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Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board



Audit Committee

Meeting Date	Agenda Item			2e
Report Title	Strategic Risk Report			
Report Author	Hazel Lloyd, Head of Patient Experience, Risk & Legal Services			
Report Sponsor	Angela Hopkins, Interim Director of Nursing & Patient Experience			
Presented by	Angela Hopkins, Interim Director of Nursing & Patient Experience			
Freedom of Information	Open			
Purpose of the Report	The report provides the Committee members with an update on risk management work and the updated corporate Risk Register following review and update by Executive Directors.			
Key Issues	The report sets out the high risks to the Health Board achieving its objectives.			
Specific Action Required <i>(please ✓ one only)</i>	Information	Discussion	Assurance	Approval
	✓			
Recommendations	Members are asked to: <ul style="list-style-type: none"> • Note the contents of the report. 			

STRATEGIC RISK MANAGEMENT REPORT

1. INTRODUCTION

This report is for information and provides the Committee members with an update on the work ongoing to progress the strategic risk management agenda with the development of a Board Assurance framework and review and revision of the underpinning Corporate Risk Register.

2. BACKGROUND

Following the Board Development session held in December 2017 work has commenced on developing a framework in Datix for a Board Assurance Framework "BAF". In support of this work a workshop will be held in March to develop the BAF and underpinning reporting arrangements which will include:

- Review and update of the Corporate Risk Register to ensure the risks of the Health Board achieving its objectives are clear and the risks are adjusted to allow for the mapping of risks to Executive Director Risk Registers.
- Re alignment of the risks to appropriate Committees following the review of the Committee structure in the Health Board.

A site visit, of staff within the Patient Experience, Risk and Legal Services Department took place in February to University Hospitals Bristol NHS Foundation Trust. The visit was helpful in supporting the risk management development work and will assist with the development required in the Datix system.

3. GOVERNANCE AND RISK ISSUES

Corporate Risk Register is attached as **Appendix 1** which has been updated following review by the Executive team.

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 have received regular updates on the 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 (Morrison).
- **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.

New Risk

A new risk relating to the failure to sustain Child and Adolescent Mental Health Services (CAMHS) has been identified and the Executive Lead is the Director of Strategy and has been added to the Corporate Risk Register linked to the Health Board objective: Delivering Excellent Patient Outcomes, Experience and Access and has been risk rated as 16.

4. RECOMMENDATION

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

Governance and Assurance					
Link to corporate objectives <i>(please ✓)</i>	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					
N/A					
Financial Implications					
N/A					
Legal Implications (including equality and diversity assessment)					
N/A					
Staffing Implications					
N/A					
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)					
N/A					
Report History	Strategic Risk Report is reported to the Audit Committee at each meeting and the Executive team on a bi monthly basis.				
Appendices	Appendix 1 Corporate Risk Register				

Appendix 1

Name of Register: CORPORATE																	
Date: February (Q4)										Initial RA				Revised RA - (2017/18)			
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 Feb 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.	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	15
Delivering Excellent Patient Outcomes, Experience and Access																	
1	Q1 2012/13 Reviewed Feb 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	<ul style="list-style-type: none"> 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	Quarterly report to the Q & S Committee. Regular updates to the Board	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	15	15	15

