Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	06 March 2023
TEITL YR ADRODDIAD: TITLE OF REPORT:	Operational Risks Assigned to Health & Safety Committee
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Director of Operations Jill Paterson, Director of Primary Care, Community & Long-Term Care
SWYDDOG ADRODD: REPORTING OFFICER:	Rachel Williams, Head of Assurance and Risk

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

ADRODDIAD SCAA
SBAR REPORT

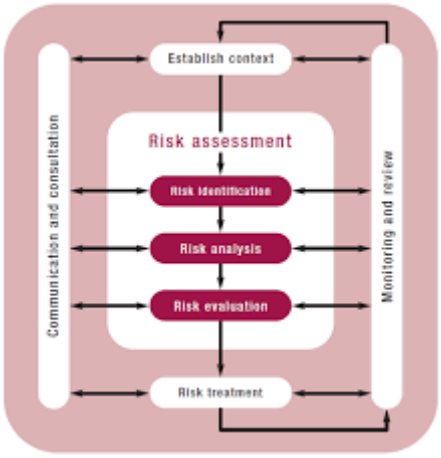
Sefyllfa / Situation

The Health & Safety Committee (HSC) is responsible for providing assurance to the Board that risks relating to health and safety are being identified, assessed and managed effectively.

The Committee is requested to seek assurance from Lead Officers/representatives of the Directorates that the operational risks identified in the attached reports are being managed effectively.

Cefndir / Background

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



(Risk Management Process, ISO 31000)

Operational risks must be managed within Directorates under the ownership and leadership of individual Executive Directors, who must establish local arrangements for the review of

their Risk Registers, which includes the validation of the information and risk scores, and the prioritisation and identification of solutions to their risks. In addition to these local arrangements, formal monitoring and scrutiny processes are in place within Hywel Dda University Health Board (HDdUHB) to provide assurance to the Board that risks are being managed effectively.

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

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

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

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

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

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

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

Asesiad / Assessment

The HSC Terms of Reference states that it will:

- Provide assurance that risks relating to health, safety, security, fire and service/ business interruption/ disruption are being effectively managed across the whole of the Health

Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate) and provide assurance that effective risk assessments are undertaken and addressed.

The 3 risks presented in the Risk Register, attached at Appendix 1, as of 10 February 2023, have been extracted from Datix, based on the following criteria:

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

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

Changes since the previous report presented to HSC at its meeting on 09 January 2023

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

Risks that are no longer included in the report

Since the previous report, the following risk have been realigned to the Operational Quality, Safety and Experience Sub Committee:

Risk Reference & Title	Date Risk Identified	Directorate/ Service	Current Risk Score	Rationale for the Current Risk Score (extracted from Datix)	Target Risk Score	Risk Review Date
369 - Disruption to business continuity in the theatre complex at Prince Philip Hospital.	04/04/18	Estates & Facilities: Carmarthen-shire East	12 →	Based on external surveys by NHS Wales Shared Services Partnership Specialist Estates Services (NWSSP-SES) and local operational maintenance officers. 1 air handling unit is currently covering two theatres, therefore if this fails both theatres will be on stop until the unit is repaired/replaced.	3	06/02/23

No change in risk score

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

Risk Reference & Title	Date Risk Identified	Directorate/ Service	Current Risk Score	Rationale for the Current Risk Score (extracted from Datix s)	Target Risk Score	Risk Review Date
951 - Fire Alarm Detection and Operation (WGH).	04/04/18	Estates & Facilities: Carmarthen-shire East	12 →	Update to system from verification has not yet happened so controls remain incomplete. All details have been sent to manufacturer and we are waiting for their programmer to complete works and attend site to input new cause and effect.	1	07/02/23
708 - Inappropriate storage solutions associated with patient files / documents affecting Ceredigion Community Sites	18/03/19	Ceredigion	12 →	A strategic steer is required to support Heads of Service use alternative storage mechanisms. Aberaeron hospital was closed on 21/09/19, and Cardigan hospital closed on 09/12/19, both of which have been used to store files. 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. A working party created an options appraisal in May 2019 to address the challenges; this paper has been escalated to Head of Information Governance. Information Governance Training has been delivered with team leaders in September 2019. Retention Guidance for Community Patient Files was published in February 2022; teams are currently ensuring adherence.	4	16/01/23

				Off-site storage facility has been secured by the HB, however access to enable use of this facility has not been openly made available.		

Reduction in risk score

Since the previous report, the following risk have had a reduction in their risk score.

Risk Reference & Title	Date Risk Identified	Directorate/ Service	Current Risk Score	Rationale for the Current Risk Score (extracted from Datix)	Target Risk Score	Risk Review Date
222 - Exposure to Asbestos through contact with asbestos containing materials.	01/02/18	Estates and Facilities: Operations Compliance	8 ↓	The likelihood score has reduced from 3 to 2 due the Estates team having a greater understanding of the likelihood of the unknown 'Asbestos Containing Materials' (ACM's) across the UH B sites. It is very unlikely that staff, patients, contractors, etc. could be exposed to higher risk ACM's but possible that they could be exposed to small amounts of damaged lower risk ACM's if these are inappropriately managed. As of February 2023, in the last 7 months there has been 1 formal concern from a member of staff, and 1 concern resulting from contractors work, regarding ACMs. These were managed appropriately by Estates staff once they were made aware, and appropriate advice and remedial work was carried out. The likelihood of estates staff and their contractors receiving a significant exposure to higher risk materials is generally considered low. There will always be a risk of accidental disturbance of ACMs,	4	09/02/23

				however over the last 4 years the estates team have improved its survey work and knowledge of ACMs across the UHB sites.		

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

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

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

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

Risk numbers presented in red text denote those where a review of the risk is overdue, based on the data as of 10 February 2023.

	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				
High	951 708 222			
Moderate				
Low				

Appendix 2 details the 75 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 and Safety Committee Risk Register

Date: February 2023

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	3	4	12	Consider alternative temporary storage arrangements.	Hawkes, Jina	Completed	Visit arranged to view the container in Cardigan, any space within the container will only temporarily ease the local situation	Health and Safety Committee	1	4	4	Treat	16-Jan-23
														Awaiting additional guidance from Information Governance to enable scoring system for prioritization of storage	Hawkes, Jina	Completed	No guidance has been issued						
														In line with Information Governance processes; organise a catalogue of boxes to be removed from local sites to the centralised store	Hawkes, Jina	Completed	Information and Governance have sent through storage process requirements in April 2022; work is underway to prioritise and catalogue contents of boxes						
														In line with Information Governance processes; implement the removal of achieved boxes into long term storage	Hawkes, Jina	Completed	Addition scoring guidance is being developed						
														Explore opportunities of combining this risk with the similar risk associated with acute sites	Hawkes, Jina	Completed	Ceredigion County Director has communicated challenges with head of Information Governance						
														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						
														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						
														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.						

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
														Source Interim storage arrangements	Rees, Gareth	Completed	Temporary storage facilities were erected at Cardigan Integrated Care Centre w/c 2/12/19						
														Respond to Head of Information Governance requesting his opinion for how the situation may be managed.	Hawkes, Jina	Completed	Communication commenced						
														HDUHB wide Physical solution to be achieved	Skitt, Peter	Completed	Paper going to Information Governance Sub Committee on the 12/10/21						
														Develop whole system engagement	Skitt, Peter	Completed	Ceredigion County Director to establish 3 County group						
														Plan for the removal of boxes from local sites to the centralised store	Hawkes, Jina	Completed	Paper raised, awaiting response from Information and Governance. Email sent to Information and Governance; awaiting response						
														Escalate the need for a HDUHB wide Physical solution to be achieved	Skitt, Peter	Completed	Discussions with Senior decision makers is on-going. Director of Nursing, Quality and Improvement aware of the situation. The situation has been raised and escalated.						
														County Director to work with senior HB colleagues to determine long term storage arrangements	Skitt, Peter	Completed	Assurance has been given to the Health Records Manager that boxes are adhering to guidance						
														Health Records Manager to obtain the resources required to enable the boxes to be moved	Skitt, Peter	30/03/2023	Communications have commenced between the Health Records Manager and Head of Finance to obtain the resources required						

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
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 that the Fire Alarm will not report properly when the system is in Fire. Any fire will be detected but the report sent to the Panel Indication may not be correct. The Cause and Effect which is the closing of the doors, operation of sounders, shutting down of plant etc, have all been identified and are waiting for completion of Zone numbering to be completed. All information will be forwarded to the system programmer for update to system. This is caused by incomplete set up during the commissioning of the system at the start. All information is now available and waiting for completion of verification and transfer to new panel systems. A new numbering system of Zones is also needed to be completed before the system can be uploaded. This will lead to an impact/affect on the fire alarm system working as proposed in initial design. Secondary effects may not work properly as the original config is incomplete. Risk location, Withybush General Hospital.	Currently we have Verified all detectors and identified where all interfaces are positioned. We have verified position of all power supplies for doors and Dampers and following on from zone verification this can be completed and sent for programming. Verification of loops and detectors are ongoing. The system is to be programmed next week which will alleviate some of the risks.	Safety - Patient, Staff or Public	6	3	4	12	Implement phase of works to bring all computer graphics up to date with the units connected to the Fire Alarm system, including elements of alterations to get the system to work in the new Zones.	Evans, Duncan	Completed	All information has been passed to FSC about all the verification works that have been carried out. This quotation has come back and has been passed for payment.	Health and Safety Committee	1	1	1	Treat	07-Feb-23
														Waiting for meetings to formulate new Cause and effect	Evans, Duncan	Completed	No further progress.						
														Verification of alarms is still going on in collaboration of FSC.	Evans, Duncan	Completed	Verifications and tracing heads						
														"The verification of floors 3,2,1 are complete but have not been mapped out. 0 and -1 are yet to be completed. Cause and effect has been identified by zones but needs updating. Residances have been completed witgh detector cahange but are awaiting verification of cable to Telephonists."	Evans, Duncan	Completed	Progress is being achieved on all aspects of the fire alarm.						
														Identification of loops, detectors and sectors. Creation of a new Cause and Effect Matrix and renewal of current out of specification detectors.	Evans, Duncan	Completed	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.						
														Verification of loops and detectors are ongoing. Verification of interface operation ongoing.	Evans, Duncan	Completed	Loops are being completed and plotted						
														Residential Blocks are complete with only Sealyham and Springfield yet to complete. Verification of top floors complete but work required on formulation of cause and effect still remaining. Completion to L1 standard not complete	Elliott, Rob	Completed	Verification and inputs from different officers required to be carried out.						

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
														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.						
														Additional Staff to be trained on how to use the system.	Evans, Duncan	**Completed**	Training has been carried out.						
222	Directorate Level Risk		E&F: Operations Compliance	Elliott, Rob	Smith, Robin	01-Jul-12	There is a risk avoidable harm to patients, visitors, staff and contractors due to exposure to asbestos through contact with 'Asbestos Containing Materials' (ACMs). This is caused by approximately 2700 known and recorded ACM's being present in the building fabric due to the age of some of the Health Board's (HB) estate, which requires refurbishment that can lead to asbestos being released/disturbed. This will lead to an impact/affect on an uncontrolled release of asbestos fibres affecting staff, contractors, patients and the public, with the potential for serious illness which could possibly lead to death. Possible enforcement action and prosecution in the event of HSE intervention in response to an incident, a complaint, or as a result of an inspection. Adverse Publicity through non compliance with the 'Control of Asbestos Regulations'(2012). Risk location, Health Board wide.	A comprehensive HB Asbestos Policy is in place. Asbestos Management Plans in both electronic and printed format available for each site containing Asbestos, based on Asbestos Management Surveys. Targeted Renovation and Demolition Surveys are also undertaken in advance of schemes. All samples undertaken for surveys and other investigations updated on the AMP's The condition of ACM's and protection where provided e.g. encapsulation is inspected annually Training of staff in Asbestos Awareness and cohort of estates staff at each acute site trained in Asbestos Non Licenced Work (NLW). Ongoing communications between Estates and other directorate managers on the reporting of building defects, and site specific asbestos issues. The control of contractors is exercised by Engaging Managers and Estates Officers. A holistic health board wide review of asbestos management has been undertaken and resulted in a new compliance team being implemented in 2022 including a compliance officer leading with asbestos management.	Safety - Patient, Staff or Public	6	2	4	8	Implementation of an all-digital asbestos management database system.	Smith, Robin	~~31/03/2023~~ 30/06/2023	A potentially suitable system has been identified (Teams by Mark One Enterprises) which our asbestos re-inspection service provider is already using to log re-inspection and new survey data under their license. The effectiveness and suitability of the system will be evaluated upon completion of the re-inspection contract.	Health and Safety Committee	1	4	4	Treat	09-Feb-23
														Improvement of compliance by the inclusion of existing asbestos data relating to leased properties, and/or by commissioning new surveys of leased properties.	Smith, Robin	~~28/02/2023~~ 30/05/2023	Working with the property team to determine all leasehold properties and to determine the duty holder in in case. New surveys have been completed for Tenby, St Clements, and Johnston Branch surgeries.						

