of risks now held in the new Boris Fire Safety System.	Bimonthly review of outstanding actions from fire risk assessments	1st			IA Fire Precautions Report - ARAC Jun18 SBAR submitted to each HSAC meeting, which includes themes of all fire safety risks. Boris Fire Safety System (UPDATE) and Fire Training Performance SBAR's submitted to Sept 24 HSAC.	General site management checks/walkarounds on all sites				
	Site Fire wardens reporting fire safety issues	1st								
	Annual Online Fire Audit Self-Assessment submitted to NWSSP	1st								
	Review of compliance through fire safety groups	2nd								
	4 Fire Safety Sub Groups (one at each site) which report into the UHB wide Fire Safety Group (reporting into the HSC)	2nd								
	Fire Safety SBAR reports regularly issued to HSC	2nd								
	Fire inspections by Fire Service & Fire Improvement Notices	3rd								
	NWSSP fire advisor inspections	3rd								

	NWSSP IA Fire Precautions Follow Up May-18 - Reasonable Assurance	3rd								
	IA Fire Governance follow up in July 2022 - Substantial assurance.	3rd								
	IA WGH Fire Precautions Works: Phase 1 in Aug 22 - Reasonable rating.	3rd								
	High level action plan meeting with MWWFRS on the 1st May 2025 with very positive comments received from then on our commitment to improve fire safety performance in relation to the EN schemes in place.	2nd								

Date Risk Identified:	Aug-23	**Executive Director Owner:**	Severs, James
Strategic Objective:		**Lead Committee:**	Health and Safety Committee
		Date of Review:	Jun-25
		Date of Next Review:	Jul-25

Risk ID:	**1745**	**Corporate Risk Description:**	There is a risk of not being able to deliver safe, effective and timely services across the HB estate, including acute, community and mental health facilities. This risk also impacts the HB's non clinical estate, educational facilities and managed practices. This is caused by further deterioration of our aging buildings and infrastructure with significant amount of the estate beyond its life expectancy. Multiple points of failure, delays in addressing reported defects and limited capital to address the increasing backlog of estate environmental issues. This could lead to an impact/affect on patient experience, our ability to deliver care in line with expected standards resulting in increased scrutiny and critical reports from auditors, regulators and inspectorates, such as HIW and HSE, and decreased public confidence and perception of our services, facilities and estate environment. Impacts also include increasing revenue costs to supplement the lack of capital funding available required to react to emerging issues, ability to comply with the Health and Safety at Work Act, including other legal regulations and engineering guidance documents such as Welsh Health Technical Memorandums (WHTMS).
Does this risk link to any Directorate (operational) risks?			1795,33,39

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	2×5=10
Expected Date To Achieve TRS:	
Trend:	⟷



Rationale for CURRENT Risk Score:

The current risk score is based upon the level of detailed information the Estates department has for its buildings, plant and infrastructure, including external reports, risk information and Estates and Facilities Performance Management System (EFPMS) data submitted to Welsh Government (WG), clearly articulating the scale of backlog and deficiencies across the Health Board. The programme business case (PBC) has been under development with WG since 2018/19.

NHS Wales Shared Services Partnership (NWSSP) has supported a three-year investment programme for major infrastructure. WG are in support of this plan (with a £5m capital expenditure limit per year).

The Major Infrastructure project is included as a WG Priority Project for Hywel Dda UHB.
Negotiations are ongoing with WG to secure funding for the development of business cases for the implementation of these projects. These negotiations will be aided by a piece of work which seeks to ascertain approximate costs, timescales and deliverability of the priorities across the acute sites.

Minimal funding has been received to date (circa £1.5m) for lift shaft improvements at Bronglais General Hospital (BGH) and electrical infrastructure at Glangwili General Hospital (GGH), with fees for the first year of plan secured.

A report has been developed by the Major Infrastructure Team and NHS Wales Shared Services Partnership (NWSSP) Estates detailing the consequences of infrastructure failure in relation to patient services and its impact on patient care. This report was presented to Strategy & Planning Committee in April 2025.

Rationale for TARGET Risk Score:

The target risk score is directly linked to the amount of funding the Health Board (HB) will receive to address the current issues faced across the organisation and our ability to successfully deliver these improvements to reduce risk.

Backlog figures are being reviewed in order to inform the current risk score, and to determine any future reduction.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Planned and Preventative Maintenance regimes CAFM system to report and prioritise breakdowns across site. Questionnaires have now been included in CAFM, to measure the performance of our maintenance service. Also to feedback any suggestions on improvements. Condition appraisals (estate survey) and NWSSP-SES audits Backlog database identifies costs of works across the estate Operational Estates staff on site to deal with breakdowns (on-call 24/7) EFAB funding to support DCP (£5.5m over 2 years 2023/24 & 2024/25) WG additional funding in 24/25 for priority items. Risks are identified by Estates and services and these inform prioritisation of DCP funding Skilled and trained Estates workforce in place. TEF bid submitted, awaiting approval from Welsh Government as at February 2025. Site walkarounds in place	Limited Discretionary Capital Programme (DCP) funding to address the £250m backlog WG support for the Major Infrastructure Programme has not been confirmed Statutory, mandatory and essential maintenance jobs are prioritised over routine helpdesk jobs (on average only 50% of helpdesk jobs are completed) Reduction in annual capital funding and statutory allocations to address key items. Increased backlog of circa £250m Frequency of site walkarounds inconsistent	Undertake general environmental monthly walkarounds across the 4 acute sites to increase understanding and proactive management of day to day estate defects.	Evans, Paul	Completed	Completed
		Development of Major infrastructure Programme for 4 main hospitals and securing external funding	Elliott, Rob	~~31/03/2024~~ ~~31/12/2024~~ ~~31/03/2025~~ 30/06/2025	Due to the lack of progress with securing capital support (noting this project dates back to 2018) the HB has changed the approach entirely and have worked since Oct last year in a partnership arrangement with NWSSP-SES to jointly develop an estates priority and risk consequence paper written as far as possible with clearly understood language. This document explains in great clarity what the potential implication could be if a specific infrastructure item was to fail. This narrative was jointly supported by estates and NWSSP-SES engineers. This document is completed and issued to WG. It has also been considered on 16/4/25 at formal executive team prior to it being submitted to formal committees of the HB. Next steps are for the HB in partnership with NWSSP to complete a scoping exercise to set out more accurate budget costs, programme information and methods of working given the sensitive systems involved.

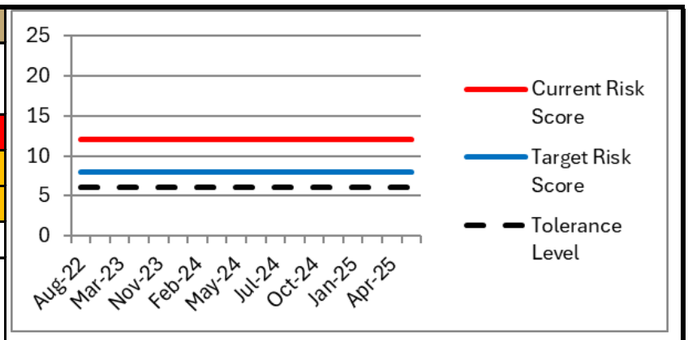
				This exercise is due to complete by end of JUNE 25. Scoping update later following business case discussion. At this point we will be engaging with WG directly to secure the resources to progress these works via the appropriate business process. On a positive note this project is one of the supported priority project by WG for investment in HB estate.
	Undertake general environmental quarterly walkarounds for all community in-patient facilities (including Mental Health facilities) to increase understanding and proactive management of day to day estate defects.	Evans, Paul	Completed	Completed
	AHMWW PBC submitted to WG in February 2022 remains not endorsed. Agreement required with Welsh Government on next steps and broader strategic direction.	Davies, Lee	31/10/2024	Nuffield Trust report on clinical strategy received and presented to Board. Management response to be agreed through SDODC. Meeting with Deputy Chief Executive, NHS Wales and Director of Finance, NHS Wales has been held and there will be an IIB meeting in February (date to be confirmed).
	the re-introduction of regular (documented) site walkabouts by operational estates and general hospital management. To potentially identify and target defects or site issues that can potentially be quickly addressed, minimising the impact of compounding backlog issues across our sites.	Day, Simon	31/03/2025	Need to establish dates, areas of focus and resource plan by the end of March 25 to commence these walkabouts for the new financial year 25-26.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Backlog figures Number of failures Cost increases due to inflation Number of call-outs	Regular review of 'environment' themed risks identified on operational service risk registers	1st								
	Feedback questionnaire on CAFM maintenance system to measure effectiveness of maintenance service and to offer additional feedback or suggestions on all closed maintenance requests	1st								
	Health and Safety Committee review of risks above tolerance	2nd								
	Independent Member & Executive Director Walkabouts	2nd								
	External surveys are undertaken, including Authorised Engineers Audits across each engineering discipline in line with Welsh Health Technical Memorandums (WHTMs)	3rd								
	NWSSP-SES Internal Audit on Estates Condition October 2024 (Limited Assurance)	3rd								
	Receipt of WHTM audit reports from NWSSP	3rd								

Date Risk Identified:	May-22	**Executive Director Owner:**	Gjini, Ardiana	**Date of Review:**	Jun-25
Strategic Objective:	4. The best health and wellbeing for our individuals and families and our communities	**Lead Committee:**	Health and Safety Committee	**Date of Next Review:**	Aug-25

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

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	31/08/2025
Trend:	⟷



Rationale for CURRENT Risk Score:

The national security and risk assessment was reviewed and re-published in November 2022, this remains unaltered. The previous pandemic influenza risk has been changed into 2 new risks, one generic pandemic event and 2 emerging infectious diseases. Current likelihood scored at a 3 to reflect the risk of the Health Board being unable to respond to the scale and severity of the pandemic - not the likelihood of the pandemic actually occurring.

Rationale for TARGET Risk Score:

A Cabinet Review of Influenza Preparedness was due just prior to COVID-19 which delayed publication. This workstream has now recommenced and together with outcomes and learning points from COVID-19 will inform our future planning approach for pandemic response. The Government Respiratory Pandemic Guidance was due late Summer 2024, but final draft for consultation now expected end of September 2025. It is hoped to reduce either the likelihood and/or impact score following consideration and implementation of these reviews/recommendations and subsequent review of internal planning arrangements.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Major Incident Plan (detailing internal command and control structures) # Well established command and control structures for managing pandemic response both nationally and locally # Continuation of current COVID-19 and wider national immunisation programmes # Extensive knowledge across Health Board in managing a pandemic event # COVID-19 response measures which can be adapted to respond to any future pandemic event # Local Resilience Forum (LRF) multi-agency plans for managing pandemic influenza (approved by Strategic LRF 14/11/18 now under review also awaiting the Gov Respiratory Pandemic Guidance) # LRF Excess Deaths Plan (which supports the LRF multi-agency pandemic influenza management arrangements) developed as a recommendation from Exercise Cygnus. Plan was ratified by the LRF Health Group. # Health Board Pandemic Influenza Response Framework and associated plan(currently under review) # Quality assurance process via national & local exercise programmes. # Access to national counter measures stockpile # Regional Health Protection service across HB and key partners # Continuous learning from COVID-19 # Pandemic Planning Group re-established	Lack of ratified Pandemic Response Framework reviewed which broadens remit from Influenza focus to generic pandemic events.	Pandemic Response Framework reviewed which broadens remit from Influenza focus to generic pandemic events.	Hussell, Sam	~~31/01/2024~~ ~~31/05/2024~~ ~~31/08/2024~~ ~~31/10/2024~~ ~~30/05/2025~~ ~~31/12/2024~~ ~~12/02/2025~~ ~~30/05/2025~~ 04/08/2025	Awaiting publication of UK Gov Respiratory Pandemic Planning Guidance prior to progressing to ratification process. On-going delays but final version out for consultation late April 2025.

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

2

10:01 AM, 0 Mins

2 - Health and Safety Updates

2.1

10:01 AM, 10 Mins

2.1 - Staff/Patient Story

For discussion

2.2

10:11 AM, 10 Mins

2.2 - Internal Audit Update Report and Associated Actions

Tim Harrison (Hywel Dda UHB - Head of Health, Safety and Security)

For assurance

Attachments

SBAR H_S Internal Audit Paper - July 25 V1.1.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	03 July 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Internal Audit Update Report and Associated Actions
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	James Severs, Executive Director of Allied Health Professions and Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	Tim Harrison, Head of Health, Safety & Security Adam Springthorpe, Health & Safety Manager

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report is presented to the Health and Safety Committee (HSC) to provide an update on the completion of actions towards compliance with the Health & Safety Final Internal Audit Report 2024/25 (HDD-2425-23).

Cefndir / Background

The Hywel Dda University Health Board (HDdUHB) Health, Safety and Security (HSS) Department were subject to an internal audit undertaken July-November 2024 by Shared Services Partnership Audit and Assurance Services. The purpose of the audit was to review the arrangements for ensuring compliance with Health & Safety Regulations within HDdUHB. The final report was issued on 15 January 2025 with an overall finding of limited assurance.

The matters arising from the report requiring management attention included:

- Lack of oversight of (non-mandatory) H&S training participation rates [Finding 1 – Medium];
- Insufficient monitoring of actions arising from H&S site visits, significant volume of outstanding actions and weakness in the methodology for prioritising actions [Finding 2 – High];
- Non-compliance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reporting timescales [Finding 3 – Medium];
- Poor Executive Director attendance at Health & Safety Committee [Finding 4 – Medium];
- Gaps in assurance reporting to the Health & Safety Committee [Finding 5 – High].

Full details of matters arising were detailed within the Findings and Agreed Action Plan section of the issued report.

Asesiad / Assessment

The HSS Team has kept a detailed action log with attached evidence of progress towards compliance with Findings 1-3. This report summarises the detail from the action log.

Finding 1: Lack of oversight of (non-mandatory) H&S training participation rates

A number of training courses sit within the HSS Team's area of responsibility, some of which are mandatory, . Mandatory courses include Manual Handling Level 1 and 2, along with several courses delivered via e-learning including:

- Health, Safety and Welfare – Level 1;
- Violence and Aggression – Module A;
- Display Screen Equipment.

Non-mandatory courses delivered by the HSS Team include:

- The Manager's Health & Safety Induction course, which provides managers with an understanding of their responsibilities under the Health and Safety at Work Act 1974 and associated statutory instruments (regulations), ACOPs and guidance, and their practical application in the workplace;
- Reducing Restrictive Practice Team training in the management of violence and aggression and the management of patients with challenging behaviours;
- Qualitative Face-Fit Train-the-Tester (For Respiratory Protective Equipment (RPE));
- Bespoke Control of Substances Hazardous to Health (COSHH) Awareness sessions.

Manager's Health & Safety Induction (MH&SI)

The HSS Department has been working with Learning and Development (L&D) and Electronic Staff Record (ESR) to establish relevant staff groups in order to be able to quantify compliance for the MH&SI course. From studying available datasets, a number of staff groups/roles have been selected that best suit the course definition, with a total of 789 staff included. It is acknowledged that there are various staff groups/roles not included in the 789 where the course would be relevant for certain staff and not others, such as management roles under Administration & Clerical and Staff Nurses. However, the course will always remain available for those that fall outside of the defined staff groups/roles.

A Request to Mandate proposal was submitted to L&D for the MH&SI at the end of March 2025. Additional information to accompany the request has been supplied as required. The proposal is now scheduled to be heard at the Mandatory Training Group on 17 June 2025.

As of 10 June 2025, 681 managers or aspiring managers within HDdUHB have successfully completed the course.

Reducing Restrictive Practice Team Training

The Reducing Restrictive Practice (RRP) Team has now undertaken a very detailed Training Needs Analysis (TNA) which identifies specific numbers of staff that require RRP training. The Team is now able to confidently track training figures and calculate compliance rates. Current training stats can be found on the separate HSC agenda item 2.5 'Compliance with Health and Safety, Fire, and Security Training'.

Qualitative Face-Fit Train-the-Tester

Qualitative Face-Fit Train-the-Tester training (for safe and correct use of RPE) training figures are compiled centrally by HSS Team. These cannot be set mandatory as fit testers are designated at local level to suit the need of the Ward/Department as required. HSS are working with ESR to ensure that this training is captured on ESR in future.

Bespoke Hazardous Substances & COSHH Awareness Sessions

The HSS Team has worked with Estates Compliance to develop a Hazardous Substances & COSHH Awareness training session in early 2025. This was delivered by HSS initially, then completed by an Estates Compliance Officer to extend to cover all Estates Maintenance Staff that use chemicals in their day-to-day work. Training figures and compliance rates are now

available and can be found on the separate HSC agenda item 2.5 'Compliance with Health and Safety, Fire, and Security Training'.

Finding 2: Insufficient monitoring of actions arising from H&S site visits, significant volume of outstanding actions and weakness in the methodology for prioritising actions

The HSS Team has an ongoing formal health and safety site visit programme which involves a visual inspection of premises and environment, culminating in a report to the responsible manager, detailing any remedial actions. Actions reference the relevant policy/regulatory requirements and can relate to opportunities for improvement, and minor or major non-compliance with policies and regulations.

At the time of the internal audit, 75% of actions were classed as 'unresolved'. A follow-up visit is undertaken in some circumstances, but reliance is placed on the site manager/lead to provide updates on implementation.

Since the Internal Audit Report, the HSS Team has focused on 2 workstreams to address the issues raised:

1. Undertaking a risk stratification exercise in order to quantify / visualise the risk of the outstanding 'unresolved' risks from the H&S site visits undertaken in 2023 and 2024.
2. A new improved system for all H&S site visits going forwards.

Risk Stratification

The HSS Team has now reviewed all 'unresolved' and 'identified but not resolved' actions and assessed whether the outstanding risk posed by the action is very negligible, minor, moderate, major or catastrophic. These have now been colour coded using the recognised green to red risk-rating convention. Having completed the risk stratification exercise, the outstanding risk to HDdUHB posed by all of the outstanding actions is as follows:

N/A	Resolved	Managed	Negligible	Minor	Moderate	Major	Catastrophic
3	41	551	51	626	375	82	0

Once the methodology has been agreed by the Estates and Facilities Integrated Governance Group Quality Health and Safety meeting, the list, which is now split by Clinical Care Group, will be taken to all of the Clinical Care Group Quality, Health and Safety meetings attended by the HSS Team.

The Clinical Care Groups will be requested to task managers to review their outstanding actions, focusing on those that present a higher risk (moderate and major risks). Once reviewed, updates will be required to be relayed back to the HSS Team within 1 month of the meeting to update the master database, stating whether actions have been resolved, managed or that the risk has been reduced. The full version of the risk stratification exercise can be found in Appendix 1.

New H&S Site Visit System

As indicated by the figures above, the previous site visit system resulted in an unacceptable number of actions that, to the knowledge of the HSS Team, had not been resolved. One of the main challenges is that feedback is rarely received from departments following the submission of the site visit report, and the H&S Advisor that undertakes the visits does not have time or resource to re-visit every site.

For this reason, the HSS Team temporarily paused their site visit programme to concentrate on exploring the feasibility of utilising the Audit Management and Tracking System (AMaT) that is used elsewhere in HDdUHB. In theory, using AMaT will allow for:

- Ownership of recommended actions e.g. Department manager, Senior Sister etc;
- Regular updates on the completion of on-going actions;
- Updated reports to be generated if required e.g. meetings;
- Site visit evidence if required e.g. Third party audit;
- Site visit report to be stored in an accessible location;
- A reduction in report writing time.

The findings from two trial site visit reports have been added to the AMaT system in order that the HSS Team can explore how that the system works as intended. Whilst adding the reports to the system is a time consuming process, this may improve with familiarity with the system.

There is an intention to adopt the risk ratings / colour codes from the risk stratification exercise for future H&S site visits. However, the 'Inspection' module within AMaT which the HSS Team has been granted access to does not support this functionality. Therefore, at the time of writing this report, the HSS Team are still exploring the best way to utilise the system to meet our needs. The HSS Team is hopeful that a resolution to the challenges will be resolved soon.

The first report has been created using the risk ratings / colour coding and has been well received, therefore it is likely that this will be the methodology used by the team going forwards. What remains is how best to report this via AMaT, or whether AMaT is even the way forwards to meet the Health Board's needs.

Finding 3: Non-compliance with RIDDOR reporting timescales

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) requires the reporting of incidents within mandatory timeframes of 10 or 15 days of the incident (depending on the nature of the incident). At the time of the internal audit, the report found that only 53% of incidents had been submitted within the required timeframe between April – December 2024.

Following the audit the HSS Team raised RIDDOR mandatory timeframes for discussion at all Q&S/Governance groups and other meetings attended, particularly promoting the team's RIDDOR Decision Making Flowchart. A selection of minutes from these meetings have been gathered as evidence. This positive work was evidenced by the (financial) year-end compliance figure of **59.62%.**

Statutory RIDDOR reporting timeframes were then included on the HSS Team's 7 Minute Briefing for Q1 2025/26 (April), a copy of which has been added to the action log. The HSS Team has also been highlighting RIDDOR timescales to managers when compiling submissions, emphasising the need for a timely response to information requests. E-mail evidence of this has also been added to the action log.

The RIDDOR section of the Manager's Health & Safety Induction has been revised and updated to specifically include timeframes in the written text of the slides, rather than just being included verbally.

At the time of writing, the compliance figure for the 2025/26 financial year currently stands at **66.67%.**

Argymhelliad / Recommendation

The Health & Safety Committee is asked to:

TAKE ASSURANCE that the Health, Safety and Security Team is making sufficient progress towards compliance with Health & Safety Final Internal Audit Report 2024/25 (HDD-2425-23).

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1 Provide assurance around the UHB arrangements for ensuring the health, safety, welfare and security of all employees and of those who may be affected by work-related activities, such as patients, members of the public, volunteers contractors etc.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	1 Workforce Stabilisation 9 Digital plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Contained within the body of the report and associated Health Board policies.
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd lechyd a Diogelwch: Parties / Committees consulted prior to Health and Safety Committee:	Health and Safety Sub-Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct costs.
Ansawdd / Gofal Claf: Quality / Patient Care:	There is a positive impact on staff and patient safety, health and wellbeing through compliance with health and safety regulations.
Gweithlu: Workforce:	Potential for adverse future staffing impacts if health and safety legislation is not complied with as they relate to employee safety.
Risg: Risk:	Risk to health and safety management.
Cyfreithiol: Legal:	A breach of health and safety regulations, such as the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, could result in the issue of prohibition or improvement notices or criminal proceedings.
Enw Da: Reputational:	Prosecutions and claims due to breaches in legislation or personal injury claims can lead to negative publicity.
Gyfrinachedd: Privacy:	Not Applicable.
Cydraddoldeb: Equality:	No evidence gathered to indicate a negative impact on any protected group/s.

