NHS Greater Glasgow and Clyde

NHS Greater Glasgow and Clyde	Paper No. 24/53
Meeting:	NHSGGC Board Meeting
Meeting Date:	30 April 2024
Title:	Corporate Risk Register
Sponsoring Director/Manager	Colin Neil, Director of Finance
Report Author:	Katrina Heenan, Chief Risk Officer

1. Purpose

The purpose of the attached paper is to:

Update members on, and provide assurance over, the Corporate Risk Register (CRR).

2. Executive Summary

The paper can be summarised as follows:

The full CRR was reported to the Board in December 2023. The Corporate Risk Register included in this paper reflects the period October 2023 to December 2023. Regular reviews of risks have taken place since and will continue to be presented in future updates.

The CRR is updated monthly via risk owners and CMT. Each risk is aligned to a standing committee with the risk register subject to regular review and scrutiny at the relevant standing committees to ensure:

- All relevant risks are identified
- Risks are clearly described in terms of risk description; risk cause; risk impact
- Risks are scored appropriately
- Mitigating actions are framed in SMART terms with clarity on how they will address the risks
- Alignment of risks to corporate objectives is appropriate
- Alignment of risk types is appropriate

The CRR will continue to be developed, reviewed and updated throughout the year via management meetings, through standing committees and Board. Detailed Risk Review

Meetings will be planned with Risk Leads to fully review all aspects of the risk including controls, mitigation actions and risk score. The updated Risks will be reported through each of the Committees for approval and then to Audit and Risk Committee and Board for assurance.

From April the Corporate Risk Register paper will include a performance metric with a target of 100% Corporate Risks reviewed each month. Engagement has been held through the Risk Champions and Risk Management Steering Group to support this.

The enclosed report details the corporate risk profile as submitted to the March Audit & Risk Committee, incorporating approved changes between the period October to December 2023.

Minor changes have been made to the layout of Appendix B, the Impact Assessment Categories Column has been removed. In addition the Initial Risk Assessment score has been removed allowing more focus on the Current and Target Risk scores which remain in the Risk Register.

Please refer to **Appendix A** for the Corporate Risk Register Update Report.

Please refer to **Appendix B** for the Corporate Risk Register.

3. Recommendations

The Board is asked to consider the following recommendations:

- To note the ongoing work of the Audit and Risk Committee and other standing committees in scrutinising, reviewing and updating the risk register and take assurance from that process.
- To review and accept the updated CRR dated December 2023.

4. Response Required

This paper is presented for assurance.

5. 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

6. Engagement & Communications

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

- The Corporate Risk Register is reviewed monthly by Risk Owners and their management teams, supported by the Chief Risk Officer.

7. Governance Route

The content of this paper has been previously considered by the following groups as part of its development:

- CMT – monthly
- Acute Services Committee – 16/1/24
- Population Health & Wellbeing Committee – 23/01/24
- Finance, Planning & Performance Committee – 06/02/24
- Staff Governance Committee – 20/02/24
- Clinical Care & Governance Committee – 05/03/24
- Audit and Risk Committee – 12/03/24

8. Date Prepared & Issued

Date Prepared: 9th April 2024
Date Issued: 23rd April 2024

Appendix A

NHS
Greater Glasgow and Clyde

Corporate Risk Register Review

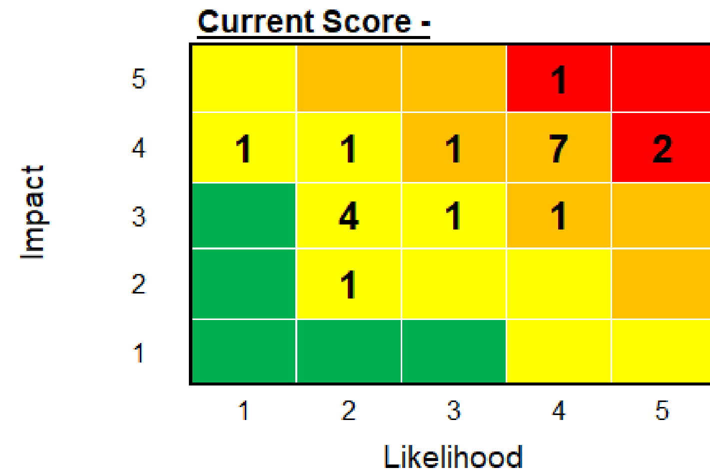
Reporting Period: October to December 2023