Health and Safety Theme Risk Register

Date: February 2023

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
1470	Service or Department Level Risk		USC: WGH	Cole-Williams, Janice	Johns, Helen	15-Sep-22	There is a risk that the ability to protect staff, patients and critical assets is compromised by the current vulnerabilities in our security management arrangements and infrastructure. This is caused by insufficient physical security measures to protect staff, patients, services and equipment. This will lead to an impact/affect on staff injury from physical assault, unauthorised access to hospital departments, placing vulnerable patients at risk, theft of HB and personal assets, increased demand on police resources, increase in complaints and claims, and non-compliance under the protect Duty under CONTEST Cyrmu. Risk location, Withybush General Hospital.	All main external doors have access controls fitted with automatic locking and unlocking. Out of hours entrance has intercom camera linked to switchboard. CCTV in place in ED and in the main hospital. Communication system (2-way radio) in use porters, clinical site team, ED, ED reception and switch. Porters have been trained in de-escalation and restraint skills. ED reception staff are positioned behind safety screens and secured by swipe access control. Hospital is secured at night using access control system.	Safety - Patient, Staff or Public	6	4	4	16	4 step appeal safety training to be booked for staff in ED and other areas to attend.	Dyer, Josephine	~~16/12/2022~~ ~~17/11/2022~~ 17/04/2023	60% of staff have now had the training. ED will continue to book more on.	Operational Quality, Safety and Experience Sub Committee	3	4	12		17-Jan-22
														To look at possibly purchasing personal alarms or body cameras for staff in ED. Nov 22: Health and Safety are looking at personal alarms.	Dyer, Josephine	~~30/11/2022~~ ~~17/11/2022~~ 17/04/2023	Ongoing. New Security adviser looking at personal alarm systems.						
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	4	4	16	Develop a plan with partners for the South of the county	Skitt, Peter	31/03/2023	Discussions have commenced	Operational Quality, Safety and Experience Sub Committee	2	4	8		16-Jan-23
														Offer the tender to the independent sector	Skitt, Peter	**Completed**	LA is leading the tendering process						
														LA Legal team to work through challenges associated with planning application for a new site in the North of the county	Skitt, Peter	~~30/11/2022~~ 31/03/2023	LA Legal team is leading the process, a barrister has been appointed. Discussions continue						
														Partnership approach to enable procurement with the independent sector	Skitt, Peter	**Completed**	Project group between HDUHB, LA, Primary care etc established to enable a tendering process to be completed by end of the financial year						
														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						
														Work with partners to stimulate a new market for Ceredigion within the foot print of HDUHB	Skitt, Peter	Completed	Meetings are being planned						
														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"						
														Work with LA and private partners to enable the stimulation of the new market	Skitt, Peter	Completed	Mid Wales growth bid has been approved.						
														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.						
														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						
														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."						
														Meet with private providers and Local Authority	Skitt, Peter	Completed	Meetings held with four providers both EMI and nursing						

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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						
														Communicate with private providers to explore opportunities.	Skitt, Peter	**Completed**	Communication commenced.						
737	Service or Department Level Risk	Standard 3.4 Information Governance and Communications Technology	Finance: Digital: Information and Communication Technology	Tracey, Anthony	Brain, Sarah	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 (specifically the right to a rest break if the working day is longer than six hours), with implications for health and safety, increased levels of sickness and potentially more time off work. Consequently this could have a direct impact on patient care. 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	Post-implementation review of system on 19th January	Brain, Sarah	19/01/2023	Results of review will generate next Actions	People, Organisational Development and Culture Committee	3	2	6	Treat	10-Jan-23
														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~~ 31/12/2022	"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. "						
														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 "						

Health and Safety Theme Risk Register

Date: February 2023

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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 registered and HCSW 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 quality of patient care and staff wellbeing due to insufficient staffing levels to meet patient need. Risk location, Tregaron Hospital.	There is a pro-active operating process associated with ensuring appropriate patients are admitted into the hospital. The process is led by the community staff. Business continuity plans have been reviewed and updated in 2022.	Safety - Patient, Staff or Public	6	4	4	16	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	Completed	Communications with decision makers commenced	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	16-Jan-23
														Develop a plan to safely staff the hospital post October 22	Hawkes, Jina	Completed	Planning and development of an OCP taking place.						
														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						
														General Mangers (Community & BGH) together with Heads of Nursing to meet and determine how to appropriately measure patient flow	Hawkes, Jina	Completed	Discussions have taken place with both BGH and GGH						
														Pilot approaches which demonstrate flow and challenges associated with patients using Tregaron hospital	Hawkes, Jina	Completed	Working closely with acute sites to adopt a single approach, however due to challenges within the independent sector, unable to demonstrate flow						
														Utilize Regional Integration Funding to build capacity in the community	Skitt, Peter	Completed	Working closely with acute sites to adopt a single approach, however due to challenges within the independent sector, unable to demonstrate flow						
														Review the medical cover / support to mitigate risks associated with limited nursing cover over night in a remote location	Hawkes, Jina	28/02/2023	Communications with clinical assistants has commenced						

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1401	Service or Department Level Risk		Scheduled Care: OPD	Hire, Stephanie	Davies, Damian	27-Apr-22	There is a risk of Slip, fall, injury from leaking roof. This is caused by leaking roof in Red conservatory main Outpatients entrance due to dislodged seals. Outpatients environment utilised 24hours/7 days a week by Outpatients and Out of hours GP service as well as being one main entrance route to hospital. This will lead to an impact/affect on on User safety. Risk location, Bronglais General Hospital.	1. Report leak to Hotel Services. Leaking areas to be cordoned off with water receptacle and signage to be put in place and area dried. 2. Report leak to Estates department to assess and monitor. 3. Estates boilerman to add walk through Outpatients department during out of hours to monitor areas. Organised by Site Works Supervisor, Estates. 4. Estates provided measurements but fabricating company to measure area themselves to ensure the tray fits. 5. Scaffolding is in place to gain access and Estates are trying to repair the leak. 6. Regular walkabouts by staff to check areas are safe, particularly after periods of large rainfall	Safety - Patient, Staff or Public	6	4	4	16	Window company to renew seals and replaced blown glass panes. Company already made site visit. Estates department to inspect the lead work and locate any leaks to stop any water ingression during above works.	Davies, Damian Davies, Damian	~~30/06/2022~~ ~~10/11/2022~~ 31/03/2023 ~~30/06/2022~~ ~~10/11/2022~~ 31/03/2023	Still awaiting window company visit Estates provided measurements but fabricating company to measure area themselves to ensure the tray fits.	Operational Quality, Safety and Experience Sub Committee	1	1	1	Treat	23-Jan-23

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1488	Service or Department Level Risk		Scheduled Care: Endoscopy	Hire, Stephanie	Edwards, Sara	26-Sep-22	There is a risk that endoscope decontamination equipment fail on a not infrequent basis, causing delays in the return of decontaminated endoscopes to front facing patients services requiring the use of flexible endoscopes. The condition of the current equipment provides a significant risk to scheduled and unscheduled service failure and ultimately a risk to clinical capabilities at Bronglais Hospital. The equipment is unreliable and there is no scope on site to meet the needs of the service with such unreliable factors. This is caused by One endoscope washer disinfector and drying cabinet were originally installed and commissioned in 2009, and are now 13 years in service and therefore 4 years beyond the recommended life cycle of 8 years. A second endoscope washer disinfector was added to augment capacity issues at Bronglais Hospital in 2014 and is nearing its 8 year recommended life cycle. This will lead to an impact/affect on The majority of endoscope	1. Regular servicing of current decontamination equipment. 2. Decontamination trained estate staff supporting daily with breakdowns and maintenance of decontamination equipment 3. Contract in place for current decontamination equipment inclusive of breakdown cover and engineer can attend hours within 48 hours	Service/Business interruption/disruption	6	3	4	12					Capital Sub Committee	2	4	8	Treat	20-Oct-22

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							decontamination equipment at Bronglais Hospital is now 4 years beyond its recommended life cycle of 8 years and fail on a not infrequent basis, causing delays in the return of decontaminated endoscopes to front facing patient services requiring the use of flexible endoscopes. As the equipment becomes older, it will become more problematic, and will inevitably present more significant impacts, which will have an effect on Referral to Treatment Time Performance. These equipment failures causes avoidable delays in the supply of decontaminated flexible endoscopes to endoscopy, theatres, outpatient departments, cardiology and intensive care units, and therefore create operational difficulties for patient endoscope procedures Due to the use of Peracetic Acid within the decontamination process, there is often a strong smell of peracetic acid within the current endoscopy unit, which on occasions can be intrusive. The current air handling unit is insufficient in removing this odour. JAG accreditation was originally deferred due to this concern until actions were put in place to eliminate this smell.													

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							[illegible] Should the endoscope decontamination equipment remain within the endoscopy department there is a possibility that JAG accreditation could be withdrawn. This would have an impact on junior doctors training as all endoscopy units must be JAG accredited for training. Furthermore compliance with Welsh Government recommendations would also be of concern as it is now recommended that endoscope decontamination units are centralised into HSDU departments and managed by decontamination staff. Risk location, Bronglais General Hospital.															

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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. Series of actions being progressed as part of measures reported to ARAC. Medical Director increased communications regarding the importance of good record-keeping. Local sites developing 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. 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. 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. 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. Re-audit of WGH took place in 2020 to develop Quality Improvement plan (to inform roll-out across other sites).	Quality/Complaints/Audit	8	3	4	12	Develop a suite of resources for education and awareness raising on the Health Board's standards for Clinical Record Keeping.	Davies, Lisa	~~30/12/2022~~ 31/01/2023	"Meetings have taken place with clinical professionals to undertake filming for each Standard within the Policy. Six videos completed and in the process of being edited. SharePoint page has been created and population with resources has commenced. Slide deck has been developed."	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	12-Dec-22
														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~~ 31/03/2023	"Action delayed - will need to be revisited following completion of the Clinical Record Keeping Policy and the supporting resources have been developed. Some focused re-audits being undertaken."						
														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~~ 31/01/2023	Stakeholder and Global consultation completed. Comments have been addressed and sign-off by owning group and approval at CWCDG awaited.						

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388	Service or Department Level Risk		Central Operations: Clinical Engineering	Rees, Gareth	Rees, Gareth	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	Recruit 2 clinical trainers in WGH and GGH.	Hopkins, Mr Chris	17/10/2022	Admin post plus BGH & PPH trainers appointed. GGH trainer to be appointed over the next 6 months. WGH trainer has now handed in her notice which means an additional trainer to be appointed.	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	
														"Establish a Medical Device Training Sub-Group. "	Gostling, Lisa	**Completed**	Completed: Medical Device Training Sub-Group established.						
														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. "						

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1409	Directorate Level Risk	Standard 7.1 Workforce	Public Health: Children's Public Health	Lewis, Bethan	Morgan, Barbara	20-Jun-22	There is a risk to the health and wellbeing outcomes and high level of safeguarding concerns for Children and Young People (CYP) within the Health Board due to a shortage of School Nurses. This is caused by 1. Difficulty in recruiting School Nurses throughout the HB but particularly in Ceredigion. Currently have 4.58 WTE deficit in our qualified school nurse workforce. 2. There are not enough registered nurses opting to attend the SCPHN (Specialist Community Public Health Nurse)training for school nursing. 3.Location of the training, which is based in Swansea University, this is not always popular with staff from Ceredigion or Pembrokeshire due to the distance they have to travel. 4. The School Nursing service is unable to complete other aspects of its Public Health Role as the service is seen as providing an Immunisation Service. 5.Registered Nurse's perception on what the School Nursing Role actually entails. This will lead to an impact/affect on 1. Reduced input by the service on CYP's Health and Emotional Wellbeing due to lack of staff and increased demands in other areas of the service. 2. Limited capacity of staff to deal with	1. Handover of care from Health Visiting to School Nursing to ensure that vulnerable children and families are identified early and an appropriate package of care implemented continues. 2. All contacts with any identified at risk CYP and their families are carried out via telephone or virtual call and an in depth verbal handover is completed. 3. In regards to increases in Safeguarding issues, supervision is available from the Safeguarding Team and support from Team Leaders or Senior Nurse Manager. 4. Face to face meetings have resumed with vulnerable CYP. 5. Skill mix model has been adopted where the service has appointed Band 5 Registered Nurse's to fill the deficit and enable them to become SCPHN's as part of the grow your own model.	Safety - Patient, Staff or Public	6	4	3	12	Promote return to face-to-face Health Visitor to School Nurse Handover by all School Nurse Team Leaders	Morgan, Barbara	~~30/09/2022~~ 01/10/2023	have made some progress in some areas however Ceredigion HV service still have significant vacancies	Operational Quality, Safety and Experience Sub Committee	2	3	6		25-Jan-23
														Provide safer support for CYP by resuming all safeguarding contacts with children back in school or home environment - driven by all School Nurse Team Leaders	Morgan, Barbara	~~30/09/2022~~ 01/04/2023	Made some progress but very difficult when covering vacant caseloads						
														Undertake recruitment campaign with Workforce, scoping and looking at the needs of the service	Morgan, Barbara	31/12/2022	Ongoing						
														To re-launch CHAT Health for CYP for the whole HB, working in collaboration with the Youth Health Team	Morgan, Barbara	31/12/2022	Ongoing						
														Meet with Education leads across the 3 counties to discuss the future Welsh Language criteria and current fluent welsh speaker recruitment challenges	Lewis, Bethan	~~31/12/2022~~ 31/03/2023	Advice taken from Welsh Language lead for Health Board. Meeting to be arranged with Education Leads for Ceredigion to discuss further before discussing further with Pembrokeshire and Carmarthenshire.						

