NHS Greater Glasgow and Clyde	**Paper No. 21/69a**
Meeting:	**Board Meeting**
Meeting Date:	**26 October 2021**
Title:	**Corporate Risk Register**
Sponsoring Director/Manager	**Mark White, Director of Finance**
Report Author:	**Lesley Aird, Assistant Director of Financial Services, Capital & Payroll**

1. Purpose

The purpose of the attached paper is to update members on, and provide assurance over, the current Corporate Risk Register (CRR).

2. Executive Summary

The paper can be summarised as follows:

The CRR has been reviewed by senior management and the relevant standing committees; some changes have been made to the register since it was presented to the last meeting of the Audit and Risk Committee on 14 September 2021. These changes are detailed on Appendix 3:

- Appendix 1 – Corporate Risk Register Summary
- Appendix 2 – Corporate Risk Register
- Appendix 3 – Changes/Updates from the Corporate Risk Register considered at the previous Audit & Risk Committee meeting

Aligned to the recommendations from Internal Audit, work is ongoing to further develop the CRR and enhance the risk descriptors to include a narrative around the anticipated impacts of each risk.

3. Recommendations

The Board is asked to consider the following recommendations: To note the ongoing work of the Audit and Risk and other standing Committees in scrutinising, reviewing and updating their risk registers and takes assurance from that process.

- To review and accept the updated overarching CRR subject to any changes or feedback to relevant Standing Committees as agreed at this meeting.

4. Response Required

This paper is presented for assurance

5. Engagement & Communications

The issues addressed in this paper were subject to the following engagement and communications activity:

The Corporate Risk Register, or relevant extracts of, has been presented to the following groups:

- Risk Management Steering Group
- CMT
- Acute Services Committee
- Staff Governance Committee
- Finance, Planning and Performance Committee
- Clinical & Care Governance Committee
- Audit and Risk Committee.

6. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:

- Better Health Positive
- Better Care Positive
- Better Value Positive
- Better Workplace Positive
- Equality & Diversity Positive
- Environment Positive

7. Governance Route

This paper has been previously considered by the following groups as part of its development:

As above

8. Date Prepared & Issued

Date Prepared: 19/10/21

Date Issued: 19/10/21

Appendix 1

Corporate Risk Register - summary **October 2021**

Corporate Risk Register - movement in risk numbers	
No. of risks at August 2021	20
Risks closed (2827)	-1
New risks escalated	
No. of risks at November 2021	**19**

Datix ID	Risk title	Division/ Directorate	Accountable owner	Category of Risk	Status	Current Score	Risk Level	Corporate Objective	Governance /review committee
2054	Scheduled care waiting time targets	Acute	Chief Operating Officer	Service Delivery - Scheduled care	Open	20	Corporate	BCCO C07	Acute Services Committee- Finance, Planning & Performance Committee
2062	Cyber threats	eHealth	Director of eHealth	Tolerated Risks	Open	6	Directorate	BCCO C07	Information Governance Steering Group
2188	Infection prevention and control	Medical	Dir Infection Control	Clinical Risks - Infection control	Open	20	Corporate	BCCO CO6	Clinical & Care Governance Committee
3062	Continual development of clinical standards, protocols and strategies	Medical	Medical Director	Clinical Risks - Clinical gaps	Open	9	Corporate	BCCO CO6	Clinical & Care Governance Committee
2199	Pandemic	Public Health	Director of Public Health	Other	Open	12	Corporate	BCCO CO7	Public Health Committee
3054	Remobilisation Plan - co-ordination, capacity and resources	Medical	Medical Director	Clinical Risks - Clinical gaps	Open	9	Corprorate	BCCO CO7	Finance, Planning and Performance Committee
3057	Delayed discharges	Acute/HSCPs	Director of Nursing	Other	Open	16	Corprorate	BHCO CO10	Finance, Planning and Performance Committee
3058	Adult and child protection	Acute/HSCPs	Director of Nursing	Other	Open	20	Corprorate	BHCO C04	Clinical & Care Governance Committee
2060	Breakdown of failsafe mechanisms for Public Health Screening	Public Health	Director of Public Health	Related (IJB/Third Party) risks - Screening	Open	12	Corporate	BHCO CO1	Public Health Committee
2730	Reputational risks around facilities and environmental issues and capacity flow	Acute	Chief Operating Officer - Acute	Reputational - QEUH	Open	20	Corporate	BVCO C012	Acute Services Committee
2021	Financial sustainability - revenue	Finance	Director of Finance	Financial Sustainability - Revenue	Open	20	Corporate	BVCO CO11	Finance, Planning and Performance Committee
2819	Capital Funding Sustainability	Finance	Director of Finance	Financial Sustainability - Capital	Open	16	Corporate	BVCO CO11	Finance, Planning and Performance Committee
3053	Medicines costs and funding availability	Medical	Medical Director	Clinical Risks - Clinical gaps	Open	12	Corporate	BVCO CO11	Finance, Planning and Performance Committee
2766	Failure to meet obligations to provide person centred care	Nursing	Director of Nursing	Workforce - Training	Open	9	Corprorate	BVCO CO14	Clinical & Care Governance Committee
2827	Moving out of NHS Scotland Board Performance Escalation Level 4 Framework	Escalation	Chief Executive	Service Delivery - Escalation	Closed	4	Corporate	BVCO CO14	Finance, Planning and Performance Committee
3051	RMP3 - ageing infrastructure	Acute/HSCPs	Director of Estates & Facilities	Other	Open	16	Corporate	BVCO CO14	Finance, Planning and Performance Committee
3052	Actions taken by a regulatory body	Acute/HSCPs	Director of Estates & Facilities	Other	Open	16	Corporate	BVCO CO14	Finance, Planning and Performance Committee
3060	Positive, engaging and diverse culture	Human Resources	Director of HR & OD		Open	16	Corporate	BWCO CO15	Staff Governance Committee
3059	Staff training and development	Human Resources	Director of HR & OD		Open	20	Corporate	BWCO CO17	Staff Governance Committee
2735	Failure to recruit and retain staff	Human Resources	Director of HR & OD	Workforce - Recruitment and retention	Open	20	Corporate	BWCO CO20	Staff Governance Committee

