Meeting Date	**17th May 2018**	**Agenda Item**	**2F**
Report Title	**Strategic Risk Report**		
Report Author	Hazel Lloyd, Head of Patient Experience, Risk & Legal Services		
Report Sponsor	Professor Angela Hopkins, Interim Director of Nursing & Patient Experience		
Presented by	Professor Angela Hopkins, Interim Director of Nursing & Patient Experience		
Freedom of Information	Open		
Purpose of the Report	This report provides an update on the work being undertaken to update the Corporate Risk Register in line with the Wales Audit Office recommendations.		
Key Issues	• Workforce planning and ensuring appropriate levels of skilled staff are in place within the Health Board (Risk Ref 3) linked to the Health Boards objective Sustainable & Accessible Services is the highest risk to the Health Board. • Health Board will complete all actions to improve risk management in the organisations by July 2018.		
Specific Action Required ***(please ✓ one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	✓			
Recommendations	Members are asked to: • **Note the contents of the report.**			

STRATEGIC RISK REPORT

1. INTRODUCTION

This report provides an update on the work being undertaken to update the Corporate Risk Register in line with the Wales Audit Office recommendations.

2. BACKGROUND

The Corporate Risk Register is attached as **Appendix 1** and has been reviewed and updated by Executive Directors and was reported to the Executive Team on 8th May 2018.

Work is ongoing in terms of revising the Corporate Risk Register in line with the Wales Audit Office recommendations:

- In taking forward its plans to improve risk management, the Health Board needs to ensure that:

  - It more clearly identifies risks to the achievement of objectives on the corporate risk register, rather than just listing issues such as "unscheduled care" and "public health".

  - It critically reviews the number of risks on the corporate risk register, as there are too many for proper collective scrutiny.

  - It re-maps risks to committees to reflect the new committee structure - actioned

  - All committees provide oversight and scrutiny for the risks assigned to them.

All actions will be completed by July 2018 when the Corporate Risk Register is scheduled to next be received by the Audit Committee. In addition to these actions a review of Informatics risks are being undertaken and the outcome will be reported to the Executive Team.

3. GOVERNANCE AND RISK ISSUES

The highest risks on the register are rated 20 and relate to:

- **Workforce planning and ensuring appropriate levels of skilled staff are in place within the Health Board (Risk Ref 3) linked to the Health Boards objective Sustainable & Accessible Services**
  The controls in place and actions being taken to decrease the risk are provided within the entry on the Corporate Risk Register for the risk identified. The Board and Workforce and OD Committee receive regular updates on this risk.

- **Risk Ref 44: Emergency Department Clinical Systems.** There is an increased risk of system failure in the clinical systems at POWH and Morriston. Full details are provided on the Corporate Risk Register.

- **Risk Ref 45: Discharge Information.** If patients are discharged from hospital without the necessary information being made available then there is a risk in relation to the continuation of their care to a high standard.

Please note that risk ref 44 and 45 will be subject to review as part of a wider review of informatics risks and how they are managed and prioritised.

A summary of the risks and their risk rating is provided in **Table 1**.

Risk Matrix	LIKELIHOOD				
CONSEQUENCES	1 Rare	2 Unlikely	3 Possible	4 Probable	5 Expected
1 Negligible					
2 Minor					
3 Moderate			RR 24: Compliance with PSN's	RR 13: Environment/ Premises	
4 Major			RR 17: Equipment Replacement RR 16: Waiting Times RR23 & 29: Business Continuity & Disaster Recovery RR 28: Service Business Interruption 46 Corporate Governance of the Board RR48: Compliance with GDPR RR 11: Dignity in Care & Needs of Older People RR42/2: Financial deficit risk of special measures RR 39: IMTP not approved by WG RR 40: Insufficient information governance resources RR 43: Deprivation of Liberties	RR 4: Infection Control RR 27: Clinical Information Systems RR 36: Management of Paper Health Records RR 37: Reporting of Clinicial Information RR 38: Lack of Single Integrated Electronic systems RR 47 Sustainability of Primary Care Services RR48 CAHMS	
5 Critical			RR 15: Population Health RR 41: Fire Safety for buildings with applied external cladding RR 1: Unscheduled Care RR9: Access to Services	RR 2: Financial deficit risk of special measures RR 3: Workforce Planning Record RR 44: ED Clinical Systems RR 45: Discharge Information	

RR – Risk Reference on the Corporate Risk Register PSN – Patient Safety Notices

4. FINANCIAL IMPLICATIONS

No financial implications in terms of carrying out the actions recommended by the Wales Audit Office.

5. RECOMMENDATION

The Committee is requested to note the report.

Governance and Assurance					
Link to corporate objectives ***(please ✓)***	Promoting and enabling healthier communities	Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships
					✓
Quality, Safety and Patient Experience					
No implications for the Committee to be notified of.					
Financial Implications					
No implications for the Committee to be notified of.					
Legal Implications (including equality and diversity assessment)					
No implications for the Committee to be notified of.					
Staffing Implications					
Staff will be briefed on the changes through workshops and also meetings held with Executive Directors and Assistant Directors to support the changes required to meet the recommendations made by the Wales Audit Office.					
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)					
No implications for the Committee to be notified of.					

Report History	Quarterly reported to the Audit Committee
Appendices	Appendix 1: Corporate Risk Register

Appendix 1

Name of Register: CORPORATE

Date: May (Q1)

