

NHS Greater Glasgow and Clyde	Paper No. 23/28
Meeting:	NHSGGC Board
Meeting Date:	25 April 2023
Title:	Corporate Risk Register
Sponsoring Director/Manager	Colin Neil, Director of Finance
Report Author:	Andrew Gibson, 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 October 2022. 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

In addition Audit and Risk Committee receives a quarterly update report on the full CRR.

The enclosed report details the corporate risk profile as submitted to the March Audit & Risk Committee meeting, incorporating approved changes between the period October 2022 to March 2023.

BOARD OFFICIAL

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

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

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

3. Recommendations

The NHS 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 March 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 | <u>Positive</u> |
| • Better Care | <u>Positive</u> |
| • Better Value | <u>Positive</u> |
| • Better Workplace | <u>Positive</u> |
| • Equality & Diversity | <u>Positive</u> |
| • Environment | <u>Positive</u> |

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 in this paper was subject to the following engagement and communications activity:

The CRR, or relevant extracts thereof, has been presented to the following groups:

- Risk Management Steering Group
- CMT
- Acute Services Committee
- Staff Governance Committee
- Finance, Planning and Performance Committee
- Clinical and Care Governance Committee
- Population Health and Wellbeing Committee
- Audit and Risk Committee

8. Date Prepared & Issued














18 April 2023

Corporate Risk Register Review

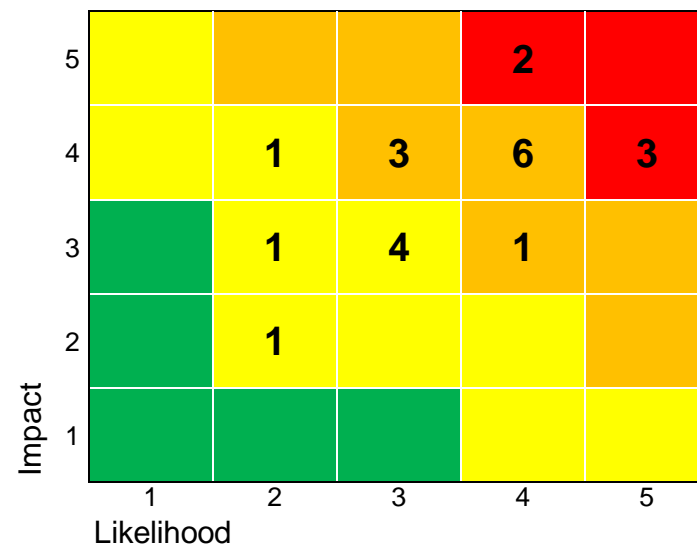
Reporting Period: October 2022 – March 2023

Board: 25th April 2023

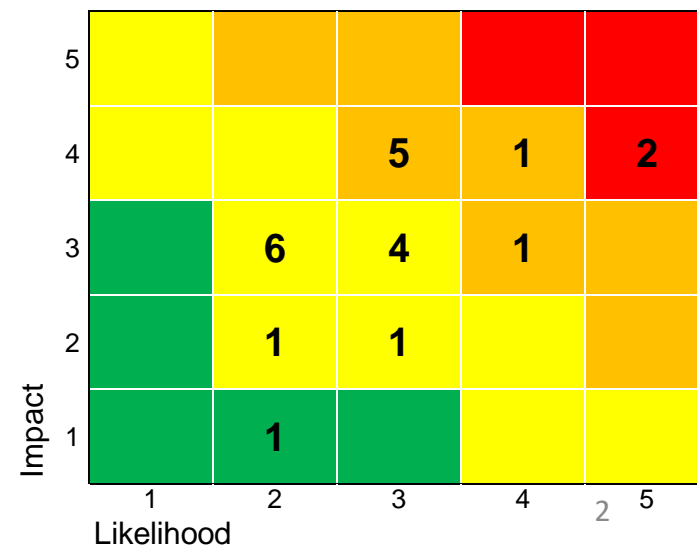
Corporate Risk Dashboard

ID	Risk Title	Current Risk Scores			Target Risk Score	Trend
		Jul - Sep 22	Oct - Dec 22	Jan - Mar 23		
Current Risks - Increased						
3057	Impact of Delayed Discharges on NHS GGC System Flow	16	16	20	9	
Current Risks - Decreased						
3036	Financial Sustainability - Revenue	25	25	20	20	
2054	In Patient / Day Case Treatment Time Guarantee - Scheduled care waiting time targets	20	20	16	12	
3343	Outpatients - Scheduled Care Waiting Time Targets		20	16	12	
3433	Succession Planning	9	6	4	2	
Current Risks - No Change						
3432	Industrial Action and Potential Impact to Service Delivery		20	20	20	
2055	Unscheduled Care Waiting Time Targets	20	20	20	16	
3058	Public Protection Failure In Relation To A Vulnerable Child Or Adult	20	20	20	12	
2819	Capital Funding Sustainability	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	
3110	Failure to Recruit and Retain Staff	20	12	12	6	
3060	Positive, Engaging and Diverse Culture	16	12	12	6	
3054	Monitoring of our Remobilisation Plan - co-ordination, capacity and our resources	9	9	9	6	
3059	Staff Training and Development	20	9	9	6	
3062	Safe & Effective Use of Medicines	9	9	9	6	
2766	Failure to meet obligations to provide person centred care	9	9	9	4	
3053	Medicine costs and funding availability	8	8	8	6	
2062	Cyber threats	6	6	6	6	