Appendix 1 – Full Risk Stratification Findings, Split by Care Group

Key: Negligible, Minor, Moderate, Major, Catastrophic

	Site Name	Department	Action 1	Action 2	Action 3	Action 4	Action 5	Action 6	Action 7	Action 8	Action 9	Action 10	Action 11	Action 12	Action 13	Action 14	Action 15	Action 16	Action 17	Action 18	Action 19	Action 20	Action 21	Action 22	Action 23	Action 24	Action 25	Action 26	Action 27
	Primary Care Clinical Care Group (to include Medicines Management)																												
1	Ashgrove Medical Centre	Full Site																											
2	Brynteg (Branch Surgery)	Full Site					M					M		M	M	M													
3	Johnston Surgery (Branch	Full Site	M		M		M	M							M			M											
4	Meddygfa Minafon -	Full Site																											
5	Meddygfa'r Sarn - Pontyates	Full Site																											
6	Solva Surgery	Full Site	M							M		M			M	M				M	R	M							
7	Tenby Surgery	Full Site			M		M			M		M		M						M		M							
	Planned and Specialist Care Clinical Care Group (covering Scheduled Care, Cancer & Oncology, and Children, Women & Family Health Clinical Service Groups)																												
1	BGH	Endoscopy	M			M																							
2	BGH	Theatres			M	M			M	M																			
3	GGH	Labour Ward / Delivery Room	M		M		M	M			M																		
4	GGH	Picton Ward	M							M	M	M																	
	Allied Health and Health Sciences Clinical Care Group																												
1	BGH	Pathology	M	M	R	M	R		M			M	M		M	M													
2	GGH	Mortuary			M			M	M			M	M	M	M		M												
3	WGH	Physiotherapy	M		M	M						M	M	M															
	Estates and Facilities Group																												
1	Amman Valley Hospital	Medical Gas Stores								M	M	M	M																
2	Llandovery Cottage Hospital	Medical Gas Stores				M		M	M	M																			
3	Tregaron Hospital	Medical Gas Stores						M		M																			
4	South Pembrokeshire	External Areas				M			M		M	M	M	M															
5	BGH	External Areas		M		M									M														
6	BGH	Medical Gas Stores					M		M	M	M	M																	
7	GGH	Boiler Room	M		M	M	M				M	M	M			M													
8	GGH	External Areas	M					M		M		M	R		M														
9	GGH	Gwili Railway Carpark	M	M	M	M	M	M	M	M	M																		
10	GGH	Medical Gas Stores		M					M				M	M	M														
11	PPH	Block 5 (H&S Office)	N/A		M	M		M		M		M		M															
12	PPH	External Areas			M					M									M		M	M							
13	PPH	Hotel Services - Housekeeping, Laundry and																											
14	PPH	Hotel Services, Estates & Facilities office																											
15	PPH	Medical Gases Stores		M						M	M	M	M	M	M			M		M									
16	WGH	Medical Gas Stores					M		M	M	M																		
17	WGH	Waste Compound Area	M	M									M																
	Mental Health and Learning Disabilities Clinical Care Group																												
1	22 Wellfield Road (MHLD)	Full Site	M			M	M		M										M	M		M							
2	Brynmair Clinic (MHLD)	Full Site	M		M		M		M			M				M			M										
3	Canolfan Bro Cerwyn St Nons	Bro Cerwyn centre	R	R		M			M			M				M	M	M				M							
4	Canolfan Bro Cerwyn St Nons	St Brynach Day Hospital					M	M	M	M				M	M	M	M	M											
5	Canolfan Bro Cerwyn St Nons	St Caradog Ward	M				M								M				M	R		M							
6	Canolfan Bro Cerwyn St Nons	St Non's Ward		R	R		R		R	R	R								R	R		R							
7	Gorwelion (MHLD)	Full Site		M	R	R	R			R	M			M	M	M	M			M									
8	Hafan Derwen	Cwm Seren - Low Secure Unit									M		M		M	M	M												
9	Hafan Derwen	Cwm Seren - PICU			M		M																						
10	Hafan Derwen	Block 5 (St Brides)			M	M																							
11	Hafan Derwen	Block 6 (Ty Bryn)	M			M		M																					
12	Hafan Hedd (MHLD)	Full Site						M	M	M	M	M						M											
13	Havenway Resource Centre	Full Site					M			M		M	M	M		M	M		M										
14	Llanion House North Building	Full Site																											
15	Swn-y-Gwynt Day Hospital	Full Site						M	R	M	M	M					M	M		M									
16	Ty Myddfai - Psychotherapy	Full Site								M	M	M			M	R	M	M	M		M								
17	BGH	Community Mental Health Team (CMHT) Enlli	M	M							M			M	M														
18	BGH	Enlli Ward								M				M															
19	PPH	Bryngofal Ward																											
20	PPH	Bryngolau Ward									M																		
21	PPH	Crisis Resolution Home Treatment Team -	M	M	M		M		M	M	M																		
22	GGH	Heddfan	M				M		M	M																			
23	GGH	Morlais Ward				M	M		M		M						M	M											
	Community and Integrated Medicine Clinical Care Group (covering Carmarthenshire Integrated System, Pembrokeshire Integrated System and Ceredigion Integrated System and TUEC)																												
	Bronglais																												
1	BGH	Cardiac Rehab Office										M																	
2	BGH	Clinical Decisions Unit			M				M	M	M			M	M	M													

3	BGH	EUCC			M				M	M	M			M	M	M														
4	BGH	MIU	M	M	M			M	M	M		M																		
5	BGH	Podiatry & Surgical Appliances		M	M							M																		
6	BGH	Rhiannon Ward	M		M	M		M																						
7	BGH	Ty Helyg	M	M		M																								
8	BGH	Y Banwy Ward	M	M		M	M	M	M	M			M																	
9	BGH	Ystwyth Ward		M	M	M		M	M			M																		
	Glangwili																													
1	GGH	A&E		M		M			M		M				M															
2	GGH	Canolfan Gwili			M				M				M		M															
3	GGH	Cardiac Rehabiitation	M	M		M	M																							
4	GGH	Cleddau Ward / SAU		M	M					M			M																	
5	GGH	Clinical Decisions Unit		R		R	M	M	M			M		M		R	R		R	R										
6	GGH	EEG		M				M	M				R	M	M		M													
7	GGH	Outpatients									R	M	M	M																
8	GGH	Ty Cymorth Hospice	M		M												M													
9	GGH	Ty Llewellyn	M	M					M						M	M			M		M									
10	GGH	Y Delyn			M		M	M	M				M																	
	Prince Philip																													
1	PPH	Acute Medical Assessment unit			M	M				M																				
2	PPH	Block 6	N/A					M																						
3	PPH	Breast Care (Ward 7)																												
4	PPH	Cardiac Rehabiitation	M		M			M																						
5	PPH	Discharge Lounge				M	M		M						M															
6	PPH	Ty Bryngwyn				M				M	M		M			M				M		M				M				
7	PPH	Ward 1	M									M																		
8	PPH	Ward 5						M		M	M	M	M																	
9	PPH	Ward 7	M		M		M	M	M																					
10	PPH	Ward 9		M		M	M			M			M																	
	Withybush																													
1	WGH	Acute Frailty	M	M					M	M																				
2	WGH	Ward 1		M					M	M																				
3	WGH	Ward 10	M	M	M	M																								
4	WGH	Ward 12					M							M																
5	WGH	Ward 8					M	M			M	M																		
	Carmarthenshire Community																													
1	Abergwili Pavilion	HB Managed Areas		M	M	M																								
2	Amman Valley Hospital	Full Site								M				M	M				M	M	M									
3	Blk 24 Stradey Business	HB Managed Areas	M			M		M			M		M	M																
4	Cartref Cynnes Day Centre	HB Managed Areas			M	M	M	M	M	M																				
5	Cwmamman Day Centre	HB Managed Areas			R	M		R	M	M																				
6	Eastgate (part of)	HB Managed Areas	M	M	M				M			M				M	M		M	M										
7	Elizabeth Williams Clinic	Full Site			M	M			M				M	M						M	M									
8	Hafan Derwen	Block 1 & 3			M			M		M				M	M															
9	Hafan Derwen	Block 4				M																								
10	Hafan Derwen	Block 7 (Tudor, Ystwyth, Alun)					M			M																				
11	Llandovery Cottage Hospital	Full Site							R																					
	Ceredigion Community																													
1	Aberaeron Integrated Care Ce	Full Site				M	M	R			M	M				M	M	M		M	M									
2	North Road Clinic	Full Site		M		M			M					M		M														
3	Tregaron Hospital	Full Site												M		M														
	Pembrokeshire Community																													
1	Bro Preseli Community	Full Site		R	M	M	M	R			M	M																		
2	Fishguard Health Centre	Full Site		M	M		M			M			M	R		R			M	M										
3	Haverfordwest Health Centre	Full Site	M			M			M					M				M												
4	Milford Haven Health Centre	Full Site						M	M				N/A																	
5	Narberth Health Centre	Full Site	M	R					M			M																		
6	New Tenby Hospital	Full Site																												
7	Pembroke Dock Health	Full Site	M					M	M					M	M		M													
8	South Pembrokeshire	Archives, Basement & Main Corridors	M	M							M			M	M			M	M											
9	South Pembrokeshire	Cleddau Ward		M								M			M															
10	South Pembrokeshire	Sunderland Ward	M				M			M			M	M			M													
11	South Pembrokeshire	Full Site					M				M								M											
	Other																													
1	BGH	Clinical Coding Department	M	M			M	R	M																					
2	Unit 2 Stradey Business	Full Site	M	M	M			M	M	M			M	M		M	M	M			M									
3	Unit 3 Dafen Ind. Est.	Full Site		M	M	M	M	M	M		M	M		M			M	M												
4	Unit 4 Stradey Business	Full Site			M	M							M		M			M	M											
5	BGH	Medical records	M		M																									
6	GGH	Library		M			M	M																						
7	GGH	Medical Records (health records)	M			M				M																				
8	PPH	Medical Records (Health Records)				M		M																						
9	WGH	Health Records (Medical Records)		M		M	M																							
10	WGH	Health Records (Filing Library)	M								M																			

2.3

10:21 AM, 10 Mins

2.3 - Monitoring of H&S Annual Work Plan

Tim Harrison (Hywel Dda UHB - Head of Health, Safety and Security)

For assurance

Attachments

SBAR H_S Workplan Update Paper - July 25 V1.1.pdf

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

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	03 July 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	H&S Annual Work Plan 2025/26 Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	James Severs, Executive Director of Allied Health Professions and Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	Tim Harrison, Head of Health, Safety & Security Adam Springthorpe, Health & Safety Manager

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report is presented to the Health and Safety Committee (HSC) to provide an update on the Health, Safety and Security annual workplan for 2025/26.

Cefndir / Background

The full detailed workplan was presented to the Health and Safety Sub-Committee (HSSC) in April 2025, with a summary presented to the HSC in May 2025. This report provides a general update on progress so far in 2025/26 towards the themes on the workplan by the Health, Safety and Security (HSS) Team, with the assistance of other key stakeholders where necessary.

Asesiad / Assessment

Internal Audit

A significant part of the HSS Team's resource has been focused on measures to comply with the Health and Safety Internal Audit Report (HDD-2425-23), with workstreams including:

- Training compliance;
- Health and safety site visit risk stratification and process development;
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) mandatory reporting timescale compliance.

Policy/Procedure Updates and Reviews

The following policies have been reviewed:

- Fit Testing for Respiratory Protective Equipment Procedure – Approved by HSSC – New expiry date 03/05/2028.
- Display Screen Assessment Procedure – Approved by HSSC – New expiry date 03/05/2028.
- First Aid at Work Procedure – Minor amendments were required following HSSC, these have been actioned and the Procedure awaits Chair's action for approval.

Management of Noise at Work

The new draft 1383 - Control of Noise at Work Policy, created by the Health & Safety Manager, has been reviewed by key stakeholders including Estates Operations Compliance, Estates Maintenance and Occupational Health. The draft Policy will be out for global consultation for the period 12/06/2025-26/06/2025.

Control of Substances Hazardous to Health (COSHH)
A report on the initial phase of environmental monitoring of nitrous oxide (Entonox) exposure in the Midwifery Led Unit (MLU) of Glangwili Hospital (GGH) has been issued to the Midwifery Department. The initial phase of monitoring was a suite of measurements across Midwifery to assess the risk prior to more detailed measurements. The findings have also been shared with Estates Maintenance and Occupational Health.

Workplan Tracking
The table below summarises some of the actions due for completion by the next two HSCs from the overarching detailed Health, Safety and Security annual workplan for 2025/26:

	Sep-25	Nov-25
Internal Audit Actions		
Risk Stratification - Update following CCG responses to review of all outstanding moderate and major risks	✓	
Final SOP for new site visit system	✓	
Update on oversight of Manager's Health & Safety Induction (MH&SI) compliance following review of proposal by the Mandatory Training Group	✓	
General Health, Safety and Security		
Manual handing training diary for 2026	✓	
MH&SI dates set for 2026	✓	
Approved Noise Policy	✓	
Noise risk assessments for areas where high levels of noise are expected/suspected.		✓
Final Dangerous Substances and Explosive Atmospheres Regulations (DSEAR) assessment for GGH Boiler house		✓
Periodic updates on the new Health & Safety Site Visit Programme (3 times a year)		✓
Approved reviewed Reducing Restrictive Practice Policy		✓
Confirmation of deferral of Assessment and Management of Environmental Ligature Risks Procedure		✓

Argymhelliad / Recommendation

The Health & Safety Committee is asked to:

TAKE ASSURANCE on the update of the Health, Safety and Security Annual Work Plan 2025/26 and that progress will continue to be monitored by the Health and Safety Sub-Committee during 2025/26.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1 Provide assurance around the UHB arrangements for ensuring the health, safety, welfare and security of all employees and of those who may be affected by work-related activities, such as patients, members of the public, volunteers contractors etc.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	1 Workforce Stabilisation 9 Digital plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

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

Effaith: (rhaid cwblhau) **Impact: (must be completed)**

Ariannol / Gwerth am Arian: **Financial / Service:**	No direct costs.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	There is a positive impact on staff and patient safety, health and wellbeing through compliance with health and safety regulations.
Gweithlu: **Workforce:**	Potential for adverse future staffing impacts if health and safety legislation is not complied with as they relate to employee safety.
Risg: **Risk:**	Risk to health and safety management.
Cyfreithiol: **Legal:**	A breach of health and safety regulations, such as the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, could result in the issue of prohibition or improvement notices or criminal proceedings.
Enw Da: **Reputational:**	Prosecutions and claims due to breaches in legislation or personal injury claims can lead to negative publicity.
Gyfrinachedd: **Privacy:**	Not Applicable.
Cydraddoldeb: **Equality:**	No evidence gathered to indicate a negative impact on any protected group/s.

2.4

10:31 AM, 10 Mins

2.4 - Compliance with Health and Safety, Fire, and Security Training

Tim Harrison (Hywel Dda UHB - Head of Health, Safety and Security)

For assurance

Attachments

SBAR HS Training Paper - July 25 V1.2.pdf

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

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	03 July 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Compliance with Health and Safety, Fire, and Security Training
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	James Severs, Executive Director of Allied Health Professions and Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	Tim Harrison, Head of Health, Safety & Security Adam Springthorpe, Health & Safety Manager

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report is presented to the Health and Safety Committee (HSC) to provide an update on compliance with Health and Safety, Fire, and Security training within Hywel Dda University Health Board (HDdUHB).

Cefndir / Background

Health and Safety training is delivered within HDdUHB via both E-learning and face-to-face methods. Mandatory health and safety-related training modules delivered via E-learning include:

- Fire Safety – Level 1;
- Health, Safety and Welfare – Level 1;
- Violence and Aggression – Modules A and B;
- Display Screen Equipment;
- Manual Handling – Level 1 (Note: Also delivered face-to-face for inanimate load handlers).

Health and safety-related courses delivered face-to-face include:

- Fire Safety – Level 2 (Note: Level 2 has recently also been made available as an E-learning module to help increase compliance, however the face-to-face option will also remain in place);
- Fire Safety for the Fire Response Team – Level 3;
- Fire Safety for Senior Managers – Level 5;
- Manual Handling for Patient Handlers – Level 2;
- Reducing Restrictive Practice Team training in the management of violence and aggression and the management of patients with challenging behaviours;
- Manager's Health and Safety Induction course;
- Qualitative Face-Fit Train-the-Tester (for Respiratory Protective Equipment (RPE));
- Statutory training for Estates Maintenance Staff and tool-box talks;
- Bespoke Control of Substances Hazardous to Health (COSHH) Awareness sessions.

Asesiad / Assessment

E-Learning Mandatory Courses

Compliance figures for the Health and Safety E-learning training modules (excluding Fire training) on 11 June 2025 were:

	Required	Achieved	Compliance
Health, Safety and Welfare – Level 1	12309	10948	88.94%
Violence and Aggression – Module A	12309	11588	94.14%
Violence and Aggression – Module B	12309	11679	94.88%
Manual Handling – Level 1*	12309	9689	78.71%
Display Screen Equipment	2499	2402	96.12%

* Note: The Manual Handling Level 1 competency can be gained in different ways dependent on role. For many this is via E-learning. However, Level 1 is face-to-face for inanimate load handlers. For patient handlers, a Level 1 competency is automatically received completion of Level 2 training. The poor compliance with face-to-face Level 2 training is therefore the likely cause of the current 78.71% compliance with Level 1.

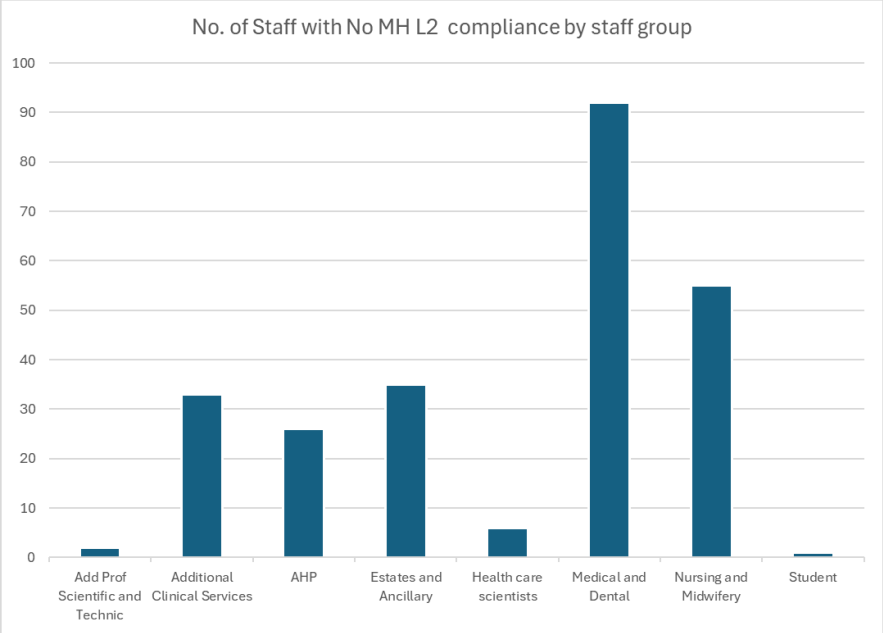
Manual Handling for Patient Handlers – Level 2

The Manual Handling (MH) Annual Report was presented to the Health and Safety Sub-Committee (HSSC) in May 2025 which included detailed training information, a summary of which is included here.

In terms of the MH Level 2 competency (patient handling), there are a number of different ways to obtain the competency, dependent on role. The overall Level 2 compliance rate on 11 June 2025 was 57.63%.

Competence Name	Assignment	Required	Achieved	Compliance %
NHS | CSTF | Moving and Handling - Level 1 - 2 Years	12309	12309	9689	78.71%
NHS | CSTF | Moving and Handling - Level 2 - 2 Years	7552	7552	4352	57.63%

Of particular concern is that there were 250 staff in HDdUHB (on 19 May 2025) that had failed to achieve any Level 2 competency. These are patient-handling staff currently working in HDdUHB that have never attended MH training, rather than having been trained but currently out of date. Not only is this impacting on the overall compliance, but it is also a risk to the organisation.



The Manual Handling Team has made dedicated efforts to improve staff attendance at training sessions, for example organising additional sessions tailored specifically for Porters, and extra Emergency Handler sessions to accommodate doctors.

Although it is acknowledged that the MH Team do not have sufficient resources to attain full MH training compliance for the Health Board along with the other elements of their service provision, the uptake of training places offered continues to be a challenge.

Face-to-Face Course	Places Offered	Places Filled	Uptake of Places
Moving and Handling - Level 1 (Load Handling)	493	232	47.06%
Moving and Handling - Level 2 (Patient Handling)	2917	1554	53.27%

Over the 12 months of 2024 the MH Team provided 2917 face-to-face training spaces for Level 2 training. Only 1554 places were filled on those courses, resulting in an uptake rate of 53.27%. (Note: During this time there was no MH training room in Ceredigion which impacted delivery in that locality). Over the same period, 493 Level 1 places were offered with only 232 filled, resulting in an uptake rate of 47.06%.

The pattern continued into 2025. The MH Team provided a total of 1090 face-to-face training spaces for Level 2 training January-March 2025, of which 505 places were filled, resulting in an uptake rate for the first three months of just 46.3%.

Some training slots go unfilled entiriely, while others are marked by no-show, where a delegate books a place but fails to attend.. The HSS Department understands that staffing shortages and the related inability to release staff from their work areas to attend training are the primary reasons for the relatively low uptake of these courses.

In addition, the H&S Team had a number of staff on long-term sickness in 2024 (continued into 2025) which has resulted in various courses being cancelled. In some instances, certain update courses have been cancelled to ensure that the team delivers sufficient Foundation Training for new members of staff joining the organisation. This impact on update courses explains part of the low compliance rates outlined above.

On a positive note, while the MH Team previously experienced challenges in enrolling new starters in Foundation MH Training in a timely manner, the majority of new starters are now offered a place on a course within 4-6 weeks.

Fire Training

Compliance figures for fire safety training Levels 1-3 are shown below, both for the Health Board as a whole, and by locality:

HDdUHB

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 2 Years|	12302	12302	10942	88.94%
100|LOCAL|Fire Safety Level 2 - 1 Year|General	5946	5946	4171	70.15%
100|LOCAL|Fire Safety Level 3 - 1 Year|General	135	135	119	88.15%

Employee Location - GGH

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 2 Years|	3413	3413	2944	86.26%
100|LOCAL|Fire Safety Level 2 - 1 Year|General	1620	1620	1056	65.19%
100|LOCAL|Fire Safety Level 3 - 1 Year|General	34	34	30	88.24%

Employee Location - PPH

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 2 Years|	1971	1971	1796	91.12%
100|LOCAL|Fire Safety Level 2 - 1 Year|General	923	923	650	70.42%
100|LOCAL|Fire Safety Level 3 - 1 Year|General	29	29	25	86.21%

Employee Location - BGH

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 2 Years|	1351	1351	1167	86.38%
100|LOCAL|Fire Safety Level 2 - 1 Year|General	631	631	402	63.71%
100|LOCAL|Fire Safety Level 3 - 1 Year|General	32	32	32	100.00%

Employee Location - WGH

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 2 Years|	2282	2282	2013	88.21%
100|LOCAL|Fire Safety Level 2 - 1 Year|General	1033	1033	806	78.03%
100|LOCAL|Fire Safety Level 3 - 1 Year|General	38	38	30	78.95%

The Fire Safety Team has recently added extra Level 2 face-to-face courses to help improve compliance. Also, an e-learning version of Level 2 has just been introduced to give staff an alternative means of gaining the competency to the usual weekly session held by the Fire Team. It is hoped that the introduction of this training format will help the Health Board achieve the 85% standard that Mid and West Wales Fire and Rescue Service (MAWWFRS) have stipulated to remove their sanctions against the Health Board.

Fire Safety for Senior Managers – Level 5

Level 5 Fire Safety for Senior Managers is currently mandatory for all staff banded at 8B or above. The module is currently delivered as part of the Manager's Health and Safety Induction course. As of 11 June 2025, 242 out of 257 staff 8B+ had completed the course (94.2%).

Reducing Restrictive Practice Team Training

The Reducing Restrictive Practice Team are now able to provide training compliance rates for their training for both the Portering teams and for Mental Health and Learning Disabilities (MH&LD) staff. Current compliance rates are shown in the adjacent tables. A recovery plan is in development for the Bronglais Portering Team.

Porters	% Trained
PPH	87%
GGH	80%
WGH	19%
BGH	0%

MH/LD	% Trained
Morlais	61%
St Caradog	59%
Bryngofal	66%
LSU	86%
PICU	88%
Bryngolau	74%
St Non	80%
Enlli	80%

Manager's Health & Safety Induction course

Since the Manager's Health and Safety Induction course launched in October 2020, 681 staff managers or aspiring managers have successfully completed the full 4 x 0.5-day course, including 11 so far in 2025. As part of the work towards the Health and Safety Internal Audit report, the Health and Safety Manager is working closely with Learning and Development and Electronic Staff Record (ESR) to establish compliance rates for the Manager's Health and Safety Induction course in order to be able to evidence assurance.

Qualitative Face-Fit Train-the-Tester (for Respiratory Protective Equipment (RPE))

The total number of fit-tester trained (new and/or refresher) by the HSS Department since November 2024 is shown in the table below. Note: A new system for logging trained staff was introduced in November 2024. As training is now valid for 2 years in line with the recently approved revised Procedure, there are more trained fit testers than those shown below.