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							increased Safeguarding and Domestic Abuse disclosure. 3.Reduction in providing the prevention aspect of the Public Health role which include the key public health messages provided by school nurses on sexual health and appropriate relationships including internet safety which could have a catastrophic impact on CYP, which is due to the post coded key targets set by Welsh Government, it has been impossible to deliver all the usual growing up talks in both primary and secondary schools. Ongoing effects on staff wellbeing due to staff shortages within the service. Low staff morale as a result of being deployed twice during the pandemic, staff feeling school nurses are undervalued by the HB. Risk location, Health Board wide.							Exploring the possibility of a blended model with the immunisation nurses to deliver school based immunisations which will reduce School Nursing workload	Lewis, Bethan	~~31/12/2022~~ 31/03/2023	Supportive model has been piloted during Autumn programme undertake evaluation and complete actions of a future blended approach.						

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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 due to the demands on services. This is caused by the COVID-19 pandemic had worsened the already challenging position, post COVID-19 some services/staff wish to return onsite which is adding to the accommodation pressures. There are some staff who hold corporate roles and are based at WGH but only spend a proportion of their working week here. 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 and are still relocated. Availability of office space for staff who have been previously based on the WGH site. Staff wellbeing, with teams being moved into other spaces or off site. Risk location, Withybush General Hospital.	Full scoping exercise undertaken of all services & staff based on the WGH site. Services relocated across the site have had to remain in place due to demand on the emergency department. All clinical areas, screens have remained in place other than where they were no longer suitable. Consideration of mixed sex bays with additional precautions to ensure dignity is maintained. Staff adhering to strict PPE guidelines when required. Additional storage obtained to support social distancing within all areas, this is still being used due to space constraints. Inventory list in place, all areas to go through Hospital service team if needing storage. Community services have moved back out into the community.	Service/Business interruption/disruption	6	3	4	12	To engage with Agile working group, community and mental health to work collaboratively across sites. "Scoping of all offices within the hospital site to determine if staff need to be onsite or could work from somewhere off site. Working again with estates to scope every office on site and monitor if the space is being utilised as told. "	Johns, Helen Johns, Helen	~~16/12/2022~~ 17/04/2023 **Completed**	ongoing "Most areas have been scoped. Springfield needs to be completed. Springfield completed. "	Operational Quality, Safety and Experience Sub Committee	3	2	6	Treat	18-Jan-22

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1419	Directorate Level Risk	Standard 7.1 Workforce	Public Health: Children's Public Health	Lewis, Bethan	Morgan, Barbara	05-Apr-22	There is a risk disruption to services and impact on School Nursing staff wellbeing who do not have a safe working environment or adequate School Nursing service. This is caused by insufficient office accommodation and lack of storage space for confidential child health records for School Nursing service across the Health Board. Lack of premises to facilitate multiagency networking and clinical debrief / supervision requirement. This will lead to an impact/affect on staff wellbeing due to an increase in staff anxiety, staff morale and resilience. Potential increase of sickness and resignations. Lack of capacity to support pre registration students. Inability to provide a safe educational base for our future workforce in order for them to achieve their educational outcomes. All of which will affect the Health Board's resilience, service delivery and patient care, and cause adverse publicity and or loss of stakeholder confidence. Risk location, Health Board wide.	Risk assessment of all School Nursing bases completed to ensure a safe environment during COVID completed. Use of rotas for desk / access to records. Use of office space on a temporary basis (there has been a request for the office to return to the original department). Working with the HWB strategic planning group to identify alternative accommodation in Aberystwyth and Carmarthen. Implemented a scope based model in line with the Nursing & Midwifery Council (NMC) 2018 Standards of Education to accommodate safe placements of Specialist Community Public Health Nursing (SCPHN) students. Carmarthen School Nursing Team are currently based in the Nursing Residences on Glangwili General Hospital site.	Service/Business interruption/disruption	6	4	3	12	Ensure accommodation requirements for the School Nursing service across the Health Board are fed into the appropriate accommodation group	Morgan, Barbara	30/09/2022	new action	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	25-Jan-23
														Work with Estates department leads and County Directors to identify suitable accommodation both within and outside of the Health Board premises.	Lewis, Bethan	~~31/12/2022~~ 31/07/2023	When Pembrokeshire School Nursing staff return from summer holidays the impact of the hot desking arrangements will be reviewed. Ceredigion School Nursing Team are one of many services based in Ty Helig who have been asked to find alternative accommodation due to Ty Helig being allocated to Bronglais acute hospital site. This is part of the Aberystwyth AICC project and a venue is currently being sourced.						
														Identify funding options for accommodation.	Lewis, Bethan	Completed	No additional funding identified but will continue to work with Estates Department within the Health Board.						

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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	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	Health and Safety Committee	2	3	6	Treat	20-Jan-23
														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 Elfyn Jones provided cost of £5K						
														Meet with Estates to establish costing for repairs.	Admin, Hywel Dda	**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						
														Temporary repair of floor completed July 2016.	Admin, Hywel Dda	**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.						
														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.						
														Flooring to be replaced.	Jones, Peter	31/03/2023	Quote has been agreed and flooring is planned to be replaced by end March 2023.						

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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.	Staff are aware and 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	Existing quote over two years old new cost requested	Daniel, Richard	Completed	Cost for total project ,£94,695	Health and Safety Committee	2	3	6	Treat	20-Jan-23
														Capital bid submitted	Daniel, Richard	Completed	Bid submitted to Capital Manager						
														New cost provided	Jones, Peter	Completed	Bid submitted 29.04.21						
														Options to remedy floor discussed with Estates Department.	Jones, Peter	Completed	"Completed- Capital bid submitted April 2021. "						
														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.	Admin, Hywel Dda	Completed	Issues raised with staff at team briefing.						
														Obtain funding to replace flooring.	Jones, Peter	Completed	"Capital bid submitted 29/04/2021, no formal feedback as of July 2021. Review at end of financial year 22-23. Resubmit bid.						
														Replace flooring.	Jones, Peter	31/03/2024	Capital bid refreshed in financial year 22/23. If not successful the capital bid will be refreshed again for 23/34. Date of March 2024 provided as, at January 2023, it is unlikely the bid will be successful for 22/23.						

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1540	Service or Department Level Risk		NQPE: Health and Safety	Passey, Sian	Harrison, Tim	21-Oct-22	There is a risk of new staff facing delays in receiving suitable and sufficient manual handling training upon commencing work with HDDUHB. This is primarily a concern within Carmarthenshire, where demand/recruitment numbers are highest. This is caused by a smaller training room capacity. The team also undertake complex and specialised clinical roles in addition to their training elements and are in constant demand in providing patient assessment and clinical advice and supporting Datix investigations in order to reduce future harm. This will lead to an impact/affect on both staff safety and patient safety. Risk location, Health Board wide.	a 4 tiered training scheme that prioritises classroom time for those that undertake patient handling. This includes two patient handling categories as below: ESR3 - Minimal and Emergency Handling is a one-day course.This course was created to better reflect the needs of some staff groups, diverting them to this course and appropriately prioritising staff who require ESR4. ESR4 -Foundation Training (FT) in People Handling consists of a two-day course. Due to demand, multiple additional dates have been added for foundation training for the remainder of the year, including accommodating all International Nurses and Apprentices. Staff receive reminders to attend training in order to try and reduce non attendance. Workplace Assessors (WPA) on the wards/departments where the new starter is to commence work can continue to carry out competency assessments reducing the need for update training. The Manual Handling Team now rigorously assess any manual handling experience/training incoming staff already possess to decide whether a manual handling update might meet their needs rather than attending the full FT course. Managers can use a newly revised risk assessment to assess the safety of that person working in their environment without having received training.	Safety - Patient, Staff or Public	6	3	4	12	Creating improved training capacity in Carmarthen The current training facility in Glien House, Carmarthen is limited to 12 trainee places, there is a clear need to improve training capacity in Carmarthenshire with a suitable venue. A venue that could support 16-24 places would greatly increase training capacity for ESR3 and ESR4 courses.	Rayani, Mandy	30/04/2023	Progress to be provided at the next review of the risk.	Health and Safety Committee	2	3	6	Treat	21-Dec-22
														Additional Training Resource Appointing two band 4 manual handling training assistants to the Manual Handling Team to work alongside current Band 6 staff would increase training provision without compromising the teamÃ¢â‚¬â„¢s non-training responsibility. Band 4s train only under supervision of band 6 staff. (Note: additional training venue(s) may be required unless a larger venue is found for the team).	Rayani, Mandy	30/04/2023	Progress to be provided at the next review of the risk.						
														Reduce Frequency of Update Training Consideration could be given to the option of altering the frequency of update training from 1-yearly to 3-yearly (Note: the requirement for urgent refresher training indicated by a clinical concern would remain). With any additional days released by reducing routine updates, additional FT courses could be added where possible.	Rayani, Mandy	30/04/2023	Progress to be provided at the next review of the risk.						

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														Medical Staff Training In response to any surge in demand for additional ESR3 courses, for example at times of year when large volume of doctors are recruited, explore options of overtime for Manual Handling team running FT (ESR3) courses on weekends in large cohorts. This model would be unlikely to work for FT (ESR4) due to equipment needed.	Vaughn, Gemma	30/04/2023	Progress to be provided at the next risk review.						

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1549	Service or Department Level Risk		NQPE: Health and Safety	Passey, Sian	Harrison, Tim	21-Oct-22	There is a risk of violence and aggression towards Health Board staff who are regularly exposed to dangerous situations. Also a risk of Health and Safety Executive (HSE) scrutiny and possible enforcement action following their intervention in 2019. This is caused by by the Training Team not having adequate resources to deliver the All-Wales Violence and Aggression Passport course and additional courses that focus on understanding behaviours that challenge to the wider Health Board, as highlighted by the Health and Safety Executive (HSE) review conducted in 2019. In addition. there is the challenge of staff not being released from their clinical duties due to staff shortages and clinical demands to undertake training. This will lead to an impact/affect on on both staff and patient safety, with staff not being aware of relevant skills and techniques to ensure their own safety, and patient safety by applying unsafe restraint techniques if not adequately trained. Potential for HSE fines for not fulfilling the actions stated in the Health Boards evidence submitted to the HSE in 2019. Risk location, Health Board wide.	The Prevention and Management of Violence and Aggression (PAMOVA)Team offer a variety of training courses and refreshers like All-Wales Violence and Aggression Passport, Restraint reduction, Positive Behaviour Management (PBM) and Reducing Restrictive Practice Care Planning and Liberty Protection Safeguards (RRPCP & LPS). Training is prioritised for higher risk areas. when notified via Datix incident reporting the team link with departments and provide practical advice and assistance and offer training where appropriate. Where risks are identified the PAMOVA team provide training - usually person specific training to reduce risk to staff and patient. PAMOVA Team liaise with the HB V&A case manager in the identification of incidents where training may be of benefit Health Board policy on Reducing Restrictive Practice PAMOVA team have a presence in clinical areas (when possible) - focussed on specific sites where risks are identified.	Safety - Patient, Staff or Public	6	3	4	12	Additional Training Resource: Appoint 3 band 4 assistant practitioners to the Team	Harrison, Tim	31/03/2023	Progress to be provided at the next review of the risk.	Health and Safety Committee	2	3	6	Treat	12-Dec-22
														Creation of Practice Leaders: Practice Leaders to provide clinical support and advice, supervised by the core Reducing Restrictive practice team.	Wood, Rachel	31/03/2023	Progress to be updated at the next review of the risk.						
														Creation of Practice Leaders: Mental Health to up skill a member of each inpatient area to work as practice leaders.	Wood, Rachel	31/03/2023	Progress to be updated at the next review of the risk.						
														Creation of Practice Leaders: Practice leaders to be trained up by the team to manage many of the requests for support that currently come in from mental health areas.	Wood, Rachel	31/03/2023	Progress to be provided at the next review of the risk.						