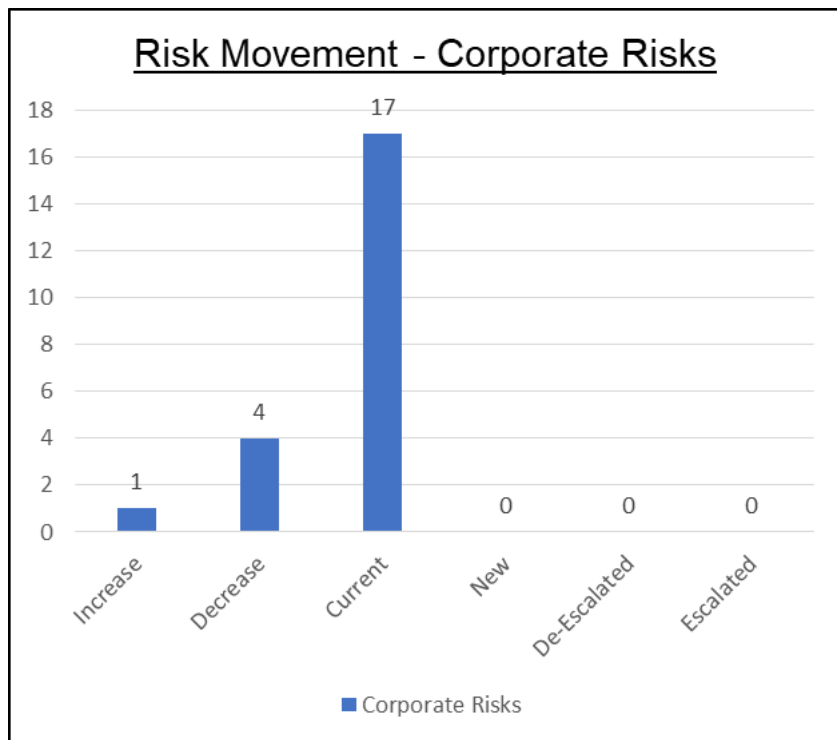
Current Score



Target Score



Corporate Risk Register - Analysis



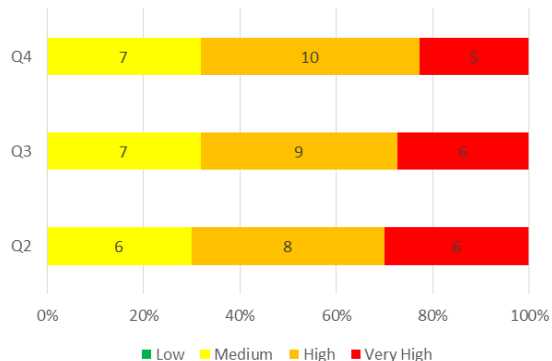
Commentary

The Corporate Risk Register comprises 22, the same number as the previous report to Board in October 2022.

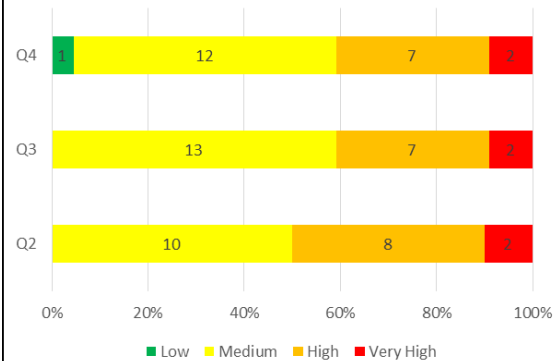
Corporate Risk Register – Movement in Risk Numbers		
Risk Movement	Totals	Risk Titles
No. of risks October 2022	22	
Risks de-escalated or closed	0	
New Risks	0	
Risks increasing in score	1	Impact of Delayed Discharges on NHSGGC System Flow
Risks decreasing in score	4	Financial Sustainability – Revenue
		In Patient / Day Case Treatment Time Guarantee – Scheduled Care Waiting Time Targets
		Outpatients – Scheduled Care Waiting Time Targets
		Succession Planning
No. of risks March 2023	22	

Corporate Risk Register - Analysis

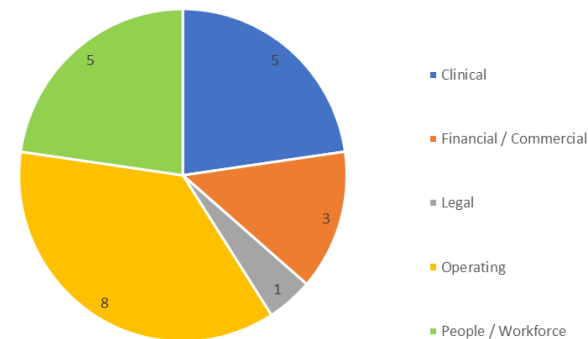
Corporate Risk Score Profile -
Current Score



Corporate Risk Score Profile -
Target Score



Risk Appetite Types - Corporate Risks



Commentary

The chart above provides a comparison of the current risk score profile and target risk score profile for the previous 3 quarters.

