Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR IECHYD A DIOGELWCH
HEALTH & SAFETY COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	09 May 2022
TEITL YR ADRODDIAD: TITLE OF REPORT:	Corporate Risks Assigned to Health and Safety Committee (HSC)
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Director of Operations Mandy Rayani, Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Wilson, Board Secretary Charlotte Beare, 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 and Safety Committee (HSC) is asked to request assurance from Executive Directors that the corporate risks in the attached report are being managed effectively.

Cefndir / Background

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

(Risk Management Process, ISO 31000)

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

- Seeking assurance on the management of principal risks included in the Corporate Risk Register (CRR) and providing assurance to the Board that risks are being managed

effectively, reporting areas of significant concern - for example, where risk appetite is exceeded, lack of action, etc.

- Reviewing operational risks over tolerance and, where appropriate, recommending the 'acceptance' of risks that cannot be brought within Hywel Dda University Health Board's (HDdUHB's) risk appetite/ tolerance to the Board.
- Providing annual reports to Audit and Risk Assurance Committee (ARAC) on the effectiveness of the risk management process and management of risks within their remit.
- Identifying through discussions any new/ emerging risks and ensuring that these are assessed by management.
- Signposting any risks outside their remit to the appropriate UHB Committee.
- Using risk registers to inform meeting agendas.

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

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

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

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

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

Asesiad / Assessment

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

The Terms of Reference state that the Committee will:

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

There are 3 corporate risks aligned to HSC (out of the 16 that are currently on the CRR), as the potential impacts of these risks relate to the health and safety of patients, staff and visitors.

A summary of these 3 corporate risks can be found at Appendix 2. Each risk has been entered onto a '*risk on a page*' template which includes information relating to the strategic objective, controls, assurances, performance indicators and action plans to address any gaps in controls and assurances.

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

HYWEL DDA RISK HEAT MAP					
	LIKELIHOOD →				
IMPACT ↓	RARE 1	UNLIKELY 2	POSSIBLE 3	LIKELY 4	ALMOST CERTAIN 5
CATASTROPHIC 5		1016 (→)	813 (→)		
MAJOR 4					
MODERATE 3				1328 (→)	
MINOR 2					
NEGLIGIBLE 1					

Below is a summary of changes since the previous report to HSC (14th March 2022):

Total number of risks	3
New/ escalated risks	0
De-escalated/Closed risks	0
Increase in risk score ↑	0
Reduction in risk score ↓	0
No change in risk score →	3

See note 1

Note 1 - No change in risk score
There has been no change in the following risk scores since these were reported to the previous HSC meeting.

Risk Reference & Title	Previous Risk Report to Board (LxI)	Risk Score Feb-21 (LxI)	Date of Review	Update
Risk 813 – Failure to fully comply with the requirements of the Regulatory Reform Order (Fire Safety) 2005 (RRO)	3x5=15	**3x5=15 →**	14/04/22	In addition to completing all actions following an internal governance review initiated by the CEO, the UHB has now embedded a fully resourced fire safety management team, with appropriate reporting arrangements for fire safety and addressing the backlog of

				out of date fire risk assessments across the UHB. There are still some significant challenges faced by the UHB to fully comply with the fire safety order, as a result of further MWWFRS inspections across the organisation and the need to address these findings within the timescales expected. Whilst the fire safety team are in a position to provide support now to the UHB in the form of expertise and technical knowledge, the UHB still needs to manage and address the physical backlog of fire safety across its estate. Also successfully embed an improved fire safety management culture and management ownership for fire safety. Phased fire safety improvement works are ongoing across our sites, with significant investments being made to address the recommendations in the MWWFRS letters. All programme dates have been agreed with the UHB, WG and MWWFRS senior inspecting officers. We intend to review the progress of our completed actions to determine the risk score as we progress with these works.
Risk 1328 - Security Management	4x3=12	**4x3=12** →	14/04/22	On average, across HDdUHB, 85 violent and aggressive incidents are reported each month. Security reviews have identified inability to lockdown sites effectively. There is no dedicated security guard force

				to discourage criminal activity or respond to demands and manage security systems. There is also variation in the standard of coverage and quality including evidential standard required of CCTV (closed circuit television) systems across HDdUHB.
Risk 1016 - Increased COVID-19 infections from poor adherence to Social Distancing	2x5=10	**2x5=10** →	14/04/22	Social Distance risk assessments have been undertaken that highlight ways to allow services to be re-introduced while maintaining the social distance measures, however successful management of the risk depends on staff, visitors or patients adhering to the social distance guidance or using the 'Key Controls' measures in place. There does appear to be an increase in the numbers of staff absent either because of close contact family members being off or contracting COVID-19 themselves hence the need for continued distancing within healthcare premises.