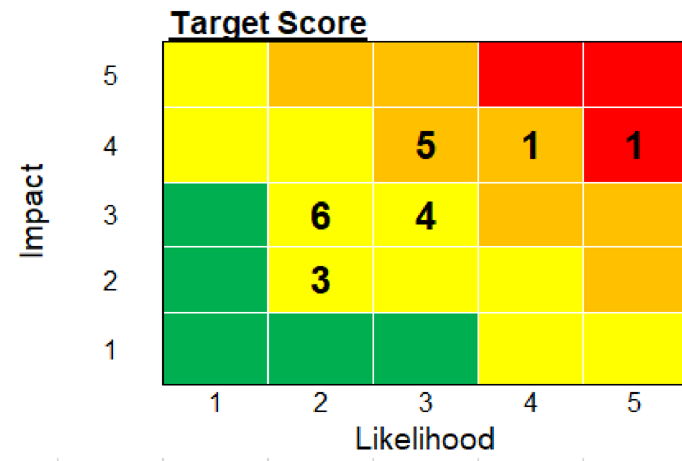
Board: 30th April 2024

Corporate Risk Dashboard

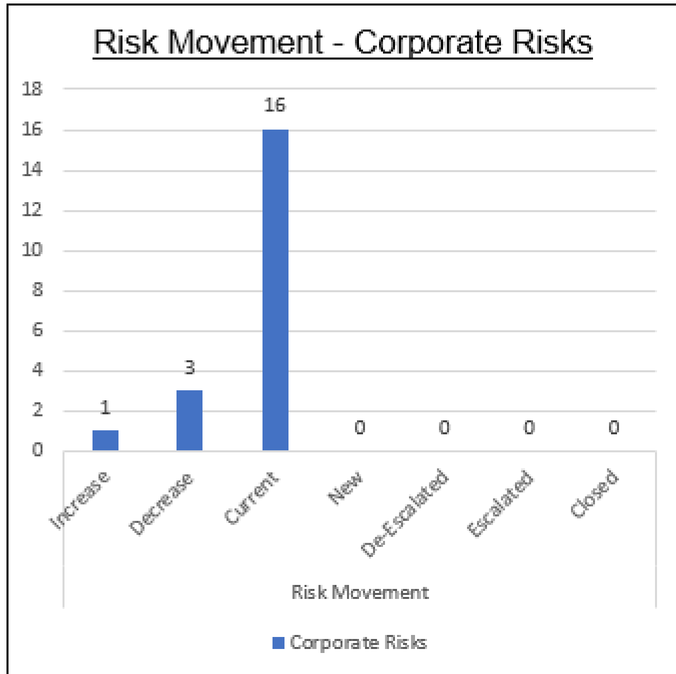
NHS Greater Glasgow and Clyde

ID	Risk Title	Current Risk Scores			Target Risk Score	Trend
		Apr - June 23	July - Sept 23	Oct - Dec 23		
Current Risks - Increased						
3058	Public protection failure in relation to a vulnerable child or adult.	12	12	16	4	
Current Risks - Decreased						
3110	Failure to Recruit and Retain Staff	12	12	6	6	
3059	Staff training and development	9	9	4	4	
3060	Positive, engaging and diverse culture	12	9	6	6	
Current Risks - No Change						
3036	Financial Sustainability - Revenue	20	20	20	20	
3057	Impact of Delayed Discharges on NHSGGC system flow.	20	20	20	9	
2055	Unscheduled Care Waiting Time Targets	20	20	20	16	
2819	Capital Funding Sustainability	16	16	16	12	
2054	In Patient / Day Case Treatment Time Guarantee - Scheduled care waiting time	16	16	16	12	
3343	Outpatients - Scheduled Care Waiting Time Targets	16	16	16	12	
2199	Pandemic Response	16	16	16	12	
3052	Regulatory body compliance	16	16	16	9	
3051	Ageing Infrastructure	16	16	16	9	
2060	Breakdown of failsafe mechanisms for Public Health Screening Programmes	12	12	12	12	
3450	Delivery of medical training to the GMC required standards	12	12	12	9	
3062	Safe & Effective Use of Medicines	9	9	9	6	
3053	Medicine costs and funding availability	8	8	8	6	
2062	Cyber threats	6	6	6	6	
3054	Monitoring of our Remobilisation Plan - co-ordination, capacity and our resources	6	6	6	6	
3432	Industrial action and potential impact to service delivery	12	4	4	4	





Corporate Risk Register - Analysis

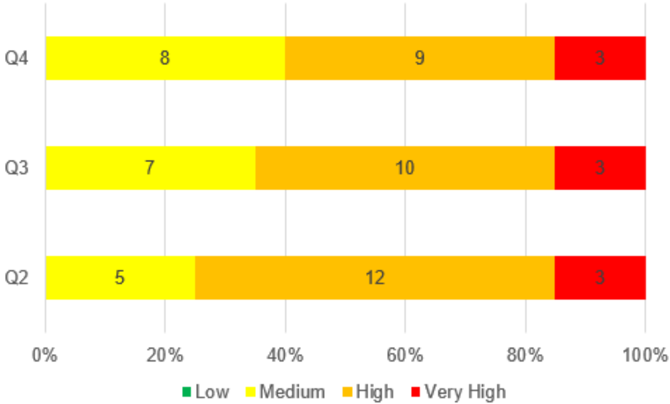


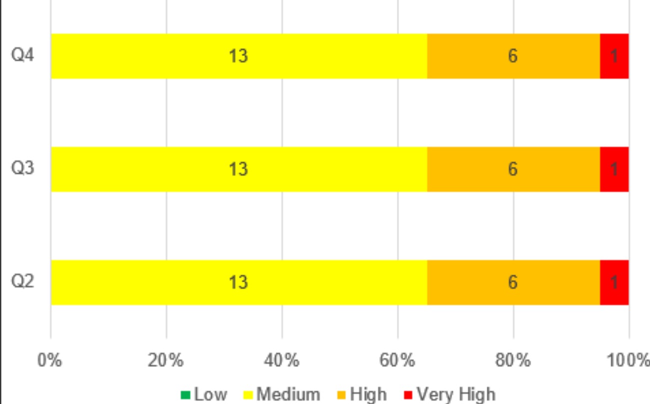
Corporate Risk Register – Movement in Risk Numbers		
Risk Movement	Totals	Risk Titles
No. of risks Sept 2023	**20**	
Risks decreased in score	3	3060 – Positive, Engaging and Diverse Culture 3110 – Failure to Recruit and Retain Staff 3059 - Staff training and development
Risks increased in score	1	3058 - Public Protection in relation to a Vulnerable Child or Adult
New or escalated risks	0	
Closed or de-escalated risks	0	
No. of risks Dec 2023	**20**	

Commentary
The Corporate Risk Register currently comprises 20 risks.

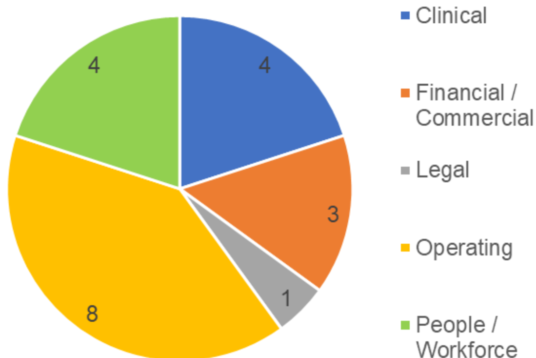
Corporate Risk Register - Analysis

NHS Greater Glasgow and Clyde





Commentary
Risk Score Profile Charts provide comparison of current risk score profile and target risk score. The overall number of risks on the Corporate Risk Register remains at 20.



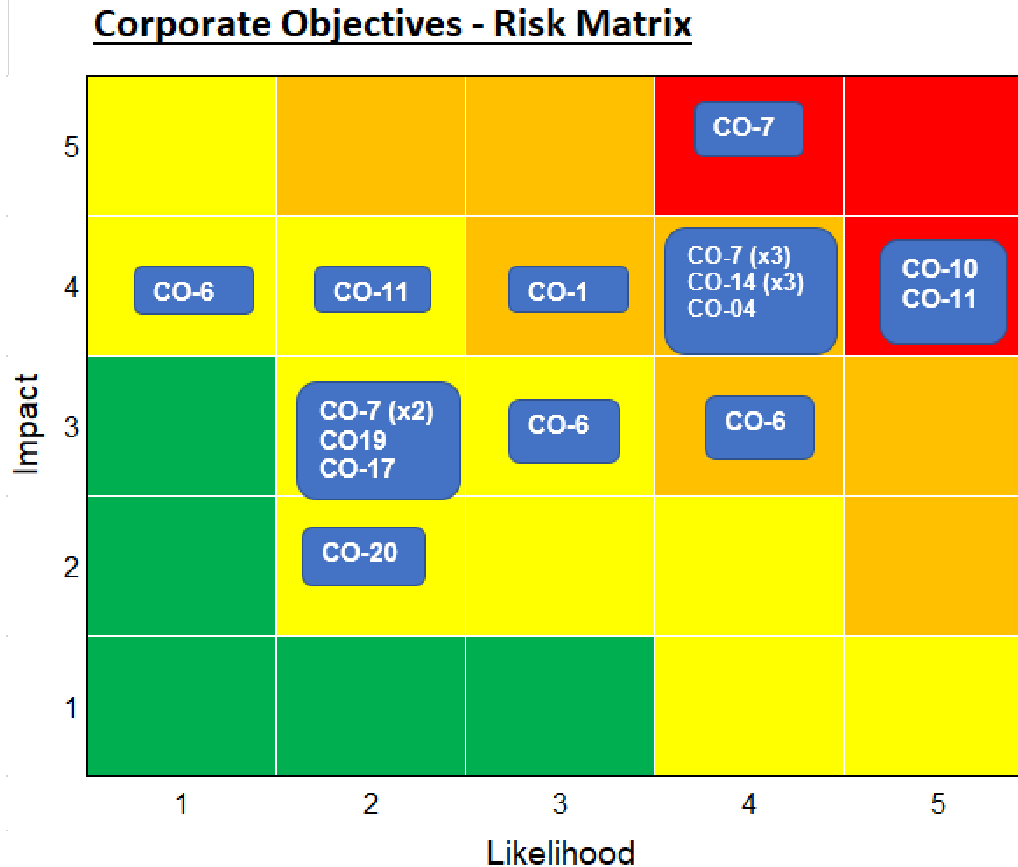
Commentary
The chart provides a breakdown of corporate risks by risk type as defined in the Risk Appetite Statement.

