ABM University Health Board	
Date of Meeting: 23rd January 2018 **Name of Meeting: Audit Committee** **Agenda item: 2e**	
Subject	*Strategic Risk Report*
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Approved by	Cathy Dowling, Interim Deputy Director of Nursing & Patient Experience
Presented by	Angela Hopkins, Interim Director of Nursing & Patient Experience

1. PURPOSE

This report is to provide the Audit Committee with an update in relation to the work ongoing on risk management.

2. BACKGROUND

Effective risk management is integral to enabling the Health Board to achieve objectives to deliver safe, high quality services and patient care.

The Health Board has developed the corporate objectives for 2017/18 which provide the basis upon which our work programme and delivery of the Annual Plan will be performance managed throughout the year. It is important that risks are identified in terms of the ability of the Health Board to deliver these objectives:

- **Objective 1 -** Promoting and Enabling Healthier Communities
- **Objective 2 -** Delivering Excellent Patient Outcomes, Experience and Access
- **Objective 3 -** Demonstrating Value and Sustainability
- **Objective 4 -**Securing a Fully Engaged and Skilled Workforce
- **Objective 5 -** Embedding Effective Governance and Partnerships

3. RISK MANAGEMENT DEVELOPMENT

A risk management workshop for the Board was held on 14th December 2017. The notes of the session have been shared with the Board members to ensure the comments have been captured accurately. The session provided an opportunity to reflect on the current corporate risk resister, requirements for updating the risks to the Health Board achieving our objectives and also an opportunity to reflect on processes and changes required. As a result of this a revised risk management work programme will be produced and the risk management strategy and policy will be updated to take account of the following:

- Board Assurance Framework to be developed;
- Three levels of risk registers will be in place underpinning the Board assurance Framework – Corporate, Executive and Unit. Each Unit has arrangements in place for how sub risk registers report into the Unit risk register;

- Corporate Risk Register template to be revised;
- Risk Matrix to be reviewed to consider the inclusion of proximity to score risks in addition to consequence and likelihood of the risk being realised.

4. INTERNAL AUDIT REPORT

Internal Audit undertook a review of risk management and assurance in the Health Board in quarter two of 2017/18. The review focussed on the processes that had been adopted to establish a robust risk management and assurance framework across all activities of the Health Board.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Risk Management is **Reasonable** Assurance. Six recommendations were made which have been accepted and an action plan to take forward the recommendations is in place.

5. CORPORATE RISK REGISTER

The Corporate Risk Register is attached as **Appendix 1.** 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.

- **Finance (Risk Ref 2) linked to the Health Board Objective Effective Governance**
  The controls in place and actions being taken to decrease the risk are provided within the relevant entry on the Corporate Risk Register for the risk identified and both the Audit Committee and Board receive reports at each meeting on financial performance and proposed actions to mitigate the risk which is a challenge for 2017/18.

- **Risk Ref 42**: Sustainable services and finances. This risk relates to 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.

- **Risk Ref 44: Emergency Department Clinical Systems.** There is an increased risk of system failure (PoWH) - and support effective and efficient working processes (Morriston).

- **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.

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 7: Adverse Publicity	RR 13: Environment/ Premises	
4 Major			RR 17: Equipment Replacement RR 24: Compliance with PSN's RR 16: Waiting Times RR23 & 29: Business Continuity & Disaster Recovery RR 28: Service Business Interruption 46 Corporate Governance of the Board	RR 4: Infection Control RR9: Access to Services RR 11: Dignity in Care & Needs of Older People 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 RR 40: Insufficient information governance resources RR 39: IMTP not approved by WG RR 43: Deprivation of Liberties RR 45: Discharge Information RR 47 Sustainability of Primary Care Services	RR48: Compliance with GDPR
5 Critical			RR 15: Population Health RR 41: Fire Safety for buildings with applied external cladding	RR 2: Financial deficit risk of special measures RR 3: Workforce Planning Record RR 42: Sustainable services & finances. 44: ED Clicnial Systems RR 1: Unscheduled Care	

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

Update on risks:

Changes made to the Corporate Risk Register include the addition of three new risks as approved by Executive Directors:

- RR 46 - risk added to the Corporate Risk register relating to the 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.

