# Ref: GJF/2017/05/18

# Golden Jubilee FoundationBoard Meeting 11 May 2017

**Subject:**  Board Risk Register Update

**Recommendation:** Board members are asked to approve the Board Rrisk Register noting updates from Strategic Risk Committee, SMT and Audit and Risk Committee Review

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1. **Background**

The changes to the format of the Board Risk Register approved by the Board Audit and Risk Committee in February 2017 have been made.

1. **SMT Reviews**

Following a presentation from the Counter Fraud Service (CFS) within National Services Scotland on bribery, the SMT agreed to review the current controls in place for Interests, Gifts and Hospitality and consider whether Bribery should be added to the register. A short-life working group is in place to assess the requirements of the following key pieces of legislation:

* Ethical Standard in Public Life (Scotland) Act;
* Public Services Reform Act;
* Bribery Act; and
* Association of British Pharmaceutical Industry requirements.

A separate paper was presented to the Audit & Risk Committee outlining the current arrangements that are in place to provide assurance. In addition further work is under way to develop a policy to cover Interests, Gift and Hospitality supported by a revised register for gifts and hospitality. Staff Workshops supported by CFS will also be delivered.

Given the assurance provided by this review, it is not proposed to add a specific risk to the register at this current time.

1. **Other Proposed Changes – April 2017 Review**

The risk owners have updated the attached risk register which has been reviewed by the Strategic Risk Committee and SMT. The proposed changes to risks are:

* + - **Risk S4 and S8 – Failure to engage staff in organisational change and Inability to develop and sustain a flexible and appropriately skilled workforce:** These risks have been re-assigned to the new Director of Quality, Innovation and People and remain at target. There will be further review over the coming months with the new risk owner to assess progress of the actions.
    - **Risk S5 – Inability to sustain Scottish National Advanced Heart Failure Service (SNAHFS):** This risk has been reviewed with the risk owner and controls updated. There is significant work ongoing in relation to the implementation of OCS and the medical staffing across surgical and cardiology posts. Taking this into account the rating has not been reduced at present but agreement that the SNAHFS strategy needs to be revised to reflect the changes in service and set out future priorities. This will then be assessed to consider strategic risks supporting strategy delivery.
* **Risk S6- Inability of current SACCS clinical service to cope with increasing demand and expectation:** There are now two substantive consultant cardiologists in post and a consultant radiographer in post, therefore the impact of this risk has been reduced from a level four to a level three, taking the total risk score from 12 to nine. This reflects the update on the current controls and takes the risk to target level at medium. Similar to SNAHFS it was agreed in discussion with the risk owner that given the changes, the service strategy should be updated and a strategic risk assessment undertaken.
* **Risk S11 – Information and technology resilience to potential IT security breaches and attacks:** This has been updated to reflect progress in the actions around business continuity and that an audit was undertaken in February. A formal report form Audit is pending, with a fuller re-assessment of risk to be undertaken afterwards.
* **Risk S13 – inability to manage and monitor clinical staff training needs**: Given the work to date and monitoring in place it is proposed that this risk is now a low risk and has been removed from the risk register.

The attached Risk Register was reviewed by the Audit and Risk Committee on 18 April 2017 and agreed to be presented to the Board for approval.

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1. **Recommendations**

The Board is asked to approve the attached register, noting the proposed changes and updated controls.

