PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	14 March 2022
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Operational Risks Assigned to Health & Safety Committee
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Director of Operations
SWYDDOG ADRODD: **REPORTING OFFICER:**	Claire Bird, 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

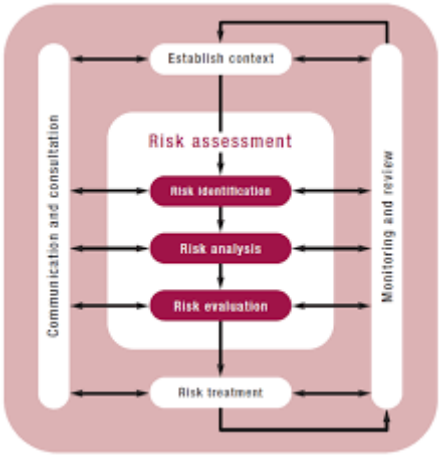
Sefyllfa / Situation

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 state 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 Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

The 5 risks presented in the Risk Register, attached at Appendix 1, as at 3rd March 2022, 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 current risk score exceeds the tolerance level, as discussed and agreed by the Board on 27th September 2018;
- Risks have been approved at Directorate level on Datix;
- Risks have not been escalated to the CRR.

The risks have scored against the following 'impact' domains':

- Safety – Patient, Staff or Public (4 risks).
- Statutory duty/inspections (1 risk).

The summary table below has been extracted from the Datix system:

Risk Ref	Date Risk Identified	Title	Directorate	Current Risk Score	Rationale for the Current Risk Score (extracted from the Datix system)	Target Risk Score
708	18/03/19	Inappropriate storage solutions associated with patient files / documents affecting Ceredigion Community Sites	Ceredigion	16	A strategic steer is required to support Heads of Service use alternative storage mechanisms. Temporary accommodation is being used close to the Cardigan Integrated Care Centre. There was a security issue on this site during May 2021 which has been escalated.	4
1167	05/07/21	Volume of remedial works at community sites	Carmarthenshire	12	Regular visits to sites are being under taken, site "responsible individuals" have been identified and work with the County nominated RI. Community Premises Governance forum re-instated to track actions. Task and Finish group to be instigated to review options.	8
951	01/02/17	Improperly functioning fire alarm detection and operation (WGH).	Estates and Facilities: Pembrokeshire	12	Update of whole system is required. Letter of conformity received 5 August 2021.	1
503	06/12/17	Risks relating to the evacuation of bariatric (plus sized) patients in the event of an emergency.	Estates and Facilities: Fire	10	Risk remains until bariatric fire evacuation is achieved and staff are trained appropriately. A full review of this risk is being carried out following completion of the	5

					Task and Finish group to assess risk position.	
425	01/08/12	Failure to undertake electrical testing of fixed electrical boards.	Estates and Facilities: Operations Compliance	8	Ongoing management as per regulations and guidance documentation.	4

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		503			
MAJOR 4		425	1167 951	708	
MODERATE 3					
MINOR 2					
NEGLIGIBLE 1					

The table below details when the 5 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 at 3rd March 2022.

	Risks updated in last month	**Risks updated within last 1-2 months**	**Risks updated within last 3-6 months**	**Risks updated within last 6-12 months**
Extreme	708			
High	425, 503, 1167	212, 215, 488, 951		
Moderate				
Low				

Appendix 2 details the 76 risks that have been identified on Datix by risk owners as having a Health & Safety theme. 'Themes' have been included on Datix to improve the 'oversight' of risks by specialist areas and functions within HDdUHB, as these are able to provide guidance to those responsible for managing risk and can also develop/improve organisational controls, i.e. policies, procedures, systems, processes, to reduce the risk to HDdUHB.

Nominated leads receive notification of when specific risks with a 'Health & Safety' theme are entered onto the Datix Risk Module. The Committee's role in respect of these themed risks is to receive assurance in terms of the management oversight of these, i.e. that advice has been provided to the management lead, where appropriate, on the management of the risk as well as assuring that any themes/trends have been picked up and addressed (e.g. social distancing measures and guidance, local extract ventilation advice, etc.).

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: Datix Risk Register Reference and Score:	Contained within the report.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report	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:	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 Pwyllgor Adnoddau Cynaliadwy: 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 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 Safety Committee Risk Register

Date: March 2022

Risk Ref	Status of Risk	Health and Care Standards	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
708	Directorate Level Risk	Standard 3.5 Record Keeping	Ceredigion	Skitt, Peter	Hawkes, Jina	18-Mar-19	There is a risk 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.	Safety - Patient, Staff or Public	6	4	4	16	Working party to create an options appraisal	Hawkes, Jina	Completed	Working group established. Draft options appraisal written 15/4/19	Health and Safety Assurance Committee	1	4	4	Treat	21-Feb-22
														Head of Information Governance to determine solutions to the challenges raised in the options appraisal paper	Hawkes, Jina	Completed	Share options paper with Head of Information Governance Paper sent on 17/04/19 - response received 10/06/19						
														To be discussed at Aberaeron and Cardigan Integrated Care Centres Commissioning Meetings	Hawkes, Jina	Completed	Commissioning meetings have been held, the lack of a clear plan may undermine the schemes						
														Respond to Head of Information Governance requesting his opinion for how the situation may be managed	Hawkes, Jina	Completed	Communication commenced						
														Head of Information Governance to communicate a way forward	Rees, Gareth	Completed	Head of Information Governance has met with County Team reassured team that Service Leads are responsible for their own record management						
														Arrange training sessions for service / team leaders	Hawkes, Jina	Completed	Information Governance delivered training sessions to service / team leaders in September 2019.						
														Source Interim storage arrangements	Rees, Gareth	Completed	Temporary storage facilities were erected at Cardigan Integrated Care Centre w/c 2/12/19						
														Work with Information Governance to determine an electronic centralized storage system for community services records management	Skitt, Peter	Completed	Communications are underway. The temporary storage facility has been approved by the Information Governance team.						
														Work with Information Governance to determine a way forward enabling the storage of non-community files to alternative sites; taking into account staffing priorities associated with COVID-19	Skitt, Peter	Completed	Ceredigion General Manager to meet with head of Information Governance						
														Risk to be escalated out-side of Ceredigion County level	Skitt, Peter	Completed	Ceredigion General Manager to meet with head of Information Governance						
														Explore opportunities of combining this risk with the similar risk associated with acute sites	Skitt, Peter	Completed	Ceredigion County Director has communicated challenges with head of Information Governance						

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														Develop whole system engagement	Skitt, Peter	Completed	Ceredigion County Director to establish 3 County group						
														HDdUHB 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 HDdUHB wide Physical solution to be achieved	Skitt, Peter	28/02/2022	Discussions with Senior decision makers is on-going. Director of Nursing, Quality and Improvement aware of the situation						
														Plan for the removal of boxes from local sites to the centralised store	Hawkes, Jina	31/03/2022	Paper raised, awaiting response from Information and Governance						
1167	Directorate Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	Carmarthenshire	Dawson, Rhian	Cameron, Sarah	05-Jul-21	There is a risk of both staff and patient harm if all remedial works are not completed by estates in a timely manner within key Carms Community Sites. This is caused by a lack of sufficient property maintenance due to the COVID-19 pandemic. Also recently fire, health and safety, social distancing and security assessments have highlighted a number of building issues which have been highlighted as red and need immediate action. The sites in question are: Llandovery Cottage Hospital, Amman Valley Hospital, Ty Bryngwyn in-patient unit, Ty Cymorth, Elizabeth Williams Community Clinic and Cross Hands Healthcare Centre. This will lead to an impact/affect on the ability for these sites to remain operational. If works are not completed they could result in direct patient and/or staff harm and could also result in litigation claims against the health board. Risk location, Amman Valley Hospital, Carmarthenshire, Cross Hands Health Centre, Elizabeth Williams Clinic, Llandovery Cottage Hospital, Ty Bryngwyn, Ty Cymorth.	Serious fire, health and safety risks have been reported to estates. All breaches that have been identified that can be resolved at a site/hospital level have been actioned and where appropriate interim processes have been amended to accommodate. Formal action log which monitors works needing completion by estates that include: a. Immediate remedial works. b. Minor works requests. c. Major works which will require capital investment and also to potentially be incorporated into the IMTP has been created and is formally reviewed and monitored in Community Premises Group. RI's requested to undertake appropriate training relevant to their premises. Term of reference for Community Premises Group includes: risk assessment, update fire plan and patient evacuation plans. Community Premises meet on a quarterly basis.	Statutory duty/inspections	8	3	4	12	Ensure all fire, health and safety and social distancing assessment have been completed for all community sites. All issues and concerns amalgamated into one action log for control purposes.	Dawson, Rhian	Completed	Confirmed this action is complete at Community Premises Group, assessments are now scheduled at regular intervals with the RI's.	Health and Safety Assurance Committee	2	4	8	Treat	03-Feb-22
														Re-commissioning of Community Premises Group meetings where serious breaches and escalations can be discussed and also prioritised.	Dawson, Rhian	Completed	07/09/21 - Action completed and agreed to be closed at risk review.						
														Compile a definite list of items that need to be completed by estates that include: a. Immediate remedial works. b. Minor works requests. c. Major works which will require capital investment and also to potentially be incorporated into the IMTP.	Dawson, Rhian	Completed	Risk and Assurance Manager confirmed now that action log is in place an being managed via community premises group this action can be closed and control measures updated.						

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														Confirmation that the following are updated: a. Building CAD plans. b. Fire Evacuation and safety/defence plans.	Dawson, Rhian	**Completed**	07/09 - Work in progress discussing with estates updates to CAD diagrams. Will be added to the Community Premises Group. 04/11 - Key sites have been completed and there is a schedule to complete task end of December. 25/11 - agreed that action was completed during RR review meeting with EDs of NQPE and Operations						
951	Directorate Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	E&F: Pembrokeshire	Elliott, Rob	Evans, Duncan	01-Feb-17	There is a risk of the fire alarm system not reporting properly at the time of an incident occurring at Withybush Hospital. A survey has shown that a number of detectors are not in the right place, Optical Heat where Heat should be installed and vice versa. Fire Alarm is detecting a Fire but the data given is not is not correct as in cause and effect and location. The cause and effect is not current. This is caused by Problems have been identified with the Autronica System and suffers from the following problems: 1. Cause and Effect not functional. Order placed completion due 3/09/21 2. Detector Heads not up to date. 420 identified out of compliance 360 replaced in 2019 2020, 60 due in 2021 Completed 20 additional spare heads on order 3. Graphics not up to date. 4. In house training required. 5. Labelling not up to date. Full test completed March 2021 report awaited. These issues can affect the ability to identify fire causes, and could lead to the failure to quickly determine the exact location of a fire at WGH. This will lead to an impact/affect on safety of patients, staff and general public, HSE investigations and fire brigade enforcement, fines and/or custodial sentences, adverse publicity/reduction in stakeholder confidence. Risk location, Withybush General Hospital.	Currently testing is continuous and a known problem is identified. This is not a significant solution. All polluted devices changed 2/08/2021.	Safety - Patient, Staff or Public	6	3	4	12	Identification of loops, detectors and sectors. Creation of a new Cause and Effect Matrix and renewal of current out of specification detectors.	Evans, Duncan	07/12/2020 30/09/2021	Identification of loops, detectors and sectors, and Cause and Effect Matrix to be completed by mid September 2021. Renewal of current out of specification detectors is completed.	Health and Safety Assurance Committee	1	1	1	Treat	21-Jan-22
														Additional Staff to be trained on how to use the system.	Evans, Duncan	30/11/2021	New action.						
														Residences are imminently being renewed and made compliant, cause and effect is waiting for a complete verification.	Elliott, Rob	**Completed**	Contractors have been to site and have started on all aspects of work.						
														Verification of loops and detectors are ongoing. Verification of interface operation ongoing.	Evans, Duncan	18/03/2022	Loops are being completed and plotted.						

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503	Directorate Level Risk		E&F: Fire	Elliott, Rob	Evans, Paul	06-Dec-17	There is a risk avoidable harm to bariatric (plus sized) patients in the event of a fire evacuation from some of our facilities. This is caused by the inability to evacuate patients in a timely manner due to evacuation routes not fully supporting efficient bariatric evacuation. This will lead to an impact/affect on serious injury, possible enforcement and Health and Safety (HSE) Executive intervention in the event of a serious incident occurring. Risk location, Health Board wide.	Estates, clinical and ward staff are fully aware of this issue. A clinical assessment is undertaken for each in-patient and if there are evacuation concerns regarding bariatric patients then this should be discussed with the fire safety team. There are BMI restrictions now inplace at some clinical locations, such as Preseli theatre/Ward area. Fire training is continually being delivered to staff. Bariatric aids have been purchased by the Health Board and are in use. However, this is not suitable for every ward and evacuation route. Additional fire compartmentation upgrades and fire door improvements have been carried out to the fire structure (in some areas) to improve integrity of our buildings. Further significant investment is required to address all breaches. Good housekeeping continues to be maintained. Internal risk assessments are undertaken by the fire safety team.	Safety - Patient, Staff or Public	6	2	5	10	A full review is required of areas where there are difficulties in evacuation. The compliance team to review this with the manual handling teams specifically focusing on areas where bariatric patients are being cared for.	Evans, Paul	Completed	Bariatric escape aids have been purchased by the Health Board and training has been provided. However there are still areas across the Health Board where this equipment would not adequately evacuate bariatric patients due to the size of door openings and equipment size. This has yet to be fully reviewed. Although this issue is being discussed at all fire safety groups and a standard bariatric evacuation document has been circulated at FSG's.	Health and Safety Assurance Committee	1	5	5	Treat	14-Feb-22
														Task and finish group required with Manual Handling teams to review this risk in detail with the fire safety team. To formally agree the delivery of on-going bariatric training - patient handling training for HB staff.	Evans, Paul	18/11/2019 20/05/2020 01/08/2021 31/10/2021	We have now been given the names of representatives to commence the T&F group to identify where we are with this risk. A meeting is now planned for the 20th Jan 2022 with MH leads and the fire team to discuss the way forward.						
425	Directorate Level Risk		E&F: Operations Compliance	Elliott, Rob	Evans, Paul	01-Aug-12	There is a risk avoidable harm to staff from potential electrical shocks on defective systems. This is caused by lack of periodic inspections of electrical systems. This will lead to an impact/affect on serious injury and closure of facilities. Failure to undertake this along with a potential incident would result in Health and Safety Executive (HSE) investigations or prosecutions. Risk location, Health Board wide.	Portable appliance testing (PAT) testing is undertaken on a rolling programme. Fixed boards are also tested on a rolling programme. Visual checks are continually carried out by maintenance staff. Low Voltage (LV) operational group formed to discuss issues of Electrical Safety and Compliance.	Safety - Patient, Staff or Public	6	2	4	8	Electrical Testing Inspections to be undertaken on a regular basis to ensure safe systems. To include visual checks through regular PPMs. Fixed testing has been carried out and continues to be undertaken.	Evans, Paul	Completed	Fixed testing carried out in 2017-18 by Norwood on a selection of units. The programme of testing will continue in 2018-19 subject to capital funding availability.	Health and Safety Assurance Committee	1	4	4	Treat	14-Feb-22
														To ensure that ongoing testing is being carried out in accordance with legislation. Also to make sure that the appropriate quantity of testing is being completed annually in accordance with the BS. Additional capital funding needs to be bid for.	Evans, Paul	Completed	Capital funding has been bid for and contractors have now been appointed to continue with testing across the HB during 2020/21. Further capital bid will be required to address the outcomes/actions that will be highlighted following testing. Outcomes will need to be prioritised as there will be insufficient capital to address all actions (in 12 months) A detailed look at the actions also needs to be undertaken to assess the full scale of the issue - infrastructure meetings are now commencing with property to do this with ops managers.						

Health Safety Committee Risk Register

Date: March 2022

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														New 2021/22 tender for LV testing needs to be finalised and issued to suitable contractors.	Evans, Paul	Completed	Tender now been issued for 2021/2022 testing, awaiting commencement date from appointed contractors - Testing will take place before the end of March 2022 for a range of areas as per AP's priority.						

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737	Service or Department Level Risk	Standard 3.4 Information Governance and Communications Technology	Finance: Digital: Information and Communication Technology	Tracey, Anthony	Holman, Roy	01-May-18	There is a risk that the staff working on the switchboards within the Health Board are not able to comply with the European Working Time Directive (EWTD). This is caused by the inability for cover single handed shifts at night, weekend and bank holidays. Currently shifts are 8 hours long. The current rotas do not allow for workers to have breaks whilst covering the night, evening, weekend, bank holiday shifts. This will lead to an impact/affect on the European Working Time Directive (EWTD) is an EU initiative designed to prevent employers requiring their workforce to work excessively long hours, with implications for health and safety. Specifically the right to a rest break if the working day is longer than six hours. Risk location, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital.	Each switchboard has a lockable door, and a panic button function is installed in each switchboard, which is linked to the security teams within the hospital site. Health Board successful for an Invest to Save bid from Welsh Government to undertake a replacement and modernisation programme for the switchboard. The project has been running for 8 months, and a tender was recently awarded based on the technical design of a modern switchboard environment. The work on the technical design is being taken forward by a third party vender (4C Strategies), who have extensive knowledge within the area. Project Team established with representation from Sites triumvirates, Estates, Workforce and OD and Informatics. Project team overseeing 2 sub-workstreams to the project- technical aspects and workforce implications.	Workforce/OD	8	4	4	16		Implement new switchboard technology to allow the seamless redirecting of calls between sites to ensure that we have business continuity.	Holman, Roy	31/03/2022	New switchboards are on all sites undergoing field trials, within the next few months on completion of successful trials we will be implementing these across the health board enable all switchboard sites to cover each other enabling us to meet the EWTD regarding staff breaks.	People, Organisational Development and Culture Committee	3	2	6		20-Oct-21
															Oganisation change programme (OCP) to be undertaken due to the need to alter a number of the staff contracts to allow either movement to a different rota pattern, or a reduction in hours.	Holman, Roy	**Completed**	Update OCP in line with current situation						
720	Service or Department Level Risk	Standard 3.1 Safe and Clinically Effective Care	Ceredigion	Skitt, Peter	Hawkes, Jina	15-Apr-19	There is a risk avoidable harm to patients and staff due to lack of staffing to meet patient acuity at Tregaron hospital. This is caused by sickness, retention and recruitment of staff. This will lead to an impact/affect on potential impact on patient care due to insufficient staffing levels to meet patient need. Risk location, Tregaron Hospital.	Trying to assure that appropriate patients are placed within Tregaron Hospital, whose needs can be met. Utilizing COVID staffing.	Safety - Patient, Staff or Public	6	4	4	16		Negate risks around gaps in rostas, ensure that appropriate patients are admitted in Tregaron (whose needs can be met).	Evans, Tracey -	**Completed**	Regular reviews and updates of situation	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	21-Feb-22
															Options paper to be taken forward in order to reduce the risk of patient harm in Tregaron hospital.	Evans, Tracey -	**Completed**	Options paper has been written						
															The CMT needs to review the contingency planning associated with staff shortages on both a short and medium term	Evans, Tracey -	**Completed**	All patients are screened prior to admission to ensure safe care can be delivered.						
															Risk needs to be escalated. Report to be written clearly demonstrating that all effort has been undertake to ensure safety regarding staff and patient care.	Evans, Tracey -	**Completed**	Contingency plan and options paper developed and submitted to Mandy Rayani. Beds have been reduced to 7						
															The staffing levels reflect the number and acuity of patients admitted in to Tregaron hospital.	Evans, Tracey -	**Completed**	Processes in place to ensure that the hospital is staffed appropriately.						

