PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	11 September 2023
TEITL YR ADRODDIAD: TITLE OF REPORT:	Operational Risks Assigned to Health & Safety Committee
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Director of Operations Jill Paterson, Director of Primary Care, Community & Long-Term Care
SWYDDOG ADRODD: REPORTING OFFICER:	Rachel Williams, Head 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 & Safety Committee (HSC) is responsible for providing assurance to the Board that risks relating to health and safety are being identified, assessed and managed effectively.

The Committee is requested to seek assurance from Lead Officers/representatives of the Directorates that the operational risks identified in the attached reports 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.
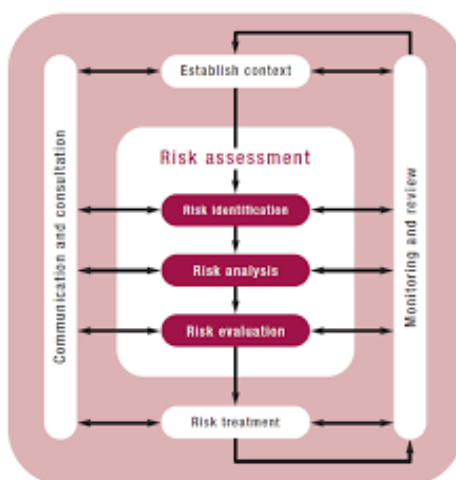
(Risk Management Process, ISO 31000)

Operational risks must be managed within Directorates under the ownership and leadership of individual Executive Directors, who must establish local arrangements for the review of their Risk Registers, which includes the validation of the information and risk scores, and the prioritisation and identification of solutions to their risks. In addition to these local arrangements, formal monitoring and scrutiny processes are in place within Hywel Dda University Health Board (HDdUHB) to provide assurance to the Board that risks are being managed effectively.

All risks identified within the Datix Risk Module must be assigned to a formal Board Committee, Sub-Committee or Group, which will be responsible for securing assurance that risks within their remit are being managed effectively.

Management Leads are asked to review risk assessments and risk actions in line with the following timescales for review:

RISK SCORE	DEFINITION	MINIMUM REVIEW FREQUENCY
15-25	Extreme	This type of risk is considered extreme and should be reviewed and progress on actions updated at least monthly.
8-12	High	This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly.
4-6	Moderate	This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months.
1-3	Low	This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually.

In monitoring the risks associated with their respective areas of activity, each Committee and Sub-Committee is responsible for:

- Scrutinising operational risks within their remit; either through receiving the Risk Registers or through Service Reports.
- Gaining assurance that risks are being appropriately managed, effective controls are in place, and planned additional controls are being implemented.
- Challenging pace of delivery of actions to mitigate risk.
- Identifying, through discussions, new and emerging risks and ensuring these are assessed by those with the relevant responsibility.
- Providing assurance to its parent Committee, or to the Board, that risks are being managed effectively and reporting risks which have exceeded tolerance through its Committee/ Sub-Committee/ Group Update Report.
- Using Risk Registers to inform meeting agendas.

It is therefore essential that the membership of these Committees and Sub-Committees includes appropriate representation from Directorates, and that they are in attendance to provide assurance and to respond to queries.

Relevant discussion should be reflected in the HSC Update Report to the Board to provide assurance on the management of significant risks. This will include risks that are not being managed within tolerance levels (see Risk Appetite Statement), and any other risks, as appropriate.

Asesiad / Assessment

The HSC Terms of Reference states that it will:

- 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.

The 3 risks presented in the Risk Register, attached at Appendix 1, as of 14 August 2023, have been extracted from Datix, based on the following criteria:

- The HSC has been selected by the Risk Lead as the 'Assuring Committee' on Datix.
- The <u>current</u> risk score exceeds the tolerance level, as discussed and agreed by the Board on 27 September 2018.
- Risks have been approved at Directorate level on Datix.
- Risks have not been escalated to the CRR.