Site	PPH	GGH	WGH	BGH
Total Staff Trained	12	28	13	9
Total No. Wards / Depts Represented	9	14	10	8

Compliance rates cannot be generated as fit testers are designated at local level to suit the need of the Ward / Department as required. The HSS Team work closely with key Wards / Departments and the Infection Prevention Team to ensure that fit testing provision is sufficient.

Statutory training for Estates Maintenance Staff and tool-box talks

The Estates Department has developed two detailed training matrices which have been shared with the HSS Team,e.g. :

1. Statutory Training. key safety training including confined spaces, work at height, AP/CP/RP qualifications for Welsh Health Technical Memorandum (WHTM) (and associated appointments) and many more. The system includes all certificates and training records.
2. Toolbox talk programme. Monthly in-house sessions for Maintenance personnel delivered by the Operations Compliance Team which have so far included:
   - Confined Space Desk Top Exercise and Safety Equipment;
   - Asbestos Awareness;
   - Risk Assessment Fundamentals;
   - Computer Aided Facility Management (CAFM) User Training;
   - Hand Arm Vibration Syndrome (HAVS) Awareness (written by HSS Team);
   - Safety Culture (written by HSS Team);
   - WHTM Awareness.

Bespoke Control of Substances Hazardous to Health (COSHH) Awareness Sessions

The HSS Team worked with Estates Compliance to develop a bespoke COSHH Awareness training session in early 2025. This was delivered by HSS initially, then completed by an Estates Compliance Officer to extend to include all Estates Maintenance Staff that use chemicals in their day-to-day work. Training figures and compliance rates are shown below:

	Total No. of Staff	No. of Sessions	No. who Attended	% Trained
WGH	30	2	27	90%
BGH	28	3	17	61%
GGH	43	4	28	65%
PPH	27	3	20	74%

The Clinical Care Groups will need to take ownership of the issues raised and ensure that staff can be released to attend H&S training.

Argymhelliad / Recommendation

The Health & Safety Committee is asked to:

TAKE ASSURANCE that the Health, Safety and Security Department is committed to delivering high quality Health and Safety training to all staff that require it.

ACKNOWLEDGE that there are ongoing challenges affecting training delivery which the teams are actively working to resolve.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1 Provide assurance around the UHB arrangements for ensuring the health, safety, welfare and security of all employees and of those who may be affected by work-related activities, such as patients, members of the public, volunteers contractors etc.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	1 Workforce Stabilisation 9 Digital plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	There are costs associated with training when sought from external suppliers.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	There is a positive impact on staff and patient safety, health and wellbeing through compliance with health and safety regulations.
Gweithlu: **Workforce:**	Potential for adverse future staffing impacts if health and safety legislation is not complied with as they relate to employee safety.
Risg: **Risk:**	Risk to health and safety management.
Cyfreithiol: **Legal:**	A breach of health and safety regulations, such as the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, could result in the issue of prohibition or improvement notices or criminal proceedings.
Enw Da: **Reputational:**	Prosecutions and claims due to breaches in legislation or personal injury claims can lead to negative publicity.
Gyfrinachedd: **Privacy:**	Not Applicable.
Cydraddoldeb: **Equality:**	No evidence gathered to indicate a negative impact on any protected group/s.

3

10:41 AM, 0 Mins

3 - Emergency Planning

3.1

10:41 AM, 10 Mins

3.1 - Major Incident Annual Plan: 2025/26

Sam Hussell (Head of Health Emergency Planning)

For assurance

Attachments

Major Incident Plan July 2025.pdf

Appendix 1 HDUHB MIP 2025-26.pdf

Appendix 2 Ex Tendley Exercise Report.pdf

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

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	03 July 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Major Incident Plan
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr Ardiana Gjini, Executive Director of Public Health
SWYDDOG ADRODD: **REPORTING OFFICER:**	Sam Hussell, Head of Emergency Preparedness, Resilience & Response (EPRR)

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Major Incident Plan (Appendix 1) has been revised and updated to reflect current structures, command and control mechanisms and response processes.

To provide assurance regarding compliance with the testing criteria of the Welsh Government NHS Emergency Planning Core Guidance (2015) by detailing Exercise Tendley, (Appendix 2) a live multi-agency major incident exercise.

Cefndir / Background

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

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

A comprehensive review process has been undertaken via the Emergency Preparedness, Resilience & Response (EPRR) Group which has involved multi-disciplinary and partner agency participation. Consultation of the revised plan has been undertaken with partner agencies and with Welsh Government and NHS Wales Performance & Improvement prior to presentation for approval.

Major Incident Plan response action cards are also updated on an on-going basis to reflect current organisational structures and are published on the intranet and amended as necessary.

Asesiad / Assessment

The main areas of change within this years' review of the Major Incident Plan are:

- Change to notification and activation process for major incidents – moving to use of a single switchboard, and immediate assessment of the incident, prior to wider site(s) activation, in order to reduce duplication and increase situational awareness across sites.
- Change to executive response roles – moving to 24/7 use of Gold on-call.
- Update to site arrangements.
- Update to scene response processes
- Inclusion of lessons identified within Exercise Tendley (live major incident exercise held in February 2025) and the Powys train crash (October 2024) debrief.

Exercise Tendley: multi-agency live major incident exercise conducted from 04-07 February 2025, which tested the Health Boards' response to a simulated major incident on Glangwili Hospital (GGH). The focus of the hospital element of the exercise was:

- Major Incident Notification and Activation
- Emergency Department (ED) Response
- Hospital Coordination Centre (HCC) Operations
- Mortuary Preparedness and Communication with Dyfed Powys Police Disaster Victim Identification (DVI) teams.

The objective was to evaluate the effectiveness of hospital major incident notification and activation procedures, response arrangements, staff preparedness, communication channels, and resource allocation during a large-scale emergency. Recommendations from the exercise report are being progressed and monitored via the EPRR Group.

Lessons Identified: The changes within the Major Incident Plan also include recommendations from debrief reports following a number of incidents/events (Powys Train Crash – October 2024; Storm Darragh – December 2024; WGH Bomb Hoax – December 2024). These mainly focus around command and control structures, role of Gold on-call and notification/activation procedures).

Argymhelliad / Recommendation

The Committee is asked to

- **APPROVE** the Major Incident Plan prior to onward recommendation to the Health Board.
- **NOTE** the content of the Exercise Tendley report
- **TAKE ASSURANCE** regarding our compliance with Welsh Government NHS Emergency Planning Core Guidance (2015).

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.6 Provide assurance to the Board that the Health Board's Emergency Management Plan is underpinned by policy and protocols, planning and performance targets and strategies to address risks to business continuity.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:	Not Applicable

Datix Risk Register Reference and Score:	
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	3. Effective Care 4. Dignified Care
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Striving to deliver and develop excellent services
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Civil Contingencies Act (2004) NHS Wales Emergency Planning Guidance (2015)
Rhestr Termau: Glossary of Terms:	Contained within the Major Incident Plan
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd Iechyd a Diogelwch: Parties / Committees consulted prior to Health and Safety Committee:	• EPRR Group • Welsh Government • NHS Wales Performance & Improvement • Wales Ambulance Service Trust (WAST) • Executive Director with lead for EPRR

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The main costs associated with the Emergency Planning agenda are staffing; training; exercising and equipment.
Ansawdd / Gofal Claf: Quality / Patient Care:	Major Incident Plan revised with relevant multi-professional input across the sites.

Gweithlu: **Workforce:**	On-going training issues form part of the UHB's Civil Contingencies Act preparedness and subsequent exercises test its response, plans and communication systems.
Risg: **Risk:**	The whole Emergency Planning agenda is based on risk and taking every practical step to mitigate against the risk of an event occurring. Identification of the highest risks, and development of plans and procedures to address and respond to them places the Health Board in a better state of preparedness.
Cyfreithiol: **Legal:**	The Major Incident Plan forms part of our response to the requirements of the Civil Contingencies Act and our duty as a Category One responder under the Act.
Enw Da: **Reputational:**	Potential. The Major Incident Plan demonstrates our level of preparedness to respond effectively to a major incident event and safeguard the reputation of the organisation.
Gyfrinachedd: **Privacy:**	No issues identified.
Cydraddoldeb: **Equality:**	Impact Assessment completed May 2025 with no negative impacts identified.

MAJOR INCIDENT PLAN 2025/26

Carmarthenshire, Ceredigion & Pembrokeshire

Plan information:

Supersedes: MIP 2024/25
Version number: MIP 2025/2026

Approval information:

Endorsed by Executive Team (18 June 2025)
Approved by Health & Safety Committee (scheduled for 03 July 2025)
Recommended by Board: (scheduled for 31 July 2025)
Date of approval:
Date made active:
Review date: July 2026

Summary of document:

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

Scope:

Organisation wide

To be read in conjunction with:

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

Owning group:

Emergency Preparedness, Resilience & Response (EPRR) Group → Formal Executive Team (18/06/25) → Health & Safety Committee (03/07/25) → Board (31/07/25)

Executive Director job title:

Executive Director of Public Health

Reviews and updates:

2015/2016 – approved 28.05.2015
2016/2017 – approved 02.06.2026
2017/2018 – approved 27.07.2017
2018/2019 – approved 27.09.2018
2019/2020 – approved 26.09.2019
2022/2023 – approved 28.07.2022
2023/2024 – approved 27.07.2023
2024/2025 – approved 25.07.2024
2025/2026 – approved

Keywords:

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

CONTENTS

Section	Page
Introduction	5
Aim	6
Command & Control	7
Types of Incident	8
Activation and Response Procedures	9
Scene Management	14
Hospital Arrangements	16
Interoperability	22
Business Continuity	23
Record Keeping	24
Management of Burns	26
Management of Chemical Incidents	28
Management of Radiation Incidents	30
Management of Biological Incidents	33
Mortuary Facilities & Deceased Persons	34
Mass Casualty Incidents	36
Bronglais Site Actions	37
Glangwili Site Actions	41
Prince Phillip Site Actions	46
Withybush Site Actions	49
Internal Major Incidents	54
Contact Telephone Numbers	57
Templates:	
Notification of a Major Incident	64
Incident Log Record Sheet	65
Discharge/Transferred Patients Log Sheet	66
Report for Declaration of an Internal Major Incident	67
Example Major Incident Alert to Day Patients/Visitors	68
Definitions	69
Glossary	71

STOP

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

DO NOT READ IT NOW!

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

STATEMENT ON HEALTH AND SAFETY

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

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

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

INTRODUCTION

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

(Ref: Civil Contingencies Act, 2004)

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

(Ref: NHS Wales Emergency Planning Guidance 2015)

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

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

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

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

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

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

(Ref: NHS Wales Emergency Planning Guidance 2015)

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

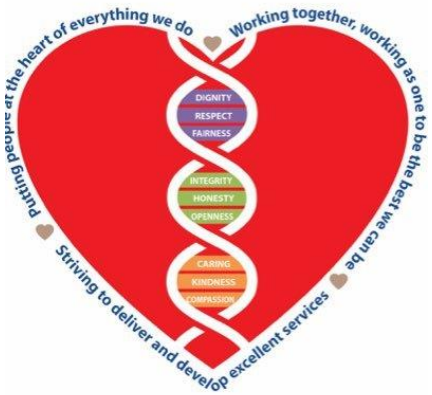
Recommendations and lessons identified from a range of incidents, public inquiries and debriefs have also been reflected within the plan (for example: RAAC Internal Major Incident 2023/4; Hillsborough Inquiry; Withybush Internal Incident June 2023, Health Prepared Wales, Exercise Red Kite, Exercise Celtic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

AIM

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

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

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



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

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

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

COMMAND AND CONTROL

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

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

Strategic Co-ordinating Group (Multi-Agency Gold)

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

Health Board Gold (Strategic) Response

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

The Gold (Strategic) Group would be based in Corporate Offices, Ystwyth Building, St. David's Park, Carmarthen. The Board Room is the designated Health Board Gold Command facility, but meetings may also be convened utilising MS Teams.

Tactical Co-ordinating Group (Multi-Agency Silver)

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

Health Board Silver (Tactical) Response

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

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

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

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

Operational Response (Multi-Agency Bronze)

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

Health Board Operational (Bronze) Response

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

Joint Major Incident Procedures Manual

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

TYPES OF INCIDENT

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

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

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

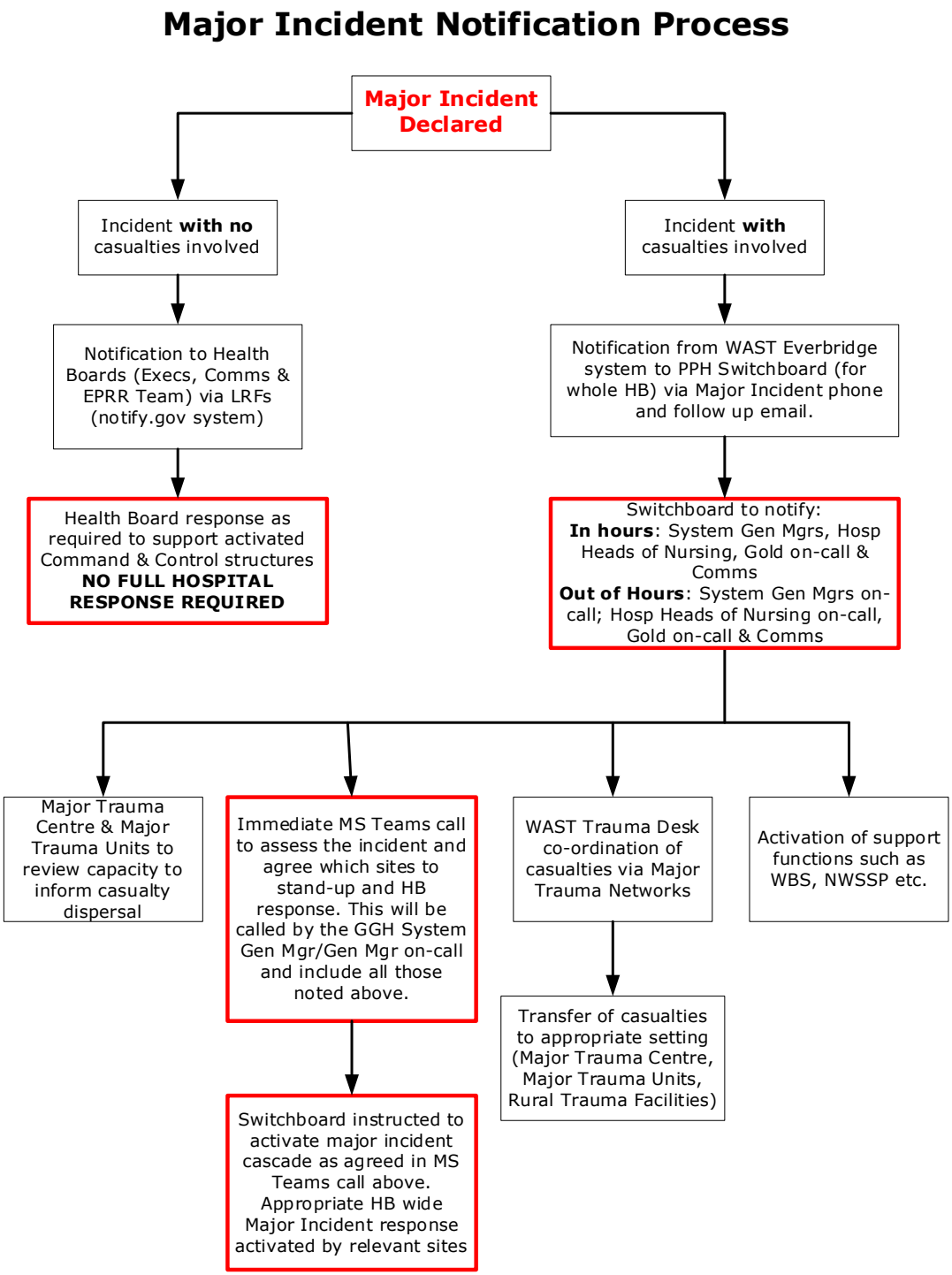
Internal Major Incident – a significant internal incident that requires the set-up of a Management Response Group together with a multi-agency response (e.g. large fire, flooding, large scale evacuation), and may also require additional resources to respond.

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

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

ACTIVATION & RESPONSE PROCEDURES

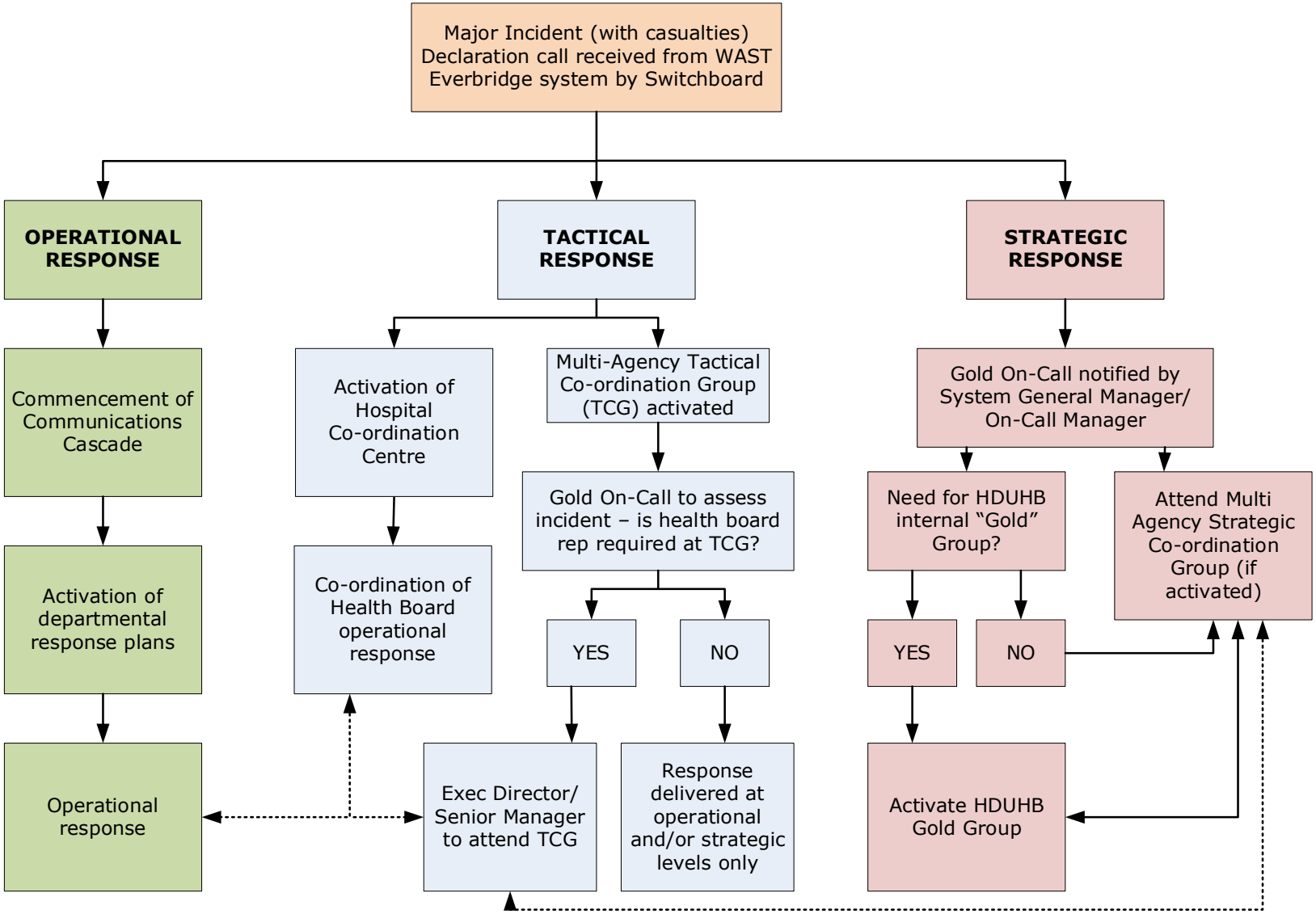
A major incident notification is received in the following way:



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

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

Major Incident with Casualties - Response Flowchart



ALERT LEVELS

There are five levels of alert:

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

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

3. **Major Incident Declared: Mass Casualty Incident –** when the threshold of the mass casualty definition has been met (where the number/type of casualties overwhelms the conventional major incident response) and the activation of the Mass Casualty Incident Arrangements for NHS Wales is required.

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

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

MAJOR INCIDENT - STANDBY

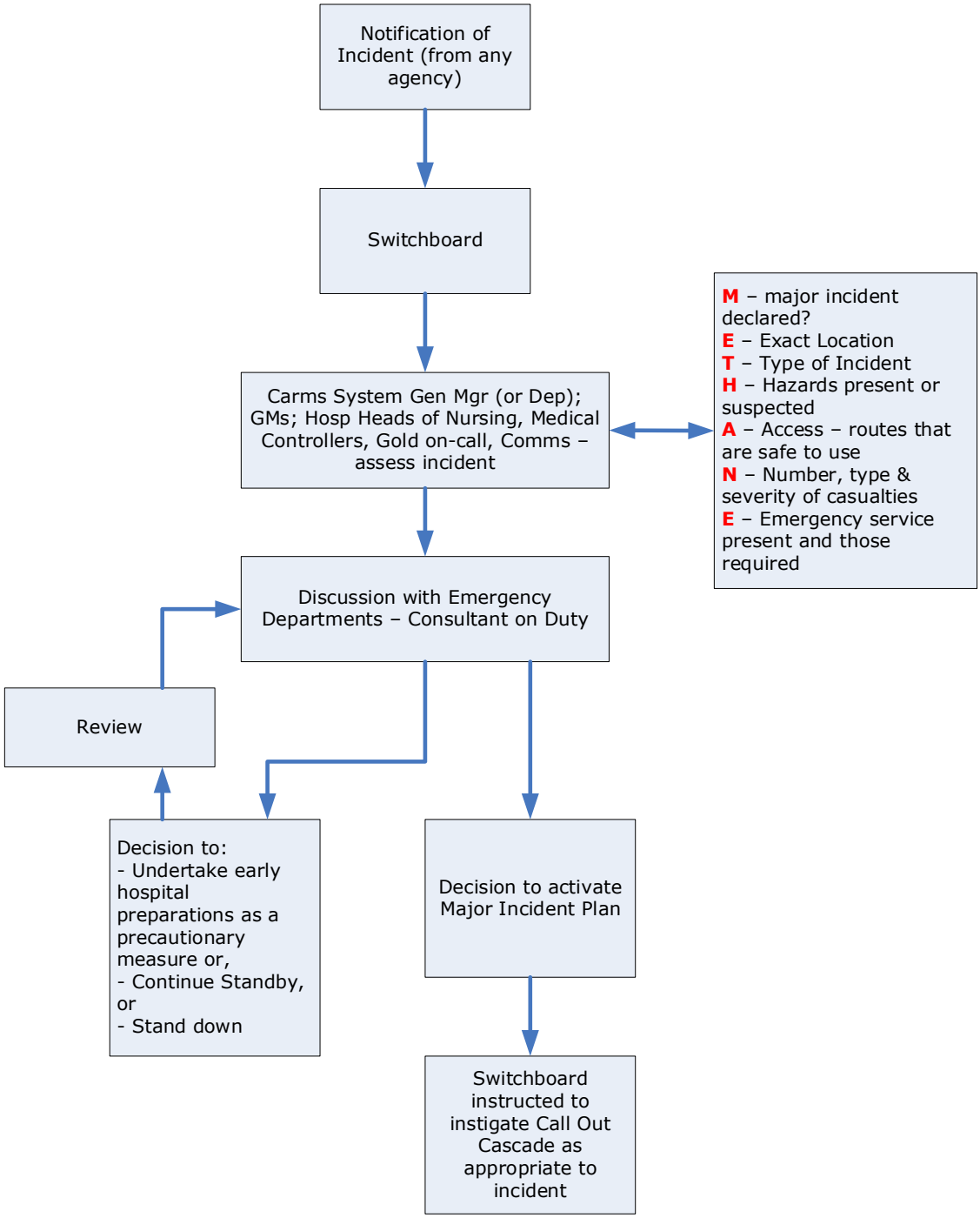
The decision on the action to be taken on a standby alert will vary depending on the incident location and whether the hospital is likely to be required as a receiving or supporting hospital.