Corporate Risk Register **October 2021**

Datix ID	Directorate/ Partnership	Category of Risk	Status	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Curent Likelihood	Current Impact	Current Score	Residual Liklihood	Residual Impact	Residual Score	Target dates for actions	Risk Level	Corporate Objectives	Governance /review committee
2062	eHealth	Tolerated Risks	Open	Director of eHealth	Cyber threats are a dynamic and growing threat to the NHS. Until recently, much of the focus of such threats was the theft of financial data, not personal or patient information. However, there is now a growing risk that the Board will be targeted in order to disrupt a key component of critical National infrastructure.	Multi layered security model in place. Anti malware defence system deployed to end point devices. Email, web policies and awareness initiatives in place. Proactive AV Patching Policy in place for the Board's devices and . supplier update patches applied to operating systems on a scheduled basis. Emergency patches are deployed on advice of National Cyber Security Teams and supplier guidance. Cyber controls subject to regular review and audit.	The risk is tolerated at this level and is mitigated by the controls currently in place; no additional actions are considered necessary at this time. NHSGGC is in the process of carrying out activities to support NIS review in late August and has put in place external support to ehance existing posture and provide additional assurance; to Board team. Recommendations will be acted upon in terms of any further controls or mitigations.	2	3	6	2	3	6	Nov-21	Corporate	BCCO CO7	Information Governance Steering Group Audit and Risk Committee
3053	Medical	Medical	Open	Medical Director	Financial risks arising from current and future medicines costs and funding availability for end of life and very rare conditions	Pharmacy/ Finance departments have developed financial models to assess the predicted costs of new medicines based on assumed uptake rates that reflect the increasing use of new medicines. Implementation of PACS2 policy across NHSGG&C	1. Development & delivery of a Financial Improvement Plan for acute medicines expenditure which doesn't compromise patient care or service delivery Update. 2. The FIP medicines work continues to progress with key contributions from the multi-disciplinary Acute Prescribing Management Group, the Pharmacy Medicines Cost Effectiveness group and the Acute Finance Team. Plans for 2020/21 are in the early stages of development.	3	4	12	3	3	9	Mar-22	Corporate	BCCO CO11	Finance, Planning and Performance Committee
2188	Medical	Clinical Risks - Infection control	Open	Dir Infection Control	Failure to comply with recognised policies and procedures in relation to infection control.	NIPC Manual is accessible on the desktop of every PC in GGC. IPC webiste is continually updated with summary SOP with links to theNIPCM. IPCT education is manditory with yearly updates for many topics as standard. IPCT present on each main site; all sites are have access to a designated IPCT. All patients with infection included in appendix 13 of the NIPCM are referred to the IPCT and a process of review is initiated to impliment controls as per NIPCM. Surveillance of surgical site infection is ongoing as per SG policy. Surveillance of blood stream infections with S. aureus bacteraemia and E. coli bacteraemia is ongoing. COVID 19 cases are reported daily to SG and are monitored via ARHAI weekly report. Electronic system ICNet pulls a feed from laboratory systems every 15 minutes and referrals go directly to the infection prevention and control team who then visit the ward and give infomation to clinical staff to ensure that control are in place for patients with organisms with the potential to spread to others. Patient are given infomation on why they are in isolation and daily check list with ongoing controls is left with clinical staff. IPCT work with collegues in the antimicrobial managment team to promote antimicrobial policy compliance. If any outbreaks or incidents occur an IMT process is initiated. Key learning from these is reported at the IPC governance committees with a 'hot debrief' submitted to these same committees at the end of the incident with specific reference to implications for other area across the board.	Programme of audit for key policies linked to CAS framework. Improvement collaborative has been initiated and is firmly linked to the GGC quality strategy which vision is 'healthcare without preventable infection' the aim is to promote key objectives for GGC around reducing harm due to avoidable infections. Monthly HH audits are ongoing. IPCT support local teams in implementing national policy into practice using improvement methodology. All patient are assessed on admission for the possibility that they have CPE/MRSA/CJD this is recoded in the nursing documentation. Lessons from incidents and outbreaks are shared with governance committees to ensure orgnasational learning. When patients are referred process of initial and ongoing review in put in place to ensure key control are consistently applied. Promotion of antimicrobial stewardship. IPCT participate in new builds and renovation projects to ensue that the patients environment promotes the prevention of infection.	5	4	20	4	4	16	Mar-22	Corporate	BCCO CO6	Clinical & Care Governance Committee