**Julie Carter Mike Higgins**

**Director of Finance Medical Director**

**(Laura Langan-Riach, Chief Risk Officer)**

| **Ref** | **Risk description** | | **Risk Owner** | **Links to Quality Ambition abd Board Objectives** | **Time**  **Scales**  **longevity** | | | **Current risk target** | | | | | **Current Mitigation and current risk level** | | | | | | | **Planned Mitigation** | | | | **Risk review date** | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Likelihood (initial)** | | **Impact (initial)** | **Risk score (initial)** | | **Current controls in place** | | **Likelihood (initial)** | **Impact (initial)** | | **Risk score (initial)** | | **Gaps in controls**  **Additional controls required to reduce risk as far as is practical** | | **Actions needed to address gaps** | |
| S1 | **Failure to deliver the Board's 2020 vision of leading quality research and innovation**  Strategic – vision is basis of Board strategy so would be significant  Financial: needs to be delivered by strong financial governance and stewardship  Regulation: Unlikely to affect regulation  Reputation: Reputational impact on the Board would be significant if vision for quality, research and innovation were not delivered through the Board strategy and objectives  Operational Delivery:  Operational services in particular the quality impact would be significant if the vision could not be delivered  Workforce: Impact on workforce could be significant if the strategy and vision was not delivered | | Chief Executive  (Jill Young) | Effective  Board Objectives ref 1-6 | To review on a 6-12 months basis | | | 2 | | 4 | 8 | | Effective and robust governance framework in place to ensure the highest quality of care for patients and to identify at an early stage if this risk level were increasing;  Ongoing scrutiny of research projects by R&D Steering Group in place to ensure early identification and resolution of issues;  Regular submission of quality reports to the Chief Scientist Office provides assurance of research quality and integrity;  Research strategy and vision has been developed;  Quality and Innovation Group established to lead on and review progress; and  Regular updates provided to the Board and Senior Management Team meetings via the Quality and Innovation Group.  Recent senior appointments to support delivery of the vision | | 2 | 4 | | 8 | | No gaps identified | | No further action needed at this stage.  On review at March 2017 there is no indication of the risk level changing. | | Sept 2017 | |
| S2 | **Adverse Effects on Board 2020 strategy as a result of consequences of the Integration of Health and Social Care**  Strategic – Impact if the Board remit or structure were to change to include integration of Health and Social Care  Financial - impact if the service level agreement income is reduced as a consequence of changes within local services  Regulatory – no impact on this risk  Reputational – limited impact on this for the Board  Operational Delivery – may impact on existing services if patient pathway were to change  Workforce – no significant impact on workforce | | Chief Executive  (Jill Young) | Effective  Board  Objectives  1,5,6 | Reviews on 6-12 month basis | | | 1 | | 3 | 3 | | Operational models within Boards are being finalised with the majority of specialities relating to general medicine. Some Boards have included all services so this will be monitored against priority plans that are being developed by the IGB’s.  The impact could be a reduction in activity referrals due to cost implications and altered budget flows within and between Health Boards and Integration Joint Boards. Service delivery models would be reviewed if this were to occur. Continued close working with Boards will be required to understand and act on risks and opportunities.  The National Clinical Strategy and the recent announcement of the Board expansion minimises this risk. | | 1 | 3 | | 3 | | No further action at this stage | | No further action needed at this stage.  At March 2017 review there is no indication at this stage of the risk level changing. | | Sept 2017 | |
| S3 | **Inability to deliver Golden Jubilee Conference Hotel Strategy 2020**  Strategic: Change in hotel core business could impact on the strategy  Financial: Failure to deliver the strategy will negatively impact the financial position of the hotel and potentially negatively impact on the Board’s financial projections.  Regulation: No regulatory impact  Reputation: May have a marginal impact on the Board reputation  Operational Delivery: Operational delivery of the conference hotel objectives will be impacted. Board operational impact will also be significant including use of patient rooms and knock on effect to Board objectives  Workforce: Will impact on conference hotel staff | | Chief Executive  (Jill Young) | Effective  Board objective 1,2,4,5 | 2020 strategy with reviews at 6-12 months | | | 2 | | 4 | 8 | | The 2020 strategy was approved by the Board in 2014. Regular updates are provided to the Board and the Senior Management Team with a governance structure put in place through the Conference hotel Strategy Group reporting to the Senior Management Team.  