NHS Greater Glasgow and Clyde	**Paper No. 22/83**
Meeting:	**NHS Board Meeting**
Meeting Date:	**25 October 2022**
Title:	**Corporate Risk Register**
Sponsoring Director:	**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 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 CRR will continue to be developed, reviewed and updated throughout the year via management meetings, through standing committees and Board.

Refer to **Appendix A** for the Corporate Risk Register Review report.

Refer to **Appendix B** for a copy of 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 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 date October 2022.

4. Response Required

This paper is presented for **assurance**.

5. Impact Assessment

The impact of this paper on NHS Greater Glasgow and Clyde'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 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

7. Governance Route

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

As above

8. Date Prepared & Issued

Prepared on 11 October 2022
Issued on 18 October 2022

Appendix A

Corporate Risk Register Review

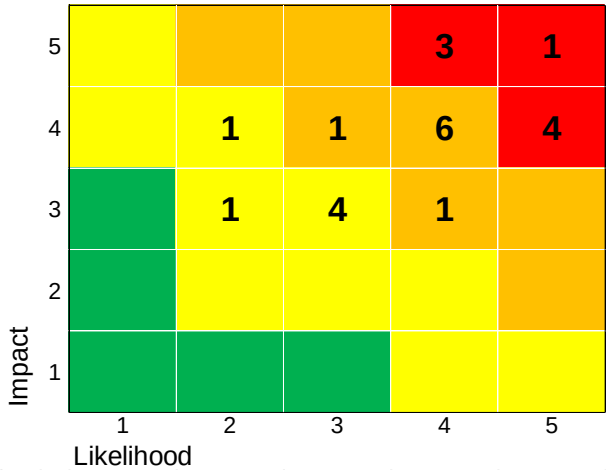
NHS Board: 25th October 2022

Corporate Risk Dashboard

Risk Title	Residual Risk Score		Target Risk Score
	Oct-21	Oct-22	
Industrial action by staff impacting on care to patients	N/A	**20**	20
Inpatient / Day Case Treatment Time Guarantee - Scheduled Care Waiting Time Targets	N/A	**20**	16
Outpatients - Scheduled Care Waiting Time Targets	N/A	**20**	16
Financial Sustainability - Revenue	20	**25**	20
Unscheduled Care Waiting Time Targets	20	**20**	16
Public Protection Failure In Relation To A Vulnerable Child Or Adult	20	**20**	12
Failure to Recruit and Retain Staff	20	**20**	12
Staff Training and Development	20	**20**	9
Impact of Delayed Discharges on NHS GGC System Flow	16	**16**	16
Pandemic Response	12	**16**	12
Capital Funding Sustainability	16	**16**	12
Remobilisation Plans - Ageing Infrastructure	16	**16**	9
Regulatory Body Compliance	16	**16**	9
Positive, Engaging and Diverse Culture	16	**16**	12
Delivery of Medical Training to the GMC Required Standards	N/A	**12**	9
Breakdown of Failsafe Mechanisms for Public Health	12	**12**	12
Succession Planning	N/A	**9**	6
Safe & Effective Use of Medicines	9	**9**	6
Monitoring of our Remobilisation Plan - Co-ordination, Capacity and Resources	9	**9**	6
Failure to Meet Obligations to Provide Person Centred Care	9	**9**	9
Medicines Costs and Funding Availability	12	**8**	6
Cyber Threats	6	**6**	6

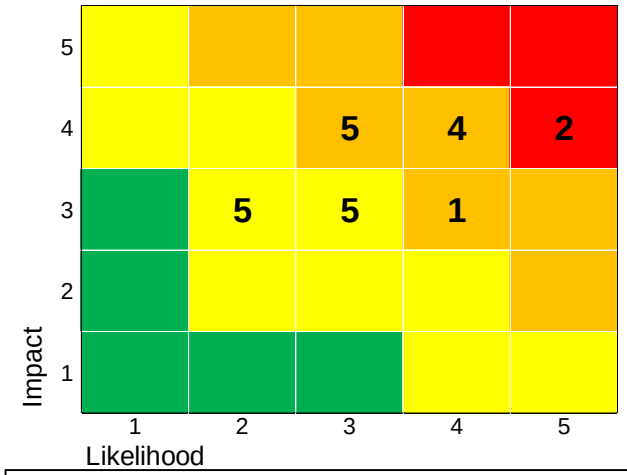
Residual Score

(current score, based on existing mitigation)



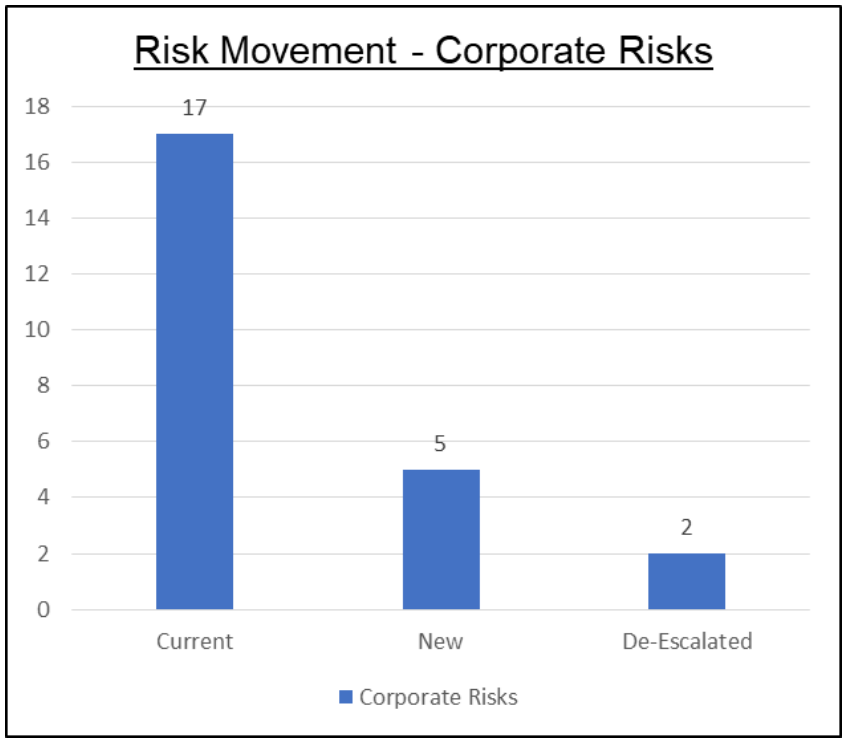
Target Score

(Forecast score, following further mitigation)