Argymhelliad / Recommendation

The HSC is requested to seek assurance that:

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

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

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.15 Provide assurance that risks relating to health, safety, security, fire and service/ business interruption/ disruption are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate), and provide assurance that effective risk assessments are undertaken and addressed.

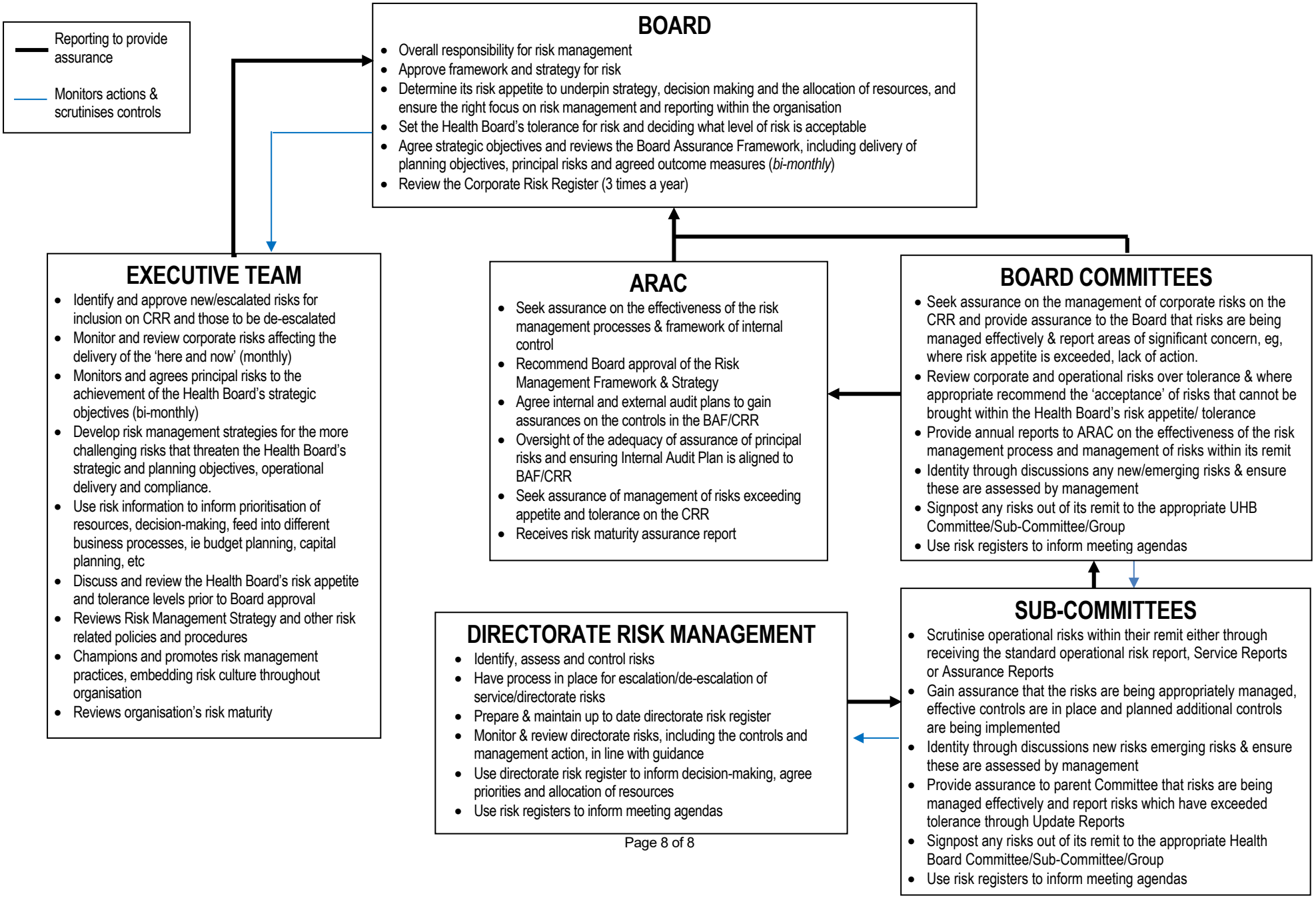
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Contained within the body of the report
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Nodau Gwella Ansawdd: Quality Improvement Goal(s):	All Quality Improvement Goals 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:	Current Risk Score - Existing level of risk taking into account controls in place. Target Risk Score - The ultimate level of risk that is desired by the organisation when planned controls (or actions) have been implemented. Tolerable risk – this is the level of risk that the Board agreed for each domain in September 2018 – Risk Appetite Statement.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd Iechyd a Diogelwch: Parties / Committees consulted prior to Health and Safety Committee:	Not applicable.