Bedroom2020 – initial phase of 12 bedrooms redesigned March 2016 and SMT approval for phase 2 with further 40 rooms approved Feb 17.  Ongoing review of income projections with financial challenges reviewed on monthly basis;  Detailed and accurate marketing activity and customer information from Opera management system being used for proactive and reactive planning;  Increased activity in place to promote ‘whole facility' including Research Institute  Performance targets being monitored for indications of need for recovery processes. | | 2 | 4 | | 8 | | Impact of increased patient room usage including the impact of the proposed hospital expansion within the bedroom stock in the hotel has to be established. | | SLWG established to review. Reported to SMT in February; number of improvements made with recommendations to further progress these supported by SMT. | | Sept  2017 | |
| S4 | **Failure to secure effective staff engagement in organisational change**  Strategic**:** decision making and strategic intent underestimates the impact of this  Financial: Failure to deliver change initiatives may lead to adverse financial impact  Regulation: Unlikely to affect regulation.  Reputation: Potential impact in delivering innovation and change management plans  Operational Delivery: Could impact on implementation of change strategies meaning service changes fail.  Workforce: Staff dissatisfaction due to increased workload pressure; increasing risk of staff absence. and turnover and with further loss of skills and knowledge.within GJF’s workforce. | | Director of Q, I & P  (Safia Qureshi) | Person Centred  Board objectives  2,4 | Reviews on a quarterly basis | | | 2 | | 2 | 4 | | Strategic Projects Group put in place to:   * Oversee Board wide activity; * Provide additional support to managers if required; * Provide a forum for resolving delays in change management related projects;   iMatter fully implemented across the Board with action plans in place for all teams;  Ongoing reviews of tools and techniques to help re-energise the change management processes;  Staff Governance action plan in place and reviewed regularly; and  Leadership Framework approved by the Board. | | 2 | 2 | | 4 | | Implementation of Leadership Framework | | Action plan and monitoring of progress to be implemented. | | June 2017 | |
| S5 | **Inability to sustain the Scottish National Advanced Heart Failure (SNAHFs) strategy, in particular the potential future increase and its impact on other services**  Strategic: change in national strategic direction  Financial: Approx £4m income and costs associated with this service so impact would be reduction in income and no offset against costs.  Regulation: Unlikely to affect regulation.  Reputation: Perceived or actual increases in risk associated with the SNAHFs could damage the Board’s reputation  Operational Delivery: Would impact on other aspects of the Board services including the other national services, cardiology and cardiac services  Workforce: Inability to sustain sufficient transplant numbers may result in deskilling of the SNAHFs team, | | Medical Director  (Dr Mike Higgins) | Safe  Board objective  1,2,3,4,5 | Reviewed on a quarterly basis | | | 2 | | 4 | 8 | | Two substantive consultants in post and 1 locum with plans to recruit third substantive  Recommendations of NORS review have been successfully implemented. This improves the funding underpinning our retrieval service and provides for a more sustainable retrieval rota pattern based on middle-grade fellows (specialty doctors).  During this initial implementation phase there is a risk of operational impact on other cardiac surgical services due to pressures on consultant and theatre staff time.  Consultant ‘road-shows’ to increase service awareness and promote referrals underway;  Scoping work started on Lung transplantation  Two new clinical fellows with retrieval experience appointed which will alleviate rota;  Consultant ‘road-shows’ to increase service awareness and promote referrals underway;  Action plan in place following trigger review process focused on building links and sharing experience with other UK units;  Continue to deliver our cardiothoracic commitment to the Scottish Organ Retrieval Team (SORT);  We continue to support NHSBT following the recent review of retrieval services and will redesign our services in line with the recommendations; and  A local (Scottish) dialogue to optimise governance around organ retrieval has taken place with input from Lothian, NSD, and NHSBT. | | 3 | 4 | | 12 | | Vulnerability of medical staffing – small super specialised staffing  Advances in cardiac transplantation to implant DCD-retrieved hearts now gathering momentum on a UK regional basis. These are based around the OCD organ optimisation and transport system,  OCD also potentially impacts positively on numbers and outcomes of DBD transplants. | | Ongoing monitoring of consultant surgical staffing in place. Plans to recruit further.  Cardiology redesign in progress (Dec 2016) precipitated by major changes in job-plan commitments from two of the consultant cardiologists (one moving to part time, one moving to academic post) with aim of implementing and consolidating 24/7 consultant rota.  Retrieval rota in place and working well although not yet up to full manpower strength (Dec 2016).  Business case to implement for this year has been approved by the SMT. NHSBT are reviewing the UK wide for this service on a sustainable basis.  SNAHFS strategy to be reviewed to reflect changes and links to OCS then re-assess risks of delivery. | | June 2017 | |