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1351	Service or Department Level Risk		USC: Pathology	Perry, Sarah	Jones*, Dylan	11-Feb-22	There is a risk There is a risk of the laboratory being unable to provide a frozen section diagnostic service which would affect both dermatology and theatres. This is caused by This is caused by the age of the present cryostat (20 years old), and is considered to be obsolete by Leica who are no longer able to supply spare parts for the machine. This will lead to an impact/affect on This will lead to an impact on delays in the turnaround of diagnostic clinical reports for cancer patients and routine tissue biopsies. Potentially delaying treatment eg: surgical procedures and chemo/radio therapy. Risk location, Glangwili General Hospital.	The machine is on a bronze preventative maintenance contract.	Safety - Patient, Staff or Public	6	4	3	12	Obtain capital monies to purchase a new cryostat	Jones*, Dylan	~~31/03/2022~~ 30/11/2022	Quotes received. John Lang to raise Capital Bid and submit to capital programme group. As at September 2022, requirements need to be reviewed and discussed with Dyfrig Mason.	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	22-Dec-22
														The department is committed to a long term joint managed service contract with ABMU commencing in 2025.	Jones*, Dylan	01-Jan-25	.						
														The service is committed to the ARCH Regional Pathology project, as the long term solution for Cellular Pathology.	Jones*, Dylan	01-Jan-28	.						

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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 Sub Committee	1	5	5	Treat	06-Dec-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	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 an 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 in warmer seasons 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. Daily monitoring of temperatures in rooms and checking comfort levels	Safety - Patient, Staff or Public	6	3	4	12	Obtain funding for ventilation unit.	Thomas, Huw	~~31/03/2022~~ 31/03/2023	Quote has been obtained (approx. £8.5k). Capital bid has been submitted, awaiting approval.	Health and Safety Committee	2	2	4	Treat	23-Jan-23

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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	3	4	12	Consider alternative temporary storage arrangements.	Hawkes, Jina	Completed	Visit arranged to view the container in Cardigan, any space within the container will only temporarily ease the local situation	Health and Safety Committee	1	4	4	Treat	16-Jan-23
														Awaiting additional guidance from Information Governance to enable scoring system for prioritization of storage	Hawkes, Jina	Completed	No guidance has been issued						
														In line with Information Governance processes; organise a catalogue of boxes to be removed from local sites to the centralised store	Hawkes, Jina	Completed	Information and Governance have sent through storage process requirements in April 2022; work is underway to prioritise and catalogue contents of boxes						
														In line with Information Governance processes; implement the removal of achieved boxes into long term storage	Hawkes, Jina	Completed	Addition scoring guidance is being developed						
														Explore opportunities of combining this risk with the similar risk associated with acute sites	Hawkes, Jina	Completed	Ceredigion County Director has communicated challenges with head of Information Governance						
														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						
														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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														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.						
														Source Interim storage arrangements	Rees, Gareth	Completed	Temporary storage facilities were erected at Cardigan Integrated Care Centre w/c 2/12/19						
														Respond to Head of Information Governance requesting his opinion for how the situation may be managed.	Hawkes, Jina	Completed	Communication commenced						
														HDUHB wide Physical solution to be achieved	Skitt, Peter	Completed	Paper going to Information Governance Sub Committee on the 12/10/21						
														Develop whole system engagement	Skitt, Peter	Completed	Ceredigion County Director to establish 3 County group						
														Plan for the removal of boxes from local sites to the centralised store	Hawkes, Jina	Completed	Paper raised, awaiting response from Information and Governance. Email sent to Information and Governance;						
														Escalate the need for a HDUHB wide Physical solution to be achieved	Skitt, Peter	Completed	Discussions with Senior decision makers is on-going. Director of Nursing, Quality and Improvement aware of the situation. The situation has been raised and escalated.						
														County Director to work with senior HB colleagues to determine long term storage arrangements	Skitt, Peter	Completed	Assurance has been given to the Health Records Manager that boxes are adhering to guidance						
														Health Records Manager to obtain the resources required to enable the boxes to be moved	Skitt, Peter	30/03/2023	Communications have commenced between the Health Records Manager and Head of Finance to obtain the resources required						

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1515	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	Carmarthenshire	Dawson, Rhian	Cameron, Sarah	07-Oct-22	There is a risk of non-compliance to health board policies relating to health, safety and fire at Elizabeth Williams Clinic. This is caused by the location of the site and the demographic surrounding it which requires permanent front of house support in order to monitor activities that occur on site and in the surrounding car park area, such as issues occurring that relate to security and also violence and aggression by members of the public towards health board staff. This will lead to an impact/affect on staff safety, increase of Datix incidents being raised, complaints from patients and visitors to the site who encounter issues including gangs who fight, consume alcohol, drugs and incite behaviour which is illegal and present infection issues. Risk location, Elizabeth Williams Clinic.	Existing staff manage the opening/closing of the site via a rota.	Safety - Patient, Staff or Public	6	3	4	12	Appoint a full-time front of house receptionist role, also ensure rotas are in place so staff are locking/closing up the site in pairs.	Toller, Heather	**Completed**	13/01/23 - New Band 2 receptionist has been recruited and starts in post on 17th Jan. Action can now be closed.	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	03-Jan-23
														Replace the current front door to include automatic closing mechanisms.	Toller, Heather	~~31/01/2023~~ 03/02/2023	13/01/23 - Submitted requested to estates, awaiting a formal quote back.						
														Review the access control systems for the building.	Toller, Heather	~~31/01/2023~~ 03/02/2023	13/01/23 - New security manager started in post this week, arranging a meeting to discuss.						
														Apply for lone worker devices and work with the violence and aggression officer.	Toller, Heather	**Completed**	13/01/23 - Devices has been offered to the services located on site. Local policing unit have added the site to the daily route by the PCSO's.						

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222	Directorate Level Risk		E&F: Operations Compliance	Elliott, Rob	Smith, Robin	01-Jul-12	There is a risk Avoidable harm to patients, visitors, staff and contractors due to exposure to asbestos through contact with 'Asbestos Containing Materials' (ACMs). Adverse Publicity through non compliance which may or may not be related to actual exposure risk. This is caused by Approximately 2700 known and recorded ACM's being present in the building fabric due to the age of some of the Health Board's (HB) estate. This will lead to an impact/affect on An uncontrolled release of asbestos fibres affecting staff,contractors, patients and the public. Possible enforcement action and prosecution in the event of HSE intervention in response to an incident, a complaint, or as a result of an inspection. Compliance with The Control of Asbestos Regulations 2012 & Asbestos Policy arrangements for Safety of Staff, Contractors, Patients and Visitors. Risk location, Health Board wide.	A comprehensive HB Asbestos Policy is in place. Asbestos Management Plans in both electronic and printed format available for each site containing Asbestos, based on Asbestos Management Surveys. Targeted Renovation and Demolition Surveys are also undertaken in advance of schemes. All samples undertaken for surveys and other investigations updated on the AMP's The condition of ACM's and protection where provided e.g. encapsulation is inspected annually Training of staff in Asbestos Awareness and cohort of estates staff at each acute site trained in Asbestos Non Licenced Work (NLW). Ongoing communications between Estates and other directorate managers on the reporting of building defects, and site specific asbestos issues. The control of contractors is exercised by Engaging Managers and Estates Officers. A holistic health board wide review of asbestos management has been undertaken and resulted in a new compliance team being implemented in 2022 including a compliance officer leading with asbestos management.	Safety - Patient, Staff or Public	6	3	4	12	Implementation of an all-digital asbestos management database system. Improvement of compliance by the inclusion of existing asbestos data relating to leased properties, and/or by commissioning new surveys of leased properties.	Smith, Robin Smith, Robin	~~31/03/2023~~ 30/06/2023 ~~28/02/2022~~ 26/05/2022	A potentially suitable system has been identified (Teams by Mark One Enterprises) which our asbestos re-inspection service provider is already using to log re-inspection and new survey data under their license. The effectiveness and suitability of the system will be evaluated upon completion of the re-inspection contract. Working with the property team to determine all leasehold properties and to determine the duty holder in in case. New surveys have been completed for Tenby, St Clements, and Johnston Branch surgeries.	Health and Safety Committee	1	4	4	Treat	05-Jan-23

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1413	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	MHLD: CAMHS	Carroll, Mrs Liz	Lodwick, Angela	22-Apr-22	There is a risk to our clients of potential self-harm attempts in our community clinical bases This is caused by not identifying potential PoL within rooms utilised for clinical space in our community settings This will lead to an impact/affect on patient safety if not risk assessed, monitored and managed annually Risk location, Health Board wide.	1. All children and young people have a WARRN Risk Assessment prior to be being assessed. 2. No lone working is undertaken in community premises where clients are allowed access. 3. Children are not left alone in Therapy Rooms	Safety - Patient, Staff or Public	6	3	4	12	Individuals need to be identified at each premises to undertake annual risk assessments, monitor and manage. Report to Stuart Bevan (Interim Service Manager)	Wade, Elaine	~~30/09/2022~~ ~~12/10/2022~~ ~~09/01/2022~~ 26/01/2022	In the process of appointing Locality Team Leads 3 in post awaiting start date for the last one. Once all in post they will be responsible for each of their localities	Quality, Safety and Experience Committee	1	4	4	Treat	26-Jan-23
														Developing a plan to undertake monitor and manage the risk assessments	Wade, Elaine	~~30/09/2022~~ ~~12/10/2022~~ ~~09/01/2022~~ 26/01/2023	Stuart Bevan has been in contact with Gerard - AL has asked Stuart Bevan for an action plan by 27.01.23						
														Undertake annual PoL risk assessments	Wade, Elaine	~~30/12/2022~~ ~~12/10/2022~~ ~~09/01/2022~~ 26/01/2023	Stuart Bevan due to meet Gerard to undertake the first of the PoL assessments in EWC on 27.01.23						

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1552	Service or Department Level Risk		USC: Pathology	Perry, Sarah	Jones*, Dylan	28-Feb-22	There is a risk of a lack of capacity in WGH mortuary to provide adequate storage for ward and community deaths. This is caused by the lack of storage units in the mortuary and is compounded by the fact that some of the units are not big enough to accommodate the increasingly larger bodies that are now coming into the mortuary. Also, the staff have now been advised not to use some of the units as they are difficult to access via the scissor lift in place (which does not reach the top and bottom units). Storage capacity would be further reduced if deteriorating body trays have to be removed from the units. This will lead to an impact/affect on the amount of pressure and time taken up by the team and the service's expenditure if there are not enough available storage units in the mortuary. In turn this adds extra pressure to other mortuaries in the health board as they have to accommodate the bodies. There is subsequently a potential impact on	1. 5 of the 25 storage spaces convert from refrigerator to freezer 2. Steps in place to access higher racks until a new scissor lift in place 3. Procedures in place for timely release of bodies following post-mortem 4. Monitoring of numbers of bodies against storage capacity 5. Business continuity plans in place 6. Contracts with local funeral directors to utilise storage of bodies 7. Bodies are relocated to other mortuary sites when needed e.g. GGH 8. Trainees are supervised at all times 9. Bariatric blanket available for short-term use 10. Procedural audits to ensure compliance with SOPs 11. All incidents and near misses recorded on Datix and QMS	Safety - Patient, Staff or Public	6	3	4	12	Scoping exercise to determine cost of installing new refrigeration (donated by Pembrokeshire council) to improve the service and reduce risk to users. Capital Bid to be drawn up.	Jones*, Dylan	31/03/2023	Update at next review	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	15-Dec-22

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							the rest of the Pathology service and outreach to other departments plus an increase in the cost of contract funeral directors having to store the bodies or transport them to other sites. It could also lead to an impact on the risk of injury to staff working in the body store (refrigeration bank) when receiving, releasing and storing bodies or when preparing them for a viewing e.g. through manual-handling incidents. Staff are unable to carry out SOPs correctly. Likewise, it could also lead to bodies being damaged when stored or transported which would compromise the dignity of the deceased (possibly resulting in relatives being unable to view them) and would subsequently require having to notify the Human Tissue Authority (HTA) as well as logging an incident on Datix. This is especially true for bariatric patients who are at a higher risk of being damaged by damaged and deteriorating surfaces on body store surfaces and equipment. There could therefore be a negative impact on the health board's reputation when it comes to providing a care after death service. Risk location, Withybush General Hospital.						Explore options regarding temporary body storage. Look at rental from Nutwell or loan from PCC	Jones*, Dylan	31/12/2023	Update at next review						