Commentary

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

Corporate Risk Register - Analysis

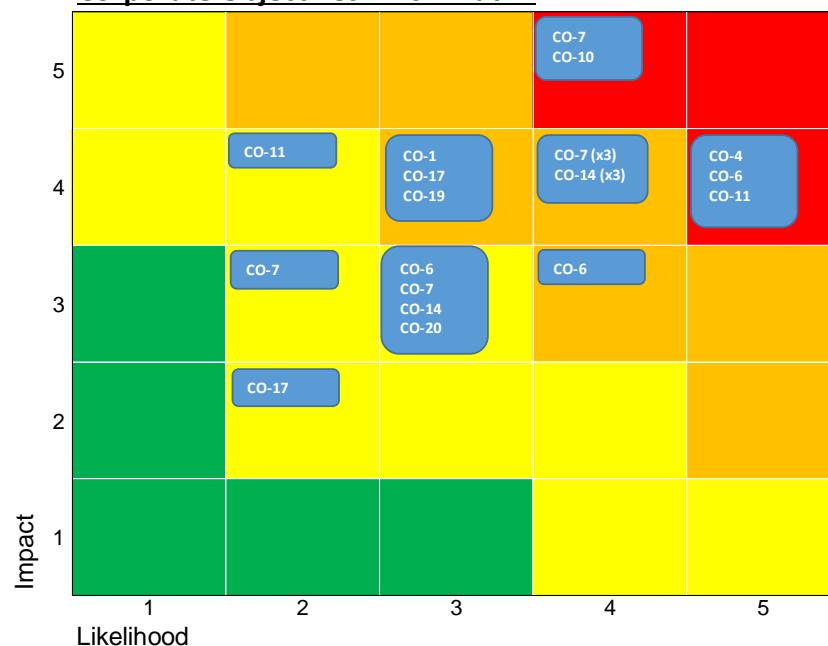
Corporate Objectives			Risk Title	Residual Score
Better Health	CO1	To reduce the burden of disease on the population through health improvement programmes that deliver a measureable shift to prevention rather than treatment	Breakdown of failsafe mechanisms for Public Health Screening	12
	CO4	To ensure 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	20
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 and potential impact to service delivery	20
			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	9
	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
			Remobilisation Plan – ageing infrastructure	16
			Regulatory body compliance	16
			Failure to meet obligations to provide person centred care	9
Better Workplace	CO17	To ensure our people are appropriately trained and developed	Positive, engaging and diverse culture	12
	CO19	To promote the health and well-being of our people	Failure to recruit and retain staff	12
			Succession planning	4
	CO20	To provide a continuously improving and safe working environment	Staff training and development	9

Corporate Risk Register - Analysis

Corporate Objectives

CO1	To reduce the burden of disease on the population through health improvement programmes that deliver a measureable shift to prevention rather than treatment
CO4	To ensure the best start for children with a focus on developing good health and wellbeing in their early years
CO6	To provide a safe environment and appropriate working practices that minimise the risk of injury or harm to our patients and our people
CO7	To ensure services are timely and accessible to all parts of the community we serve
CO10	To shift the reliance on hospital care towards proactive and coordinated care and support in the community
CO11	To ensure financial planning across the healthcare system that supports financial sustainability and balance budgets
CO14	To utilise and improve our capital assets to support the reform of healthcare
CO17	To ensure our people are appropriately trained and developed
CO19	To promote the health and well-being of our people
CO20	To provide a continuously improving and safe working environment
CO2	To reduce health inequalities through advocacy and community planning
CO3	To reduce the premature mortality rate of the population and the variance in this between communities
CO5	To promote and support good mental health and wellbeing at all ages
CO8	To deliver person centred care through a partnership approach built on respect, compassion, and shared decision making
CO9	To continuously improve the quality of care engaging with our patients and our people to ensure healthcare services meet their needs
CO12	To reduce cost variation, improve productivity and eliminate waste through a robust system of efficiency savings management
CO13	To exploit the potential for research, digital technology and innovation to reform service delivery and reduce costs
CO15	To ensure our people are treated fairly and consistently, with dignity and respect and work in an environment where diversity is valued
CO16	To ensure our people are well informed
CO18	To ensure our people are involved in decisions that affect them

Corporate Objectives - Risk Matrix



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.

For example, the most commonly occurring objective is CO7, with 6 risks linked to this objective. CO11 is linked to the risk with the highest residual score (25).