The residual risk is **the risk score based on current controls and mitigations.**
The target risk score is **the forecast risk score once additional controls and mitigations have been delivered**

Corporate Risk Register - Analysis

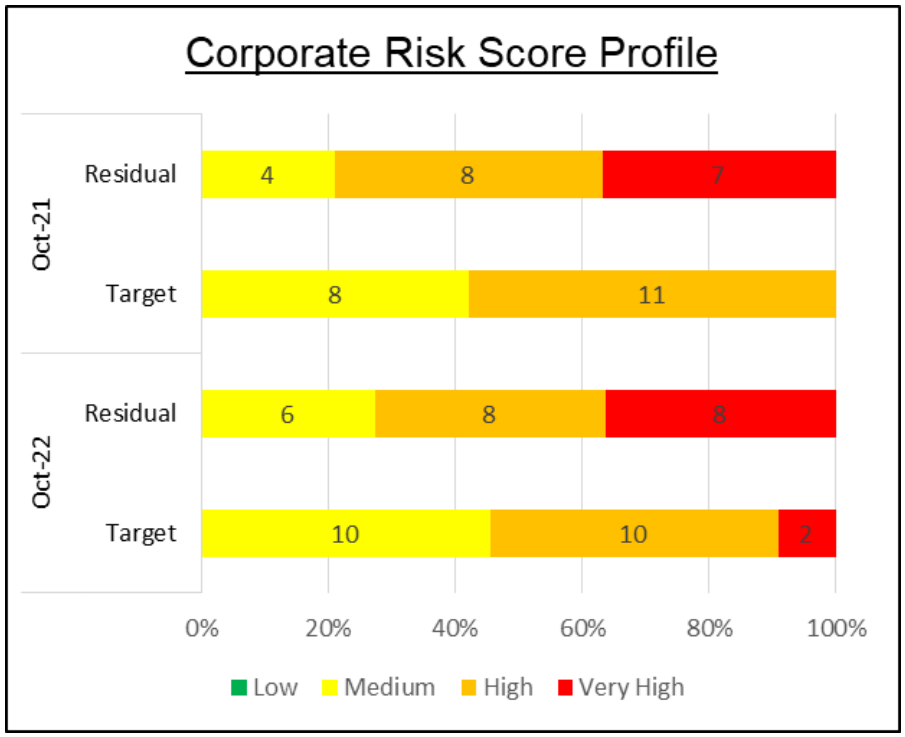


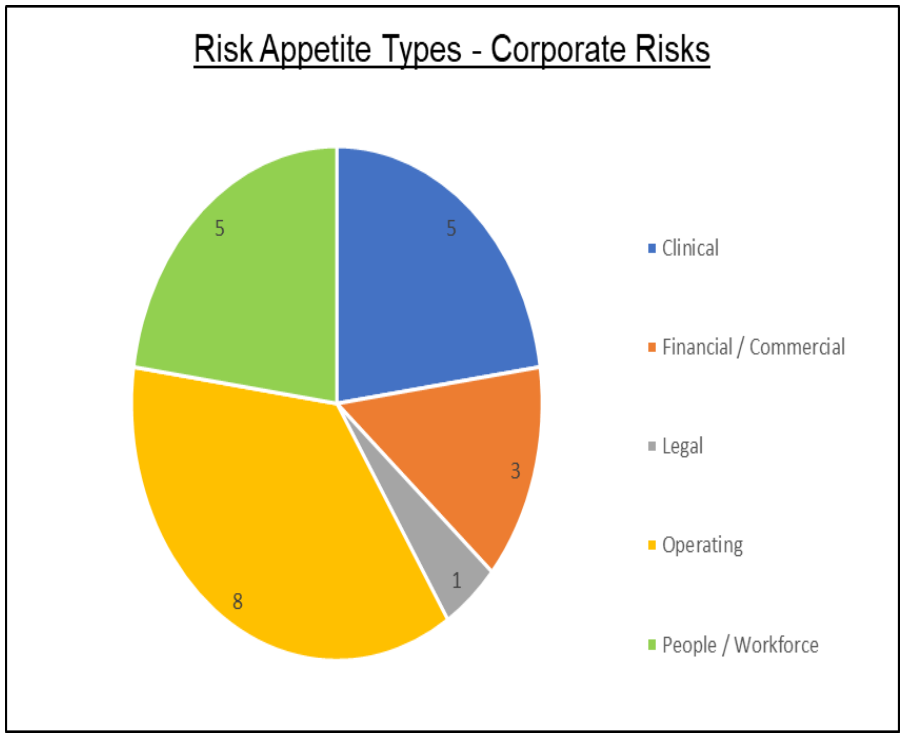
Commentary

The Corporate Risk Register comprises 22 risks, increased from 19 in October 2021.

Corporate Risk Register – Movement in Risk Numbers		
Risk Movement	Totals	Risk Titles
No. of risks October 2021	19	
Risks de-escalated	2	1. Infection Prevention and Control
		2. Reputational risks around facilities and environmental issues and capacity flow
New Risks	5	1. Industrial action by staff impacting on care to patients
		2. Inpatient / Day Case Treatment Time Guarantee – Scheduled Care Waiting Time Targets
		3. Outpatients – Scheduled Care Waiting Time Targets
		4. Delivery of Medical Training to the GMS Required Standards
		5. Succession Planning
No. of risks October 2022	22	

Corporate Risk Register - Analysis





Commentary

The chart above provides a comparison of the residual risk score profile and target risk score profile between October 2021 and October 2022.