4	Q1 2012/13 Reviewed Feb 18	Delivering Excellent Patient Outcomes, Experience and Access	Infection Control Reducing Healthcare Associated Infections	<p>If we fail to reduce hospital acquired infections then:</p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Appropriate organisational structures, management systems and workforce for infection prevention & control must be in place: <ul style="list-style-type: none"> Interim HB-wide ICD appointed, but designated number of clinical sessions only 2/week insufficient for HB. Gap in strategic leadership in IPC and decontamination at corporate level following departure of Assistant Director of Nursing IPC. Imminent reduction in senior IPC operational leadership, expertise and experience 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) 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 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: <ul style="list-style-type: none"> 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 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. reactive room environmental decontamination utilising hydrogen peroxide vapour or UVC light is not being used consistently, due to staff safety concerns 	<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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. <p>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.</p> <ul style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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. 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. Reduce overuse and inappropriate use of antibiotics across the Health Board by: <ol style="list-style-type: none"> Introducing a more restrictive antimicrobial guideline (restrict the use of Co-amoxiclav) Auditing antimicrobial prescribing, to identify clinical justifications for prescriptions. Establish local HCAI Reduction Collaborative, and agree drivers aligned to Health Board Quality & Safety priorities, as well as participating in national collaborative. Provision of decant facilities as part of capacity redesign Revisit cleaning specifications to take into account new builds and service redesign. Review provision, structure and function of Rapid Response Teams to be responsive to service pressures and demands. Increase segregation capacity by increasing single room provision within capacity redesign: a proportion of these to include en suite provision. Capital development of first negative pressure isolation room on Morriston medical ward to be completed by March 2018. 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. <ul style="list-style-type: none"> Progress and monitor improvement actions in relation to C. difficile. 	Director of Public Health	Treat	Unit performance reviews/ Quality and safety committee/Infection control committee	<ul style="list-style-type: none"> 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. The 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 methods were 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	16
9	Q1 2012/13 Reviewed Feb 18 COO	Delivering Excellent Patient Outcomes, Experience and Access	Access - to services	<p>If we fail to managed bed capacity at peak times then this will have a major impact on service delivery around access particularly.</p>	<p>Patient Flow Programme. Board Rounds</p> <ul style="list-style-type: none"> 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	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 work stream on patient flow. Patient flow metrics for Q2 provide evidence of improvement.	15	15	15	15
New Entry	Q4 2017-18 New Entry January 2018 Dir Strategy Reviewed Feb 18	Excellent Patient Outcomes & Experience	Failure to sustain Child and Adolescent Mental Health Services	<p>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.</p>	<p>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.</p>	4	4	16	<p>The CAMHS Network have advised ABMU of the following action to be taken to improve the position:</p> <p>Implementation of the Choice and Partnership Approach (CAPA) started on 1st April 2017 and being closely monitored. Additional investment expected - from Welsh Government is supporting the delivery of Waiting List Initiative clinics to support the position.</p> <p>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.</p>	Director of Strategy	Treat	Commissioning meeting Q&S Committee	<p>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.</p>	n/a	n/a	n/a	16

11	Q1 2012/13 Reviewed Feb 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. <ul style="list-style-type: none"> 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	16
17	Q1 2012/13 Reviewed Feb 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	Medical Device Committee Investment and Benefits Group	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	12	12	12	12
24	Q4 2012/13 Reviewed Feb 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	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	12
16	Q1 2012/13 Reviewed Feb 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	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	12
13	Q1 2012/13 Reviewed Feb 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 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 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 tandem 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	12	12	12	12

Securing a Fully Engaged and Skilled Workforce																	
3	Q12012/13 Reviewed Feb 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	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 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	20	20	20
Demonstrating Value and Sustainability																	
42	Q2 2017/18 Dir of Finance - Feb 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.	£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	20
39	Q4 2016/17 Reviewed Feb 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.	<ul style="list-style-type: none"> 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 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.	16	16	16	16

36	Q2 2016/17 Reviewed Feb 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	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	16
38	Q2 2016/17 Reviewed Feb 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	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	16
37	Q2 2016/17 Reviewed Feb 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	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	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.	16	16	16	16
47	Q3 Feb 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 in place.	4	4	16	Primary Care & Community Services Strategy developed and being implemented.	Chief Operating Officer	Treat	Board	Primary Care & Community Services Strategy developed.			16	16

27	Q1 2012/13 Reviewed Feb 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	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	16
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Embedding Effective Governance and Partnerships

2	Reviewed Feb 18 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 work streams 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 dashboards Focus on whole Board financial recovery plans rather than by unit: Sickness absence; Rostering; Non-Pay Financial Control Framework.	20	20	20	20
44	Q2Feb 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. Alternative temporary arrangements are being explored (see action plan) WEDs - appropriate project management in place. Issues escalated via NWIS to supplier. Alternative 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	20

45	Q2 Feb 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	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	20
40	Q4 2016/17 Reviewed Feb 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	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	12	12	12	12
43	Q1 2017-18 Updated Feb 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.	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	Safeguarding Committee	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. The above measures are expected to reduce the number of breaches.	n/a	16	16	16
23	Q4 Mar 2015 Reviewed Feb 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	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	12

28	Q3 2013/14 Reviewed Feb 18 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. <i>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.</i>	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	16
29	Q3 2013/14 Reviewed Feb 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. <i>The impact of any interruption could range from negligible to catastrophic and as such the risk has been scored as a worst case scenario.</i>	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	12
41	Q2 2017/18 Reviewed Feb 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	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 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.	n/a	15	15	15
46	Q3 Feb 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	Board	Recruitment of Executive posts being progressed.			12	12