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

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

Who will:

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



HOSPITAL CO-ORDINATION CENTRES

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

Key functions:

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

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

The core membership should include:

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

MAJOR INCIDENT DECLARED

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

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

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

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

MAJOR INCIDENT STAND-DOWN AND ASSOCIATED FUNCTIONS

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

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

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

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

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

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

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

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

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

SCENE MANAGEMENT

Incident Site Action

Co-ordination of operations at the site of the incident will normally be in the hands of the Police. In the case of a major fire, this co-ordination will be in the hands of the Senior Fire Officer. If the incident is within the premises of a major industrial concern (e.g. the oil industry) co-ordination may be in the hands of a Senior Officer of that industry.

If required, the Welsh Ambulance Service NHS Trust will call in appropriate Voluntary Aid Societies to the site of the major incident and/or the receiving hospitals.

Medical Advisor

Overall responsibility for the management of medical resources at the scene of the major incident will be that of the first Doctor and Ambulance Operational Commander. The Emergency Medical and Retrieval Transfer Service Cymru (EMRTS) will fulfil the Medical Advisor role remotely from the scene.

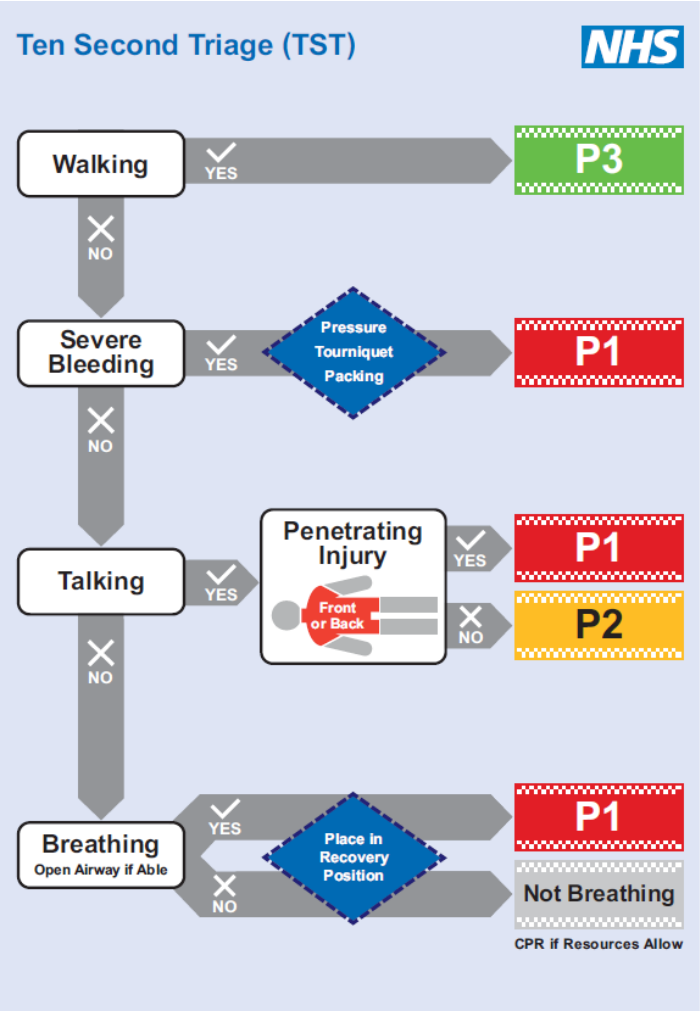
Casualty Clearing Point/Station

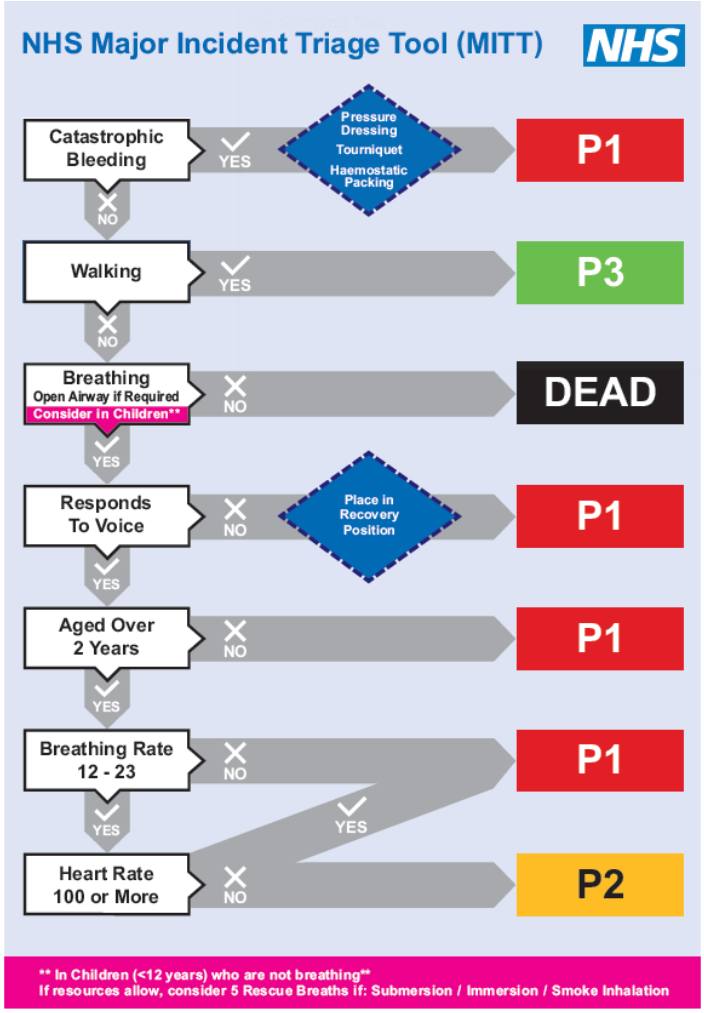
The WAST Casualty Clearing Officer and EMRTS CCS Medical Lead Doctor will establish a Casualty Clearing Point/Station to treat, sort and arrange ongoing transport for casualties. Priorities for evacuation should follow the following coding. Each casualty to be colour coded according to their injury / severity.

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

Triage

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





Major Trauma Network

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

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

Trauma Units:

- Morriston Hospital (with specialist services)
- Grange University Hospital
- Princess of Wales Hospital
- Prince Charles Hospital
- Glangwili Hospital

Local Emergency Hospitals/Rural Trauma Facilities:

- Royal Glamorgan Hospital
- Withybush Hospital
- Bronglais Hospital

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

Decisions on casualty dispersal from the scene of a major incident will be taken in conjunction with the SWTN to facilitate casualty transfer to the most appropriate facility.

HOSPITAL ARRANGMENTS

BLOOD

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

INTENSIVE CARE

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

INFECTIOUS DISEASE EMERGENCIES

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

VOLUNTARY AID SOCIETIES

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

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

INCIDENT CARE TEAMS

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

RELIGIOUS AND CULTURAL SENSITIVITY

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

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

INTERPRETATION AND TRANSLATION SERVICES

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

STAFF WELFARE

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

- Health and safety
- The availability of food and other refreshments
- Working hours
- Rest breaks
- Travel arrangements
- Consideration of personal circumstances
- Emotional support during and after the incident including access to Staff Psychological Well Being Service

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

HEALTH AND SAFETY

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

COMMUNICATIONS TEAM

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

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

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

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

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

LOCKDOWN

A lockdown of individual buildings or a specific location may be required to either contain the major incident or prevent an external threat from gaining access to Health Board facilities. Lockdown can only be effective if is conducted quickly, either in response to a localised incident or intelligence received. More information is contained within the Health Board Lockdown Policy (opens in a new tab).

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

CHILDREN AND MAJOR INCIDENTS

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

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

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

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

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

MATERNITY SERVICES

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

POLICE HOSPITAL DOCUMENTATION TEAM

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

- Withybush: CCTV room/Police room, Reception Area, Emergency Department
- Glangwili: ED Seminar Room, Emergency Department
- Bronglais: CCTV room/Porter's room (rear of the Dining room)

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

POLICE CASUALTY BUREAU

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

information. This unique Police Casualty Bureau number will be issued as soon as practically possible during incidents.

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

ARRANGEMENTS FOR VIP VISITS

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

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

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

Post Incident Follow Up/Counselling Support For Patients/Relatives

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

C.A.L.L. Helpline

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

Incident Debriefing

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

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

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

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

COMMUNITY INCIDENT

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

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

In particular, we may be called upon to provide:

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

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

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

CYBER INCIDENTS

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

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

INTEROPERABILITY

Joint Emergency Services Interoperability Programme (JESIP)

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

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

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

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

Joint Decision Model (JDM)

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

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

	Develop a working strategy to guide subsequent stages.			

BUSINESS CONTINUITY

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

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

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

Mutual Aid

Mutual Aid is an agreement to lend assistance across neighbouring boundaries and partner organisations. This may occur due to a significant incident response that exceeds local resources. It can involve offering resources to help support partners e.g. man-hours, materials etc. Prior to Mutual Aid being agreed, the Health Board will take reasonable appropriate steps to assess that all services and supplies are self-protected during a Major Incident or emergency.

RECORD KEEPING

Casualty Documentation

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

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

Preservation of Documents

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

Definition of "Documents"

For these purposes "documents" means not only pieces of paper but also photographs, video, CCTV footage, Teams/Zoom recorded calls, Teams Chat, WhatsApp/Text, and digital information held on computers. It also includes internal email. The vital message 'Preserve and Protect' – needs to be

spread very quickly during a Major Incident and must reach those who might quite unknowingly hold significant documents.

Incident Log Sheets

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

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

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

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

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

Incident recording

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

MANAGEMENT OF BURNS

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

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

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

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

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

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

Children who sustain burns which require centre level care require transfer to the Paediatric Burns Centre at Bristol Children's Hospital.

The criteria for referral to burn services has been agreed by the National Network of Burn Care and has been widely circulated to all Emergency Departments.

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

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

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

Relatively small numbers of burn-injured patients can overwhelm burn care capacity particularly if children and young people are involved.

It is important that those patients admitted to the Centre are those who are likely to benefit most from the specialised facilities.

The Burns Centre in Morriston hospital can admit a maximum of 10 major burns cases (>30% body surface area) but this would be dependent upon the bed occupancy rate of the centre at the time and the availability of staff.

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

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

As many patients as possible will be transferred to Morriston Burns Centre up to capacity. When capacity is reached the on-call Burns Consultant will advise on availability of beds within the South West UK Burn Care Operational Delivery Network and will have liaised with clinical colleagues in Burns services throughout the UK. Patients should be transferred to a level of care that is appropriate for their level of injury.

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

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

In the event of a burns major incident within the SWUK network, the on call Burns Consultant at Morriston (for adults) and Bristol Children's Hospital (for children) and Burns Liaison Manager will advise where patients should be transferred to.

The National Burns Bed Bureau (NBBB) can be contacted 24 hours a day on 01384 679036 to ascertain where there are available burn beds.

Further information can be obtained from:

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

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

MANAGEMENT OF CHEMICAL INCIDENTS

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

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

Personal Protective Equipment (PPE)

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

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

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

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

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

Other Sources of Information/Advice

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

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

CHEMSAFE: Tel: 01235 836002 (24hr line)

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

National Focus for Chemical Incidents: Tel: 0541 545654

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

National Poisons Information Service: Tel: 0344 892 0111

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

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

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

Known Hazardous Sites in the Hywel Dda area:

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

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

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

- Ministry of Defence, RAC Range Castle Martin, Pembroke

MANAGEMENT OF RADIATION INCIDENTS

1. Management of radioactively contaminated/ irradiated casualties in hospital

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

Radioactive material can harm individuals if:

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

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

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

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

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

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

a) Medical Physicists (including a Radiation Protection Adviser) based in Medical Physics at Singleton Hospital in Swansea can attend and perform radiation monitoring of casualties and to provide advice on decontamination requirements. Medical Physicists can be contacted via the Singleton hospital switchboard emergency call-out on 01792 205666.
b) The UK Health Security Agency (UKHSA) Radiation Emergency Response Group is available to provide support via their on-call officer on 01235 834590/ 01235 831818.

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

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

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

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

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

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

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

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

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

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

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

Public monitoring

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

2. Management of other types of radiation incident

2.1 National Arrangements for Incidents Involving Radiation (NAIR)

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

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

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

2.2 Conventional transport accident involving radioactive materials

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

MANAGEMENT OF BIOLOGICAL INCIDENTS

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

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

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

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

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

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

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

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

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

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

MORTUARY FACILITIES AND DECEASED PERSONS

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

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

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

Temporary Mortuary

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

Dyfed Powys Mass Fatalities Plan

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

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

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

National Emergency Mortuary Arrangements (NEMA)

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

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

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

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

Forensic Considerations

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

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

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

MASS CASUALTY INCIDENTS

Definition of a mass casualty incident

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

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

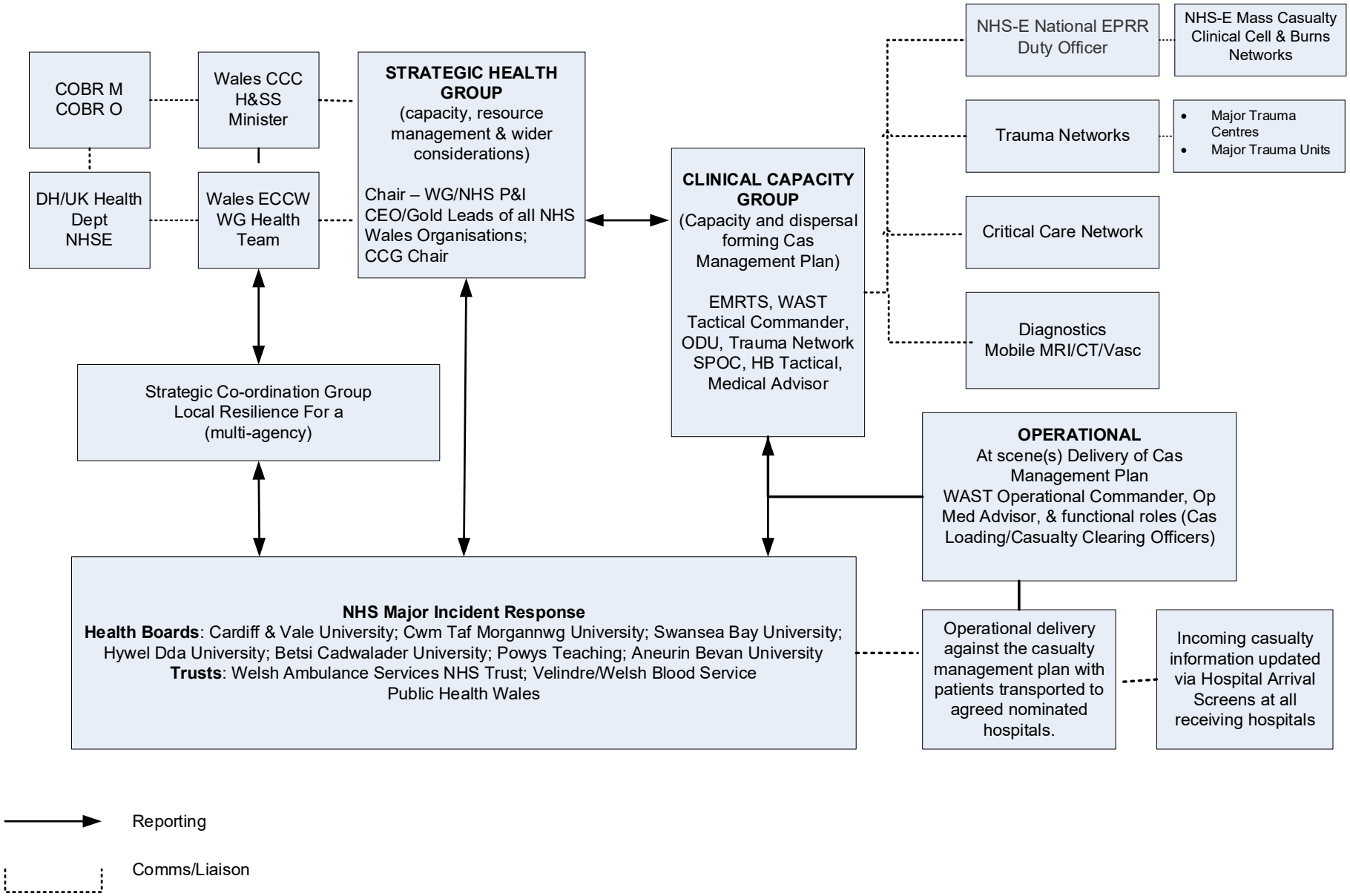
General information

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

Command, control and co-ordination arrangements of NHS Wales for dealing with a mass casualty incident, building on existing major incident plans, are set out in the “Mass Casualty Incident Arrangements for NHS Wales” document issued by Welsh Government. *(Version 5 is currently progressing through the governance/ratification process and will be published Summer 2025).*

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

NHS Wales Mass Casualty Response Structure



HYWEL DDA UNIVERSITY HEALTH BOARD

BRONGLAIS HOSPITAL SITE ACTIONS

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

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

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

	General Site Arrangements
	Patients may be transferred to Community Hospitals or other neighbouring Health Board hospitals. Inter-hospital transfers will be arranged in conjunction with the Ambulance Service, and Central Transport Unit.

CASUALTY HANDLING

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

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

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

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

PATIENT FLOW/ALLOCATION FROM EMERGENCY DEPARTMENT

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

HYWEL DDA UNIVERSITY HEALTH BOARD

BGH EMERGENCY DEPARTMENT MAJOR INCIDENT PATIENT FLOW

MAJOR INCIDENT TRIAGE IN AMBULANCE BAY

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

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

P1
RESUS / MAJORS 3, 4, 5 & 6

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

As per individual Action Cards

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

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

As per individual Action Cards

P3
EMERGENCY DEPARTMENT

Once assessed, stabilised and treated ➔ to best placed ward area or to be discharged

As per individual Action Cards

PAEDIATRICS

PAEDIATRICS P1
RESUS

Once stabilised ➔ PAA, Main Theatres or DSU (for minor surgical procedures)

PAEDIATRICS P2 / P3
MINORS

Once stabilised ➔ PAA, Main Theatres or DSU (for minor surgical procedures)

PATIENTS CURRENTLY IN THE EMERGENCY DEPARTMENT

The Nurse in Charge is to briefly inform members of the public of the situation and to clear the department. Instructing patients to return to their own GP, attend the ED the following day, or if they have minor injuries requiring treatment – **In Hours**: patients can be redirected to the Outpatients Department

Out of Hours: patients can be redirected to call the NHS 111 Service – see below

Existing CDU patients to be re-located to ward C / Existing core ED patients to be re-located into the CDU / Existing Paediatric patients to be re-located to Paeds Room 8

IN HOURS:

Outpatients' staff (after clearing their department) will assist with the treatment of ED patients / minor injuries. However, serious non-incident patients will re-locate to CDU3

Once assessed and treated ➔ to the best placed ward area or to be discharged

As per the Outpatients Action Card

OUT OF HOURS:

Link with the Out Of Hours Service to assist with current ED patients within the Outpatients area, please be aware of the current availability/capacity of the OOH Service

Once assessed and treated ➔ to the best placed ward area or to be discharged

As per the Out Of Hours Services Action Card

GLANGWILI HOSPITAL SITE ACTIONS

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

	General Site Arrangements
Hospital Co-ordination Centre	Meeting Rooms 1&2, Ty Nant, Glangwili Hospital. The Hospital Co-ordination Centre at Glangwili Hospital will act as the lead HCC for ensuring Health Board wide co-ordination of the response. The General Manager (or deputy) will convene a multi-site Teams call early in the incident to provide a system wide approach to casualty allocation and receipt, repatriation of patients, possible medical and surgical diverts and if required temporary boundary changes
Parking	On arrival at the hospital, all staff must avoid parking in the immediate vicinity of the Emergency Unit.
Hospital Preparations	Key personnel (including General Managers and Senior Nurse Managers) should report their arrival or presence at the hospital to the Hospital Control Centre (Meeting Room 1/2, Ty Nant, extension 8743). Emergency Department staff will report direct to the Emergency Department. Middle Grade Doctors should go to the Emergency Department Staff Base and report to the Senior Emergency Department Doctor. FP1& 2 Post Holders should report to their specialty wards. The On-Call Orthopaedic and General Surgery Consultants should report to the Senior Emergency Department Doctor in the Emergency Department Staff Base. Once casualty numbers have been estimated/determined and they exceed the current capacity of the Emergency Department, then existing patients may be moved to the Endoscopy Unit to release capacity. This will be determined by the Senior Emergency Department Doctor and the Nurse in Charge in conjunction with the Hospital Co-ordination Centre. The Hospital/On-Call Manager will establish regular liaison with the Ambulance Liaison Officer, situated in the Outpatient Department. The Nurse Controller will inform senior nursing staff of the incident and assess nursing resources. The Nurse Controller will call in the Night Nurse Practitioners and Senior Sister OPD as required and arrange for the recall of nursing and essential administrative staff as necessary. If requested by the Medical Controller, the Nurse Controller will ask the Operating Theatres Department to make arrangements for the cessation of non-emergency surgery and to prepare the Theatres for the treatment of the injured.
Organisation Of Beds	The organisation of beds will be the responsibility of the Medical Controller, who will be the Hospital Clinical Lead who will be based in the Hospital Control Centre. The Medical Controller will assume responsibility for co-ordinating the discharge of patients nearing convalescence or waiting for non-urgent surgery, in order to make beds available to accommodate casualties from the incident. They will decide on the cancellation of routine admissions and advise on any matters of medical priority as necessary.

	General Site Arrangements
Bed State	The Site Manager (holder of Bleep 070) will be responsible for keeping the Medical Controller up to date with the bed state in the hospital and for establishing the bed state at neighbouring hospitals. In Glangwili General Hospital beds may be needed in several wards and Ward Sisters (or senior nurse on the ward) should liaise with their respective FP1 & FP2 post holders in order to advise on patients suitable for discharge. All inpatients suitable for discharge from specialty wards will be sent to Out-Patients Reception for collection. Patients from Ward Blocks 1, 2, 3 and 4 should be directed to use Out-Patients exit. (Discharge sheet to be completed on patients discharged – see Page 63).
Theatres	If required, the Senior Theatre Nurse on duty will prepare operating theatres for substantive treatment of the injured.
Intensive Care Unit	The ICU Consultant Anaesthetist and Senior Nurse in Charge will advise on ICU & HDU bed availability. The ICU Consultant Anaesthetist will advise on the patient's that need to be admitted to ICU/HDU for treatment
Helicopter Landing Facilities	Helicopters carrying casualties can be landed in the field adjacent to the roundabout prior to transfer to the Emergency Department. Helicopter transfers from Glangwili to other hospitals e.g. Morriston will be co-ordinated by the Ambulance Service.
Relatives	Relatives arriving at the hospital should be directed to the Relatives' Reception Area located in the **Cardiac Respiratory Unit**. This area will act as a point of contact for the voluntary services and other agencies involved. Beverages will be made available by Hotel Services staff.
Communications	**Communication with Staff** Staff will be kept informed of the incident response at appropriate intervals via existing communication and I.T. systems. **Internal Communication** Volunteer and off-duty staff will be used as runners between the Hospital Control Centre and hospital departments. The current system of internal radio links will also facilitate effective two-way communication. If necessary, hand-set radios may be issued to the Medical Controller, Nurse Controller, by Head of Hotel Services or deputy. **Media** The Hospital Co-ordination Centre will arrange for an area to be set aside for the use of the media - the **Post Grad Centre,** noting however, that media may request access to other areas of the health board site, which will be considered and dealt with by the Communications Director and team. Media may also film from the highways (as is their right and particularly if the major incident site is on hospital grounds itself), the Communications Director will arrange for a Communications Team member to be present as staffing and situation allows, to manage filming permissions and interaction with the press and media. Staff should not share photos, information or film, from the site of the incident, nor should they take recording devices on to the site of the incident on behalf of the media/press.