3062	Medical	Clinical Risks - Clinical gaps	Open	Medical Director	Failure to continually develop clinical standards, protocols and strategies which support the safe and effective use of medication for all patients	Paper presented to CMT in 2019 outlining Medicine Governance arrangements in NHSGG&C. Safer Use of Medicines groups established within each Acute Sector/Directorate. Board oversight through Area Drugs and Therapeutic Committee/ Clinical and Care Governance Committee Ongoing development of Medicine Governance policies, procedures and protocols supported by multi-level education embedded within Clinical and managerial supervision arrangements. Ongoing use of pharmacy service redesign and engagement with senior management to extend the integration of clinical pharmacy within multidisciplinary teams across GG&C.	1. Continue to implement HEPMA across all acute and mental health wards replacing the paper Kardex. Pilot completed at QEUH site with full QEUH Implementation underway from April 2021. 2. Review governance arrangements and pharmacy processes to safely manage medicine shortages – e.g. supply of critical care medicines during the pandemic. 3. Review arrangements for future challenges to the supply chain e.g. a resurgence in COVID, Brexit. 4. Review Procedures for Preparation and Dissemination of Proactive Medicines Information and Advice to healthcare professionals	3	3	9	2	3	6	Mar-22	Corporate	BCCO CO6	Clinical & Care Governance Committee
2054	Acute	Acute	Open	Chief Operating Officer	Failure to deliver NHSGGC scheduled care and unscheduled care Waiting Time targets to agreed timescales impacting on patient experience and outcomes.	The Board received notification of 1. Compliance with Waiting Time Targets and TTG - regular reports are provided to Board, Acute Services Committee, Directors Access Group / SMG. 2. As appropriate, these include exception reports on OP Waiting Times, the 12 week TTG and Diagnostic Waiting Times. The exception reports summarise current performance, national performance, the 12 month trend and a summary of the specialties with the most significant numbers of patients waiting over the waiting time targets. In addition to the performance summary, the reports also set out the actions to address performance and the projected timeline for improvement. 3. The Directors' Access Group oversees the Elective work programme relating to improving patient access and meeting national and local waiting time targets. 4. NHSGGC Cancer Waiting Time's monthly Meeting oversees the Cancer plan to meet the 31 day and 62 day targets is in place and reviewed monthly at the Directors Access Meeting. 5. Continuous cancer tracking and weekly review of cancer tracking reports.	Remobilisation is being progressed with significant work ongoing to move to virtual patient management/ telephone consultations. Training and support is being provided across the division, in particular around Attend Anywhere with roadshows being held around this. New sector groups resource bank will be made available. Delivery of inpatient and day case activity has been supported by a wide range of actions to support the remobilisation process. These include: • Prioritising cancer care • Establishing green elective pathways for patients for planned operative care • Clinically validating waiting lists to ensure priority patients identified • Re profiling the allocation of theatre capacity to meet priority care requirements • Increasing day case management of patients • Using external capacity at GJNH and Louisa Jordan Hospitals • Improving testing access and increasing pre-operative assessment and pre admission management to avoid patient cancellation	4	5	20	4	4	16	Mar-22	Corporate	BCCO CO7	Acute Services Committee
2199	Public Health	Public Health	Open	Director of Public Health	Inability to respond to a predicted 3rd wave of COVID 19 in respect of capacity and resources impacting on service delivery (COVID and non COVID) and overall recovery.	Our pandemic plans were tested on 13 March 2020. NHSGGC has established a robust governance structure to manage the pandemic. This conists of a "slimmed-down" Board governance process, a twice weekly Covid SEG meeting, (underpinnned by both Acute and HSCP Tactical Groups) a range of risk/issue specific groups and meetings and national calls/meetings. The SEG meeting will be returned to a daily meeting should the "3rd wave" intensify. Mobilisation plans (currenlty RMP3) are in place and are being implemented. NHSGGC has established testing facilities for social and healthcare staff as well as for residents in care homes over and above hospital based testing. National guidance on infection control including PPE is followed National and local guidance is shared across the organisation in daily Core Briefs National and local campaigns to ensure people attend health services as appropriate for non-COVID related illnesses	The RMP3 will attempt to capture learning for future pandemics or further waves of COVID-19 and will plan phased return to service delivery. Remobilisation plans for NHSGGC covering the initial period to the end of July 2020 has been developed. This forms part of NHSGGC wider recovery planning work which extends into 2021. The vaccination programme and Track and Trace are having a impact (at national level and local level) in limiting the link between infections and hospitaliation. The current effort and focus is on maintaining these programmes, particularly the vaccine roll-out.	3	4	12	3	4	12	Dec-21	Corporate	BCCO CO7	Public Health Committee