- RR 47 – Primary Care Services and sustainability of the services.

- RR 48 – this relates to the risk of the Health Board not being able to the comply with the requirements under the General Data Protection Regulation (GDPR) The outcome of a national and local assessment is that the Health Board **will not be compliant with the new data protection law GDPR from May 2018, due to current resources**. The Information Commission Officer and Wales Audit Office have noted concern that the Health Board will not be compliant due to under resourcing. A report for the Investment and Benefits Group is being drafted for consideration in terms of options to reduce the risk.

6. External Inspections October - November 2017

There have been three inspections in the Health Board since the last report was submitted to the Committee, summarised as follows:

- **Ward 12 Singleton Hospital**

  25th September, HIW paid an unannounced visit to Ward 12 Singleton Hospital. The Unit Nurse Director for the Singleton Service Delivery Unit was provided with verbal feedback at the end of the visit. A draft report was received from HIW on 3rd November 2017, confirmation an action plan was returned on the November 2017.

- **Singleton Admissions Unit**

  13th & 14th November HIW paid an unnannounced vist to Singleton Admissions Unit. The Unit Nurse Director for the Singleton Service Delivery Unit provided an account of the feedback received.

  At the beginning of the verbal feedback the HIW team confirmed that there were three immediate concerns identified that would trigger an immediate assurance request, but that the Team in SAU had been well engaged and very welcoming and that the Patient Experience and Feedback had been excellent and Standards of Care good. These are detailed below.

Singleton Admissions Unit	
Improvement needed	**3 immediate Improvements were identified**
1	To provide HIW with details of the action taken to ensure that medicines are safely stored on the SAU, the MIU and on other wards and departments across the health board. **Two of the three sections of this are now complete.**
2	The health board is required to provide HIW with details of the action taken to ensure that resuscitation equipment/medication is always available and safe to use in the event of a patient emergency on the MIU and other wards and departments across the health board. **Two of the three sections of this are now complete.**
3	The health board is required to provide HIW with details of the action taken to ensure that cleaning solutions are safely stored on the SAU and other wards and departments across the health board. **This action is now complete.**

- **Singleton Radiology Department**

  14th and 15th November, HIW made an announced IRM(E)R inspection of Singleton Radiology Department.

7. **Healthcare Inspectorate Wales (HIW) Inspections Letters from External Inspections Bodies**

There were 14 letters received from HIW during October 2017 to and November 2017 follows:-.

Correspondence Summary	
Date	Correspondence Details
26.09.17	E-mail was received from HIW regarding the care and treatment of her partner. The Health Board assured HIW that the concerns are being dealt with under Putting Things Right Regulations.
01.10.17	Immediate assurance letter was issued to a dental practice (Crescent Dental) by HIW as a member of staff was not up to date with CPR training. The letter has been sent to the dental practice requesting a response by 6th October to Director of Primary Care and Community. The practice responded and HIW wrote to the practice accepting their improvement plan.
03.10.17	Health Board returned an improvement plan to HIW in regard to Angelton Clinic, Glanrhyd. HIW have now approved the plan.
03.10.17	Health Board replied to a monthly follow up letter. Progess is noted and the Service Delivery Units are being chased to try and bring these issues to close.
05.10.17	HIW wrote to the Health Board to say they were not assured with on aspect of our Angelton Clinic Improvement plan. The plan was amended and resubmitted and accepted. The plan is being implemented by the Service Delivery Unit at Mental Health & Learning Disabilities Quality and Safety meetings.
05.10.17	HIW also issued a draft investigation report following an inspection on Taith Newydd. Comments re factual accuracy and completion of an action plan were returned to HIW and accepted
12.10.17	HIW issued a report on Cefn Coed Hospital Mental Health Act Compliance. An action plan and agreement of accuracy was returned to HIW on 24th October and accepted.