The residual risk score can be described as **the risk score based on current controls and mitigations.**

The target risk score can be described as **the forecast risk score once additional controls and mitigations have been delivered.**

Commentary

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

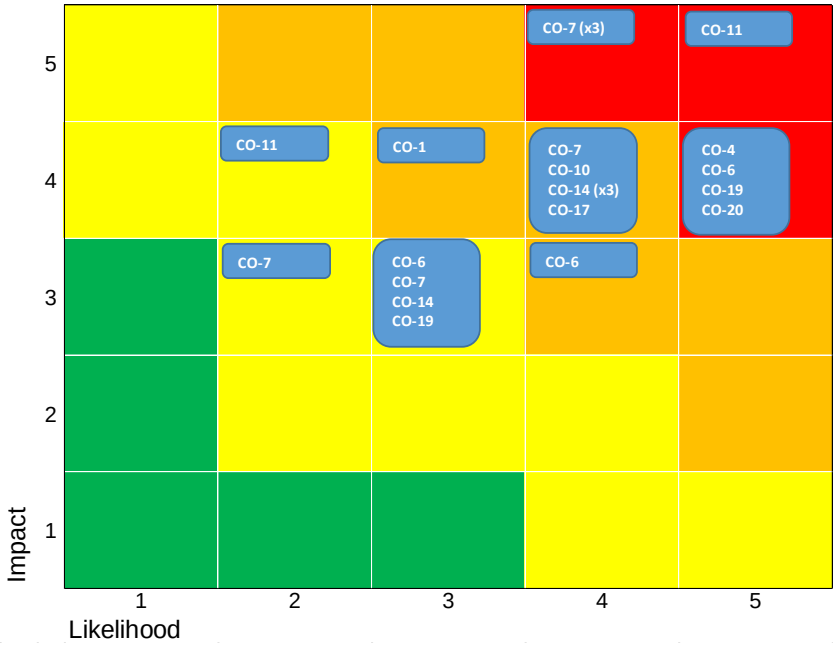
Corporate Risk Register - Analysis

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 by staff impacting on care to patients	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	20
			Outpatients – Scheduled care waiting time targets	20
			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	16
Better Value	CO11	To ensure financial planning across the healthcare system that supports financial sustainability and balance budgets	Financial sustainability – revenue	25
			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	16
	CO19	To promote the health and well-being of our people	Failure to recruit and retain staff	20
			Succession planning	9
	CO20	To provide a continuously improving and safe working environment	Staff training and development	20

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 liked to this objective. CO11 is linked to the risk with the highest residual score (25).

NHS GGC Corporate Risk Register

Appendix B

07.10.22

Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Score based on current controls: Residual Likelihood	Residual Impact	Residual Score	Mitigating action to further reduce, eliminate or transfer residual risk	Forecast score following mitigation: Target Likelihood	Target Impact	Target Score	Review Notes	Target dates for actions	Corporate Objectives	Risk Type	Risk Appetite	Governance (review committee
Director of Human Resources & Organisational Development	**Risk Title** Industrial action by staff impacting on care to patients **Risk:** Failure to provide the appropriate levels of care to patients **Cause:** 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 **Impact:** 1. Service Interruption: Pressure on service and staff / potential that some services require to be paused 2. Complaints / Claims: Complaints from patients families or carers. 3. Reputation / Adverse Publicity: Poor public relations; local media coverage short term 4. Staffing and Competence: Short term low staffing level temporarily reduces service quality 5. Patient Experience: Unsatisfactory patient experience / clinical outcome directly related to care provision - readily resolvable	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 action cards for industrial action and prioritisation of staffing to maintain service levels	5	4	20	1. Reassignment of staff who are clinically trained to support application of care (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 (Target Date: as and when required). 3. Review of contingency / business continuity plans in readiness for periods of industrial action (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 (Target Date: ongoing) 5. Creation of toolkits and FAQs for staff (Target Date: October-22) 6. Creation of national Once for Scotland guidance for NHS GGC staff and managers (Target Date: October-22)	5	4	20	New risk. Discussed at September CMT and developed via HROD SMT. The risk articulates the impact on deliver of care in the event of any industrial action as a result of lack of agreement on pay negotiations at a nationala level and any mitigating action to minimise impact to patients and services. All clinical staff not involved in strike actions will require to be reassigned to maintain essential services - main areas of risk are nursing and support services	Oct-22	BCCO CO 6	People / Workforce	2 - Cautious	Staff Governance Committee
Chief Operating Officer	**Risk Title** In Patient / Day Case Treatment Time Guarantee - Scheduled care waiting time targets **Risk:** NHSGGC fails to deliver Scheduled Care Waiting Time targets to agreed timescales **Cause:** 1. High or increasing levels of demand / pressures on emergency departments impacting planned care programme 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 **Impact:** 1. Patient Experience: unsatisfactory patient experience / clinical outcomes - long term effects 2. Service / Business Interruption - some disruption in service with unacceptable impact on patient care 3. Financial - increased / unbudgeted costs of delivering services 4. Staffing and competence - uncertain delivery of service due to lack of staff 5. Adverse publicity / reputation - Local media coverage - long term adverse publicity. Significant effect on public perception of the organisation	Monitoring and Analyses of Compliance with WTTs and TTGs is reported to the SG Access Team and to each meeting of the Acute Services Committee , Acute Directors Access meeting and Acute Strategic Management Group. Weekly oversight of trends/activity reporting through the Senior Executive Group. The Board receives notification of compliance with Waiting Time Targets 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 in line with targets Annual operting plan Performance Monitoring template is reviewed at corporate level and oversees the drive for compliance with targets and key improvement actions. • Continuous monitoring of delivered activity against plan • 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	5	20	Remobilisation work continues with : *Cancer Plan *NHSGGC Scopes Improvement Plan Continuous review of elective capacity ongoing to support delivery of the Scottish Government 's published targets as set out in its letter of 6th July 2022 • two years waits for inpatient/daycases in the majority of specialities by September 2022. (Delivery of the agreed trajectory as at Sept 2022) • 18 month waits for inpatient/daycases in the majority of specialities by September 2023 • one year for inpatient/daycases in the majority of specialities by September 2024 There is a risk to the Board that this target of 18 month waits by september 2023 will be particularly challenging without additional external capacity. Further analyses will be undertaken to ascertain additional opportunities in conjunction with scottish Government collegues to identify additional capacity in some challenging specialties where capacity is less than required. A detailed trajectory for each specialty is in place and monitored to ensure delivery of SG trajectories.	4	4	16	Decreased Target Score. Risk controls were reviewed by the Chief Operating Officer and the Corporate Management Team and Risk target score has reduced. Target score has reduced to 16 to reflect current delivery of Scottish Government / GG&C agreed trajectories. Montioring of mitigating actions continues in the challenging climate.	Dec-22	BCCO CO 7	Operating	3 - Open	Acute Services Committee