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3054	Medical Acute/ HSCPs	Corporate	Open	Medical Director	Failure to deliver the Remobilisation Plan in respect of co-ordination, capacity and resources.	Recovery Tactical Group (RTG) established. Weekly meetings held to monitor implementation with Executive Leads aligned to each action. Paper presented to SEG in May 2021 outlining monitoring arrangements for RMP3 and future role of RTG. RMP3 Action Tracker developed identifying 400+ actions and commitments from RMP3. Monthly tracker updates presented to RTG and SEG. Internal Audit Report of RMP3 Planning has been completed in April 2021 and shared with SEG	1. Robust programme management controls and processes in place to drive RMP3. 2. Ongoing review of RMP3 tracking tool as part of continous improvement and learning. 3. Implement actions from Internal Audit report RMP3 from April 2021. 4. Produce a closure report for the previous re-mobilisation tracker actions (RMP2).	3	3	9	2	3	6	Sep-21	Corporate	BCCO CO7	Finance, Planning and Performance Committee
3057	Acute/ HSCPs Acute/ HSCPs	Partnerships/Acute	Open	Director of Nursing	Failure to timely discharge patients from acute settings resulting in bed pressures, inappropriate patient placement, delays in Emergency Departments, delays in admissions, cancellations of planned admissions and acute hospital overcrowding.	• Reducing delays remains a key priority for both HSCP and acute colleagues • The Delayed Discharge Operational Group continues to meet regularly to expedite discharges and improve working practices where appropriate	Work continues to help reduce the number of patients unnecessarily delayed in their discharge with a particular focus on Adults with Incapacity and COVID-19 related delays: - Local Teams continue to work with infection control and community partners to support care homes to mitigate these pressures and ensure acute sites continue to maintain patient flow. - HSCP Commissioning Teams and Community Services continue to support care homes to ensure they are prepared for the care of patients discharged from hospitals. - All HSCPs are prioritising hospital discharge activity with a focus on anticipatory planning and early discharge. Early assessment and engagement with families ensures that the next stage of care is in place prior to patients being deemed fit for discharge wherever possible. - The implementation of the Discharge to Assessment (D2A) approach and the Standard Operating Procedure (approved in December 2020) across all HSCPs. This aims to ensure that no person who has been in hospital less than seven days will have their social work assessment undertaken whilst they are in	4	4	16	4	4	16	Dec-21	Corporate	BCCO CO10	Finance, Planning and Performance Committee
3058	Acute/ HSCPs	Nursing	Open	Director of Nursing	Failure to identify and act on potential risk (following referral to the Public Protection unit) within an appropriate time period which then results in avoidable harm to a vulnerable child or adult.	• Newly established Public Protection Team(PPT) provides expert professioanl and strategic leadership in child and adult protection across NHSGGC and with partner agencies improving complaince with CP and ASP requirements. • All PPT and administartive staff offered extra hours and overtime •Temporary reassignment of available NHSGGC staff with CP Post-Graduate Certificates (CP PgCert) to support IRDS. •Successful appointment of 2 secondment posts (18 mths and 9 mths) from staff with CP PgCert •Emergency IRDs continue to take place within agreed timescales •0.8 WTE additional hours to suport health record analysis for IRDS. • 4 x 1 yr CPNA posts successfully appointed • Full time ASP trainer and Lead Nurse for AP • Comprehensive programme of level 1 and 2 ASP training now available for all staff •MDT ASP Operational Group to have oversight and governnace to board issues relating to ASP • Mutal	• A Board wide Public Protection communication strategy is under development • Governance arrangements have been strengthened and extended by establishment of Public Protection Forum • Ten places have been secured for PPT staff to undertake the Adult Support and protection Course at Stirling University •Collaboration with partner agencies re effective utilisation of CP process. •NHSGGC PPT business case for additional staffing has been escalated for consideration to CMT. • Learning and Education strategy for ASP in development as per Intercollegiate Professional guidance.	