13.10.17	Health Board responded to HIW's review of transition for young people between paediatric and adult services in Wales. A questionnaire had been circulated to all Service Delivery Units for information to aid the review. Returns were collated and a reply sent with in the required time scale.
16.10.17	Health Board received the report from HIW IRM(E)R visit to Morriston Cardiac Unit. The report contained a very positive endorsement of the department and no improvements are required.
17.10.17	Health Board submitted to HIW the required documentation regarding the forthcoming IRM(E)R visit to Singleton in November
18.10.17	Health Board received an outstanding issues letter in respect of three matters . A response has been sent to HIW
02.11.17	Health Board received the report and action plan for Caswell Clinic, Glanrhyd. The plan has been completed by the Service Delivery Unit and has been sent to HIW
03.11.17	Health Board received the draft report and improvement plan for Ward 12 Singleton following their visit on 25th September. The action plan and accuracy assessment have been returned to HIW.
07.11.17	HIW Informed the Health Board that they have completed reviews looking into the clinical care provided to an individual following their death while in custody in a local Childrens Home in 2016. The full report will be shared with the Health Board once finalised.

8. Reviews Sent to Welsh Government

During the period no results of review were sent to Welsh Government.

9. RECOMMENDATION

The Audit Committee is asked to note the contents of the report.

Name of Register: CORPORATE

Date: December (Q3)

Ref	Opened/ Received Update	Objective for 17/18	Risk	Current context	Controls in place	Initial RA: Consequence	Initial RA: Likelihood	Initial RA: Rating	Action Plan	Action Lead	Option Agreed	Board/ Committee	Progress	Revised RA - (2016/17): Q1	Q2	Q3	Q4
Promoting and Enabling Healthier Communities																	
15	Q1 2013/14 Reviewed Jan 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 achieveing 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	15	15	
Delivering Excellent Patient Outcomes, Experience and Access																	
1	Q1 2012/13 Reviewed Dec 2017 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	5	20	• 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 •Winter planning arrangements implemented for 2017/18	Chief Operating Officer	Treat	Quarterly report to the Q & S Committee and monthly reports to performance and finance committee. Regular updates to the Board	Q3 performance has deteriorated compared with the Q3 in the previous year. External improvement support similar to that previously provided at Morriston hospital is commencing at Princess of Wales hospital on 8th January. Units continuing to refine and develop new models of care to work towards best practice. The winter plan has been implemented and additional surge capacity of circa 91 beds have been opened above baseline capacity. The total number of days lost owing to delayed discharges have increased in the Q3 compared with the previous year - HB and LA Executive to Exec discussions to explore short term and longer term solutions are taking place in early January. HB wide campaign to highlight risk to patients through prolonged lengths of stay	15	15	20	