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1554	Service or Department Level Risk		USC: Pathology	Perry, Sarah	Jones*, Dylan	28-Feb-22	There is a risk of equipment-related incidents in WGH mortuary This is caused by deteriorating equipment such as the refrigeration units (which could fail at any time due to their age), the internal trays used to place bodies on (which have perished beyond repair and have become splintered and dangerous), the roller guides (which have also perished) and the air ventilation system (which has been the subject of some concern on recent viewings). Some equipment is now inadequate e.g. the scissor lift, used to access the body stores, which cannot go high or low enough to access the top and bottom storage units respectively. This will lead to an impact/affect on the staff working in the body store (refrigeration bank) who could be injured when receiving, releasing and storing bodies or when preparing for a viewing. Likewise, it could also lead to bodies being damaged when stored or transported which would compromise the dignity of the deceased, possibly resulting in relatives being unable to view them, and would subsequently require notifying the Human Tissue Authority (HTA) as well as logging an incident on Datix. This is especially true for bariatric patients who are at a higher risk of being damaged by damaged and deteriorating surfaces on body store surfaces and equipment. If the storage unit fails this would lead to decomposition of bodies, distress to relatives of the deceased, distress to staff (with a higher likelihood of staff sickness) and increased time and cost pressures if the bodies have to be transported to alternative storage facilities. There have been recent complaints from staff and visiting family members about the smell in the mortuary, a problem arising from the extraction unit failure.	1. Manual handling assessments undertaken and regularly reviewed 2. Manual handling training for staff 3. SOPs in place for use of manual handling equipment 4. 24/7 continuous temperature monitoring and alarm testing system in place to detect failure of body storage unit 5. Equipment is maintained to the best ability 6. All incidents and near misses, however minor, are reported on Datix and QMS 7. Trainees supervised at all times 8. Contingency plans in place for transporting bodies to alternative sites 9. Business continuity plans developed and reviewed for when units fail 10. Bariatric blankets available for short-term use 11. Step in place to assist safe access to top level of refrigeration units when using scissor lift	Safety - Patient, Staff or Public	6	3	4	12	Health & Safety have requested removal of trays from use at earliest opportunity.	Jones*, Dylan	31/01/2023	New action	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	15-Dec-22
														Capital Bid for Enabling works to accommodate New body storage	Jones*, Dylan	28/02/2023	New action						
														Enabling works to accommodate new body storage	Jones*, Dylan	31/07/2023	New action						
														Capital Bid for new scissor lift to fit with racking levels of new refrigeration	Jones*, Dylan	31/07/2023	New action						
														Capital Bid for new extraction system	Jones*, Dylan	31/07/2023	New action						

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							The inadequacy of the scissor lift means that mortuary staff and porters have to lift the bottom trays into the fridge when receiving or releasing bodies in the lower storage units and have to use a step to reach the highest units, both of which pose a manual handling risk. Staff are unable to carry out SOPs correctly. There is a potential impact on the rest of the Pathology service and outreach to other departments. There could be a negative impact on the health board's reputation when it comes to providing a care-after-death service. Risk location, Withybush General Hospital.							Purchase new concealment trolley.	Jones*, Dylan	31/12/2023	New ACTION						

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1367	Directorate Level Risk		Women and Children	Humphrey, Lisa	Humphrey, Lisa	29-Oct-21	There is a risk That women and children services estate are not fit for purpose, in particular community premises that provide care for Children and Young People and the Sexual Health Service. This is caused by Old underinvested estate which does not allow for safe clinical and therapeutic delivery for children and young people. This will lead to an impact/affect on Inability to provide timely access to care or expand capacity to meet current and expected demand. Inability to provide care in a safe physical environment e.g. clinical spaces do not meet clinical specification. Does not support multidisciplinary or therapeutic interventions due to lack of above causing extended waiting times in excess of 3 years for children and young people. Difficulty recruiting the appropriate workforce due to above. Wellbeing of staff impacted due to lack of reasonable rest facilities, office space and poor clinical working environment caused by poor estate as above. Lack of defined locations for the Sexual Health Service. Risk location, Health Board wide.	Temporary relocation of sexual health service from Pond Street clinic to Penlan, Carmarthen allowing increased capacity and appropriate clinical space and waiting area for patients.	Safety - Patient, Staff or Public	6	4	3	12	To establish the timeline of delivery for the Aberystwyth Integrated Care Centre	Skitt, Peter	30/11/2022	Directorate are included in the planning of the integrated care centre at Aberystwyth. The Aberystwyth Integrated Care Centre will include accommodation that is fit for purpose for the Sexual Health Service, the outpatient and ambulatory gynaecology service, the acute and community paediatric team and associated therapies, however confirmation on timescales are required from the County Director.	Capital Sub Committee	2	2	4	Tolerate	08-Sep-22
														To move the Sexual Health Service, the outpatient and ambulatory gynaecology service, the acute and community paediatric team and associated therapies to Carmarthen Integrated Care Centre	Humphrey, Lisa	31/12/2024	Directorate are included in the planning of the integrated care centre at Carmarthen town centre. The Carmarthen Integrated Care Centre will include accommodation that is fit for purpose for the Sexual Health Service, the outpatient and ambulatory gynaecology service, the acute and community paediatric team and associated therapies. The project is on course to deliver in 2024.						
														To identify suitable accommodation in Pembrokeshire	Humphrey, Lisa	31/12/2022	The sexual health service, in collaboration with Public Health Wales, are updating the local sexual health strategy and needs assessment which includes identification of a suitable fit-for-purpose accommodation within the Pembrokeshire county. As an interim measure, the sexual health service have registered their interest for inclusion in the development of the integrated care centre at Fishguard.						

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104	Directorate Level Risk		USC: Pathology	Perry, Sarah	Jones*, Dylan	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. Datix incident reporting system utilised to report and monitor any incidents. Collected by staff trained in handling clinical waste.	Safety - Patient, Staff or Public	6	4	3	12	Submit a capital funding application to Welsh Government.	Jones*, Dylan	~~30/11/2022~~ 31/01/2023	"As at September 2022, bid has been submitted and awaiting outcome and notification from NWSSP. Capital Bid via HB must be submitted first (Submitted in Nov-22)"	Operational Quality, Safety and Experience Sub Committee	1	3	3	Treat	22-Dec-22

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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	Following the internal audit recommendations, risk assessments are being completed for all community facilities across the Directorate.	Carroll, Mrs Liz	**Completed**	Community facilities have been audited and are now in an annual cycle. These are considered a managed risk.	Operational Quality, Safety and Experience Sub Committee	2	5	10	Tolerate	13-Dec-22
														Exceptional review of the risk will be held during August.	Carroll, Mrs Liz	**Completed**	Points of Ligature audit undertaken and action plan developed. All actions are on target for closure following review today. All service level risk assessments have been completed.						
														Audit tool and process for resolving and escalating estates work in relation to point of ligature risks has been developed. Some areas awaiting training. Standing item on Accommodation Strategy Group meeting.	Isaacs, Kay	31/12/2022	New action.						
														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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														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	Completed	No standards have been forthcoming. Operational services will undertake environmental risk assessments and have risk management plans in place to ensure safety.						
														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.						
														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 31/03/2023	Estates Advisory Board has been awarded addition funding for Point of Ligature capital improvement work during the 2021/22 financial year. Schemes have experienced some delays in terms of contractor availability on site. Works are continuing to progress within revised timeframe. These have re-scheduled for finalising at the end December 2022.						
														The Directorate is allocated circa Ã‚£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).						

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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 pedestrian 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 Committee	1	5	5	Treat	05-Jan-23
														"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	"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. "						
1304	Service or Department Level Risk		Scheduled Care: OPD	Hire, Stephanie	George, Helen	15-Nov-21	There is a risk that staff in Outpatients B will be unable to alert other staff in the department if there is an emergency (eg threat of violence or patient becomes acutely unwell). This is caused by there not being an emergency call bell system in Outpatients B. This will lead to an impact/affect on staff and patient's safety as there could be a significant delay in assistance arriving to the emergency. Risk location, Withybush General Hospital.	Outpatients has a large nursing staff team. There is often other staff in close vicinity and within earshot within the department that could be called upon to assist in the event of an emergency. There is no lone working in the department. There are telephones in all rooms that can be used to contact others in an emergency, for example, 2222 in the event of a cardiac arrest or 2222 â€œcode Georgeâ€•/999 in a situation involving an aggressive patient. All staff are aware of the emergency procedures in place. Staff have completed Violence and Aggression training and BLS/ILS training.	Safety - Patient, Staff or Public	6	2	5	10	Install call bell system in Outpatients B.	Kennard, Annmarie	~~31/03/2022~~ ~~30/06/2022~~ 31/03/2023	Estates are currently arranging with an outside company for the quote. Fire Officer has visited department to scope. Discussions taking place with SM regarding funding. Further update to be established.	Operational Quality, Safety and Experience Sub Committee	1	5	5	Treat	23-Jan-23
														A Capital Bid has been submitted -	George, Helen	31/03/2023	More information to follow.						

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93	Directorate Level Risk		USC: Pathology	Perry, Sarah	Jones*, Dylan	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.	Jones*, Dylan	~~30/09/2021~~ 30/11/2021	Capital works currently progressing, with confirmation to be sought from contractors on final completion date. Chaser e-mail sent Sept 22 for progress update.	Operational Quality, Safety and Experience Sub Committee	1	5	5	Treat	22-Dec-22
														Reconfigure Consultant office and replace with a Containment level 2 laboratory space with Class 2 cabinet to support processing of non gynae specimens.	Jones*, Dylan	~~29/10/2021~~ 30/11/2021	Chaser e-mail sent Sept 22 for progress update.					

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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 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.	Operational Quality, Safety and Experience Sub Committee	1	5	5	Treat	15-Sep-22
														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.						
														Synbiotix meal ordering / clinical sign off screen implemented in WGH / GGH / PPH. not BGH due to foodservice model.	Jones, Peter	~~30/12/2022~~ 30/03/2023	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.						
														All cooks and supervisory staff to undertake Level 2 Allergen Training	Jones, Peter	**Completed**	"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"						

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503	Service or Department Level Risk		E&F: Fire	Elliott, Rob	Evans, Paul	06-Dec-17	There is a risk avoidable harm to 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 plus sized patient 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 plus sized 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. Plus sized patient 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	Task and finish group required with Manual Handling teams to review this risk in detail with the fire safety team. To formally agree the	Evans, Paul	Completed	Completed	Health and Safety Committee	1	5	5	Treat	24-Jan-23
														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.					
														With the T&F group now established for this, led by the Manual Handling Team and the Fire Safety Team, we need to be able to draw a full conclusion and assess the risk to the HB.	Evans, Paul	Completed	Completed -						
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	"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 Ã‚£70k. □ EFAB bid to Welsh Government has been submitted in November 2022, awaiting outcome."	Health and Safety Committee	1	5	5	Treat	17-Nov-22

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1376	Service or Department Level Risk		MHLD: Older Adult Mental Health Services	Mason, Neil.	Davies, Guto	11-Nov-21	There is a risk suicide attempts by people admitted to older adult mental health wards using available ligature points on the Older Adult Mental Health Inpatient Ward environments. This is caused by a mixed clinical cohort of people admitted to Older Adult Mental Health Wards, with some experiencing serious functional mental health problems and suicidal phenomena, alongside people living with complex, advanced dementia, frailty and comorbidities. Reasonable consideration needs to be applied in an anti-ligature (reduce the risk of self-harm) approach, to avoid inadvertently raising one risk whilst lowering another, to ensure balance against other fixtures and fittings designed to help people living with dementia to mobilise and navigate safely to maintain independence. This will lead to an impact/affect on 1.Patient safety (falls/hip fractures), self-harm injury, accident or death 2.Levels of patient and public confidence and experience of safe effective care delivery 3.Staffing levels to safely manage the scope of nursing practice this wide range of needs requires 4.Staff wellbeing, confidence and morale whilst attempting to meeting a broad scope of practice within two different clinical cohorts with widely different sets of need 5.Limitations of ward environmental design and psychological milieu whilst catering for diverse clinical cohorts Risk location, Health Board wide.	1. Annual Ligature Anchor Point Audits undertaken and Managers along with review of risk mitigation and resultant action plan. 2. Ligature Anchor Points where the ward staffs are unable to mitigate (procedural & relational security measures) are identified (via annual Audit) with recommendations to remove escalated to the Accommodation Strategy Group, Quality, Safety Experience Group and BPPAG). 3. Ligature Anchor Point Audit is [electronically] available to all Ward Staff in order to raise and maintain awareness to integrate into day to day clinical risk management. 4. Each older adult mental health inpatient ward has a suite of bedrooms modified and designated as low ligature risk environments for patients assessed with suicide risks and are therefore also subject to greater observations levels proportionate to assessed risk. 5. Rooms not classed as low Anchor Point rooms, are design compliant with dementia friendly standards and patients assessed as low suicide risks placed in these rooms. 6. Mental Health and Wales Applied Risk Research Network (WARRN) Risk Assessments applied for each admission to identify and manage needs and risks. 7. Clinical Pathway Lead wraps around risk management oversight for older adults with suicide risk on the Older Adult Mental Health Pathway (Wards & Community). 8. Observation & Engagement Policy applied upon admission subject to frequent multidisciplinary clinical risk management review. 9. Significant changes in individual clinical risk presentations are escalated to, and reviewed within, the Ward Multidisciplinary team. 10. Operating arrangements are in place to determine the most suitable inpatient ward based upon need/risk as opposed to a delineated age cut-off, which can afford a higher risk presentation being in lower risk environment (e.g. Adult Mental Health Ward). No update 20/06/22 until the SOP is ratified in the next WCDG meeting 18th July 2022	Safety - Patient, Staff or Public	6	2	5	10	85% Registered mental health nurses to have completed Wales Applied Risk Research Network (WARRN) Training	Davies, Guto	31/03/2023	Operational capacity compromised due to vacancies, course cancellations and acuity. In the process of collating of data.	Operational Quality, Safety and Experience Sub Committee	1	5	5		22-Nov-22
														85% Registered mental health nurses trained in STORM Suicide Prevention Training	Davies, Guto	31/03/2024	Operational capacity compromised due to vacancies, course availability and acuity. In the process of collating of data.						
														85% Registered and un-registered staffs to complete the following recommended learning: Suicide Awareness (Health Board Intranet eLearning)	Davies, Guto	31/03/2023	Operational capacity compromised due to vacancies, and acuity. In the process of collating of data.						
														85% Registered and un-registered staffs to complete the following recommended learning: Suicide Prevention (Health Board Intranet eLearning) We need to talk about Suicide	Davies, Guto	31/03/2023	Operational capacity compromised due to vacancies, and acuity. In the process of collating of data.						
														85% Registered and un-registered staffs to complete the following recommended learning: Suicide Awareness Training - Zero Suicide Alliance (Internet eLearning endorsed by Royal College of Nursing)	Davies, Guto	31/03/2023	Operational capacity compromised due to vacancies, and acuity. In the process of collating of data.						
														85% Registered and un-registered staffs to complete the following recommended learning: Suicide Awareness Training - Zero Suicide Alliance (Internet eLearning endorsed by Royal College of Nursing)	Davies, Guto	**Completed**	See action above, as duplicate						