5	4	20	4	3	12	Dec-21	Corporate	BHCO C04	Clinical & Care Governance Committee
2060	Public Health	Related (UB/Third Party) risks - Screening	Open	Director of Public Health	There is a risk of patients coming to harm and loss of stakeholder confidence as a result of failures to identify errors in the delivery of Public Health Screening Programmes: - Abdominal Aortic Aneurysm, Bowel, Breast, Cervical, Diabetic Retinopathy, Pregnancy & Newborn, Preschool Vision screening programmes	• Each programme has failsafe mechanisms monitored by experienced staff, regular quality assurance monitoring and feedback. • Implement the learning from the use of Critical Incident Reporting tool, look back exercises and remedial action. • There is an automatic recall of individuals after set time period has elapsed. • Adherence to national guidelines, procedures and quality assurance processes. • Regular governance reports: quarterly reports on screening; annual report to NHS Board	• Escalation of screening incidents to national screening co-ordination and oversight structures.	3	4	12	3	4	12	Dec-21	Corporate	BHCO CO1	Public Health Committee
2730	Acute	Corporate	Open	Chief Operating Officer	Failure to implement the recommendations published in respect of the QEUH and RHC; The External Review, The Oversight Board Report, The Case Note Review Report, impacting on patient care, staff resilience, the reputation of the Board and public confidence in services provided.	• Robust escalation process in place to proactively manage any issue to ensure patient and staff safety in respect of the Board's facilities • Clinical focus remains on patient safety, with extensive reporting and monitoring, e.g. robust infection control procedures • Significant senior management capacity allocated to addressing recent incidents. • Proactive media handling • Programme Board established to oversee the reviews • Steering Group established and meeting to collate review and supply the documents and information required for the inquiries. • Programme Management Office being established at Board HQ. • Clinical Management Team Established to liaise directly with the Scottish Government Oversight Board In response to concerns raised, the Board commissioned three internal reviews covering areas central to the delivery of safe, high quality healthcare on the QEUH Campus.The key findings from the reviews were: • Facilities and Environmental Impact Review - An external advisor was appointed to examine eleven areas where issues had arisen with the building • Capacity and Flow Review - This review found the QEUH to be treating considerably higher numbers of patients than originally anticipated in the Full Business Case. An improvement programme was developed to address the issues. • The Clinical Outcomes Review concluded that NHS GGC has maintained an appropriate set of clinical governance arrangements within services responsible for patient care in the QEUH and the RHC.	Creation of a robust Action Plan against all recommendations across the reports. Monitor through Gold and Silver Command, CMT and upwards to respective governance committees, over seen by the Finance Planning and Performance Committee. Work with the Scottish Government and the newly established Action and Assurance Review Group (AARG) to provide assurance around progress and delivery.	5	4	20	4	4	16	Sep-21	Corporate	BVCO C012	Acute Services Committee