07.10.22

Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Score based on current controls: Residual Likelihood	Residual Impact	Residual Score	Mitigating action to further reduce, eliminate or transfer residual risk	Forecast score following mitigation: Target Likelihood	Target Impact	Target Score	Review Notes	Target dates for actions	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
Chief Operating Officer	**Risk Title** Outpatients - Scheduled care waiting time targets **Risk:** NHSGGC fails to deliver Scheduled Care Waiting Time targets to agreed timescales **Cause:** 1. Sub-optimal patient flow planning, management and monitoring 2. Staff skill levels / mix 3. Staff absences/unplanned leave/maternity leave 4. No succession planning for senior level posts 5. Recruitment challenges/work force shortages **Impact:** 1. Patient Experience: unsatisfactory patient experience / clinical outcomes - long term effects 2. Service / Business Interruption - some disruption in service with unacceptable impact on patient care 3. Financial - increased / unbudgeted costs of delivering services 4. Staffing and competence - uncertain delivery of service due to lack of staff 5. Adverse publicity / reputation - Local media coverage - long term adverse publicity. Significant effect on public perception of the organisation	Monitoring and Analyses of Compliance with WTTs and TTGs is reported to the SG Access Team and to each meeting of the Acute Services Committee , Acute Directors Access Meeting and Acute Strategic Management Group. Weekly oversight of trends/activity reporting through the Senior Executive Group. The Board receives notification of compliance with Waiting Times Targets 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 in line with targets Annual operating plan Performance Monitoring template is reviewed at corporate level and oversees the drive for compliance with targets and key improvement actions. • Continuous monitoring of activity against plan • Clinically validating waiting lists to ensure priority patients identified	4	5	20	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 fot 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 specialities by the end of December 2022 and One year waits for outpatients in most specialities 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	4	4	16	Decreased Target Score. Risk controls were reviewed by the Chief Operating Officer and the Corporate Management Team and Risk target score has reduced. Target score has reduced to 16 to reflect current delivery of the initial phase of the Scottish Government OP target. Montioring of mitigating actions continues in the challenging climate.	Dec-22	BCCO CO 7	Operating	3 - Open	Acute Services Committee
Director of Finance	**Risk Title** Financial sustainability - revenue **Risk:** 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. **Cause:** 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 **Impact:** 1. Service Interruption - sustained loss of service which has serious impact on delivery of patient care; Remobilisation Plan may not be affordable or deliverable within existing financial envelope longer term 2. Patient Experience - unsatisfactory patient experience / clinical outcome: long term effects 3. Financial - unbalanced budget 4. Adverse publicity / reputation - long term adverse publicity	• 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 IJBs to discuss performance and projections; o Detailed reports, scrutiny and challenge to the ASC, FP&P Cttee 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.	5	5	25	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. Detailed Covid-19 expenditure forecasts are submitted regularly to SG, highlighting recurring and nonrecurring spend. (Target date 31/03/2023) 2. Review areas of covid spend to reduce/remove costs where possible in line with latest SG guidance (Target date - ongoing to be concluded by 31/10/2022) 3. System wide communication on overarching financial challenges (Target date 30/09/2022) 4. Roll out new education and training programme for budget holders (Target Date 31/12/2022)	5	4	20	Static. Scores reviewed and confirmed no change at this stage. Cause and current controls narrative updated	Mar-23	BVCO CO 11	Financial / Commercial	3 - Open	Finance, Planning and Performance Committee