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															Ongoing review of staffing levels and patient acuity.	Evans, Tracey -	Completed	Processes in place to ensure that the hospital is staffed appropriately to meet patient need.						
															Utilise the site to enable flow from the acute sites during the COVID-19 pandemic and therefore utilise additional capacity associated with the pandemic.	Evans, Tracey -	Completed	Developed an SBAR to enable Tregaron to be used as a green step down / step up and re-hab facility to enable patient flow.						
															Ensure that robust operational measures are in place to enhance and enable good communication with the new staff. Senior staff need to ensure that all staff are supported and aware of operational procedures.	Evans, Tracey -	Completed	Plan developed with timelines.						
															Whole system review of staffing structures to be undertaken due to the position change associated with COVID-19	Evans, Tracey -	Completed	Scoping of review underway; comparing staffing across 3 County Community Hospitals. E-Roster system now in place which will flex to meet staffing for 20 beds						
															Whole system review of staffing to be undertaken on a daily basis in line with escalation process	Evans, Tracey -	Completed	Daily touch point meetings are used to prioritise staffing requirements						
															Assurance required to demonstrate that consistent safe staffing levels are sustainable due to the increase of bed numbers in Tregaron	Evans, Tracey -	Completed	Daily touch point meetings are used to prioritise staffing requirements						
															Undertake regular risk assessments to demonstrate current situation and appropriately escalate	Evans, Tracey -	Completed	July 21 Risk Assessment undertaken and escalated. Seeking agency cover for July and August; where possible, block booking of agency cover; ongoing communication with bank						

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															Recruitment is ongoing with some new staff being appointed.	Evans, Tracey -	Completed	Some new staff have now commenced employment						
															Staffing to be reviewed on a daily basis to mitigate risks	Evans, Tracey -	Completed	Staffing is discussed at the daily touchpoint meeting						
															Decision required in relation to on-going funding of additional staff brought in to cover the COVID pandemic to increase the bed base.	Hawkes, Jina	31/03/2022	Communications with decision makers commenced						
708	Directorate Level Risk	Standard 3.5 Record Keeping	Ceredigion	Skitt, Peter	Hawkes, Jina	18-Mar-19	There is a risk 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.	Safety - Patient, Staff or Public	6	4	4	16		Working party to create an options appraisal	Hawkes, Jina	Completed	Working group established. Draft options appraisal written 15/4/19	Health and Safety Assurance Committee	1	4	4	Treat	21-Feb-22
															Head of Information Governance to determine solutions to the challenges raised in the options appraisal paper	Hawkes, Jina	Completed	Share options paper with Head of Information Governance Paper sent on 17/04/19 - response received 10/06/19						
															To be discussed at Aberaeron and Cardigan Integrated Care Centres Commissioning Meetings	Hawkes, Jina	Completed	Commissioning meetings have been held, the lack of a clear plan may undermine the schemes						
															Respond to Head of Information Governance requesting his opinion for how the situation may be managed.	Hawkes, Jina	Completed	Communication commenced						
															Head of Information Governance to communicate a way forward	Rees, Gareth	Completed	Head of Information Governance has met with County Team reassured team that Service Leads are responsible for their own record management						

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															Arrange training sessions for service / team leaders	Hawkes, Jina	Completed	Information Governance delivered training sessions to service / team leaders in September 2019.						
															Source Interim storage arrangements	Rees, Gareth	Completed	Temporary storage facilities were erected at Cardigan Integrated Care Centre w/c 2/12/19						
															Work with Information Governance to determine an electronic centralized storage system for community services records management	Skitt, Peter	Completed	Communications are underway. The temporary storage facility has been approved by the Information Governance team.						
															Work with Information Governance to determine a way forward enabling the storage of non-community files to alternative sites; taking into account staffing priorities associated with COVID	Skitt, Peter	Completed	Ceredigion General Manager to meet with head of Information Governance						
															Risk to be escalated out-side of Ceredigion County level	Skitt, Peter	Completed	Ceredigion General Manager to meet with head of Information Governance						
															Explore opportunities of combining this risk with the similar risk associated with acute sites	Skitt, Peter	Completed	Ceredigion County Director has communicated challenges with head of Information Governance						
															Develop whole system engagement	Skitt, Peter	Completed	Ceredigion County Director to establish 3 County group						

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															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	28/02/2022	Discussions with Senior decision makers is on-going. Director of Nursing, Quality and Improvement aware of the situation						
															Plan for the removal of boxes from local sites to the centralised store	Hawkes, Jina	31/03/2022	Paper raised, awaiting response from Information and Governance						
1228	Service or Department Level Risk	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	Carmarthenshire:Community Hospitals	Dawson, Rhian	Cameron, Sarah	15-Jul-21	There is a risk that used/soiled and infected laundry has a potential of fly and insect infestation with subsequent risk of cross infection/ contamination. General public could set a fire to the materials as is in an accessible area of a car park and not secured behind locked gates/doors. Any potential move of the used laundry trollies to the secure waste compound area will not be in line with M&H assessments and the need to support the new used laundry disposal pathway with the appropriate staffing resource to perform the task of moving the laundry skips. This is caused by inappropriate, unsafe and unsecured storage area for used/soiled and infected laundry. This will lead to an impact/affect on risk of infection to any member of the public intentionally accessing the used laundry trollies of which are not secured. Risk of fire to the whole building. Substandard Patient/visitor and staff experience and perception of LCH Risk location, Llandovery Cottage Hospital.	Additional staffing resource in place to assist the weekly laundry delivery Assessment undertaken by manual handling team of the risks involved in the moving and handling of the skips. Fire Safety Officer has undertaken assessment of the suitability of the storage area	Safety - Patient, Staff or Public	6	4	4	16		Used laundry trollies to be moved to a firmly constructed base with ramps in the secure waste compound.	Jones, Kevin	09/11/2021 03/02/2022	Quotes back from estates from minor works which has been approved, estates are currently scheduling the works - weather permitting. 06/12 - Awaiting arrival of material on site. 11/01 - Update from estates required.	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	11-Jan-22
															Additional staffing resource to assist the weekly laundry delivery by transferring the clean laundry to the clean linen cupboard and then take the empty trollies to the waste compound for ongoing access by the nursing team over the week.	Alberto, Dawn	**Completed**	Confirmation that additional staffing has been obtained. Agreed to close.						
															Assessment by Manual handling team of the risks involved in the moving and handling of the skips.	Alberto, Dawn	**Completed**	Manual handling assessor (sian Mills) has visited, not an issue for moving skips if ramp present. Agreed to closed.						
															Fire officer to assess suitability of the proposed storage area.	Jupp, Richard	**Completed**	Fire Safety Officer confirmed via Community Premises Group that the area is suitable and will need an additional fire sensor installed which estates have included in the works programme.						

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993	Service or Department Level Risk		E&F: Carmarthenshire West	Elliott, Rob	Jones, Kevin	05-Jun-20	There is a risk avoidable harm to patients who require oxygen therapy through lack of available capacity of bulk oxygen supplies at GGH. This is caused by demand and capacity issues of bulk oxygen supplies which would be exacerbated by a pandemic spike. This situation has been highlighted as a result of existing oxygen infrastructure systems being unable to generate the flow capacity required to support the oxygen therapy needs of patients during respiratory pandemic situations such as Covid-19 when demand for oxygen is likely to be at its highest. When significantly higher than normal numbers of patients require oxygen therapy at an average minute rate of 10 litres simultaneously, the site's oxygen supply will be exhausted. This will lead to an impact/affect on significant disruption to patient care services with patient care invariably being compromised, potential adverse impact on patient safety/harm, complications resulting in long term, irreversible health effects. As this situation will be seen as predictable and hence avoidable it is conceivable that remedies under corporate manslaughter could be sought. Risk location, Glangwili General Hospital.	1. Recent enhancements have been made to the site infrastructure, such as two new vaporisers which has increased oxygen flow rates approximately 850 L/min to 2500 L/min. These figures are given by BOC. 2. A temporary ring main arrangement has been incorporated with limited capacity although improving site capacity to deliver oxygen but will add system resilience. 3. Housekeeping system leaks have largely been eradicated. 4. AVSU back feeding in place but very limited in scope.	Safety - Patient, Staff or Public	6	3	5	15		Submit bids to capital for the required remedial works in the 2021 /2022 financial year.	Jones, Kevin	**Completed**	Bids have been submitted funding received	Operational Quality, Safety and Experience Sub Committee	1	5	5	Treat	18-Jan-22
															Additional metering is required to accurately measure the quantity of oxygen used in key consuming areas, by individual supply from VIE compound.	Jones, Kevin	**Completed**	action complete						
															Installation of new dedicated 35mm Oxygen pipeline with valve sets to each block and new pipeline to each AVSU albeit street or departmental.	Jones, Kevin	31/12/2020 31/12/2021	forms part of the VIE WG bid works to be completed by December 2021						
															Removal of 'Saunders' type isolating valves from system to achieve maximum flow through diameter of pipe.	Jones, Kevin	31/12/2020 31/12/2022	This work will form part of the phase 2 bid to be submitted in 2022. this work will be reviewed following the phase 1 completion works						
															Additional VIE to provide capacity increase and resilience.	Jones, Kevin	31/12/2020 31/12/2021	this work will be resolved following the installation of the Phase 1 Vie installation						
															Need a suitable connection point for a temporary supply.	Jones, Kevin	31/12/2020 31/12/2021	This will be resolved following Phase 1 Vie project						

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895	Service or Department Level Risk	Standard 1.1 Health Promotion, Protection and Improvement	Scheduled Care: Critical Care	Hire, Stephanie	Knight, Diane	20-Jul-20	There is a risk of potential cross infection. This is caused by each critical care unit only having one side/isolation room. This will lead to an impact/affect on patient safety, staff safety, complaints, claims and adverse publicity for the Health Board. Risk location, Bronglais General Hospital, Prince Philip Hospital, Withybush General Hospital.	All staff/patients to wear appropriate PPE A second patient requiring a side/isolation room would need to be transferred to GGH critical care unit.	Safety - Patient, Staff or Public	6	3	5	15		Prepare capital bid for the purchase of mobile/portable isolation room for BGH, PPH & WGH critical care units	James, David	31/08/2020 31/03/2021 30/06/2021 31/10/2021	Capital bid has been submitted to address this issue on a more permanent basis. Discussions re installation of Pods ongoing. On capital request list for 2021/22. Awaiting final drawings. 09/07/21 Single Tender Action being submitted. Estates ok to go ahead with installation once approved. 18/08/21 Funding has not been approved. 23/09/2021 Awaiting result of tender process 22/10/2021. Bioquell pods to be installed from December 2021 to February 2022	Operational Quality, Safety and Experience Sub Committee	1	1	1	Treat	16-Nov-21
896	Service or Department Level Risk	Standard 1.1 Health Promotion, Protection and Improvement	Scheduled Care: Critical Care	Hire, Stephanie	Knight, Diane	03-Apr-20	There is a risk of contamination of critical care staff from aerosol generating procedures leading to infection. This is caused by the infectious status of patients not always being known. This will lead to an impact/affect on the health and safety of critical care staff. Risk location, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital.	All requiring and AGP are to be treated as though they are infectious. All staff to wear full PPE when performing or assisting with AGP's. All patients with Covid-19 symptoms are screened.	Safety - Patient, Staff or Public	6	5	3	15		Continue to follow latest government advice on the use of AGP	Jenkins, Meryl	31/03/2021 30/06/2021 31/08/2021	Awaiting the latest guidance from WG/Health Board	Operational Quality, Safety and Experience Sub Committee	1	1	1	Treat	16-Nov-21
															On site testing not available in PPH, Microbiology 'Hot' lab to be installed.	Jenkins, Mel	30/11/2020	New action.						
1215	Service or Department Level Risk		Scheduled Care: Critical Care	Hire, Stephanie	Knight, Diane	02-Aug-21	There is a risk of cross contamination of patients/staff. This is caused by the size of the Redirooms. The Redirooms were purchased during the first wave of the Covid-19 pandemic to address the lack of isolation rooms within the Health Board. There is great difficulty in getting behind the bed to do any airway management. There are leads and cables in the way that must come through the back of the tent. If we were to need to intubate we would have to wheel the patient out of the redi room which, giving that intubation is an AGP, is a risk in itself and it means moving the patient further away from oxygen supply etc. This will lead to an impact/affect on patient safety, staff safety and staff morale Risk location, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital.	Staff try to ensure infectious patient are kept within the confines of the redroom	Safety - Patient, Staff or Public	6	3	5	15		Restrict use of Redirooms where possible.	Lewis, Lisa	31/03/2022	Ongoing	Operational Quality, Safety and Experience Sub Committee	1	1	1	Treat	18-Nov-21

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576	Service or Department Level Risk	Standard 3.1 Safe and Clinically Effective Care	Ceredigion	Skitt, Peter	Hawkes, Jina	04-Oct-17	There is a risk avoidable harm to patients, increased attendance at A&E and DTOCs arising from an increased inability to discharge patients requiring a general or Elderly Mentally Infirm (EMI) nursing home placement. This is caused by fragile EMI and General Nursing Home capacity due to nursing homes de-registering and becoming residential homes. This will lead to an impact/affect on patients' loss of functional ability, delayed transfers of care, risk of hospital acquired infection and being able to maintain patients within their own home (which could be private, residential or nursing with additional support). Risk location, Health Board wide.	There is a daily review of the Health Board Complex Patients Work List SharePoint report and on a weekly basis a review through the Delayed Transfers of Care (DToC) validation process of patients awaiting nursing home placement with reporting structure. There are discussions with the Independent Sector to identify any potential for de-registering from a nursing home to a residential home. The long-term care team provides some support to nursing homes. Regular meetings between the LA and HB take place.	Safety - Patient, Staff or Public	6	3	4	12		Communicate with private providers to explore opportunities.	Skitt, Peter	Completed	Communication commenced.	Operational Quality, Safety and Experience Sub Committee	2	4	8		21-Feb-22
															Meet with private providers and Local Authority	Skitt, Peter	Completed	Meetings held with four providers both EMI and nursing						
															Communicate with and without Local Authority with private providers	Skitt, Peter	Completed	Meetings have taken place.						
															Understanding the impact associated with the Regional Dementia Funding	Skitt, Peter	Completed	Awaiting the 2019-20 Dementia Plan to be agreed and circulated by West Wales Care Partnership. A Ceredigion Joint Leadership Group has been established.						
															Meetings are on going with LA and private sector. Work is required to understand the viability of options	Skitt, Peter	Completed	A providers think tank meeting was held w/c 9/12/19						

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															Regional Dementia Plan	Skitt, Peter	Completed	Regional Dementia Plan has not been signed off by WWCP. Dementia Steering group has been re-established to drive the work. TOR and membership will be reviewed.Progress has been delayed due to staff sickness. Regional Dementia Lead in post.						
															Determine the feasibility of alternative service models	Skitt, Peter	Completed	Work underway to invite expressions of interest from the private sector for alternative service models						
															Work with partners to stimulate a new market for Ceredigion within the foot print of HDUHB	Skitt, Peter	Completed	Meetings are being planned						
															Work with LA and private partners to enable the stimulation of the new market	Skitt, Peter	Completed	Mid Wales growth bid has been approved.						
															In light of the impact of COVID-19 and the sustainability of private providers, work with the LA and private partners to enable the stimulation of the new market.	Skitt, Peter	Completed	Mid Wales growth bid has been approved. Communications have commenced with a provider						
															Co-design the action plan associated with the Mid Wales growth bid.	Skitt, Peter	Completed	Issues associated with COVID continue to have an impact on care homes, making engagement difficult at this current time. Guidelines and restrictions are evolving, so engagement will continue when restrictions allow.						
															Working with Ceredigion County Council, Mental Health and Long Term Care develop a model to meet needs	Skitt, Peter	Completed	Project group commenced with planned regular meetings						

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															Working in partnership develop a sustainable proposal	Skitt, Peter	**Completed**	Work underway to understand demand						
															Partnership approach to enable procurement with the independent sector	Skitt, Peter	31/03/2022	Project group between HDUHB, LA, Primary care etc established to enable a tendering process to be completed by end of the financial year						
1167	Directorate Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	Carmarthenshire	Dawson, Rhian	Cameron, Sarah	05-Jul-21	There is a risk of both staff and patient harm if all remedial works are not completed by estates in a timely manner within key Carms Community Sites This is caused by a lack of sufficient property maintenance due to the COVID-19 pandemic. Also recently fire, health and safety, social distancing and security assessments have highlighted a number of building issues which have been highlighted as red and need immediate action. The sites in question are: Llandovery Cottage Hospital, Amman Valley Hospital, Ty Bryngwyn in-patient unit, Ty Cymorth, Elizabeth Williams Community Clinic and Cross Hands Healthcare Centre. This will lead to an impact/affect on the ability for these sites to remain operational. If works are not completed they could result in direct patient and/or staff harm and could also result in litigation claims against the health board. Risk location, Amman Valley Hospital, Carmarthenshire, Cross Hands Health Centre, Elizabeth Williams Clinic, Llandovery Cottage Hospital, Ty Bryngwyn, Ty Cymorth.	Serious fire, health and safety risks have been reported to estates. All breaches that have been identified that can be resolved at a site/hospital level have been actioned and where appropriate interim processes have been amended to accommodate. Formal action log which monitors works needing completion by estates that include: a. Immediate remedial works. b. Minor works requests. c. Major works which will require capital investment and also to potentially be incorporated into the IMTP has been created and is formally reviewed and monitored in Community Premises Group. RI's requested to undertake appropriate training relevant to their premises. Term of reference for Community Premises Group includes: risk assessment, update fire plan and patient evacuation plans. Community Premises meet on a quarterly basis.	Statutory duty/inspections	8	3	4	12		Ensure all fire, health and safety and social distancing assessment have been completed for all community sites. All issues and concerns amalgamated into one action log for control purposes.	Dawson, Rhian	**Completed**	Confirmed this action is complete at Community Premises Group, assessments are now scheduled at regular intervals with the RI's.	Health and Safety Assurance Committee	2	4	8	Treat	03-Feb-22
															Re-commissioning of Community Premises Group meetings where serious breaches and escalations can be discussed and also prioritised.	Dawson, Rhian	**Completed**	07/09/21 - Action completed and agreed to be closed at risk review.						
															Compile a definite list of items that need to be completed by estates that include: a. Immediate remedial works. b. Minor works requests. c. Major works which will require capital investment and also to potentially be incorporated into the IMTP.	Dawson, Rhian	**Completed**	Risk and Assurance Manager confirmed now that action log is in place an being managed via community premises group this action can be closed and control measures updated.						
															Confirmation that the following are updated: a. Building CAD plans. b. Fire Evacuation and safety/defence plans.	Dawson, Rhian	**Completed**	07/09 - Work in progress discussing with estates updates to CAD diagrams. Will be added to the Community Premises Group. 04/11 - Key sites have been completed and there is a schedule to complete task end of December. 25/11 - agreed that action was completed during RR review meeting with EDs of NQPE and Operations						

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1227	Service or Department Level Risk	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	Carmarthenshire:Palliative Care	Dawson, Rhian	Cameron, Sarah	07-Sep-21	There is a risk of harm to both Health Board staff and patients within the community due to the currently processes and mechanism in place that manage the storage, cleansing and transportation of specialist palliative care equipment. This is caused by unsatisfactory processes in place to manage and monitor to ensure that equipment and devices are maintained, cleaned and calibrated in accordance with manufacturers' guidelines and the relevant EN (European) Standards. This includes storage decommissioning and disposal. This will lead to an impact/affect on ensuring the safe and effective procurement, use and disposal of medical equipment, devices and diagnostic systems. Risk location, Ty Bryngwyn, Ty Cymorth.	SPC Therapy team completing cleaning tasks and identifying if equipment is faulty or needs repair. Larger items (Riser Recliner Chairs) are transported by an external company Just Wales. SPC Therapy team now liaise Wider SPCT and with 3rd parties for procurement of equipment and where applicable seek guidance from NWSSP and HDUHB Medical Devices Group. Risk assessment completed by H&S officer for safe moving and handling of equipment by staff.	Safety - Patient, Staff or Public	6	3	4	12		Centralise storage of SPC Team Equipment at CICES or by another provider.	Cameron, Sarah	04/11/2021 07/04/2022	15/02 - Service Support Delivery Manager is currently reviewing new NHS Framework agreement for equipment with the County Director to form an approach.	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	03-Feb-22
															Servicing and Repairs undertaken at CICES or by another provider.	Cameron, Sarah	09/11/2021 07/04/2022	15/02 - Service Support Delivery Manager is currently reviewing new NHS Framework agreement for equipment with the County Director to form an approach.						
															Transportation (Collections & Deliveries) undertaken by CICES or by another provider. Same day or next day delivery required. Decontamination of equipment on return from service user by CICES or by another provider.	Cameron, Sarah	09/11/2021 07/04/2022	15/02 - Service Support Delivery Manager is currently reviewing new NHS Framework agreement for equipment with the County Director to form an approach.						
															Purchasing of new equipment to be agreed as to most appropriate process either Palliative Care Charitable Funds or equipment procured through CICES or by another provider.	Cameron, Sarah	09/11/2021 07/04/2022	15/02 - Service Support Delivery Manager is currently reviewing new NHS Framework agreement for equipment with the County Director to form an approach.						
689	Service or Department Level Risk	Standard 3.5 Record Keeping	MD: Effective Clinical Practice	Evans, John	Davies, Lisa	28-Jan-19	There is a risk compromised patient safety. This is caused by improper completion or organisation of medical records and non-conformity to agreed best practices and standards. This will lead to an impact/affect on unnecessary delay, frustration, clinical misadventure and litigation. Risk location, Health Board wide.	Regular audits are being undertaken to monitor standards of record keeping. Concerns highlighted relating to individual and or Team record keeping performance are addressed through signposting to relevant courses based on required record keeping standards. Concerns highlighted relating to individual and or Team record keeping performance are reflected upon at appraisal and evidence of remediation included as part of the appraisal information. Doctors are being reminded of the importance of good record keeping on a regular basis by the Medical Director through email and letter communication.	Quality/Complaints/Audit	8	3	4	12		Medical Director to increase communications regarding the importance of good record keeping and send regular bimonthly updates with details of relevant courses.	Evans, John	**Completed**	Letter was sent out on 10th July 2018. Further correspondence to follow and important of good record keeping to be added to MD newsletter.	al Quality, Safety and Experience Sub Committee	2	4	8	Treat	04-Feb-22
															Medical Appraisers to reinforce the importance of good record keeping during appraisal and signpost to relevant courses where applicable.	Williams, Helen	**Completed**	To be included on agenda for next Appraiser meeting. Confirmed that it is not appropriate to include Record Keeping as part of appraisal.						