	General Site Arrangements
Communication	Otherwise, media representatives will be directed to the Postgraduate Lecture Theatre. Beverages will be made available by Hotel Services staff. A senior manager or nominated deputy will be responsible for liaison between media, the HCC and the LRF Media Cell until the arrival of the Communications Team. The LRF Media Cell will usually take the lead in joint-agency co-ordination of media information. Liaison must occur between the Communications Team and the other agencies to agree media involvement and press statements. Only the On-Call Executive (or nominated deputy) should give media interviews. Interviews will be under the guidance of the Communications Team member on site and in agreement with the Communications Director or deputy. Outside broadcast vehicles to be sited in the parking area to the rear of the Cambrian Room.

CASUALTY HANDLING

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

Hospital	P1		P2		P3	
	D	N	D	N	D	N
Glangwili Hospital, Carmarthen	3	2	8	6	40	25

Not all life-threatened casualties would require surgery as the condition of some could be life-threatening by virtue of, for example, the need for airway management rather than surgery.

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

If the number of patients exceeds the maximum capacity of the Emergency Unit, patients in lower priority categories will be treated in the following locations:

- Green Suite, OPD (Priority 3 patients only)
- Appropriate Specialty Wards

Decisions on the location of patients will be determined by the Triage Officer. All patients found to be dead on arrival will be sent to Mortuary.

The needs of children will be recognised as far as practical with the resources available. Paediatric expertise will be called as required.

If there are paediatric casualties, the Nurse in Charge/Deputy Nurse in Charge will notify the Hospital Co-ordination Centre who will inform the Consultant Paediatrician On-Call.

	Emergency Department Arrangements
Triage	A Triage Area will be established at the Emergency Department Ambulance Entrance Foyer. The Triage Officer will be the Emergency Department **Consultant On-Call** (supported by a Senior Emergency Department Nurse) Deputy – Senior Emergency Department Doctor. The Triage Officer will divide the medical and nursing staff into teams so that patients can be assessed as soon as they enter the hospital.
Non incident Emergency Department Patients	Any patients arriving who need treatment but who are not part of the major incident will be advised of the current situation, assessed, and informed of appropriate alternative treatment options. The Medical Day Unit will be used, in hours, to assist with the treatment of minor injuries.
Out Of Hours Service	**Normal Working Hours:** During normal working hours the unit is not functional. **Out Of Hours:** Out of hours, the unit is functional and is located in the Medical Day Unit. The aim will be to continue to function as normal. Non incident Emergency Department patients to be redirected to the GP in the unit where possible to alleviate any extra burden on the Emergency Department. If incident numbers/type are such that unit cannot continue, then HCC to be informed immediately.
Emergency Ambulance Release	To enable WAST to respond to the incident with an appropriate number of resources to provide clinical care to patients at the scene, the following release of emergency ambulances from outside hospital emergency departments has been agreed: • 50% of vehicles released within 10 minutes. • 75% of vehicles released within 20 minutes. • 100% of vehicles released within 30 minutes. Further details contained within ED Major Incident Action Cards.

GGH EMERGENCY DEPARTMENT MAJOR INCIDENT PATIENT FLOW

MAJOR INCIDENT TRIAGE IN AMBULANCE BAY

If possible, casualties requiring end of life care will be directed to, and cared for in, an alternative environment to the ED

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

P1
RESUS
(Alternative location: ED)

Once stabilised → Intensive Care Unit, Main Theatres, Day Surgery Unit or best placed ward area

As per the individual service's Action Cards

P2
EMERGENCY DEPARTMENT
(Alternative location: MIU/best placed ward area)

Once stabilised → Main Theatres, Day Surgery Unit or best placed ward area

As per the individual service's Action Cards

P3
MIU
(Alternative location: Green Suite, OPD /best placed ward area)

Once assessed, stabilised and treated → to best placed ward area or to be discharged

PAEDIATRICS

PAEDIATRICS P1
RESUS
Once stabilised → PACU, Main Theatre or DSU

PAEDIATRICS P2
INJURY DEPENDENT
RESUS / PACU
Once stabilised → PACU, Main Theatre or DSU

PAEDIATRICS P3
PACU

PATIENTS CURRENTLY IN THE EMERGENCY DEPARTMENT

The Nurse in Charge is to briefly inform members of the public of the situation and to clear the department. Instructing patients to return to their own GP, attend the ED the following day, or if they have minor injuries requiring treatment - **In Hours**: patients can be redirected to the Medical Day Unit
Out of Hours: patients can be redirected to call the NHS 111 Service – see below

IN HOURS

Medical Day Unit staff (after clearing their department) will assist with the treatment of minor injuries

Once assessed and treated → to the best placed ward area or to be discharged

As per the Medical Day Unit Action Card

OUT OF HOURS

Link with the Out Of Hours Service to assist with current ED patients within the Medical Day Unit area, please be aware of the current availability/capacity of the OOH Service

Once assessed and treated → to the best placed ward area or to be discharged

As per the Out Of Hours Action Card

SUPPORTING HOSPITAL - PRINCE PHILIP HOSPITAL

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

	General Site Arrangements
Hospital Co-ordination Centre	Management Offices, PPH (the Board Room may also be utilised). The Hospital Co-ordination Team will be required, early in the incident, to join a multi-site Teams call (co-ordinated by GGH HCC) to provide a system wide approach to casualty allocation and receipt, repatriation of patients, possible medical and surgical diverts and if required temporary boundary changes.
Hospital Role	Prince Phillip Hospital's main role in a Major Incident would be to continue the intake of medical emergencies from Carmarthenshire, provide a decant facility from Glangwili General Hospital, and where appropriate management of walking patients involved in the Major Incident.

	General Site Arrangements
Hospital Capacity	Prince Phillip Hospital has no capacity to stabilise causalities requiring definitive surgical management but could in extreme circumstances manage patients requiring airway management prior to transfer for definitive treatment. At Prince Philip Hospital the maximum capacity to stabilise "serious casualties" by resuscitative treatment is 2 in a two-hour period.
Hospital Alerting Procedure	Any notification of a major incident will be received from GGH General Manager/Manager on call as part of their action card responsibilities. If the call is received via any other external route, the call **must** be directed to GGH Switchboard for verification and determination of the nature and scope of the incident. If the Hospital/On-Call Manager is not present on the PPH site, they should immediately arrange for an alternative senior manager to deputise in this role.
Parking	On arrival at the hospital, all staff must avoid parking in the immediate vicinity of the Minor Injury Unit (MIU) and Acute Medical Assessment Unit (AMAU). The car parking areas in front of the MIU and AMAU Units must be cleared and reserved for ambulances. Head of Hotel Services (or deputy) will arrange for the clearing of the area as soon as possible.
Hospital Preparations	Key personnel should report their arrival or presence at the hospital to the Hospital Co-Ordination Centre (Management Offices Co-ordination Hub Ext. 3709, 3530, 3073 or 3450). MIU and AMAU staff will report directly to their respective units. Medical staff should report to their normal place of work and await further instruction (unless action card holders). Staff with no particular departmental duties should make themselves available to be called by the Hospital Co-ordination Centre, to assist in the provision of a system of "runners/messengers". When a major incident is declared Paediatric casualties of any type **should not** be admitted or received by Prince Phillip Hospital.
Organisation of Beds	The organisation of beds will be the responsibility of the Site Manager/Bleep 600 Holder The Medical Controller will be based in the Hospital Co-ordination Centre. The Medical Controller will assume responsibility for co-ordinating the discharge of patients nearing convalescence or waiting for non-urgent surgery, to make beds available to accommodate for casualties from the incident. They will decide on the cancellation of routine admissions and advise on any matters of medical priority as necessary. The Site/Bed Manager (the holder of bleep 600) will be the Nurse Controller until relieved by the Head of Nursing or Senior Nurse Manager and will be based in the Hospital Co-Ordination Centre.

	General Site Arrangements
	The Nurse Controller will inform senior nursing staff of the incident and assess nursing resources. The Nurse Controller will call Emergency Nurse Practitioners, as required.
Bed State	The Site/Bed Manager (holder of bleep 600) will be responsible for keeping the Medical Controller up to date with the bed state in the hospital and for establishing the bed state at neighbouring hospitals. In Prince Philip Hospital beds will be needed in several wards and Ward Sisters (or senior nurse on the ward) will liaise with their respective medical teams to advise on patients suitable for discharge. All inpatients suitable for discharge from specialty wards will be sent to the Discharge Lounge/Gerontology Day Hospital for collection
Intensive Care / High Dependency Unit	The ICU Consultant Anaesthetist and Senior Nurse in Charge will advise on ICU & HDU bed availability. The ICU Consultant Anaesthetist will advise on the patient's that need to be admitted to ICU/HDU for treatment
Helicopter Landing Facilities	There are no helicopter landing facilities on site, however it may be possible to land locally in Dafen. Helicopter transfers from Prince Phillip to other hospitals will be co-ordinated by the Ambulance Service.
Relatives	Relatives arriving at the hospital should be directed to the Post Grad Lecture Theatre.
Communications	**Media Facilities** The Hospital Co-ordination Centre will arrange for an area to be set aside for the use of the media - the **Caebryn Conference Room,** noting however, that media may request access to other areas of the health board site, which will be considered and dealt with by the Communications Director and team. Media may also film from the highways (as is their right and particularly if the major incident site is on hospital grounds itself), the Communications Director will arrange for a Communications Team member to be present as staffing and situation allows, to manage filming permissions and interaction with the press and media. Staff should not share photos, information or film, from the site of the incident, nor should they take recording devices on to the site of the incident on behalf of the media/press. Otherwise, media representatives will be directed to the Postgraduate Lecture Theatre. Beverages will be made available by Hotel Services staff. A senior manager or nominated deputy will be responsible for liaison between media, the HCC and the LRF Media Cell until the arrival of the Communications Team. The LRF Media Cell will usually take the lead in joint-agency co-ordination of media information. Liaison must occur between the Communications Team and the other agencies to agree media involvement and press statements. Only the On-Call Executive (or nominated deputy) should give media interviews. Interviews will be under the guidance of the Communications Team member on site and in agreement with the Communications Director or deputy. Outside broadcast vehicles will be sited in the Consultants car park at the front of the hospital

	General Site Arrangements
	Communication with Staff Staff will be kept informed of the incident response at appropriate intervals via existing communication and I.T. systems. **Internal Communication** Volunteer and off-duty staff will be used as runners between the Hospital Co-ordination Centre and hospital departments. The current system of internal radio links will also facilitate effective two-way communication. If required, hand-set radios will be issued to Medical Controller and Nurse Controller by Head of Hotel Services or deputy.

WITHYBUSH HOSPITAL SITE ACTIONS

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

	General Site Arrangements
Hospital Co-ordination Centre	Patient Flow Office, 1st Floor (above EUCC), WGH. The Hospital Co-ordination will be required, early in the incident, to join a multi-site Teams call (co-ordinated by GGH HCC) to provide a system wide approach to casualty allocation and receipt, repatriation of patients, possible medical and surgical diverts and if required temporary boundary changes.
Hospital Preparations	The Switchboard operator will call out key staff in accordance with the cascade system. If on-call personnel of a department are unavailable this should be reported to the Hospital Co-ordination Centre (Tel. No. 3547, 3548 or 3576) on completion of calls as listed. The Senior Manager/On-Call Manager will establish the Hospital Control Centre. On arrival at the Hospital, all Action Card holders must either attend or report (action card will specify) to the Hospital Co-ordination Centre where a record of their attendance will be maintained and a brief incident update given.
Hospital Discharges / Maximising Bed Availability	The organisation of beds will be the responsibility of the Medical Controller. The Medical Controller will assume responsibility for co-ordinating the discharge of patients nearing convalescence or waiting for non-urgent surgery, in order to make beds available to accommodate for casualties from the incident. They will decide on the cancellation of routine admissions and advise on any matters of medical priority as necessary. Arrangements will be made for the discharge or transfer to South Pembrokeshire Hospital, Health & Social Care Resource Centre, Tenby Cottage Hospital, commissioned beds within the community and Community Services of patients from the relevant wards, depending upon the type of Major Incident. This will be co-ordinated by the Bed Manager / Senior Nurse in charge of each ward supported by the medical staff. Patients nominated as Discharges / transfers from wards will be relocated to the facilitated Patients' Discharge Waiting Area in the Physiotherapy Treatment area. The staff in the Patients Discharge Waiting Area will co-ordinate and document all inpatient movements via the Discharge / Transferred Patients log (page 63) and ensure that the Hospital Co-ordination Centre is kept informed. The Bed Manager (holder of bleep 2138) will be responsible for keeping the Medical Controller up to date with the bed state in the hospital and for establishing the bed state at neighbouring hospitals. All patients leaving the hospital will exit the hospital via the Physiotherapy Department entrance.
Intensive Care Unit	The ICU Consultant Anaesthetist and Senior Nurse in Charge will advise on ICU & HDU bed availability. The ICU Consultant Anaesthetist will advise on the patient's that need to be admitted to ICU/HDU for treatment

	General Site Arrangements
Relatives And Friends Reception Centre	Relatives arriving at Withybush should be directed to the Ante-Natal area. This area will act as a point of contact for the voluntary services and other agencies involved. Hospital Chaplains will be asked to assist in this role.
Communications	**MEDIA CENTRE** The Hospital Co-ordination Centre will arrange for an area to be set aside for the use of the media - the **Auditorium at the Conference Centre,** noting however, that media may request access to other areas of the health board site, which will be considered and dealt with by the Communications Director and team. Media may also film from the highways (as is their right and particularly if the major incident site is on hospital grounds itself), the Communications Director will arrange for a Communications Team member to be present as staffing and situation allows, to manage filming permissions and interaction with the press and media. Staff should not share photos, information or film, from the site of the incident, nor should they take recording devices on to the site of the incident on behalf of the media/press. Otherwise, media representatives will be directed to the Postgraduate Lecture Theatre. Beverages will be made available by Hotel Services staff. A senior manager or nominated deputy will be responsible for liaison between media, the HCC and the LRF Media Cell until the arrival of the Communications Team. The LRF Media Cell will usually take the lead in joint-agency co-ordination of media information. Liaison must occur between the Communications Team and the other agencies to agree media involvement and press statements. Only the On-Call Executive (or nominated deputy) should give media interviews. Interviews will be under the guidance of the Communications Team member on site and in agreement with the Communications Director or deputy. Outside broadcast vehicles will be sited in the parking area adjacent to the Conference Centre and/or other suitable area of the hospital grounds. **COMMUNICATION WITH STAFF** Staff will be kept informed of the incident response at appropriate intervals via existing communication and I.T. systems. Radios will be held by core staff members to ensure effective and timely communication. A list of designated holders is maintained in the Switchboard. **EXTERNAL COMMUNICATIONS LINK** A communications link will be provided between the Co-ordinating Medical Officer, Ambulance Service Major Incident Vehicle and the Medical Incident Commander as a priority and should be kept open at all times. Radio users need to be aware that sensitive information should not be transmitted on radio links, as these are insecure and can be scanned by public and media scanners. All sensitive information should be transmitted by landline or face to face and not mobile communication.

	General Site Arrangements
Helicopter Landing Facilities	Helicopters carrying casualties can be landed on the helipad to the rear of the Emergency Department and/or Withybush Airport. Helicopter transfers from Withybush to other hospitals e.g. Morriston will be co-ordinated by the Ambulance Service. WAST will notify Switchboard if a helicopter is to land on the helipad, Switchboard with notify the Fire Service and the Creche (located adjacent to helipad).

CASUALTY HANDLING

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

Hospital	P1		P2		P3	
	D	N	D	N	D	N
Withybush Hospital, Haverfordwest	2	1	4	2	12	20

Not all life-threatened casualties would require surgery as the condition of some could be life-threatening by virtue of, for example, the need for airway management rather than surgery.

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

	Emergency Department Arrangements
Triage	A Casualty Triage point will be established inside the Ambulance entrance to the Emergency Department. Triage will be carried out as the casualties arrive by the allocated experienced Nurse and the Emergency Department Middle-Grade Doctor.
Patient Flow/Allocation From Emergency Department	The planned allocation of patients is as outlined below however the Hospital Co-ordination Centre may deviate from this plan as dictated by the nature of the Incident (numbers and case mix of casualties) Following Triage, patients will be allocated as follows: a) Minor casualties and apparently non-injured will be directed to the waiting areas designated within the Outpatients Department or treated within the Emergency Department and discharged. b) Casualties requiring Urgent/Emergency surgery should be transferred to Main Theatres (after being stabilised). If Theatre capacity is full, patients are to be placed in the most appropriate facility to await transfer to Theatre (e.g. Day Surgery Unit / Same Day Admit / High Dependency Unit).

	Emergency Department Arrangements
	c) Casualties requiring hospitalisation but not urgent surgery will be allocated ward beds as appropriate. d) Casualties requiring end of life care will be directed to and will be cared for in an alternative environment to the Emergency Department. The environment (e.g. Endoscopy, Medical Day Unit, CDU) will be dependent on the nature of the Major Incident and the numbers of casualties requiring end of life care.
Out Of Hours Service	The Out of Hours service is based in the out-patient corridor adjacent to the Emergency Department. Therefore, the service will continue to function as normal during a major incident. The aim will be to continue to function as normal. Non incident Emergency Department patients to be redirected to the GP in the unit where possible to alleviate any extra burden on the Emergency Department.
Emergency Ambulance Release	To enable WAST to respond to the incident with an appropriate number of resources to provide clinical care to patients at the scene, the following release of emergency ambulances from outside hospital emergency departments has been agreed: • 50% of vehicles released within 10 minutes. • 75% of vehicles released within 20 minutes. • 100% of vehicles released within 30 minutes. Further details contained within ED Major Incident Action Cards.

WGH EMERGENCY DEPARTMENT MAJOR INCIDENT PATIENT FLOW

MAJOR INCIDENT TRIAGE IN AMBULANCE BAY

If possible, casualties requiring end of life care will be directed to, and cared for in, an alternative environment to the ED

This environment (e.g. Endoscopy, MDU, PHODU) will be dependent on the nature of the Major Incident and the number of casualties requiring end of life care

P1
RESUS
(Alternative location: ED)

Once stabilised → Intensive Care Unit, Main Theatres, Day Surgery Unit or best placed ward area

As per the individual service's Action Cards

P2
EMERGENCY DEPARTMENT
(Alternative location: MIU/best placed ward area)

Once stabilised → Main Theatres, Day Surgery Unit or best placed ward area

As per the individual service's Action Cards

P3
MAJORS / MIU / SDEC / PUFFIN UNIT

Once assessed, stabilised and treated → to best placed ward area or to be discharged

PAEDIATRICS

PAEDIATRICS
P1 RESUS
Continuation of care to be discussed with Paediatric Team

PAEDIATRICS
P2 / P3 MIU
Continuation of care to be discussed with Paediatric Team

PATIENTS CURRENTLY IN THE EMERGENCY DEPARTMENT

As per the Action Card, the Nurse in Charge is to briefly inform members of the public of the situation and to clear the department. Instructing patients to return to their own GP, attend the ED the following day, or if they have minor injuries requiring treatment - **In Hours**: patients can be redirected to the Outpatients Department **Out of Hours**: patients can be redirected to call the NHS 111 Service – see below

IN HOURS:

Outpatients' staff (after clearing their department) will assist with the treatment of ED patients / minor injuries

Once assessed and treated → to the best placed ward area or to be discharged

As per the Outpatients Action Card

OUT OF HOURS:

Link with the Out Of Hours Service to assist with current ED patients within the Outpatients area, please be aware of the current availability/capacity of the OOH Service

Once assessed and treated → to the best placed ward area or to be discharged

As per the Out Of Hours Services Action Card

INTERNAL INCIDENTS AND INTERNAL MAJOR INCIDENTS

An incident within Health Board premises that warrant special arrangements for the co-ordination, command and control of the situation, by a management response group.

Serious situations affecting small numbers of patients and/or staff may also be co-ordinated in this manner, if deemed appropriate.

However, **responses to escalating emergency pressures are not covered by this plan.**

HDUHB must plan to handle incidents in which its own facilities - or neighbouring ones – may be overwhelmed. The organisation itself may be affected by its own internal major incident or by an external incident that impairs its ability to work normally. Fire, breakdown of utilities, major equipment failure, hospital acquired infections, violent crime or the need to deal with one or more contaminated person(s) may paralyse the provision of services and jeopardise safety arrangements. This plan should be considered in conjunction with service level Business Continuity Plans.

There are three levels of internal incident that the relevant Senior Manager(s) can consider during their assessment of the situation.

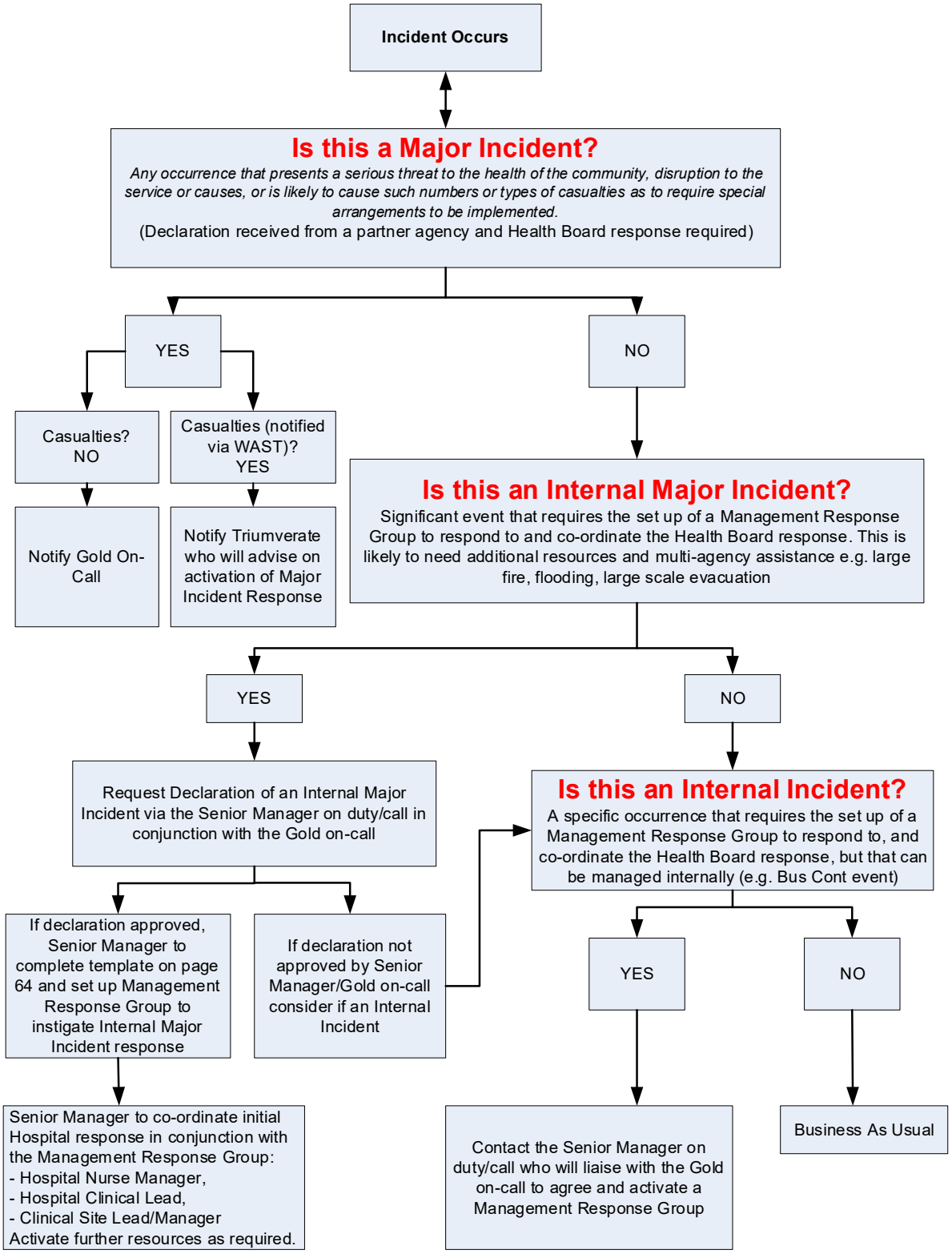
- **Internal Major Incident** – significant event that is likely to require additional resources and multi-agency assistance
- **Internal Incident** – specific occurrence that can be managed internally
- **Business Continuity event** – can be managed via activation of relevant business continuity plans

SELF DECLARATION OF A MAJOR INCIDENT

In the RARE event of the hospital needing to self-declare its own major incident, the most Senior Manager on duty/call shall:

- Assess the situation and discuss with the relevant Executive Director (In hours: Director of Public Health – lead for EPRR, or Out of Hours: Executive Director on-call (rota held in switchboard).
- Advise the Switchboard to activate the communications cascade to notify staff.
- Advise Ambulance Control of the situation on 01267 229476 (Duty Manager) or 999 if unavailable)
- Advise Dyfed Powys Police control of the situation (Tel 01267 226144, identify yourself and ask to speak to the Control Room Duty Inspector urgently).
- Set up a Management Response Group to co-ordinate the response.