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														85% Registered and un-registered staffs to complete the following recommended learning: Launch of WHO (World Health Organisation) LIVE LIFE - Guide on suicide prevention (Internet YouTube eLearning)	Davies, Guto	31/03/2023	Operational capacity compromised due to vacancies, and acuity. In the process of collating of data.						
														85% Registered and un-registered staffs to complete the following recommended learning: The hidden risks of suicide and depression for seniors living in long-term care (YouTube Internet eLearning)	Davies, Guto	31/03/2023	Operational capacity compromised due to vacancies, and acuity. In the process of collating of data.						
														Older Adult Community Mental Health Team appointed Care Coordinators to continue Care Coordination [and see] the service user throughout the inpatient stay of any patient identified with suicide risks, and will proactively lead discharge process and associated MDT positive risk taking plans.	Hayward, Lydia	**Completed**	Care co-ordinators continue to provide, however acknowledge the frequency can be impacted by teams' acuity levels and proximity to the wards especially for Ceredigion south based staff and North Carmarthenshire CMHT staff in the main.						
														Review the demand, capacity, capability and suitability of Older Adult Mental Health Services to continuing to offer an inpatient service for two clinical cohorts. Produce an options appraisal for BPPAG in the form of an SBAR.	Davies, Guto	31/03/2023	Operational pressures have hindered progress, aiming for initial draft at the end of December 22.						
														Ongoing - 85% Registered mental health nurses trained in STORM Suicide Prevention Training, Also to continue to complete recommended learning.	Davies, Guto	31/03/2024	see action above, as duplicate.						

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949	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting 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 water-borne bacteria within water systems and air conditioning systems. 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.	Currently a frequent flushing regime is in process with extended temperature testing and monitoring. Constant problems are being recorded in all areas and flushing in progress. Further temperature monitoring required and detailed work on removal of dead ends / legs are required. Pipes identified as large are removed as required.	Safety - Patient, Staff or Public	6	2	5	10	Further temperature monitoring required and detailed work on removal of dead ends / legs are required. Pipes identified as large need to be removed.	Elliott, Rob	30/09/2022	No further progress only maintenance carried out.	Capital Sub Committee	1	2	2	Treat	06-Dec-22
														Electronic monitoring is showing deficiencies in temperatures and schemes are not removing Dead Ends as are being identified. Escalation of risk will be required if further pathogen samples return Positive.	Elliott, Rob	~~09/07/2022~~ 31/03/2024	Further electronic monitoring required, to be considered in 2023/24 Capital bid.						
														Constant problems are being recorded in all areas and flushing in progress.	Evans, Duncan	25/11/2022	No further progress to report.						
														Further Bacterial testing of the water supply in the kitchen is showing an exposure risk to Legionella again. 60cfu in 100ml. Flushing in process.	Evans, Duncan	24/11/2022	No further progress available as eliminating all the time but remerging constantly indicating a flow and return problem with temperatures.						
														Replacement of pipes in kitchen.	Evans, Duncan	31/03/2023	Capital bid to be submitted. We have planned and identified works required, awaiting quote from contractors.						
														Very high legionella scores have been detected in Residential blocks and has been entered as a separate Datix to the main Hospital.	Elliott, Rob	30/12/2022	All shower heads are being cleaned and plans being drawn up for Chlorination. Please refer to Datix filed for Residences.						
														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.						

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														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.						
														Continual flushing, Temperature monitoring and extra maintenance required	Elliott, Rob	**Completed**	Action closed- the process of continuous monitoring is in place.						
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 Committee	2	3	6	Treat	27-Sep-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	**Completed**	"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. Re-lining of the lower staff PPH car park was completed in August 2022 to increase the available capacity of existing car parking areas "						

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														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	31/01/2023	"The Health Board is currently engaging with the Gwili Railway on their future car park development. A paper has been submitted to the Director of Operations for consideration in respect of shared use of the Gwili Railway car park.£55k recurrent investment needed to enable this. Anticipate potential completion date of new development by Winter 2022"						
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	~~31/08/2021~~ 06/11/2021	"No budget available for 2021/2022 Awaiting Allocation for 2022/2023"	Health and Safety Committee	2	3	6	Treat	06-Dec-22

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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. Therapy Hub created in GGH and MSK physio relocated to Alun Ward Hafan Derwen relocation of MSK Service BGH to CCC Rheidol Building Provision of Neurotherapy Dept in PDH / GGH	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	12-Oct-22
														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	**Completed**	Completed						
														Relocation of Physiotherapy Dept, Priory Day Hospital GGH to Therapy OPD area GGH	Reed, Lance	**Completed**	Completed						

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1425	Service or Department Level Risk		Cancer Services	Humphrey, Lisa	Beard, Gina	04-Jul-22	There is a risk of immunosuppressed patients attending treatment at PPH and GGH of becoming further unwell due to increased opportunity for contact with others and the inability to observe isolation requirements. There is also a risk that the HB will not be able to accommodate additional oncology clinics in the future This is caused by inadequate facilities and lack of appropriate clinical space for patients attending for Oncology outpatients at GGH and PPH, along with an increase in activity. This is further exacerbated due to staffing levels, with no dedicated HCA for the service. Tertiary provider (SBUHB) increasingly requesting additional outpatient accommodation at Carmarthenshire as consultants will not travel to Pembrokeshire or Ceredigion. South West Wales Cancer Centre Strategic Programme Case sets out plans that visiting consultant oncologist will no longer travel to Pembrokeshire or Ceredigion This will lead to an impact/affect on compromising the safety of those being on treatment by a heavy footfall in the unit, and their privacy and dignity of care. There are no waiting areas as a result of Covid, and the restrictions remain in place for the Oncology service. This could also lead to an inability to provide outpatient oncology capacity that meets the needs of the patient group. Risk location, Glangwili General Hospital, Prince Philip Hospital.	Limit family members attending with the patient to 1 (outpatients) to reduce footfall. Advice provided to those attending the unit to not arrive early and to wait in the car in order to reduce footfall on the sites. Advice given to not attend should they display any symptoms of Covid, or being generally unwell. Continue to observe Covid protocols (isolation, masks, PPE etc). Appointments made, with efforts made to ensure they are kept to time to reduce the number of patients waiting. Where possible, consideration also given to undertaken appointments virtually.	Safety - Patient, Staff or Public	6	3	3	9	Discuss with site managers for GGH and PPH the possibility for portacabins on site to accommodate as temporary measures	Beard, Gina	~~31/01/2023~~ 28/04/2023	ongoing	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	24-Nov-22
														Identify and work alongside hospital management alternative locations to deliver the outpatient service.	Beard, Gina	07-Jun-23	Met with estates and environment audit to be carried out against current compliance (awaited)						
														To include in future IMTP Submission.	Bennett, Debra	~~06/12/2022~~ 28/04/2023	Progress to be provided at next risk review. On agenda to discuss at IMTP meeting on 25/01/2023						

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1365	Service or Department Level Risk	Standard 3.1 Safe and Clinically Effective Care	MHLD: AMH Inpatient Services	Carroll, Mrs Liz	Bassett-Gravelle, Ms Lisa	10-Mar-22	There is a risk to patients in respect to medical clerking, treatment plans and review of care There is a requirement in respect to the Mental Health Act 1983 Code of Practice (chapter 36) as "every patient must h This is caused by a deficit in our adult mental health medical workforce staff. This will lead to an impact/affect on substantive medical arrangements at required grades on our in-patient wards and community teams being inadequate, and being non-compliant with the requirements of the MHA1983 Code of Practice. Risk location, Carmarthenshire, Ceredigion, Pembrokeshire.	Twice daily mental health bed conference to confirm medical cover arrangements for following 24 hour period Weekly meeting to agree cover arrangements in all areas where there is a deficit. This meeting is chaired by the Clinical Director in attendance are medical staff, Mental Health Act administration colleagues, senior nursing staff, clinical staff, head of service, pharmacy and advanced nurse practitioners Internal transfer of patients as required to meet their needs Continued liaison with Medical Workforce in respect of medical recruitment.	Safety - Patient, Staff or Public	6	3	3	9					Operational Quality, Safety and Experience Sub Committee	2	3	6		06-Jan-23

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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	Safety - Patient, Staff or Public	6	3	3	9	Develop action plans including costs and savings associated with each specific work stream identified at the HRMPG.	Rees, Gareth	Completed	The Health Board has decided to take a different approach to the digital record project and whilst financial savings will be identified it will be through working directly with services as they become digitally ready.	Information Governance Sub Committee	2	3	6	Treat	03-Jan-23
														Implementation 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.						
														Develop a business case for the implementation of a scanning solution to deal with long term issue.	Rees, Gareth	Completed	The business case is no longer required as the health board has taken a different approach to scanning and implementing digital records. Funding has been allocated within the Organisation allowing a mix of private scanning and in house scanning over an agreed period of time.						
														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.						

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								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. Scanning of 227,500 non active records						Identify additional storage capacity to negate the immediate risk within the health records service.	Bennett, Mr Steven	**Completed**	A suitable storage facility has been identified on an industrial estate in Llanelli and the lease was finalised, signed off and occupancy commenced from the 28th March 2022.						
														Re-implement annual weeding programme within the health records service for appropriate non-active records.	Bennett, Mr Steven	**Completed**	Weeding plans now fully implemented.						
														Complete weeding process for 2020 non active patient records	Bennett, Mr Steven	30/11/2023	Weeding process has now commenced.						
														Introduce an internal scanning bureau within the offsite storage facility.	Bennett, Mr Steven	29/09/2023	Tender document developed ready for submission and cost identified.						

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1567	Service or Department Level Risk		USC: Pathology	Perry, Sarah	Jones*, Dylan	10-Oct-22	There is a risk of the Human Tissue authority (HTA) assessing the mortuary and having good grounds to note that the mortuary is not meeting the necessary standards with regards access to CCTV This is caused by the mortuary facility at GGH not being able to access the CCTV that is based in the HUB room. The HTA require, as per their standards and guidance that, " Premises are secure (for example there is controlled access to the body storage area(s) and the use of CCTV to monitor access). Security arrangements should be robust, with effective mechanisms to strictly control access. Security arrangements must protect against unauthorized access and ensure oversight of visitors and contractors who have a legitimate right of access. Several attempts have been made to communicate this with the Security department in Hywel Dda. As it stands, if the mortuary had a Security breach. We would not be able to access CCTV. This means any serious incident where security	1. Swipe card access at each entrance 2. Digital code locks on internal doors 3. Contacted Head of security to review the CCTV	Safety - Patient, Staff or Public	6	3	3	9	Review and obtain quote for advanced security system for internal and external doors	Jones*, Dylan	31/01/2023	Action to be updated at next review	Health and Safety Committee	2	2	4	Treat	11-Jan-23

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							procedures are breached, in areas covered by the HTA license, we would risk losing our licence. This will lead to an impact/affect on the outcome of any HTA inspection and makes it difficult for the mortuary to control or deal with any security issues. Should access not be obtained and action taken immediately to resolve this, it will result in the HTA viewing this as a critical shortfall where there is risk to human safety and/or dignity. A breach of the Human Tissue Act 2004 the following actions may be taken. •Possible revoking of the HTA license •Some or all licensable activity ceasing with immediate effect. At a service level this will impact on the mortuary effectively undertaking Post-mortems for the Corners service impacting on. •A loss of revenue •Disruption to the coroner's service •Ineffective mortuary service, poor reputation. The impact of not ensuring the safeguarding of staff, bodies stored on site and the facilities as a whole will not only compromise but also effect/impact; •Safety & wellbeing of staff •Information governance •Dignity of the deceased •Distress to relatives of the deceased •Adverse publicity •Lack of confidence Risk location, Glangwili General Hospital.						Organise with Head of Security a contract company to review and gain access to the CCTV system	Jones*, Dylan	31/01/2023	Action to be updated at next review						

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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 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, Prince Philip Hospital.	Visual inspections and Planned Preventative Maintenance (PPM) is in place to check systems.	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	"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.Alterations to the endoscopy area will be dependant on TCS outcome for PPH 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 "	Capital Sub Committee	1	3	3	Treat	17-Nov-22

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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	The operations managers are looking at the quotes and seeking funding for the work from 2020 infrastructure backlog business case.	Health and Safety Committee	1	3	3	Treat	17-Nov-22
														Insulate pipework in the upstairs offices to address the Datix incident regarding excess temperatures.	Rosser, Brian	31/12/2022	Awaiting date from contractor to insulate.						
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 Committee	1	3	3	Treat	17-Nov-22
														New plant to be in place as part of new Cross Hands Health Centre.	Rosser, Brian	~~29/07/2022~~ 31/03/2024	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, however this work has been delayed due to Covid.						