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								Series of actions being progressed as part of measures reported to ARAC.							Health Board e-learning module relating to good record keeping is in the process of being developed and will be complete by the end of April 2019.	Davies, Lisa	30/04/2019 31/03/2022	The content of the e-learning module will be dependent upon the principles agreed for the Clinical Record Keeping Policy which is in draft. Once the Policy has been agreed the e-learning module can be revisited. Delayed due to redeployment of staff during COVID wave.	Operation					
															There is a long-term plan in development, which will commence with an approach to audit 10 sets of notes initially, per specialty and site, and inclusion of the audit on the Clinical Audit Forward Plan, making it mandatory for each specialty to undertake yearly.	Davies, Lisa	**Completed**	Each site will develop local QI plan for record keeping, based on audits completed. QI Leads will lead, along with Hospital Director and QIST members. QI project will focus on cultural/behavioural change.						
															Quality Improvement (QI) Leads are to be recruited and will be responsible at hospital sites to work with Hospital Directors and clinical leads in order to progress the audit. Associate Specialist doctors in each specialty to take a lead role in achieving the work. The Clinical Director for Clinical Audit will discuss with the QI leads and disseminate from there down to each specialty lead.	Davies, Lisa	**Completed**	QI Lead in WGH taking forward work on that site and lessons learned to be rolled out across all sites, using the QI Leads network.						

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															Review of Clinical Record Keeping Policy to clearly identify record keeping standards and explore potential development of single Health Board wide Record Keeping Policy.	Davies, Lisa	31/12/2020 31/03/2022	Steering Group has been convened with representation from medical/surgical, nursing, therapies, health sciences, pharmacy, legal, complains, informatics, medical records, coding. Meetings held on 24/11/20, 24/02/21 and 26/05/21. Terms of reference agreed and mapping existing record keeping standards ongoing. Sub-Group established to review common set of standards, and content of the record. Document circulated for comment. Agreement for single policy for clinical record keeping to be developed, this is in draft. Progress has been impacted by lack of capacity within the department. Timescale moved to 31/03/2022 - delayed due to re-deployment of staff during further wave of COVID.						
															Re-audit of WGH and quality improvement plan to address findings. To be rolled out across all sites using QI Leads Network.	Davies, Lisa	**Completed**	WGH re-audit has taken place, results being analysed and findings will inform QI plan. Meeting on 9.12.2020 to discuss roll-out of the approach to BGH, GGH and PPH.						
															Each site to develop local QI plan for record keeping, based on audits completed. QI Leads will lead, along with Hospital Director and QIST members. QI project will focus on cultural/behavioural change. Progress to be provided to ARAC in 9-12 months.	Davies, Lisa	19/10/2021 31/03/2022	Re-audits in progress on BGH, GGH and PPH, following the approach developed in WGH, and under leadership of the QI Leads. Outcomes to inform local QI projects. Timescales are impacted by COVID and different approaches may need to be progressed as prospective ward based audits are challenging. Clinical Audit Team are supporting. Meeting with QI Leads taking place on 8/11/21 To be supported by securing dedicated capacity to take this work forward however this has been delayed due to re-deployment of this capacity during recent further wave of COVID.						

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388	Service or Department Level Risk		Central Operations: Clinical Engineering	Rees, Gareth	Hopkins, Mr Chris	23-Sep-17	There is a risk avoidable harm to patients and staff arising when medical equipment is used on patients not in accordance with its design and manufacture. This is caused by inadequate staff training and general awareness of the safety and legal issues. This will lead to an impact/affect on potential injury of patients and staff, delayed care and potential enforcement action. Risk location, Health Board wide.	Recruitment of a medical device trainer in March 2018. Review of staff training to identify categories required for each staff group. Medical Devices Training Sub-Group established reporting to the Medical Devices Sub-Committee. Review of high/medium/low risk medical devices for training requirements has been completed.	Statutory duty/inspections	8	3	4	12		Establish a Medical Device Training Sub-Group.	Gostling, Lisa	**Completed**	Completed: Medical Device Training Sub-Group established.	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	07-Feb-22
															Risk should be transferred to Lisa Gostling, Director of Workforce and OD. Email sent on 2nd August 2019.	Gostling, Lisa	**Completed**	Completed: Agreement transferred. Follow up meeting to update Director of Workforce and OD being organised.					
															Develop a training record of users of medical devices showing that users know how to use the device safely and have received the relevant training.	Hopkins, Mr Chris	20/12/2022	Learning and Development administrative staff to input remaining infusion device records and will continue to update attendance on high risk devices.					
															Recruit 1 admin and 3 clinical trainers.	Hopkins, Mr Chris	31/08/2022	Admin post plus BGH & PPH trainers appointed. GGH trainer to be appointed over the next 6 months.					
496	Service or Department Level Risk		E&F: Specialist Services (Catering/Laundry)	Elliott, Rob	Jones, Peter	01-Jul-12	There is a risk avoidable harm to staff within the main kitchen and dishwashing area due to uneven and raised flooring that cannot be cleaned adequately. This is caused by damaged flooring around the drain area by the dishwasher area. Water seeps through the flooring and raises the covering to seep through to the lower level. Initial remedial work has not proved 100% effective. This will lead to an impact/affect on potential accidents, sickness, claims and possible slips, trips and falls. This may result in an enforcement notice from Environmental Health and non compliance with The Health and Safety at Work Act 1974. Risk location, Bronglais General Hospital.	Short term replacement of damaged flooring has been completed. Rubber mats purchased to cover the affected area to reduce further damage.	Safety - Patient, Staff or Public	6	4	3	12		Temporary repair of floor completed July 2016.	Baines, Mr Tim (Inactive User)	**Completed**	Despite some remedial work to flooring within dishwashing area being carried out, repair not 100% effective. A Datix incident has been recorded as an employee recently slipped and fractured her wrist.	Health and Safety Assurance Committee	2	3	6	Treat	21-Dec-21
															Formal bid for capital funding submitted for 2017/18 funding, refreshe the bid and resubmit.	Jones, Peter	**Completed**	Action closed- old action referring to 17/18, no long applicable.					
															Meet with Estates to establish costing for repairs.	Baines, Mr Tim (Inactive User)	**Completed**	No response from estates.					
															Work with Estates department to establish costs and develop a capital bid for repair work.	Jones, Peter	**Completed**	2013 cost used plus 30% uplift = £31,980					

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															Head of Specialist Services to ask catering manager to contact estates for quote to repair/replace floor	Jones, Peter	17/03/2020 29/04/2021	Requested again - Awaiting response						
															Cost requested by catering maanger	Lepetit, Carole	**Completed**	Action closed- to be rewritten						
															Estates to be contacted re quote to replace flooring	Lepetit, Carole	31/08/2020	Carole Lepetit asked by Tim Baines to contact estates						
															Estates to be contacted as no quote received	Lepetit, Carole	31/08/2020	Tim Baines asked Carole Lepetit 29.7.20 to contact estates asap						
															cost of replacement floor provided by estates	Jones, Peter	21/08/2020	capital bid to be produced now cost provided						
1292	Directorate Level Risk	ontrol (IPC) and Decontamination	Pembrokeshire	Lorton, Elaine	Griffiths, Ceri	25-Nov-21	There is a risk that Pembrokeshire System-wide Services would be unable to maintain business continuity in the event of an infection prevention and control outbreak situations (COVID / Influenza / Enteric infections etc)and experience significant service disruptions. This is caused by community nursing teams, domiciliary care providers and care homes experiencing significant staffing challenges as a result of increased sickness absence, self-isolation or requirements for staff to be deployed into non patient facing roles resulting in limited resilience to meet service demands. Wider impacts on	National and local IP&C guidance is in place across Pembrokeshire and includes specific guidance and risk assessment tools for social distancing, use of PPE, screening/testing, managing absence and return to work, signage and use of posters are well established and regularly updated by NHS Wales and Welsh Government. All health and social care staff are encouraged to uptake all mandatory and voluntary vaccinations including annual flu vaccinations and COVID vaccinations(inc boosters).	Safety - Patient, Staff or Public	6	3	4	12		A review of social distancing within offices and clinical settings will be undertaken following the recent update of social distancing guidelines by WG and any actions completed within the agreed time frames.	Griffiths, Ceri	**Completed**	To be discussed at next CMT Governance and Assurance meeting in December 2021. Completed.	and Experience Sub Committee	2	3	6	Treat	31-Jan-22

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		Standard 2.4 Infection Prevention and Co					care homes due to IP&C regulations and limitations on admissions to care homes during any outbreak will also impact on the Pembrokeshire system wide services to deliver and maintain patient services. This will lead to an impact/affect on the delivery of safe and effective quality patient care resulting in potential harm to patient due to delays in timeliness of patient visits and ability to respond to care needs. Delays in accessing care in the community may result in reduced patient flow from acute and community hospitals resulting in delayed discharge, increased numbers of avoidable admissions and additional pressure on community nursing services. Increased pressures on staff to manage service needs could lead to reduced staff wellbeing and increased stress and anxiety resulting in increased staff absence. Risk location, Pembrokeshire.	A daily Pembrokeshire wide system sit rep call has been established to enable oversight and early identification of any potential IP&C outbreaks / risks which may impact on services to deliver and support timely and effective patient care. An e-scheduling system (Malinko) has been implemented across community nursing teams in Pembrokeshire allowing oversight and opportunity for redistribution of clinical activity in event of increased demand and reduced capacity. This system along with the development of a single point of access ensures early identification of potential delays in patient care and opportunity to manage all activity being directed to community services. Community Nursing Escalation Plans and business continuity plans have been reviewed in line with increasing operational pressures and updated to reflect the learning gained following the COVID 19 Pandemic.							A 3 month review of IP&C and COVID infections will be undertaken in March 2022. Any additional actions identified following this review will be agreed and implemented in April 2022	Griffiths, Ceri	31/03/2022	Monthly IP&C audits continue	Operational Quality, Safety					
461	Service or Department Level Risk		E&F: Specialist Services (Catering/Laundry)	Elliott, Rob	Jones, Peter	01-Sep-13	There is a risk avoidable staff injury due to uneven and raised flooring that cannot be cleaned adequately. This is caused by water seeping through the flooring and tiles within the dishwashing area in the catering area. This will lead to an impact/affect on potential accidents, sickness, claims, slips, trips and falls. Risk location, Glangwili General Hospital.	Care to be observed when working in this area. Floor signs to be used whenever possible. Observational checks to be undertaken throughout the day. Spillages to be cleaned immediately.	Safety - Patient, Staff or Public	6	4	3	12		Options to remedy floor discussed with Estates Department.	Jones, Peter	Completed	Completed- Capital bid submitted April 2021.	Health and Safety Assurance Committee	2	3	6	Treat	21-Oct-21
															Develop a Capital funding 19/20.	Jones, Peter	Completed	Closed- no funding received in 19/20.						
															Further discussion taking place with Estates.	Jones, Peter	Completed	Closed- new action to be written.						
															Raise awareness with staff working in the area.	Baines, Mr Tim (Inactive User)	Completed	Issues raised with staff at team briefing.						

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															Capital bid submitted	Daniel, Richard	Completed	Bid submitted to Capital Manager						
															Existing quote over two years old new cost requested	Daniel, Richard	Completed	Cost for total project £94,695						
															New cost provided	Jones, Peter	Completed	Bid submitted 29.04.21						
															Obtain funding to replace flooring.	Jones, Peter	31/03/2022	Capital bid submitted 29/04/2021, no formal feedback as of July 2021.						
911	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	USC: WGH	Cole-Williams, Janice	Johns, Helen	29-Jul-20	There is a risk that WGH will be unable to accommodate all services & staff who are currently based at and are requesting accommodation on site plus potential risk of being unable to accommodate patients within inpatient areas without compromising social distancing requirements. This is caused by the COVID-19 pandemic has worsened the already challenging position with social distancing requirements having to be factored in to accommodation & service area allocation and usage. There are some staff who hold corporate roles and are based at WGH but only spend a proportion of their working week here. 3 staff have had to move onto the WGH site following the conversion of a Community Health Centre into a 'Red' COVID response facility. Demand on beds outweighs socially distanced bed capacity within ward areas. This will lead to an impact/affect on the delivery of Services, some services have had to relocate in response to the COVID-19 pandemic. Availability of office space for staff who have been previously based on the WGH site. Staff wellbeing, with some staff needing to continue to work from home in the longer term or relocate their base away from WGH. Potential harm to patients due to increased risk of contracting Covid 19 due to recommended social distancing requirements not being able to be maintained. Risk location, Withybush General Hospital.	Full scoping exercise undertaken of all services & staff based on the WGH site. This has been completed to include social distancing requirements. Summary report to be formulated and presented to the Health Board's social distancing cell for review and consideration. Services relocated across the site to areas which have had less activity on site during the COVID pandemic. Wherever possible staff have been advised to work from home. Working patterns spread over 7 days and longer hours to support less staff on site at any given time. All clinical areas scoped against social distancing requirements Perspex screens placed in reception and public facing areas. Consideration of mixed sex bays with additional precautions to ensure dignity is maintained. Areas considered as potential for escalation/surge that breach social distancing requirements are reviewed with vaccination status of patients in area being considered. Staff adhering to strict PPE guidlines.	Service/Business interruption/disruption	6	3	4	12		Scoping of all offices within the hospital site to determine if staff need to be onsite or could work from somewhere off site.	Johns, Helen	21/01/2022	Most areas have been scoped. Springfield needs to be completed.	Operational Quality, Safety and Experience Sub Committee	3	2	6	Treat	16-Dec-21

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473	Service or Department Level Risk		E&F: Carmarthenshire West	Elliott, Rob	Jones, Kevin	01-Sep-14	There is a risk avoidable disruption to business continuity. This is caused by engineering infrastructure components failing at Hafan Derwen. This will lead to an impact/affect on failure of the heating system at Hafan Derwen and continual leaking of radiators and pipe work, leading to service disruption. Risk location, Hafan Derwen.	On-going maintenance and PPMs are being carried out. Visual inspections are also being undertaken. Communications with staff has also taken place.	Service/Business interruption/disruption	6	4	3	12		Quotations have now been obtained. A capital bid is to be submitted in December 17 for funding from 2018/19 capital funding. Works are to be undertaken in April 2018.	Jones, Kevin	01/04/2018 30/09/2018 09/08/2021	Phase 1 works has now been completed. evaluation and review of potential capital bid for phase 2 works	Health and Safety Assurance Committee	2	3	6	Treat	18-Jan-22
															Phase 2 of this project needs to be supported by capital bids	Jones, Kevin	31/03/2019 20/03/2020 31/03/2022	Capital bid needs to be supported for 2020/2021. Re-evaluate the extent of phase 2 repairs for capital bid submission						

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251	Service or Department Level Risk	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	E&F: Ceredigion	Elliott, Rob	Jones, Elfyn	07-Apr-17	There is a risk of avoidable loss of Joint Advisor Group (JAG) accreditation, which is essential to support the provision of clinical services within endoscopy units as required by Welsh Government. This is caused by a strong and intrusive smell of Peracetic Acid within the decontamination area of the endoscopy unit. This will lead to an impact/affect on loss of JAG accreditation which results in non-compliance with Welsh Government's requirements for endoscopy and a consequential impact on the Health Board's ability to attract junior doctors to fulfil placements within the unit. Risk location, Bronglais General Hospital.	SMTL have carried out gas analysis testing within the clean and dirty areas, which were below the acceptable exposure limit. A contract has been set up to monitor gas exposure on a quarterly basis. Paracetic Acid containers are stored in a carbon filtered COSHH cupboard. Endoscopy staff receive annual COSHH training. Continued PPM in place.	Business objectives/projects	6	3	4	12		Prepare SBAR outlining option appraisals to take endoscope decontamination forward.	Flear, Philip	Completed	20.05.19 It has been requested that this risk is now transferred to the Estates risk register.	Capital, Estates and IM&T Sub Committee	1	5	5	Treat	13-Jan-22
															Procure Paracetic Monitors for the clean and dirty areas of the endoscope decontamination unit.	Flear, Philip	Completed	Capital bid submitted, funding approved. Awaiting delivery of Peracetic monitors. Update 13.08.19 Monitors received and have been installed for use. 14.09.18 Update 14.09.18 Peracetic monitors received and identified to be faulty - replacement monitor received 12.09.18 will continue to monitor closely and review in a months time. 26.10.18 Continuing to work effectively being monitored on a regular basis. 30.11.18 The paracetic monitor is working effectively no further action needs to be on this action.						
															Obtain updated quotation for replacement of air handling unit.	Griffiths, Jill	Completed	Quotation received.Update 13.08.19 Looking at re locating the decontamination service into HSDU 2019/20. No further update 14.09.18 26.10.18 - No further update on the centralisation of decon into HSDU however whilst this remains a priority the endoscopy washers at PPH are problematic causing cycles failures on a regular basis and will therefore need addressing prior to BGH. 30.11.18 No further update. Update 27.12.18						
															Looking at re locating the decontamination service into HSDU in 2020/21.	Jones, Elfyn	Completed	Action closed- new action written for 2021/22						
															Service looking at relocation the decontamination service into HSDU in 2021/22	Jones, Elfyn	31/03/2021 06/11/2021 31/03/2022	Currently on hold due to COVID-19 pressures						