Appendix B - Corporate Risk Register

ID	Opened	Title	Description	Cause	Impact	Likelihood	Impact	Rating	Risk level	Controls in place	Likelihood	Impact	Rating	Risk level	Further Controls Required	Action Owner	Due date	Likelihood	Impact	Rating	Risk level	Last Review Date	Review Notes	Risk Movement	Risk Owner	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee	
Increased Risks																															
###	#####	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.	Adverse publicity / reputation, Financial: including damage / loss / fraud, Injury: physical and psychological, Patient experience, Service / Business interruption, Staffing and competence	5	5	25	Very High	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. Each HSCP has a trajectory to reduce delays by 25% by end of December 2022. This target was not met. 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 structure 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.	4	5	20	Very High	Performance data weekly for all HSCPs to review position against trajectory to meet 25% reduction by December. Escalation letters have been revised (Oct 2022) to support firstly communicate awareness and early discussion with families and secondly if required. Daily HSCP discharge meetings taking place between 2-5 days depending on escalation. 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. - Support to care home staffing via newly set up HCSW care home bank- recruitment and induction, underway - 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 hospital. Further a Home First Response Team will be tested at QEUH and RAH phased starting 31st October in order to reduce frailty admissions and Frailty pt Length of stay - setting up pt pathway linked to discharge codes and use for improvement. work on larger Dwd dashboard. - Shared learning re AWI 13za processes Work is ongoing with HSCP teams, acute, hospital at home and care homes to expedite discharges. Immediate issues are resolved in daily local oversight huddles and board overarching huddles. External HSCPs with patients within GGC health board are represented at DD Huddle. Discharge without Delay (Dwd) Programme started with SG initial self-assessment sessions complete - improvement plan being established.	Rodgers, Jennifer	31/03/2023	3	3	9	Medium	#####	1. Pathway now available for DD codes but not yet live. able to pull reports and use for improvement for each HSCP, specifically to focus on areas where they have largest bed days lost. HCSW Bank now in place to support care home staffing issues being limiting factor to receiving discharges 2. Performance meetings to review each HSCP against trajectory in place. 3. Dwd project lead commenced 5th December 2022. Steering group now in place (Inaugural meeting 24/10/22) Focus on reducing bed days lost to delayed discharge, improving the percentage of patients discharged without delay and discharge over 7 days. 4. Dwd work programme commenced first meeting 24/10/22 5. Risk score reviewed and increased following the CMT action in January 2023.	↑	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	
Decreased Risks																															
###	#####	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) 5. Insufficient COVID funding and recovery cost funding	Adverse publicity / reputation, Financial: including damage / loss / fraud, Patient experience, Service / Business interruption	5	4	20	Very High	• Budgetary monitoring and oversight o 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 o Ongoing focus on cost containment and financial grip to manage in year and emergent financial pressures, particularly around Acute medical and nursing costs; o Review all current and potential sources of income, including non-recurring to maximise opportunities; o Detailed in-year forecasting carried out and reviewed o Regular meetings with CO and CFOs of UBs to discuss performance and projections; o Detailed reports, scrutiny and challenge to the ASC, FP&P Ctee and Board o Scheme of delegation and Standing Financial Instructions clearly set out Budget Holder responsibility/accountability o Maximisation of non-recurring in-year funding to offset underlying budget pressures on a one-off, in-year basis • Financial Improvement Plan - workstreams with renewed focus on recurring savings, governance structure in place and working well; locally identified FIPS; • Covid cost control - exit planning and close monitoring all related costs • Working closely with Scot Govt to identify potential funding to close in year gaps and regular dialogue on overall position; Quarterly monitoring returns to SG; Quarterly meetings between the CE, DoF and SG NHS DoF. • System wide communication on over reaching financial challenges has been undertaken. • Review of areas of Covid spend to reduce / remove costs where possible and in line with SG guidance has been completed.	5	4	20	Very High	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. Detailed Covid-19 expenditure forecasts are submitted regularly to SG, highlighting recurring and nonrecurring spend.	McEwan, Fiona	31/03/2023	5	4	20	Very High	#####	The financial position of NHS GGC has been getting monitored closely and Covid-19 expenditure is now within the financial envelope. There has also been an improvement in core deficit in line with the work set out in the financial recovery plan which has allowed us to improve the financial position for 2022/23. This has resulted in the score being reduced. Further work is ongoing to see if the position can be improved further for 2022/23.	