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

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

Appendix 1 – Committee Reporting Structure



Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Apr-22	Trend	Target Risk Score	Risk on page no...
813	Failure to fully comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO)	Carruthers, Andrew	Statutory duty/inspections	8	3×5=15	3×5=15	→	1×5=5	3
1328	Security Management	Rayani, Mandy	Safety - Patient, Staff or Public	6	4×3=12	4×3=12	→	3×2=6	8
1016	Increased COVID-19 infections from poor adherence to Social Distancing	Rayani, Mandy	Safety - Patient, Staff or Public	6	2×5=10	2×5=10	→	2×5=10	11

Assurance Key:

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

Key - Assurance Required	
	Detailed review of relevant information
	Medium level review
	Cursory or narrow scope of review

NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you

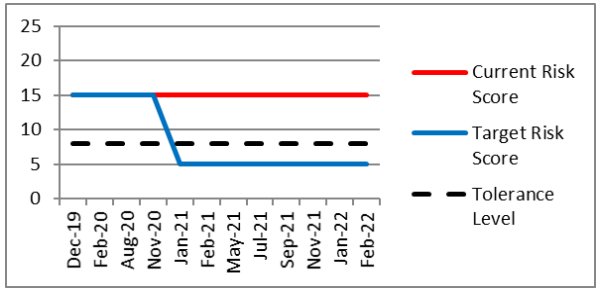
Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective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

Date Risk Identified:	Oct-19
Strategic Objective:	3. Striving to deliver and develop excellent services

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Apr-22
Lead Committee:	Health and Safety Assurance Committee	**Date of Next Review:**	May-22

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

Risk Rating:(Likelihood x Impact)	
Domain:	Statutory duty/inspections
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	1×5=5
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
In addition to completing all actions following an internal governance review initiated by the CEO. The HB has now embedded a fully resourced fire safety management team, with appropriate reporting arrangements for fire safety and addressing the backlog of out of date fire risk assessments across the UHB. There are still some significant challenges faced by the UHB to fully comply with the fire safety order, as a result of further fire brigade inspections across the organisation and the need to address these findings within the timescales expected. Whilst the fire safety team are in a position to provide support now to the UHB in the form of expertise and technical knowledge. The UHB still needs to manage and address the physical backlog of fire safety across its estate. Also successfully embed an improved fire safety management culture and management ownership for fire safety. Phased fire safety improvement works are ongoing across our sites, with significant investments being made to address the recommendations in the MWWFRS letters. All programme dates have been agreed with the HB, WG and MWWFRS senior inspecting officers. We intend to review the progress of our completed actions to determine the risk score as we progress with these works.	Further improvements in culture and ownership for fire safety. It is the scale of physical backlog for fire safety compliance (additional surveys) that will remain until appropriate measures are put in place to address the deficit. Despite annual investment from statutory capital for fire safety components (circa £200k), the scale of current investment is clearly not adequate to address the true scale of backlog the UHB has.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
1.Pre Planned Maintenance (PPM) checks are carried out across the UHB on fire safety components. 2. A detailed physical estates backlog system is in place that identifies the scale (£) and risk of backlog for UHB. Data used to manage backlog maintenance & statutory decision making also regularly reported to WG. Extensive fire safety improvement works are being undertaken at WBH, GGH and at BGH from WG agreed funding (EFAB bids for BGH and funding and From submitted business cases), with phased timelines fully agreed with MWWFRS. Regular communications and dialogue is taking place between HB and MWWFRS. 3. Individual Fire Risk Assessments (FRA's) in place for all sites across the UHB identifying fire related risks. 4. Training Needs Analysis (TNA) for fire safety training in place, as defined in Fire Policy. 5. UHB has implemented a governance structure for fire safety reporting. 6. Estate plans with fire zones, fire doors, fire compartmentation, fire infrastructure items (alarm and detection system). 7. UHB assesses its performance in respect of operational maintenance work carried out on fire safety components and presents this information as a formal paper at all UHB wide fire safety meetings. 8. Annual prioritisation of investment against high risk backlog.	Despite significant investments already in place following enforcement notices and letters of fire safety matters, additional investment is required to address fire safety defects at other sites within the UHB, which are being inspected by MWWFRS. Inability to allocate fire risk actions to appropriate owners on current fire risk assessment system hosted by NHS Wales Specialist Estates Services (NWSSP-SES). Inability to manage and control recommendations within the HB's own Fire Risk Assessments. Staff fire training attendance figures are below targeted figures set by the HB at 85% for all levels - inability to undertake face to face training has impacted (Covid). Despite making improvements to the culture of fire safety management and ownership, the HB does need to ensure this is organisational wide and embedded within it's workforce and cascaded by management.	Introduce a system to manage fire risk assessment recommendations more effectively. System to have the ability to assign risks to risk owners, to track/manage risk and to demonstrate progress on the actions.	Evans, Paul	Completed	The fire team are utilising the current system as best as possible. An Excel system is being introduced (completion Jun20) however a more robust automated system is needed by the HB to track the significant number of actions. Progressing this has been delayed due to COVID-19, however quotes have now been obtained and are under discussion with the Director of Facilities. Approval has now been provided to purchase a system. Completion date for system trial on site by July 2021. System now being tested on site on a few Fire Risk Assessments, we plan to go fully live in Nov/Dec 2021.
		Implementation of a new software system to manage the content of the HB's fire risk assessments. Boris software has now been purchased and is currently being implemented. Date agreed as part of internal fire safety governance review.	Evans, Paul	Completed	Boris software now purchased Dec 2020, initial implementation planned for March 2021. Implementation of risk assessments will now be planned for July 2021. System now supports the use of mobile technology therefore risk assessments can be completed live on the system. System now being tested on site, fully operational by Jan (now Feb) 2022.

