SCOTTISH HOSPITALS INQUIRY

Bundle of document for Oral hearings commencing from 16 September 2025 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Bundle 45 – NHS Greater Glasgow and Clyde Corporate Risk Register

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The terms of that restriction order are published on the Inquiry website.

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NHS Greater Glasgow and Clyde	*Corporate Risk Register*

Completed by	**Risk Management Steering Group**	**Date created/ updated**	**December 2008**

Risk is the chance of something happening which will cause harm or detriment to the organisation, staff or patients. It is assessed in terms of likelihood of an event occurring and the severity of its impact upon the organisation, staff or patients.

NHS Greater Glasgow and Clyde has adopted, as illustrated below, a scoring system which enables the risks to be prioritised.

Likelihood (L)		**Consequence (C)**		**Risk (LxC)**	=	**Priority**
Almost certain	5	Extreme	5	20 - 25	=	Priority 1: VERY HIGH
Likely	4	Major	4	12 - 19	=	Priority 2: HIGH
Possible	3	Moderate	3	6 - 11	=	Priority 3: MEDIUM
Unlikely	2	Minor	2	1 - 5	=	Priority 4: LOW
Rare	1	Negligible	1			

The Corporate Risk Register comprises those risks that have been assessed as being high or very high.

NHS Greater Glasgow and Clyde — *Glossary of Terms*

ACH - Ambulatory Care Hospital

ASD - Acute Serices Division

CGIG - Clinical Governance Implementation Group

CHKS - Caspe Healthcare Knowledge Systems Ltd *(independent consultancy)*

CHP - Community Health Partnership

CHCP - Community Health & Care Partnership

CIT - Corporate Inequalities Team

HEAT - Health Improvement, Efficiency, Access, Treatment

ISD - Information Services Division

LDP - Local Delivery Plan

MAPPA - Multi-Agency Public Protection Arrangements

MMC - Modernising Medical Careers

PFPI - Patient Focused Public Involvement

POD - Point of Dispensing

PRG - Performance Review Group

QIS - Quality Improvement Scotland

RRL - Revenue Resource Limit

RTT - Referral to Treatment

SGHD - Scottish Government Health Directorates

SHC - Scottish Health Council

SIGN - Scottish Intercollegiate Guidelines Network

SMG - Strategic Management Group

SPSP - Scottish Patient Safety Programme

SUM - Safer Use of Medicines

NHS Greater Glasgow and Clyde
Corporate Risk Register January 2009

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	PREVIOUSLY AGREED ACTIONS TO MANAGE RISK	FURTHER ACTION REQUIRED
Acute	1.1	[redacted]								
	1.2	ASD Chief Operating Officer	**Application of emerging guidance on the provision of single room accommodation for inpatients in new and refurbished projects will impact upon the number of beds available in existing wards on completion of refurbishment works. This will potentially have a major impact on nursing resources.**	**Ongoing engagement and consultation with SGHD on practical application of the guidance.**	4	4	16	2	**The new Southern General adult hospital is designed with 100% single rooms; the children's hospital with the recommended proportion of single rooms.**	
Child Protection	2	[redacted]								
CHP/CHCP	3.1	[redacted]								
	3.2	CHP/CHCP Directors	Local authority and NHS service objectives related to jointly provided services are not achieved on account of unclear levels of delegated authority combined with uncertainty regarding the impact of the Concordat agreed by the Scottish Government and COSLA.	CHCP Plan built upon corporate objectives and priorities; CHCP Plan agreed by parent organisations; Individual Performance objectives built upon agreed CHCP Plan; Mid year review of Objectives by Chief Executives in both organisations; Quarterly Performance Management results; The CHP Committee as a sub-committee of the NHS Board monitors through quarterly performance; Funding of any service change is agreed with appropriate parent organisation; Ongoing monitoring/review of CHCP performance by Joint Executive Group.	3	4	12	2		

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Text shown in bold is an addition to, or a change from the previous Corporate Risk Register