07.10.22

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Chief Operating Officer	**Risk Title** Unscheduled care waiting time targets **Risk:** 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 **Impact:** 1. Patient Experience: unsatisfactory patient experience / clinical outcomes - long term effects 2. Service / Business Interruption - some disruption in service with unacceptable impact on patient care 3. Financial - increased / unbudgeted costs of delivering services 4. Staffing and competence - uncertain delivery of service due to lack of staff 5. Adverse publicity / reputation - Local media coverage - long term adverse publicity. Significant effect on public perception of the organisation	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	* ED system real time reporting through information dashboards linked to day time management and Out of Hours on call process with 365 days Director Cover. *Workforce planning, winter and pandemic planning. *Plans in place which seek to develop alternatives to admissions and reduce hospital attendances. *Tracking priority actions from recovery plan. *National Re-design of Urgent Care Programme.	4	4	16	Static. Risk controls reviewed at Strategic Managment Group and the Chief Operating Officer.	Nov-22	BCCO CO7	Operating	3 - Open	Acute Services Committee
Director of Nursing	**Risk Title** Public protection failure in relation to a vulnerable child or adult **Risk:** Failure to identify and act on a potential risk following referral to the Public Protection Unit. **Cause:** 1. Increased operational demands exceed resource capacity 2. Lack of oversight or non-compliance with processes 3. Due to workforce pressures uptake of CP training is low. 4. Limited admin resource due to vacancy and longterm absence resulting in child 5.Adult Support and Protection - Low attendance at L3Teams training due to covid and staffing issues 6. Current FAI - reuputation and impact on staff contributing. Commencing July 2022 7. Vacancy for Chief Nurse & Head of Public Protection Service 8. AP1 and Datix can be completed independently and does not provide accurate reporting 9. Not having access to Badgernet to enable Pre-birth documentation being uploaded. Currently sending historical documentation to Health visitors, Family Nure Partnerships & GPs 10. Out of date policies on website, **Impact:** 1. Patient Experience - avoidable harm to a vulnerable child or adult. Detrimental impact on patient care, experience outcomes and safety 2. Adverse publicity / reputation - significant effect on public perception of the organisation; adverse media coverage 3. Financial - financial penalty	'1. The Public Protection Team(PPT) provides expert professional and strategic leadership in child and adult protection across NHSGGC and with partner agencies improving compliance with CP and ASP requirements. 2. All PPT and administrative staff offered extra hours and overtime. 3. Successful appointment of 4 secondment posts (18 mths) 4. Emergency IRDs continue to take place within agreed timescales 5. MDT ASP Operational Group to have oversight and governance to board issues relating to ASP 6. Mutual aid request to Scottish Executive Nurse Directors (SEND) 7 minute briefings released 7. Recruitment process underway for admin vacancy and temporary staff sought from test and trace team 8. Full time ASP trainer and Lead Nurse for AP 9. Comprehensive programme of level 1 and 2 ASP training now available for all staff; Training offered at different times (including out of hours) and via Teams but still very low attendance; Training advertised on staffnet and training dates sent to Chief Nurses in acute 10. Board has been made aware with papers submitted to BCGF and discussed at PPF and CPF. Preparation is underway and has included:- Discussion with CLO; Independent expert report commissioned; Positional review with improvement actions; Relevant staff have been identified and support provided 11. Engagement with e-health to build AP1 onto Clinical Portal for easier access for staff to locate and complete. Reporting can then be provide via Microstrategy reporting. 12. Learning and Education strategy for Public Protection Service has been established. 13. Prioritisation of policies undertake and allocated to Nurse Advisors who will lead process. Staff made aware and to contact PP Service if clarity on policies is needed, Expected timescales for completion of out of date policies end October 2022.	5	4	20	1. Governance arrangements have been strengthened and extended by establishment of Public Protection Forum 2. Four staff have successfully completed Adult Support and protection Course at Stirling University and business case for additional staff to attend in progress. 3. Website will be developed to promote ASP training. Paper to be taken to PP Forum to discuss and facilitate attendance. 4. FAI health review group established to provide oversight and coordination of health board response 5. SBAR was submitted to ehealth for AP1 form to be built on Clinical Portal and an agreed action is for a SLWG to be established with partner agencies to progress. 6. Currently requesting access to Badgernet. 7.Further extension of 3 Bnd 7 CPNA posts until end March 2023. 8. Service model analysis and review to be completed by Oct-Nov 2022. 9. Alert placed on policies page on website advising staff that policies are in the process of being updated and to contact PP Service should they wish clarification about a policy.	4	3	12	Progress made across a number of actions: Monies have been ringfenced to allow further staff to attend Adult Support and protection Course at Stirling University. NHSGGC PPT business case for additional staffing has been escalated and considered by CMT. Low attendance discussed at ASP training with report provided at Acute ASP meeting and further actions planned to promote training.	Mar-23	BHCO CO 4	Clinical	1 - Minimal	Clinical & Care Governance Committee

07.10.22

			Score based on current controls				Forecast score following mitigation								
Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Residual Likelihood	Residual Impact	Residual Score	Mitigating action to further reduce, eliminate or transfer residual risk	Target Likelihood	Target Impact	Target Score	Review Notes	Target dates for actions	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
Director of Human Resources & Organisational Development	**Risk Title** Failure to recruit and retain staff **Risk:** Inability to recruit and retain high calibre staff to the right roles, at the right times, in the right place, within an affordable budget. **Cause:** 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 **Impact:** 1. Staffing and Competence - Uncertain delivery of service due to lack of staff; ongoing problems with staffing levels; errors due to lack of available trained / qualified staff 2. Service Interruption - Sustained loss of service with serious impact on delivery of patient care 3. Injury: physical and psychological - Detrimental impact on other staff, impact on staff wellbeing and resilience 4. Patient Experience - Unsatisfactory patient experience / outcomes: long term impact. Inability to meet winter bed demands	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.	5	4	20	1. One Year Workforce Plan in place and 3 Year Workforce Plan is under development, with Local Partnership Groups, with Board Workforce Steering Group established to develop the plan. (Target date End of October 2022.) 2. Development of Employment Strategies and Recruitment Strategy as part of Workforce Strategy, linked to service demands and projections. The Recruitment Strategy is ongoing as part of Workforce Strategy 2025 Action Plan. (Target Date TBC)	3	4	12	A number of mitigating actions have been reviewed and now part of BAU and moved into Current Controls. Risk score to be reviewed by HRSMT due to the volume of controls now in place.	Oct-22	BWCO CO 19	People / Workforce	2 - Cautious	Staff Governance Committee
Director of Human Resources & Organisational Development	**Risk Title** Staff training and development **Risk:** Failure to train and develop staff members to deliver role or key competencies not identified and developed **Cause:** 1. Lack of organisation wide fit for purpose training & development programme(s) 2. Training not effectively promoted, implemented and monitored 3. Increased levels of demand reducing available protected time for training 4. Lack of awareness of training opportunity availability 5. Staff not engaging / taking up available training opportunities **Impact:** 1. Staffing and competence - major errors due to ineffective training or training not implemented 2. Service interruption - Some disruption in service with unnaceptable impact on patient care 3. Injury: physical and psychologial - potential for non-compliance with health and safety legislation and increased risk of accidents / incidents 4. Complaints / claims 5. Adverse publicity / reputation - local media coverage if there is a perception NHS GGC staff are not appropriately trained.	1. Annual Reviews (Turas/KSF). 2. Statutory and Mandatory Training. 3. Monitoring of Statutory and Mandatory Training compliance, 4. Performance targets and KPIs. Agreed KPIs and performance target trajectories in place for all Sectors and reviewed at Performance Review Groups (PRGs) and Acute Services Committee and Finance Planning and Performance Committee. (All managers within designated directorates are leading on their activities to address and improve the performance.) 5. Annual reviews for all staff to discuss PDP and objectives and agree support - linked to Knowledge and Skills Framework (KSF) to agreed competencies, and medical staff monitoring and appraisal process.	5	4	20	1. Development and enhancement of online learning and training through Turas Learn. Progress the development of profession based career pathways with these areas incorporated as key elements. (Target Date TBC) 2. Employee engagement programme will enable us to better identify staff groups where training and learning opportunities are not being consistently deployed (Target Date TBC)	3	3	9	A number of mitigating actions have been reviewed and now part of BAU and moved into Current Controls. Risk score to be reviewed by HRSMT due to the volume of controls now in place.	Oct-22	BWCO CO 20	People / Workforce	2 - Cautious	Staff Governance Committee
Director of Public Health	**Risk Title** Pandemic Response **Risk:** Inability to fully respond to further waves of COVID 19; inability to deliver all required services (COVID and non-COVID) **Cause:** 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 **Impact:** 1. Patient experience - negative patient experience / outcomes / safety; delayed overall recovery from the pandemic 2. Service interruption - reduction or postponement of services / resource abstraction to manage response to pandemic 3. Staffing / competence - potential for reduced staffing levels through sickness absence / isolation	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 . NHSGGC has established testing facilities for residents in care homes over and above hospital based testing. 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. High uptake of the primary course of COVID-19 vaccine and the autumn booster has been achieved in adults, reducing the risk of infection and reducing the risk of severe outcomes.	4	4	16	1. The Annual Delivery Plan includes the need to ensure that all services are prepared for a possible further increase in cases. - Draft submitted on 29/7 . 2. Winer vaccination campaign has started - weekly reporting to SEG . L	3	4	12	Static. Case numbers , the number of people in hospital and Staff absence continues to fluctuate but is not the main service pressure being experienced . All local control measures and actions remain under review. GGC has a limited ability to influence the decision making through escalation pathways to national fora and SG and continues to participate in these disucssions.	Dec-22	BCCO CO 7	Operating	3 - Open	Population Health & Wellbeing Committee