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1234	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	Scheduled Care: OPD	Hire, Stephanie	George, Helen	24-Aug-21	There is a risk to patients and staff health and safety. This is caused by inadequate control of temperature due to lack of air flow management in the clinical areas in OPD B (old area) at WGH. These temperature breaches working conditions which has been highlighted in a recent (August 2021) internal Health & Safety audit report (regulation 7 'during working hours the temperature in all work places inside buildings should be reasonable). The rooms gets incredibly hot and due to confidentiality, dignity issues the doors have to be closed in rooms 5 and dressing room during consultations and whilst dictating afterwards. This will lead to an impact/affect on patients and staff safety. Doctors and health care professionals refusing to work in room 5 as not appropriate/comfortable. Patient complaints and possible claims, staff morale and wellbeing, utilisation of the department. Possible increase of infection when wounds are being redressed. Risk location, Withybush General Hospital.	Doors opened for short periods between patients- insufficient time to relieve problem Access to drinking water to keep hydrated. Health and safety policy and Occupational Health service. Risk highlighted again to SNM and SDM, and has been escalated to the portfolio leads.	Safety - Patient, Staff or Public	6	3	4	12		Obtain funding for ventilation unit.	Thomas, Huw	31/03/2022	Quote have been obtained (approx. £8.5k). Capital bid has been submitted, awaiting outcome. Hoping to obtain approval by Q4 2021/22.	Health and Safety Assurance Committee	2	2	4	Treat	25-Jan-22
1041	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	Women and Children: Midwifery and Maternity	Humphrey, Lisa	Thomas, Sharon	01-Feb-21	There is a risk potential harm to staff and patients when reconfiguring labour ward beds to undertake procedures. This is caused by the poor condition of the delivery beds being in excess of 20 years old. This will lead to an impact/affect on safety of staff and patients. Compliance to HB infection control and moving and handling standards. Potential for incidents and complaints. Risk location, Bronglais General Hospital.	Processes in place for monitoring via infection control audits and DATIX clinical incident and complaints.	Quality/Complaints/Audit	8	3	4	12		Capital bid for replacement beds request form was completed and submitted on 24/2/2021.	Davies, Dawn T	**Completed**	Capital Bid has been submitted. 06/08/2021 Awaiting final approval of bid.	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	02-Feb-22
															Risk and Governance Midwife is working with the Capital Bid Team on the procurement of the beds.	Thomas, Sharon	31/03/2022	Feb 22 - requisition has been approved, with procurement process ongoing.						
1280	Directorate Level Risk		USC: Radiology	Perry, Sarah	Roberts-Davies, Gail	09-Nov-21	There is a risk of failure and damage of the MRI scanner at WGH This is caused by failures in the chilled water supply (which is shared by the whole hospital site, used by services such as Endoscopy, Theatres and A&E) that results in the MRI scanner stopping. This will lead to an impact/affect on patient safety, as there is a clinical risk should the MRI scanner fail mid-scan, particularly on patients who have received intravenous contrast. Repeated machine failures can damage the gradient cupboard, with an estimated replacement cost of £250,000	Electronic monitoring of the flow of chilled water supply, with an associated alarm system in place. Cleaned the filters of all sediment.	Safety - Patient, Staff or Public	6	3	4	12		Arranging a down time of service to flush and clear the pipes of the chilled water supply.	Lingwood, Gill	**Completed**	Advice obtained where this action was not required. Action therefore closed.	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	18-Jan-22
															Julian Wheeler-Jones is to seek advice from a mechanical engineer to cost and survey a dedicated chilled water supply to MRI.	Lingwood, Gill	**Completed**	Action completed by Julian Wheeler Jones.						

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							£200,000. The equipment warranty and service contract would become void as a result of there being a lack of a robust chilled water supply in place at the time of the equipment being installed. There is also risk of reputational damage to the service, site and the Health Board. Risk location, Withybush General Hospital.								Investigate possibility of diverting the chilled water supply from A&E to MRI in an emergency.	Lingwood, Gill	**Completed**	Action no longer applicable due to the purchase of the new chilled water system	Operational Qua					
															Develop a plan for the scheduled work and its impact on both operations radiology and wider services affected by no chilled water supply.	Lingwood, Gill	30/11/2021 31/03/2022	Plan has been devised, and capital has been obtained for the purchase of a new chilled water system with the help of mechanical engineering advice. Equipment has been purchased, and scheduled to be installed by March 2022.						

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															Rearrangement of scheduled appointments for patients to allow corrective work to take place for outpatients. Ensure contingency plans are in place to provide availability of urgent MRI imaging for inpatients at other sites within HB, which will include transportation arrangements with WAST	Lingwood, Gill	31/12/2021 31/03/2022	Plan has been devised, and capital has been obtained for the purchase of a new chilled water system with the help of mechanical engineering advice. Equipment has been purchased, and scheduled to be installed by March 2022. Appointments to be rescheduled if and when needed during the installation phase.						
															Lesson learnt to share with the wider radiology directorate for future MRI installations.	Perry, Sarah	**Completed**	Task and Finish Group where Estates, Radiology and Capital are in attendance meet weekly, and the lessons learnt has been widely discussed in this forum. Action complete.						
767	Service or Department Level Risk		Scheduled Care: Theatres	Hire, Stephanie	Knight, Diane	01-Aug-19	There is a risk of patient trolleys failing/being condemned and the department not being able to move patients to and from theatres. This is caused by the age of the trolleys. There are currently 24 patient trolleys that are between 13 & 18 years old. One trolley has been recently condemned. The Health Board has now received communication from the manufacturer stating that a number of components are no longer available should ours fail. This will lead to an impact/affect on the ability to collect patients from the wards which would lead to delays in surgery, RTT, complaints and Health Board reputation. Risk location, Glangwili General Hospital.	Trolleys serviced yearly and repaired where parts are available. Trolleys regularly cleaned and checked by staff.	Service/Business interruption/disruption	6	3	4	12		Capital bid for replacement to be submitted.	James, David	**Completed**	Awaiting submission.	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	24-Jan-22
															Obtain quote for replacement of trolleys.	James, David	**Completed**	Awaiting quote.						
															Risk needs to be broken down by site.	James, David	**Completed**	Site specific risk assessments being completed.						
															2020/21 Capital bid to be submitted.	James, David	30/06/2021	New action.						

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139	Directorate Level Risk	Standard 3.1 Safe and Clinically Effective Care	MHLD	Carroll, Mrs Liz	Amner, Karen	16-Oct-14	There is a risk of avoidable deliberate self harm attempts by patients. This is caused by the Directorate having inpatient units that are not compliant with Point of Ligature (POL) standards with variation in compliance across the service and insufficient capital funds to undertake this work. This will lead to an impact/affect on serious injury or death. Prosecution for failure to comply with anti-ligature standards as set out by Welsh Government might follow such outcomes. Loss of public confidence for failure to introduce improvements on the basis of lessons learnt as a consequence of serious injury or death. Risk location, Health Board wide.	Clinical Risk assessment on an individual patient basis. Welsh Applied Risk Research Network (WARRN) and Skills based Training on Risk Manager(STORM). An annual POL audit is in place.	Safety - Patient, Staff or Public	6	2	5	10		A review of the Observation and Engagement Policy is being undertaken to further strengthen the existing policy and ensure that opportunities to therapeutically engage with clients is maximised and for the risk to be mitigated and minimised where suicidal intent is evident.	Carroll, Mrs Liz	Completed	The policy has been finalised and is going through the organisation's written control document procedures. Update 5.6.18: A decision has been made to merge the Observation and Engagement Policy with a wider Health Board document so that there is parity in the terminology being used for patient observation. Update 3.12.18: Policy can not be merged as the All Wales Observation levels for mental health are set. The policy is now going through the Clinical Written Control Document group for final sign off and to be uploaded to the intranet.	Operational Quality, Safety and Experience Sub Committee	2	5	10	Tolerate	14-Feb-22
															Nationally further work is required, and the Health Board will engage, to better clarify anti-ligature approaches in Older Adult Mental Health wards that need to balance dementia friendly environments.	Carroll, Mrs Liz	Completed	Statutory funding 17/18 to be focussed on Older Adult mental health units due to the significant spend already in place for Adult inpatient services. Meeting taking place 4.10.17.						

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															Annual POL programme to understand the risks, the clinical areas to mitigate the risks and for funding to be prioritised to rectify. This work reports into the Directorate Business, Performance and Planning Assurance Group in relation to capital and the Mental Health and Learning Disabilities Quality, Safety and Experience Assurance Sub-Committee in relation to risk and quality of care.	Carroll, Mrs Liz	30/06/2018 31/03/2022	Estates Advisory Board has been awarded addition funding for Point of Ligature capital improvement work during the 2021/22 financial year. Schemes are on target to complete within this timeframe.						
															The Directorate is allocated circa £50K from the Discretionary capital fund annually for legislation based work POL is prioritised from this funding.	Carroll, Mrs Liz	**Completed**	Due to the extensive nature of the works taking place in this financial year the next POL audit will take place in the forthcoming financial year (18/19).						
															Standards need to be agreed in respect of the Older Adult inpatient services balancing dementia friendly environments with building regulation requirements associated with points of ligature. This is part of the All Wales MH ligature task and finish group workplan which includes representation from the Directorate.	Carroll, Mrs Liz	30/09/2019 31/03/2023	A Health Board wide dementia friendly environment steering group meeting led by the Advance Practitioner Occupational Therapist in Dementia has been established to consider function of spaces, enviro. Environmental design and signage.						
															Following a near-miss when a ligature had been found on the anti-ligature replacement bathroom doors the Estates department has been in touch with the manufacturer to inform them of the incident and to determine if there is any remedial action that can be taken. The manufacturer has identified an upgraded hinge system that will need to be installed.	Davies, Nevin	**Completed**	Bedroom doors have been reviewed and replaced across all inpatient areas.						

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477	Service or Department Level Risk		E&F: Carmarthenshire West	Elliott, Rob	Jones, Kevin	25-Sep-17	There is a risk serious harm to pedestrians resulting from heavy traffic crossing the GGH stores delivery area. This is caused by insufficient measures in place to restrict access to this area and divert pedestrians to alternative routes. No segregation between normal parking and that of heavy goods vehicle parking and manoeuvring. This will lead to an impact/affect on serious harm to a pedestrians in an event of an incident happening, leading to a potential prosecution on the grounds of corporate manslaughter. Risk location, Glangwili General Hospital.	Route is already under tight control by CP Plus, yet further controls are necessary.	Safety - Patient, Staff or Public	6	2	5	10		Installation of clear pedestrian crossing point at entrance to main stored delivery area. Quotations for this work will be obtained by December 17, capital funding will be requested for the scheme to progress from 2018/19 funding.	Evans, Paul	**Completed**	Formal risk assessment has been undertaken. THIS RISK NEEDS TO BE FORMALLY ASSESSED AGAIN TO ASSESS THE LEVEL OF RISK FACED BY THE HB.	Health and Safety Assurance Committee	1	5	5	Treat	22-Dec-21
															Installation of barrier preventing pedestrians from using the stores delivery area as a short cut between Mortuary and rear GGH entrance. Quotations for this work will be obtained by December 17, capital funding will be requested for the scheme to progress from 2018/19 funding.	Jones, Kevin	20/03/2018 31/03/2019 31/03/2022	Funding in 2021/2022 has not been supported as of August 2021. This risk needs to be re-evaluated and an updated capital bid submitted .					
															Introduction of zero tolerance parking along the full length of the rear access road leading up to the stores delivery point, including restriction on vehicles parked on curbs.	Evans, Paul	**Completed**	A significant portion of this route is already under tight control. CP Plus to arrange for this area to be extended all the way to the stores access point.					
93	Directorate Level Risk		USC: Pathology	Perry, Sarah	Stiens, Andrea	01-Oct-14	There is a risk avoidable harm to staff and others by contact, ingestion or inhalation of hazardous substances. This is caused by ineffective segregation of formaldehyde which is now a category 1 carcinogen. This will lead to an impact/affect on serious harm to staff from exposure to formaldehyde leading to sensitisation and lasting health issues. Criminal prosecution under Health & Safety law. Risk location, Glangwili General Hospital.	Risk assessments completed March 2015. Formaldehyde environmental monitoring in place. Levels are below recommended safety levels. Staff who display symptoms are referred to Occupational Health for advice and on-going monitoring.	Safety - Patient, Staff or Public	6	2	5	10		Phase 2 - reconfigure office space, improve ventilation and transfer the tissue processor equipment from cut up room to this new facility.	Stiens, Andrea	30/09/2021 30/11/2021 31/03/2022	Capital works currently progressing.	Operational Quality, Safety and Experience Sub Committee	1	5	5	Treat	15-Nov-21
															Reconfigure Consultant office and replace with a Containment level 2 laboratory space with Class 2 cabinet to support processing of non gynae specimens.	Stiens, Andrea	29/10/2021 30/11/2021 31/03/2022	Capital works progressing.					

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503	Directorate Level Risk		E&F: Fire	Elliott, Rob	Evans, Paul	06-Dec-17	There is a risk avoidable harm to bariatric (plus sized) patients in the event of a fire evacuation from some of our facilities. This is caused by the inability to evacuate patients in a timely manner due to evacuation routes not fully supporting efficient bariatric evacuation. This will lead to an impact/affect on serious injury, possible enforcement and Health and Safety (HSE) Executive intervention in the event of a serious incident occurring. Risk location, Health Board wide.	Estates, clinical and ward staff are fully aware of this issue. A clinical assessment is undertaken for each in-patient and if there are evacuation concerns regarding bariatric patients then this should be discussed with the fire safety team. There are BMI restrictions now inplace at some clinical locations, such as Preseli theatre/Ward area. Fire training is continually being delivered to staff. Bariatric aids have been purchased by the Health Board and are in use. However, this is not suitable for every ward and evacuation route. Additional fire compartmentation upgrades and fire door improvements have been carried out to the fire structure (in some areas) to improve integrity of our buildings. Further significant investment is required to address all breaches. Good housekeeping continues to be maintained. Internal risk assessments are undertaken by the fire safety team.	Safety - Patient, Staff or Public	6	2	5	10		A full review is required of areas where there are difficulties in evacuation. The compliance team to review this with the manual handling teams specifically focusing on areas where bariatric patients are being cared for.	Evans, Paul	Completed	Bariatric escape aids have been purchased by the Health Board and training has been provided. However there are still areas across the Health Board where this equipment would not adequately evacuate bariatric patients due to the size of door openings and equipment size. This has yet to be fully reviewed. Although this issue is being discussed at all fire safety groups and a standard bariatric evacuation document has been circulated at FSG's.	Health and Safety Assurance Committee	1	5	5	Treat	14-Feb-22
															Task and finish group required with Manual Handling teams to review this risk in detail with the fire safety team. To formally agree the delivery of on-going bariatric training - patient handling training for HB staff.	Evans, Paul	18/11/2019 20/05/2020 01/08/2021 31/10/2021 20/01/2022	We have now been given the names of representatives to commence the T&F group to identify where we are with this risk. A meeting is now planned for the 20th Jan 2022 with MH leads and the fire team to discuss the way forward.					
471	Service or Department Level Risk		E&F: Carmarthenshire East	Elliott, Rob	Rosser, Brian	25-Sep-17	There is a risk serious harm to pedestrians resulting from a road traffic accident occurring on the PPH access road between the Acute Medical Admissions Unit (AMAU) and staff car park. This is caused by no pavement or pedestrian walkway available along this stretch of road and curvature of road limiting the view of motorists using this area. This will lead to an impact/affect on death or serious harm to a pedestrian or motorist. Risk location, Prince Philip Hospital.	There are existing speed restrictions in place such as speed warning signs and a two way mirror to help with visibility around the corner of the site.	Safety - Patient, Staff or Public	6	2	5	10		Installation of a pedestrian foot path or hatched area along this stretch of road is recommended, along with road re-surfacing and road markings.	Rosser, Brian	22/01/2018 31/03/2020 31/03/2021 31/03/2022	Ops have been to review the area and quotations sought for a designated hatched area along the roadway. Capital bid has not been supported since 2018/19. Bid has been submitted for road re-surfacing 2021/2022 road markings to be included, at a cost of circa £70k. As of October 2021 this has not yet been funded.No change at December 2021	Health and Safety Assurance Committee	1	5	5	Treat	22-Dec-21

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846	Service or Department Level Risk	Standard 2.5 Nutrition and Hydration	E&F: Specialist Services (Catering/Laundry)	Elliott, Rob	Jones, Peter	10-Mar-20	There is a risk that a patient, member of staff or a member of the public may receive a meal that contains an allergen that they are allergic to. This is caused by a meal containing one of the recognised allergens being consumed by someone allergic to a particular allergen. There is limited compliance across all Health Board sites against the 8 actions required against the NHS Alert 2020 001- Estates and Facilities Alert (EFA) Allergens Issues. This will lead to an impact/affect on the health of a person with very serious consequences. Possible complaints. Risk location, Health Board wide.	Catering staff are trained in allergens as part of their food hygiene training. Allergen Information is displayed in dining rooms. Allergen information is available. Diet clerks in post in PPH and GGH. Diet cook in post in GGH. Allergen training included in Level 2 Basic Food Hygiene Training. provided to catering staff. HACCP's contain section on management of allergens. Allergen posters displayed in catering departments. PPH and GGH has " Daymark" labelling system which allows allergen information to be displayed. Snack boxes contain allergen advice.	Safety - Patient, Staff or Public	6	2	5	10		All cooks and supervisory staff to undertake Level 2 Allergen Training	Jones, Peter	30/10/2020 31/10/2021	Current training progress as of June 2021 show improvements as follows: GGH - 49/56 87.5% catering staff trained on allergens BGH - 23/32 72% catering staff trained on allergens PPH - 13/31 42% catering staff trained on allergens WGH - 36/45 80% catering staff trained on allergens SPH - 11/16 68.95 catering staff trained on allergens	Operational Quality, Safety and Experience Sub Committee	1	5	5	Treat	29-Oct-21
															All domestic staff to undertake Level 2 Allergen Training	Jones, Peter	31/10/2021 31/01/2021	As of October 2021, approx 70% of domestic staff have received training.						
															Agree appropriate training method for nurses to receive Level 1 Food Hygiene training, and Level 1 Allergen training. Apart from BGH where nurses will also need to receive Level 2 training as they serve the food on this site.	Jones, Peter	31/10/2021	Discussions taking place at Nutrition & Hydration Group with Senior Nurses and Head of Specialist Services (Chair of group), to agree training method to be agreed at Board level. This is an NHS Wales wide issue.						
															At an All Wales level continue to explore with the Food Standards Agency (FSA) whether it can be linked into Electronic Staff Record (ESR).	Jones, Peter	31/03/2022	As of July 2021 there has been no progress, however discussions are ongoing at an All Wales level.						
															Roll out Symbiotic system.	Jones, Peter	31/03/2022	Roll out currently taking place. This new system will replace the " Daymark" labelling system currently in place.						
															Risk to be discussed at Nutrition and Hydration Group (NHG) to establish key actions, and which Directorate risk register this risk should sit with going forward.	Thomas, Karen	31/10/2021	Risk to be discussed at NHG in October 2021.						
949	partment Level Risk	g Health and Safety	E&F: Pembrokeshire	Elliott, Rob	Evans, Duncan	15-Aug-17	There is a risk that the water services will remain non compliant and pathogens will be detected in increased sampling. This is caused by poor balancing of the water inside the building causing losses of temperature either up too high on the cold and too low in the hot, leading to exposure to	Currently a frequent flushing regime is in process with extended temperature testing and monitoring.	itient, Staff or Public	6	2	5	10		Continual flushing, Temperature monitoring and extra maintenance required	Elliott, Rob	**Completed**	Action closed- the process of continuous monitoring is in place.	M&T Sub Committee	1	2	2	Treat	21-Jan-22

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	Service or De	Standard 2.1 Managing Risk and Promotin	E				water-borne bacteria within water systems and air conditioning systems. Additonal £20K alloated from Capital programme 2021-2022. This will lead to an impact/affect on closure of services. Patient, staff and public illness, and possible enforcement or Health and Safety Executive (HSE) prosecution in the event of an serious incident occurring. (Linked to HB wide risk 223). Risk location, Pembrokeshire, Withybush General Hospital.		Safety - Pa						Obtain funding via Capital process for alteration of excessive size pipework and removal of redundant pipework.	Evans, Duncan	31/12/2021	2 Capital bids submitted (outcome not yet known) and a further 3 Capital bids currently being drafted.	Capital, Estates and IM					
															Further monies are being made available to enhance our temperature monitoring throughout the site with the introduction of L8 radio outstations. We are still flushing and still sampling as local eradication only is being exercised. Chemicals have been used in Blood Sciences due to the enormity of the results.	Evans, Duncan	31/03/2022	Orders have been placed on oracle.						
104	Directorate Level Risk		USC: Pathology	Perry, Sarah	Stiens, Andrea	01-Sep-16	There is a risk avoidable infection from contaminated hazardous microbiological waste. This is caused by a >10 year old autoclave failing to reach sterilisation temperatures. Decreased maintenance and service support from estates due to age of equipment. This will lead to an impact/affect on prolonged autoclave downtime resulting in build up of infectious hazardous waste on site with potential for environmental enforcement. Risk location, Withybush General Hospital.	Triple bagging of waste prior to incineration.	Safety - Patient, Staff or Public	6	5	2	10		Capital Bid submitted for consideration in the 2017/18 capital allocation process.	Stiens, Andrea	**Completed**	Await outcome of the allocation of Health Board capital £40-£58k. No capital funding identified in 2017/18.	Operational Quality, Safety and Experience Sub Committee	1	2	2	Treat	08-Feb-22
															Capital bid to 2019/20 capital programme allocation.	Williams, Mike	**Completed**	No allocation of capital funding in 2019/20.						
															PHW have produced an All Wales capital funding application for autoclaves both within PHW and Health Boards to be submitted to Welsh government.	Stiens, Andrea	30/04/2020	Awaiting outcome of submission.						