4	Q1 2012/13 Reviewed Jan 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 relation to bed/bay/ward closures for the recommended period of communicability due to competing pressures and associated clinical risks arising from unscheduled care admissions. o reactive room environmental decontamination utilising hydrogen peroxide vapour or UVC light is not being used consistently, due to staff safety concerns o Health Board C. difficile Infection Improvement Group disbanded	● 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, Health Board C. difficile Infection Improvement Group; Corporate Infection Prevention & Control Nursing Team; Water Safety Group; and Directly Managed Unit Infection Prevention & Control Groups. ● External review of Infection Prevention & Control and the Management of Clostridium difficile infections within ABM UHB (2015). Recommendations have been incorporated within the Health Board's C. difficile Infection Improvement Plan.	5	4	20	1. Develop Job Description for Deputy Director for IPC, with responsibility for strategic leadership on IPC and decontamination, to go to vacancy panel in January 2018. 2. Redesign team to future-proof corporate IPC nursing service, to align with Quality & Safety Priorities of Health Board and the HCAI Reduction Collaborative Improvement Programme, by 31 March 2018. 3. Reduce overuse and inappropriate use of antibiotics across the Health Board by: a. Introducing a more restrictive antimicrobial guideline (restrict the use of Co-amoxiclav) b. Auditing antimicrobial prescribing, to identify clinical justifications for prescriptions. 4. Establish local HCAI Reduction Collaborative, and agree drivers aligned to Health Board Quality & Safety priorities, as well as participating in national collaborative. 5. Provision of decant facilities as part of capacity redesign 6. Revisit cleaning specifications to take into account new builds and service redesign. 7. Review provision, structure and function of Rapid Response Teams to be responsive to service pressures and demands. 8. Increase segregation capacity by increasing single room provision within capacity redesign; a proportion of these to include en suite provision. 9. Capital development of first negative pressure isolation room on Morriston medical ward to be completed by March 2018. 10. Development of capital scheme for provision of negative pressure isolation rooms in: Morriston Emergency Department and Morriston ITU in 2018/19 FY and 2019/2020 FY. ● Progress and monitor improvement actions in relation to C. difficile. ● Continue with Root Cause Analysis to ensure monitoring and lessons continued to be learned from HAI.	Director of Public Health	Treat	Unit performance reviews/ Quality and safety committee/Infection control committee	•Progress is being made in agreeing an option appraisal for the location of negative pressure isolation facilities within the HB. ● The HB is off trajectory against all its tier one targets. All Units have been advised of their individual trajectory and target to be met. No progress has been made in reducing C difficile - with rising average numbers of cases per month across the HB in Q1, Q2 and Q3. he challenge now is to sustain this reduction. ● All hospital sites and wards have been issued with upper control triggers so that hospital management IPC groups are able to take proactive measures to reassess controls and implement further requirements. The management group are multi professional in their terms of reference which is supporting a team based approach to problem solving and management of risks and solutions. Performance is being monitored through monthly performance reviews with directorates with the highest target to meet being met with more regularly to offer support and monitor progress against agreed action plans. ● The HPV and UV environmental decontamination methodswere suspended shortly after being introduced, due to staff concerns about safety. Clear protocols are in place. support from the supplier has been negotiated and negotiations with staff have overcome most of the resistance. UV cleaning is expected to be re-introduced in January 2018. Negotiations over HPV cleaning are ongoing, but the supplier has proposed providing some interim cleaning pro bono.	16	16	16	
9	Q1 2012/13 Reviewed Dec 2017 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 workstream of the recovery and sustainability programme.	Chief Operating Officer	Treat	Bi monthly Board meetings Recovery and sustainability board.	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 workstream on patient flow. Patient flow metrics for Q2 provide evidence of improvement.	15	15	15	
11	Q1 2012/13 Reviewed July 2017 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	Chief Executive	Treat	Bi Monthly Board	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.	16	16	16	

17	Q1 2012/13 Reviewed Dec 2017 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	Medical Device Committee Investment and Benefits Gropu	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 eqiupment replacement in December 17.	12	12	12	
24	Q4 2012/13 Reviewed December 17	**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 majoirty 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	Quality & Safety Forum and Q&S Committee	Action Plans for each notice monitored on an exception basis through the Assurance & Learning Group 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:	12	12	12	
16	Q1 2012/13 Reviewed Dec 2017	**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	Monthly Board meetings	•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	12	12	
13	Q1 2012/13 Reviewed Dec 2017 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 and Q&S Committees Health Board	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	12	12	12	
Securing a Fully Engaged and Skilled Workforce																		