The following flowchart highlights the process required following assessment of the incident, and agreed level of declaration, and response.


Incident Occurs
Is this a Major Incident?
Any occurrence that presents a serious threat to the health of the community, disruption to the service or causes, or is likely to cause such numbers or types of casualties as to require special arrangements to be implemented.
(Declaration received from a partner agency and Health Board response required)
YES
NO
Casualties? NO
Casualties (notified via WAST)? YES
Notify Gold On-Call
Notify Triumverate who will advise on activation of Major Incident Response
Is this an Internal Major Incident?
Significant event that requires the set up of a Management Response Group to respond to and co-ordinate the Health Board response. This is likely to need additional resources and multi-agency assistance e.g. large fire, flooding, large scale evacuation
YES
NO
Request Declaration of an Internal Major Incident via the Senior Manager on duty/call in conjunction with the Gold on-call
Is this an Internal Incident?
A specific occurrence that requires the set up of a Management Response Group to respond to, and co-ordinate the Health Board response, but that can be managed internally (e.g. Bus Cont event)
If declaration approved, Senior Manager to complete template on page 64 and set up Management Response Group to instigate Internal Major Incident response
If declaration not approved by Senior Manager/Gold on-call consider if an Internal Incident
YES
NO
Senior Manager to co-ordinate initial Hospital response in conjunction with the Management Response Group:
- Hospital Nurse Manager,
- Hospital Clinical Lead,
- Clinical Site Lead/Manager
Activate further resources as required.
Contact the Senior Manager on duty/call who will liaise with the Gold on-call to agree and activate a Management Response Group
Business As Usual

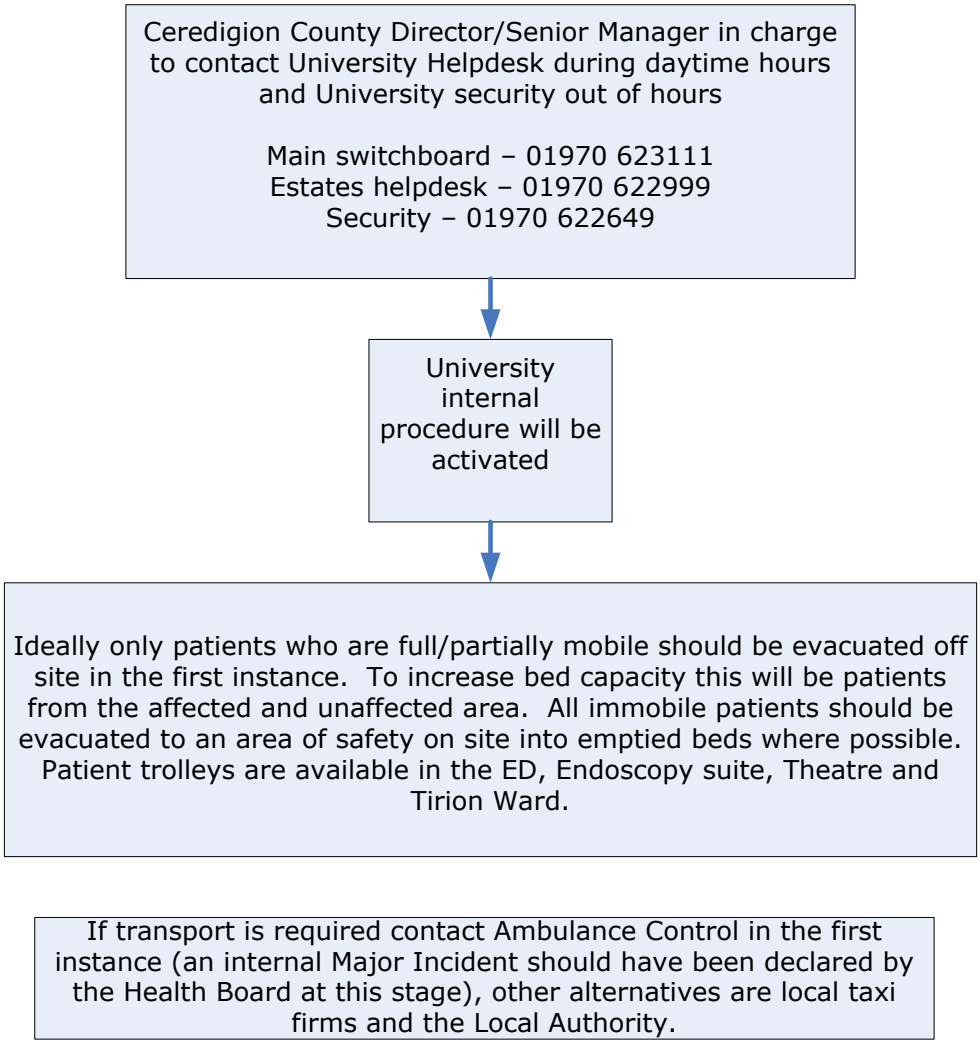
INTERNAL INCIDENT REQUIRING EVACUATION

FOR BRONGLAIS HOSPITAL ONLY:

Use of Aberystwyth University

Aberystwyth University has kindly agreed to assist us if possible, in providing temporary patient holding facilities if we need to evacuate part/whole of the hospital. The degree of assistance will depend on their circumstances e.g. examinations etc. It is anticipated that the Sports Cage/Hall or Pantycelyn would be the initial areas of choice due to access, size and services available.

Procedure to request assistance:



HYWEL DDA UNIVERSITY HEALTH BOARD

CONTACT TELEPHONE NUMBERS

Dyfed Powys Hospitals:		
Glangwili General Hospital Carmarthen		01267 235151
Prince Phillip Hospital Llanelli		01554 756567
Withybush General Hospital Haverfordwest		01437 764545
Bronglais General Hospital Aberystwyth		01970 623131
Other Hospitals in Wales:		
Ysbyty Gwynedd		01248 384384
Wrexham Maelor General Hospital		01978 291100
Ysbyty Glan Clwyd		01745 583910
University Hospital of Wales		02920 747747
Prince Charles Hospital		01685 721721
Llandough Hospital		02920 711711
Royal Gwent Hospital		01633 234234
Nevill Hall Hospital		01873 732732
Morriston Hospital		01792 702222
Princess of Wales Hospital		01656 752752
Welsh/English Border Hospitals/Trusts:		
Royal Shrewsbury Hospital		01743 261000
Hereford Hospital		01432 355444
Gloucester Royal NHS Trust		08454 222222
East Gloucester NHS Trust		08454 222222
Local Authority Emergency Planners:		
Ceredigion County Council		07970 261425
Carmarthenshire County Council		07900 570431
Pembrokeshire County Council		07964 577671
Powys County Council		07970 005072
	Emergency (24 hours)	01597 825275/08450 544847
Duty Emergency Planning Officer for Carms, Ceredigion & Pembs – 24/7	Contacted via Careline out of hours	01558 824283
Directors of Environmental Health:		
Ceredigion	Daytime	01545 572105
	Out of Hours	08457 566766
Carmarthenshire	Daytime	01267 234567/228736
	Out of Hours	01267 224398
Pembrokeshire	Daytime	01437 764551
	Out of Hours	08456 015522
Powys	Daytime	01597 826659
	Out of Hours	08450 544847
Directors of Social Services:		
Ceredigion		01545 572562
	Out of Hours	08456 015392
Carmarthenshire		01267 224697
	Out of Hours	0300 3332222
Pembrokeshire		01437 775831
	Out of Hours	08708 509508
Powys		01597 826906
	Out of Hours (via Brecon Hospital switchboard)	01874 622443

National Bodies:		
Welsh National Poisons Unit	24 hours	02920 709901 / 02921 825554
National Blood Transfusion Service (Wales)	Daytime	01443 622000
Welsh Water	24 hours	0800 0520130
Natural Resources Wales	Anytime	0800 807060
Ministry of Agriculture Food & Fisheries (Wales)		
BASIS Registration Ltd (Pesticides)	Daytime	01335 343945
Health & Safety Executive	Daytime	01267 244230
	Emergency	08453 009923
Public Analyst (Cross Hands)		01269 833990
Military – Joint Regional Liaison Officer	Daytime 24 hours	01874 613381 07766 420496
RVS Emergency Services	24 hours	02476 681369
Coroners Offices:		
Ceredigion		01970 612567/617931
Carmarthenshire		01558 822215
Pembrokeshire		01646 698129
Dyfed Powys Local Resilience Forum:		
Partnership Team		01267 248454
Strategic Co-ordination Centre		01267 226201

BRONGLAIS INTERNAL CONTACT NUMBERS

Key Activity Centres used in the event of a major incident	Location	Tel Ext.
Hospital Co-ordination Centre	MDT/Meeting Room, 1st Floor, Management Offices	**5432** **01970 617006**
Emergency Department	Reception Nurse Office Plaster Room Resus Room Team Leader Doctors Room Base Station 1 Base Station 2	**5753** **5736** **5740/Bleep 3302** **5502** **7615** **5738/7810/5450** **5736/7807** **7809**
Operating Theatres **Main Theatres**	Main Number Back Office/Manager Staff Room	**7114** **7117** **7113**
DSU 2	Main Number Recovery	**8866** **8865**
DSU 3	Theatre Office Theatre 1/2 Theatre 3 Recovery	**5606** **5611** **5612** **5608**
HSDU		**5701**
Wards	Endoscopy ITU Ceredig Rhiannon Short Stay Gwenllian Angharad Meurig Dyfi East Dyfi West Dyfi Reception Ystwyth Enlli	**5925/8876** **5621/2** **5644/5646/8847** **5640** **5633** **5757** **5752** **5941** **5746** **5745** **5986** **5932**
Radiology	Reception CT - Reception	**5681** **5697**
Medical Records		**7038 /5664 / 8892**
Pathology	Blood Bank Coagulation Laboratory Biochemistry Histopathology Laboratory Mortuary	**5945** **5712** **5786 Sec. 5934** **5715** **5743**
Press Centre	Postgraduate Centre	**5806**
Porters	 Head Porter	**5570/7026 Bleep 3506** **5349**
Information	Senior person	**7001**
IT Helpdesk		**01267 232000**
Pharmacy		**5732/5733**
Clinical Engineering		**5926**

GGH INTERNAL CONTACT TELEPHONE NUMBERS

Key Activity Centres used in the event of a major incident	Location	Tel Ext.
Hospital Co-ordination Centre	Based in Meeting Rms 1&2, Ty Nant	8743
Media Reception Area	Based in Cambrian/Coracle Rooms	6270
Family Reception Area	Based in Cardiac Respiratory Unit	
Staff Rest Centre	Based in Staff Restaurant	2053
Patients Discharge Area	Based in Out-Patients Department	
Ambulance Liaison Officer	Based in Out-Patients Department	2022
Police Documentation team	Based in 2nd Consultant Office in EU	3979/68
Key Departmental Numbers		
Emergency Unit	Navigator	Bleep 194
	Reception	3961
	Nurse's Main Duty Office	3987
	Staff Base	3960
	Sisters Office	3971/72
	Resuscitation Rooms	3980,3966
	Plaster Room	3969
Operating Theatres	Reception	2333
	ODP - Bleep	107
	Theatre Senior Sister/ Manager - Bleep	176/2424/226
	Theatre – 1	2571
	Theatre – 2	2572
	Theatre – 3	2573
	Theatre – 4	2574
	Theatre – 5	2776
	Theatre – 6	6092
	Recovery	2576
	Day Surgical Unit	2372
	Endoscopy Unit	2355
Wards	CDU	8721
	Adult Critical Care	2043
	CADOG	2624
	CCU	2760
	TOWY	2621
	PADARN	2612
	STEFAN	2950
	PICTON	2784
	PRESELI	2963
	SAU/CLEDDAU	2606
	TEIFI	6491
	MERLIN	2418
	TYSUL	2173
	DINEFWR	2591
	CERI	2600
	COTHI	2624
	Y LOLFA	2403
Radiology	X-RAY (Bleep 125)	2092,2645
	CT SCAN	2556
Pathology	Reception	2453
	Biochemistry Lab -Out of Hrs Bleep – 110	2456
	Haematology & Blood Bank - Out of Hrs Bleep – 109	2458
	Microbiology Infection Control (Bleep 100)	2502 2596,2422
Pharmacy		2465
Physiotherapy	(Bleep 118 / 119)	2808
Physiological measurements		2084

CSSD		2369 2061/ 62/ 63
Occupational Health		0300 3039674
Clinical Engineering		2793, 2499
Estates		2942-Hotline 2332 -Secretary
Fire Officer		2107
Medical Records		2097 / 8490

PRINCE PHILLIP CONTACT NUMBERS

Key Activity Centres used in the event of a major incident	Location	Tel Ext.
Hospital Co-Ordination Centre Press Room Relatives Reception Area Volunteers Reception Area Staff Rest Centre Patients Discharge Area	Management Offices Co-ordination Hub Based in Postgrad Conference Room Based in Postgrad Lecture Theatre Based in Seminar Room 2 Based in Staff Restaurant Based in Discharge Lounge/Geriatric Day Hospital	3709/3530/3073/3450 1385 6662 6663 3029 3213
Key Departmental Numbers		
Minor Injuries Unit	Reception Sisters Office	3230 3237
Operating Theatres	Reception Theatre Senior Sister/ Manager Theatre – 1 Theatre – 2 Theatre – 3 Theatre – 4 Recovery Day Surgical Unit Endoscopy Unit	3088 6690 3096 3095 3094 3527 3093 3551/6763/6762 3117
Wards	Ward 1 AMAU Ward 3 Ward 4 Ward 5 Ward 6 Ward 7 Ward 9 Critical Care	3217 3303 3131 3136 3105 3108 3380 3313 3121/3118
Radiology	X-RAY CT Scan	1416 3268
Pathology	Reception Biochemistry Lab Haematology Microbiology Infection Control	3520 3062 3056 3068 3066
Pharmacy		3212/3209
Physiotherapy		3204
Physiological measurements		3157
HSDU		3299
Occupational Health		0300 303 9674
Clinical Engineering		0300 303 6115 Option 1
Estates		3689

WITHYBUSH CONTACT NUMBERS

Key Activity Centres used in the event of a major incident	Location	Tel Ext.
Hospital Co-ordination Centre	Based in 24/7 Room, E&UCC	3547/3548/3576
ED Triage Area	Based in ED-Ambulance Entrance Foyer	3081
Relatives Reception Area	Based in Ante-Natal Area	3286
Press Room	Based in Conference Centre Auditorium	3150
Patients Discharge Area	Based in Physiotherapy Treatment Area	3263
Ambulance Liaison Officer	Based in Out-Patients Department	3666
Police Documentation Team	Based in Consultant's Office in ED	3380
Additional Staff Reception	Based in New Outpts Ophthalmology Reception	2435
Communications Team	Based in the Springfield Block	4476/4482
Key Departmental Numbers		
Emergency Department	Reception	3446/3142
	Sisters Office	2364/2492
	Staff Base	3447/3503
	Staff Office	3380
	Staff Rest Room	3457
	Resuscitation Rooms	2369
	Plaster Room	3276
Operating Theatres	Reception	3500
	Theatre Manager	3577
	Theatre One	2416
	Theatre Two	2415
	Recovery	3141/3274
	Theatre Supply Office	3294
	Central Department	3551
	Theatre Bleep	2159
	ODP Bleep	2233
	Day Surgical Unit	3277
	Day Theatre Manager	3316
	Endoscopy Unit Reception	3421
	Endoscopy Nurse Station	3477
	Endoscopy Recovery	2547
	Endoscopy Sister	2548
Wards	Ward 1	3201/3001
	Ward 3	3203/4284
	Ward 4	3204/2455
	Ward 7	3707
	Ward 8	3868/3062
	Maternity	3306
	PACU	3209
	Ward 10	3210/3580
	Ward 11	3211/3911
	Ward 12	2352/3212
	ACDU (Adult Clinical Decision Unit)	3214/2471
	CCU	3558
	ITU	3337/3440
Radiology	X-RAY	3279
	Radiology Manager	3178
	Radiology Office	3385
Pathology	Blood Transfusion	3230
	Haematology	3271
	Biochemistry	3293
	Microbiology	3318
Pharmacy		3137
Physiotherapy		3260
HSDU		3475
Clinical Engineering		3130/3076
Estates		3463
Medical Records		3108 / 3106

HYWEL DDA UNIVERSITY HEALTH BOARD

SWITCHBOARD LOG SHEET FOR MAJOR INCIDENT CALL
NOTIFICATION OF A MAJOR INCIDENT FOR:

Bronglais Hospital ☐ Glangwili Hospital ☐
Withybush Hospital ☐ Prince Phillip Hospital ☐

Major Incident Stand-By ☐ Major Incident Declared ☐

Identity of Caller (Agency)	
Tel No	
Name	
Title/Rank	
Time of Call	Time of Incident

M Major Incident?	**YES**	**NO**
E Exact Location		
T Type of Incident		
H Hazards present		
A Access		
N Number, type & severity of casualties		
E Emergency services present		

Any additional information?	

Authenticity verified by ringing caller back	Yes ☐ No ☐

Signature & name of person receiving call:.....

.....Date.....

INCIDENT LOG RECORD SHEET

Date:	**Incident:**
Role being carried out:	**Name of Person undertaking role:**

Time	Message/Decision/Action	Signature

HYWEL DDA UNIVERSITY HEALTH BOARD

DISCHARGE/TRANSFERRED PATIENTS LOG SHEET

Name of Patient	Hospital Number	Transferred/ Discharged from:	Transferred/ Discharged to:	Escort Required? Yes/No	Notes, X-Rays to go with patient? Yes/No

REPORT FOR DECLARATION OF INTERNAL MAJOR INCIDENT

Incident Site:	
Date/Time:	
Name of Person initiating request for internal Major Incident declaration:	
Name of Duty Manager receiving request:	
Time of discussion with County on-call/Executive Director:	
Time of alert call to Ambulance Control:	
Time of alert call to Dyfed Powys Police Control Room:	
Other agencies notified:	
Nature of Incident:	
Number of known casualties:	
Nature of injuries:	
Decision process that led to Major Incident request: - who was consulted: e.g. other colleagues/external agencies - bed state at time (if relevant) i.e. incident due to volume as opposed to type of injury - additional resources required to respond to incident - any other relevant information	

Signature & name of person completing form:……

……Date…….……..

Example Major Incident Alert to Day Patients/Visitors:

We have received notification that a major incident has occurred and this hospital is on standby to receive casualties.

It is policy to cancel all clinics and procedures. Day patients, outpatients, and visitors must be evacuated immediately. Our medical teams will be proceeding to their designated areas to take up their roles in a major incident.

We apologise for the inconvenience of this situation and ask you to do the following:-

- If you are able to leave the hospital by your own means, please do so without delay.
- If you came to the hospital by ambulance, please wait in the designated area in the Outpatients department. A member of staff will be in attendance shortly to make arrangements.
- If you have any problems with your transport, please wait in the Outpatients department until a member of staff arrives to assist.

You will need to reschedule your appointment by contacting the relevant area in 2 working days' time (contact numbers to be handed out by all clinic areas)

Enghraifft Digwyddiad Mawr Rhybudd I Gleifon Dydd/Ymwelwyr:

Rydym wedi cael ein hysbysu bod digwyddiad mawr wedi digwydd a bod yr ysbyty hwn wrth gefn i dderbyn y rhai a anafwyd.

Mae'n bolisi gennym i ganslo pob clinig a thriniaeth. Rhaid ceisio gwagio'r ysbyty o gleifion dydd, cleifion allanol ac ymwelwyr yn syth. Bydd ein timau meddygol yn mynd i'w hardaloedd dynodedig i ymgymryd â'u rolau mewn digwyddiad mawr.

Ymddiheurwn am anghyfleustra'r sefyllfa hon a gofynnwn i chi wneud y canlynol:

- Os oes modd i chi adael yr ysbyty ar eich pen eich hun, gwnewch hynny yn ddioed.
- Os daethoch i'r ysbyty mewn Ambiwlans, arhoswch yn yr ardal ddynodedig yn yr adran Cleifion Allanol. Bydd aelod o staff yn dod atoch cyn bo hir i wneud trefniadau.
- Os oes gennych broblemau gyda'ch trafnidiaeth, arhoswch yn yr adran Cleifion Allanol hyd nes bod aelod o staff yn cyrraedd i'ch helpu.

Bydd angen i chi aildrefnu eich apwyntiad drwy gysylltu â'r adran berthnasol ymhen 2 ddiwrnod gwaith

DEFINITIONS

EMERGENCY SERVICES

The Ambulance, Fire, Police, Mountain Rescue & Coast Guard services. (Military personnel deployed in support of civil powers are not included in this designation).

POLICE CASUALTY BUREAU

A bureau set up by the Police to maintain a list of casualties resulting from a major incident (including casualties dealt with at the site without referral to hospital).

POLICE DOCUMENTATION TEAM

A team provided at a Receiving Hospital by the local Police Force to pass information regarding casualties to the Police Casualty Bureau.

COMMAND SUPPORT UNIT

The vehicle on site provided by the Ambulance Service, which acts as the base for the Medical Incident Commander/Medical Advisor and the Ambulance Incident Commander. It will serve as the Health Service communication centre on site.

MEDICAL ADVISOR

The Medical Officer with overall responsibility, in close liaison with the Ambulance Incident Commander, for the management of medical resources at the scene of a major incident. He/she **should not** be a member of the MERIT (Medical Emergency Response Incident Team) during the incident.

AMBULANCE STRATEGIC COMMANDER

The Senior Ambulance Officer who manages, in close liaison with the Medical Incident Officer/Medical Advisor, the NHS resources at the scene of the incident

LISTED HOSPITALS

Hospitals equipped to receive casualties on a 24-hour basis.

RECEIVING HOSPITALS

Hospitals selected by the Ambulance Service to receive casualties in the event of a major incident.

DESIGNATED HOSPITAL

The **first** Receiving Hospital designated to receive casualties.

SUPPORTING HOSPITALS

A hospital which receives casualties after the Designated Hospital or receives patients transferred from the Designated Hospital to allow for a larger number of casualties to be accepted.

HOSPITAL CONTROL TEAM

The Team, led by the Hospital/On-Call Manager and including the Medical Controller and Nurse Controller, that manages the Hospital's response to a major incident. The Hospital Control Team will be based in the Hospital Co-ordination Centre.

HOSPITAL CO-ORDINATION CENTRE

A centre set up at a Receiving Hospital to collate details of casualties received, their condition and location, hospital bed status, theatre availability, and all necessary information to assist the hospital's response to the incident.

TRIAGE OFFICER

The Doctor who receives and assesses all casualties as soon as they enter the hospital and then decides priority for treatment.

AMBULANCE LIAISON OFFICER

An Ambulance Officer at a Receiving Hospital who is responsible for the provision of mobile radio communications between the hospital and Ambulance Services; for the supervision of Ambulance Service activity and for liaison at the Receiving Hospital.

MEDICAL CONTROLLER
The Doctor responsible for co-ordinating all hospital medical arrangements relating to the major incident.

NURSE CONTROLLER
The Senior Nurse responsible for co-ordinating all hospital nursing arrangements relating to the major incident.