Corporate Risk Register - Analysis

NHS Greater Glasgow and Clyde

Corporate Objectives			Risk Title	Current Score
Better Health	CO1	To reduce the burden of disease on the population through health improvement programmes that deliver a measureable shift to prevention rather than treatment	Breakdown of failsafe mechanisms for Public Health Screening	12
	CO4	To ensure the best start for children with a focus on developing good health and wellbeing in their early years	Public Protection failure in relation to a vulnerable child or adult	16
Better Care	CO6	To provide a safe environment and appropriate working practices that minimise the risk of injury or harm to our patients and our people	Industrial action by staff impacting on care to patients	4
			Delivery of medical training to the GMC required standards	12
			Safe and effective use of medicines	9
	CO7	To ensure services are timely and accessible to all parts of the community we serve	In Patient / Day Case Treatment Time Guarantee - Scheduled care waiting time targets	16
			Outpatients – Scheduled care waiting time targets	16
			Unscheduled care waiting time targets	20
			Pandemic response	16
			Cyber Threats	6
			Monitoring of our Remobilisation Plan – co-ordination, capacity and our resources	6
	CO10	To shift the reliance on hospital care towards proactive and coordinated care and support in the community	Impact of Delayed Discharges on NHS GGC system flow	20
Better Value	CO11	To ensure financial planning across the healthcare system that supports financial sustainability and balance budgets	Financial sustainability – revenue	20
			Medicines costs and funding availability	8
	CO14	To utilise and improve our capital assets to support the reform of healthcare	Capital funding sustainability	16
			Ageing Infrastructure	16
			Regulatory body compliance	16
Better Workplace	CO17	To ensure our people are appropriately trained and developed	Positive, engaging and diverse culture	6
	CO19	To promote the health and well-being of our people	Failure to recruit and retain staff	4
	CO20	To provide a continuously improving and safe working environment	Staff training and development	4

Corporate Risk Register - Analysis



Commentary

In total there are 10 Corporate Objectives linked to Corporate Risks.

The heat map provides a breakdown of residual risk scores aligned to the relevant corporate objective(s). This in turn can provide an indicative 'risk profile' for the corporate objectives.