						Initial RA								Revised RA - (2018/19)			
Ref	**Opened/ Received Update**	**Objective for 17/18**	**Risk**	**Current context**	**Controls in place**	**Consequence**	**Likelihood**	**Rating**	**Action Plan**	**Action Lead**	**Option Agreed**	**Board/ Committee**	**Progress**	**Q1**	**Q2**	**Q3**	**Q4**
Promoting and Enabling Healthier Communities																	
15	Q1 2013/14 Reviewed May 18 Director of Public Health	**Promoting and enabling Healthier Communities**	Serious outbreak, e.g. flu or measles	If we fail to prevent a serious outbreak by effectively achieving herd immunity in the population through immunisation and vaccination programmes, or to effectively manage an outbreak by disrupting the spread, this will result in serious harm to individual, maybe death, and pressure on health services, disruption to flow, business continuity and reputational damage to the health board and public health team.	• Public Health Strategy and work plan • Strategic Immunisation Group, MMR Task & Finish group, Childhood Imms Group; & Primary Care Influenza Group • Support from PHW Health Protection	5	3	15	• Deliver immunisation awareness training for pre-school settings to promote key vaccination messages • Contribute to the implementation of recommendations made in the "MMR Immunisation: process mapping of the child's journey" report • Continue to promote the benefits of immunisation through Healthy Schools and Pre-Schools e-bulletins • Develop local resources/ products to share good practice	Director of Public Health	Treat	Quality & Safety Cttee	School flu imms target over 70% (second highest in Wales). All other childhood imms targets below trajectory. Flu vaccine uptake poor in under 65 at risk groups, better in over 65s, but still below trajectory. Staff flu uptake around 53% (target 60%).	15			
Delivering Excellent Patient Outcomes, Experience and Access																	
1	Q1 2012/13 Reviewed May 18 COO	**Delivering Excellent Patient Outcomes, Experience and Access**	**Compliance with Tier 1 target - Unscheduled Care**	If we fail to comply with Tier 1 target - Unscheduled Care then this will have an impact on patient and family experience. Challenges with capacity /staffing across the Health and Social care sectors.	Individual Unit improvement plans in place. Daily Health Board wide conference calls/ escalation process in place. Regular reporting to Executive Team, Executive Board and Health Board/Quality and Safety Committee. Increased reporting as a result of targeted intervention status.	4	4	16	• Implementation of service delivery unit unscheduled care improvement plan -key areas include pre hospital, front door assessment/ambulatory care models, development of frailty models and patient flow and discharge . Morriston delivery unit plan reflects recommendations from external support. • Executive monitoring/support to achieve improvement plans on a weekly basis. • External capacity/demand modelling undertaken in community services to inform sustainable capacity solutions/ system shifts •Commenced winter planning arrangements for 2017/18 using lessons learnt from 2016/17.	Chief Operating Officer	Treat	Quality & Safety Cttee	End of Q2 performance demonstrates evidence of continual improvement in 4 and 12 hour performance and better performance compared with the same quarter in 2016. The service delivery units have been implementing models of care that reflect National priorities and that improve patient flow. External improvement support has been sought to work with Princess of Wales hospital where 4 hour performance has not met the Q2 internal HB improvement trajectory.	15			

4	Q1 2012/13 Reviewed May 18	**Delivering Excellent Patient Outcomes, Experience and Access**	**Infection Control Reducing Healthcare Associated Infections**	If we fail to reduce hospital acquired infections then: • Healthcare associated infection (HCAI) causes patients harm. HCAI also results in increased socio-economic burden, length of stay, with subsequent loss of available beds. Current situation: • Appropriate organisational structures, management systems and workforce for infection prevention & control must be in place: o Interim HB-wide ICD appointed, but designated number of clinical sessions only 2/week insufficient for HB. o Gap in strategic leadership in IPC and decontamination at corporate level following departure of Assistant Director of Nursing IPC. o Imminent reduction in senior IPC operational leadership, expertise and experience o Limited resource of Consultant Microbiologist resource in ABMU to support IPC agenda and to deliver the service requirements to a Health Board the size and complexity of ABMU (unchanged since the Duerden report recommendation in 2015) o Reliance on bank and agency staff, staff vacancies impact on adherence to infection prevention and control measures consistently • Insufficient standard isolation and negative pressure isolation facilities make it difficult to adhere to recognised evidence-based standards for the management of patients with a suspected or actual transmissible infection. • Environments of care that that are not adequately cleaned and maintained can compromise the ability to prevent increased incidence HCAI and outbreaks, can impact on the patient experience; increase morbidity and mortality and may damage the reputation of the organisation. • There are very few inpatient care areas that meet the national guidance on the standard for bed spacing: o High bed capacity with increasing utilisation of extra trolleys / pre-emptive beds on wards resulting in a greater than 85% bed occupancy impacts on adherence to infection prevention and control measures, particularly thoroughness and consistency of cleaning o Difficult to sustain full adherence to requirements of protocols in	● Infection Prevention & Control Policies & Procedures / SOPs in place, reflecting Welsh National Model Policies for IP&C. ● Infection Control Doctor - 2 sessions/week ● Comprehensive improvement programmes in place, including: - IPC education and training, - hand hygiene coach programme and hygiene observational audit; roll out of Aseptic non touch technique (ANTT) training and competence assessment programme - antibiotic stewardship, - national minimum standards of cleaning monitoring via C4C, - reactive room environmental decontamination utilising hydrogen peroxide vapour or UVC light as appropriate, with proactive programme undertaken whenever feasible. - assurance spot checks undertaken to assess compliance with Infection Prevention & Control policies and best practice. ● Localised infection surveillance in place, to monitor trends, establish baseline rates, calculate "early warning" triggers and identify at an early stage when sites are nearing or breaching triggers to enabling early interventions with the objective of early identification of, or prevention of, outbreaks of infection; adoption of ICNet in 2016 in ABMU - an electronic surveillance system being rolled out nationally to facilitate improved case and outbreak management which will increase the potential scope of surveillance, make it less labour intensive (freeing up ICN time for proactive IPC interventions) and less prone to error. Clear assurance framework in place at Corporate level with Health Board Infection Prevention & Control Committee; Corporate Infection Prevention & Control Nursing Team; Water Safety	5	4	20	● Infection Prevention & Control Policies & Procedures / SOPs in place, reflecting Welsh National Model Policies for IP&C. ● Infection Control Doctor - 2 sessions/week ● Comprehensive improvement programmes in place, including: - IPC education and training, - hand hygiene coach programme and hygiene observational audit; roll out of Aseptic non touch technique (ANTT) training and competence assessment programme - antibiotic stewardship, - national minimum standards of cleaning monitoring via C4C, - reactive room environmental decontamination utilising hydrogen peroxide vapour or UVC light as appropriate, with proactive programme undertaken whenever feasible. - assurance spot checks undertaken to assess compliance with Infection Prevention & Control policies and best practice. ● Localised infection surveillance in place, to monitor trends, establish baseline rates, calculate "early warning" triggers and identify at an early stage when sites are nearing or breaching triggers to enabling early interventions with the objective of early identification of, or prevention of, outbreaks of infection; adoption of ICNet in 2016 in ABMU - an electronic surveillance system being rolled out nationally to facilitate improved case and outbreak management which will increase the potential scope of surveillance, make it less labour intensive (freeing up ICN time for proactive IPC interventions) and less prone to error. Clear assurance framework in place at Corporate level with Health Board Infection Prevention & Control Committee; Corporate Infection Prevention & Control Nursing Team; Water Safety Group; and Directly Managed Unit Infection Prevention & Control Groups.	Director of Nursing	Treat	Quality & Safety Cttee	• Job desriptions for the additional HCAI/AMR Collaborative teams developed and approved ready for advertising . • Review design of existing IPC Nursing team establishment for closer alignment with the 'whole system QI plan' - first draft by end of June 2018 ready for consultantion. • Pilot of proposed national 'Start Smart, Then Focus'-based Antimicrobial Chart commenced. Initial audit results indicate fvourable reception and further review and revision. Health Board has agreed the implementation of more restrictive Antimicrobial Guidelines (restricting Co-Amoxiclav use). Proposed implementation date - 12th June 20187. • Early stage HCAI Collaborative PDSA style QI projects commenced in March 2018. Methodologies being reviewed and amended through PDSA process. • Capacity redesign within 2018/19 Annual Plan will consider options for decanting bays and for increasing single room capacity. • Building work on the negative pressure facility in Morriston was completed by end of March, 2018. Commissioning and validation checks progressing before final handover - before 30 June 2018. The Morriston A&E provision will be within the 2018/19 capital programme. • 2018/19 HCAI improvement goal trajectories for Health Board and DSUs circulated in April 2018. • Successful 2017/18 influenza immunisation campaign-increase from 2016/17 and close to achieving WG target. If bank and students included in denominator, target was achieved.	16			
9	Q1 2012/13 Reviewed May 18 COO	**Delivering Excellent Patient Outcomes, Experience and Access**	**Access - to services** …….. …….	If we fail to managed bed capacity at peak times then this will have a major impact on service delivery around access particularly.	Patient Flow Programme.• Board Rounds • 7 day working. • Analysis of < 15 day LOS • Community capacity increase • Increased staffing levels • Improved operational pathways. Prudent health care	4	4	16	Supported by Service Improvement Team and through the Patient flow service optimisation work stream of the recovery and sustainability programme.	Chief Operating Officer	Treat	Performance & Finance Committee	Sustainable and accessible services are affected by bed capacity and utilisation and exacerbated by staffing /vacancy levels. • The HB is redesigning models of care to support admission avoidance and earlier transfers of care. This includes improvements to our ambulatory care services/capacity to support admission avoidance, changes to the model at Neath Port Talbot hospital (Enabling Ethos/ discharge to assess model), and development of frailty ambulatory care services at Singleton and Princess of Wales hospitals following new consultant appointments.• Linking and promoting messages about patient safety and avoidance of harm with the evidence of the impact of prolonged hospitalisation on patient outcomes and dependencies. HB wide support to this approach is being provided by the Executive Led work stream on patient flow. Patient flow metrics for Q2 provide evidence of improvement.	15			
New Entry	Q4 2017-18 New Entry January 2018 Dir Strategy Reviewed May 18	**Excellent Patient Outcomes & Experience**	Failure to sustain Child and Adolescent Mental Health Services	The specialist CAMHS Network is delivered by Cwm Taf University Health Board on behalf of ABMU. Cwm Taf have confirmed that they will not meet the 28 day target by the end of March 2018. This is as a result of pressures across the entire CAMHS network in relation to demand & capacity and recruitment & retention.	**Performance Scrutiny** - is undertaken at monthly commissioning meetings between ABM & Cwm Taf University Health Boards. **Improved governance -**ensures that issues and concerns are discussed by all interested parties including local authorities to support the network identify local solutions.	4	4	16	The CAMHS Network have advised ABMU of the following action to be taken to improve the position: **Implementation of the Choice and Partnership Approach** (CAPA) started on 1st November 2017 and being closely monitored. **Additional investment expected - f**rom Welsh Government is supporting the delivery of Waiting List Initiative clinics to support the position. **The Network is seeking to recruit agency staff** to fill existing and upcoming vacancies to ensure that core capacity is maximised. ABMU will continue with its role as commissioner.	Director of Strategy	Treat	Q&S Committee	The service is now in the 2nd cycle of CAPA with new job plans agreed from January, with updated demand & capacity mapping. WLI Clinics initiated at POW Hospital, Bridgend which enabled the 80% target to be achieved by end of end March. This was also achieved for NPT area. However Swansea had a significant backlog, which is starting to be addressed with waiting list initiatives from March 2018.	16			