All 3 risks have scored against the Safety – Patient, Staff or Public 'impact' domain.

<u>Changes since the previous report presented to HSC at its meeting on 09 May 2023</u>

Total Number of Risks	3	
New risks	0	
Risks that are no longer included in the report	1	*Note 1*
Increase in risk score ↑	0	
No change in risk score →	3	*Note 2*
Reduction in risk score ↓	0	
Extreme (red) risks (based on 'Current Risk Score')	0	
High (Amber) risks (based on 'Current Risk Score')	3	

Note 1 – Risks that are no longer included in the report Since the previous report, one risk has been escalated to the Corporate Risk Register.

Risk Reference & Title	Date risk identified	Date of risk escalation	Lead Director
1382 - Health and safety risk to patients and staff resulting from lack of assurance of safe estate as a consequence of reinforced autoclaved aerated concrete (RAAC), Withybush General Hospital (WGH)	19/04/19	01/09/2023	Director of Operations

Note 2 - 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
708 - Risk of staff safety due to inappropriate	18/03/19	Director of Primary Care, Community	**3x4=12** (Reviewed 17/07/23)	There are over a thousand archive boxes which require appropriate storage;	**1x4=4**

storage solutions associated with patient files / documents affecting Ceredigion Community Sites		& Long Term Care		many of these are currently stored in the upper floors of Tregaron Hospital as well as a full container unit in Cardigan Integrated Care Centre car park. The community teams continue to generate patient records in a paper format as there is no community system to offer an alternative to paper. Whilst 83 boxes were removed from community sites in March 2023, other boxes remained in situ. There are no additional storage facilities available in Ceredigion as the Cardigan temporary facility is already full. Retention Guidance for Community Patient Files was published in February 2022; teams are currently ensuring adherence. Information Governance Training was delivered with team leaders in September 2019. A working party created an options appraisal in May 2019 to address the challenges; this paper has been escalated to Head of Information Governance to support and access Heads of Service use alternative storage mechanisms.	
951 - Risk of avoidable harm to staff and patients due to incorrect Fire Alarm System reporting at WGH	01/02/17	Director of Operations	**3x4=12** (Reviewed 14/08/23)	Fire alarm contractors have updated the 'cause and effect' system, and ongoing system verifications are taking place. This will be undertaken in conjunction with the	**1x1=1**

				capital fire improvement works.	
222 - Risk of avoidable harm to patients, visitors, staff and contractors due to contact with asbestos containing materials.	01/07/12	Director of Operations	**2x4=8** (Reviewed 11/08/23)	The likelihood score was reduced in February 2023 from 3 to 2 due the Estates team having a greater understanding of the likelihood of the unknown 'Asbestos Containing Materials' (ACM's) across Health Board sites. It is very unlikely that staff, patients, contractors, etc. could be exposed to higher risk ACM's however it is possible that they could be exposed to small amounts of damaged lower risk ACM's if these are inappropriately managed. From September 2022 to April 2023 there have been 2 occurrences of formal concerns from staff, and 2 occurrences of concern resulting from contractors work regarding ACMs. These were managed appropriately by the Estates Compliance team and the applicable Estates teams, and appropriate advice given and remedial work carried out where required. Since April 2023, there have been no further occurrences. The likelihood of estates staff and their contractors receiving a significant exposure to higher risk materials is generally considered low. There will always be a risk of accidental disturbance of ACMs, however over the last 4	**1x4=4**

			years the Estates team have improved its survey work and knowledge of ACMs across Health Board sites.	

The Risk Register, attached at Appendix 1, details the responses to each risk, i.e. the Risk Action Plan. Below is a heatmap of the risks presented in the Risk Register.