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2021	Finance	Financial Sustainability - Revenue	Open	Director of Finance	Financial Sustainability The Board faces an annual financial challenge to achieve break even and carries an underlying recurring deficit. Costs increasing in excess of funding will widen this financial gap and may result in the Board: - being unable to deliver all of its strategic commitments - having to reduce or limit some services - reputational damage to the Board Remoblisation Plan may not be affordable or deliverable within the financial envelope longer term	- Working closely with Scot Govt to identify potential funding to close in year gaps and regular dialogue on overall position; - Ongoing focus on cost containment and financial grip to manage in year and emergent financial pressures, particularly around Acute medical and nursing costs; - Robust budgetary controls, monitoring, scrutiny and reporting (to CMT, Acute, OMG etc) throughout the year and regular finance meetings with budget holders, including challenge around material variances; - Review all current and potential sources of income, including non-recurring to maximise opportunities; - FIP Workstreams; - Locally identified CRES; - Regular meetings with CO and CFOs of IJBs to discuss performance and projections; - Detailed reports, scrutiny and challenge to the ASC, F&P Cttee and Board - Mthly monitoring returns to SG; - Quarterly meetings between the CE, DoF and SG NHS DoF; - MFT transformational programme to deliver National Clinical Strategy, Health and Social Care Delivery Plan and other associated strategies & policies, - Covid LMP monitoring and reporting.	1. Whole service redesign through the Transformation Programme - now the post Covid Remobilisation Plan. Focus on outcomes, inclusion, accessibility and sustainable service design. 2. The Remobilisation Plan, and its financial implications, are regularly and extensively analysed by the Finance Team to ensure all decision are being properly considered and discussed with SEG. Detailed Covid-19 expenditure forecasts are submitted regularly to SG, highlighting recurring and nonrecurring spend. 3. Financial Improvement Plan has been relaunched for 2021/22 with a renewed focus on recurring savings. A governance stucture has been put in place and is working well. Progress is monitored on an ongoing basis.	4	5	20	4	4	16	Mar-22	Corporate	BVCO CO11	Finance, Planning and Performance Committee
2766	Nursing	Medical	Open	Director of Nursing	Failure to comply with legistlation and obligations in regards to patient rights, patient feedback and person centred care	Implementation of the NHSGGC Healthcare Quality Strategy and stakeholder communications and engagement strategy and associated work streams for both. Implementation of person centred care boardwide work plan. Multiple methods from ward to board level to gain feedback from and support patients, families, and the public in regard to care experience. Network of explicit formal responsibilities including Executive leads and professional local leadership for the person centred care agenda. A range of education, training, development and supervision opportunities provided by NHSGGC to enhance staff skills and behaviours. Internal governance arrangements to ensure collection, analysis including identification of themes and learning across the organisation. Person centred competencies embedded in staff recruitment, support, and development arrangements.	NHSGGC Healthcare Quality Strategy implementation plan will lead to: • Deliver on the Board's commitments described in both stratgey documents. • Expansion of data collection assurance and outcomes linked to feedback and person centred care • Work with public partners to develop easily streamlined mechanisms to improve and enhance collaboration with our population.	3	3	9	3	3	9	Oct-21	Corporate	BVCO CO14	Clinical & Care Governance Committee
2819	Finance	Financial Sustainabili	Open	Director of Finance	The Capital programme is based on available funding. Funding does not meet ongoing need. Key elements of this risk include: - Insufficient funding to do everything that's required - Significant overspends on some projects resulting in pressure on the overall budget	- Work closely with Scottish Govt - Annual Capital Plan - Capital Planning Group - Property Asset Steering Group - Regular Capital monitoring of spend and income - Risk based approach adopted through PAMS Group	More work is needed to longer term capital planning to address the backlog maintenance issues across the Boards estate within the financial envelope	4	4	16	4	4	16	Mar-22	Corporate	BVCO CO14	Corporate Management Team Capital Planning Group Finance, Planning