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283	Directorate Level Risk		USC: WGH	Cole-Williams, Janice	Johns, Helen	01-Jun-17	There is a risk avoidable harm to bariatric patients and harm to staff moving these patients. This is caused by environmental constraints and equipment availability. This will lead to an impact/affect on bariatric patients will not receive the required level of care leading to poor patient outcomes and delays in care delivery and treatment. Increased staff injury and sickness resulting in long term disability. Risk location, Withybush General Hospital.	1 Bariatric space on Ward 7, Ward 9, ward 10 and ACDU. 1 Mobile gantry hoist system. Fixed gantry hoist system available on ACDU, Ward 10, Ward 9, Ward 1 and Ward 11. Ward 9 also have bariatric shower and toilet facilities. Purchase of bariatric bed. Out of Hours hire information available via the hospital Site Nurse. Moving and Handling team available for support in managing bariatric patients.	Safety - Patient, Staff or Public	6	3	3	9		Implementation of bariatric care plans.	Cole-Williams, Janice	01/10/2017 20/12/2019 28/09/21 10/12/21 02/08/2022	Care plan has been written, but not implemented or used on the wards. In discussions with Jennifer Lewis MH manager about a plan going forward.	Operational Quality, Safety and Experience Sub Committee	3	3	9	Treat	10-Dec-21
															Capital bid submitted, identify is any slippage money is available.	Cole-Williams, Janice	31/03/2022	Awaiting response from Capital.						
															Chase up and establish if any Capital money is being allocated or if the work is being done via minor works..	Johns, Helen	31/03/2022	Chase up ongoing, progress to be updated at next review.						
1318	Directorate Level Risk		Therapies and Health Science	Reed, Lance	Reed, Lance	10-Dec-21	There is a risk of avoidable patient and staff harm. This is caused by lack of suitable and sufficient Therapies accommodation that is fit for purpose. This will lead to an impact/affect on reduction in the effectiveness and efficiency of service delivery, possible increase in injury, compliance to infection prevention and control standards, staff well being and dignity and respect standards. Risk location, Health Board wide.	Contribute to all new capital build projects. Adhere to all safety requirements e.g. relocate staff and limit exposure. Some short term work has been carried out in various sites by estates.	Safety - Patient, Staff or Public	6	3	3	9		Submit requirements for potential to move to Leri Day unit.	Reed, Lance	31/03/2022	New action to progress to be updated at next review.	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	13-Dec-21
															Submit requirements for new builds, in Cross Hnads , Pentre Awel and Aberystwyth.	Reed, Lance	31/03/2022	New action progress to be updated at next review.						
															Paper to be submitted to Ceredigion County management Team for BGH requirements.	Davies, John	31/03/2022	New action, progress to be updated at next review.						
1072	Service or Department Level Risk		E&F: Ceredigion	Elliott, Rob	Jones, Elfyn	02-Dec-13	There is a risk avoidable harm to patients, visitors and staff from slips, trips and falls on external roads and pathways at BGH. This is caused by degration of road surfaces as a result of weather conditions. This will lead to an impact/affect on financial claims or Health and Safety Executive (HSE) inspections on Hywel Dda University Health Board following an incident. (Linked to HB wide risk 362). Risk location, Bronglais General Hospital.	Maintenance teams manage the worst affected areas around the sites. Regular site inspections are carried out. Planned preventative maintenance is in place.	Safety - Patient, Staff or Public	6	3	3	9		Secure money via Capital bid.	Jones, Elfyn	**Completed**	No budget available for 2021/2022 Awaiting Allocation for 2022/2023	Health and Safety Assurance Committee	2	3	6	Treat	14-Jan-22

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828	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	Central Operations: Health Records	Rees, Gareth	Bennett, Mr Steven	01-Apr-19	There is a risk avoidable harm or injury to staff working in the Health Records services undertaking routine daily activities. This is caused by detrimental and unsafe working environments, specifically with insufficient storage capacity for patient records and a lack of investment to ensure the availability of adequate electronic systems to deliver a sustainable solution. This will lead to an impact/affect on staff injury including slips, trips and falls. Increased complaints and possible litigation. Short term and long terms staff sickness, increased financial costs due to the utilisation of overtime to cover services and short term service disruption. Risk location, Health Board wide.	Health Board Corporate Induction Programme. Manual Handling Training. Health Records training and departmental induction. Corporate policies, manual handling policy, health & safety policy, risk management policy. Annual weeding and destruction programme agreed and facilitated across the Health Board. Scanning of deceased patient records. Alteration to current racking and purchase of additional racking at GGH. Resourcing of additional racking for the offsite storage facility Health Records Modernisation Programme Group reviewing records management arrangements and e-working (May 19) Overtime process for condensing offsite storage facility supported by BPPAC and Exec Team. Datix incident reporting is utilised within the health records service so we can identify any themes or trends around staff injury or impact on service delivery. Specific accident review process within the Health Records service. Provision of equipment, kick stools, ladders trolleys. Purchase of electric trolley as per recommendation from H&S review. H&S reviews and inspections. Health Records KPI's. Internal audit reviews.	Safety - Patient, Staff or Public	6	3	3	9		Implement of weeding plan 2018/2019	Bennett, Mr Steven	**Completed**	All non active 2016 records have now been relocated from the Health Records departments to the offsite storage facility.	Information Governance Sub Committee	2	3	6	Treat	05-Jan-22
															Develop a business case for the implementation of a scanning solution to deal with long term issue.	Rees, Gareth	31/03/2019 31/03/2021 31/07/2021 31/12/2021 30/06/22	Agreed funding has been provided for a 3 year period to commence to the implementation of an EPR within the Health Board. Designated project manager recruited in November 2021. Business process assessment with an external organisation was undertaken, and final report received in December 2021, providing more detailed and definitive information and will be reviewed. This will provide the critical basis for the development of a business case. Two tender specifications are being developed for the purchased of an EDMS for some additional scanning work.						
															Implement weeding plan 2019/2020	Bennett, Mr Steven	**Completed**	All 2017 and 2018 non active records have now been relocated to the offsite storage facility.						
															Develop action plans including costs and savings associated with each specific work stream identified at the HRMPG.	Rees, Gareth	31/07/2020 31/03/2021 31/07/2021 31/10/2021 31/12/21 30/06/2022	The Health Records Modernisation Programme Group identified various work streams for progressing the digital programme within the Health Board. Plans are currently ongoing to recruit a designated project manager to support identified service leads to finalise project/action plans and timescales for delivery. Once plans have been agreed it will provide better detail and understanding in regards completion dates and the benefits involved.						

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															Identify additional storage capacity to negate the immediate risk within the health records service.	Bennett, Mr Steven	31/03/2022	A suitable storage facility has been identified on an industrial estate in Llanelli. An initial review has been completed with a draft Heads of Terms developed by the estates team. Further discussions are underway with the landlord and shared services. Looking to take occupancy at the identified site by the end of FY 21/22						
880	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	Central Operations: Out of Hours	Rees, Gareth	Richards, David	06-Jul-20	There is a risk that OOH clinicians and support staff may inadvertently be exposed to Covid-19 infection despite current patient flow processes. This is caused by insufficient communication being provided by patients when discussing their complaints during telephone assessment resulting in a face-to-face review with a patient who may be suffering with Covid-19. This will lead to an impact/affect on the health and welfare of OOH staff, insufficient staffing levels in OOH as staff members may need to self isolate, risk to service readiness if staff feel risk is unmanageable. Risk location, Carmarthenshire, Ceredigion, Pembrokeshire.	# Screening of each patient presentation via telephone/ telemedicine prior to Face-to-face review; # Support for increase risk-taking decisions in line with national guidance; # Support for increased remote prescribing based on telephone consultation, avoiding need for face-to-face review; # Supply and use of personal protective equipment in line with HB issues guidelines (extends to patients where assessment is required) # IP&C training provided to staff at a OOH journal club on 13th October 2021.	Safety - Patient, Staff or Public	6	3	3	9		Generate agreed procedures to avoid clinicians having to assess patients on a face to face basis without prior agreement. This involves reconfiguration of the Adastra clinical system to allow telephone advice assessments (including those completed by remote telephone advice clinicians) to be assigned to treatment centre waiting lists for individual bclinicians to reassess and if required arrange appointment.	Davies, Nick	Completed	This work has now been concluded and will be fully operational from 10 July 2020	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	11-Jan-22
															Introduce "Attend Anywhere" virtual consultation system to assist clinicians with reducing face-to-face requirements and enhancing quality of remote consultations.	Davies, Nick	Completed	Procurement complete in collaboration with 111 project team. Local IT have completed infrastructure requirements and hardware has been distributed to all OOH bases. NHS email access for a selected group of clinicians has been confirmed and the pilot phase of the use of the system has commenced. A national review of the pilot will commence in September 2020.						
															Contact all staff to support with workforce (BAME) risk assessments and conduct individual assessments where requested/ required. Service has been modified to support majority of staff in a safe environment	Davies, Nick	Completed	2 sets of emails plus a service newsletter have bene circulated to all OOH staff and all 22 respondants have been assessed. The majority of the workforce has not responded, but service modifications support staff with low and medium risk to operate in a safe environment.						

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															Await the development/ approval of a COVID-19 vaccine-inoculation may support reduction in the risk faced by clinicians posed by the virus in the given context. When available, OOH clinical lead will need to direct the vaccination program in collaboration with the HB leads.	Archer, Dr Richard	**Completed**	COVID-19 Vaccine now being rolled out and staff being encouraged to book for vaccination via HB systems. All other risk-reducing actions remain in place						
															Administer vaccine to Out of Hours staff.	Davies, Nick	**Completed**	Out of Hours staff are now considered a priority group and all operational staff are encouraged to make appointments with minimal delay. A short notice link has been established.						
															Review 'Attend Anywhere' and other digital platforms.	Richards, David	30/04/2021 30/06/2021 31/08/2021 31/10/2021 31/12/2021 30/06/2022	Attend Anywhere' poorly received. Other digital platforms are still being explored with the clinical team. The service has re-engaged with I.T colleagues, however progress remains slow. The preferred option (Whatsapp) has Information Governance issues associated with this. Will be exploring other options available with primary care colleagues.						
															Requesting support from the ambulance service for fit testing, which will hopefully provide reassurance and confidence to staff.	Richards, David	**Completed**	Update and refresher session has taken place. Action complete but work is ongoing to work with colleagues for fit re-testing as required.						

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480	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	Central Operations: Central Transport Unit	Rees, Gareth	Skye, Gareth	01-Mar-14	There is a risk avoidable detriment to business objectives. This is caused by site congestion and significant disruptions during busy periods. Insufficient car park spaces around the site cause blockages and congestion. This will lead to an impact/affect on blocking of access for fire engines, deliveries from British Oxygen (BOC) to the VIE, fuel oil deliveries to the main boiler house, woodchip deliveries to the biomass boiler and failure and delay in patients being able to attend clinical appointments. Risk location, Glangwili General Hospital, Prince Philip Hospital.	CP Plus, dedicated car park management contractor to control vehicle flow. Park and ride facility available. Transport management team implementing a range of car parking improvements on site. ANPR system established to enable monitoring of car parking demand levels and enforce controls as and when required. Bollards introduced across the GGH site to ensure that areas of high risk, e.g. fire escape routes and emergency access roads are not obstructed by inappropriately parked vehicles.	Service/Business interruption/disruption	6	3	3	9		The HDUHB is reconsidering its policy on dedicated named spaces for consultants etc. as it is regularly reported that at least 50 of these spaces are regularly empty. These actions are being driven by the transport team and a review of the number of consultant car parking spaces is being undertaken.	Evans, Paul	Completed	Action completed. Consultant spaces reduced from 92 to 53 in November 2016.	Health and Safety Assurance Committee	2	3	6	Treat	08-Feb-22
															Implement a Car Park Improvement Strategy for GGH and PPH	Skye, Gareth	Completed	GGH and PPH car park improvement strategies have been implemented.						
															Implementation of Car Park Improvement Strategy for PPH, including plans to increase parking capacity at PPH.	Skye, Gareth	31/03/2019 30/06/2020	PPH Car Park Improvement Strategy has been signed off by the Executive Management Team. Awaiting provision of capital funding to enable commencement of improvement works.						
															Work with Gwili Railway Company to scope the potential for implementing a shared car parking arrangement on their planned site adjacent to the GGH site.	Skye, Gareth	02-Jan-23	The Health Board is currently engaging with the Gwili Railway on their future car park development. Anticipate potential completion date of new development by Winter 2022						
474	Service or Department Level Risk		E&F: Carmarthenshire East	Elliott, Rob	Rosser, Brian	01-Sep-14	There is a risk avoidable disruption to business continuity from engineering infrastructure components failing at the Elizabeth Williams Clinic. This is caused by failure of the heating system comprising of three boilers in excess of 20 years old at the Elizabeth Williams Clinic and obsolete controls of the boiler plant, which have been prone to previous failure. This will lead to an impact/affect on loss of heating and hot water services and service resilience issues. Risk location, Elizabeth Williams Clinic.	On-going maintenance and PPMs are being carried out. Visual inspections are also being undertaken. Communications with staff has also taken place.	Service/Business interruption/disruption	6	3	3	9		Quotations have been received by contractors.	Rosser, Brian	12/12/2017 31/03/2019 31/03/2021 31/03/2022	The operations managers are looking at the quotes and seeking funding for the work from 2020 infrastructure backlog business case.	Health and Safety Assurance Committee	1	3	3	Treat	18-Jan-22

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476	Service or Department Level Risk		E&F: Carmarthenshire East	Elliott, Rob	Rosser, Brian	01-Sep-14	There is a risk avoidable disruption to business continuity risks at Cross Hands Health Centre. This is caused by boiler systems significantly old and beyond economical life. This will lead to an impact/affect on resilience issues if components of the building fail during service. Risk location, Cross Hands Health Centre.	On-going maintenance and Planned Preventive Maintenance (PPMs) are being carried out. Visual inspections are also being undertaken. Communications with staff has also taken place.	Service/Business interruption/disruption	6	3	3	9		Quotations have been sought regarding the replacement boilers. Hot water systems need updating. Capital bid required from 19/20capital funding to address issues.	Rosser, Brian	**Completed**	Action closed- new actions written regarding new plant to be in place as part of new Cross Hands Health Centre.	Health and Safety Assurance Committee	1	3	3	Treat	22-Dec-21
															New plant to be in place as part of new Cross Hands Health Centre.	Rosser, Brian	29/07/2022	Business case for new Health Centre has gone to Welsh Government for funding, awaiting response. It is hoped that funding will be received for 2022/23, and building work to begin July 2022. A new plant is planned as part of the new building work.						
483	Service or Department Level Risk		E&F: Carmarthenshire East	Elliott, Rob	Rosser, Brian	01-Jan-18	There is a risk Non-compliance with Health Technical Memoranda (HTM) guidance. This is caused by the Endoscopy Department at PPH is currently served off one general air handling unit(AHU)which also covers ITU,CCU, DCU and MIU and is not providing the air changes required for Endoscopy treatment rooms. This will lead to an impact/affect on Failure to comply with published HTM guidance. Risk location, Prince Philip Hospital.	Visual inspections and Planned Preventative Maintenance (PPM) is in place to check systems. However there is no dedicated AHU plant for Endoscopy Treatment Rooms to provide the required Air Changes .	Safety - Patient, Staff or Public	6	3	3	9		Capital funding required to address the issues as identified and for the remedial work to be undertaken.	Rosser, Brian	20/04/2018 31/03/2020 31/03/2021 31/03/2022	This risk has been identified on the property and infrastructure backlog system, a capital bid submitted by the ops management teams at PPH will be required for future funding. Infrastructure meetings are now being scheduled by the property team to review these issues individually to assess the need of the work. This is also been looked at for JAG accreditation	Estates and IM&T Sub Committee Capital, Estates	1	3	3	Treat	23-Nov-21
102	Directorate Level Risk		USC: Pathology	Perry, Sarah	Stiens, Andrea	08-Sep-16	There is a risk failure of the Blood Bank Issue room fridge (WGH) leading to delay in access to blood products and an impact on patient safety. This is caused by lack of air conditioning and temperature control in the Blood Bank Issue room. This will lead to an impact/affect on the >10 year old Blood issue fridge is over compensating to maintain safe temperature for storage of blood stocks. Risking failure of this fridge which will result in wastage of blood products and possible life threatening delay to patients requiring emergency blood transfusions. Blood inappropriately stored can become contaminated with bacteria and if given to patients can result in adverse transfusion reaction. Risk location, Withybush General Hospital.	Maintenance contract in place for Blood Issue fridge. Contingency plans in place should fridge fail. Fridges are alarmed to notify on temperatures	Safety - Patient, Staff or Public	6	3	3	9		Submit capital bid to 2021/ 22 Capital programme.	Stiens, Andrea	30/07/2021 31/12/2021	Refresh previous capital bids. Not been prioritised as part of the HB capital programme in 2021/22.	Operational Quality, Safety and Experience Sub Committee	1	3	3	Tolerate	15-Nov-21
															Explore with Estates if there are any remedial measures that can be used to increase cooling in the room	Stiens, Andrea	31/03/2022	Progress to be updated at next risk review.						