11	Q1 2012/13 Reviewed May 18 Director of Therapies and Health Science	**Delivering Excellent Patient Outcomes, Experience and Access**	**Dignity in Care and the needs of older people**	If we fail to provide an appropriate healthcare model for aging population then this will impact on quality and availability of services in the health board. .Providing good services to enable citizens to live independently at home is a major challenge. Over next 20 years care resident population will see a 24% increase in people of a pensionable age and 15% increase in people of non working age.	Development of an Older Persons Charter underway. Action to comply with recommendations of the Older Persons Commissioner. Full implementation of the Butterfly Scheme and Dementia Training in Place across the Health Board. Developments within planning to develop new models of care and local resource centres and wellness villages	4	4	16	Being taken forward as part of the Action after Andrews. • Twelve standards of care for older people in hospital have been drafted jointly by clinical staff, patient groups and voluntary sector organisations • The 'See It Say It' campaign established to make it easier for staff, patients and visitors to raise concerns – anonymously if they wish – by phone, text or email • Introduction of the '15 Step Challenge' to improve the first impression patients and visitors get when they enter a ward	Director of Therapies and Health Science	Treat	Q&S Committee	20/12/2017 - An external Clinical Review of Mental Health Services for Older People in ABMU was undertaken between June & August 2017. The key findings of the review supported a move to a balanced service model with bed provision reducing over time, development of community OPMH Hubs, community development and essential infrastructure services such as support & stay, care home support, memory clinics and Day Services. The Delivery Unit is now working on plans to move the service in this direction.	12			
17	Q1 2012/13 Reviewed May 18 Director of Strategy	**Delivering Excellent Patient Outcomes, Experience and Access**	**Equipment Replacement**	If we unable to replace key pieces of equipment then this could adversely affect capacity and patient well being	Ensure that asset life information will be produced in the new single EBME system from 2011/12, is consistent with the Fixed Asset Register and will allow equipment replacement programmes to be planned for future years. Ensure equipment replacement requirements are identified within all future capital new build/ refurbishment schemes	4	3	12	Equipment bids regularly reviewed and risk rating of the equipment bids considered.	Director of Strategy	Tolerate	Performance & Finance Committee	Database being developed to support an ongoing equipment replacement programme. A Capital Prioritisation Group has been established to allocate discretionary capital in accordance with risk rating. All bids received for funding are risk assessed and verified by the Head of the Medical Equipment Management Service before being considered. When a business case is developed an allocation is included for equipment. WG requires this this allocation is verified rather than estimated and Room Data sheets are costed to provide an initial budget which is then reviewed to identify any equipment that can be transferred as part of the scheme before a final allocation is agreed. Proposals submitted to Welsh Government on use of discretionary capital slippage for medical equipment replacement in December 17.	12			
24	Q4 2012/13 Reviewed May 18	**Delivering Excellent Patient Outcomes, Experience and Access**	**Compliance with Patient Safety Notices/Alerts (Solutions) issued by Welsh Government**	If we fail to comply with Patient Safety Solutions issued by Welsh Government then we could increase the risk of an incident happening. Non compliance with the alerts exposes the Health Board to safety risks.	Exception reports produced for the Quality & Safety Forum and reported to the weekly Executive High Risk meeting. Risk Advisor attends the Medicines Safety Group to support as the majority of alerts/notices involve the work of this Group.	4	3	12	Continuous monitoring. Action plans developed for each alert/notice.	Director of Nursing & Patient Experience	Treat and Tolerate for the alert re neuralaxial connectors	Q&S Committee	Action Plans for each notice monitored on an exception basis through the Quality & Safety Forum and T&F Groups set up to oversee implementation of the actions for specific alerts. Currently one PSS has been escalated to the Quality & Safety Forum:	9			
16	Q1 2012/13 Reviewed May 18	**Delivering Excellent Patient Outcomes, Experience and Access**	**Access to services - Waiting Times**	If we fail to achieve compliance with waiting times, then we will fail to ensure Equity planning maps through our access plans.	Weekly calls with Units to support delivery and monitor performance. Monthly performance and finance meetings between executive team and service directors. Modest investment package agreed to support additional activity to increase capacity.	4	3	12	Quarter 2 improvement plan in developed and the Health Board is progressing national speciality implementation frameworks. Increased assurance being worked on to support delivery.	Chief Operating Officer	Treat	Performance & Finance Committee	•OP position for quarter 2 achieved target levels and was 9% better than expected. •36 week position for quarter 2 was above target levels by 143 patients (3.5%) •Diagnostics over profile by 135 patients, all in endoscopy.	12			