Additional fire surveys are required across various sites to obtain costs for all fire compartmentation defects, doors, fire alarm systems and other associated items.	Evans, Paul	31/03/2023	fire safety team and compliance team are working with site operations to determine what the gaps are and to agree what surveys will be required.
Introduce new innovative ways of improving fire training attendance across the HB to increase the percentage figures agreed and set by the HB. As part of the next risk review the fire team intend to split this action into individual sections so we can track and close off action as and when completed.	Evans, Paul	31/03/2023	The fire safety team have been trialing the use of MS teams for L2 Fire training, which has proved to be very successful. We are planning to roll this out to other areas of fire training levels, such as L5/L4 & L3. This will have a positive impact on staff being able to attend the session. We will need to improve communications on this and to ensure staff are made fully aware of the sessions taking place and the dates.
To introduce ways to help improve the culture and ownership of fire safety across the HB. Although management training is taking place at the "Managers Induction Programme" and this is well received. The HB still needs to do more to avoid areas of poor practice that is sometimes identified.	Evans, Paul	31/03/2023	To look at improving the current training content and programme that's currently on offer for management. Regular global communications of do's and don'ts. Having a fire safety share point system, with links to interesting info on effective fire safety management.
Key MWWFRS email correspondence to be logged formally with the Corporate Correspondence team.	Evans, Paul	31/03/2023	Corporate team fully sighted on all actions from the MWWFRS letters for all actions - these are regularly updated as part of action plan meeting with estates management and the corporate risk team.
Implement agreed phased fire safety improvement works at Hospital Sites, to support the work necessary as part of the letters of fire safety matters and improvement notices issued to the HB. Each site will have an agreed timeline fully communicated and agreed with MWWFRS.	Evans, Paul	30/04/2025	Each site has its own phased work programme and delivery date, as detailed in the SBAR submitted to Health and Safety Committee.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Maintain a zero or as low as possible number of outstanding fire risk assessments.	Bimonthly review of outstanding actions from fire risk assessments	1st			IA Fire Precautions Report - ARAC Jun18 SBAR submitted to each HSAC meeting, which includes themes of all fire safety risks.	General site management checks/walkarounds on all sites				
	Site Fire wardens reporting fire safety issues	1st								
	Annual Online Fire Audit Self-Assessment submitted to NWSSP	1st								
	Review of compliance through fire safety groups	2nd								
	SBAR reports regularly issued to HSEPSC	2nd								
	Fire inspections by Fire Service & Fire Improvement Notices	3rd								
	NWSSP fire advisor inspections	3rd								
	NWSSP IA Fire Precautions Follow Up May-18 - Reasonable Assurance	3rd								