RELATIVES RECEPTION AREA
An area allocated to relatives or friends involved in the major incident, which will be attended by the appropriate specialist personnel, Counsellors, Hospital Chaplain etc.

INCIDENT RESPONSE TEAM
A team of Senior Representatives from Hywel Dda University Health Board, Public Health Wales and other nominated agencies which will usually only be activated in certain circumstances, i.e. communicable disease, radiation incidents, chemical incidents, flu pandemic or other unforeseen circumstances.

TRAUMA NETWORK
A network of hospitals, emergency services and rehabilitation services across the region, working together to ensure patients with life-threatening or life-changing injuries receive the best possible treatment and care.

LOGGIST
Person responsible for recording decisions made, and the time/date and rationale behind the decision.

GLOSSARY

A&C	Acute and Community
AIC	Ambulance Incident Commander
ALO	Ambulance Liaison Officer
AMAU	Acute Medical Assessment Unit
BGH	Bronglais General Hospital
BIRT	Burns Incident Response Team
BSCT	Burns Specialist Care Team
CBRN	Chemical, Biological, Radiational and Nuclear
CCS	Casualty Clearing Station
ChaPD	Chemical Incident Hotline
CIMSU	Chemical Incidents Management Support Unit
CNC	Clinical Night Co-ordinator
COMAH	Control of Major Accident Hazards Regulations
DH	Department of Health
DI	Designated Individual
DoTH	Director of Therapies and Health Science
DPH	Director of Public Health
DSU	Day Surgery unit
DVI	Disaster Victim Identification
ED	Emergency Department
EMRTS	Emergency Medical Retrieval and Transfer Service
EPRR	Emergency Preparedness, Resilience & Response
EU	Emergency Unit
GGH	Glangwili General Hospital
EUCC	Emergency & Unscheduled Care Centre
GP	General Practitioner
HALO	Hospital Ambulance Liaison Officer
HCC	Hospital Co-ordination Centre
HDU	High Dependency Unit
ID	Identification
IP&C	Infection Prevention & Control
ITU	Intensive Therapy Unit
JDM	Joint Decision Model
LRF	Local Resilience Forum
MIO	Medical Incident Officer
MIP	Major Incident Plan
MIU	Minor Injuries Unit
MOU	Memorandum of Understanding
NAIR	National Arrangements for Incidents involving Radioactivity
NBBB	National Burns Bed Bureau
NEMA	National Emergency Mortuary Arrangements
NHS	National Health Service
NNP	Night Nurse Practitioner
NWSSP	NHS Wales Shared Services Partnership
OCM	On Call Manager
OPD	Outpatients Department
PPE	Personal Protective Equipment
PPH	Prince Phillip Hospital
RMU	Radiation Monitoring Unit
RTC	Road Traffic Collision

SAR	Surgery, Anaesthetics & Radiology
SCG	Strategic Co-ordination Group
SPH & HSCRC	South Pembrokeshire Hospital and Health & Social Resource Centre
STAC	Scientific and Technical Advisory Cell
SWTN	South Wales Trauma Network
TCG	Tactical Co-ordination Group
VIP	Very Important Person
WAST	Welsh Ambulance Services NHS Trust
Wd	Ward
WG	Welsh Government
WGH	Withybush General Hospital

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Exercise Tendley

4 -7 February 2025

Live Major Incident Exercise Report

1. Introduction

This report outlines the findings of the multi-agency live major incident exercise conducted from 04-07 February 2025, which tested the Health Boards response to a simulated major incident on the Glangwili Hospital site. The focus of the hospital element of the exercise was:

- Major Incident Notification and Activation
- Emergency Department (ED) Response
- Hospital Coordination Centre (HCC) Operations
- Mortuary Preparedness and Communication with Dyfed Powys Police Disaster Victim Identification (DVI) teams.

The objective was to evaluate the effectiveness of hospital major incident notification and activation procedures, response arrangements, staff preparedness, communication channels, and resource allocation during a large-scale emergency.

2. Exercise Overview

Scenario – Day 1

The exercise simulated a passenger train derailment incident on the main Carmarthen to Cardiff line (scenario set up on the Gwili Railway in Carmarthen). Casualty numbers, injury types, and logistical challenges were designed to test response notification and activation, ED major incident response, ED decontamination procedures, surge capacity, communication efficiency, and hospital co-ordination centre response.

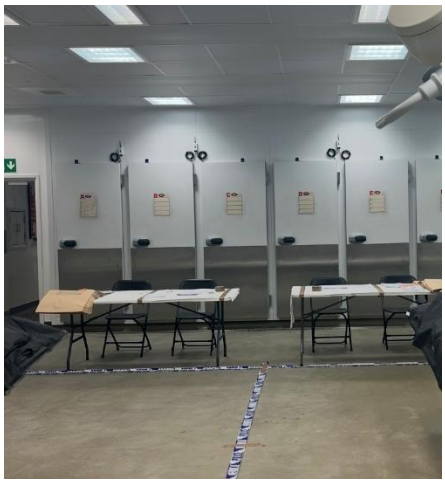
Scenario – Day 2

Health Board Mortuary and EPRR staff attended the "incident scene" and observed Urban Search & Rescue (USAR) assessment of, and solution to, the logistical challenge of accessing the trains carriages without use of a platform.

Once achieved, the DVI team commenced retrieval and processing of the deceased.

Scenario – Day 3

Exercise play moved to the Mortuary at Glangwili Hospital where the DVI team worked with Mortuary colleagues to process the deceased in line with UK DVI procedures and standards.



Participants

- Exercise Facilitators
- Switchboard Staff
- Emergency Department Staff (Doctors, Nurses, Healthcare Support Workers, Administrators)
- Hospital Co-ordination Centre (Major Incident Action Card Holders, Loggist, Admin Support)
- Mortuary Staff
- External Agencies (WAST, EMRTS, Dyfed Powys Police, Mid & West Wales Fire & Rescue Service, Coroner's Office, Local Authorities, Transport for Wales, British Transport Police, 4x4 Response Wales, Red Cross)

3. Key Objectives and Findings

3.1 Major Incident Activation

Objective: Test the notification process between WAST and Glangwili Hospital Switchboard and the ability to activate and escalate a major incident response in an effective and timely manner.

Findings: The notification was received, and key personnel were notified efficiently.

Strengths:

The major incident notification was received by Switchboard from WAST and the escalation process followed the major incident communications cascade process. A condensed cascade was utilised for the exercise. However, a full hospital cascade was undertaken the week before the exercise to test the full cascade process.

Areas for Improvement:

Staff to be familiar with cascade process of all sites.

3.2 Emergency Department (ED) Response

Objective: To test Glangwili Emergency Department response arrangements to a major incident event and the ability to manage a surge of casualties, triage efficiently, and coordinate patient care. Decontamination procedures were also tested.

Findings: some objectives were difficult to assess due to the limitations of the environment (ED portacabin) and exercise scope. However, the exercise has provided a valuable opportunity to test the ED's response strategies, improve coordination, and identify gaps in preparedness. Insights gained should help build resilience and ensure a more effective response to actual incidents

Strengths:

- Clear establishment of Lead Consultant with early discussion around preparation of department, with considerations of staffing, equipment and other resources.
- Good working relationship established at front-door; triage process worked well.
- Initially clear allocation of doctor roles.
- Updates clearly communicated by Lead Consultant throughout exercise.
- Good support and communication from Hospital Ambulance Liaison Officer (HALO).
- Ambulances cleared swiftly.

- Once established, clear record keeping and communication to HCC by Loggist.
- Additional scribes were quick to learn and maintained accurate records of clinical scenarios.
- Good clinical assessments observed with the majority observed having clear intervention and treatment plans.
- Prepacked patient records available and accessible.

Areas for Improvement:

- Raise awareness of major incident trolley and resources available there.
- Clarification of role allocation process.
- Communication between the team, in particular the feedback loop from within the "department" to the Leads at the "front door".
- Consideration of staff fatigue.
- Initial log and record keeping to be reviewed (until Loggists/scribes arrive). Number of trained Loggists to be increased.
- Review of decontamination process activation within ED.
- Stock levels of critical emergency supplies were adequate for the exercise, but some concern for availability of quantity of consumables needed in a real incident.

3.3 Hospital Coordination Centre (HCC) Operations

Objective: Assess the effectiveness of the HCC in overseeing hospital-wide response, resource allocation, and external coordination.

Findings: The HCC was activated via the Communications Cascade process and was set up and operated effectively throughout the exercise.

Strengths:

- The HCC was activated promptly, and key personnel/action card holders assembled.
- Digital systems worked well, linking HCC with the ED.
- Communication between the HCC and services areas was effective.

Areas for Improvement:

- No Hospital Ambulance Liaison Control Officer (HALCO) allocated by WAST for exercise, but the HALO located in ED did attend the HCC to provide an update.
- Additional casualty information required to facilitate decision making.
- Action cards need updating to reflect organisational re-structuring.
- Communication - mobile signal in the Ty Nant building limited.

3.4 Mortuary Preparedness

Objective: Test the mortuary's capacity to handle mass fatalities and coordinate with the DVI Teams and Coroner's Office.

Findings: the exercise provided an excellent opportunity to test Mortuary arrangements for responding to an incident of this type and has enabled a number of challenges to be recognised. Additionally, relationships with Police, DVI and the Coroners' Office have been strengthened greatly by the opportunity to exercise collaboratively.

Strengths:

- The mortuary team were able to observe the deceased retrieval process at the scene of the incident prior to the exercise moving to the mortuary.
- The mortuary was able to accommodate the simulated influx of deceased.
- Briefing was informative and debrief provided good feedback, strong communication throughout – Police staff willing to answer questions, good communication both ways between HM Coroner, Senior Police Staff, DVI Officers and Mortuary staff.
- Excellent multi-disciplinary relationship/team-building – involvement of all exercise members as part of one training team.
- DVI documentation and body identification procedures were followed efficiently and supported by the mortuary team.
- Staff have received training in DVI procedures and major incident response.

Areas for Improvement:

- Storage capacity would be insufficient in a real large-scale disaster; contingency planning needed in additional to business-as-usual surge capacity planning.
- Confidential footprint in the Mortuary perimeter to maintain dignity for the deceased and/or confidentiality of incident.

4. Recommendations

1. An action plan of issues identified within the exercise be developed and progressed via the EPRR Group.
2. The Health Board to participate in the multi-agency exercise debrief to ensure key lessons identified feed into the wider exercise report.
3. Learning from the exercise be incorporated into the Major Incident Plan during its annual review process.
4. Learning from the exercise be incorporated into the ED Major Incident procedures.
5. Learning from the exercise be incorporated into appropriate Local Resilience Forum plans.
6. Scoping of options for increasing the Mortuary footprint in the event of a mass fatality incident be undertaken.

5. Conclusion

The exercise successfully tested Glangwili Hospital's ability to respond to a major incident, identifying both strengths and areas for improvement. While staff demonstrated commendable teamwork and adherence to protocols, specific challenges in communication, role allocation, stock availability, space/capacity management, and digital incident response systems need addressing.

Prepared by: Sam Hussell

Designation: Head of Emergency Preparedness, Resilience & Response, Hywel Dda University Health Board.

Exercise Participants

Exercise Facilitators

Sam Hussell, Head of EPRR

Claire Conroy, Emergency Planning & Business Continuity Co-ordinator

Claire Hathway, Trauma Lead Manager

Fern Wilson, Practice Educator

Dylan Jones, Emergency Nurse Practitioner

Switchboard

Nesta Evans, Switchboard Operator

Kelly Beynon-Thomas, Switchboard Manager

Hospital Co-ordination Centre

Trish Butchers, Service Manager, Paediatrics

Iona Evans, Head of Nursing

Louisa Standeven, Interim Deputy Head of Nursing

Robbie Ghosal, Hospital Director

Stephen Bryer, Loggist

Mel Jones, Loggist

Caryl Bowen, Service Delivery Manager – Unscheduled Care

Sarah Perry, General Manager – Carmarthenshire System

Abbi Daniel-Thomas, Senior Nurse Manager

Diane Knight, Service Delivery Manager – Theatres/DSU/PAC

Laura Tipping, Business Manager – Unscheduled Care

Emergency Department

Sarah Letheren, Scribe

Mo Nasser, ED Consultant

Allen Roby, ED Clinical Teaching Fellow

Sandra Hopkins, Major Trauma Practitioner

Vicki Brown, Major Trauma Practitioner

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Kostas Karmpaliotis, ED Consultant

Fatma Aly, ED Registrar

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Leah Jonathan, B5

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Jo Griffith, B5

John Mackrell, B2

Amanda Kelly, Receptionist/Scribe

Mortuary

Yasmin Brown, Regional Mortuary Manager

Cathy Cenayko, Mortuary Manager

David Morris, Mortuary and Cellular Pathology Technician

Molly Saunders, Lead Anatomical Pathology Technologist

Shaun John, Assistant Mortuary Attendant

Observers

Mark Ransom, Switchboard Operator

Dr. Ardiana Gjini, Executive Director of Public Health

Jason Evans, Head of EPRR, NHS Executive

Gareth Lewis, Senior Coroner – Carmarthenshire & Pembrokeshire

Lauren Williams, Dyfed Powys Police Casualty Bureau Manager

Craig Baker, Cellular Pathology Service Manager

Maurizio Brotto, Regional HTA Designated Individual/Consultant Pathologist

4

10:51 AM, 0 Mins

4 - Policies to be Approved

4.1

10:51 AM, 10 Mins

4.1 - Business Continuity & Planning Policy

Sam Hussell (Head of Health Emergency Planning)

For approval

Attachments

Health and Safety SBAR BC Planning Policy June 2025.pdf

Appendix 1 186 Business Continuity Planning Policy FOR APPROVAL.pdf

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PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	03 July 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Business Continuity Planning Policy
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr Ardiana Gjini, Executive Director of Public Health
SWYDDOG ADRODD: **REPORTING OFFICER:**	Sam Hussell, Head of Emergency Preparedness, Resilience & Response

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Business Continuity Planning Policy is being presented to the Health & Safety Committee for approval following review.

The policy is intended to embed Business Continuity planning arrangements within the Health Boards' working practices, as well as ensuring the development of appropriate command and control structures within Directorates, Services and Departments should an incident/event occur.

Cefndir / Background

The Business Continuity Planning Policy was first developed in 2011 to facilitate compliance with the Civil Contingencies Act (2004) and provide the Health Board with a process for developing robust business continuity management systems. Subsequent versions of the policy have been developed to ensure content reflects current organisational structures and processes.

Asesiad / Assessment

The Health Board's routine business may, at any time, be interrupted by an emergency or other significant event. This could range from something that affects just one area of operation to a more serious event affecting the Health Board's buildings, staff or service functions, as well as an incident affecting the wider community.

The Business Continuity Policy lays out how the development of robust business continuity plans can enable a rapid, proportionate and efficient response to bring about a timely return to business as usual. Lack of such arrangements can lead to potential injury/harm, interruption to service delivery as well as financial and reputational damage.

Changes focus on process for declaration of a business continuity incident and reflection of organisational changes.

The Policy has been reviewed and consulted upon within the Emergency Preparedness, Resilience & Response (EPRR) Group and via wider global consultation process.
Argymhelliad / Recommendation The Health & Safety Committee is asked to **APPROVE** the Business Continuity Planning Policy.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.3 Approve organisational health and safety policies, procedures, guidelines and codes of practices (policies within the scope of the Sub-Committee).
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 3. Effective
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	5. Whole systems persepctive
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Civil Contingencies Act (2004) NHS Wales Emergency Planning Guidance (2015)
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd lechyd a Diogelwch: Parties / Committees consulted prior to Health and Safety Committee:	EPRR Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No financial impact or capital requirements identified
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Explicit within the policy
Risg: Risk:	Explicit within the policy
Cyfreithiol: Legal:	Demonstrates compliance with the Civil Contingencies Act (2004)
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	EqIA undertaken with no negative impact identified

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Business Continuity Planning Policy

Policy information

Policy number: 186
Classification: Corporate
Supersedes: previous versions
Version number: 4
Date of Equality Impact Assessment:

Approval information

Approved by: Health and Safety Committee
Date of approval:
Date made active:
Review date:

Summary of document:
This policy enables the development of Business Continuity Plans and, therefore, a robust business continuity management system, and clarifies the responsibilities that are held by Hywel Dda University Health Board

Scope:
This policy applies to all staff within Hywel Dda University Health Board

To be read in conjunction with:
Hywel Dda University Health Board Emergency Plans e.g. Major Incident & Pandemic Plans

Major Incident Plan
193 Retention and Destruction of Records Policy (opens in a new tab)
608 Risk Management Framework Policy (opens in a new tab)
1138 Security Management Policy (opens in a new tab)
1155 Critical Threat Level Procedure (opens in a new tab)

Patient information: NA
Owning group: Health & Safety Assurance Committee
Executive Director job title: Executive Director of Public Health

Reviews and updates:
Version 1 – Feb 2011
Version 2 – 01/2017
Version 3 – 11/7/2022
Version 4 – full review

Keywords
Business Continuity; Emergency Planning; EPRR

Glossary of terms

BC – Business Continuity
BCM – Business Continuity Management
EPRR – Emergency Preparedness, Resilience and Response

Key points:
This policy enables the development of Business Continuity Plans and a robust Business Continuity Management System, and clarifies the responsibilities that are held by Hywel Dda University Health Board

Contents

Policy information....1
Approval information....1
Introduction....4
Policy Statement....4
Scope....4
Aim....4
Objectives....5
Definitions....5
Timescales....6
Business Continuity Management....7
Developing Business Continuity Plans....7
Critical Function Analysis....7
Business Continuity Plans....8
Records Management....10
Accountability and Responsibility....10
Training, exercising and integration of Business Continuity Plans....12
Monitoring, Assurance and Review....12
Appendix 1 - Examples of critical functions:....13
Appendix 2 - Risk Rating Matrix....15
Risk Consequence Table – Guidance....16

Introduction

The Health Board's routine business may, at any time, be interrupted by an emergency or other significant event. This could range from something that affects just one area of operation to a more serious event affecting the Health Board's buildings, staff or service functions, as well as an incident affecting the wider community. Alternatively, while responding to an emergency, a serious Service Interruption/Business Continuity incident may occur within the organisation's buildings or services. Such incidents may activate Directorate, Service or Departmental Business Continuity Plans so as to support a rapid, proportionate and efficient response, and to bring a timely return to 'business as usual'.

Hywel Dda University Health Board is defined as a Category 1 responder in the Civil Contingencies Act 2004 (CCA). The Act places a number of responsibilities on the Health Board in this regard and under the umbrella of Emergency Preparedness, Resilience and Response (EPRR).

These include:

- Respond to an emergency
- Continue to support emergency response partners
- Continue to provide critical services to the public
- Put in place Business Continuity Management arrangements

This Business Continuity Planning Policy is separate from, but may operate alongside, the Major Incident Plan for Hywel Dda University Health Board.

Policy Statement

This policy is intended to embed Business Continuity Plans within Hywel Dda University Health Boards' working practices, as well as ensuring the development of appropriate command, control, coordination and communication structures within Directorates, Services and Departments should an incident/event occur.

Scope

The scope of this policy applies to all staff within Hywel Dda University Health Board. Executive Directors and Senior Managers need to be aware, and supportive of, the development of their Directorate, Services or Departmental Business Continuity Plans.

Aim

The aim of this policy is to support staff within Hywel Dda University Health Board to develop and understand Business Continuity Plans, and to enable a robust Business Continuity Management system to be established.

OBJECTIVES

- Identifying, planning, resourcing and implementing preventive actions that reduce the risk of disruption to key services
- Establishing arrangements to respond to serious disruptions; by prioritising actions and allocating resources to recover critical functions, and therefore preparing for the return to normal working as quickly as possible
- Supporting effective communication during a service disruption; by being aware, and assisting with the development, of the appropriate command, control, coordination and communication structures within Directorates, Services and Departments
- Linking, when necessary, to other local resilience agency arrangements (including strategic, tactical and operational command structures)
- Ensuring Hywel Dda University Health Board can continue to exercise its core functions in the event of an emergency

Definitions

The following definitions will apply in the policy as shown in the table below:

Term	Meaning
Major Incident	Any occurrence, which presents serious threat to the health of the community, disruption to the service or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance trusts or primary care organisations". (NHS Emergency Planning Guidance 2005).
Service Interruption*	Any incident which threatens personnel, buildings or the operational procedures of an organization and which requires special measures to be taken to restore normal functions. An appropriate response would aim to maintain essential services and restore normal services as soon as possible under the circumstances prevailing at the time.
Business Continuity	Business Continuity is the process of facilitating the recovery of critical business services, systems and processes within agreed timeframes, while maintaining the organisation's critical functions and delivery of vital services. Is defined as "*an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level." (NHS England, EPRR Framework 2015)*
Service Recovery	The restoration and support of utilities and services without which the core organisational functions would not be able to continue.

*There are many varied possible causes of service interruption. As a general guide, Business Continuity must be carried out to minimise the effects of a number of potentially disruptive events, for example:

- Major accident or incident, national disaster, epidemic/pandemic or terrorist attack
- Fire, flood, extreme weather conditions
- Major disruption to staffing e.g. as a result of an epidemic/pandemic, transport disruption, industrial action, inability to recruit or mass resignations
- Loss of utilities, including Information Technology (I.T.) and communication systems
- Loss of a Key Supplier or Partner

Timescales

The timescales used to determine the provision of adequate levels of services are classified as follows:

Respond immediately

- Acute danger/distress to staff and/or patients
- Provision of an essential service/function cannot be carried out

Respond within one hour

- Danger/distress to staff and/or patients
- Prevents provision of an essential service/function

Respond within one day

- Disruption/discomfort to staff and/or patients
- Hinders or restricts normal business operations

Respond within one week

- Will not directly disrupt services but will cause inconvenience to staff and/or patients

Respond within one month

- Will involve non-urgent repairs

The use of timeframes is to ensure that priority is given to providing resources to facilitate key services within each department or directorate. The consequences of not providing essential services may lead of life being endangered, statutory duties not being met and the ability of the Health Board to recover from an incident.

Business Continuity Management

The Business Continuity Plans for Hywel Dda University Health Board have been developed in line with the NHS England Business Continuity Management Framework (service resilience) (2013) and to comply with ISO 22301: Management system requirements for Business Continuity.

The stages in the process are:

- Understanding the organisation's business, i.e. defining the critical/core functions of the organisation.
- Identifying the risks and establishing how they are to be managed.
- Developing a response to risks.
- Raising awareness and embedding plans.
- Maintaining and auditing plans.

Each Executive Director and their services/teams are required to carry out an assessment of their headline functions/activities and then complete a Business Impact Analysis plan for each risk identified, examples will be provided as these will be of assistance with this analysis. To ensure uniformity of the corporate plan it is essential that the business continuity plan templates are completed.

Developing Business Continuity Plans

It is important that each Executive Director has ownership of the Business Continuity Plans that relate to their Directorate, Service or Department, therefore each Director is responsible for ensuring the completion of the Business Continuity Plans.

Elements involved in developing Business Continuity Plans are as follows:

- Identifying the Headline Functions / Activities
- Allocation of a Risk Assessment category
- Identifying Single Points of Failure, and subsequently highlighting the mitigating corrective or preventative actions needed
- Identifying the correct mutually supporting departmental and service providers
- Training, maintaining and testing the plans

Hands-on-support, guidance and instruction on the completion of these plans is offered by the EPRR Team, this support can vary according to the content of the plans. Both paper and electronic copies of the Business Continuity Plans should be held within the Directorate, Service or Department that they have been developed for, enabling them to be cascaded to all staff as appropriate. Copies will also be held by the EPRR Team, where they will be collated and reviewed continuously.

Critical Function Analysis

Critical functions are those functions that underpin the ability of the organisation to:

- Provide an appropriate response to an emergency.
- Fulfil any statutory functions.
- Impact on the credibility and public perception of the organisation in not providing services.

Key risks to critical functions, which would result in the loss of function, should be identified and documented. Examples of critical functions have been provided to assist in the process of determining critical functions within each Directorate (see Appendix 1).