13	Q1 2012/13 Reviewed May 18 Director of Strategy	**Delivering Excellent Patient Outcomes, Experience and Access**	**Safety** …….. ….. Environment - Premises	If we do not have accommodation that meets statutory/health and safety requirements then this could have an adverse impact on citizens, staff, financial and operational performance. This is a problem in the acute setting as well as across primary care in community clinics and surgeries.	Key areas where performance linked to health & safety/fire issues flagged through Health & Safety and Quality & Safety Committees and actions agreed to mitigate impacts. Issues raised through site meetings held regarding service changes for all 4 acute hospital sites	4	4	16	Develop a strategy to improve primary and community services estate. Develop BJC's to improve the infrastructure of the 3 acute hospital sites (not including Neath Port Talbot). As well as a case for asbestos removal at Singleton Hospital for submission to Welsh Government.	Director of Strategy	Treat and Tolerate	H&S Committee	An Estates Strategy is being developed by Primary and Community Services. This will take into account all premises across Swansea, Neath Port Talbot and Bridgend and will include a condition survey of all premises and outline plans to improve the Estate. It will identify any properties which are currently under utilised and propose plans to co-locate services in the best of the building stock. When complete the strategy will also list any properties that can be declared surplus to requirements. Welsh Government has recently announced the award of funding to the Health Board as part of the Primary Care Pipeline. Funding of £16.2m will be utilised for the refurbishment of Murton and Penclawdd Health Clinics and the development of a Well Being Centre in Bridgend along with a new Wellness Centre in Swansea. Architects have been appointed to prepare the Master Plan for the Sunnyside site in Bridgend where the Health Board is working with BCBC and LINC Housing on this ambitious project and a brief and specification is being developed for the refurbishment work at both Health Clinics. Discussion is continuing with CSCC and the University on the scope of the Swansea Wellness Centre. The first of the Infrastructure BJC's was approved by Welsh Government on the 5th January 2017 and consists of 11 separate schemes across the Morriston, Singleton and Princess of Wales hospital sites. Work has already been completed on 6 schemes and is well underway on the remaining 5 schemes to be completed by the end of this financial year. The main issues on the project have been caused by the presence of asbestos in Singleton Hospital and, in a more limited way, at PoWH. Where it is identified any asbestos material found at either Hospital is being removed as part of individual schemes. The remaining contingency from this years Discretionary Capital Programme together with slippage opportunities is to be utilised to fund the replacement of Chillers at Morriston Hospital which has to be completed in the winter months. Design for this work is being progressed in tamdem with the interim BJC for the scheme while discussion on the priorities for BJC Infrastructure 2 are proceeding. An allocation has also been granted from the current years Discretionary Capital allocation to undertake the refurbishment of Ward J at Morriston Hospital. It is anticipated that should funding be made available this will be the first stage of a rolling ward refurbishment programme at the Hospital. An Estates Manager has been appointed within Primary Care to help talk the agenda forward.	12			
Securing a Fully Engaged and Skilled Workforce																		
3	Q12012/13 Reviewed May 18 Director of HR	**Securing a Fully Engaged and Skilled Workforce**	**Workforce Planning** - Deliver services effectively through trained competent staff and develop new roles as services change over time. Compliance with Mandatory and statutory training	If we are unable to appoint to vacancies as a result of a national shortages of numbers in some areas then this can lead to: Unable to recruit sufficient numbers of trainees to fulfil rotas on all sites Unable to attract non training grades to complete rotas Unable to fill Consultant grade posts in some specialties with adverse affects on patient safety and industrial relations. Unable to recruit sufficient registered nursing staff. Unable to recruit qualified therapies and health's science staff lead to: use of agency staff to fill rotas e.g. pathology/biomedical science shortages,	Regular monitoring of recruitment position with reports to Executive Team and Board via Medical Director and Medical Workforce Board. Specialty based local workforce boards established to monitor and control specific issues. The new HB Workforce & OD Committee will seek assurance of medical workforce plans to maintain services. Engagement of the Deanery about recruitment position Regular monitoring of nurse recruitment position with reports to Executive Team and Board via Nurse Director and Nursing and Midwifery Board.	5	4	20	Medical workforce issues are seen as a lever for service planning and factored into C4B and South Wales service plans. Ongoing discussions and communication with Deanery about recruitment position. Recruitment campaigns for additional non training posts to fill gaps. Specific Medical Workforce Group for Integrated Medicine and Paediatrics to develop short term workforce plans. Medical Workforce Board to consider current and future shape of medical workforce. Review of primary care in terms of recruitment and retention underway. Funding to be secured to increase nurse staffing levels. Number of workforce risks have been identified relating to staffing issues of therapy and health science staff. Action plans being worked through to ensure appropriate controls in place.	Director of Human Resources	Treat	W&OD Committee Quarterly	The Workforce and OD Committee meets on a bi-monthly basis to provide assurance on WF and OD issues including staffing levels and recruitment. Focus of Changing for the Better and South Wales Programme is to redesign services and roles that take account of recruitment difficulties in key specialties. There is a regular report to WFODC from the Medical Workforce Board. A number of medical training initiatives has been pursued in a number of specialties to ease junior doctor recruitment which have proved successful. International recruitment has been undertaken through BAPIO on two occasions and has proved successful. 8 Physicians associates training posts have been made available within ABMU. The Medical Workforce Board continues to monitor recruitment and junior doctor's rotas. Nurse recruitment days have been held and European and international recruitment project has been expanded to include India, however this was put on hold due to our financial position at the time. Two recruitment trips to the Philippines undertaken in 2016. Recruitment work is ongoing with the Bank staff and HCSW's recruited across the Health Board. Nurse commissioning numbers have been increased and work is underway with the university to allow early recruitment of nurses in their third year. Work is underway to improve retention of nurses, including enhanced preceptorship. Introduction of exit interviews for nursing staff to understand reasons for leaving to inform retention strategy. International nurse recruitment strategy to be reviewed following the introduction of the Immigration Skills Levy from April 2017. Process for EU nurse recruitment has been revised following evaluation of process and increased financial challenge. Dedicated area developed on our internet site for nurse recruitment. Nurse open recruitment days continue to be conducted across the Delivery units. Plans are now being put into place to combine resources and conduct these events on an East and West basis only. This will reduce internal competition for nurses and make more efficient use of resources required to support these days. A business case is in the process of being agreed to continue support for non EU nurse recruitment for the remainder of 2017/18 and into 2018/19	20			
Demonstrating Value and Sustainability																		