Risk Register Template

ID	Title	Description	Cause	Controls in place	Risk Score - Current: Likelihood	Consequence	Rating	Risk level	Further Controls Required	Action Owner	Due date	Risk Score - Target: Likelihood	Consequence	Rating	Risk level	Last Review Date	Review Notes	Risk Owner	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
3051	Ageing infrastructure	The ageing infrastructure across the estate could raise operational and financial issues which could result in service disruption and impact on patient care	1. Lack of funding to invest in improvements to the building estate, such as Ventilation Systems, High & Low Voltage infrastructure, Domestic Hot & Cold Water systems, Medical Gas Systems (particularly oxygen capacity), Building Fabric Condition 2. Lack of sufficient staff resource to identify, plan and manage the required investment works 3. Recent findings in relation to RAAC concrete may pose a risk to buildings within GGC.	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure and identifies the areas of the estate at high risk of failure and therefore of highest priority for repair. 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. 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. Prioritisation is informed by EAMs and the 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 NHS Board. 7. 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. 8. RAAC HFS are currently undertaking surveys and sampling to determine current risk if any to GGC until these findings have been shared no further mitigations can be implemented.Surveys co-ordinated via NHS Assure and started on 13th November 2023.	4	4	16	High				3	3	9	Medium	23/11/2023	Updated to reflect RAAC Survey commencing.	Steele, Tom	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Operating	Open	Finance, Planning and Performance Committee
2060	Breakdown of failsafe mechanisms for Public Health Screening Programmes	Breakdown of failsafe mechanisms for all Public Health Screening Programmes - Abdominal Aortic Aneurysm, Bowel, Breast, Cervical, Diabetic Retinopathy, Pregnancy & Newborn, Preschool Vision screening programmes.	1. Lack of governance and oversight; quality assurance monitoring 2. Lack of training and awareness or suitably qualified and experienced staff	• Each programme has failsafe mechanisms monitored by experienced staff, regular quality assurance monitoring and feedback. The requirement for failsafe mechanisms is defined as part of the national standards each screening programme is subject to standards set out by Healthcare Improvement Scotland • 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 National screening co-ordination and oversight structures work in close collaboration with the health board teams to ensure incidents highlighted by one health board are investigated across all health boards. They ensure systematic implementation of retrospective remedial measures to rectify the incident, as well as integrating the learning from the incident into national guidelines and standard operating procedures to avert future recurrence. Thus national coordination and learning from incidents from all health boards further mitigates the risk across all health boards. "	3	4	12	High				3	4	12	High	13/12/2023	"Static. The 'Mitigation actions to further reduce, eliminate or transfer residual risk' form a continuous improvement cycle, which flows into/ already underpins the 'current controls' to reduce risks, but can never entirely eliminate these. Hence the risk score pre and post mitigation actions is the same. Programme level risk registers are reviewed on a regular basis at screening programme steering groups " Programme level risk registers continue to be monitored in relation to this risk and no change to scoring anticipated. Risk again reviewed with no change to the above narrative.	Crighton, Emilia	Better Health - To reduce the burden of disease on the population through health improvement programmes that deliver a measurable shift to prevention rather than treatment	Clinical	Moderate	Population Health and Wellbeing Committee
2819	Capital Funding Sustainability	The Board's required Capital/Infrastructure Investment Programme becomes undeliverable in full and needs to be scaled back	1. Insufficient funding 2. Increasing number of projects and/or increased project costs 3. Lack of staff resources to oversee and deliver the programme 4. Additional demand for spend due to aging estate and infrastructure	• Capital Plan – short and medium term plans in place – detailed annual plan and high level 3 year plan • Capital budget monitoring and oversight o Regular Capital monitoring of spend and income. Monthly forecast trajectory fully in place to ensure progress against plan can be monitored. Spend profile monitored on a monthly basis and followed up with depts. to ensure spend and commitments are carried out in a timely manner, o Detailed monitoring reports and updates provided to CMT and FP&P o Property Asset Steering Group – adopting a risk based approach • Delivery of the Capital plan supported by: o Capital Planning Group Investment Prioritisation Process in place to ensure Investment is focussed on key priority areas o additional Capital Planning staff resources funded by HSCPs and Scottish Government o EAMS system detailing required backlog maintenance and improvements works to ensure the Board can respond quickly to any additional funding opportunities and maximise available capital funding • Work closely with Scottish Govt, Quarterly returns, detailed project progress / spend risk analysis to SPG in Qtr 4 each year, monthly FPR returns, monthly meetings with Scottish Government Capital Team to discuss current and future capital position and funding	4	4	16	High	Infrastructure Planning development work ongoing	Steele, Tom	31/03/2024	3	4	12	High	23/11/2023	Reviewed - no change at this stage - current controls and mitigation narrative updated	Neil, Colin	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Financial / Commercial	Moderate	Finance, Planning and Performance Committee
2062	Cyber threats	Cyber security of the organisation may be compromised and leave the organisation increasingly vulnerable to attack.	1. Lack of effective processes for detection and prevention of cyber attacks 2. Lack of staff training and awareness 3. Increased external threat - frequency and complexity	1. Multi layered security model in place. 2. Anti malware defence system deployed to end point devices. 3. Email, web policies and awareness initiatives in place. 4. Proactive Anti Virus Patching Policy in place for the Board's devices and supplier update patches applied to operating systems on a scheduled basis. 5. To manage Out of Date Operating Systems as Microsoft retire legacy operating systems an external penetration testing company has analysed and provided recommendations which are being acted up on through the robust device replacement plan which eHealth has in place. An operational Lifecyle has been developed to address any servers with legacy operating systems with replacement based on a criticality and tiering model. 6. Emergency patches are deployed on advice of National Cyber Security Teams and supplier guidance. 7. Cyber controls subject to regular review and audit. 8. The Cyber Incident Response Plan (CIRP) completed. 9. NIS 2023 Audit complete and 93% score achieved. Report and actions presented to November 2023 Information Governance Steering Group and to the Corporate Management Team and Audit and Risk Committee in December. 10. A Cyber Incident Response Test (CIRT) completed. 11. For Supplier Assurance there are measures in place through the procurement process with a defined mandatory questions set in place for tender responses. A full System Security/Cloud System Security assessment process is in place with a new rapid risk assessment also implemented. Supplier contracts are being revisited based on tiering with specific cyber security questions being added to the contracts, the Cyber Security compliance letter has been updated with cyber security questions based on the output from the internal audit and will be re-issued following approval received from the Information Governance Steering Group (IGSG) on 29 November 2023. 12. For Password management a change of the current policy is being implemented from December 2023 following approval from the IGSG and in accordance with a robust communication process. An external penetration testing company has analysed the current password policy which informed this revised approach. This will ensure the policy and controls align with industry best practice.	2	3	6	Medium				2	3	6	Medium	12/12/2023	NIS 2023 Audit outcome received and excellent outcome. Updates since November are in relation to supplier assurance and also the change in password management controls which were approved by the IGSG at its November meeting and these will be put in place in December 2023. Review of overall NIS Action Plan will be overseen by the IGSG at its quarterly meetings with reports to CMT and bi annual update to ARC.	Duncan, Tricia	Better Care - To ensure services are timely and accessible to all parts of the community we serve	Operating	Open	Information Governance Steering Group
3450	Delivery of medical training to the GMC required standards	Units / Departments do not meet the GMC standards of training	1. Lack of awareness of GMC standards of training 2. Lack of compliance with and oversight of training standards implementation 3. Increased levels of demand reduces available protected time for training. 4. Staffing levels may not be adequate to deliver standards required	1. Routine weekly Quality management team meetings focus on visit schedule and quality management / improvement processes for each current and planned visit. 2. There is proactive engagement with local teams / units to undertake internal quality improvement meetings / virtual visits, utilising information and data from a range of sources, including deanery visit feedback, GMC NTS data, STS data, and local intelligence on current key issues. 3. Quality improvement engagement meetings take place with local trainers and trainees ahead of all deanery visits. 4. Direct support is provided to quality improvement action planning processes with local teams.	4	3	12	High				3	3	9	Medium	30/11/2023	Risk has been updated to relfect the work carried out by the DME Team to further mitigate this risk through service support and active engagement.	McCamley, Pamela	Better Care - To provide a safe environment and appropriate working practices that minimise the risk of injury or harm to our patients and our people	Clinical	Moderate	Staff Governance Committee
3058	Public protection failure in relation to a vulnerable child or adult.	Lack of knowledge and awareness about Adult Support & Protection leading to a failure to identify and act on potential risk within an appropriate time period which then results in avoidable harm to a vulnerable child or adult.	1. Lack of data to support specific training requirements across services to enable the development of a learning and development trajectory. 2. Lack of training and development capacity within PPS. 3. Lack of attendance at training sessions currently provided. 4. Staff capacity - Lack of requisite knowledge and skills to fulfil Lead Reviewer role for SAERs.	1. Update PP Learning & Education Framework which will include the guidance outlined within the intercollegiate document which states L2 and L3 should be completed within 12 months of start date and refresher timeframes have been updated. 2. Continue to offer training which is advertised Staffnet, Core Brief and PP governance structures. 3. AP1 flowchart has been distributed to wards across acute services and outpatient settings. 4. Robust system in place to monitor SAERs through clinical and care governance groups/committee; statutory adult and child protection committees within the respective HSCPs and Cross Partnership CP Quality Improvement Group, and Children's Services Operational Group. 5. Monitoring of SAER database within PPS on a monthly basis. 6. Delays escalated to Chief Officers and/or Directors.	4	4	16	High	Review and confirm access to the CareFirst electronic system on an ongoing basis. Delivery of internal actions.	Love, Elaine Wallace, Angela	29/12/2023 31/01/2024	2	2	4	Medium	20/11/2023	A new action has been created for the delivery of the management plan, which is subject to review on a monthly basis.	Wallace, Angela	Better Health - To ensure the best start for children with a focus on developing good health and wellbeing in their early years	Clinical	Moderate	Clinical and Care Governance Committee