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102	Directorate Level Risk		USC: Pathology	Perry, Sarah	Jones*, Dylan	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	Explore with Estates if there are any remedial measures that can be used to increase cooling in the room	Stiens, Andrea	**Completed**	Discussions have been held with Estates, with no alternative solution provided.	Operational Quality, Safety and Experience Sub Committee	1	3	3	Tolerate	22-Dec-22
														Submit capital bid to 2021/ 22 Capital programme.	Stiens, Andrea	**Completed**	New fridges procured in March 2022 via managed service contracts. Action complete.						
														To explore alternative strategies to manage the risk - frequency of fridges being replaced	Jones*, Dylan	30/12/2022	To be provided at next risk review						
														To explore alternative strategies to manage the risk - finding alternative locations for fridges	Jones*, Dylan	31/12/2022	To be provided at next risk review						
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, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital.	Trolleys serviced yearly and repaired where parts are available. Trolleys regularly cleaned and checked by staff.	Service/Business interruption/disruption	6	3	3	9	Capital bid for replacement to be submitted.	James, David	**Completed**	Awaiting submission.	Operational Quality, Safety and Experience Sub Committee	1	1	1	Treat	13-Dec-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~~ 30/05/2022	New action.						

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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	Matthews, Rhian	Swinfield, Anna	18-Aug-20	There is a risk that Managed Practices premises are not wholly compliant with the current national and local guidance and law. This is caused by the lack of awareness and technical knowledge within the Primary Care team to initiate the necessary estates changes to comply with law (e.g. H&S, Fire regulations, IP&C, etc). This can be difficult, and delayed, due to buildings being in the ownership of private landlords (retired partners) who can fail or be slow to engage. This will lead to an impact/affect on patient safety/care in an appropriate environment and staff safety and wellbeing. Potential closure of a managed practice (as the case with Johnston Surgery, January 2023). Risk location, Carmarthenshire, Pembrokeshire.	Infection control action plans have been completed. A programme of building works has been undertaken in winter 22/23.	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 MeddygfaÃ¢'r Sarn due to the poor quality of the building)	Swinfield, Anna	~~01/09/2022~~ 31/03/2023	Work for the main priority areas across all sites, risk levels will reduce once work is underway. The waiting area in Sarn has been identified as a key priority as this is obstructing the practice unlocking the doors to patients. Assurance has been provided by the estates team that ongoing work will be concluded by March 2023 and within the £330k allocated capital budget.	Operational Quality, Safety and Experience Sub Committee	1	1	1	Treat	01-Feb-23
														Review job plans in sustainability team to establish a named manager to lead on premises for the managed practices.	Swinfield, Anna	28/02/2023	New action.						

Health and Safety Theme Risk Register

Date: February 2023

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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	2	4	8	Centralise storage of SPC Team Equipment at CICES or by another provider.	Cameron, Sarah	~~04/11/2021~~ 28/02/2023	15/02 - Service Support Delivery Manager is currently reviewing new NHS Framework agreement for equipment with the County Director to form an approach. 07/04 - Meeting booked in with County Director on 26/04/22 to discuss. 09/05 - Meeting held and progressing actions. 08/08 - Senior Management to discuss to see if this in now a managed issue. 04/10 - On hold until a meeting with CICES has occurred to discuss alternative options. 03/01/23 - To be discussed at CICES Board this month.	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	03-Jan-23
														Servicing and Repairs undertaken at CICES or by another provider.	Cameron, Sarah	~~09/11/2021~~ 28/02/2023	15/02 - Service Support Delivery Manager is currently reviewing new NHS Framework agreement for equipment with the County Director to form an approach. 07/04 - Meeting booked in with County Director on 26/04/22 to discuss. 09/05 - Meeting held and progressing actions. 08/08 - Senior Management to discuss to see if this in now a managed issue. 04/10 - On hold until a meeting with CICES has occurred to discuss alternative options. 03/01/23 - To be discussed at CICES Board this month.						

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														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~~ 28/02/2023	5/02 - Service Support Delivery Manager is currently reviewing new NHS Framework agreement for equipment with the County Director to form an approach. 07/04 - Meeting booked in with County Director on 26/04/22 to discuss. 09/05 - Meeting held and progressing actions. 08/08 - Senior Management to discuss to see if this in now a managed issue. 04/10 - On hold until a meeting with CICES has occurred to discuss alternative options. 03/01/23 - To be discussed at CICES Board this month.						
														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~~ 28/02/2023	15/02 - Service Support Delivery Manager is currently reviewing new NHS Framework agreement for equipment with the County Director to form an approach. 07/04 - Meeting booked in with County Director on 26/04/22 to discuss. 09/05 - Meeting held and progressing actions. 08/08 - Senior Management to discuss to see if this in now a managed issue. 04/10 - On hold until a meeting with CICES has occurred to discuss alternative options. 03/01/23 - To be discussed at CICES Board this month.						

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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	2	4	8	Requesting support from the ambulance service for fit testing, which will hopefully provide reassurance and confidence to staff. Review 'Attend Anywhere' and other digital platforms.	Richards, David Richards, David	**Completed** ~~30/04/2021~~ ~~30/06/2021~~ ~~31/08/2021~~ ~~31/10/2021~~ ~~31/12/2021~~ ~~30/06/2022~~ 31/08/2023	Update and refresher session has taken place. Action complete but work is ongoing to work with colleagues for fit re-testing as required. '"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. Due to IT system failure we haven't explored this avenue further.	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	24-Jan-23

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														Administer vaccine to Out of Hours staff.	Richards, David	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.						
														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						
														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.	Richards, David	Completed	This work has now been concluded and will be fully operational from 10 July 2020						

Health and Safety Theme Risk Register

Date: February 2023

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														Introduce "Attend Anywhere" virtual consultation system to assist clinicians with reducing face-to-face requirements and enhancing quality of remote consultations.	Richards, David	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	Richards, David	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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742	Service or Department Level Risk	Standard 2.1 Managing Risk 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. 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.	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	**Completed**	completed	Health and Safety Committee	2	3	6	Treat	24-Jan-23
														Review security arrangements as smoking materials found outside of the office.	Humphreys, Helen	07-May-19	Agreed area secured from 9pm each night as within general hospital lock up.						
														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~~ 31/03/2022	"This will be completed as part of the phase 2 fire works at GGH as part of GGH enforcement letter managed by Jason Woods. "						
														Provide suitable emergency lighting.	Evans, Paul	**Completed**	"completed "						

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1356	Service or Department Level Risk		Scheduled Care: Ophthalmology	Hire, Stephanie	Hill, Carly	13-Aug-21	There is a risk There is a risk that the use of external transformers, also known as 'blue boxes', with the Optical Coherence Tomography (OCT) equipment might lead to harm to staff and patients. This is caused by This is caused by the fact that these boxes are a way to correct an electrical fault with the machines, being connected on one end to the machine and the other to the electric socket. This will lead to an impact/affect on This could lead to electrical faults taking place if the equipment is moved or disconnected and not connected back in the proper way, with the potential to become a fire hazard. It can also lead to falls of staff or patients due to trailing cables. There is potential for injury for staff moving or handling the equipment as the blue box weights 25kg and would need to be picked up from the floor and lifted and/or carried. Risk location, Aberaeron Hospital, Amman Valley Hospital, Cardigan Integrated Care Centre, Glangwili General Hospital, North Road Clinic, Prince Philip Hospital, Withybush General Hospital.	1. All staff within or supporting the Ophthalmology service, clinical and clerical, to be emailed with the risks associated to the use of the blue boxes and the ways to avoid them. 2. All staff to be made aware of and have access to risk assessment document. 3. All OCTs affected to be clearly identified as such using laminated signs placed on the machines, on the blue boxes and near the electrical socket in use. 4. All staff to be aware to not move these OCTs if possible. 5. Current equipment and attached blue boxes to be checked and deemed safe to use by Clinical Engineering, prior to start using them. 6. Use trekking where required to conceal electric cables and avoid risk of falls.	Safety - Patient, Staff or Public	6	2	4	8	Obtain from Topcon a permanent and reliable solution to the current arrangement, which will need to pass Clinical Engineering safety tests and remove all the risks highlighted.	Wilson, Jon	01/07/2022 30/09/2022	Awaiting company feedback. Update: Topcon continuing with works needed but no solution finalised yet.	Quality, Safety and Experience Committee	1	4	4		11-Oct-22

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1558	Service or Department Level Risk		USC: Pathology	Perry, Sarah	Jones*, Dylan	10-Oct-22	There is a risk of the Human Tissue Authority (HTA) assessing the mortuary and having good grounds to note that the mortuary is not meeting the necessary standards This is caused by mortuary facilities not being maintained and cleaned daily. The HTA require, as per their standards and guidance that " The establishment must be clean, well maintained and subject to a programme of planned preventative maintenance. Suitable environmental controls should be in place to avoid potential contamination." Mortuary facilities are currently not being cleaned daily or consistently. The following areas not cleaned and actions not taken: Bathroom areas cleaned and disinfected, showers cleaned and disinfected, floors brushed & mopped, walls wiped down, windows cleaned, gardens cut back, waste bins emptied. Soft furnishings and hard surfaces wiped and dusted. With no regular planned maintenance and cleaning schedule carried out on a regular basis, as a department we	Mortuary staff cleaning surface areas, emptying bins, brushing floors.	Safety - Patient, Staff or Public	6	2	4	8					Operational Quality, Safety and Experience Sub Committee	2	2	4		21-Dec-22

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							are failing to meet any standards as set by the HTA, safeguard staff and public and operate effectively. This will lead to an impact/affect on the outcome of any HTA inspection. Deterioration of the facilities. Risk of infection spreading, impacting not only on health but on staff sickness levels. Given the mortuary is already short of staff any sickness will thus weigh heavily on other staff, increasing levels of stress and anxiety. Irregular or no cleaning also impacts on those who visit the mortuary to see loved ones. It is evident that cleaning is not a regular occurrence or maintained to what should be a very high standard. To save face and in an attempt to minimise risks, mortuary staff are now undertaking some cleaning tasks. This adds pressure to the role of mortuary staff and impacts on the time, that should be used to undertaking other necessary mortuary duties. The impact of this not only weighs heavily on the designated individual, licence holder and mortuary staff but also the Health Board. The mortuary is a clinical area, which is not only															

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							is a clinical area, which is not only accessed by staff, but also the bereaved (public). This is where the bereaved come to view loved ones, some, under tragic circumstances and where staff operate a service not only for the Health Board but also for the Coroner's service. Should a maintenance and cleaning schedule not be maintained, and action taken immediately to resolve such inconstancy will result in the HTA viewing this as a critical shortfall where there is risk to human safety and/or dignity. A breach of the Human Tissue Act 2004 the following actions may be taken. •Possible revoking of the HTA license •Some or all licensable activity ceasing with immediate effect.At a service level this will impact on the mortuary effectively undertaking Post-mortems for the Corners service impacting on. •A loss of revenue •Disruption to the coroner's service •Ineffective mortuary service, poor reputation The impact of not ensuring the safeguarding of staff and the public that enter the mortuary potentially poses a risk to. •The mortuary department operating effectively •Increased workplace stress •Risk of infections, •Increased levels of staff sickness •Possible compensation claims •Bad publicity Risk location, Glangwili General Hospital.															

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1440	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	E&F: Carmarthenshire West	Elliott, Rob	Jones, Kevin	01-Aug-22	There is a risk of loss of cold and hot water services throughout the Hospital Site. Unable to undertake Statutory maintenance on the cold water storage tanks This is caused by cold water section panelling jointing compound is breaking down. Additionally the internal support rods have failed. Unable to drain down tanks for Statutory Maintenance This will lead to an impact/affect on wards and departments being without cold and hot water causing business interruption. Risk location, Glangwili General Hospital.	increase PPM`s to monitor Proposed to install a mains water by-pass received quote and engaged contractor to undertake modifications.	Service/Business interruption/disruption	6	2	4	8	Funding being sourced to address the leaking Cold water storage Tank	Jones, Kevin	31/03/2023	project feasibility request submitted to the Discretionary Capital Team	Health and Safety Committee	1	4	4	Treat	17-Jan-23
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~~ 31/07/2022	Action plan being progressed and to be fully implemented by March 2022.	Health and Safety Committee	1	4	4	Treat	06-Dec-22

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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 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.	Safety - Patient, Staff or Public	6	2	4	8	Request Capital money for 2023/24.	Jones, Kevin	30/04/2023	Bids have been submitted, awaiting outcome.	Health and Safety Committee	1	4	4	Treat	11-Jan-23
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	Need to arrange when ward decant can take place to allow flooring work to be undertaken.	Jones, Elfyn	~~31/03/2021~~ 06/11/2021	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.	Health and Safety Committee	1	4	4	Treat	06-Dec-22
														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.						