↓	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	
###	#####	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	Adverse publicity / reputation, Financial: including damage / loss / fraud, Patient experience, Service / Business interruption, Staffing and competence	4	5	20	Very High	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. Weekly oversight of trends/activity reporting through the Senior Executive 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 Annual operating plan Performance Monitoring template is reviewed at corporate level and oversees the drive for compliance with targets and key improvement actions. • 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 • Using external capacity at GJNH	4	4	16	High	Outpatient Capacity and Productivity Programme established to review capacity/demand and identify productivity gains in each specialty. The objectives of the programme are: - Examining the current gap with and without the use of additional sessions funded through Waiting List Initiatives (WLIs); - Developing a series of productivity and efficiency actions for each specialty at Division and Sector level that will increase the available capacity; and - Reassess the potential gap between demand and the improved capacity after actions have been put in place to identify priority areas for any additional funds. One of the fundamental areas which is currently WIP but moving to completion, is the completion of Consultant Job Plans, which will be reviewed across all specialities. capacity is utilised fully. A redesign of scope provision has been established to maximise productivity, and run a cross sector single virtual waiting list.	McFadyen, Susan	31/03/2023	3	4	12	High	#####	Score reduced from 4x5=20 to 4x4 = 16. Unscheduled care performance improved in January (69% achievement of WTT compared to 54.2% in December and 60.8% in November) which has in turn released capacity to increase elective care provision.	↓	Edwards, William	#####	Better Care - To ensure services are timely and accessible to all parts of the community we serve	Operating	Open	Acute Services Committee	
###	#####	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	Adverse publicity / reputation, Financial: including damage / loss / fraud, Patient experience, Service / Business interruption, Staffing and competence	4	5	20	Very High	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. Weekly oversight of trends/activity reporting through the Senior Executive 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 care Annual operating plan Performance Monitoring template is reviewed at corporate level and oversees the drive for compliance with targets and key improvement actions. • 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	4	4	16	High	Remobilisation work continues with : *Increase where possible in virtual patient management/ telephone consultations. *Current controls framework and governance has supported delivery of the outpatient targets as set by the Scottish Government for the initial phase of two year waits for outpatients in most no patient waiting for outpatients in most specialties by the end of August 2022 Further planning is underway to ensure delivery of 18 month waits for outpatients in most specialties by the end of December 2022 and One year waits for outpatients in most specialties by the end of March 2023 The formal governance arrangements as part of controls to monitor delivery will ensure that the existing plans and trajectory will support delivery or highlight where alternative actions need to be implemented	Best, Jonathan	31/03/2023	3	4	12	High	#####	Score reduced from 4x5=20 to 4x4 = 16. In December we managed and maintained over and above the recovery trajectory target, consistently delivering between 5,900-6,000 appointments on a weekly basis - delivery being 21,326 against the RMP5 target of 20,448. This has seen continued improvement in January and February but requires close monitoring.	↓	Edwards, William	#####	Better Care - To ensure services are timely and accessible to all parts of the community we serve	Operating	Open	Acute Services Committee	
###	#####	Succession Planning	Failure to implement succession planning for key roles	1. Identified skill shortages 2. Resourcing issues causes long delays in vacancy filling 3. Lower numbers of candidates for key roles 4. Candidates applying who are not ready	Service / Business interruption, Staffing and competence	3	3	9	Medium	1. Career Development & Succession Planning Framework developed and being implemented across all Directorates but with varying success. Getting consistency in application remains a challenge and further proposals to help effectiveness and consistency have been set out. 2. Proposals to improve Succession Planning in Directorates have been set out for Director discussion and agreement. These include assurance that individuals with potential for SMT and hard to fill roles are identified and have personal development in place to target 'vacancy readiness' within agreed timescales. 3. Proposals have been passed at the CMT for implementation starting in October 2022	2	2	4	Medium	OD support to career upward individuals listed in each directorate for director and SMT positions.	Mann, Douglas	28/02/2023	2	1	2	Low	#####	Risk score has reduced from 3x3=9 (initial) to 2x2=4 (current) and once mitigating actions are complete the final rating will be 1x2=2 (target). Mitigating actions are underway at the moment (November)with career conversations as part of PDP mid term reviews. All career upward individuals to posts at SMT level will be identified by end December and development plans in place.	↓	MacPherson, Anne	#####	Better Workplace - To ensure our people are appropriately trained and developed	People / Workforce	Moderate	Staff Governance Committee	