					Risk Score - Current							Risk Score - Target										
ID	Title	Description	Cause	Controls in place	Likelihood	Consequence	Rating	Risk level	Further Controls Required	Action Owner	Due date	Likelihood	Consequence	Rating	Risk level	Last Review Date	Review Notes	Risk Owner	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
3110	Failure to Recruit and Retain Staff	Failure to recruit and retain staff members resulting in reduced capacity and continual hard to fill areas.	1. Challenging external job market conditions 2. Terms and Conditions uncompetitive and unappealing to prospective external candidates 3. Poor advertising of opportunities / lack of promotion of NHS GGC as an employer of choice	1. DDiT Monitoring. Workforce Plans and Winter Plans. 2. Corporate Performance Storyboards details workforce turnover and demographics to consider short, medium and long term impacts. 3. Alongside this a weekly BRAVE (Bank-Recruitment-Absence-Vacancies-Establishment) has been developed which will outline the current position on these areas and presented to SEG on weekly basis). 4. Weekly Workforce Group meets to consider hard to fill roles and resource gaps, as well as contingency planning e.g. Winter/COVID. 5. Medical, Nursing and Midwifery and Administration Banks provides supplementary staffing contingency across NHSGGC. 6. Annual iMatter Survey to gain staff feedback and development of service/team actions plans. 7. Dentists and Doctors in Training monitoring undertaken locally to ensure appropriate fill of roster gaps and compliant rosters. 8. Workforce Junior Doctors Meeting established to monitor governance arrangements. 9. The NHSGGC Workforce Plan 2022-2025 is in place. 10. Recruitment and Attraction Plan is in place and approved by CMT.	2	3	6	Medium				2	3	6	Medium	04/12/2023	All actions closed and Risk Score Target reached. Staff turnover has reduced. This is helping to increase stability, meaning that recruitment activity in the form of job adverts, on site events, careers fairs and dedicated NHSGGC events is increasing the numbers of staff in key roles. Where hard to fill areas persist, workforce planning groups are considering alternate approaches to delivering service within a multidisciplinary team.	MacPherson, Anne	Better Workplace - To promote the health and well-being of our people	People / Workforce	Moderate	Staff Governance Committee
3036	Financial Sustainability - Revenue	NHS Greater Glasgow and Clyde cannot achieve and maintain financial sustainability and / or cannot maintain current / expected levels of service provision due to financial challenges around delivery of the Financial Plan resulting from significantly higher than expected cost pressures above the allocated funding.	1. Insufficient SG revenue funding allocation 2. Increased cost base / cost of service provision 3. Increased demand 4. Lack of alignment between financial plans and other strategic plans (e.g workforce planning)	• Budgetary monitoring and oversight • 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 • Ongoing focus on cost containment and financial grip to manage in year and emergent financial pressures, particularly around Acute medical and nursing costs; • Nursing - • Focus has been on reducing the premium rate agency which has reduce to almost zero at end of October 2023. There has been established weekly expected Bank and Agency shifts have been set for Sector and Directorate with the focus of reducing standard rate agency. Established the weekly nurse budget tracker within the service which enables the service to monitor the use of Bank and Agency Staff to ensure within available hours. • Medical - • Senior medical is focussing on the reduction of Agency Locums as posts are recruited to within the Service. Reviewing the use of adhoc sessions for Seniors. • Juniors Medical have revised all the Junior medical establishments that fulfil the rota requirements of the Service. Weekly budget tracker has been rolled out, targeting the use of bank and agency. • Review of Junior Doctors Bank rate applying to day time shifts and out of hours shifts. Established guiding principles for all rotas ensuring that the junior doctors take their natural breaks, supporting rota compliance. • Nonpay - Review and scrutiny of all non-pay expenditure focus on product mix and price ranges. • Contracts - review of all contracts to ensure best values for money. • Continue to extrapolate ideas identified at S&V across all services. • Review all current and potential sources of income, including non-recurring to maximise opportunities; • Detailed in-year forecasting carried out at departmental and sector level. Scrutiny at SMG S&V Programme board. • Regular meetings with CO and CFOs of IJBs to discuss performance and projections; • Chief Exec and DOF have installed mid year review meeting with Chief officer and finance officer on recovery plans and future year positions. • Detailed reports, scrutiny and challenge to the ASC, FP&P Cttee and Board. , • Scheme of delegation and Standing Financial Instructions clearly set out Budget Holder responsibility/accountability - targeted training was provided. • Maximisation of non-recurring in-year funding to offset underlying budget pressures on a one-off, in-year basis • Sustainability and Value Programme- weekly S&V Board meetings, governance structure in place and working well, work streams established with renewed focus on recurring savings, locally identified S&V. Contributing to the National Financial Improvement Group, implementing ideas. • Working closely with Scot Govt to identify potential funding to close in year gaps and regular dialogue on overall position; Monthly monitoring returns to SG; Quarterly meetings between the DoF and SG NHS DoF. • Roll out new education and training programme for budget holders has been completed	5	4	20	Very High	1. The Annual Delivery 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. 2. System wide communication on overarching financial challenges (Director of Finance & Director of Communications and Public Engagement - March 2024 3. Initiate a programme of controls to improve compliance and authorisation checks are being implemented in PECOS. - March 2024 4. Automated budget checking controls in place through PECOS - for budget management has commenced implementation, this will be ongoing until completion. March 2024 5. Standardise and rationalise groups re-established with a view to standardise product use across all areas. March 2024 6 Targeted review and challenge of QEUH ward stock management levels, based upon pilot carried out in November 2023. March 2024 7. Cease all discretionary spend in Q4. 8. Further develop benchmarking of the key areas where significant opportunities ha been identified.	McEwan, Fiona	29/03/2024	5	4	20	Very High	23/11/2023	Scores reviewed and confirmed no change. Current controls and mitigation narrative has been updated .	Neil, Colin	Better Value - To ensure effective financial planning across the healthcare system that supports financial sustainability and balance budgets	Financial / Commercial	Moderate	Finance, Planning and Performance Committee