3	Q12012/13 Reviewed Dec 2017 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	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. 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. 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	20	20	20
Demonstrating Value and Sustainability																			
42	Q2 2017/18 Dir of Finance - Dec 2017	**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.	£39m deficit posted 2016/17. £36m deficit forecast/ target 2017/18. The cost drivers include • long term care • staffing costs • clinical supplies • efficiency and productivity performance such as length of stay. Key spend areas have grown significantly over the last three years: • Long Term Care £16m • Clinical Supplies £30m • Staff Costs £72m Staff growth of 1000 since 2014	Financial Recovery Controls, Weekly pay and non-pay dashboard; medical agency cap; QVC non-clinical non-pay control panel; spending controls reissued to Units with pay and non-pay control totals; Investment and Benefits Group operating.	5	5	25	Financial Recovery meeting refocused : fortnightly meetings focussing on 30;60;90 Planning and delivery. Ongoing improvement in financial reporting to provide Insight and better support Executive and Unit decision making. Establishment of Investment Group	Director of Finance	Treat	Board	20/12/2017 - Exec lead Work streams to focus on the Opportunities in the PWC Report Sickness absence targets to be issued. Non-pay control framework to be implemented Investment and Benefits Group operational Improved financial reporting and insight to improve transparency and accessible of financial date, in support of better decision making. Develop and implement Capability Plan for Finance Directorate Develop Action Plan in light of WAO NHS Finance Act Report, and the Deloitte Financial Governance Review Value Based Healthcare approach to be embedded into financial planning. Service and Financial Planning 18/19 being finalised as the R&S Work Programme for 18/19	20	20	20
39	Q4 2016/17 Reviewed Dec 2017	**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	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.	Chief Executive	Treat	Health Board	Health Board has written to Welsh Government to advise that an annual plan will be developed for 2018/19, and aim ot 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.	16	16	16

36	Q2 2016/17 Reviewed Dec 2017 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	IGC, Informatics Programme Board	A business case has been drafted proposing the introduction of RFID tracking of the paper health record combined with a scan forward model. The case includes the provision of effective retention and destruction, addresses current storage issues with the proposed developments at Glanrhyd and stops the addition of more paper to the health record. The Business Case was submitted to WG in December 2016 - the HB are awaiting the outcome of the submission. 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. October - WG still haven't formally fed back on the Health records modernisation 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. An invest to Save and ETTF bid have been developed and submitted to WG for alternative funding to support the implementation of RFID solution that will improve the service delivery and bring financial savings. Presentation to WG in October outcome expected in November	16	16	16	
38	Q2 2016/17 Reviewed Dec 2017	**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	IGC, Informatics Programme Board	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.	16	16	16	

37	Q2 2016/17 Reviewed Dec 2017 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	IGC, Informatics Programme Board	Following the investment and the introduction of revised ways of working in the coding department their achievement of the targets have significantly improved. This will 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. The Health Board has continued to invest in the provision of Dashboards including Qlik Sense and Qlik view. Mortality and Community Care Dashboards have been developed and are currently undergoing user acceptance testing. A Clinical Variation Dashboard has also been developed and deployed to Unit Medical Directors to enable them to discuss variation with unit colleagues. The information department is also in the process of submitting a Business Intelligence Information Manager post to the Appeals process in order to ensure that a Business Intelligent Strategy and implementation plan are developed in the very near future. 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. Recruitment to this post underpins the strategic direction in understanding information requirements across the Health Board, ensuring links with	16	16	16
27	Q1 2012/13 Reviewed Dec 2017 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	MSP Programme Board; Informatics Clinical Reference Group	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.	16	16	16
Embedding Effective Governance and Partnerships																		
2	Reviewed Dec 2017 Director of Finance	**Effective Governance**	If the Board does not achieve the target of £36m deficit it risks moving from Targeted Intervention status to Special Measures.	£39m deficit posted 2016/17. £36m deficit forecast 2017/18. No prospect of balanced position being achieved 2017/18; the Boards accounts will be qualified.	Plans and controls are in place to endeavour to achieve a target. £36m deficit position. Further detailed planning needed on the savings plans (CIPs) Financial Control Framework Savings Plans Financial Recovery Meetings with Units	5	5	25	Monitoring and reporting of financial performance. Regular financial performance meetings between SDU and management teams, R&S Director. Action Plan to £36 agreed and actively managed and monitored., DoF. R&S Programme Board to oversee Exec Lead workstreams chaired by CEO	Director of Finance	Treat	Board	20/12/2017 - Financial Recovery meetings refocused : fortnightly meetings focussing on 30;60;90 Planning and delivery. Improved financial analysis and reporting to provide insight and better support decision making; weekly pay and non-pay dashbordas Focus on whole Board financial recovery plans rather than by unit: Sickness absence; Rostering; Non-Pay Financial Control Framework.	20	20	20