2827	Corporate Acute/HSCPs	Service Delivery - Escalation	Closed	Chief Executive	The Board is at level 4 of the NHS Scotland Board Performance Escalation Framework in respect of scheduled care, unscheduled care, GP out of hours, and culture and leadership. There is a risk that the Board is delayed in moving out of this framework.	An Oversight Board was appointed, and considered unscheduled care, scheduled care and GP OOHs. It also considered the culture and leadership within the organisation. • The Board was on course to achieve the revised targets set for 31st March 2020; however, the process was paused due to the outbreak of COVID-19. • Further work continues internally to address the issues associated with the Performance Escalation. An internal Oversight Board continues to meet regularly to oversee progress with GP OOHs, Unscheduled Care and Scheduled Care. The Board have largely met the relevant targets in the RMP2 and RMP3 and the Scottish Government have acknowledged the efforts made by NHSGGC to remobilise activity. • The culture and leadership work continues to progress - agreeing its Culture Framework and its approach to collective leadership.	• The post of Deputy Medical Director for Primary Care has now been advertised on a substantive basis. Redesign work • Work has been progressing around service redesign in order to support the staff working in the service to provide appropriate care to patients. Further work is ongoing to consider the feasibility of re-establishing a GP OOH service presence in Inverclyde and increase the cover in the Vale of Leven area. • "Walk-in" attendances were ceased and an appointment system, via NHS24, was launched throughout the service. In addition the service has launched "Near Me" video consultations to support patient assessment. • The rollout of the Investors in People Standard commenced at Inverclyde Royal Hospital in October 2020 and the learning from this pilot site will inform a wider rollout across NHSGGC in a three year implementation programme. Preparations in relation to the other key development activities in this important initiative are underway and these will be progressed early in 2021.	1	4	4	1	4	4	Jun-21	Corporate	BVCO CO14	Finance, Planning and Performance Committee
3051	Acute/HSCPs	Other	Open	Director of Estates & Facilities	The RMP3 relies upon infrastructure, much of which requires significant investment. Particular elements of concern include but are not limited to; Ventilation Systems, High & Low Voltage infrastructure, Domestic Hot & Cold Water systems, Medical Gas Systems (particularly oxygen capacity), Building Fabric Condition	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure andidentifies the areas of the estate at high risk of failure and therefore of highest priority for repair. 2. Implementation of Board wide property management approach including assessment of premises compliance with standard consistent methodologies. 3. Regular reports to CMT/ CPG/SMG / OMG on deployment of capital resources and investment priorities. Investment Priorities are based on PAMS data. 4. A revenue allocation of £9m enables the sector estates teams to undertake Statutory operational maintenance and repair. These requirements have set maintenance, inspection and testing levels as detailed within Statutory Compliance legislation. 5. Property Asset Management Strategy in place. 6. The annual capital and revenue funding for Estates & Facilities takes cognisance of the statutory obligations applied to the NHS Board. Prioritisation is informed by EAMs and the PAMS data.	A review of NHSGGC's EAM system was undertaken in order to review the accuracy of data and to change the presentation of information. The outcome of this provided management with more understandable data, and informed us where we have risk, and, therefore, enable us to mitigate risks. The asset management review details areas which require investment, and risk assess those areas. The Statutory Compliance Audit and Risk Tool (SCART) Steering Group meets quarterly to monitor SCART performance and to ensure all necessary records and other forms of evidence to support compliance are readily available and in date.	4	4	16	3	3	9	Sep-21	Corporate	BVCO CO14	Finance, Planning and Performance Committee
3052	Acute/HSCPs	Corporate	Open	Director of Estates & Facilities	Actions taken by a regulatory body (e.g HSE, SEPA, Fire) in regards to statutory compliance and impact of the Boards Estate and its activities on the: health, safety and wellbeing of staff, patients and the general public as well as the surrounding environment.	Control measure sin place include: 1. Fire risk assessments 2. Environmental PPC Permits in place at two facilities namely, GRI & QEUH. Environmental Authorisations (Scotland) Regulations (EASR) Permits in place across seven sites for nuclear waste. 3. High level Environmental Legal Register in place to monitor relevant environmental legislation applicable to the Board. 4.Estate Asset Management System (EAMs) 5. Statutory Compliance Audit and Risk Tool (SCART) 6. Topic specific Authorised Persons (AP) and Authorised Engineer oversight and audit	1. Development of whole building risk assessments. Risk assessments will be conducted across the Estate with risk assessment for the QEUH already completed. 2. Authorised Engineer audits conducted for specialist areas i.e. water, ventialtion and LV. 3. Authorised person training and competence 4. Regular internal and external (SEPA) audits for PPC Permits. Permits currently sitting at "Excellent".	4	4	16	3	3	9	Sep-21	Corporate	BVCO CO14	Finance, Planning and Performance Committee
3060	Human Resources	Workforce (HR)	Open	Director of HR & OD	Failure to cultivate, promote and enhance a positive, engaging and diverse culture.	Workforce Strategy. Leadership development programmes, culture framework and initiatives. Succession Planning Framework. Equality Action Plan.	Promotion of culture framework and associated programmes and initiatives. Medical Managment programme introduced. Executive and non-executive development programme. Review of Ready to Lead programme underway. Development of Equality Action Plan to support activity and initatives across NHSGGC.	4	4	16	3	4	12	Dec-21	Corporate	BWCO CO17	Staff Governance Committee