Business Continuity Plans

Plans should be concise and accessible to those with responsibilities defined in the plans. Plans should be fully understood by the staff and the teams responsible for specific actions within the plans.

Plans should clearly state any interdependencies and reliances, both within the organisation and with other stakeholders.

Plans must also include:

- A description of the risk identified and a risk score (using the risk rating matrix in Appendix 2).
- Details on how to control the risk.
- Details of who is responsible for overseeing contingency planning and activating plans.
- Details of who is responsible for implementing action plans.
- Details of external organisations to be involved if appropriate.
- A description of escalation procedures if appropriate.
- Details of who within the organisation should be informed that the plan has been activated (e.g. Director, Executive Director on Call, Chief Executive).

Plans should estimate the resources that each activity will need to get started again. These may include:

- People (workers) – numbers, skills and knowledge.
- Work site (premises) and facilities.
- Supporting technology (pay close attention to software needs/Digital Services), plant and equipment.
- Access to previous work or current work-in-progress information.
- External services and supplies.
- What are the needs of your stakeholders? This may have an effect on your resource levels.

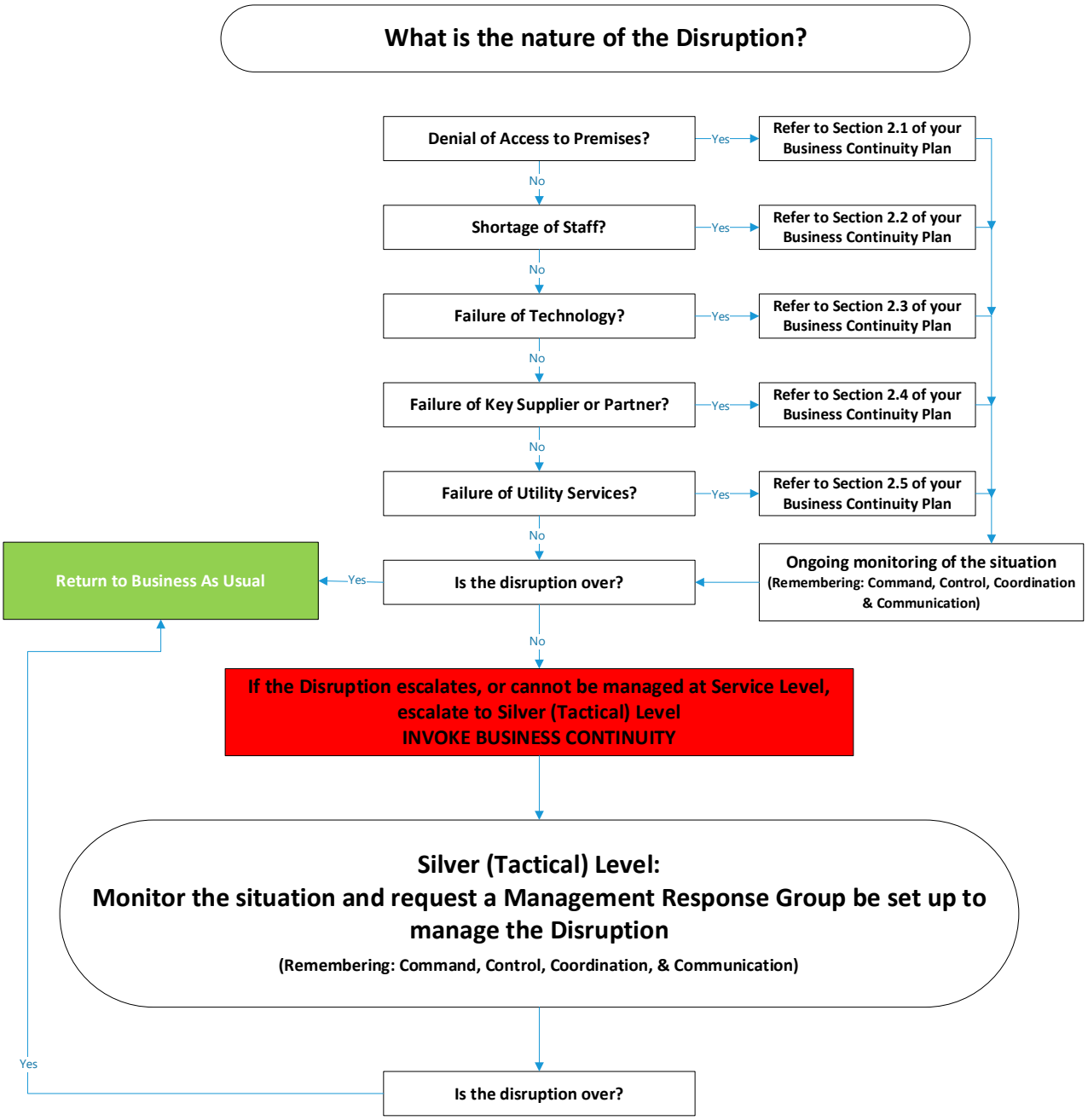
The plan must document how it is to be invoked and how this is to be achieved in the shortest possible time following the occurrence of a service disruption. Criteria and clear guidelines to identify individuals with authority to invoke plans, and under what circumstances, will facilitate a timely, co-ordinated and consistent approach. Plans must also contain information about how their implementation will be monitored and recorded.

While it is difficult to predict the type of incident, it is assumed that these are likely to be associated with scenarios including fire, flood, building collapse, computer failure, telecommunication failures, loss of utilities, fuel shortages, staff shortages and terrorism. The list is not exhaustive and those dealing with business continuity within their department or directorate should assume that they might be called upon to provide an adequate level of their service in unusual circumstances and to varying degrees.

Activation

Notification of a Business Continuity disruption may originate from any source by following the activation sequences in the flowchart below, most disruptions should by manageable. However, the Silver (Tactical) Level of management will be responsible for invoking Business Continuity, please complete the template in Appendix 3.

The situation should be closely monitored. If the disruption escalates, or impacts a number of key services, consider requesting that a Management Response Group be set up to assemble the appropriate personnel to deal with the disruption. This should be discussed with, and agreed with, the Gold On-Call. This will aid the Health Boards recovery and protect itself from any further effects of the disruption.



This flow chart will now be included in all Business Continuity Plans as they are developed, reviewed and updated.

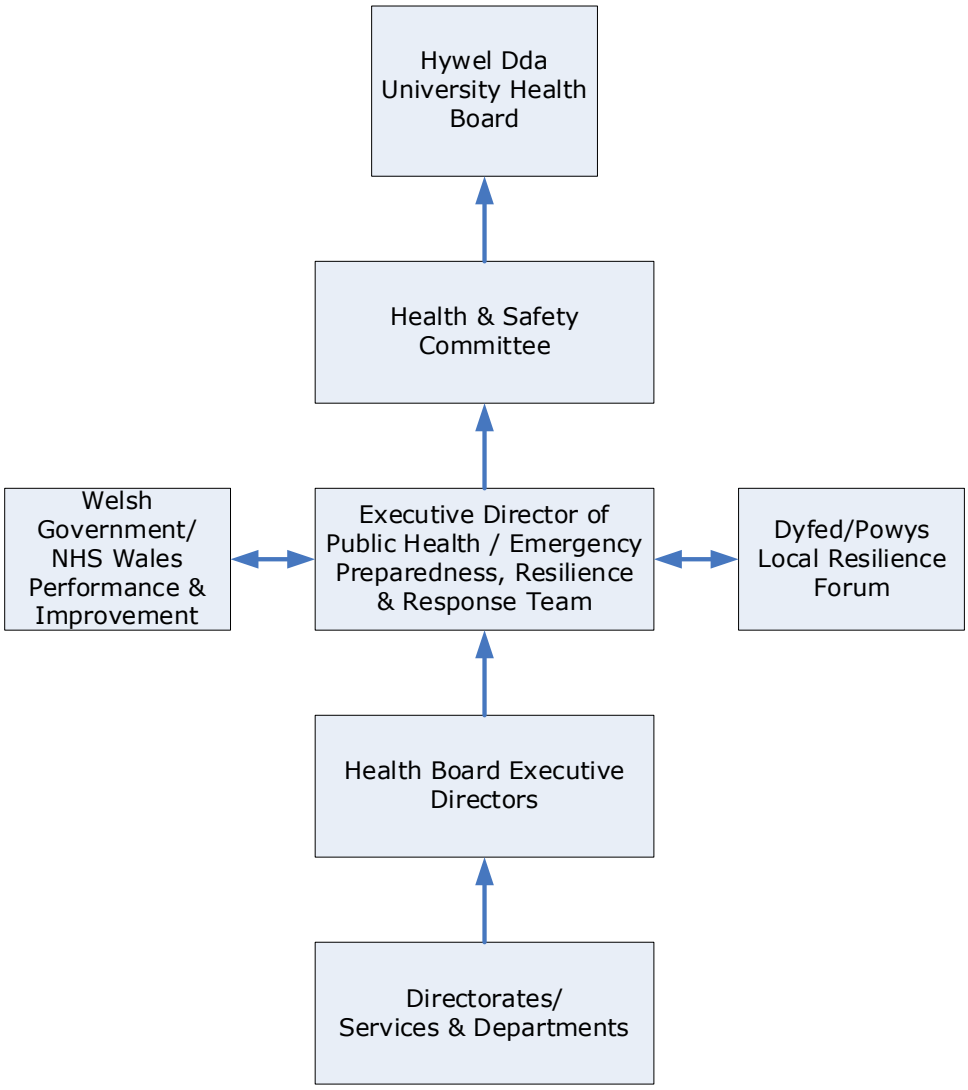
Records Management

All records created during the implementation of a business continuity plan must be kept to ensure an appropriate response at a later review.

For the retention period of these records see the following document: Retention and Destruction of Records Policy (Including Health Records). (opens in a new tab). Here you will be signposted to the Records Management Code of Practice for Health and Social Care, where current retention guidance can be found.

Accountability and Responsibility

Line of Accountability:



Roles and Responsibilities:

Those responsible for Business Continuity Planning must consider the following general points:

- Risk Management and Business Continuity work side by side. The risk management strategy integrated with Business Continuity should ensure a sound risk culture.
- Business Continuity must be embedded within services and supported by good management and not considered in isolation from other working practices.
- The first few hours after an incident are crucial and good management, supported by robust Business Continuity plans, will considerably aid recovery.
- Business Continuity Planning is not simply about knowing the answers when an incident occurs but knowing what questions to ask.
- Business Continuity Planning can improve existing procedures, improve services and assist in the prevention of disruption to service provision.
- It is essential to have shared risks covered in any Business Continuity Plan. Do not try to 'go it alone', remember to involve other agencies and similar organisations who will be only too willing to provide support if the appropriate plans are in place.

Chief Executive/Executive Director of Public Health

The Chief Executive has overall responsibility for ensuring that Hywel Dda University Health Board has effective arrangements in place to respond to an incident that has the potential to affect service provision. Responsibility for ensuring that there are Hywel Dda Business arrangements in place is delegated to the Executive Director of Public Health and the EPRR Team.

Executive Directors/Senior Managers

Executive Directors and their Senior Managers are responsible for ensuring that:

- Directorates and services complete an analysis of critical functions and risk assessments.
- Business continuity plans are completed for each risk identified.
- Business continuity plans are cascaded to appropriate staff within the directorate and appropriate information and training is given.
- Plans and critical function analyses are reviewed annually, although periods of review can be predetermined, or sooner as appropriate.
- Business continuity plans are available on directorate shared drives.

EPRR Team

- Provide appropriate hands-on support to Directors and Senior Managers.
- Collate completed critical function analyses and business continuity plans.
- Ensure the master plan is kept electronically and is available on request.

All Staff

All staff must make themselves familiar with their individual roles as set out in this policy and procedure and individual business continuity plans.

Training, Exercising and Integration of Business Continuity Plans

Hands-on guidance and instruction by the EPRR Team can be provided to support individual(s) responsible for creating the Business Continuity Plan for each service/department.

All Departmental Business Continuity plans to be shared, managed and reviewed through departmental shared drives. This is the responsibility of the individual(s) responsible for creating the Business Continuity Plans for each service/department.

A range of model Business Continuity plans will be placed on the intranet as examples of good practice for guidance purposes.

Business Continuity Plans must be tested by the plan owners to demonstrate they work and to correct errors/omission identified. Familiarity with the plan is critical as staff need to be aware of the processes included, and without testing procedures cannot be relied upon to work.

Monitoring, Assurance and Review

Business Continuity Plans will be monitored contemporaneously by the EPRR Teams using the Business Continuity Management System. This will provide information to the Performance Team, who manage the Health Board's 'Our Performance Dashboard' management process.

In line with Health Care Standards Theme 2 Safe Care: Standard 2.1 *Managing risk and promoting Health & Safety*, Business Continuity Plans will be audited on a regular basis. With the resultant outcomes and action plans being reported to the Health & Safety Committee and the Hywel Dda Board. This, along with the 'Our Performance Dashboard', will provide assurance that the Health Board have plans in place.

The acknowledged plans shall be reviewed annually, two yearly, or three yearly, as agreed at the time of completion, or earlier if required.

Appendix 1 - Examples of critical functions:

Organisational functions:

- Clinical Care Groups
- Corporate Services (including Board functions)
- Digital Services
- Estate Operations (site provision)
- Finance
- Workforce
- Primary Care
- Public Health

Critical business functions:

Planning for restoration and support of utilities and services without which the core business functions would not be able to continue e.g.

- Digital Services – Digital Systems and Communications
- Estates Operations Services – Utilities (gas, water, electricity)
- Estates Operations Services Facilities – Catering, Portering, and Domestic
- Estates Operations Services – Fire Alarms and Security Systems
- NHS Supplies

Contractor services/primary care

Contingency planning in respect of the Health Board's obligation to provide Primary Care services e.g. the Health Board's response to unplanned loss of a contractor or contractor service.

Three-tier approach to business continuity

Tier 1

These are essential services and must be delivered. The services defined here are selected on the rationale that front line health services and services to high-risk groups e.g. vulnerable patients in the community, must be maintained.

Examples of Tier 1 services:

- Child protection
- Rapid response team
- General Practitioners
- Information technology and communications
- In-patient services
- Pharmacies

Tier 2

Tier 2 services are important, but suspension should be considered (if Tier 3 services are already suspended). Services defined as Tier 2 services should be neither life-threatening health services nor essential corporate services.

Examples of Tier 2 services:

- Elective surgery
- Annual health assessments or screening
- Falls services
- Cardiac rehabilitation classes
- Out-patient clinics

Tier 3

Tier 3 services are the first services the Health Board should suspend in the event of a prolonged major incident and in the interested of reallocating resources to Tier 1 business continuity.

Examples of Tier 3 services:

- Health promotion activities
- Training/study leave

Appendix 2 - Risk Rating Matrix

ACTUAL RISK OUTCOME			
LOW (Green)	**MODERATE** (Yellow)	**SIGNIFICANT** (Amber)	**HIGH** (Red)

LIKELIHOOD	CONSEQUENCE				
	INSIGNIFICANT 1	MINOR 2	MODERATE 3	MAJOR 4	CATASTROPHIC 5
ALMOST CERTAIN 5	5 (Yellow)	10 (Amber)	15 (Red)	20 (Red)	25 (Red)
LIKELY 4	4 (Yellow)	8 (Amber)	12 (Amber)	16 (Red)	20 (Red)
POSSIBLE 3	3 (Green)	6 (Yellow)	9 (Amber)	12 (Amber)	15 (Red)
UNLIKELY 2	2 (Green)	4 (Yellow)	6 (Yellow)	8 (Amber)	10 (Amber)
RARE 1	1 (Green)	2 (Green)	3 (Green)	4 (Yellow)	5 (Amber)

Risk Likelihood Table – Guidance

Descriptor	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost Certain
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability	<1%	1-5%	6-29%	21-50%	>50%
	Will occur only in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not

Risk Consequence Table – Guidance

Risk Impact Domains	Negligible - 1	Minor - 2	Moderate - 3	Major - 4	Catastrophic - 5
Safety of Patients, Staff or Public	Minimal injury requiring no/minimal intervention or treatment. No time off work.	Minor injury or illness, requiring minor intervention. Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days.	Moderate injury requiring professional intervention. Requiring time off work for 4-14 days. Increase in length of hospital stay by 4-15 days. Agency reportable incident. An event which impacts on a small number of patients.	Major injury leading to long-term incapacity/ disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.	Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impact on a large number of patients.
Quality, Complaints or Audit	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment or service suboptimal. Formal complaint. Local resolution. Single failure to meet internal standards. Minor implications for patient safety if unresolved. Reduced performance if unresolved.	Treatment or service has significantly reduced effectiveness. Formal complaint - Escalation. Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on.	Non-compliance with national standards with significant risk to patients if unresolved. Multiple complaints/ independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety if findings not acted on. Inquest/ombudsman inquiry. Gross failure to meet national standards / performance requirements.
Workforce & OD	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff. Unsafe staffing level or competence (>1 day). Low staff morale. Poor staff attendance for mandatory/key training.	Uncertain delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory/ key training.	Non-delivery of key objective/service due to lack of staff. Ongoing unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/ improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/delivery requirements. Critical report.	Multiple breaches in statutory duty. Prosecution. Complete systems change required. Low achievement of performance/delivery requirements. Severely critical report.
Adverse Publicity or Reputation	Rumours. Potential for public concern.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly). Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss. Risk of claim remote.	Loss of 0.1–0.25 per cent of budget. Claim less than £10,000.	Loss of 0.25–0.5 per cent of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget. Claim(s) between £100,000 and £1 million.	Non-delivery of key objective/ Loss of >1 per cent of budget. Failure to meet specification/ slippage Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas within a location and possible flow onto other locations.	Loss/interruption of >1 week. All operational areas of a location compromised. Other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.

Appendix 3 - Declaration to Invoke Business Continuity

Incident Site:	
Date/Time:	
Nature of Disruption:	
Services Impacted:	
Name of Person initiating Declaration to Invoke Business Continuity:	
Name of Silver (Tactical) Manager receiving request:	
Time of discussion with Gold On-Call:	
Agencies notified:	
Decision process that led to Business Continuity request: - who was consulted: e.g. other colleagues/external agencies - bed state at time (if relevant) i.e. incident due to volume as opposed to type of injury - additional resources required to respond to incident - any other relevant information	

Signature & Name of person completing form: …….

……

Date: ……..

Please email a copy of the completed form to the EPRR Team: EPRR.HDD@wales.nhs.uk

5

11:01 AM, 0 Mins

5 - For Information

5.1

11:01 AM, 2 Mins

5.1 - HSC Workplan

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

For information

Attachments

HSCommittee Work Programme 2025-26.pdf

GIG CYMRU NHS WALES | Bwrdd Iechyd Hywel Dda Health Board

HEALTH & SAFETY COMMITTEE WORK PLAN APRIL 2025 – MARCH 2026

Currently, Health & Safety Committee (HSC) meets bi-monthly. Based on this, the following table represents a proposal to incorporate the duties as outlined in the Committee's Terms of Reference into a basic work plan April 2025 – March 2026.

AGENDA ITEM/ ISSUE	Purpose	LEAD	Responsible Officer	6 May 2025	3 July 2025	9 Sept 2025	11 Nov 2025	13 Jan 2026	10 March 2026
GOVERNANCE & RISKS									
Welcome and Apologies	N/A	Chair	All	✓	✓	✓	✓	✓	✓
Declarations of Interests	N/A	Chair	CSO	✓	✓	✓	✓	✓	✓
Minutes from previous meeting	N/A	Chair	CSO	✓	✓	✓	✓	✓	✓
Matters Arising (not on agenda)	N/A	Chair	All	✓	✓	✓	✓	✓	✓
Table of Actions (ToAs)	N/A	Chair	CSO	✓	✓	✓	✓	✓	✓
Review of Terms of Reference (TORs)	Approval	Chair	JW						✓
HSC Self-Assessment Outcome Report 2025/26	Assurance	Chair	JW						✓
Health & Safety Committee Annual Report 2025/26	Assurance	Chair	JS	✓					
Health and Safety Sub-Committee Update	Assurance	JS	JS	✓	✓	✓	✓	✓	✓
Corporate Risks Assigned to HSC	Assurance	JS	RW		✓	✓		✓	
H&S Sub-Committee TOR	Approval	JS	JS		✓				✓
HEALTH AND SAFETY UPDATES									
Staff/Patient Story	Assurance	JS	various	✓	✓	✓	✓	✓	✓
H&S Dashboard and Compliance report (cover the work of reporting groups and other legislation) (3.1, 3.2, 3.3, 3.4, 3.11, 3.12, 3.14, 3.18)	Assurance	JS	TH	✓	✓	✓	✓	✓	✓
Site Visit Report and associated actions	Assurance	JS	TH		✓			✓	
*Safety Management Systems and Audits, and associated corrective actions * (3.7 & 3.10)*	Assurance	JS	TH			✓			✓

AGENDA ITEM/ ISSUE	Purpose	LEAD	Responsible Officer	6 May 2025	3 July 2025	9 Sept 2025	11 Nov 2025	13 Jan 2026	10 March 2026
Accident, Incident and Notifiable Statistics Process Review* Including V&A (3.8)	Assurance	JS	TH	✓			✓		
Monitoring of H&S Annual Work Plan (3.9)	Assurance	JS	TH	✓	✓	✓	✓	✓	✓
Review of efficacy of the health, safety, fire and security training programmes (3.13)	Assurance	JS	TH		✓			✓	
Health and Safety Policy (3.17) *not due for review until Sep27)*	Approval	JS	TH						
Produce Health and Safety Annual Report for Board (3.19)	Approval	JS	TH					✓ draft	✓ final
Electrical Infrastructure Risks	Assurance	JS		✓					
Risk 1745 – Estates Condition	Assurance	JS		**D**	✓				
RAAC Assurance Report	Assurance	JS		✓					
Power Outages Assurance Report	Assurance				**D**	✓			
Trade Union Health & Safety Group Update	Assurance				✓				
EMERGENCY PLANNING									
Critical Threat Level Response Framework		AG	SH						
Major Incident Annual Plan: 2025/26 (3.6)		AG	SH		✓				
PREVENT and CONTEST: Update 6-monthly update		AG	TH		IC		IC?		
Counterterrorism Assessment Report: Gap Analysis & Response to Martyn's Law						IC			
Policies									
Business Continuity & Planning Policy	Approval	AG	SH		✓				
Administration									
Agenda setting meeting with Chair & Exec Lead (at least 6 weeks before the meeting)	N/A	CSO	N/A	✓	✓	✓	✓	✓	✓
Draft agenda to go to Executive Team	N/A	CSO	N/A	✓	✓	✓	✓	✓	✓
Call for papers (at least 6 weeks before the meeting to receive papers at least 14 days before the meeting	N/A	CSO	N/A	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	Purpose	LEAD	Responsible Officer	6 May 2025	3 July 2025	9 Sept 2025	11 Nov 2025	13 Jan 2026	10 March 2026
Disseminate agenda/papers 7 days prior to meeting	N/A	CSO	N/A	✓	✓	✓	✓	✓	✓
Issue a draft TOA within two days of the meeting	N/A	CSO	N/A	✓	✓	✓	✓	✓	✓
Circulate minutes and TOA to the Lead Director within 7 days of meeting	N/A	CSO	N/A	✓	✓	✓	✓	✓	✓
Issue minutes and TOA to Members (including the Committee Chair) following Lead Director review	N/A	CSO	N/A	✓	✓	✓	✓	✓	✓

Chair: Ann Murphy **Vice Chair:** Delyth Raynsford **Lead Executive:** James Severs

JS	James Severs	**JW**	Joanne Wilson	**AC**	Andrew Carruthers	**AG**	Ardiana Gjini
TH	Tim Harrison	**CW**	Charlotte Wilmshurst	**SA**	Shaun Ayres	**SH**	Sam Hussell
		CSO	Committee Services Officer	**D**	Deferred		

6

11:03 AM, 2 Mins

6 - Any Other Business

All

7

11:05 AM, 2 Mins

7 - Matters for Escalation to Board

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

8

11:07 AM, 0 Mins

8 - Date and Time of Next Meeting

Tuesday 9 September 2025, 9:30-11:30