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Director of Nursing	**Risk Title** Impact of Delayed Discharges on NHS GGC System Flow **Risk:** Increased and / or ongoing high levels of delayed discharges from acute settings has a continued negative impact on NHS GGC system flow **Cause:** 1. Demand for staffed care home places exceeds capacity. Care home staggered admission processes. 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. **Impact:** 1. Suboptimal patient and family experience. 2. Pressure on whole system flow: pressure on bed numbers resulting in cancellation of planned activity and overcrowding/ long waits in ED due to bed pressures. 3. System demand exceeds capacity 4. Staffing and competence - increased pressure on staff (demand vs capacity) leads to uncertain delivery of service; additional staffing and resource required to manage patients who are medically fit for discharge 5. Increased risk of infection 6. Adverse publicity / reputational impact	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. Daily Delayed Discharge Huddle in place to expedite patient discharge and improve working practices where appropriate. 4. Huddles take place 3x per week with all HSCP representation and acute discharge team to review, action, and share learning.	4	4	**16**	1. 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. COVID-19 related delays: - Local Teams continue to work with infection control and community partners to support care homes to mitigate these pressures and ensure acute sites continue to maintain patient flow. - HSCP Commissioning Teams and Community Services continue to support care homes to ensure they are prepared for the care of patients discharged from hospitals. - All HSCPs are prioritising hospital discharge activity with a focus on anticipatory planning and early discharge. Early assessment and engagement with families ensures that the next stage of care is in place prior to patients being deemed fit for discharge wherever possible. - The implementation of the Discharge to Assessment (D2A) approach and the Standard Operating Procedure (approved in December 2020) across all HSCPs. This aims to ensure that no person who has been in hospital less than seven days will have their social work assessment undertaken whilst they are in hospital. - A project was set up to deliver a peer review process for AWI patients with a view to identify if there is learning and best practice clinical and process guidance that we can establish to ensure our process is as effective and efficient as possible. 2. Escalation letters have been agreed to support firstly communicate awarness and early discusison with familes and secondly if required to seek a resolution to a choices or interim placement dispute. Patient discharge transport servcie commenced. 3. Work is ongoing with HSCP teams and care homes to expedite dicharges. 4. Discharge without Delay (DwD) Programme started with SG initial self-assessment sessions complete - improvement plan being established. DwD is a long-term programme but a high level plan should be in place by the summer 2022.	4	4	**16**	Static.	Nov-22	BCCO CO10	Operating	3 - Open	Finance, Planning and Performance Committee
Director of Finance	**Risk Title** Capital Funding Sustainability **Risk:** The Board's required Capital/Infrastructure Investment Programme becomes undeliverable in full and needs to be scaled back **Cause:** 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 ageing estate and infrastructure **Impact:** 1. Financial - additional costs from an ageing estate; overspend on projects increases overall budget pressures 2. Patient Experience - unsatisfactory patient experience due to ageing estate 3. Injury: physical and psychological - increased risk of injury / harm due to ageing estate 4. Inspection / Audit: increased risk of enforcement action from regulatory body due to ageing estate	• 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 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**	- Infrastructure Planning development work ongoing (Target Date 31/03/23) - Development of a more detailed medium term (3 year) capital plan (Target Date 31/03/23)	3	4	**12**	Static. Scores reviewed and confirmed no change at this stage. Cause and current controls narrative updated	Mar-23	BVCO CO 14	Financial / Commercial	3 - Open	Finance, Planning and Performance Committee