Appendix B - Corporate Risk Register						Risk Score - Initial				Risk Score - Current				Risk Score - Target																	
ID	Opened	Title	Description	Cause	Impact	Likelihood	Impact	Rating	Risk level	Controls in place	Likelihood	Impact	Rating	Risk level	Further Controls Required	Action Owner	Due date	Likelihood	Impact	Rating	Risk Level	Last Review Date	Review Notes	Risk Movement	Risk Owner	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee	
Current Risks																															
###	#####	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	Adverse publicity / reputation, Complaints / Claims, Patient experience, Service / Business interruption, Staffing and competence	5	4	20	Very High	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.	5	4	20	Very High	1. Reassignment of staff who are clinically trained to support application of care (Owner: relevant sectors/directorates; Target Date: as and when required). 2. Redeployment of other staff who are not clinically trained to support the delivery of non care related activities (Owner: relevant sectors/directorates. Target Date: as and when required). 3. Review of contingency / business continuity plans in readiness for periods of industrial action (Owner: relevant sectors/directorates in conjunction with Civil Contingencies Unit(Target Date: as and when required) 4. Monitoring of ongoing pay negotiations at a national level between Scottish Government and Trade Unions for any developments (Owner: Director of Human Resources and Organisational Development. Target Date: ongoing) 5. Creation of toolkits and FAQs for staff (Director of Human Resources and Organisational Development. Target Date: Nov-22) 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 UBs 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	Owens, Nareen		5	4	20	Very High	#####	No change. The risk articulates the impact on delivery of care in the event of industrial action due to lack of agreement on pay negotiations at a national level and any mitigating actions to minimise impact to patients and services. Clinical staff not involved in strike action will require to be reassigned to maintain essential services - main areas of risk are nursing and support services.	↔	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	
###	#####	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	Adverse publicity / reputation, Financial: including damage / loss / fraud, Patient experience, Service / Business interruption, Staffing and competence	4	5	20	Very High	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 UBs 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	Best, Jonathan	31/03/2023	4	4	16	High	#####	Unscheduled care performance improved in January (69% achievement of WTT compared to 54.2% in December and 60.8% in November) which has in turn released capacity to increase elective care provision, however this remains a Very High risk and there is a continued requirement to review and monitor high occupancy rates across all sites.	↔	Edwards, William	#####	Better Care - To ensure services are timely and accessible to all parts of the community we serve	Organisational/Service	Open	Acute Services Committee	
###	#####	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.	•Staff not being released to attend Adult Support and Protection L3 teams training due to staff absence and increased demand on staff across NHSGGC resulting in inability to free up time for staff to attend training. •Child death - Fatal Accidental Enquiry, commencing July 2022 is a risk for organisational reputation and has an impact on wellbeing of staff who are contributing to this. This is an area of ongoing focus for the service. •Learning and actions from Significant Adverse Event Reviews (SAERs) not being shared Boardwide – SAERs are commissioned by individual partnership areas and learning is not being shared Boardwide. •Lack of staffing / Increased operational demands exceed resource capacity – unable to meet IRD timeframes in accordance with National Guidance (National Guidance states IRDs will now take place for pre-birth and 16 - 18 year olds). •No access to social work electronic recording system in Glasgow City HSCP – Unable to share information between health and social work services	Adverse publicity / reputation, Financial: including damage / loss / fraud, Patient experience	5	4	20	Very High	1. Posters distributed to all wards across NHSGGC to raise awareness of ASP process. >Training offered at different times via Teams but still low attendance. >Training advertised on Staffnet Core Brief and Hot Topic with specifics who should attend Level 3 training and how to book a place. >Comprehensive programme of Level 1 and 2 ASP training now available for all staff on Learnpro. Acute Adult Operational Group advised of ongoing developments to cascade learning opportunities to staff >Low attendance discussed with report provided at Acute ASP meeting. >7 minute briefings developed for staff to access information re process and responsibilities 2. Board has been made aware with papers submitted to Board Clinical Governance Forum (BCGF) and discussed at Public Protection Forum (PPF) and Child Protection Forum (CPF). >Preparation is underway and has included:- discussion with CLO, independent expert report commissioned, postional review with improvement actions, relevant staff have been identified and support provided. >FAI health review group established to provide oversight and coordination of health board responses. 3. Paper has been circulated to Board Clinical Governance Forum and Public Protection Forum. >Specific group set up to address backlog and open actions. >Cross-partnership group has been put in place going forward to address this issue in partnership areas. 4. Two additional seconded Child Protection Nurse Advisors in post until Sept 2023. >Appointed two permanent members of staff to the team with a view of adding third member of staff. 5. Application has been submitted for PP Service to have access to Badgernet - access provided January 2023. •NHSD4 Referrals and Pre-birth IRD advice lines are emailed to two named midwifery staff who will upload to Badgernet in the interim.	5	4	20	Very High	Training projection being developed by Lead Nurse for Adult Support and Protection. Implementation of any further recommendations arising from the FAI process. PP Service will establish process to have oversight of all child protection SAERs and actions for all service areas. Service review and workforce analysis to be undertaken by the Public Protection Senior Management Team on behalf of the Executive Nurse Director. Issue with tasking on the Badgernet system which is being taken forward by the Lead Nurse for Child Protection.	Ocherty, Margaret	31/03/2023	4	3	12	High	#####	1. ASP training - Following an increase in numbers, these have now fallen again. 2 FAI process has concluded and is awaiting the determination of the Sheriff. 3. Meeting with PP team has taken place and system now in place ensuring outstanding actions for SAERs are progressed with relevant professionals assigned the action on DATIX. 4. NHSGGC PPT business case for additional staffing is underway. 5. Access to pre-birth information. PP staff now have access to the Badgernet system (Jan 2023)but there are ongoing issues with tasking on the system that require to be resolved. 6. Sharing of information between health and SW. No progress. 7. Issue with addition of API Form onto Clinical Portal - this is being progressed with eHealth and PP lead nurses. Some progress made but a number of actions remain outstanding.	↔	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	
###	#####	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	Financial: including damage / loss / fraud, Injury: physical and psychological, Inspection / Audit, Patient experience	5	4	20	Very High	• Capital Plan – short and medium term plans in place – detailed annual plan, high level 3 year plan and indicative 5 year plan • Capital budget monitoring and oversight o Regular Capital monitoring of spend and income o Detailed monitoring reports and updates to CMT and FP&P o Property Asset Steering Group – adopting a risk based approach • Delivery of the Capital plan supported by: o Regular meeting of Asset Investment Prioritisation Forum to review Capital Expenditure priorities to ensure investment is focused on the correct 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	4	4	16	High	Infrastructure Planning development work ongoing	Steele, Tom	31/03/2023	3	4	12	High	#####	Static	↔	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	
###	#####	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	Financial: including damage / loss / fraud, Patient experience	4	4	16	High	1. NHS Scotland's Estate Asset Management System (EAMS) appraises the existing estate and assesses 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. 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. 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. 7. 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. 8. 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	High	Repairs to AHU highlighted in the annual validation report in terms of maintenance and lighting should be undertaken asap.	Cullen, Gary	29/03/2023	3	3	9	Medium	#####	'Static. Work is currently ongoing to assess current compliance and subsequent requirements to improve compliance to a statutory level where necessary. 26.01.23 Title and description were updated to remove reference to Covid and Covid remobilisation as the remobilisation is complete. 26.01.23 Of highest concern is the ventilation systems across the estate which in many cases have exceeded their 20 year life span which SHTM** states should see the systems upgraded, the systems may begin to fail audits as a result of their life span even if they are still fully operational. The energy inefficiency of the aging AHU's also brings additional utilities costs and is energy inefficient in contradiction with the boards sustainability agenda(26.01.23 Updates by Amanda Parker on behalf of Mark Riddell).	↔	Steele, Tom	#####	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Operating	Open	Finance, Planning and Performance Committee	
															Business case to be produced on CDU AHU identifying a solution to replacing the ageing AHU.	Riddell, Mark	29/03/2023														