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933	Service or Department Level Risk	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	P,C,LTC: Primary Care	Bond, Rhian	Swinfield, Anna	18-Aug-20	There is a risk that Managed Practices premises are not wholly compliant with the current guidance on IP&C as a result of COVID-19. This is caused by the inability to make the necessary estates changes. In June 2021 Healthcare Inspectorate Wales (HIW) undertook a remote quality check at a managed practice resulting in an extensive action plan, including works by Estates. All 5 managed practice sites have been reviewed and priorities identified. Some works have been undertaken with a commitment from Estates to complete by 31/03/2022, other works are outstanding with Estates. This will lead to an impact/affect on patient safety/care in an appropriate environment and staff safety and wellbeing. Risk location, Carmarthenshire, Pembrokeshire.	Infection control action plans are regularly reviewed in light of Covid-19 for each managed practice premises, identifying works outstanding for compliance. Head of Capital Planning and Assistant Director of Strategic Planning in conversation with primary care colleagues to agree priorities and funding mechanisms as part of an ongoing process. Some works have been completed, others remain outstanding with no plan to complete before 31/03/2022.	Safety - Patient, Staff or Public	6	3	3	9		Estates to prepare a discretionary capital bid. Estates colleagues had identified works which could not be completed by 31st March 2022, noting these were mostly larger projects or those requiring an external contractor (including Meddygfa'r Sarn due to the poor quality of the building)	Swinfield, Anna	31/03/2022	Estates required a discretionary capital bid, and a meeting for this was being organised. The work on the flooring in Meddygfa Minafon had been scheduled. In relation to the cleaning of Managed Practices, PP confirmed that cleaning cover has been provided from Secondary Care and that Hotel Services had confirmed that they hoped to provide cover moving forward.	Operational Quality, Safety and Experience Sub Committee	1	1	1	Treat	09-Feb-22
1314	Service or Department Level Risk		MHLD: Learning Disability Services	Carroll, Mrs Liz	Evans, Melanie	03-Oct-16	There is a risk of avoidable harm to staff or visitors, and of avoidable deterioration of the structure of the building internally and externally. This is caused by by the gradual deterioration of the external and internal condition of the building. Water penetration of the building has affected entire wall elevations and is penetrating into internal walls and office spaces. This will lead to an impact/affect on • the health and wellbeing of staff and visitors exposed to mould and damp conditions. Service is experiencing increased sickness absence due to respiratory issues; eye, throat and sinus problems. • the ability to ensure business continuity due to: o Condemned and sealed office and clinical spaces reducing capacity of the team to function / access the building. o Reduced availability of network data and electrical points due to being isolated and shut off further restricting access to electrical systems by staff. o Reduced availability of office furniture due to being condemned and removed. o Continuity of care for clients who attend the building for clinics and appointments. Risk location, Penlan (MHLD).	1. Closure of 11 condemned office/ clinical rooms. Electrical points isolated and shut down in affected areas. 2. Immediate development of a room usage plan. • Staff moved to alternative rooms within the building. • Time limits of room usage clearly marked on doors of affected spaces where appropriate (as advised by Estates Team). • Improved ventilation of office spaces during office hours. • Remote access tokens ordered for staff to enable remote working on a rota basis. • Minimise client interventions within the building. Increased home visits and relocation of clinics where possible. 3. Secondary Covid Workforce Plan • Majority of staff now working from home on a rota basis • Only essential, and risk assessed visits to Penlan by clients and others. • Use of MSTeams and Attend Anywhere to conduct meetings and clinics wherever possible. 4. Enhanced monitoring of sickness absence reasons with automatic referral to Occupational Health if potential/actual risk of environmental cause. 5. Estates have completed external works on the building and put in place interim safety measures in affected spaces.	Safety - Patient, Staff or Public		3	3	9						Health and Safety Assurance Committee	1	1	1		10-Dec-21
742	Service or Department Level Risk	Standard 2.4 Infection Prevention and Control (IPC) and Promoting Health and Safety	E&F: Fire	Elliott, Rob	Evans, Paul	14-Mar-19	There is a risk to staff that in the event of a fire the photocopier, printer and open plan kitchen and various combustible materials are all within the escape route. This is caused by the location of the photocopier and printer within the escape route, the use of extension leads due to lack of electrical sockets, microwave, fridge and facilities for making beverages, one means of escape and the roof ceiling is not of a required standard.	Microwave and toaster removed. (A1.1, A1.2) All unnecessary items/paper covering walls removed. (A2.4) Discussion with Hotel Services re: door to the courtyard to be locked out of hours. (A1.6) Confirmation that all staff are in date with ESR requirements. (A4.2)	Safety - Patient, Staff or Public	6	2	4	8		Review needed of additional sockets required: review undertake and quote submitted.	Evans, Paul	23/09/2019 31/12/2019 31/03/2022	Capital bid submitted to Capital (discretionary) Group. This work will form part of the roof replacement scheme when completed.	Health and Safety Assurance Committee	2	3	6	Treat	14-Feb-22

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	Se	Standard 2.1 Managing Risk ar					This will lead to an impact/affect on staff in the event of a fire as they would be unable to evacuate the building. Risk location, Glangwili General Hospital.								Review security arrangements as smoking materials found outside of the office.	Humphreys, Helen	Completed	Agreed area secured from 9pm each night as within general hospital lock up.	Health an					
															High risk item (printer) to be unplugged and disconnected.	Humphreys, Helen	Completed	Printer removed						
															Program to be develop staff fire training.	Humphreys, Helen	Completed	Staff have booked themselves onto fire training - Request information from ESR team to confirm 100% compliance.						
															Install fire doors within the office space to FD30S specification.	Evans, Paul	Completed	Fire doors are not required in this area.						
															Ensure suitable and sufficient escape route for staff	Humphreys, Helen	Completed	Doorway created in the bottom office to provide an additional means of escape						
															The roof, ceiling should ideally be upgraded to a 60 minutes fire rated standard to protect the adjacent wards opposite on the GF/FF levels. Capital bid required.	Evans, Paul	31/03/2021	This will be completed as part of the phase 2 fire works at GGH as part of GGH enforcement letter managed by Jason Woods.						

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															Provide suitable emergency lighting.	Evans, Paul	05/07/2019 31/12/2019 31/03/2022	Quotes now received for this circa £1,500 of capital is required. Awaiting capital allocation for 2020/21 to proceed. This work will form part of the roof replacement scheme when undertaken.						
1068	Service or Department Level Risk		E&F: Ceredigion	Elliott, Rob	Jones, Elfyn	01-Aug-12	There is a risk avoidable harm to staff from potential electrical shocks on defective systems. This is caused by lack of periodic inspections of electrical systems. Currently testing 20% of the installation annually. This will lead to an impact/affect on serious injury and closure of facilities. Failure to undertake this along with a potential incident would result in Health and Safety Executive (HSE) investigations or prosecutions. (Linked to HB wide risk 425). Risk location, Bronglais General Hospital.	Portable appliance testing (PAT) testing is undertaken on a rolling programme. Fixed boards are also tested on a rolling programme. Visual checks are continually carried out by maintenance staff. Low Voltage (LV) operational group formed to discuss issues of Electrical Safety and Compliance. Ward testing on a rolling 5 year basis.	Safety - Patient, Staff or Public	6	2	4	8		Bid for additional Capital funding for more testing to take place, which will help the UHB achieve British Standards.	Jones, Elfyn	**Completed**	Capital budget available for 2021/22. Awaiting Statutory capital allocation for 2022/2023	Health and Safety Assurance Committee	1	4	4	Treat	14-Jan-22
674	Service or Department Level Risk	Standard 3.1 Safe and Clinically Effective Care	Ceredigion	Skitt, Peter	Hawkes, Jina	23-Oct-14	There is a risk avoidable harm to patients and staff arising from inherent building and environmental hazards at Tregaron hospital. This is caused by widespread Health and Safety issues (including leaking roof), deteriorating condition, lack of full disability access, etc. This will lead to an impact/affect on potential injury to patients and or staff, or a need to limit activity on site. Risk location, Tregaron Hospital.	Welsh Government approval for Business case for the construction of a fit for purpose new build. Process in place to monitor the condition and respond to the works required to maintain a safe environment. Stakeholder group implemented to fully engage the public.	Safety - Patient, Staff or Public	6	2	4	8		Report current unsafe environmental issues to the estates department.	Evans, Tracey -	**Completed**	Regular communications with maintenance and ongoing review.	Health and Safety Assurance Committee	1	4	4	Treat	21-Feb-22
															Undertake a risk assessment and develop a mitigation plan.	Jones, Elfyn	**Completed**	Incidents have been communicated from Tregaron Hospital. Estates have visited the site and supplied de-humidifier.						
															Work with Ceredigion County Council to support the development of Cylch Caron	Skitt, Peter	**Completed**	Attendance at regular meetings						
															One of the construction company who expressed an interest in the Cylch Caron scheme has now gone into administration. This will cause a delay in appointing a construction partner.	Skitt, Peter	**Completed**	Discussions are on going with the Local Authority						

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															The CMT needs to review the contingency planning associated with the building not being fit for purpose.	Evans, Tracey -	Completed	Contingency plan is written						
															HSE inspection of hospital has been undertaken, awaiting feedback to inform contingency planning.	Evans, Tracey -	Completed	Awaiting report from HSE Inspection; some confusion relating to asbestos in the attic area.						
															HSE inspection report made mention of asbestos in the attic area. Estates to check.	Evans, Tracey -	Completed	Awaiting for response from estates						
															HSE inspection report made mention of asbestos in the attic area. Estates to check.	Skitt, Peter	Completed	Estates have confirmed that there is no new issues with asbestos in the building.						
															Due to COVID-19 investment in estates is being planned.	Skitt, Peter	Completed	Estates have been on-site and developed a schedule of works which will enable temporary measures to be in place during the Coronavirus pandemic.						
															Implement the temporary schedule of works to enable Tregaron Hospital to operate during the Coronavirus pandemic	Skitt, Peter	Completed	Estates have been on-site. An estates SBAR has been escalated through COVID metallic command, however there is no confirmation for capital spend - This has been followed up as an operational demand in relation to the potential second wave of COVID and Winter planning.						
															Develop the Cylch Caron scheme time frame to enable a decommissioning of the Tregaron site	Skitt, Peter	Completed	New Cylch Caron project lead has been appointed. The Cylch Caron scheme is currently on hold as alternative options are explored.						

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															Implement the COVID-19 temporary schedule of works to enable Tregaron Hospital to operate during the Coronavirus pandemic	Skitt, Peter	Completed	Works to the patient areas have now been completed, however work associated with staff and outpatient areas is still required						
															Develop the program of works associated with the outpatient / treatment rooms and non-patient areas	Skitt, Peter	Completed	Scoping work has commenced, funding agreed and out to tender						
															Continue to work with Estates to overcome snagging issues	Evans, Tracey -	Completed	Estates have been very pro-active with their attempts to address the leak in the roof. Issues identified in relation to over bed lights and call bell system						
															Review Clych Caron business case with Welsh Government	Skitt, Peter	Completed	Tender process has re-commenced						
															Engage with potential partners in the Clych Caron initiative	Skitt, Peter	Completed	Information from the meet the buyer event to be used to inform procurement						
															Work with Local Authority to overcome challenges associated with new Planning Regulations	Skitt, Peter	Completed	Change in Planning Regulations affecting Teifi Valley have been circulated						
															Raise the change in Planning Regulations and effect on Cylch Caron with Welsh Government	Skitt, Peter	31/03/2022	The challenges associated with planning for Cylch Caron are All Wales. Awaiting feedback from Welsh Government						

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583	Service or Department Level Risk		Therapies and Health Science: Podiatry and Surgical Appliances	Reed, Lance	Mulroy, Mike	30-Dec-16	There is a risk avoidable harm to staff and patients. This is caused by the lack of consistent access to clinical accommodation which is fit for purpose. This will lead to an impact/affect on reduction of both the effectiveness and efficiency of service delivery, injury, potential breach of information governance standards, infection prevention and control standards, and dignity and respect standards. Risk location, Bronglais General Hospital, Elizabeth Williams Clinic, Pond Street Clinic, Tregaron Hospital, Withybush General Hospital.	Patients are offered appointments as close to home as possible with a choice of 4 sites across Ceredigion. BGH Leri Day Unit Orthotic room - Limited staff access only due to high risk of infection to immunocompromised patients receiving cancer treatment. Orthotic clinics now held in OPD. Limited availability for MSK clinics in Aberystwyth off site. Bronglais Level 6 clinical room situated next to ITU and endoscopy. No waiting area. Patients have to attend on time so as not have to wait and limiting numbers booked into clinics. Room is too small and should be maximum of two people without masks but often have to up to 4 people routinely-all wearing PPE. No storage for appliances and instrument boxes hence storage of instrument boxes in corridor. No adequate ventilation, too hot in the summer. No room for the computer and printer, printer currently stored under the desk. No room for the couch to be horizontal without having to squeeze past the worktop. Tregaron Hospital has had some work carried out by estates. Computer server in clinic room which is very noisy and affects communication with patients and is a risk to staff working in the room. Also identified as lone working risk. No waiting area. No current Open Access Clinic in Aberystwyth due to limited waiting area in OPD and no F2F patients seen in Consultant Diabetic clinic. Open Access clinic is held weekly in Tenby Cottage Hospital due to lack of accommodation in Withybush. Needs to be held in OPD with access to consultant clinic due to nature of emergency that patients attend for. EWC carpet is dangerous and has been reported. Pond Street clinic is old and in ill-repair and is no longer suitable as a clinic but there is currently no alternative accommodation.	Safety - Patient, Staff or Public	6	4	2	8		Organise delivery of services from Teifi surgery. Move unused community nurse plinth from CILC, Felinfach to Teifi Surgery for two chair clinics thus avoiding lone working problem.	James, Enfys	Completed	Teifi Surgery has been rented long term and unused plinth has been acquired and awaiting delivery. Equipment moved into clinic ready for podiatry to commence but awaiting deep clean of clinic rooms and access to building. Identify when other staff members in building to avoid lone working scenario. Attend meetings to enable Podiatry service. Next meeting 9/7/2019.Clinics start 5/9/2019.	Capital, Estates and IM&T Sub Committee	2	2	4	Treat	14-Dec-21
															Enquire re alternative room in Aberaeron to improve on existing "shed"	James, Enfys	Completed	No alternative room available for required access. Difficulty with moving equipment for sessional use when available as bulky and causes confusion to patients. Await move to Minaeron in August.						
															Outline future requirements at Leri Day Unit to include podiatry and orthotics integrated with other therapies to estates and attend regular meetings.	James, Enfys	28/06/2019 31/12/2022	13/10/2021 update: awaiting further instruction on available accommodation in BGH. MSK clinics currently on hold but may be able to use the Morlan Centre until Dec 2021. Plinth to be moved from Leri Day Unit. Currently holding 1 CMATS clinic a month and weekly Orthotic clinic in OPD BGH. No further developments on storage/office space instead of Leri Day Unit. Tregaron Hospital: some improvements carried out by estates. 14/12/2021 update-Tregaron OPD clinic-noise from computer server in room to be addressed by IT. Identified as lone-working risk. Panis alarm to be fitted. No waiting area, patients wait in cars. Safe and Steady/MSK clinics held in Morlan Centre until March 2022. Site visit to Rheidol Building to scope interim therapy area for MSK/Safe and Steady current clinic activity. Request for more regular MSK to address waiting list and accommodate new staff member.						

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															Meeting with County Manager regarding podiatry services in Withybush to highlight need for OPD room for Open Access clinic.	Greer, John	**Completed**	Meeting attended but room in OPD has been taken. Meeting to be followed up as room still needed. Clinic currently continues in Surgical Appliance room at Withybush therefore managed. Meeting with Service Delivery Manager has identified a room in OPD. Will have feedback next week.						
															Carmarthenshire clinics at Pond Street, Carmarthen and EWC, Llanelli issues reported to estates. Awaiting repair/refurb.	Mulroy, Mike	15/06/2021 27/07/2021 14/12/2021 08/02/2022	27/4/2021 - estates have been notified of issues in both clinics. 13/10/2021 update:Pond street is having some refurbishment, however the real answer is the Debenhams new build which will come in the next few years hopefully. Existing building is extremely unsuitable. EWC is structurally fine, problem is new flooring in main areas still not been approved and has caused a number of trips and falls. 14/12/2021 update-Increasing pressure to relocate from PDH to community setting strongly opposed due to risk with current community accommodation and risk of timely access to ward patients requiring urgent podiatry intervention.						
602	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	Therapies and Health Science: Physiotherapy	Reed, Lance	Davies, John	02-Mar-16	There is a risk avoidable patient and staff harm. This is caused by lack of consistent accommodation that is fit for purpose. This will lead to an impact/affect on reduction of both the effectiveness and efficiency of service delivery, injury, infection prevention and control standards, staff well being and dignity and respect standards. Risk location, Aberaeron Hospital, Bronglais General Hospital, Cardigan Memorial Hospital, St Anne's - Family Child Health, Tregaron Hospital, Withybush General Hospital.	Contribute to all new capital build projects. Adhere to all safety requirements e.g. relocate staff and limit exposure. Some short term work has been carried out in the Aberaeron clinic. Tregaron Hospital has had some work carried out by estates and the room has been cleared of non used equipment.	Safety - Patient, Staff or Public	6	4	2	8		Submitted requirements for potential move to Leri Day Unit. Cardigan, Aberaeron, Tregaron no change.	Annandale, Helen	**Completed**	Submitted requirements for BGH outpatients and Leri Day.	Capital, Estates and IM&T Sub Committee	2	2	4	Tolerate	01-Oct-19
															Submitted requirements for new builds Ceredigion	Annandale, Helen	**Completed**	Detail submitted						
															Risks highlighted to Withybush management leads	Annandale, Helen	**Completed**	Pigeon control measures implemented						

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															Review clinical record storage and use of lymphoedema space at PPH and BGH and timetable use of clinical space and manage patients in other environments e.g. Aberaeron when possible	Annandale, Helen	**Completed**	Improved staff well being with timetabling and hot desking in other areas						
															Submitted new requirements for Cross Hands build	Annandale, Helen	**Completed**	Submitted plans						
															In partnership with PPH site develop and implement plan reducing infection control issues for Lymphoedema service	Stevenson, Vicky	12-Feb-19	New action						
															Submit physio and lymphoedema requirements as part of Llanelli Wellness Village. Continue to develop integration planning e.g. leisure partnership	Stevenson, Vicky	12-Sep-19	New action						
															Additional therapy paper submitted to Ceredigion county management team to articulate accommodation requirements specific to the Bronglais site.	Davies, John	31/12/2021	New action to be updated at next review.						
425	Directorate Level Risk		E&F: Operations Compliance	Elliott, Rob	Evans, Paul	01-Aug-12	There is a risk avoidable harm to staff from potential electrical shocks on defective systems. This is caused by lack of periodic inspections of electrical systems. This will lead to an impact/affect on serious injury and closure of facilities. Failure to undertake this along with a potential incident would result in Health and Safety Executive (HSE) investigations or prosecutions.	Portable appliance testing (PAT) testing is undertaken on a rolling programme. Fixed boards are also tested on a rolling programme. Visual checks are continually carried out by maintenance staff. Low Voltage (LV) operational group formed to discuss issues of Electrical Safety and Compliance.	Safety - Patient, Staff or Public	6	2	4	8		Electrical Testing Inspections to be undertaken on a regular basis to ensure safe systems. To include visual checks through regular PPMs. Fixed testing has been carried out and continues to be undertaken.	Evans, Paul	**Completed**	Fixed testing carried out in 2017-18 by Norwood on a selection of units. The programme of testing will continue in 2018-19 subject to capital funding availability.	Safety Assurance Committee	1	4	4	Treat	14-Feb-22

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							Risk location, Health Board wide.	[illegible] issues of Electrical Safety and Compliance	0)						To ensure that ongoing testing is being carried out in accordance with legislation. Also to make sure that the appropriate quantity of testing is being completed annually in accordance with the BS. Additional capital funding needs to be bid for.	Evans, Paul	Completed	Capital funding has been bid for and contractors have now been appointed to continue with testing across the HB during 2020/21. Further capital bid will be required to address the outcomes/actions that will be highlighted following testing. Outcomes will need to be prioritised as there will be insufficient capital to address all actions (in 12 months) A detailed look at the actions also needs to be undertaken to assess the full scale of the issue - infrastructure meetings are now commencing with property to do this with ops managers.	Health and					
															new 2021/22 tender for LV testing needs to be finalised and issued to suitable contractors.	Evans, Paul	Completed	Tender now been issued for 2021/2022 testing, awaiting commencement date from appointed contractors - Testing will take place before the end of March 2022 for a range of areas as per AP's priority.						
465	Service or Department Level Risk		E&F: Carmarthenshire West	Elliott, Rob	Jones, Kevin	01-Jan-13	There is a risk avoidable harm to electrical estates staff carrying out work on various electrical circuits and electrical distribution boards around the hospital. This is caused by current electrical infrastructure in parts being non compliant and requiring replacement. This will lead to an impact/affect on increased danger of electric shock, possible Health and Safety Executive (HSE) investigation following an incident and possible enforcement or HSE prosecution in the event of an serious incident occurring. Risk location, Glangwili General Hospital.	Ongoing maintenance and PPMs are being carried out. Visual inspections are also being undertaken. Fixed electrical testing undertaken. Only trained operational electrical staff who are fully aware of these defects and deficiencies work within these areas (OLD SCBU GGH).	Safety - Patient, Staff or Public	6	2	4	8		Only trained operational electrical staff will be allowed access to work within these areas, being fully aware of these defects and deficiencies. Regular communication between engineers and operational staff in terms of extra care and vigilance.	Jones, Kevin	31/03/2020	This defect will be considered in phase 2 of the neonatal scheme. Completion in late 2018 subject to business case funding. Capital money will be bid for in 2018-19 to phase replace the higher risk DB's.	Health and Safety Assurance Committee	1	4	4	Treat	21-Oct-21