Datix ID	Directorate/ Partnership	Category of Risk	Status	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Curent Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Target dates for actions	Risk Level	Corporate Objectives	Governance /review committee
2735	Human Resources	Workforce (HR)	Open	Director of HR & OD	Failure to recruit and retain staff members resulting in reduced capacity and continual hard to fill areas.	Workforce Meeting. Storyboard. DDiT Monitoring. Workforce Plans and Winter Plans.	Corporate Performance Storyboards detail workforce turnover and demographics to consider short, medium and long term impacts. Workforce meetings now established at local level to consider hard to fill and resource gaps, as well as Winter/COVID planning. Dentists and Doctors in Training monitoring undertaken locally to ensure appropriate fill of roster gaps and compliant rosters. Medical, Nursing and Midwifery and Administration Banks provide supplementary staffing contingency across NHSGGC. Annual iMatter Survey to gain staff feedback and development of service/team actions plans. Compliation of Interim 1 Year Workforce Plan for NHSGGC and all HSCP's. Local Partnership Groups being estbablished to develop 3 Year Plans. Development of Employment Strategies and Recruitment Strategy as part of	5	4	20	3	4	12	Sep-21	Corporate	BWCO CO19	Staff Governance Committee
3059	Human Resources	Workforce (HR)	Open	Director of HR & OD	Failure to train and develop staff members to deliver role, or key competencies not identified and developed.	Annual Reviews (Turas/KSF). Statutory and Mandatory Training. Performance targets and KPIs.	Annual reviews for all staff to discuss PDP and objectives and agree support linked to the Knowledge and Skills Framework (KSF) to agreed competencies for AFC staff, and medical staff monitoring and appraisal process. Monitoring of Statutory and Mandatory Training compliance, agreed KPIs and performance target trajectories in place for all Sectors and reviewed at Performance Review Groups (PRGs) and Acute Services Committee and Finance Planning and Performance Committee. Development and enhancement of online learning and training through Turas Learn.	5	4	20	3	3	9	44440	Corporate	BWCO CO20	Staff Governance Committee

Appendix 3

Extract from current CRR (Oct-21)

Datix ID	Directorate/ HSCPs Partnership	Category of Risk	Status	Accountable owner	Description of risk	Changes since last CRR (Y/N)	Change approved by	Status	Curent Likelihood	Current Score	Residual Likelihood	Residual Score	Corporate Objective - Level 1	Corporate Objective - Level 2	Corporate Objective	Governance /review committee
3057	Acute/HSCPs	Service Delivery - Escalation Partnerships/Acute	Open	Director of Nursing	Failure to timely discharge patients from acute settings resulting in bed pressures, inapproprate patient placement, delays in Emergency Departments, delays in admissions, cancellations of planned admissions and acute hospital overcrowding.	Y	FPP						Corp Obj Level 1 updated	Corp Obj Level 2 updated	Changed from BHCO C04 to BHCO CO10	Amended from Clinical & Care Gov to FP&P
2827	Corporate		Closed	Chief Executive	The Board is at level 4 of the NHS Scotland Board Performance Escalation Framework in respect of scheduled care, unscheduled care, GP out of hours, and culture and leadership. There is a risk that the Board is delayed in moving out of this framework.	Y	FPP	Status updated	-3	-12	-2	-8				