3057	Impact of Delayed Discharges on NHSGGC system flow.	Increased and / or ongoing high levels of delayed discharges from acute settings has a continued negative impact on NHS GGC system flow	1. Demand for staffed care home places exceeds capacity. Care home staggered admission processes are in place. 2. Delay in availability of care at home packages. 3. Infection control restrictions including Outbreaks leading to short term closures of care homes / impact on staff availability in care homes and care at home. 4. Whole system flow delays impacting on LOS and overall number of patients delayed. 5. Increased demand from complex patients throughout the system.	1. Reducing delays remains a key priority for both HSCP and acute colleagues. 2. Each HSCP has a dedicated lead focussing in detail on delays and underlying issues to resolve them. 3. Board wide discharge Huddles take place 2x per week with all HSCP representation and acute discharge team to review, action, and share learning. 4. Discharge without Delay programme in place to support whole system improvement trajectory. 5. Additional capacity has been opened by acute services to support the patients delayed in their discharge in response to the high % occupancy. 6. Patient discharge transport service commenced and in place. 7. Steering group in place. Focus on reducing bed days lost to delayed discharge, improving the percentage of patients discharged without delay and discharge over 7 days.	5	4	20	Very High	Develop a new DD Storyboard and begin discussions to agree new performance metrics/trajectories. Work continues to help reduce the number of patients delayed in their discharge with focus on both Adults with Incapacity and the regular care home / care at home pathways. Work is ongoing with HSCP teams, acute, hospital at home and care homes to expedite dicharges. Immediate issues are resolved in daily local oversight huddles and board overarching huddles.	Rodgers, Jennifer Rodgers, Jennifer Rodgers, Jennifer	31/12/2023 31/12/2023 31/12/2023	3	3	9	Medium	14/12/2023	Risk reviewed and significant work is continuing including - • A test of change has been undertaken on medical wards at the GRI and QEUH to implement the Red2Green practice and visual management system. • Following these tests of change, the DwD Lead is working with BI to plan for a wider roll out across other wards • Winter DOCA which is running for 7 days reviewing all medical patients currently with in GG&C with daily updates being held • The Discharge Team are working alongside all 6 HSCPs to ensure that further delays to discharges from acute are escalated. • The Discharge Team, Executive/Deputy Nurse Director, and -Discharge/Care Home Service Manager (RHSCP) are working with Comms to undertake a 'Home for Christmas" campaign to promote the benefits of having patients moved and settled into care homes over the Christmas period. • Sustainment Programme in place and progressing across all sites, initial focus Dwds in Medicine. Sustainment actions plans in place in each sector	Wallace, Angela	Better Care - To shift the reliance on hospital care towards proactive and coordinated care and support in the community	Operating	Open	Finance, Planning and Performance Committee
2054	In Patient / Day Case Treatment Time Guarantee - Scheduled care waiting time targets	NHSGGC fails to deliver Scheduled Care Waiting Time targets to agreed timescales	1. High or increasing levels of demand / pressures on emergency departments 2. Sub-optimal patient flow planning, management and monitoring 3. Access to facilities (e.g. theatres) and vital equipment 4. Staff skill levels / mix 5. Staff absences/unplanned leave/maternity leave 6. Pressures and blockages in patient flows 7. No succession planning for senior level posts 8. Recruitment challenges/work force shortages	• Monitoring and Analyses of Compliance with WTTs and TTGs is reported to the SG Access Team and monthly to the Acute Services Committee and Acute Strategic Management Group. • The Board receives notification of compliance with WTT/TTG/Access at each Board Meeting. • Performance is scrutinised at Acute Performance Review Group meetings for each Acute Sector and Directorate at quarterly intervals. The Director of Access is a dedicated role to support delivery of in line with targets. *Prioritising cancer • Weekly review of the trends/activity is reported to the Senior Executive working group. • Performance report to CMT and Acute Services for all outpatient and inpatient monitoring. • Weekly KPI are reported to Directors and General Managers. • Monthly report submitted to Directors Access and SMG. • Annual operating plan Performance Monitoring template is reviewed at corporate level and oversees the drive for compliance with targets and key improvement actions. Update provided every 2 weeks to Scottish Government colleagues in regular meeting. • Ongoing review of elective pathways for patients for planned operative care, this is continually evolving. • Clinically validating waiting lists to ensure priority patients identified on a regular basis. • Re profiling the allocation of theatre capacity to meet priority care requirements on an ongoing basis. • Using external capacity at GJNH - regular review meetings held to discuss the pathways of care and optimum arrangements for maximum wait patients. • NTC capacity at NHS Forth Valley pending for orthopaedics and gynaecology - constraints for NTC capacity in 2023/24 , discussion at senior level for patients to transfer for Forth Valley for operative management. • Internal at GGC Planned theatre capacity being reviewed at specialty level to support an incremental increase in theatre sessions delivery - this is reviewed, monitored and reported weekly. • Recruitment in theatres - enhanced recruitment incl international is currently ongoing. • Onward training and development of staff in theatres - requirement for additional specialist theatre training. Parallel training through Nursing Team ongoing to accelerate training, for current and recently recruited staff. • Staff absence levels are reported on a monthly basis. HR working to support managers on managing staff absence level • Review continuing into the available access funds, cancer funds and diagnostic funds at directors access to identify other investment of support that can be put in place to maximise delivery. • Identified the current gap with and without the use of additional sessions funded through Waiting List Initiatives (WLIs) - this was completed in June and further updated in November 2023.	4	4	16	High	1. Delivery the ADP incl Diagnostic commitments for 2023/24 for Inpatient and Day case. 2. Develop a series of productivity and efficiency actions for each speciality at Division and Sector level that will increase the available capacity; 3. Clinic capacity review at sector, speciality level - continue to seek out opportunities for maximising the capacity available. 4. Re-Assess the potential gap between demand and the improved capacity after actions have been put in place to identify priority areas for any additional funds. 5. NTC at Forth Valley - Ongoing review for 2024/25 with Scottish Government. re allocation at Forth valley NTC.	McFadyen, Susan	31/03/2024	3	4	12	High	18/12/2023	No changes to risk score which remains static. KPI's continue to be monitored, reported and managed vs ADP delivery and funding. Work was carried out in June to identify the current gap with and without the use of additional sessions funded through Waiting List Initiatives (WLIs) - this was completed in June and further updated in November 2023.	Edwards, William	Better Care - To ensure services are timely and accessible to all parts of the community we serve	Operating	Open	Acute Services Committee
3432	Industrial action and potential impact to service delivery	Failure to provide the appropriate levels of care to patients	1. Lack of available staff 2. Lack of alternative cover staff to support (Bank staff) 3. Lack of prioritisation / readiness of essential service provision 4. Ongoing pay negotiations at a national level	1. Assuming Trade Union arrangement in place to provide the minimum resource to allow care during target periods of industrial action. 2. Business Continuity plans in place for critical service areas. This includes actions cards for industrial action and prioritisation of staffing to maintain service levels. 3. Creation of national Once for Scotland guidance for NHS GGC staff and managers 4. Monitoring of ongoing pay negotiations at a national level between Scottish Government and Trade Unions for any developments 5. Industrial action guidance document up to date for information. Information session delivered by Director of HR to service leads. FAQ document up to date and under review	1	4	4	Medium				2	2	4	Medium	04/12/2023	Continue to monitor the situation and review the ongoing requirement for this risk over the rest of 23/24.	MacPherson, Anne	Better Care - To provide a safe environment and appropriate working practices that minimise the risk of injury or harm to our patients and our people	People / Workforce	Moderate	Staff Governance Committee