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1075	Service or Department Level Risk		E&F: Ceredigion	Elliott, Rob	Jones, Elfyn	01-Jan-13	There is a risk avoidable harm to patients. This is caused by non-compliant clinical wash hand basins with defects such as no or defective mixer valves, overflows and incorrect elbow and lever taps fitted. These are patient accessed devices. This will lead to an impact/affect on infection control concerns and non compliance. Potential scalds and burns. Possible enforcement and Health and Safety Executive (HSE) prosecution in the event of a serious incident occurring. (Linked to HB wide risk 435). Risk location, Bronglais General Hospital.	Infection control and operational maintenance staff have identified units around the Health Board that are non-compliant. All patient accessed units are now fitted with thermostatic mixing valves, however, despite maintenance, these devices still have a potential to fail, causing excessive temperatures of water at source. Visual inspections are also being undertaken on remaining non compliant units. The major infrastructure investment plan is now being reworked to support critical estates risks to ensure appropriate business continuity between the intervening years before the new hospital facilities/repurposing projects are complete.	Safety - Patient, Staff or Public	6	2	4	8		Implement water risk assessment action plan.	Jones, Elfyn	31/03/2022	Action plan being progressed and to be fully implemented by March 2022.	Health and Safety Assurance Committee	1	4	4	Treat	19-Jan-22
1052	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	MHLD: Older Adult Mental Health Services	Carroll, Mrs Liz	Davies, Guto	17-Feb-21	There is a risk of patients causing avoidable harm to themselves whilst an inpatient and attending the ward. This is caused by access to ligature points, and the need to identify any significant issues. This will lead to an impact/affect on patients who may cause harm and possible serious injury or death. Potential claims and reputation risk to the Health Board. Risk location, Prince Philip Hospital.	1. Staff training to identify high risk patients, Obs & Engagement skills and WARRN. 2. Observation process in place for inpatients - All new admissions / High risk patients are placed on at least Level 2 observations and this is reviewed daily by the MDT. 3. WARRN risk assessment carried out on admission. 4. Rooms 11 and 12 are categorised as high risk rooms on the ward and have equipment to reduce the risk of point of ligature e.g. Towel / Soap dispensers are attached via magnetic plates. Also room 11 and 12 also have no en-suite for improved lines of site for staff undertaking observations and rooms 11 and 12 are in direct line of site from the Ward Office and the Nurses Office. 5. Annual POL audit undertaken and areas of concern reported to Estates - link in with the capital program.	Safety - Patient, Staff or Public	6	2	4	8		Ward Manager to work with Estates to link into the annual audit identifying remedial action required.	Davies, Guto	31/08/2021	New action will be updated at next review.	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	29-Nov-21
															All new admissions will be risk assessed on admission using WARRN and will be immediately subject to at least level 2 observations until review by the MDT. (Ward manager and ward team)	Davies, Guto	30/09/2021	New action will be updated on next review.						

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1260	Service or Department Level Risk		MHLD: Psychological Therapies	Carroll, Mrs Liz	Marshall, Selina	15-Jul-21	There is a risk the inability to deliver services in line with waiting list demands due to inadequate accommodation. The MHLD estates have depleted and are not in line with growing demands This is caused by lack of accommodation in which to expand services and enable the high volume delivery of services. The IPTS service have one dedicated premises in Carmarthen which is shared with Perinatal and Eating Disorders, the remaining sites rely upon the good will of other MHLD services for use of the venues. Electronic booking systems are not in place. This will lead to an impact/affect on delivery of services as demand outweighs current capacity, and inconsistent clinic bookings. It also impacts on budgets, time and carbon footprint as staff are required to travel across several sites. This can also impact on staff wellbeing. Risk location, Health Board wide.	1. The provision of as many AA virtual platforms as possible to reduce the need for accommodation. This is done by the good will of staff who are mainly reliant on their own IT and telephone equipment. (Governance concern over personal mobile phone usage) 2.Staff working flexible hours to accommodate clinical commitments for F2F appointments 3. Staff travelling to different sites where capacity to see clients, this impacts on clinical time and carbon footprint and travel costs. 4. H&S review undertaken in Llys steffan to free up space for more therapy provision	Safety - Patient, Staff or Public	8	4	2	8						Quality, Safety and Experience Assurance Committee	2	2	4	Tolerate	15-Oct-21
492	Service or Department Level Risk		E&F: Ceredigion	Elliott, Rob	Jones, Elfyn	13-Jun-17	There is a risk avoidable harm to patients and potentially the general public from slipping or falling on uneven flooring in specific areas around the ward. This is caused by damaged floor surfaces to a range of areas. This will lead to an impact/affect on serious injury. Possible Health and Safety Executive (HSE) intervention in the event of a serious incident occurring. Risk location, Bronglais General Hospital.	Both estates staff and ward staff are fully aware of this issue. Temporary improvements have taken place previously to patch the floor as best as possible to the worst affected areas.	Safety - Patient, Staff or Public	6	2	4	8		Due to the scale of work required and the need to replace the entire ward floor, the estates department would need the ward vacated for up to 7 days. Due to current patient demand this is unlikely. Capital funding for this has been submitted. The issue is closure of ward related and not a financial issue. Discussions with ward staff remain ongoing.	Jones, Elfyn	**Completed**	A formal bid will be submitted for 2019-20 funding.	Health and Safety Assurance Committee	1	4	4	Treat	13-Jan-22
															Need to arrange when ward decant can take place to allow flooring work to be undertaken.	Jones, Elfyn	31/03/2021 06/11/2021 31/03/2022	Action owner to discuss at site senior managers meeting when decant of ward can potentially take place. This currently continues to be delayed due to COVID-19.					
1278	Service or Department Level Risk	aging Risk and Promoting Health and Safety	nen and Children: Paediatrics and Neonates	Humphrey, Lisa	Milward, Janet	10-Nov-21	There is a risk of patient harm unauthorised access or exit from PACU entrance. This is caused by the door being an old fire exit which functions on a push bar to open. There is no security locking mechanism. No 24hr vision on the door due to staff activity and lack of security camera. Easily accessible to all patients, parents and staff on PACU and ward. This will lead to an impact/affect on patient absconding and unauthorised access, parent absconding with patient or potential for kidnapping. Unauthorised access to PACU and ward if the door not closed properly or if unauthorised person opens door. Potential theft of	Staff monitoring door as often as possible. Ward staff discourage the use of PACU entrance/exit by ward patients and parents, unless escorted by a member of staff. Capital Bid process for new door access and system. CCTV Monitoring.	Safety - Patient, Staff or Public	6	2	4	8		Identify funding (capital bid) to install swipe card access to ensure authorised personnel access only and to remove bar open mechanism.	Milward, Janet	**Completed**	New action to be updated with progress at next review.	ality, Safety and Experience Sub Committee	1	4	4	Treat	02-Feb-22
															Install working doorbell to alert staff of presence at entrance.	Milward, Janet	31/03/2022	New action to be updated at next review.					

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		Standard 2.1 Mana	Wom				unauthorised person opens door. Potential theft of equipment and personal items. location of the risk is PACU main entrance. Risk location, Glangwili General Hospital.								Work with security to identify funding and install security camera at door to allow staff to monitor door from PACU staff office when ward clerk unavailable.	Milward, Janet	31/03/2022	New action to be updated at next review.	Operational Qua					
															awaiting installation of the entrance door to PACU with full alarm system and CCTV Function	Milward, Janet	18/02/2022	update on design and potential company installation In February						
1180	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	E&F: Pembrokeshire	Elliott, Rob	Evans, Duncan	12-Jun-17	There is a risk of oversize pipes not allowing an adequate flow of water to stop any problems with Pseudomonas, Legionella or excessive TVC from occuring. This is caused by no flow or compared to pipe size not enough flow in pipework and resting in a warm ceiling causing problems with pathogen growth. This will lead to an impact/affect on sickness of patients/staff/visitors entering the hospital lower levels and coming into contact with atomised awter. Risk location, Withybush General Hospital.	Flushing and monitoring but limited effect on enlarged storage of water.	Safety - Patient, Staff or Public	6	2	4	8		Pipework alterations are required as we are unable to control temps.	Elliott, Rob	30/09/2021	Scheme to be compiled and entered into capital bid.	Capital, Estates and IM&T Sub Committee	2	1	2	Treat	21-Jan-21
															Further enquiries for removal and installation of an electronic monitoring system to identify areas where circulation is not happening.	Evans, Duncan	24/03/2022	Monitoring carrying on and reports being generated.						
															Bu reference to our monitoring system we can see further problems with the pipework in this area. Valves are not holding and there are mixers that are passing.	Evans, Duncan	30/03/2022	No further progress has been made.						
931	Service or Department Level Risk	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	E&F: Pembrokeshire	Elliott, Rob	Evans, Duncan	14-Aug-17	There is a risk of failure of the main plant serving Theatre 3 and 4. This is caused by age and poor condition of Air Handling Units which are severely corroded and can be sometimes saturated with rain water. The control panel is extremely rusted and the air pressures do not comply to HTM standards. The Air hood in theatre 4 has also fails the 2m and 1m tests. This will lead to an impact/affect on disruption to theatres operations resulting in increased waiting times, possible concerns and complaints, Health Board reputation. Risk location, Withybush General Hospital.	Continual excessive maintenance to ensure that ingress of dampness does not take place.	Quality/Complaints/Audit	6	2	4	8		The replacement of the complete plant.	Evans, Duncan	30/09/2020 31/03/2022	Awaiting priority confirmation from Service Delivery Managers.	Capital, Estates and IM&T Sub Committee	2	1	2	Treat	21-Jan-22
															Complete Drive unit and balance test required.	Evans, Duncan	30/09/2020 31/03/2022	This forms part of the plant replacement- awaiting priority confirmation from Service Delivery Managers.						
															Continual Maintenance is being carried out but the plant which is outside is facing severe weather damage.	Elliott, Rob	24/03/2022	No further progress.						

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947	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	E&F: Pembrokeshire	Elliott, Rob	Evans, Duncan	03-Aug-17	There is a risk avoidable harm to patients, visitors and staff. This is caused by the brick Pavement and Driveway into Hospital sliding down towards the bottom of the carpark allowing excessive gaps and holes to appear which are trip hazards. This will lead to an impact/affect on personnel that are entering the Hospital being exposed to the danger of such potholes, possible trips and falls, claims and complaints. Risk location, Pembrokeshire, Withybush General Hospital.	Sand is being placed between the joints but has not any long-term effect. Slippage is still occuring.	Safety - Patient, Staff or Public	6	4	2	8		Removal of hard standing and either tarmac complete area or install concrete dividers to stop creep of brickwork.	Evans, Duncan	30/09/2020 31/12/2021	Costs have been obtained and Capital bid to be submitted.	Health and Safety Assurance Committee	1	1	1	Treat	21-Jan-22
991	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	E&F: Pembrokeshire	Elliott, Rob	Evans, Duncan	11-Sep-17	There is a risk of leaks being detected in the natural gas pipework at Withybush Hospital. This is caused by the Mains Gas pipework not being up to Gas Safe standards and is showing signs of corrosion and wear due to age of installation. Labelling and isolation/solenoids, and valves are not up to current standards. Soundness tests need to be completed to verify condition of distribution system. This will lead to an impact/affect on possible closure of services whilst leaks are repaired. Isolation of gas main would be a reality. Risk location, Withybush General Hospital.	Constant monitoring and inclusion of local contractor.	Safety - Patient, Staff or Public	6	4	2	8		Inspection carried out and recommendations have been accepted. Capital bid required to eradicate problems.	Evans, Duncan	15/03/2021 31/10/2021	Capital Bid Required to be identified to complete recommendations. Capital bid has been submitted, awaiting outcome.	Capital, Estates and IM&T Sub Committee	1	1	1	Treat	21-Jan-22
1007	or Department Level Risk	moting Health and Safety	E&F: Directorate Team	Elliott, Rob	Williams, Heather	04-Nov-20	There is a risk porters and hotel services staff not being able to appropriately assist with outbursts of behavioural or clinical violence and aggression in acute or complex settings under increased pressures of Covid. This is caused by the large number of new hotel services and porters recruited that have not received appropriate training per the V&A passport scheme. Large numbers of porters are recruited and may be requested to assist with	Training courses have restarted and porter staff are undertaking the training. Completion of all staff training anticipated for completion in December 21 All relevant staff will be booked on asap. Due to reduced capacity available in the training sessions , it is taking longer to complete all the sessions and therefore the date has been amended .	y - Patient, Staff or Public	6	2	3	6		consideration to extend and obtain training to facilitate large numbers of staff in Covid complaint manner including internal delivery or external agencies.	Wood, Rachel	Completed	Closed. Action no longer relevant. Face to face training has resumed.	ety Assurance Committee	2	3	6	Treat	26-Jan-22

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	Service	Standard 2.1 Managing Risk and Pro					outbursts of behavioural or clinical violence and aggression. The health board has obligations to provide safe health care and comply with appropriate Information, Instruction, Supervision and Training for staff. There is currently limited capacity for training of correct Restrictive Physical Intervention (RPI) techniques and protocols being introduced. This will lead to an impact/affect on safety of patients and staff in ward and department settings. Safety of participants in RPI, leading to the likelihood of increased sickness. Increased likelihood of harm and adverse incidents including litigation or reputational harm. The health board staff and patients, reputation and finances are potentially compromised due to a lack of training and resilience due to likelihood of sickness and increased demand including confused or violent patients in acute or complex settings. Risk location, Health Board wide.	GGH 70% in compliance PPH 100% in compliance WGH 56% in compliance BGH 100% in compliance On the larger sites it is not necessary to train all staff , clinical waste and mail room porters do not require this training . Adequate shift coverage is currently being maintained and all other staff have been booked onto courses before March 2022	Safet						All relevant portering staff to receive face to face V&A training.	Williams, Heather	30/09/2021	Face to face training has resumed (reduced to 6 people per training sessions due to social distancing guidelines), with front line staff having already been trained, or are booked in for a training session in the near future.	Health and Safe					
867	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	MHLD: Adult Mental Health Services	Carroll, Mrs Liz	Isaacs, Kay	03-Apr-19	There is a risk of patients (potentially)causing avoidable harm to themselves whilst attending the building. This is caused by access to ligature points in the toilet, reception area and consultants room. This will lead to an impact/affect on patients who may cause harm and possible serious injury and death. Staff are required to check on the movements and supervision of patients in the building. Potential claims and reputation risk to the HB. Risk location, Pembrokeshire, South Pembrokeshire Hospital.	All service users in the building are visible and are abled to be supervised. No one in areas that are unsupervised or left alone in clinic rooms. Toilet areas, male and female, no disabled toilet. privacy and dignity to be maintained,reception are aware of who enters the building via security doors, toilets are visible to the receptionist. Staff are reminded regularly of the need to have direct supervision of those in the building and at monthly MDT meetings. Offices unused are secured.	Safety - Patient, Staff or Public	6	2	3	6		MH management lead to follow up the request for the camera to be installed.	Isaacs, Kay	31/12/2020	Camera have been applied for and waiting work to commence.	Operational Quality, Safety and Experience Sub Committee	1	4	4		22-Oct-21
															MH Management to ensure that local procedures are followed by staff including supervision of patients and the securing of unused offices and access to the toilets.	Isaacs, Kay	30/11/2020	Staff are reminded regularly of the need to have direct supervision of those in the building, forms part of discussions at monthly MDT meetings.						
864	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	MHLD: Adult Mental Health Services	Carroll, Mrs Liz	Isaacs, Kay	28-Mar-19	There is a risk of patients (potentially)causing avoidable harm to themselves whilst attending the building. This is caused by access to ligature points in the building. This will lead to an impact/affect on patients who may cause harm and possible serious injury and death. Staff are required to check on the movements and supervision of patients in the building. Potential claims and reputation risk to the HB. Risk location, 22 Wellfield Road (MHLD).	The public have no unsupervised access to 19 of 24 rooms identified in the ligature point audit.	Safety - Patient, Staff or Public	6	2	3	6		Ensure all staff are aware of the process for patient using the toilets. Toilets are used privately by the patient, the receptionist will ask if patient is alright if in for long time, if no response will sound the alarm.	Isaacs, Kay	30/12/2020	Toilets are locked at all times and service users must ask at reception for access, which allows staff to assess the person before use.	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	25-Oct-21
865	Department Level Risk	ing Risk and Promoting Health and Safety	Mental Health Services	Carroll, Mrs Liz	Isaacs, Kay	24-Apr-19	There is a risk of patients (potentially)causing avoidable harm to themselves whilst attending the building. This is caused by access to ligature points in the building. This will lead to an impact/affect on patients who may cause harm and possible serious injury and death. Staff are required to check on the movements and supervision	Patients have no unsupervised access while in the building. Patients only have unsupervised access when using the toilet. (dignity and respect) Offices are secured when not in use.	. Patient, Staff or Public	6	2	3	6		MH management to ensure all staff are aware of and follow the safety procedures including supervision of patients and access to toilets.	Isaacs, Kay	30/12/2020	Discussed in MDT meetings and supervision	Safety and Experience Sub Committee	1	4	4	Treat	25-Oct-21

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	Service or	Standard 2.1 Managi	MHLD: Adult				of patients in the building. Potential claims and reputation risk to the HB. Risk location, Hafan Hedd (MHLD).		Safety -						MH management to follow up the Estate work application has been completed but work has not yet been undertaken.	Isaacs, Kay	31/12/2020	new action to be updated at next review.	Operational Quality,					
220	Directorate Level Risk		E&F: Fire	Elliott, Rob	Evans, Paul	01-Sep-14	There is a risk avoidable harm to patients, staff and visitors due to staff being unaware of their roles and responsibilities in the event of a fire incident. Also avoidable non-compliance with legislation. This is caused by whilst recent figures show that improvements in attendance for fire training have improved. Now at circa 70% for the HB, there are still concerns that staff may not be fully aware of how to operate evacuation aids appropriately. This will lead to an impact/affect on possible enforcement and Health and Safety Executive (HSE) prosecution in the event of a serious incident occurring. The risk of external enforcement and prosecution remains on this item. This risk assessment however is purely based on the risk of injury to individuals, staff and public. Compliance with HTM-05 guidance documentation for fire safety within the healthcare sector and the Regulatory Reform Order. Risk location, Health Board wide.	New fire safety team in place to now deliver training at each acute site. New TNA for fire in place April 2019 to standardise fire safety training content (soon to be reviewed) A new fire policy has been implemented with a revised Training Need Analysis (TNA) for training. Eeasier and more understandable training categories to make staff attending sessions much easier. Training prospectuses now been fully updated and are available online for staff.	Safety - Patient, Staff or Public	6	2	3	6		Target for training for this group of staff should be in excess of 80% annually, so the HB are almost meeting this target percentage.	Evans, Paul	**Completed**	MS Teams training programme now being rolled out across the HB for staff to attend. Commencing in August. Weekly sessions will be available for L2 staff to attend. This has been introduced since Covid-19 to address the backlog of training. We will be reviewing this in Dec to see how effective the programme has been.	Health and Safety Assurance Committee	2	2	4	Treat	14-Feb-22
															A new target has been set at >80% attendence by the end of Nov 2019, this will be dependent upon staff attending training. New fire team in place with adequate capacity to deliver training demand. Regular updates on training performance are being issued to ensure that the target is achieved.	Evans, Paul	29/11/2019	TNA approved for 2019 and new fire team in place with dates for training identified. Global communications have been issued on this with regular reminders.					
															It is necessary to undertake a review of a selection of inpatient wards to assess the adequacy of learning for fire evacuation aids equipment, this will be undertaken in conjunction with the MH teams and the work that is scheduled for the T&F group to look a the bariatric evacuation situation.	Lloyd, Gareth	**Completed**	This is being discussed at the forthcoming meetings that have now been arranged with MH teams to establish a way of how to test and measure the levels of efficiency and leaning for the use of our evacuation aids.					