Appendix B - Corporate Risk Register

ID	Opened	Title	Description	Cause	Impact	Likelihood	Impact	Rating	Risk level	Controls in place	Likelihood	Impact	Rating	Risk level	Further Controls Required	Action Owner	Due date	Likelihood	Impact	Rating	Risk level	Last Review Date	Review Notes	Risk Movement	Risk Owner	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee	
###	#####	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. The risk of pausing screening programmes during the pandemic. 1.AAA- The risks with pausing are a delay to diagnosis of an AAA and the associated costs.	1. Lack of governance and oversight; quality assurance monitoring 2. Lack of training and awareness or suitably qualified and experienced staff	Adverse publicity / reputation, Complaints / Claims, Patient experience	3	4	12	High	• 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	#####	"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.	↔	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
###	#####	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	Adverse publicity / reputation, Patient experience, Service / Business interruption	4	3	12	High	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	Ongoing internal review processes, informed by triangulation of data/information including GMC NTS/ STS data and other feedback.	McCamley, Pamela	31/03/2023	3	3	9	Medium	#####	An update on Enhanced Monitoring was presented to the Staff Governance Committee in November 2022. A further update is planned in Spring 2023. In October 2022, Inverclyde Royal Hospital was recognised as having one of the UK's top performing departments for medical training and education. Recent data from the 2022 General Medical Council's National Training Survey and the Scottish Deanery National Training Survey ranked the general medicine department in the top 2% of performers across the country.	↔	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	
###	#####	Failure to meet obligations to provide person centred care	Failure to comply with legislation related to patient rights; patient feedback; person centred care.	1. Lack of co-ordinated, organisation wide strategy and approach to patient centred care; patient rights; patient feedback 2. Lack of training and awareness for staff 3. Lack of clearly defined roles and responsibilities	Adverse publicity / reputation, Financial; including damage / loss / fraud, Patient experience	5	3	15	High	1. Implementation of the NHSGGC Healthcare Quality Strategy. 2. Implementation of person centred care board wide work plan. 3. Implementation of the Fairer NHSGGC 2020 – 24 Equality Scheme 4. Multiple methods to seek feedback from patients and service users in regard to care experience. 5. Established Person centred steering group and sub groups supported by a network of professional local leadership for the person centred care agenda. 6. A range of education, training, development and supervision opportunities provided by NHSGGC to enhance staff skills and behaviours. 7. Internal governance arrangements to ensure collection, analysis including identification of themes and learning across the organisation. 8. Person centred competencies embedded in staff recruitment, support, and development arrangements. 9. Commitment to delivering on the board's principles of PCC as outlined in the strategy. 10. Workplan implemented with rigorous review of objectives, milestones and timelines. 11. Project plan for person-centred care planning is in place - engagement and testing phase is now complete, implementation is integral to the digital clinical notes programme of work with early adopter phase commencing Feb 2023.	3	3	9	Medium					2	2	4	Medium	#####	The following actions support the reduction in the risk scoring: - Regular reporting of feedback mechanisms and associated processes for reflection, learning and improvement via person centred steering group. - Robust reporting from established PCC Groups to Quality Strategy Oversight and Clinical and Care Governance Committee. - Education in place and promoted via specific PCC workstreams including 'What Matters to You Group' and 'Digital Clinical Notes' - Values based recruitment now standard in all recruitment. Additionally: - Person centred visiting is now fully in place with evaluation underway and learning and improvement plans in place. - Project plan for person-centred care planning is in place - engagement and testing phase is now complete, implementation is integral to the digital clinical notes programme of work with early adopter phase commencing Feb 2023. Full implementation will commence in Spring 2023 (A McLinton, PHC Team) - Board Patient Story Development processes and coordination have been reviewed with a greater focus on reflection, learning and improvement. Patient story is delivered bi-monthly at each board meeting. Process being progressed to share the story wider across all services. (J Rodgers/D Connelly/A McLinton) - Lived Experience Volunteers have now been recruited to join the 'What Matters to You' Group and will, following learning further recruitment will be progressed. - A Realistic Medicine Toolkit has been launched which includes person-centred care resources, education material etc (A Ireland/Breeda Ojo, Realistic Medicine Team). - The Care Experience Improvement Model remodelled in March 2022 in a small cohort of five teams which is underpinned by the Excellence in Care Standard for Person-centred Care.(A McLinton, PHC Team)	↔	Wallace, Angela	#####	Better Care - To deliver person centred care through a partnership approach built on respect compassion and shared decision making	Clinical	Moderate	Clinical and Care Governance Committee
###	#####	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	Injury: physical and psychological, Patient experience, Service / Business interruption, Staffing and competence	5	4	20	Very High	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 Matter 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 was developed in partnership, supported by Board Workforce Steering Group. It was approved by the Staff Governance Committee in Aug 22 and submitted to Scottish Government. Positive feedback was received with requests for additional information met. There was no material change to the plan and it was published on NHSGGC website on 31.10.22. 10. Development of Recruitment and Attraction Plan as part of Workforce Strategy, in order to meet future workforce demand and to ensure all routes to employment within NHSGGC are open. The Recruitment Plan was presented to HRSMT in November 2022 and subsequently approved by CMT.	3	4	12	High	Progress against implementation of the Recruitment and Attraction Plan will be monitored for positive impact on hard to recruit roles and overall risk reduction	Munce, Steven	31/03/2023	2	3	6	Medium	#####	This remains a high risk, however progress has been made with the approval of the Recruitment and Attraction Plan by CMT. Implementation of the plan in support of risk mitigation will be monitored over the coming months.	↔	MacPherson, Anne	#####	Better Workplace - To promote the health and well-being of our people	People / Workforce	Moderate	Staff Governance Committee	
###	#####	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	Patient experience, Service / Business interruption, Staffing and competence	4	4	16	High	"1. NHSGGC established a robust governance structure to manage the pandemic. This consists of a ""slimmed-down"" Board governance process, a Covid SEG meeting, (underpinned 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. 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.Winter vaccination campaign completed. Awaiting guidance on possible spring booster campaign. "	4	4	16	High					3	4	12	High	#####	"Static. Case numbers , the number of people in hospital and Staff absence continues to fluctuate. All local control measures and actions remain under review. GGC has a limited ability to influence the decision making through escalation pathways to national for a and SG and continues to participate in these discussions. Winter vaccination campaign completed. Awaiting National Guidance on anticipated spring booster campaign "	↔	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
###	#####	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 speciality to ensure sign off of permits and provide resilience.	Adverse publicity / reputation, Injury: physical and psychological, Inspection / Audit	4	4	16	High	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.	4	4	16	High	Mitigating action to further reduce, eliminate or transfer residual risk: 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, ventilation, LV, HV and pressure systems. 3. Authorised person training and competence 4. Regular internal and external (SEPA) audits for PPC Permits. Permits currently sitting at "Excellent".	Riddell, Mark	#####	3	3	9	Medium	#####	Static. Work remains ongoing new funding to the amount of £1.2 million has been allocated across the 4 main geographical areas to improve compliance in statutory issues such as fire damper testing, PAT testing and fixed wire testing.	↔	Steele, Tom	#####	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Legal	Cautious	Finance, Planning and Performance Committee	
###	#####	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	Service / Business interruption	4	4	16	High	"1. Workforce Strategy. 2. Leadership development programmes. 3. Succession Planning Framework. 4. Equality Action Plan. 5. Medical Management programme introduced. 6. Review of Ready to Lead programme underway. 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. 13. Refreshed approach to Succession Planning underway. Prioritisation at this stage for Directors and SMT members. Career conversations as part of mid term reviews of PDPs will complete end November.	3	4	12	High	12. Application of IIP is underway and includes assessment and development plans for each site cluster. Initial assessments of all acute and corporate clusters will be complete by end of March 2023. 13. Refreshed approach to Succession Planning underway. Prioritisation at this stage for Directors and SMT members. Career conversations as part of mid term reviews of PDPs will complete end November. Identification of career upward individuals and OD support to these individuals will be complete in Feb 2023 14. Development of our approach to 'Civility Saves Lives' and the development of a Success Register are underway with target date for finalising end March 2023. Doug's action 15. First two phases of Collaborative Conversations complete. As part of newly approved staff internal communications and employee engagement strategy, a third phase is now being planned with programme to be agreed by December 2022, for launch in early 2023.	Mann, Douglas	31/03/2023	2	3	6	Medium	#####	Updated the action in collaborative conversations.	↔	MacPherson, Anne	#####	Better Workplace - To ensure our people are appropriately trained and developed	People / Workforce	Moderate	Staff Governance Committee	