44	Q2 Dec 2017 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	IGB, Informatics Programme Board	See action plan - 1st update requested	n/a	20	20
45	Q2 Dec 2017 17 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	Informatics Programme Board/Quality and Safety 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	n/a	20	20
40	Q4 2016/17 Reviewed July 2017 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	Information Governance Board	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). 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	12	12	12
43	Q1 2017-18 Updated Dec 2017 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	Legislative requirement to authorise DoLS applications within timescales (7 days or 28 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	Process in place within P&C Unit for management of authorisations and identifications of breaches in timescales	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	Safeguarding Committee	20/12/2017 - There has been a DoLS Improvement Group set up to identify solutions. This is chaired by the Interim Lead Nurse in Corporate Safeguarding Team. It was identified that the HB needed more BIAs so further training has taken place. It has been recommended that the HB BIAs need to work across the service. A meeting has been arranged between the three Localities within Primary Care & Community SDU in December to set up an efficient BIA service.	n/a	16	16

23	Q4 Mar 2015 Reviewed Dec 2017 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	Emergency planning and Informatics Strategy and Governance Board	Plan to be considered by the Emergency planning and Informatics Strategy and Governance Board.	12	12	12		
28	Q3 2013/14 Reviewed Dec 2017 Director of Strategy	**Effective Governance**	**Service/Business interruption/ disruption**	**If we do not have plans in place for Service/Business interruption (unplanned events** - such as major infectious diseases; pandemic flu; major incidents; severe weather episodes; mass casualty incidents etc) then this could have major implications for ABMU in terms of its resilience, service response and financial cost. *The likelihood of one of these events occurring is almost certain, however the likelihood of all of them occurring is unlikely. The impact of such an event however could range from minor to catastrophic.*	1. Range of Policies and Plans developed on a national, All Wales, South Wales and ABMU basis covering and mitigating against the risks as far as possible. 2. Risks such as these are identified on: National Risk Register - http://www.cabinetoffice.gov.uk/national-security South Wales LRF Community Risk Register, NPT and Swansea Joint resilience partnership, chaired by the local authority. 3. ABMU participation in the All Wales Health Emergency Planning Advisory Group which is a forum for discussing and promoting NHS emergency preparedness and emergency planning policy. 4. ABMU participation in South Wales Local Resilience Forum and Health Board/Trust Emergency Planners Group.	4	4	12	ABMUHB Emergency Preparedness, Resilience and Response, (EPRR) Annual Work Plan in place and monitored through the EPRR.	Director of Strategy	Treat	Emergency Preparedness, Resilience & Response (EPRR) Strategy Group, Local resilience Forum and all Wales Working Groups	The work plan will continue with the emergency planning cycle to ensure that the Health Board is prepared in emergency planning and business continuity arrangements and will include the progression and continued assurance in meeting the civil protection duties as noted within the Civil Contingencies Act 2004. Consideration is being given, in view of a number of business continuity issues recently to establishing an instant response team / plan for such urgent issues to ensure timely and consistent interventions to minimise risk.	16	16	16		
29	Q3 2013/14 Reviewed Dec 2017 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	Emergency Preparedness, Resilience & Response (EPRR) Strategy Group, Local resilience Forum and all Wales Working Groups	The EPRR Strategy Group will focus in 2017 on Unit specific services business continuity plan development.	12	12	12		
41	Q2 2017/18 Reviewed Dec 2017 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	Board	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 Frire 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 eisting cladding and insulationwith 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.	n/a	15	15		