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															review of evacuation training is required with MH teams across the HB, to ensure that staff are receiving the correct level of training. T&F group required.	Evans, Paul	21/12/2020	Discussions on this have taken place to agree on a formal action plan. Fire safety training TNA is also being reviewed and the HB will be reverting back to e-learning for non-inpatient staff for up to 2 years. Due to Covid-19 issues, only e-learning module will be used for fire training, this aims to get 80% attendance by Dec 2020.						
1137	Service or Department Level Risk		E&F: Carmarthenshire West	Elliott, Rob	Jones, Kevin	04-Jun-21	There is a risk of avoidable harm to staff, patients, and visitors. And disruption to business continuity. This is caused by damaged electrical wiring systems and the incorrect flooring for a clinical environment. . This will lead to an impact/affect on significant disruptions to clinical services affecting patient services. Closure of services and possible enforcement or Health and Safety Executive (HSE)prosecution. Risk location, Glangwili General Hospital.	The electrical supply to Ty Llewelyn has been isolated for safety reasons. The electrical cables throughout the attic space have been damaged by rodents and need replacing immediately. Staff have relocated to alternative premises.	Safety - Patient, Staff or Public	6	2	3	6		Urgent capital funding is required to replace the entire electrical infrastructure in Ty Llewelyn, and replace all of the flooring throughout due to an infection control risk.	Jones, Kevin	30/07/2021	A capital bid for the electrical re-wire and replacement flooring has been submitted.	Capital, Estates and IM&T Sub Committee	1	3	3	Tolerate	22-Dec-21
1157	Service or Department Level Risk		E&F: Carmarthenshire West	Elliott, Rob	Jones, Kevin	15-Aug-12	There is a risk avoidable harm/discomfort to patients and staff, and possible disruption to theatre waiting lists. This is caused by extreme temperatures of circa (30'C +) during peak summer months in the recovery area. this is due to the fact there is no mechanical cooling systems installed in the area. This will lead to an impact/affect on extreme discomfort for patients and staff who are expected to work in the high temperatures for long periods of time. Furthermore, this could lead to disruption to services if the department is closed as a result of the high temperatures. Risk location, Glangwili General Hospital.	During periods of excessive temperatures desk fans are installed within the department. Although the fans do not offer any cooling facility, they do provide air movement which gives some relief to the occupants in the department.	Safety - Patient, Staff or Public	6	2	3	6		Capital funding is required to install mechanical air conditioning with Day Surgical Recovery Area.	Jones, Kevin	24/12/2021	Estates have previously received a quotation to install air conditioning within the department, however, it was never supported and taken forward. The quotation has since expired, Kevin Jones to request updated quotation.	Capital, Estates and IM&T Sub Committee	1	3	3	Tolerate	04-Aug-21
1147	Service or Department Level Risk		E&F: Carmarthenshire West	Elliott, Rob	Jones, Kevin	01-Aug-12	There is a risk of the single glazed windows smashing or falling out of their frame especially when left open in high winds. Furthermore, the single glazed windows are not energy efficient. This is caused by the ageing single glazed windows. This will lead to an impact/affect on disruption to clinical services and possible prosecution if an accident occurred. Risk location, Glangwili General Hospital.	Preventative maintenance checks are carried out on the windows.	Service/Business interruption/disruption	6	2	3	6		Capital funding is required to replace the ageing single glazed windows in various locations around the GGH site.	Jones, Kevin	24/06/2022	Replacing the windows was considered as an energy saving scheme, however, this was not taken forward as the pay back period was not favourable.	Capital, Estates and IM&T Sub Committee	1	3	3	Tolerate	18-Jan-22

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1148	Service or Department Level Risk		E&F: Carmarthenshire West	Elliott, Rob	Jones, Kevin	01-Aug-12	There is a risk of avoidable harm to patients and staff, and also a risk of prosecution if an accident occurs. This is caused by the angle poise bed lamps throughout the hospital are very old, unsafe, and no longer comply. The light fittings use halogen bulbs which are being banned from September 2021, and there are no guards/covers over the bulb itself. Therefore, patients, children, or staff could easily touch the hot bulb and receive a nasty burn. Furthermore, we have had encountered many instances where individuals are stealing bulbs or removing them to use in another light, the danger when this happens is that a child or adult could easily place their finger inside the bulb holder and potentially receive an electric shock. This will lead to an impact/affect on enforcement or Health and Safety Executive prosecution in the event of an incident. Risk location, Glangwili General Hospital.	Ward staff check the lights on a regular basis and report any faulty lights and missing bulbs.	Service/Business interruption/disruption	6	2	3	6		Capital funding is required to replace all of the ageing bed lights. In a few months we will find ourselves in a situation where we can no longer use halogen bulbs and finding alternative/suitable bulbs is proving difficult. The bed lights need replacing for LED type fittings.	Jones, Kevin	31/08/2021	Estates staff have been trying to source a suitable replacement bulb, however, this is proving difficult as the light fitting has a night mode/function and modern energy saving bulbs and LED bulbs are not able to perform this function.	Capital, Estates and IM&T Sub Committee	1	3	3	Tolerate	18-Jan-22
1150	Service or Department Level Risk		E&F: Carmarthenshire West	Elliott, Rob	Jones, Kevin	01-Aug-12	There is a risk avoidable injury/harm to estates staff and external contractors. This is caused by inappropriate access/egress to Block 4 lift motor room. Access to the motor room is via a small cat ladder, and the individual is expected to step off the ladder and crawl through an opening in the brick wall. This is made even more tricky when exiting the motor room backwards. The motor room is located in the roof space and more than often individuals are in that area on their own, and if they fall many hours could go by before anyone knows they are injured. This will lead to an impact/affect on injury/harm to estates staff and contractors leading to time off work. Possible prosecution in the event of an incident. Risk location, Glangwili General Hospital.	We have implemented contractor control sign in/out procedures. The work activity is discussed upon sign in, and if the motor room needs to be accessed we send a safety man with the contractor. When this is not possible we ask the contractor to phone us when he has exited the motor room. If no contact has been made after a set timeframe estates staff visit the area to check that the contractor is ok.	Safety - Patient, Staff or Public	6	2	3	6		Capital funding is required to modify the entrance to Block 4 lift motor room. This has been identified on numerous occasions by our lift maintenance provider as a Health and Safety risk.	Jones, Kevin	24/12/2021	Capital bid required.	Capital, Estates and IM&T Sub Committee	1	3	3	Tolerate	18-Jan-22

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482	Service or Department Level Risk		E&F: Operations Compliance	Elliott, Rob	Evans, Paul	31-Mar-15	There is a risk avoidable detriment to site security and site access for contractors. This is caused by the current paper system not being completed by contractors, an inability to verify where contractors are onsite, a lack of operational control of the contractors' actions, especially at GGH, specialist contractors outside estates' control and potential disruption to services and impact on patient. This will lead to an impact/affect on failure to have properly controlled access resulting in unauthorised access and work being carried out that may have consequential outcomes. Risk location, Health Board wide.	Paper signing in sheets are currently available in estates at each of the acute sites and control measures within estates are in place. To confirm who signs in. Formal permits are issued and signed off as completed by contractors to access sites.	Safety - Patient, Staff or Public	6	3	2	6		The department are reviewing the current paper-based systems across each of the acute sites.	Evans, Paul	Completed	The estates team have now decided to standardise the current paper-based signing in sheets across the Health Board, by implementing the version currently used at the WGH site. Improvements on the GGH process have recently been completed and the sheets are now held in the maintenance department for greater control and verification. However, orders will be raised by the end of February 2018 for new contractor books for the Health Board.	Health and Safety Assurance Committee	2	1	2	Treat	14-Feb-22
															Formal policy for control of contractors is required.	Evans, Paul	Completed	A new control of contractors policy is now being developed by the compliance team and estates staff with a view of implementing this in early 2020. Global communications planned for Jan 2020. Full task and finish group established chaired by the Director of Facilities to improve the control of contractors systems for the HB.						
															Following policy approval, department now need to fully implement the new system and procedures acros the HB.	Williams, Heather	Completed	Systems have now been developed to record contractor management,these are being rolled out across the HB sites, full compliance with this will be in place by Sept 2020, as agreed in ARAC. We are undertaking an internal review of the effectiveness on this to see if risk item can be formally removed (By March 2022)						

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1270	Service or Department Level Risk		E&F: Pembrokeshire	Elliott, Rob	Evans, Duncan	15-Oct-19	There is a risk that the wiring carried out by small schemes in the past is not up to standards of safety in Healthcare buildings. One such area which was exposed during the fire code work of two small rooms required extra isolations due to way in which the wiring and compartmentations had been carried out. This is caused by using the wrong type of materials to allow circuits that carry 240v no compartmentation. Twin Flat, metal Conduit, Plastic C all in same area. This will lead to an impact/affect on earthing and exposure to live equipment being available. Risk location, Withybush General Hospital.	Visual Inspections and periodic testing being carried out.	Safety - Patient, Staff or Public	6	3	2	6						Capital, Estates and IM&T Sub Committee	2	1	2		21-Jan-22
1216	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	Pembrokeshire	Lorton, Elaine	Hay, Sonia	16-Sep-21	There is a risk the Haverfordwest District Nursing team will be unable to meet the requirements of the patient caseload safely or effectively. This is caused by a lack of clinical and line management oversight, current staff vacancies, high levels of staff sickness, poor caseload management and failure to adhere to HB processes and procedures. This will lead to an impact/affect on the quality of patient care, care becoming task orientated and reduction or loss of holistic care planning. Compromised patient care, patient harm or neglect, missed visits leading to patient harm, decreased patient experience leading to an increase in complaints as well as impact upon patients recovery and wellbeing. Delayed reporting of incidents. Delayed identification of safeguarding. Delayed MDT referrals. Poor communication. Poor compliance with record keeping. There is the potential of increased sickness levels due to increased workloads and stress levels will further reduce staff resilience which will result in being unable to maintain a safe level of care to patients on the caseload as well as mandatory training, PADR compliance not being meet and timely investigations of Datix not undertaken resulting in harm to patients. Risk location, Pembrokeshire.	Senior clinical and managerial oversight has been established to support the team. Minimum standards for patient documentation, assessment and care planning have been established and shared with team members. Daily handover processes have been established and increased administration support implemented to support with Malinko e-scheduling of patient caseload. All patient documentation, notes in office are being reviewed against active and archived patient records to ensure that all active patients have a full set of documentation including care planning and risk assessments in the home Enhanced pay rates have been agreed for bank staff to mitigate existing staff sickness and vacancies. Staff are being redeployed from other DN teams to support the current staffing shortfalls and to ensure safe staffing levels for the patient caseload are in place. Staff are being offered 1-1 meetings with senior managers to undertake Workplace Stress Risk Assessments to manage ongoing sickness levels with anxiety and stress. Processes and procedures for clinical and operational oversight of the team and caseload are being established and put into place.	Safety - Patient, Staff or Public	6	1	4	4		Outstanding datix investigations to be prioritised and all potential avoidable pressure damage to be discussed with the Head of Governance regarding reporting to Delivery Unit	Griffiths, Ceri	**Completed**	meeting arranged. Plan agreed and actions commenced.	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	31-Jan-22
															All staff to receive a Review / PADR by the Practice and Professional Development Nurse within the next 2 months to identify specific areas of training and development needs	Griffiths, Ceri	**Completed**	Process in place and agreed with DNTL					
															Weekly Training sessions for team to be established by September 30th 2021 to meet needs identified from training needs analysis	Griffiths, Ceri	**Completed**	Review in team meetings. Update meeting in November 2021.					
															Audit of previous serious incidents to be undertaken to ensure that reporting has been accurate and consistent	Griffiths, Ceri	**Completed**	Review in Directorate QSE meetings					

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								Community HON has discussed concerns with Health board Safeguarding Lead Nurse and explored need for reporting team to LA Safeguarding. Processes currently in place and no clear evidence of harm having occurred - to monitor. Community HON has requested support from Head of Governance to manage outstanding datix investigations and management of serious incidents which may need reporting to Delivery Unit - await feedback.						HR processes for staff management and oversight to be established and include absence management, off duty management and ESR	Griffiths, Ceri	Completed	Review in team meetings. Action completed.						
															Patient Experience feedback questionnaires to be prioritised for Haverfordwest DN Team and areas of concern highlighted and escalated for action	Griffiths, Ceri	Completed	Process for patient experience feedback in place						
															BABAS team to support with all new and follow up Continence Assessments	Griffiths, Ceri	Completed	Process agreed for all new referrals to go to BABAS. Action completed						
															A formal review of the action plan developed for HF DN Team to be completed in February 2022. If all actions completed and no additional risks identified this risk can be closed.	Griffiths, Ceri	28/02/2022	Meeting date confirmed.						
866	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	MHLD: Adult Mental Health Services	Carroll, Mrs Liz	Isaacs, Kay	03-Apr-19	There is a risk of patients (potentially) causing avoidable harm to themselves whilst attending the building. This is caused by access to ligature points in the building. This will lead to an impact/affect on patients who may cause harm and possible serious injury and death. Staff are required to check on the movements and supervision of patients in the building. Potential claims and reputation risk to the HB. Risk location, Canolfan Bro Cerwyn St Nons and St Caradogs.	Staff awareness or risk and awareness of patients in the building Use of visitor log and reception to monitor people entering the building. New locks/keypads to be in place to lock rooms not in use. In toilet areas, privacy and dignity to be maintained however, if there for several minutes staff to ask if they are alright.	Safety - Patient, Staff or Public	6	1	4	4		MH management to ensure staff follow procedures including supervision of patients, signing in and access to toilets.	Isaacs, Kay	30/11/2020	All staff now meet the patients at the front door at their allocated time. They are always supervised in the building.	Operational Quality, Safety and Experience Sub Committee	1	4	4	Tolerate	22-Nov-21
															MH Management to follow up the costing and installation of new locks to improve safety of patients and staff.	Isaacs, Kay	31/12/2020	Awaiting costings from Estates for the digital locks for the consultants rooms. All staff now meet patients at the front at their allocated time for appointments.						

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863	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	MHLD: Adult Mental Health Services	Carroll, Mrs Liz	Isaacs, Kay	19-Apr-19	There is a risk of patients (potentially) causing avoidable harm to themselves whilst attending the building. This is caused by access to ligature points in the porch of the building, the reception area, the disabled toilet and the consulting rooms. This will lead to an impact/affect on patients who may cause harm and possible serious injury and death. Staff are required to check on the movements and supervision of patients in the building. Potential claims and reputation risk to the HB. Risk location, Brynmair Clinic (MHLD).	The porch and reception area has a high volume of staff around these areas through the day. The reception area is constantly staffed and all patients are checked in and out of the building. The disabled toilet can be opened from outside but due to privacy and dignity issues this room would be used privately by the patient. All consulting rooms are not accessible to patients without a staff member and patients are never left alone in a consultation room.	Safety - Patient, Staff or Public	6	1	4	4		Due to the toilet being in the reception area, staff would be able to manage patients in the building, and monitor length of time, and action accordingly if needed. At present most patients prefer to stay outside until their appointment. Pop up tents have been purchased for patients to sit outside until their appointment.	Isaacs, Kay	Completed	Patients are met by staff for their appointment, and escorted to the clinical rooms. Toilet is in the reception, whereby staff are visisble at all times.	Operational Quality, Safety and Experience Sub Committee	1	4	4	Tolerate	22-Nov-21
															Staff in Brynmair are managing the patients that enter the building, majority of patients stay outside until their appointment time.	Isaacs, Kay	Completed	Pop up tents purchased for the patients that wish to stay outside until their appointment.						
504	Directorate Level Risk		E&F: Operations Compliance	Elliott, Rob	Jones, Stephen	06-Dec-17	There is a risk avoidable harm to building occupants, as a result of prolonged exposure to Radon Gas, which is released from the substructure of buildings. This is caused by buildings where there is Radon Gas at levels which exceed the threshold levels. This will lead to an impact/affect on increase risks attributing to lung cancer and other associated symptoms that are associated to Radon exposure. Risk location, Health Board wide.	Full Radon surveys of all buildings have been undertaken, this was a phased approach which commenced in 2012 and is still being carried out. Remedial work has been undertaken and communications with staff and occupants have been carried out where high levels have been found. Remedial work has now been completed at South Pembrokeshire Hospital and at Swn-y-Gwynt, Ammanford.	Safety - Patient, Staff or Public	6	1	4	4		Capital funding has again been released in 2019-20 for a number of further tests across the HB. Following this exercise a review of the findings will be required to determine if any of action is necessary. Ops compliance manager to liaise with OH management to establish if there are other issues to consider about the health and exposure to staff.	Evans, Paul	Completed	Capital money secured and additional testing has recently been undertaken - at a selection of sites, the results of which will be returned in March 2019. UPDATE - tests are being returned in May 2019, where a full review will be completed.	Health and Safety Assurance Committee	1	4	4	Treat	24-Nov-21
															Test data following the recent round of tests will now need to be analysed to check levels and to determine what remedial work will be required. Test data due back in now July 2019(later than agreed) . Funding has been bid for and is available for high risk remedial work (up to £20k)2019.	Evans, Paul	Completed	Contacted RPW and the test data is being released by the dates agreed.						

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															Survey results now back and are being reviewed by compliance team, one non HB owned property has shown high levels of Radon during the test. There are a few HB sites also close to the control limit witch are being retested in 3 months.	Jones, Stephen	**Completed**	Remedial work completed now awaiting post remedial testing to check validity of system, this takes 3 months. Monitors are being placed end of August 2020. Revised timescale of 10/12/2020 for full completion and post testing. The work is progressing according to plan, and near completion with ongoing review and monitoring						
196	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	Central Operations: Central Transport Unit	Rees, Gareth	Skye, Gareth	31-Jan-18	There is a risk avoidable harm or injury arising from the use of vehicles owned or leased by Hywel Dda University Health Board (HDUHB) This is caused by a lack of appropriate vehicle checking policies and procedures resulting in vehicles not being checked in a standardised way and in line with manufacturers' guidelines. This will lead to an impact/affect on potential for prosecution of HDUHB officers. A significant fine for not complying with the organisation's duty of care. Negative media. Risk location, Health Board wide.	Department managers are responsible for ensuring vehicle checks are carried out on a routine basis. Applies to fleet and department pool vehicles. A pool car user procedure is in place setting out vehicle check requirements for those making use of pool cars. Applies to the central pool car scheme. A pool car administration procedure in place setting out vehicle check requirements for those administering the Central Pool Car Scheme. All lease vehicle contracts include service, maintenance and tires as part of the lease agreement.	Safety - Patient, Staff or Public	6	1	4	4		Develop a Driving for Work Policy outlining the organisation's minimum standards for the checking and maintenance of vehicles.	Skye, Gareth	**Completed**	Pool car policies have been finalised and implemented. Duty of care module implemented to ensure staff utilising grey fleet vehicles present appropriate documentation prior to being eligible for making travel reimbursements	Health and Safety Assurance Committee	1	4	4	Treat	08-Feb-22
															Develop an online training package for all staff expected to use HDUHB vehicles as part of their role to specify responsibilities when driving for work.	Skye, Gareth	01/12/2017 01/11/2018	No progress is possible until driving for work policies have been completed.						