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Director of Estates & Facilities	**Risk Title** Remobilisation Plan - ageing infrastructure **Risk:** COVID Remobilisation Plan is not delivered to the required standard within expected timescales **Cause:** 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 **Impact:** 1. Patient Experience - Unsatisfactory patient experience / clinical outcome - long term effects - delayed recovery from the pandemic 2. Financial - unbudgeted financial impact / cost in the event of emergency works being required or alternative premises having to be sourced.	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. 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.	4	4	**16**	1. '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. 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.	3	3	**9**	Static. Work is currently ongoing to assess current compliance and subsequent requirements to improve compliance to a statutory level where necessary.	Mar-23	BVCO CO 14	Operating	3 - Open	Finance, Planning and Performance Committee
Director of Estates & Facilities	**Risk Title** Regulatory body compliance **Risk:** Failure to achieve and maintain statutory compliance through regulatory bodies **Cause:** 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 **Impact:** 1. Injury (physical and psychologial) - negative impact impact on the health, safety and wellbeing of staff / patient / general public, e.g. incident(s) leading to major injuries / long term incapacity / death 2. Inspection / Audit - Enforcement Action or prosecution 3. Adverse publicity / reputation - public confidence undermined.	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**	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".	3	3	**9**	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.	Mar-23	BVCO CO 14	Legal	1 - Minimal	Planning and Performance Committee
Director of Human Resources & Organisational Development	**Risk Title** Positive, engaging and diverse culture **Risk:** Failure to cultivate, promote and enhance a positive, engaging and diverse workforce culture **Cause:** 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 **Impact:** 1. Staffing and Competence / Service Interruption - Increased staff turnover leads to reduction in service quality	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.	4	4	**16**	1. Executive and non-executive development programmes. (Head of Organisation Developement - Target Date is ongoing) 2. Application of Investors in People Standard, and development plans on each site agreed by site workforce groups. (Target Date is end of March 2023 for initial assessment of all clusters) 3. Continued facilitation of Collaborative Conversations. Part of staff internal communications and employee engagement strategy Target Date for agreeing programme is Dec-22, target date for deployment TBC) 4. Collaborative development of Internal Communication and Employee Engagement Strategy. Currently with CMT and been through the Staff Governence Committee. (Target Date October 2022)	3	4	**12**	A number of mitigating actions have been reviewed and now part of BAU and moved into Current Controls. Risk score to be reviewed by HRSMT due to the volume of controls now in place.	Mar-23	BWCO CO 17	People / Workforce	2 - Cautious	Staff Governance Committee

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Director of Medical Education	**Risk Title** Delivery of medical training to the GMC required standards **Risk:** Units / Departments do not meet the GMC standards of training **Cause:** 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 **Impact:** 1. Adverse publicity / reputation - escalation to enhanced monitoring by GMC 2. Patient Experience - impact on quality of patient care 3. Service interruption - interruption to operational activity	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**	1. Ongoing internal review processes, informed by triangulation of data/information including GMC NTS/ STS data and other feedback. 2. Appropriate escalation where units are not meeting GMC standards for education and training. 3. Ongoing collaboration with the Deanery and development of SMART objectives to deliver demonstrable improvements in key areas as defined by the Deanery in visit feedback reports.	3	3	**9**	Static.	1. Sep 22 2. Sept 22 3. Sept 22	BCCO CO 6	Clinical	1 - Minimal	Staff Governance Committee
Director of Public Health	**Risk Title** Breakdown of failsafe mechanisms for Public Health Screening **Risk:** Breakdown of failsafe mechanisms for Public Health Screening Programmes **Cause:** 1. Lack of governance and oversight; quality assurance monitoring 2. Lack of training and awareness or suitably qualified and experienced staff **Impact:** 1. Patient experience - increased likelihood of patient harm 2. Adverse publicity / reputation - loss of public confidence in NHS Greater Glasgow & Clyde 3. Complaints / claims	• 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**	• Escalation of screening incidents to national screening co-ordination and oversight structures. • 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**	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.	Dec-22	BHCO CO 1	Clinical	1 - Minimal	Population Health & Wellbeing Committee
Director of Human Resources & Organisational Development	**Risk Title** Succession Planning **Risk:** Failure to implement succession planning for key roles **Cause:** 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 **Impact:** 1. Pressure on service and staff 2. Disruption when hurried contingencies have to be put in place.	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. 4. A specific session with Directors to discuss and agree proposals is being planned. 5. Launch of local collective leadership development in each Acute Directorate focused on an identified cadre of emerging leaders at all levels with a programme of OD support. 6. All Directorates have identified this cohort and the development support is underway. In some acute directorates this has also included specific support to SCNs and future SCNs as a priority.	3	3	**9**	All mitigating actions have been delivered and moved into Current Controls column.	2	3	**6**	A number of mitigating actions have been reviewed and now part of BAU and moved into Current Controls. Residual Risk score to be reviewed by HRSMT due to the volume of controls now in place.	N/A	BWCO CO 19	People / Workforce	2 - Cautious	Staff Governance Committee

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Medical Director	**Risk Title** Safe & Effective Use of Medicines **Risk:** Preventable patient and organisational harm from the use of medicines **Cause:** 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 **Impact:** 1. Patient Experience - negative impacts on patient health and recovery 2. Financial - potential for financial penalties 3. Adverse publicity / reputation - negative impact on reputation and loss of public confidence	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	3	3	9	1. Implement HEPMA across all acute and mental health wards replacing the paper Kardex (Target Date Oct '22) 2. Develop an NHSGGC Safer Use of Medicine Workplan & engage services to identify ongoing medicies safety improvements and opportunities for new areas of work (Target Date Dec '22)	2	3	6	Static. 1. HEPMA implementation is progressing on schedule. Rollout to adult & paediatric acute wards and theatres is now complete. Final stage is roll out to main inpatient Mental Health sites which is underway and on track 2. Safer Use of medicines Activities Log created and will now be promoted/shared with Division CG groups and all groups with a responsibility for medication safety/improvement. Pharmacy Medicines Governance team will maintain the log, seek new initiatives for inclusion/sharing, highlight gaps and promote the SUM strategic framework. Oversight will be via ADTC with regular updates to Division CG groups.	Dec-22	BCCO CO 6	Clinical	1 - Minimal	Clinical & Care Governance Committee
Medical Director	**Risk Title** Monitoring of our Remobilisation Plan - co-ordination, capacity and our resources **Risk:** 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 **Cause:** 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 **Impact:** 1. Patient experience - detrimental impact on patient experience and outcomes; delayed treatment of COVID and non-COVID patients; increased waiting lists and overall delayed recovery from the pandemic; increased demand for services 2. Financial - increased cost pressures 3. Adverse publicity / reputation - media coverage of any negative impact on service delivery (e.g. increased waiting lists) 4. Staffing and competence - impact on staff wellbeing / staff turnover and availability of staff	-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. - PMO process established around RMP3 to ensure systematic tracking of commitments. Internal Audit provided external assurance on robustness of process - Closure report prepared for RMP3 - PMO processes will be carried forward for Annual Delivery Plan - Annual Delivery Plan submitted to SG	3	3	9	1. Prepare regular updates on Remobilisation for SEG/ RTG and respond to latest SG guidance (Fortnightly updates to RTG- Director of Planning)	2	3	6	Static. 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. The above is accurate up to July 2022	Sep-22	BCCO CO 7	Operating	3 - Open	Finance, Planning and Performance Committee