42 & 2	Q2 2017/18 Dir of Finance - May 18	**Demonstrating Value and Sustainability**	If the Board is unable successfully to deliver a sustainable service and a sustainable financial position then the performance, safety and quality of our provision will be at risk.	£32m deficit posted 2017/18 £7.4m RTT claw back Savings plan under-performance Improved controls and financial performance pay and non-pay	• Monthly Financial Recovery meetings • Weekly pay and non-pay dashboard • Medical agency caps • Spend Controls • QVC weekly panel • Investment & Benefits Group	5	4	20	• Recovery & Sustainability Plan, via Exec led work stream in place and assessed for delivery risk. • Monthly Performance, Quality and Finance Recovery meetings (joint with COO). • Contract/commercial relationship review with NWSSP. • QVC 1 - Clinical Procurement data analysis, clinical engagement, action to deliver savings (joint with MD). • Strengthen spending controls in expenditure. • Intervention & contingency options for under performance being identified.	Director of Finance	Treat	Performance & Finance Committee	• Recovery & Sustainability - detailed plan for all but 3 work streams; plans in development urgently for remaining 3. • NWSSP providing schedule of contracts and SHOs for each. • QVC 1 - meetings taken place with clinical cabinet and MD.	12			
39	Q4 2016/17 Reviewed May 18	**Demonstrating Value and Sustainability**	Health Board does not have an **Integrated Medium Term Plan** signed off by Welsh Government primarily due to the inability to align performance and financial plans. In September 2016, the Health Board was escalated to 'targeted intervention'	If the Health Board fails to have an approvable IMTP for 2018/19 then we will loose public confidence.	• De-escalation taskforce • Corporate objectives to frame the implementation of the Annual Plan underpinned by actions to ensure clear performance and risk management. • Service improvement plans, quality plans, workforce plans and Recovery and Sustainability Programme have been linked to the Health Boards financial plan.	4	4	16	Recovery and Sustainability Programme Board has been established to focus on year in recovery to enable ongoing sustainability. Revised framework for developing the 2018-2021 IMTP is being developed (July 2017). Integrated planning approach (service, workforce, finance) in place to develop fresh approach.	Director of Strategy	Treat	Performance & Finance Committee	Health Board has written to Welsh Government to advise that an annual plan will be developed for 2018/19, and aim to prepare an IMTP for 2019/20 and beyond. Draft Unit plans received, and draft plan in preparation. Board agreed the proposed financial and service plan and impacts at its meeting on 8th December. Draft plan to go to Board January 2019.	12			
36	Q2 2016/17 Reviewed May 18 Medical Director	**Demonstrating Value and Sustainability**	**Management of the Paper Health Record**	If we fail to provide adequate storage facilities for paper records then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced if there is poor records management in some wards.	Temporary retention and destruction plans are in place but these are unfunded. Alternative storage arrangements are being identified and utilised where appropriate. Ward protocols and audits have been rolled out across sites.	4	5	20	Identification of resources required to implement effective retention and destruction plan on ongoing basis. Acquire capital investment to utilise storage space available in Glanrhyd. Develop Business Case to WG under the IMT SOP to secure investment to Digitise the Paper Health Record	Medical Director	Treat	Audit Committee	There has been a successful submission/application to Welsh Government under the auspices of the "Invest to Save" initiative which has secured the sum of £769,223, towards the cost of the RFID Health Records modernisation project. The shortfall, originally the subject of an unsuccessful ETTF BID is now coming from 2018/19 discretionary capital (£449,124) and 2019/20 revenue (£177,923k). The model has been successfully implemented in Betsi Cadwaladar Health Board, they have been successful in improving records efficiencies and delivering cost savings. The benefits model for ABMU has been based on the outcome of the programme in North Wales. Improvements in the areas below will address the challenges being faced by the Service: • Introduction of location based filing and increase in storage • Improved health record tracking capabilities • Reduction of clinical risk • Staff and process efficiencies • Improved reporting The procurement is planned for April 2018 and implementation from May 2018, the introduction of the project will reduce this risk	16			