Date Risk Identified:	Dec-21	**Executive Director Owner:**	Rayani, Mandy	**Date of Review:**	Apr-22
Strategic Objective:	1. Putting people at the heart of everything we do	**Lead Committee:**	Health and Safety Assurance Committee	**Date of Next Review:**	Jun-22

Risk ID:	**1328**	**Principal Risk Description:**	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 could 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.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	**No trend information available.**
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	4×3=12
Target Risk Score (L x I):	3×2=6
Tolerable Risk:	6
Trend:	⟷

Rationale for CURRENT Risk Score:

Porters at one acute site were called to support staff involved in Violence and Aggression incidents on 178 occasions between February and October 2021. 19 of which required Police intervention. On average, across the Health Board 85 violent and aggressive incidents are reported each month. Security reviews have identified inability to lockdown sites effectively. There is no dedicated security guard force to discourage criminal activity or respond to demands and manage security systems. There is also variation in the standard of coverage and quality including evidential standard required of CCTV systems across the Health Board.

Rationale for TARGET Risk Score:

A new planning objective has been agreed by Board which recognises the Board's commitment to strengthening security arrangements within Hywel Dda, investment will be required to reduce the level of risk to the target risk score.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Certain external doors are fitted with automated locking. Access Control in certain departments CCTV in place across Health Board with Aberaeron and Cardigan having good examples of more robust security management arrangements. Communication systems (2-way radio) in use in certain departments Porters have been trained in de-escalation and restraint skills. Use of external security teams in vaccination centres and when deemed appropriate, eg potential high risk situation at acute sites. Planning objective to undertake a review of the existing security arrangements within the Health Board agreed by Board in Jan22. Support and pursue police prosecutions of incidents relating to theft and issuing of anti-social behaviour disorders (ASBO) Information sharing exists with Police in relation to safeguarding/Prevent, Controlled drug loss/theft (Local Intelligence Network), incident data from A&E	Not all doors are fitted with automated locking systems therefore require manually locking Inability to efficiently lockdown sites or departments quickly if required. Variation in coverage and quality of CCTV provision across sites Lack of dedicated day-to-day management and resource of security systems. Lack of a dedicated security guard force to respond to incidents, management of CCTV, response to violence and aggression incidents, act as a visible deterrent, ID badge issue, management of access control systems, perform a key role in the event of emergencies or when lockdown is required.	A review of external door security to be undertaken.	Harrison, Tim	Completed	External door review completed in Mar22 however capital bid was unable to be submitted in time for financial year end due to equipment availability. However BGH and WGH have improved external door security on a number of doors during Mar22.
		Undertake a review of security arrangements within Hywel Dda (linked to new PO agreed by Board in Jan22)	Harrison, Tim	~~31/03/2023~~ 31/05/2022	Partially complete. Draft HB Security Framework has been produced. Terms of Reference for HB Security Management Group produced with first meeting arranged for May22. Arrangements for a CCTV survey and appraisal taking place during May22 using external provider. Police undertaken a review of security of residences at WGH and aim to roll this out across the HB residences. PO updated.
		Additional electronic lock doors to be fitted at BGH.	Harrison, Tim	Completed	Contractors currently on site.

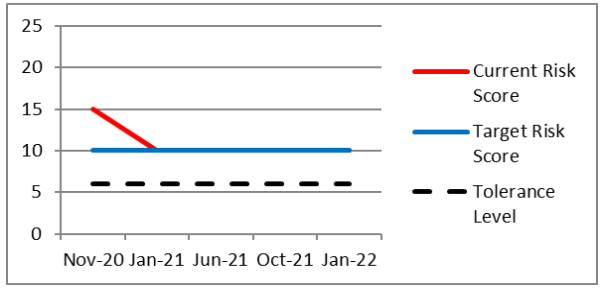
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Security incidents breaches are reported via Datix and investigated	1st			Premises and Security Update Deep Dive - HSC (Nov21)	Review of high risk areas to improve mitigations	Undertake security risk assessment in high risk areas	Harrison, Tim	30/06/2022	Work to commence.
	Reports on security arrangements and related incidents are provided to Health and Safety Committee	2nd					Establish Task & Finish Security Management Group, including involvement from Facilities colleagues.	Harrison, Tim	Completed	Terms of reference produced and first meeting arranged for May 22.
	Mass vaccination Centres were reviewed by the Counter-terrorism Security Advisors (CTSA)	3rd								
	CTSA External Review in 2017 advised of areas that required addressing	3rd								