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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.	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). Staff working flexible hours to accommodate clinical commitments for F2F appointments. Staff travelling to different sites where capacity to see clients, this impacts on clinical time and carbon footprint and travel costs. H&S review undertaken in Llys Steffan to free up space for more therapy provision. Implementation of more group therapy sessions to increase capacity.	Safety - Patient, Staff or Public	6	4	2	8	Aim to introduce a SMS text facility to advise of clinical appointments to minimise delays this has been requested a number of times but the informatics team are unable to give a timeline of when this can be implemented. Virtual appointments are still offered where possible to reduce the footfall on accommodation and enable staff to work remotely. Not all modalities can offer online therapy as it is not suitable for clients in this format. Staff requests for condensed hours is becoming a popular request, however this is not always appropriate due to lone working risks. There are no dedicated premises for individual services and currently more than one service runs from a premise. Services are expanding yet the Estate does not accommodate the additional service/staff.	Marshall, Selina	28/02/2023	Due to limited accommodation in Hafan Hedd a risk assessment was being undertaken to review staff working on site. Ongoing contact with estates regarding outstanding works in Bro Cerwyn.	Quality, Safety and Experience Committee	2	2	4	Tolerate	12-Dec-22
														Increase of AA (attend anywhere) virtual platforms to reduce the need for accommodation.	Marshall, Selina	31/03/2023	New action						
														To undertake a review of the number of staff working condensed hours in order to accommodate clinical commitments for face to face appointments.	Marshall, Selina	31/01/2023	New action						

Health and Safety Theme Risk Register

Date: February 2023

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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 Committee	1	4	4	Treat	06-Dec-22

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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	Water Board Inspection has picked this up and we are awaiting the report.	Elliott, Rob	20/01/2023	No Further progress.	Capital Sub Committee	2	1	2	Treat	18-Nov-22
														No further works planned for pipelines as funding required.	Elliott, Rob	31/03/2022	No further progress carried out.						
														No action taken on changing the position of the water pipe size or valve replacement. Observations have indicated further problems during firecode works.	Elliott, Rob	30/09/2022	Further progress required.						
														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.						
														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.						
														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.						

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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	Included in Capital infrastructure renewal plans.	Capital Sub Committee	2	1	2	Treat	07-Dec-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.						
														These units are external and are suffering severe corrosion.	Elliott, Rob	30/03/2023	No further progress.						
1461	Service or Department Level Risk	Standard 2.6 Medicines Management	P,C,LTC: Medicines Management	Pugh-Jones, Jenny	Rees, Stuart	11-Jul-22	There is a risk There is a risk that the lack of suitable storage of Controlled Drugs in non-Health Board premises may reduce the ability of the CDAT service to offer local services in some areas of the Health Board. This is caused by This is caused by a shortage of suitable Health Board premises which CDAT can work from in some areas of the Health Board (e.g. Llanelli) This will lead to an impact/affect on This will lead to an impact on clients who are unable to access the full range of services (e.g. Buvidal) locally which may reduce engagement and lead to worse outcomes for clients and an inequity of access. It will also lead to CDAT staff having to transport Controlled Drugs to and from the clinics from the nearest hospital pharmacy which reduces the clinic time available for clients. Reputational damage to Health Board. Risk location, Carmarthenshire.	2 x CDAT staff collect Controlled Drugs from the nearest hospital pharmacy and return any unused medicines to the hospital pharmacy at the end of clinic. 2 x CDAT staff used to increase security and protection of staff. Current CD cupboard suitable for temporary supervised storage during the clinic session LIN & MMOG have approved the current protocol'COMMUNITY DRUG AND ALCOHOL TEAM STANDARD OPERATING PROCEDURE FOR THE HANDLING AND SAFE KEEPING OF BUVIDAL IN NON-HEALTH BOARD PREMISES FOR THE DURATION OF BUVIDAL ADMINISTRATION CLINICS'	Safety - Patient, Staff or Public	6	2	4	8	Identify suitable HB (preferably) or non-HB premises where Controlled Drugs can be stored securely between clinics in accordance with CD storage regulations.	Dainton, Joanna	04-Mar-23	The Area Planning Board for Substance Misuse is making progress with regard to developing a new base in Llanelli. The current plan is for this to be a new HB property which should help with the storage of controlled drugs.	Quality, Safety and Experience Committee	1	2	2	Treat	25-Aug-22

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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 occurring. Inspections being carried out by Estates staff but there is not a great deal that maintenance are able to do.	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	New quotes to be required, after which a Capital bid will be raised.	Health and Safety Committee	1	1	1	Treat	06-Dec-22
														Further reports that there is still slippage happening at the Hospital. Unable to close off as this is the main entrance.	Elliott, Rob	30/12/2022	No further progress.						
														Brick Walkways are deteriorating and larger gaps appearing. Filling put in to minimise gaps but do not last long.	Elliott, Rob	23/03/2023	No further actions.						
														Inspections being carried out but there is not a great deal that maintenance are able to do.	Elliott, Rob	24/09/2021	No further progress to report.						
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 has been submitted to complete recommendations.	Capital Sub Committee	1	1	1	Treat	07-Dec-22
														No further progress on the report received from a commercial gas contractor.	Elliott, Rob	25/03/2022	No further progress.						

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1007	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	E&F: Directorate Team	Elliott, Rob	Jones, Peter	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 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.	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 . 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	Safety - Patient, Staff or Public	6	2	3	6	All relevant portering staff to receive face to face V&A training.	Jones, Peter	Completed	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 Safety Committee	2	3	6	Treat	15-Sep-22
														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.						

Health and Safety Theme Risk Register

Date: February 2023

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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 Sub Committee	1	3	3	Tolerate	30-Sep-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 Sub Committee	1	3	3	Tolerate	08-Aug-22

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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 Sub Committee	1	3	3	Tolerate	08-Aug-22
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 Sub Committee	1	3	3	Tolerate	17-Jan-23

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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 Committee	2	1	2	Treat	24-Jan-23
														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.						

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														Following policy approval, department now need to fully implement the new system and procedures acros the HB.	Evans, Paul	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 March 2023, as agreed in ARAC. The compliance team have now decided to undertake a deep dive on this to assess the level of assurance we can take from the systems we have in place. This will be started in June and will take 2/3 months to complete. Paper being submitted to HSAC in July 22 providing the committee with what systems we have in place and what our gaps are and a delivery programme for completion. We have agreed a full review of this and provided dates to the HSAC."						
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	The wiring in places is in a poor condition which has been exposed by the firecode works.	Elliott, Rob	24/09/2021	No progress to report.	Capital Sub Committee	2	1	2		08-Nov-22

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
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 installing a new additional VIE bulk oxygen cylinder therefore giving the site a potential new oxygen flow rates from 2500 L/min to 6500 l/min. These figures are given by BOC. 2. A new ring main arrangement has been incorporated improving site capacity to deliver oxygen but and 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	1	5	5	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	28-Nov-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	Further capital bids to be submitted once budget costs are attained						
														Removal of Saunders type isolating valves from system to achieve maximum flow through diameter of pipe.	Jones, Kevin	~~31/12/2020~~ 31/12/2021	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	**Completed**	Action completed						
														Need a suitable connection point for a temporary supply.	Jones, Kevin	**Completed**	Now complete						

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1416	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	MHLD: Older Adult Mental Health Services	Mason, Neil.	Hayward, Lydia	28-Apr-22	There is a risk There is a risk of attempts of self-harm by those attending assessment appointments in community settings. This is caused by This is caused by a mixed clinical cohort of people attending assessment appointments, with some experiencing serious functional mental health problems and suicidal phenomena, along with people living with dementia, frailty and comorbidities. Additionally, environmental settings may present the opportunity for an individual to self-harm. This will lead to an impact/affect on 1.Patient safety (falls/hip fractures), self-harm injury, accident or death 2.Levels of patient and public confidence and experience of safe effective care delivery 3.Staffing levels to safely manage the scope of nursing practice this wide range of needs requires 4.Staff wellbeing, confidence and morale whilst attempting to meeting a broad scope of practice within two different clinical cohorts with widely different sets of need 5. Reputational damage to the Service and Health Board, complaint and litigation risks Risk location, Carmarthenshire, Ceredigion, Pembrokeshire.	1. All Service Users attending the premises are referred by their GP, or subject to part 3 of the Welsh measure (previously under the care of the team) and so screened for Risk using the Mental Health Triage Screening Tool (a reliable and valid algorithm). Service users risk profiles attending the CMHT base appointments are known in advance, and appropriate arrangements in place to supervise the patient on site based on their profile. 2.Entrance door to the premises is electronically-locked (managed entries) so entry is controlled. This assists with the management of patients who may present at the site without appointment, as the duty officer can then risk assess the individual as noted per control measure 1. 3.Service users are generally accompanied by a carer/relative due to the nature of their condition, or conveyed via transport therefore accompanied and supervised. 4.Very few areas on site where individuals are not supervised in order to balance dignity of care with the risk. However, due to the supervision of all clients on site, client activity is closely monitored, and facilities can be accessed by staff should there be any concerns regards to their welfare.	Safety - Patient, Staff or Public	6	5	1	5	Following the introduction of the revised policy, training has been requested and is awaited.	Harrison, Tim	~~01/01/2023~~ 12/06/2023	Training planned for 13/12/2023 on POL's.	Operational Quality, Safety and Experience Sub Committee	5	1	5		04-Jul-22
														Reassess each of the Community Team Bases in accordance to the new Assessment and Management of Environmental Ligature Risks Procedure 1069	Hayward, Lydia	~~04/01/2023~~ 30/07/2023	In process						
														Complete (Business & respective Team Manager) the Mental Health Learning Disability Ligature Point Audit Sheet for each of the Community Team Bases Appendix 4 - Ligature Audit Environment Action Plan -	Hayward, Lydia	~~04/01/2023~~ 30/06/2023	In process						
														Once the Mental Health Learning Disability Ligature Point Audit Sheet for each of the Community Team Base has been completed, send to Gerard Sellek (Hywel Dda UHB - Health and Safety Adviser)	Cole, Teifion	~~04/01/2023~~ 30/06/2023	In process						
														Gerard Sellek (Hywel Dda UHB - Health and Safety Adviser) to visit each of the community bases following receipt of the respective Mental Health Learning Disability Ligature Point Audit Sheet	Sellek, Gerard	~~04/01/2023~~ 30/06/2023	In Process						
														Find out whether ligature-cutters can be made available (with associated training) in Community Team bases	Sellek, Gerard	~~04/01/2023~~ 30/06/2023	In process						
														Submit the Audit Environment Action Plan to the Accommodation Strategy Group	Hayward, Lydia	~~04/01/2023~~ 30/06/2023	In process						

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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. Phase 1 works complete.	Service/Business interruption/disruption	6	2	2	4	Phase 2 of this project needs to be supported by capital bids	Jones, Kevin	~~31/03/2019~~ 20/03/2020	Re-evaluate the extent of phase 2 repairs for capital bid submission	Health and Safety Committee	2	3	6	Tolerate	18-Nov-22
														"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	**Completed**	Phase 1 works has now been completed. evaluation and review of potential capital bid for phase 2 works						
1355	Service or Department Level Risk	Standard 2.9 Medical Devices, Equipment and Diagnostic Systems	Scheduled Care: Ophthalmology	Hire, Stephanie	Hill, Carly	17-Feb-22	There is a risk There is a risk that using the YAG laser located in Blue Suite (GGH) might lead to injury to patients or staff. This is caused by This is caused by the fact that the company no longer supports this equipment due to age, it hasn't been serviced since 2019 and its use was limited during the pandemic period (March 2020 - January 2022). This will lead to an impact/affect on This could lead to damage to patients undergoing treatment or to the user, if the equipment has or develops a fault that goes unnoticed by the user. Risk location, Glangwili General Hospital.	YAG laser unit on lease until a permanent solution has been achieved.	Safety - Patient, Staff or Public	6	1	4	4	Ensure teams are aware not to book any routine patients for YAG laser in GGH.	Barreiro, Marta	**Completed**	completed 18/02/2022	Operational Quality, Safety and Experience Sub Committee	1	4	4		11-Oct-22
														Ensure medical team is aware of danger and are extra vigilant when performing laser checks	Barreiro, Marta	**Completed**	Email sent.						
														Update Capital Bids with urgency of requirement	Barreiro, Marta	**Completed**	to be completed						
														Sort a rental or lease laser until purchase is finalised	Barreiro, Marta	**Completed**	contacted company for quotes; contacting EBME and Finance						
														Purchase new laser (Capital Bids) & establish maintenance contract	Barreiro, Marta	30/09/2022	Update: capital bid submitted and urgency discussed						