38	Q2 2016/17 Reviewed May 18	**Demonstrating Value and Sustainability**	**Lack of Single integrated electronic record**	If the clinician does not have all the information for a patient at the point of care then the provision of intelligent information is dependent upon clinical information systems that effectively support and assure clinical process. Currently information systems are often disparate and not joined up to provide a view of the whole healthcare process. There are approximately 300,000 duplicate records and there is still a risk that the clinician will not have all the information for a patient at the point of care, as there is not enough capacity in Health Records to retrieve all the records for that patient and amalgamate them.	Guidance issued to staff on how to choose the most relevant number where duplicates exist. The most relevant paper case note is pulled for the patients new consultation i.e.. the note with any cardiology activity would be pulled for a cardiology appt etc.	4	5	20	Implement Informatics Development plan and move to paperlite outpatients and more electronic ways of working, reducing the need for paper case notes. Medium to long term investigate funding for scanning of historical paper records to also reduce reliance on paper.	Medical Director	Treat	Audit Committee	There is a national Welsh Care Records Service project to provide views of clinical electronic information such as clinic letters, discharge summaries, operation notes via the Welsh Clinical Portal. In the interim a clinical document viewer has been made available as part of the ABMU clinical portal enabling available ABMU clinical information at the point of care. The Informatics SOP has been refreshed and was approved by WG in August 2016. The case will provide the necessary wireless infrastructure into Singleton and community hospitals (bringing them in line with the three other acute hospital sites) and will provide the platform to deliver projects that will enable the provision of electronic information at the point of care. The Wireless Business Case was approved by WG in December 2016. The implementation of the Wireless infrastructure has commenced with a view to having been completed by the end of Calendar year 2017. The RFID and Scanning business case was submitted to WG in December 2016 and the HB are awaiting the outcome. WG still haven't formally fed back on the business case but have indicated that, although supportive in principle, are unlikely be able to support the case in 17/18. Informatics are now exploring alternative models and funding solutions to take the case forward. ABMU have been working with NWIS and the HBs to accelerate the convergence of the patient record into WCP. ABMU have now got access to all Wales Radiology and Pathology reports, the GP record and will go live with an all Wales view of documents during Autumn 2017. This will be achieved through the proposed allocation of a proportion of the £10m available from WG (still to be confirmed) and supplemented by commitments identified in the Informatics discretionary capital allocation. ABMU are live with the Welsh Care Record Service and therefore	16			
37	Q2 2016/17 Reviewed May 18 Medical Director	**Demonstrating Value and Sustainability**	**Reporting of clinical information is insufficient to meet the HB needs.**	If we are unable to access intelligent information then it will be difficult to make informed decisions and improve activities to support operational and strategic service development. Although there has been an increase in the availability of Business Intelligence tools the use of data and information remains fragmented and is not always at the heart of decision making. There is a requirement to expand on provision of these tools, improve the skills and capabilities across the Health Board in the use of data and measurement to inform decision making and undertake measures to improve data quality and timeliness. For example there is insufficient capacity within the coding teams to meet Tier 1 targets in clinical coding which impacts on timeliness and accuracy of data for reporting. ABMU is not fully utilising the data that is available to measure clinical effectiveness and patient safety.	Flexible operational management of Coding Teams on a daily basis to cope with demand. Training programme in place for new coders. Numerous reports submitted to Executive Team for additional funding; Short term funding secured at year end to support meeting tier 1 targets but does not resolve ongoing issues Information Dept. working with service leads in Planning and Finance to develop meaningful indicators also utilising dashboards to present information in a user friendly way	4	4	16	Dashboard technology; assist in developing indicators / triangulating information to identify issues	Medical Director	Reduce	Audit Committee	The Health Board has continued to invest in the provision of Dashboards and we have just doubled our licensing stock for both QlikSense and QlikView Business Intelligence Platforms. These platforms will help us move towards more advanced data analytics. There are now 16 dashboards in place using the aforementioned technology including the recent additions of a Mortality, Clinical Variation and Primary & Community Care Delivery Unit Dashboard. A Ward Dashboard (already under user acceptance testing) will be released in May. This dashboard will allow senior managers and matrons to access readily available data relevant to their wards to support patient flow and decision making. The Information Department has now appointed a Business Intelligent Information Manager, who will take the lead for creating a Business Intelligence Strategy and Implementation Plan. The Business Intelligence Strategy will focus on the delivery of efficient information management, specification, design and development of information reporting systems covering the breadth of health informatics. This post underpins the strategic direction in understanding information requirements across the Health Board, ensuring links with the University, Health Boards and commercial partners to ensure the most effective methods of information provision and delivery. Following the investment and the introduction of revised ways of working in the coding department and the ABMU coding targets have significantly improved and this improvement has been maintained. These changes have improved the quality and timeliness of the data being received. However improved electronic recording of information would support the ongoing delivery of the service and in the long term provide opportunities to consider increasing the amount of automatic electronic coding that is completed.	16			
47	Q3 May 18	**Demonstrating Value and Sustainability**	**Sustainability of Primary Care Services**	Across the range of clinical services in PC & CS there are risks relating to insufficient staff which may affect the sustainability of the services provided.	Clinical and clinical support vacancies to be filled promptly All services continually review efficiency and prioritise workloads Escalation plans in place for each service Skill mix reviews undertaken Hotspots - District Nursing and Speech and Language Therapy, and Community Hospitals. Each of the local services has a mitigation plan	4	4	16	Primary Care & Community Services Strategy developed and being implemented.	Chief Operating Officer	Treat	Quality & Safety Cttee	Primary Care & Community Services Strategy developed.	16			