Date Risk Identified:	Nov-20
Strategic Objective:	N/A - Operational Risk

Executive Director Owner:	Rayani, Mandy	**Date of Review:**	Apr-22
Lead Committee:	Health and Safety Assurance Committee	**Date of Next Review:**	Jun-21

Risk ID:	**1016**	**Principal Risk Description:**	There is a risk of increasing COVID infections across the Health Board. This is caused by staff and others not adhering to the Health Board guidance and National Social Distance legislation. This could lead to an impact/affect on increased levels of staff absence due to COVID infection and self isolation, some essential services being closed leading to longer waiting times and delays for treatment for patients, enforcement action/fines from HSE for non-compliance with Social Distancing legislation.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	2×5=10
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
Social Distance risk assessments have been undertaken that highlight ways to allow services to be re-introduced while maintaining the social distance measures, however successful management of the risk depends on staff, visitors or patients adhering to the social distance guidance or using the 'Key Controls' measures in place. The current risk remains at 10 whilst the social distance measures continue to be required. Possibly as a result of relaxing COVID-19 controls in the community there has been an increase in the numbers of staff absent after contracting COVID-19 themselves.

Rationale for TARGET Risk Score:
The TARGET score focuses on reducing the likelihood of an incident as the impact score would remain at 5 (as outlined under CURRENT score). By introducing effective social distancing measures such as screening in high priority areas and alternative solutions in other areas, such as PPE, staff would be able to man more areas thus allowing services to resume as far as reasonably practicable. In terms of inpatient bed space, by reviewing all ward spaces and field hospitals against current guidelines and introducing either physical barriers or increasing spaces, as many services as possible will be able to return, however, strict adherence to the controls in place will be required to meet the target score.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Social distancing guidance in place for staff and is available on the intranet # Safety screen installations in hospital and ward/clinic reception areas # Instructional social distance posters, phones messages and floor signs # Hand sanitisers stations # Personal protective equipment (PPE) # Reducing room capacities to allow for social distancing # Use of IT systems e.g. Microsoft Teams to reduce the need for face to face meetings # Reduction in travelling between sites # Home working being encouraged where possible # Accommodation facilities for medical staff have been risk assessed and alterations made in line with social distance measures. # SD information on patient appointment letters, leaflets # One way pedestrian walkways # Controlled access into surgical wards and theatres # Hospital bed screens installed in identified wards in order to maximise inpatient capacity and minimise bed losses # Additional accommodation in Trinity St David's Campus to improve social distancing # Patient visiting arrangements include agreed timeslots and management arrangements #Global communication issued 23/03/22 relating to the universal use of surgical face masks for staff and face masks/coverings for all patients/visitors remaining as an IPC measure until further notice, as well as advising staff to continue to work from home where possible.	Due to the relaxation of COVID-19 rules outside of health settings, staff, visitors or patients are less likely to adhere to the social distance measures in healthcare. Staff returning to work on sites may lead to a reduction to the availability of staff room and changing facilities as these spaces return to their original use. Longer term working from home/agile working will need further consideration for ensuring compliance with DSE Regulations. Compliance with new WG government guidance in respect of relaxation of social distancing measures in some areas.	Review current home working guidance for agile/homeworkers	Harrison, Tim	~~30/09/2021~~ 31/03/2022 31/05/2022	Finalising HB guidance although need clarification with Agile Working Group regarding the HB position on supplying potential DSE equipment to 'home workers' in line with DSE Regulations.
		Increase screens in patient waiting areas to support compliance with new WG SD guidance to provide additional protection for patients whilst maintaining capacity	Chiffi, Simon	Completed	Screens installed within Patient Waiting areas to enable additional internal patient waiting capacity during winter months.
		Issue new guidance to operational & corporate management and request them to review social distancing arrangements and risk assessments in their areas in line with latest WG guidance, eg, non-clinical areas can reduce SD to 1m	Harrison, Tim	Completed	SBAR containing latest WG guidance to be considered by Executive Team, prior to communicating across HB.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Oversight is provided by the Social Distancing Cell, Chaired by Director of NQPE	1st				None identified.				
	Reviewing grade 4&5 incidents (RIDDOR reportable) involving staff contracting hospital acquired COVID	1st								
	Social Distancing Cell reports into Silver and Gold Groups	2nd								
	HSE visit Oct21 with no issues identified across the 2 acute and 2 community sites	3rd								