| S6 | **Inability of current SACCS clinical service to cope with increasing demand and expectation**  Strategic**:** Change in strategic direction  Financial: Lack of substantive medical sessions and increased demand increases reliance on WLI payments.  Regulation: Unlikely to affect regulation.  Reputation: not significant providing service delivered  Operational Delivery: Medical vacancies plus increasing demand means limits SACCS capacity. This could potentially restricts patient access to treatment and could impact clinical outcomes.  Workforce: Staff dissatisfaction due to increased workload pressure; increasing risk of absence and turnover. | | Medical Director  (Dr Mike Higgins) | Safe  National services objectives | On a monthly basis | | | 3 | | 3 | 9 | | Two substantive consultant cardiologists in place,  Radiographer post with advanced practice skills to support remote working in place to support MRI;  Consultant Radiologist post recruited and in place;  Consultant time optimised through implementation of nurse led clinics;  Admin support enhanced;  SACCS transition nurse is in place;  Outreach clinics well established in the North and East of the country;  Glasgow regional clinics were repatriated;  Recurring funding from NSD to support additional medical posts; and  Pre-emptive consultant appointment for surgical team made (with a 2 year overlap).  Review of the cardiac obstetric service for SACCS patients undertaken and presented to CGRMG. | | 3 | 3 | | 9 | | Vulnerability of medical staffing- small superspecialised service.  . | | Monitoring of consultant recruitment process ongoing; and  Ongoing identification of trainees to train as SACCS consultants (medium term solution of 2 years plus).  SACCS strategy to be reviewed to reflect changes then re-assess risks of delivery. | | June  2017 | |
| S7 | **Impact of Healthcare Associated Infection on ability to deliver corporate objectives / patient care**  Strategic- unlikely to be change in strategic intent  Financial: Unlikely to significantly affect delivery of financial targets.  Regulation: no significant issues associated with this  Reputation: Prevalence of HAI within GJF would damage the Board’s reputation  Operational Delivery: HAI has the potential to negatively impact patient clinical outcomes and also affect operational delivery through events such as ward closures threatening SLA delivery.  Workforce: Increased incidence of HAI may negatively impact staff both morale and productivity through ward closures and additional scrutiny | | Nurse Director  (Annemarie Cavanagh) | Safe  Board Objectives  3,2 | Reviews on a monthly basis | | | 2 | | 4 | 8 | | Annual work plan approved and progress monitored at PICC meeting;  Surveillance in place for   * Monitoring of alert organisms; * Surgical site infection; * Enhanced SAB surveillance; * E-Coli;   Appropriate clinical risk assessment and patient screening for MRSA and CPE;  Monitoring and analysis of HEAT target data for SAB and CDI supported by multidisciplinary reduction interventions;  Scheduled HAI audits in place for 2016/17;  SCNs fully engaged via weekly visits and monthly peer reviews and HEI preparedness committee;  HAI reports presented to all relevant Board and management committees  HAI Scribe process in place that ensures Infection Control built in to all building / estates issues. | | 2 | 4 | | 8 | | The GJNH are currently supporting a national and international issue with regard to invasive cardiovascular infection by M.chimera associated with 3T heater-cooler systems used during open heart surgery. The risk is low with the quantifiable risk of endocarditis as 0.6-16 episodes per 10,000 patient years.  The risk of cancellation of cardiac surgery is seen as a higher risk than progressing with surgery with a air positive potentially contaminated cooler.  Currently our equipment has been tested as negative however it is possible further heater coolers could be tested positive and this is being closely monitored.  This risk based approach in terms of case selection is in place and is being supported nationally. | | The situation is being closely monitored and a national approach to patient consent is in place. | | April 2017 | |