HYWEL DDA RISK HEAT MAP					
	LIKELIHOOD →				
IMPACT ↓	RARE 1	UNLIKELY 2	POSSIBLE 3	LIKELY 4	ALMOST CERTAIN 5
CATASTROPHIC 5					
MAJOR 4		222 (→)	951 (→) 708 (→)		
MODERATE 3					
MINOR 2					
NEGLIGIBLE 1					

The table below details when the four Directorate level risks assigned to the HSC were last updated on Datix. Risks are required to be updated along the following timescales, dependant on their risk level:

- Extreme Risks – Monthly.
- High Risks – Bi-monthly.
- Moderate Risks – Six-monthly.
- Low Risks – Annually.

Risk numbers presented in red text denote those where a review of the risk is overdue, based on the data as of 14 August 2023.

	Risks updated in last month	Risks updated within last 1-2 months	Risks updated within last 2-6 months	Risks updated within last 6-12 months
Extreme				
High	951 708	222		
Moderate				
Low				

Risk owners can allocate themes to their risks, which allows the Health Board to share risk information on specific areas with relevant experts as part of the 2nd line of defence. Risk themes provide assurance that a holistic approach to risk management is undertaken and

enable the Health Board to better identify the risk appetite, risk capacity and total risk exposure in relation to each risk, group of similar risks, or generic type of risk.

The following risk themes are currently aligned to HSC:
• Estates
• Fire
• Health & Safety
• Security

The Estates theme risk register is reviewed on a monthly basis at the Central Compliance & Assurance Audit Meeting (CCAAM), attended by the Director of Estates, Facilities and Capital Management and key Estates & Facilities colleagues.

Fire theme risks are reported bi-monthly to the Fire Safety Group by the Head of Estates Risk & Compliance. The Head of Estates Risk & Compliance maintains oversight and provides necessary guidance to those responsible for the risk and develop/improve organisational controls, i.e. policies, procedures, systems, processes, to reduce the risk to the Health Board.

Health & Safety theme risks are shared with the Health & Safety team on a bi-monthly basis to allow them to maintain oversight and provide necessary guidance to those responsible for the risk and develop/improve organisational controls, i.e. policies, procedures, systems, processes, to reduce the risk to the Health Board.

Security theme risks are shared with the Health Board's Security Advisor on a bi-monthly basis to allow oversight.

The Assurance and Risk team will continue to support risk theme owners to ensure appropriate review and oversight of risks to provide additional assurance around Health Board systems.

Argymhelliad / Recommendation

The Health and Safety Committee is requested to:

• Review and scrutinise the risks included within this report to seek assurance that all relevant controls and mitigating actions are in place.
• Discuss whether the planned action will be implemented within stated timescales and will reduce the risk further and/ or mitigate the impact, should the risk materialise.

Subsequently, the Committee will provide the necessary assurance to the Board that these risks are being managed 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:	Contained within the report.

Datix Risk Register Reference and Score:	
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	9. All HDdUHB Well-being Objectives apply

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:	Risk Appetite - *the amount of risk that an organisation is willing to pursue or retain*' (ISO Guide 73, 2009). Risk Tolerance - *the organisation's readiness to bear a risk after risk treatment in order to achieve its objectives* (ISO Guide 73, 2009).
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	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 the report, however, impacts of each risk are outlined in the risk description.
Gweithlu: Workforce:	No direct impacts from the report, however, impacts of each risk are outlined in the risk description.

Risg: **Risk:**	No direct impacts from the report, however, organisations are expected to have effective risk management systems in place.
Cyfreithiol: **Legal:**	No direct impacts from the 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 from the report, however, impacts of each risk are outlined in risk description.
Cydraddoldeb: **Equality:**	Has EqIA screening been undertaken? No Has a full EqIA been undertaken? No