ID	Title	Description	Cause	Controls in place	Risk Score - Current				Further Controls Required	Action Owner	Due date	Risk Score - Target				Last Review Date	Review Notes	Risk Owner	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
					Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level							
3053	Medicine costs and funding availability	Overall medicines costs for NHS Greater Glasgow and Clyde are unsustainable in the future	1. Cost of new medicines is excessive 2. External prices rise beyond expected / projected budgeted levels 3. Increased volumes of medicines require to be prescribed	1. 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. 2. Implementation of PACS2 policy across NHSGG&C	2	4	8	Medium				2	3	6	Medium	14/12/2023	The target for medicines FIP saving continues to be monitored and reviewed. All other schemes are under ongoing review.	Armstrong, Jennifer	Better Value - To ensure effective financial planning across the healthcare system that supports financial sustainability and balance budgets	Financial / Commercial	Moderate	Finance, Planning and Performance Committee
3054	Monitoring of our Remobilisation Plan - co-ordination, capacity and our resources	There is a risk that NHS Greater Glasgow and Clyde will be unable to deliver on the commitments in our annual and medium term Delivery Plans in a structured, controlled manner and within required timescales	1. Lack of available capacity and resource to provide oversight and monitoring of plan deliverability 2. Operational pressures impacting on its deliverability 3. Changes in national position 4. Reduced financial envelope	1. Overarching action tracker developed covering all actions in the Delivery Plan with the planning team providing reporting / oversight against this with RAG rating. Monthly progress reporting to RTG and SEG. Close working with Executive Leads aligned to each action. 2. Additional impact and measurement included in Delivery Plan tracker to support internal monitoring. 3. PMO process established to ensure systematic tracking of commitments. Internal Audit provided external assurance on robustness of process 4. Plans submitted to SG within timescale and agreed level of reporting in place. 5. Close working and regular engagement with SG.	2	3	6	Medium				2	3	6	Medium	14/12/2023	ADP guidance received and work commenced on content development.	Armstrong, Jennifer	Better Care - To ensure services are timely and accessible to all parts of the community we serve	Operating	Open	Finance, Planning and Performance Committee
3343	Outpatients - Scheduled Care Waiting Time Targets	NHSGGC fails to deliver Scheduled Care Waiting Time targets to agreed timescales	1. High or increasing levels of demand / pressures on emergency departments 2. Sub-optimal patient flow planning, management and monitoring 3. Access to facilities (e.g. theatres) and vital equipment 4. Staff skill levels / mix 5. Staff absences/unplanned leave/maternity leave 6. Pressures and blockages in patient flows 7. No succession planning for senior level posts 8. Recruitment challenges/work force shortages	• Monitoring and Analyses of Compliance with WTTs and TTGs is reported to the SG Access Team and monthly to the Acute Services Committee and Acute Strategic Management Group. • The Board receives notification of compliance with WTT/TTG/Access at each Board Meeting. • Performance is scrutinised at Acute Performance Review Group meetings for each Acute Sector and Directorate at quarterly intervals. The Director of Access is a dedicated role to support delivery of in line with targets. *Prioritising cancer • Weekly review of the trends/activity is reported to the Senior Executive working group. • Performance report to CMT and Acute Services for all outpatient and inpatient monitoring. • Weekly KPI are reported to Directors and General Managers. • Monthly report submitted to Directors Access and SMG. • Report every 2 weeks to Scottish Government. • Annual operating plan Performance Monitoring template is reviewed at corporate level and oversees the drive for compliance with targets and key improvement actions. • Ongoing review of elective pathways for patients for planned operative care, this is continually evolving. • Clinically validating waiting lists to ensure priority patients identified on a regular basis. • Re profiling the allocation of theatre capacity to meet priority care requirements on an ongoing basis. • Using external capacity at GJNH - regular review meetings held to discuss the pathways of care and optimum arrangements for maximum wait patients. • NTC capacity at NHS Forth Valley pending for orthopaedics - constraints for NTC capacity in 2023/24 no activity undertaken , discussion at senior level for patients to transfer for Forth Valley for operative management for other specialt • Internal at GGC Planned theatre capacity being reviewed at specialty level to support an incremental increase in theatre sessions delivery - this is reviewed, monitored and reported two weekly . • Recruitment in theatres - enhanced recruitment incl international recruitment is currently ongoing. • Onward training and development of staff in theatres - requirement for additional specialist theatre training. Parallel training through Nursing Team ongoing to accelerate training, for current and recently recruited staff. • Staff absence levels are reported on a monthly basis. HR working to support managers on managing staff absence leve • Review continuing into the available access funds, cancer funds and diagnostic funds at directors access meeting to approve the allocation of resources and to identify other investment of support that can be put in place to maximise delive • Identified the current gap with and without the use of additional sessions funded through Waiting List Initiatives (WLIs) - this was completed in June and further updated in November 2023. • Nationally Speciality Delivery Groups under CFSD are in place to lead on a once for Scotland level the delivery of care. with GGC reps participating in each workstream	4	4	16	High	• Maximise delivery through core staffing. • Work with Primary Care to optimise care for high volume pathways. • Return Patient through PIR and PIFU - release return outpatient capacity and maximise care. • Work with In sourcing for a number of specialities in order to deliver additional capacity to reduce waiting times. • Support Clinical Pathways through ESP and ANP to give alternative clinical support to the management of outpatients. • Use resources for short term increase capacity through WLI.	McFadyen, Susan	31/03/2024	3	4	12	High	18/12/2023	Continued regular monitoring of KPI's and delivery against ADP reported as per controls. Ongoing actions to mitigate risks being progressed.	Edwards, William	Better Care - To ensure services are timely and accessible to all parts of the community we serve	Operating	Open	Acute Services Committee
2199	Pandemic Response	Inability to fully respond to further waves of COVID 19; inability to deliver all required services (COVID and non-COVID)	1. Further waves of COVID 19 in the context of >2 years of managing and responding to the pandemic 2. Insufficient staff and other resources to meet increased demand	1. NHSGGC established a robust governance structure to manage the pandemic. 2. Re-Mobilisation plans are in place and are being implemented . 3. National guidance on infection control including PPE is followed 4. National and local guidance is shared across the organisation in daily Core Briefs 5. National and local campaigns to ensure people attend health services as appropriate for non-COVID related illnesses 6.Spring Booster campaign completed. Autumn/Winter campaign underway. Awaiting JCVI guidance on future requirements	4	4	16	High				3	4	12	High	13/12/2023	Static. The autumn/winter vaccination campaign started on the 4th of September for FLu and starts from the 18th of September for Covid and all eligible cohorts have been offered appointments. the programme will continue to run till 31st March	Crighton, Emilia	Better Care - To ensure services are timely and accessible to all parts of the community we serve	Operating	Open	Population Health and Wellbeing Committee
3060	Positive, engaging and diverse culture	Failure to cultivate, promote and enhance a positive, engaging and diverse culture.	1. Lack of overarching workforce strategy and associated policies, procedures and initiatives 2. Strategy not fully implemented 3. Lack of appropriate training, information, instruction and support for staff 4. Lack of sufficient staff engagement with available training, instruction and support packages	1. Workforce Strategy. 2. Leadership development programmes. New programme for Senior Managers has started. 3. Succession Planning Framework. 4. Equality Action Plan. 5. Medical Management programme introduced. New approach to start by end November. 6. Review of Ready to Lead programme underway. New programme commencing March 2024. 7. iMatter response and results; analysis of NHSGGC Board Report; and focus on action planning and sharing success stories across teams. 8. Promotion of culture framework and associated programmes and initiatives. This is now part of the Workforce Strategy and action plan which is BAU. 9. Internal Communication and Employee Engagement Strategy, now approved by NHSGGC Board as at 25/10/22 10. Additional modules on Equalities & Diversity are now part of our leadership programmes. 11. Senior, middle, and medical manager leadership programmes have all been reviewed and are currently being delivered. The Executive Leadership Programme is completed. 12. Application of IIP is underway and includes assessment and development plans for each site cluster. Initial assessments of all acute and corporate clusters have been completed with improvement plans in place. IRH and Corporate Cluster now accredited. Summative assessments for remaining clusters running from October 2023 to April 2024. 13. Refreshed approach to Succession Planning now in place. Prioritisation at this stage for Directors and SMT members 14. First two phases of Collaborative Conversations complete. As part of newly approved staff internal communications and employee engagement strategy, a third phase is now underway from March 2023. 15. Success Register has now been implemented and being used to share good practice and show appreciation between staff for excellent work. 16. Civility Saves Lives initiative underway. Champions groups in each IiP Cluster. Civility Leads training starting November 2023.	2	3	6	Medium				2	3	6	Medium	04/12/2023	The range of mitigations and culture change programmes are now all underway and being implemented across the organisation, with our target risk score reached. Going forward, we will gain assurance through the IIP assessment programme taking place in our acute services from November 2023 to May 2024 that these programmes are delivering real change throughout NHSGGC. 2024 Internal Comms Employee Engagement Plan (ICEE) is under development and will be reported through our governance in early 2024.	MacPherson, Anne	Better Workplace - To ensure our people are appropriately trained and developed	People / Workforce	Moderate	Staff Governance Committee
3052	Regulatory body compliance	Failure to achieve and maintain statutory compliance through regulatory bodies	1. Insufficient or inadequate programme of staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance 3. Insufficient authorising persons within the board to sufficiently provide the required two AP's per specialty to ensure sign off of permits and provide resilience.	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. 7. Asbestos compliance team use contractors to manage ACM's on sites.	4	4	16	High	Single building fire risk assessments to be conducted across the entire NHSGGC estate. Authorised Engineer audits conducted for specialist areas i.e. water, ventilation, LV, HV and pressure systems. 1. Sufficient authorised persons to be trained and competency assessed to ensure compliance. 2. Sufficient responsible persons (Water) to be trained and competency assessed to ensure compliance. 3. Competence persons training for technicians. Regular internal and external (SEPA) audits for PPC Permits. Permits currently sittin at "Excellent".	Cowley, David Riddell, Mark Riddell, Mark Riddell, Mark	29/03/2024 29/03/2024 29/03/2024 29/03/2024	3	3	9	Medium	10/05/2023		Steele, Tom	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Legal	Cautious	Finance, Planning and Performance Committee