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Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Residual Likelihood	Residual Impact	Residual Score	Mitigating action to further reduce, eliminate or transfer residual risk	Target Likelihood	Target Impact	Target Score	Review Notes	Target dates for actions	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
Director of Nursing	**Risk Title** Failure to meet obligations to provide person centered care **Risk:** Failure to comply with legislation related to patient rights; patient feedback; person centred care **Cause:** 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 **Impact:** 1. Patient experience - detrimental impact on patient care, experience, outcomes and safety 2. Adverse publicity / reputation - significant effect on public perception of the organisation; adverse media coverage 3. Financial - financial penalty	1. Implementation of the NHSGGC Healthcare Quality Strategy and stakeholder communications and engagement strategy and associated work streams for both. 2. Implementation of person centred care boardwide work plan. 3. Implementation of the Fairer NHSGGC 2020 – 24 Equality Scheme 4. Multiple methods from ward to board level to gain feedback from and support patients, families, and the public in regard to care experience. 5. Network of explicit formal responsibilities including Executive leads and 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.	3	3	**9**	NHSGGC Healthcare Quality Strategy implementation plan will lead to: 1. Deliver on the Board's commitments described in both strategy documents. 2. Review and scoping of corporate feedback mechanisms and associated processes for reflection, learning, improvement and reporting is complete. Design of new approach underway 3. Visiting Review Team met every 1 -2 weeks during pandemic to assess scope for return to person-centred visiting. PCV remobilised on 23/05/2022 with maximum of two visitors at a time. Evaluation commenced on 15/08/2022 to assess scope of application of the core principles and expereince of pateints, family and staff. This will drive any firther actions to support PVC fully across the board. 4. Project plan for person-centred care planning is in place - main engagement phase is completed, testing and improvement design phase commenced. User Acceptance testing is complete and changes now being progressed. Proff of concept testing commences in October 2022. Full implementation will commence in Spring 2023. 5. 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. 6. Testing and development is in progress for the recruitment of Lived Experience Volunteers to join a small cohort of strategic working groups and committees related to person-centred care activity. Recruitment will commence late Summer 2022 7. A Realistic Medicine Toolkit has been launched which includes person-centred care resources, education material etc. 8. The Care Experience Improvement Model remobilised in March 2022 in a small cohort of five teams which is underpinned by the Excellence in Care Standard for Person-centred Care. 9. Expansion of data collection assurance and outcomes linked to feedback and person centred care 10. Ensure the needs of those with protected characteristics are mainstreamed into all workstreams	3	3	**9**	Static. Current and further controls reviewed and updated	Mar-23	BVCO CO 14	Clinical	1 - Minimal	Clinical & Care Governance Committee
Medical Director	**Risk Title** Medicines costs and funding availability **Risk:** Overall medicines costs for NHS Greater Glasgow and Clyde are unsustainable in the future **Cause:** 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 **Impact:** 1. Patient Experience - some treatment options become cost prohibitive and require limits (e.g. end of life support or very rare conditions); worsening patient outcomes 2. Potential budget overspends 3. Adverse publicity / reputation - potential for adverse media coverage if some treatment options are limited	Pharmacy/ Finance departments have developed financial models to assess the predicted costs of new medicines based on assumed uptake rates that reflect the increasing use of new medicines. Implementation of PACS2 policy across NHSGG&C	2	4	**8**	1. Development & delivery of a Financial Improvement Plan for acute medicines expenditure which doesn't compromise patient care or service delivery Update. (ongoing throughout the year)	2	3	**6**	Static. The FIP medicines savings plan for 22/23 continues to progress with key contributions from the multi-disciplinary Acute Prescribing Management Group, the Pharmacy Medicines Cost Effectiveness group and the Acute Finance Team. The current full year end savings target is £6.1M	Mar-23	BCCO CO 11	Financial / Commercial	3 - Open	Finance, Planning and Performance Committee
Director of eHealth	**Risk Title** Cyber threats **Risk:** Cyber security of the organisation may be compromised and leave the organisation increasingly vulnerable to attack **Cause:** 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 **Impact:** 1. Service interruption - disruption to key systems and services within the critical National infrastructure	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. E mergency patches are deployed on advice of National Cyber Security Teams and supplier guidance. 6. Cyber controls subject to regular review and audit.	2	3	**6**	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 and outcome is expected before the end of the calendar year.	2	3	**6**	Static. No material change but robust NIS action plan in place and progress being reported through the IGSG.	Dec-22	BCCO CO 7	Operating	3 - Open	rmation Governance Steering Group

07.10.22

Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Score based on current controls: Residual Likelihood	Residual Impact	Residual Score	Mitigating action to further reduce, eliminate or transfer residual risk	Forecast score following mitigation: Target Likelihood	Target Impact	Target Score	Review Notes	Target dates for actions	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
	2. Data loss / breach of patient confidentiality - Enforcement action arising from loss of data that could have an adverse effect on individuals or services; loss of personal identifiable data that could lead to fraud 3. Adverse publicity / reputation - local media adverse publicity affecting public perception of the organisation														Info