Health and Safety Committee Risk Register

Risk Ref	Status of Risk	Domains of Quality	Directorate	Directorate lead	Management or service lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Risk Tolerance Score	Current Likelihood	Current Impact	Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Detailed Risk Decision	Review date
951	Directorate Level Risk		E&F: Pembrokeshire	Elliott, Rob	Arnold, Malcom	01-Feb-17	There is a risk of avoidable harm to staff and patients in the event of a fire at WGH. This is caused by This is caused by the Fire Alarm system not correctly reporting when the system is in Fire, due to the incomplete set up during the commissioning of the system at its implementation. Any fire will be detected but the report sent to the Panel Indication may not be correct and therefore there could be a delay in the appropriate/correct response. This will lead to an impact/affect on possible injuries or fatalities if a fire occurs. Possible enforcement or prosecution. Major disruptions to the delivery of essential services. Adverse publicity/reduction in stakeholder confidence. Risk location, Withybush General Hospital.	Currently we have Verified all detectors and identified where all interfaces are positioned. We have verified position of all power supplies for doors and Dampers and following on from zone verification this can be completed and sent for programming. Verification of loops and detectors have been completed. Fire alarm contractors have updated the 'cause and affect' system, and ongoing system verifications are taking place.	Safety - Patient, Staff or Public	6	3	4	12	Implement phase of works to bring all computer graphics up to date with the units connected to the Fire Alarm system, including elements of alterations to get the system to work in the new Zones.	Evans, Duncan	Completed	All information has been passed to FSC about all the verification works that have been carried out. This quotation has come back and has been passed for payment.	Health and Safety Committee	1	1	1	Treat	03-Jul-23
														Implement new Cause and effect.	Evans, Duncan	Completed	Waiting for meetings to be set up with FSC and site team.						
														FSC Autronica are in process of rewriting new 'cause and affect' scheme.	Elliott, Rob	Completed	Cause and affect' completed and installed.						
														Complete system verifications at WGH.	Arnold, Malcom	31/12/2023	This is in progress.						

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708	Directorate Level Risk		Ceredigion	Skitt, Peter	Hawkes, Jina	18-Mar-19	There is a risk of staff safety from inappropriately stored records Health and Safety of staff in addition to the structure of buildings This is caused by inappropriate use of community buildings for the storage of patient files / documents where archived boxes are stored in inappropriate places; when a corporate solution should be in place This will lead to an impact/affect on inability to access patient files, documents and non-adherence to retention and destruction policies. Staff Health and safety where trying to manage and access these boxes. Non-compliance with Fire Safety Regulations and Health and Safety standards Risk location, Cardigan Health Care Site, Ceredigion, Tregaron Hospital.	Work is underway to clear Tregaron Hospital which has structural defects with the 1st and 2nd floors being condemned by the Fire Service in May 2021. There is now controlled access to the upper floors of Tregaron Hospital and no additional boxes may be stored on site. In September 2019 Aberaeron Hospital was decommissioned, the building had been used to store achieved boxes, the Aberaeron Integrated Care Centre does not have storage facilities. In December 2019 Cardigan Hospital was decommissioned, the building had been used to store achieved boxes, the Cardigan Integrated Care Centre has a storage container on site for the temporary provision of storage, but this is full. In May 2021 there was a security incident involving this container (which was escalated). Procedures have been put in place to reduce the risk of repetition, however the risk remains. 83 boxes were collected in March 2023 and taken to central storage. Whilst this temporarily reduced risk associated with Health & Safety on some premises, the risk is not mitigated as boxes continue to be generated with no storage options in the County.	Safety - Patient, Staff or Public	6	3	4	12	Explore opportunities of combining this risk with the similar risk associated with acute sites	Hawkes, Jina	Completed	Ceredigion County Director has communicated challenges with head of Information Governance	Health and Safety Committee	1	4	4	Treat	17-Jul-23
														Risk to be escalated out-side of Ceredigion County level	Skitt, Peter	Completed	Ceredigion General Manager to meet with head of Information Governance						
														Respond to Head of Information Governance requesting his opinion for how the situation may be managed.	Hawkes, Jina	Completed	Communication commenced						
														HDUHB wide Physical solution to be achieved	Skitt, Peter	Completed	Paper going to Information Governance Sub Committee on the 12/10/21						
														Escalate the need for a HDUHB wide Physical solution to be achieved	Skitt, Peter	Completed	Discussions with Senior decision makers is on-going. Director of Nursing, Quality and Improvement aware of the situation. The situation has been raised and escalated.						
														Medical Records Manager to obtain the resources required to enable the boxes to be moved	Bennett, Mr Steven	Completed	Communications have commenced between the Medical Records Manager and Head of Finance (January 23) to obtain the resources required						
														Prioritising boxes within in-appropriate storage facilities in order to achieve, dispose / re-locate	Hawkes, Jina	30/09/2023	Audit commenced						