33	Q4 2012/13 Reviewed Mar 2015 COO/DCE	**Excellent Patient Outcomes & Experience …… …… Sustainable & Accessible Services**	Cardiac Services - Access	Delay in access to Cardiac Surgery.	Patients are admitted and treated according to clinical need. Patients are advised to discuss their condition with their GP should they have concerns recording their condition. Patients are formally pre-assessed prior to elective surgery. Emergency admissions are retained until a date for surgery can be provided. Options assessment with architect new build required have been explored for the development and expansion of CITU/CHU unit to increase capacity and flexibility.	4	5	20	Discussions are ongoing with WHSCC and WG about options to extend Cardiac ITU. Cardiac Action Plan in place. • A Cardiothoracic Directorate has been established. • Appointment of a Consultant Cardiac Intensivists • Clinical leadership has been enhanced for CITU with the appointment of a Director of CITU. • Regular communication with staff has continued through fortnightly staff briefings led by the Chief Executive and Chief Operating Officer. • Workforce plans to address gaps and deficiencies have been developed and costed. Revised operational processes in place regarding team briefing and Board rounds which are maximising throughput.	Chief Operating Officer/Deputy Ceo	Treat	Quarterly report submitted to the Quality & Safety Committee on progress.	Cardiac Action plan in place and reviewed by the Q&S Committee quarterly. On track to deliver revised trajectory this year as a result of the actions taken and therefore the risk has reduced to 12	12	12		
26	Q2 2012/13 Reviewed May 2015	**Effective Governance**	Effective Governance …… …… ….. Patient Feedback team	Prolonged period of reduced resourcing within the department, arising through high staff turnover resulting in limited knowledge levels within the team. Increased volume of work entering the	Interim Complaints strategist recruited to review complaints arrangements and progress devolvement of work. Interim Operational Manager for Complaints assisting within department to progress backlog complaints and resolve complaints capacity issues through the next 3 months. Former departmental staff assisting undertaking work as external contractors. Executive oversight of Ombudsman correspondence.	4	4	16	Progress restructuring and redesign of corporate functions provided by the existing department to ensure ownership is appropriately allocated to increase awareness and likelihood of improvement actions being realised and more effective in reducing recurrence.	Director of Nursing and Patient Experience	Treat	Bi monthly to the Quality & Safety Committee	Reduced number of complaints for 2014/15 compared to 2014/13, reduced number of Ombudsman referrals and complaints upheld by the Ombudsman. Serious Incidents investigat	12	12		

18	Q1 2012/13 Reviewed Mar 2015	**Excellent People**	All 6 Domains - Workforce …… …… ….. Employee engagement and staff support and Appraisals	If employees are not engaged / supported appropriately this may have a potential adverse effect on the organisation's ability to deliver its strategic plans and maintaining employee relations / employee wellbeing. Other risks include: Negative perceptions of senior staff engagement (senior staff may not have the opportunity	Workforce & OD Committee will expect assurance of employee engagement and staff support issues. Leadership & OD development to create a culture of change, through leadership and team working. Partnership working with Professional and Trade Union organisations through the ABMU Partnership Forum to engage staff groups in supporting and facilitating employee engagement and staff support initiatives Shared outcome of Quality & Safety Committee.	3	4	12	Develop and implement '1000 lives plus quality and safety staff survey' corporate and Locality / Directorate Action Plans. Significantly invest in team development across the organisation, using the Aston Team Based Working Model and the development of Lead Team Coaches in Localities and Directorates. Use 'Changing for the Better' Editorial Board to drive and monitor the ABMU engagement and staff support agenda Renewed focus on PDRs/appraisals driven by the Executive Board. Sustain and build on the success and impact of the Executive Walkarounds and Staff Open Forums to engage with and listen to our staff to improve performance and the patient experience. Celebrate success and share learning through events, staff communication and forums	Director of Workforce and OD	Treat	ABMU Workforce & OD Committee	HB continues to hold: Chief Executive blog, Rumour Line, monthly cascade of ABMU Team Brief; staff forums; C4B community and hospital events; medical staff forums, leadership walk rounds, specific site meetings. Organisational values launched. Operational structures continue to apply Team Based working.	8	8		