ID	Title	Description	Cause	Controls in place	Risk Score - Current				Further Controls Required	Action Owner	Due date	Risk Score - Target				Last Review Date	Review Notes	Risk Owner	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
					Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level							
3062	Safe & Effective Use of Medicines	Preventable patient and organisational harm from the use of medicines	1. Practice does not comply with standards/best practice 2. Failure/gaps in medicines governance arrangements 3. Failure to learn from medication incidents 4. Medication shortages/Supply chain challenges	1. 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 2. Ongoing development of Medicine Governance policies, procedures and protocols supported by multi-level education embedded within Clinical and managerial supervision arrangements. 3. Ongoing use of pharmacy service redesign and engagement with senior management to extend the integration of clinical pharmacy within multidisciplinary teams across GG&C. 4. Robust arrangements in place to manage medication shortages and take appropriate action to mitigate the impact on patient care 5. HEPMA implementation complete to all planned in-patient areas. 6. SUM Strategic Framework in place and ongoing programme of risk management/improvement activities supported across the Board	3	3	9	Medium				2	3	6	Medium	14/12/2023	HEPMA implementation is now complete to all planned in-patient areas Safer Use of medicines Activities Log complete and will be maintained with regular reporting to Divisional and Board Clinical Governance Groups for assurance	Armstrong, Jennifer	Better Care - To provide a safe environment and appropriate working practices that minimise the risk of injury or harm to our patients and our people	Clinical	Moderate	Clinical and Care Governance Committee
3059	Staff training and development	Failure to appropriately train and develop NHSGGC staff to enable individuals to deliver their role and responsibilities, or where requirements for key competencies are not identified, developed and achieved.	1. Organisation wide training & development programme(s)that are do not meet identified need/ or are fit for purpose 2. Training & development provision is not effectively implemented and monitored 3. Increased levels of demand for the acquisition of knowledge and skills reduce the available protected time for training 4. Lack of awareness for managers and staff of the availability of training and development opportunities 5. Staff not engaging / taking up available training opportunities	1. Annual Reviews for all staff to discuss PDP, objectives and agree support. Conversations to be agreed and recorded on the appropriate system for job family to enable data to be available for corporate recording and performance monitoring. 2. Identification of training that is agreed as statutory and mandatory for the organisation. 3. Completion of core statutory and mandatory training is recorded on learning management systems that enable data to be available for corporate reporting and performance monitoring via Microstrategy Monitoring of Statutory and Mandatory Training compliance, 4. Agreement of performance targets and KPIs for PDP&R and Statutory and Mandatory training. 5. Agreed KPIs and performance target trajectories in place for all areas for review at Performance Review Groups (PRGs), Acute Services Committee and HR Commissioning Meetings. (All service managers are responsible for leading activities to address and improve local performance.) 6. Embedded educational governance throughout learning pathways, developing learning with partners and in line with national standards to ensure pathways support workforce skills and capabilities outlined in the Workforce Strategy 7. Key internal profession based career pathways developed as identified in the workforce plan, incorporating key principles of fairness and accessibility	2	2	4	Medium				2	2	4	Medium	17/10/2023	All actions closed and Risk Score Target reached. Ensuring the agreed actions are having the required impact, we continue to monitor the uptake of our key learning and education programmes, including statutory and mandatory training. While we are on an improvement trajectory, if we do not meet our targets this year we will review the associated risk controls and put in place revised mitigations	MacPherson, Anne	Better Workplace - To provide a continuously improving and safe working environment	People / Workforce	Moderate	Staff Governance Committee
2055	Unscheduled Care Waiting Time Targets	NHSGGC fails to deliver Unscheduled Care Waiting Time targets to agreed timescales	Cause: 1. High or increasing levels of demand / pressures on emergency departments 2. Sub-optimal patient flow planning, management and monitoring 3. Access to facilities (e.g. theatres) and vital equipment 4. Staff skill levels / mix 5. Staff absences/unplanned leave/maternity leave 6. Pressures and blockages in patient flows 7. No succession planning for senior level posts 8. Recruitment challenges/work force shortages	Monitoring and Analyses of Compliance with WTTs and TTGs is reported to the Acute Services Committee, Acute Tactical Group and Acute Strategic Management Group. The Board receives notification of compliance with WTT at each Board Meeting. Performance is scrutinised for each Directorate and Sector at quarterly intervals through the Chief Operating Officer Performance Review Group Meetings . A new Head of Unscheduled Care is now in post and will progress actions from the National Re-design of Urgent Care Programme.	4	5	20	Very High	1. UCC Programme recommendations have been prioritised and improvement work is being progressed as part of the Board Action Plan 2. Flow Hubs are being established to provide system wide operational management of the daily demand with a target focus on managing Flow through the ED's 3. Escalation policies are being refreshed as part of the UCC Programme and the Board wide escalation process is being reviewed as part of the Winter Plan. 4. UCC Delivery Board established to implement report and oversee performance and local implementation to achieve 95%. Local Sector Delivery Groups include IJBs to ensure an integrated approach to UCC. 5. HSCP Service Profiles are being developed to improve information and visibility of what services are available in the community and their hours of operation 6. Acute Hospitals participating in the National Daily Dynamic Discharge Collaborative to ensure all processes are geared to supporting timely patient discharges, increase weekend discharges and to avoid delays. 7. Enhanced pathways group established to progress joint pathway redesign for high volume conditions, currently focusing on Frailty, Mental Health and COPD	Edwards, William	31/07/2023	4	4	16	High	01/12/2023	USC Group continues to monitor challenges presented at the front door and work is ongoing within the USC Action. DWD roll out is almost complete with DOCA ongoing.	Edwards, William	Better Care - To ensure services are timely and accessible to all parts of the community we serve	Operating	Open	Acute Services Committee