| S8 | **Inability to develop and sustain a flexible and appropriately skilled workforce**  Strategic: Unlikely to be any significant strategic change workforce planning  Financial: may have an impact on use of agency, locum or waiting list initiative payments to cover short term gaps  Regulation: Unlikely to affect regulation  Reputation: Potential impact on recruitment.  Operational Delivery: lack of appropriately trained staff would undermine the Board’s ability to operate.  Workforce: Staff dissatisfaction due to increased workload pressure; increasing risk of staff absence and turnover and with further loss of skills and knowledge. | | Director of Q, I & P  (Safia Qureshi) | Person Centred  Board objectives  2, 4 | Reviews on a quarterly basis | | | 2 | | 4 | 8 | | Recruitment drive underway for remaining anaesthetic medical vacancies;  Recruitment data monitored on a regular basis and presented to the Board twice a year via the Workforce Monitoring Report;  Full programme of training and education reviewed annually and underpinned by training needs analysis across the Board; and  Board local HR/strategic policy mirrors national guidance and policy on terms and conditions.  Medical and nursing revalidation delivery on track in line with plan. This will be monitored closely over the next 3-6 months and reviewed for the quarter in Dec 2016. To date no issues have been identified | | 2 | 4 | | 8 | | A specific piece of work has been actioned undertaking a risk assessment on services with single or low operator dependency and succession planning | | Risk assessment to be undertaken across the services to identify high risk areas and control plan to be put in place. This is a Board wide review and led by the Workforce and Education Steering Group. The work has commenced and due to be completed by February 2017. | | june 2017 | |
| S9 | **Failure to deliver Boards financial targets as set out in the Financial Plan**  Strategic: Risk in strategic decision making that impacts on financial position  Financial: Failure to deliver financial targets would result in a recovery plan being put in place with a likely impact on services  Regulation: Unlikely to affect regulation.  Reputation: Failure to deliver financial targets would damage the Board’s reputation as an effective healthcare provider with SGHD and with the public.  Operational Delivery: Recovery plan is likely to impact on some operational delivery. Non clinical vacant posts would be held, reviews of stock, purchasing and services would be undertaken .  Workforce: Would impact on vacancies in non clinical posts and possible skill mix reviews of clinical services | | Finance Director    (Julie Carter) | Effective  Board Objectives  2,5 | Reviews on a monthly basis | | | 2 | | 3 | 6 | | 2017-2019 financial plan submitted with plans to achieve financial balance  Efficiency and productivity plans agreed for 2017/18  Specific risks highlighted within the financial plan are being closely monitored;  Monthly financial reviews are in place to identify any variations from the plan;  A recovery plan will be actioned immediately if this is required; and  A detailed forecast will be from month 3 onwards with a balanced financial position delivered for the year. | | 2 | 3 | | 6 | | Efficiency and Productivity schemes for £4.5m required to achieve financial balance.  Total of £4.1m schemes identified to date and plans agreed. Budgets are being finalised.  Contingency plans are in place if cost pressures are increasing and/or efficiency schemes start to slip  Work s ongoing to review the 10% shortfall in efficiency schemes | | Ongoing rigorous monitoring of financial position.  Financial position and forecasts presented to Senior Management Team and Board on a monthly basis.  A review plan is in place of the 10% efficiency gap cannot be achieved. | | April  2017 | |
| S10 | **Failure to meet SLA and waiting times activity targets**  Strategic**:** Impact of change in strategy for Scottish Government  Financial: Failure to deliver operational targets may lead to loss of income but likely to be minimal impact  Regulation: Unlikely to affect workforce  Reputation: Seen as unable to deliver operational targets and negative impact on reputation  Operational Delivery: review of pathways and capacity would be undertaken and a recovery plan put on place  Workforce: impact on existing services and short term recovery planning | | Director of Business Services.  (June Rodgers) | Effective  Board Objectives  2,1,6 | Reviews on a monthly basis | | | 1 | | 3 | 3 | | Waiting Time pressures are monitored within the Divisional Operational Team, at weekly and monthly operational meetings and monthly at Performance & Planning & Senior Managers Meetings; and  Engagement with referring Boards continues with a national Leads meeting established. | | 1 | 3 | | 3 | | No specific gaps at the moment with a new 3 year contract with Boards has been agreed for 2016-2019. | | No further action needed at this stage.  No indication at this stage of the risk level changing. | | Jan 2016 | |