27	Q1 2012/13 Reviewed May 18 Medical Director	**Demonstrating Value and Sustainability**	**Clinical Information Systems**	If we lose access to key clinical and support service information due to insufficient level of capital funding for technical system and hardware refresh then there will be an increase in demand for ICT solutions. There has been an increase in the number of devices in circulation by 1000 (13%) over the last 3 years without an increase in IT support capacity.	Limited discretionary capital (approx. £500k pa) is utilised to invest in priority areas. Resilient systems and networks implemented wherever possible. Working closely with Finance to secure additional capital annually on an ad-hoc basis. Ongoing requirement is £2.3 million on an annual basis. Ensuring IT revenue costs are included in all business cases that require additional devices.	4	4	16	Continue to invest in technology which reduces capital requirement such as server virtualisation and thin client technology. Investigate feasibility of implementing 'bring your own device' (BYOD) facility to improve access for clinicians. Develop strategic outline programme (SOP) for Informatics to bid for capital investment from WG Update IT procurement policy to ensure it reflects the on going revenue consequences for the purchase of new equipment.	Medical Director	Treat	Audit Committee	The HB has identified £1.3m from discretionary capital to support technology refresh of existing equipment in 2016/17. In addition the HB has secured £1.1m in 2016/17 from WG to replace the LAN at Morriston hospital and a further £350k for cyber security issues. The refreshed SOP was approved by WG in August 2016. A digital strategy has been developed and circulated for comment and feedback in October 2016. At the end of 2015/16 the HB secured WG funding to support the mobilisation of community staff and has, as a result, identified £1m revenue (of which £400k relates to staff) to support the service on an ongoing basis. Further work is ongoing to ensure that both revenue and capital investment in informatics continues to increase. The final draft of the Digital Strategy is currently out for consultation. Following approval of the Digital Strategy plans will be developed to ensure delivery, including the resources required. The discretionary capital allocation for 17/18 currently stands at £600k compared to a requirement of £3.75m. This remains a significant risk. No additional revenue funds have been allocated to support the increase in activity and Informatics have been asked to realise a CIP in 17/18. The volume of telephone calls to the IT Helpdesk in 2017 have increased by 36% compared to the same period in 2014 - despite the introduction of automation and self help services. Plans are currently being reviewed to determine the impact on quality service provision and exploring opportunities for further automation and other service delivery mechanisms. A total £2.5m was made available for Technology refresh in 2017/18 with just under half of this being released in the last 3	16			
Embedding Effective Governance and Partnerships																				
44	Q2 May 18 Medical Director	Sustainable & Accessible Services	**Current ED systems are not fit for purpose: - - There is an increased risk of system failure (PoWH) - do support effective and efficient working processes (Morriston)**	ABMU currently has 2 ED systems in use - WPAS in Morriston and ACCENT in POW/NPTH. Current functionality in the WPAS ED module its limited, does not support electronic ways of working and is considered to be inefficient. ACCENT is an aging system, the software is unsupported and it has to be hosted on Servers that are also unsupported due to it being incompatible with up to date infrastructure. ABMU have planned to move to the all Wales ED system, WEDS, which was anticipated to improve performance in Morriston by 3% from Dec 2017 (releasing £112k efficiency savings) and provide POWH with a resilient ED system. WEDS has failed to be delivered by the supplier.	Resilience (PoWH) - Business continuity plans in place within ED. If Accent were to fail plan to migrate from ACCENT to WPAS. This may impact on efficiencies with POW. Alterative temporary arrangements are being explored (see action plan) WEDs - appropriate project management in place. Issues escalated via NWIS to supplier. Alterative temporary arrangements are being explored (see action plan)	5	4	20	NWIS are leading negotiations with WEDS supplier. Breach of contract notice has been issued - aim is to get the Supplier to meet system requirements within an agreed timeframe. Contingency plans are being drawn up and agreed with the service. Currently the plan is to migrate to an upgraded version of WPAS to provide improved functionality in Morriston. The way forward for POWH/NPT will be decided once the process relating to the Breach of Contract has completed.	Medical Director	Treat	Audit Committee	A successful upgrade to WPAS 505 took place across the Health Board in November 2017. This upgrade included a change of business processes for Morriston ED staff such that users changed working practices to support electronic triage and recording of meds and diagnosis electronically. A request has been submitted to NWIS to support a WPAS go live in PoW ED and NPT. However, consultation may be required with Cwm Taf before formalising an agreed plan. In parallel, the Health Board remain committed to the national WEDS programme and await a new release for testing in Autumn 2018.	20			

45	Q2 May 18 Medical Director	Excellent Patient Outcomes & Experience	**Patients are discharged from hospital without the necessary information being made available to continue their care to a high standard**	Despite the provision of an electronic discharge summary available across the Health Board to support the processing of discharge summaries within agreed targets, compliance with the targets, on average, remains low. GPs are therefore not always provided with the information required to provide continued care on discharge of the patient.	1. Executive directive issued to all SDUs to improve compliance. 2. Medical Director in Morriston SDU leading "no discharge summary, no discharge" initiative with training support being provided by Informatics to improve performance. 3. E-learning package now available to support training requirements. 4. Performance Dashboard available to provide "live" view of EToC status	4	5	20	1. All SDUs to focus on improved performance - actions plans required from each SDU to demonstrate how compliance will be achieved 2. Implementation of WCP will include the MTED module which will allow extra project support to facilitate improved compliance.	Medical Director	Treat	Audit Committee	• The most recent HB "completed & sent" performance was 60% (August 2017) compared with 48% a year ago.• In August 2017 the best performing hospital is NPTH (83%), this is reduced by the poor performance on wards not directly managed by NPT. Medical Wards regularly achieve 99%• August 2016 v August 2017 Delivery Unit comparisons demonstrate substantial improvement in Morriston, POW & Singleton• Morriston is coming to the end of a 6-month improvement programme which is bearing fruit, performance was 46% in March when it started• Singleton are looking to recruit two Physicians' Associates to help drive up performance further A meeting of the Discharge Information Improvement Group that is chaired by the Executive Medical Director and attended by all the secondary care UMDs, or their representatives, will be taking place on 23rd November to review progress and agree further improvement actions. Every Unit has targeted improvement adopting a "no summary – no discharge approach" There has been a sustained improvement in performance and it is now possible to target individual clinical teams. During 2017 improvements have been made and in Q4, 72% of EToC forms were approved and sent, however only 63% were approved and sent within 5 working days.	20			
40	Q4 2016/17 Reviewed May 18 Medical Director	**Effective Governance**	**Insufficient Information Governance resourcing and low mandatory Information Governance training compliance**	If we are unable to mitigate against the risk then financial penalties may result due to inappropriate management of information and poor IG practice across the Health Board. Lack of training increases risk of breaches. ICO consider training compliance when deciding on level of action to take / fine amount. Toolkit requires 95% compliance across the organisation current compliance for ABMU is 32%. Currently 5 breaches pending ICO decision at risk re financial penalties of up to £0.5m per breach.	IGB established. IGB Leads identified. Improvement plans developed. Communications available to all staff. Training programme in place - e learning, face to face, open sessions. IG intranet pages to direct staff and to cover short term placements for students and locums. SIRO identified. Resource requirements raised at IGB, Audit Committee and to Exec Team.	4	4	16	Report training compliance to IGB bi monthly. ICO training audit action plan. Further bulletins and letter from CEO/SIRO. Local e-learning and training video in development. Prioritise workload based on available resources.	Medical Director	Treat	Audit Committee	Executive Director reviewing options and will report to the Executive Team to consider options to treat the risk. Executive Director reviewing options and will report to the Executive Team to consider options to treat the risk. The Medical director and Chief Executive has written to every director of staff outlining training compliance and requirements for improvement. There has been a 17% increase in compliance since April, but compliance still stands at 54% and this improvement needs to be continued to meet the requirements of the ICO who are auditing our training compliance Oct 2017. Resources have not allowed for local eLearning or training video, and revised national eLearning incorporating GDPR is awaited instead (agreed by IGB Sep 2017). A funding bid was submitted to IBG in January 2018 which successfully secured funding for the recruitment of an IG team. The funding included an additional 2wte band 7s, 1wte band 6, 1 wte band 5 and 1 wte band 3. This will significantly improve the compliance with legal standards and compliance with best practice of the IG team. The recruitment process has been successful and all posts appointed. The team will be at full complement from June 2018, at which point the risk of resources in the IG team will be removed. The Medical director and Chief Executive has written to every director of staff outlining training compliance and requirements for improvement. There has been a 15% increase in compliance since April but compliance still stands at 47% and this improvement needs to be continued to meet the requirements of the ICO. Executive Director reviewing options and will report to the Executive Team to consider options to treat the risk. The Medical director and Chief Executive has written to every director of staff outlining training compliance and requirements for improvement. There has been a 17% increase in compliance since April, but compliance still stands at 54% and this improvement needs to be continued to meet the requirements of the ICO who are auditing our training compliance Oct 2017.	12			
43	Q1 2017-18 Updated May 2018 Dir N&PE	**Excellent Patient Outcomes & Experience**	If the Health Board is unable to complete timely completion of DoLS Authorisation then the Health Board will be in breach of legislation and claims may be received in this respect.	Legislative requirement to authorise DoLS applications within timescales (7 days or 21 days depending on type of application). Following a Legal Judgement there has been around a tenfold increase in the number of applications requiring processing leading to a significant number of breaches of the timescales. This is a national issue and the Law Commission has recommended a review of the DoLS process. An update of this is expected Spring 2018. May 2018 position in ABMU HB.	Process in place within P&C Unit for management of authorisations and identifications of breaches in timescales. The Corporate Safeguarding Team is monitoring this.	4	4	16	Paper presented to Executive team by P&C Unit outlining resource requirements to address authorisation breaches. Added to IMPT. Safeguarding Committee convened a T&F group to work with Units to identify potential solutions to reduce the impact on the process	Director of Nursing & Patient Experience	Treat	Quality & Safety Cttee	The HB DoLS Improvement Group continues to meet and the managing authorities are reporting their breaches to the Safeguarding Committee on a bi-monthly basis. A total of 34 BIAs have now been trained, 12 of which are waiting to shadow practicing BIAs prior to acting independently. Supervisory Body have increased the number of signatories from 3 to 7. There is additional administrative support being agreed in Primary Care and Community Services to address the breach position.	12			