Risk Ref	Status of Risk	Domains of Quality	Directorate	Directorate lead	Management or service lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Risk Tolerance Score	Current Likelihood	Current Impact	Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Detailed Risk Decision	Review date
222	Directorate Level Risk	Safe	E&F: Operations Compliance	Elliott, Rob	Smith, Robin	01-Jul-12	There is a risk of avoidable harm to patients, visitors, staff and contractors due to exposure to asbestos through contact with 'Asbestos Containing Materials' (ACMs). This is caused by approximately 2700 known and recorded ACM's being present in the building fabric due to the age of some of the Health Board's (HB) estate, which requires refurbishment that can lead to asbestos being released/disturbed. This will lead to an impact/affect on an uncontrolled release of asbestos fibres affecting staff, contractors, patients and the public, with the potential for serious illness which could possibly lead to death. Possible enforcement action and prosecution in the event of HSE intervention in response to an incident, a complaint, or as a result of an inspection. Adverse publicity through non compliance with the 'Control of Asbestos Regulations'(2012). Risk location, Health Board wide.	A comprehensive HB Asbestos Policy is in place. Asbestos Management Plans are available for each site containing asbestos, based on Asbestos Management Surveys and statutory re-inspections of asbestos-containing materials (ACMs). Each AMP document contains the relevant asbestos register data for the site which is also viewable on-line via the Teams software portal as provided by the current asbestos re-inspection service provider. Targeted Renovation and Demolition Surveys are also undertaken in advance of construction / refurbishment schemes. All samples undertaken for surveys and other investigations updated within the relevant AMP documents. The condition of ACMs and protection where provided e.g. encapsulation is inspected annually. ACMs are removed in accordance with the Control of Asbestos Regulations (CAR) 2012 where the effectiveness of protection is questionable, or to facilitate maintenance / refurbishment. Training of staff in Asbestos Awareness and cohort of estates staff at each acute site trained in Asbestos Non Licenced Work (NLW). Ongoing communications between Estates and other directorate managers on the reporting of building defects, and site specific asbestos issues. The control of contractors is exercised by Engaging Managers and Estates Officers. A holistic health board wide review of asbestos management has been undertaken and resulted in a new compliance team being implemented in 2022 including a compliance officer leading with asbestos management.	Safety - Patient, Staff or Public	6	2	4	8	Implementation of an all-digital asbestos management database system. Improvement of compliance by the inclusion of existing asbestos data relating to leased properties, and/or by commissioning new surveys of leased properties.	Smith, Robin Smith, Robin	Completed Completed	Completed. A suitable system has been identified (Teams by Mark One Enterprises) which our asbestos re-inspection service provider is already using to log re-inspection and new survey data under their license. Working with the property team to determine all leasehold properties and managed practices, and to determine the duty holder in in case. New surveys have been completed for Unit 3 Dafen Industrial Estate, Antioch Centre Phlebotomy Clinic, and Ashgrove Medical Centre. A new survey is being commissioned for the Medical Records facility at Unit 2 and 4 Llangennech.	Health and Safety Committee	1	4	4	Treat	29-Jun-23