| S11 | **Information and Technology resilience to potential IT security breaches and attacks**  Strategic**:** Decision making exposes risk to Board  Financial: Potential for financial impact should a breach occur.  Regulation: Potential for sanctions and, or litigation should a breach occur.  Reputation: A data security breach is likely to negatively impact GJF’s reputation and damage brand perception among patients, the media and Scottish Government.  Operational Delivery: Disrupted access to electronic systems such as TrakCare and SCI would impact day to day operations in wards, clinics, theatres and admin functions resulting in disrupted patient care and loss of productivity.  Workforce: Unlikely to affect workforce significantly | | Director of Finance  (Julie Carter) | Safe  Board Objectives  1,2,5 | Reviews on a quarterly basis | | | 2 | | 4 | 8 | | Information Technology security measures and controls are in place across the organisation and supported by the wider NHS network;  Further controls implemented following recent IT security attacks on private sector organisations;  Board wide review of information security established with self assessment against NHS Scotland IT Security Framework completed and action plan developed; and  Work has commenced to undertake a mock cyber attack to assess the Boards contingency plan.  Additional software controls implemented June 2016 which will then reduce risk | | 2 | 4 | | 8 | | I  Contingency plans for system down time  Mock cyber attack planned for October workshop and will develop Board response plan | | SMT workshops held for TRak, Portal and Orion failures with some medium risk areas identified – new downtime procedures developed and shared on Duty Manager site.  Penetration testing took place and no issues identified.  An internal audit undertaken February looking at best practice and developing a gap analysis for the Board to action. Report awaited from this. | | June 2017 | |
| **Ref** | **Risk description** | | **Risk Owner** | **Links to Quality Ambition** | **Time**  **Scales**  **longevity** | | **Current risk level** | | | | | | **Current Mitigation** | | | | | | | | **Planned Mitigation** | | | | **Risk review date** |
| **Likelihood (initial)** | | | **Impact (initial)** | **Risk score (initial)** | | **Current controls in place** | **Likelihood (initial)** | | | **Impact (initial)** | | **Risk score (initial)** | | **Gaps in controls**  **Additional controls required to reduce risk as far as is practical** | | **Actions needed to address gaps** | |
| S13 | **Inability to manage and monitor clinical staff training needs**  Strategic: Unlikely to change strategic intent  Financial: Risk of litigation if untrained staff are involved in an incident i.e. manual handling fall  Regulation: Staff unable to treat patients and undertake full role if training not up to date  Reputation: Impact on Board as leader in quality  Operational Delivery: Staff unable to undertake role leaving shortages in clinical areas  Workforce: Staff dissatisfaction due to increased workload pressure; increasing risk of staff absence. | Acting HR Director  (David Miller) | | Safe | Reviews on a monthly basis | 1 | | | 3 | | | 3 | Regular reporting of mandatory stats about training to P & P, SMT and PF and Board.  Alignment to the quality measures to ensure there is no adverse impact on patient safety this is monitored regularly through the clinical dashboards  A recent internal audit on clinical education whilst highlighting a number of areas of good practice also identified two high risk findings that required managements immediate attention. These are   * There is no integrated centralised approach for the monitoring of medical staff education and * The Board has set a training target of 80% and during the period under review completion of mandatory training by both Medical and Nursing staff fell short of the target | 1 | | | 3 | | 3 | | In response to the internal audit the Chief Executive has initiated a urgent review of the monitoring and management of clinical staff training needs. This will focus on 3 key areas:   1. Do our current tolerances eg 80% target reflect the organisations requirements 2. A review of how we collect and monitor the data and 3. How do we manage staff who are not undertaking their annual mandatory training | | SLWG commissioned produced a detailed report and recommendations that have been approved by SMT and the Board.  In addition the Audit and Risk Committee is due to receive a management report in March responding to the audit findings.  Revised tolerances and monitoring now in place via P&P and SMT. | |  |

**Heat Map; Scoring Key and Objective Overview**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Likelihood | Consequence/ Impact | | | | |
| 1 | 2 | 3 | 4 | 5 |
| 5 |  |  |  |  |  |
| 4 |  |  |  |  |  |
| 3 |  |  |  | **(S5)** |  |
| 2 |  | **(S4)** | **(S9) (S6)** | **(S1) (S3) (S7) (S8) (S11)** |  |
| 1 |  |  | **(S2) (S10) (S12)** |  |  |

|  |  |  |
| --- | --- | --- |
| Grading | Score | Colour Code |
| Low risk | 1-3 |  |
| Medium risk | 4-9 |  |
| High risk | 10-16 |  |
| V high risk | 17-25 |  |

|  |  |
| --- | --- |
| **Board Objectives** | **Risks linked to Objective** |
| **1** | **S2 S10**  **S1 S3 S11**  **S5** |
| **2** | **S10**  **S1 S3 S4 S7 S8 S9 S11**  **S5** |
| **3** | **S12**  **S1 S7** |
| **4** | **S1 S3 S4 S8**  **S5** |
| **5** | **S2 S12**  **S1 S3 S6**  **S5** |
| **6** | **S2 S10 S12**  **S1** |