23	Q4 Mar 2015 Reviewed May 18 Director of Strategy	**Effective Governance**	**Business continuity and Disaster Recovery**	If there is a large scale system failure then this may impact on the delivery of key services	ICT Business Continuity Task and Finish Group set up to develop coordinated disaster recovery plan.	4	3	12	Business Continuity plans to be developed for key IT and Clinical Systems to be made available across the Health Board via the Emergency Planning Web Site	Medical Director	Treat	Audit Committee	Plan to be considered by the Emergency planning and Informatics Strategy and Governance Board. The Informatics Business Continuity Plan has been updated and a draft discussed with the Head of Emergency Preparedness Resilience and Response. Suggestion for further improvement will be incorporated into the Plan and signed off by the Informatics Senior Team. A table top exercise will be held in 18/19 to test the plan.	12			
28	Q3 2013/14 Reviewed May 18 Director of Strategy	**Effective Governance**	General Data Protection Regulation (GDPR)	The outcome of a national and local assessment is that that ABMU **will not be compliant with the new data protection law GDPR from May 2018, due to current resources**. The ICO and Wales Audit Office have noted concern that ABMU will not be compliant due to under resourcing.	· Action plan developed and progress reported to Information Governance Board. (December 17) · Identify resources required to improve compliance (December 17) · Gain approval for additional resource (January 2018) · Update Health Board and Audit committee on position (January 2018) · If approved by Investment and Benefits Group recruit resources (January 2018) · Subject to resources, deliver action plan to improve compliance (February - May 2018, then ongoing in future years) · Monitor and report compliance to Information Governance Board and Audit committee (a continuous requirement)	4	5	20	Gap Analysis taken to Sep IGB, action plan to take to Dec IGB. Executive team received GDPR briefing	Executive Medical Director	Treat	Audit Committee	Approved by IGB Dec 2017 to escalate to corporate risk register. Paper to Investment and Benefits Group being drafted . A funding bid was submitted to IBG in January 2018 which successfully secured funding for the recruitment of an IG team. The funding included an additional 2wte band 7s, 1wte band 6, 1 wte band 5 and 1 wte band 3. This will significantly improve the compliance with legal standards and compliance with best practice of the IG team. The recruitment process has been successful and all posts appointed. The team will be at full complement from June 2018, at which point the risk of resources in the IG team will be removed. The team will deliver against a robust GDPR action plan to achieve a comprehensive level of compliance by December 2018. The risk of non compliance will then be managed at a more local level.	12			
29	Q3 2013/14 Reviewed May 18 Director of Strategy	**Effective Governance**	**Service/Business interruption/ disruption**	**If we do not ensure we have robust and resilient Business Continuity Plans** across the organisation then we may not be able to prevent/limit service disruption and possible financial implications. *The impact of any interruption could range from negligible to catastrophic and as such the risk has been scored as a worst case scenario.*	1. Existing BCM Plans for each Locality and Directorate. 2. Generic HB wide Business Continuity plans 3. Business Continuity Framework.	4	4	12	BCM Planning & Review process to continue across the Health Board, building on the work already undertaken. Individual service support offered via Emergency Planning to assist in development of BCM plans.	Director of Strategy	Treat	Audit Committee	The EPRR Strategy Group will focus in 2017 on Unit specific services business continuity plan development.	12			
41	Q2 2017/18 Reviewed May 18 Dir of Strategy	**Effective Governance**	**Fire safety for buildings with applied external cladding**	Currently an uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations	Fire risk assessments. Evacuation plans (vertical and horizontal). Fire safety training. Professional advice sought on compliance of panels.	5	3	15	Professional assessment of panel compliance being taken forward with NWSSP-SES, building control and WG colleagues. H&S team to engage on site (week commencing 3rd July)	Director of Strategy	Treat	H&S Committee	Situation is updating daily. Actions are in place. Further professional assessment w/k23/10/2017. A draft Stage 2 Fire Safety Risk Mitigation Review Report has been received from ARUP Fire Engineers indicating immediate risk mitigation management control measures which have been implemented and are being continually monitored to ensure compliance is maintained. Medium Term measures will be implemented within the next 6 months which will include a change in fire evacuation plans and alarm and detection cause and effect. Long term risk mitigation measures include permanent remediation of the external wall cladding to comply with HTM 05-02 and Building Control Regulations Approved Document B. This will mean replacing the existing cladding and insulation with alternative specifications and inserting 30 minute fire cavity barriers where appropriate. The final report is due to be presented by ARU's early January and will be shared with the Executive Team and Health Board.	15			
46	Q3 May 18	**Effective Governance**	**Governance of the Board**	This risk relates to the number of new Independent Members and a number of Executive Directors in interim positions which poses a risk to Board governance arrangements and effective committee working.	An induction programme and Board development programme are planned to help mitigate the risk.	4	3	12	Board Secretary will review the induction programme and development programme and consider any further actions which can be taken to help minimise the risk further.	Board Secretary	Treat	Audit Committee	Recruitment of Executive posts being progressed.	12			