Appendix B - Corporate Risk Register

Appendix B - Corporate Risk Register						Risk Score - Initial				Risk Score - Current				Risk Score - Target																
ID	Opened	Title	Description	Cause	Impact	Likelihood	Impact	Rating	Risk level	Controls in place	Likelihood	Impact	Rating	Risk level	Further Controls Required	Action Owner	Due date	Likelihood	Impact	Rating	Risk level	Last Review Date	Review Notes	Risk Movement	Risk Owner	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
###	#####	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	Service / Business interruption	5	4	20	Very High	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.)	3	3	9	Medium	6. Embedding 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. Review and develop key internal profession based career pathways as identified in the workforce plan, incorporating key principles of fairness and accessibility 8.Employee engagement programme will enable us to better identify staff groups where training and learning opportunities are not being consistently deployed. Programme of collaborative conversations due to be in place 9. Supporting Sector/ Directorate/ HSCP to put in place performance trajectories, identify actions and develop solutions to achieve compliance targets by March 2023 on Core Statutory and Mandatory learning and recording of PDP&Rs on Turas Appraisal . Trajectories will allow targeting of support and actions by the Learning and Education Team through the HR Commissioning meetings and agreed SMT support .	MacDonald, Moira	31/03/2023	3	2	6	Medium	#####	Five Mitigating actions have been reviewed and now part of BAU and moved into the Current Control column. Residual risk rating to be reviewed by HRSMT due to the volume of controls now in place. 5/9 mitigating actions are now current controls. 4 Remaining mitigating actions are on track.	↔	MacPherson, Anne	#####	Better Workplace - To provide a continuously improving and safe working environment	People / Workforce	Moderate	Staff Governance Committee
###	#####	Monitoring of our Remobilisation Plan - co-ordination, capacity and our resources	NHS Greater Glasgow and Clyde will be unable to deliver on the requirements of the COVID 19 Re-mobilisation Plan in a structured, controlled manner within required timescales	1. Lack of available capacity and resource to provide oversight and monitoring of plan deliverability (>400 action points). 2. Lack of governance and control of delivery of the plan 3. Further waves of COVID 19 impact on its deliverability 4. Increased demand outstrips capacity	Adverse publicity / reputation, Financial: including damage / loss / fraud, Patient experience, Staffing and competence	3	3	9	Medium	1. Monitoring plan developed and encompasses 443 action points across a variety of services and the planning team provide reporting / oversight against this with RAG rating.-Recovery Tactical Group (RTG) established. Weekly meetings held to monitor implementation with Executive Leads aligned to each action. 2. PMO process established around RMP3 to ensure systematic tracking of commitments. Internal Audit provided external assurance on robustness of process 3. Closure report prepared for RMP3 4. PMO processes will be carried forward for Annual Delivery Plan 5. Annual Delivery Plan submitted to SG	3	3	9	Medium				2	3	6	Medium	#####	Annual Delivery Plan was submitted SG and awaiting feedback. Monitoring of RMP encompasses 443 action points across a variety of services and the planning team provide reporting / oversight against this with RAG rating. RMP3 Tracker was first developed in April 2021. Of the 443 actions contained within the RMP3 tracker: • 309 were completed within the reporting period. • 102 actions had an expected completion date after the end of the reporting period or were marked as 'Ongoing'. • 6 actions were delayed at the end of the reporting period. • 26 actions were removed and assigned to an alternative governance structure.	↔	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
###	#####	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	Adverse publicity / reputation, Financial: including damage / loss / fraud, Patient experience	3	3	9	Medium	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	#####	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
###	#####	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	Adverse publicity / reputation, Financial: including damage / loss / fraud, Patient experience	3	4	12	High	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	Development & delivery of a Financial Improvement Plan for acute medicines expenditure which doesn't compromise patient care or service delivery Update	Watt, Janice	31/03/2023	2	3	6	Medium	#####	The FIP medicines savings plan for 22/23 remains on track with key contributions from the multi-disciplinary Acute Prescribing Management Group, the Pharmacy Medicines Cost Effectiveness group and the Acute Finance Team. The current full year end savings target is £6.1M	↔	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
###	#####	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	Adverse publicity / reputation, Data loss / breach of patient confidentiality, Service / Business interruption	3	4	12	High	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. Emergency patches are deployed on advice of National Cyber Security Teams and supplier guidance. 6. Cyber controls subject to regular review and audit. 7. The Cyber Incident Response Plan (CIRP) is in the process of being updated with accompanying playbooks and role based action cards. 8. A cyberIncident Response Test (CIRT) is being scheduled.	2	3	6	Medium	The risk is tolerated at this level and is mitigated by the controls currently in place. NHSGGC has completed a Networks and Information Systems (NIS) audit from which a risk based action plan has been completed. Robust action plan being actively managed and reviewed through the IGSG. Latest NIS annual review was undertaken on 23rd August 2022. The 2022 NIS Review report has just been received which shows improved compliance from 75% (2021) to 81% and reduction in risk exposure of 3% (2021) to no residual risk exposure and achievement of key performance indicators set by Scottish Government the deadline for which was December 2023. The report has been is currently being reviewed and the NIS action plan will be updated and considered for initial consideration by the Information Governance Steering Group in November and at its meeting on 23rd November and thereafter CMT in December and Audit and Risk Committee	Duncan, Tricia	22/02/2023	2	3	6	Medium	#####	No material change in risk status other than controls 7 and 8 added. A review of the CIRP has taken place and the plan has entered the revision stage. Action cards based on Subject Matter Expert (SME) roles have been created and presented to eHealth Senior Management Team for feedback. A cyber incident response exercise has been developed and is now being scheduled. Robust NIS action plan in place and updated against latest NIS review outcome and progress being reviewed through the IGSG.	↔	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