NHS Greater Glasgow and Clyde
Corporate Risk Register January 2009

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	PREVIOUSLY AGREED ACTIONS TO MANAGE RISK	FURTHER ACTION REQUIRED
CHP/CHCP	3.3	[redacted]								
Clinical	4.1	Medical Director	Compliance with all applicable clinical standards and protocols is not achieved, impacting on the delivery of safe, effective and patient-focused treatment for patients.	Well established dissemination arrangements for all SIGN and NHS QIS clinically related publications. Review and implementation of each product focused through planning and general management structures with links to local professional and clinical governance arrangements. Implementation tracking and exception reporting maintained with regular reports to ASD Strategic Management Group and CGIG. Independent scrutiny through periodic NHS QIS peer reviews or monitoring assessments in addition to Internal Audit reviews. Oversight maintained through role of Clinical Governance Committee.	3	4	12	2	Continuous review and improvement of detail and quality of tracking information.	
	4.2	[redacted]								
	4.3	[redacted]								

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Communications	5	Director of Communications	Legislation and SGHD guidance on consultation/ engagement to involve patients in service change is not followed at all times. Possible consequences of failing to meet the obligation or not meeting guidance include: · Reputational damage · Legal challenge to NHS Board decisions on basis guidance was improperly followed · Censure by the Scottish Health Council (SHC) which may result in NHSGGC being instructed to repeat engagement or consultation resulting in potential delay or abandonment of service change or clinical development · Ministerial action/censure against NHSGGC · Not engaging with patients may result in services failing to meet their needs or address deficiencies	1) Individual consultation exercises are pre-planned to adhere to guidance – the SHC is normally involved in assessing these in advance of delivery 2) System-wide strategy for Patient Focused Public Involvement (PFPI) is formally reviewed by the SHC 3) Each CH(C)P Public Partnership Forum has an Executive Group and formal remit 4) Each service is responsible for ensuring PFPI process and best practice are embedded – this is overseen by the Communications and PFPI Group which comprises senior representation from all CHPs, Partnerships and Directorates 5) Ultimate review of methodologies and systems lies with the Board's Involving People Committee 6) Regular reporting to the PRG	3	4	12	2		
Corporate Planning & Policy	6.1	[redacted]								
	6.2									

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Finance	7	[redacted]								
Healthcare Acquired Infection	8	Medical Director	**Emergence of outbreaks or incidence of infection that are indicative of a failure to ensure that all policies, protocols and procedures to support the effective Prevention and Control of Infection are developed and implemented with NHSGGC**	**Annual Infection Control Programme which is aligned to National and Local priorities for the Prevention and Control of Infection and which is monitored through reports to Board Infection Control Committee, Clinical Governance Committee and NHS Board. Environmental audit exercise and ongoing monitoring arrangements**	**4**	**4**	**16**	**2**	Environmental audit exercise and ongoing monitoring arrangements Implementation of HAI action plan	**Revision of Infection Control Structure to facilitate monitoring of Key Performance Indicators on an exception reporting basis from Ward to Board with an emphasis on embedding within existing Acute and Partnership Governance systems.**
Health Information & Technology	9.1	[redacted]								

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NHS Greater Glasgow and Clyde
Corporate Risk Register January 2009

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Health Information & Technology	9.2	[redacted]								
Human Resources	10	[redacted]								
Public Health	11.1	[redacted]								
	11.2	[redacted]								

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NHS Greater Glasgow and Clyde	*Corporate Risk Register*

Completed by	**Risk Management Steering Group**	**Date created/ updated**	**December 2009**

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HEAT - Health Improvement, Efficiency, Access, Treatment

LDP - Local Delivery Plan

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MMC - Modernising Medical Careers

PCAT - Primary Care Audit Tool

PFPI - Patient Focused Public Involvement

PPPG - Planning, Policy and Performance Group

PRG - Performance Review Group

QIS - Quality Improvement Scotland

RRL - Revenue Resource Limit

RTT - Referral to Treatment

SGHD - Scottish Government Health Directorates

SHC - Scottish Health Council

SIGN - Scottish Intercollegiate Guidelines Network

SPSP - Scottish Patient Safety Programme

SUM - Safer Use of Medicines

NHS Greater Glasgow and Clyde
2. A51154736

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Acute	1.1	[redacted]							
	1.2	ASD Chief Operating Officer	Application of emerging guidance on the provision of bed spacing and single room accommodation for inpatients in new and refurbished projects. This impacts upon the number of beds available in existing wards on completion of refurbishment works, on the nursing workforce models and on appropriate patient selection in bed spaces.	Ongoing engagement and consultation with SGHD on practical application of the guidance. The new Southern General adult hospital is designed with 100% single rooms; the children's hospital with the recommended proportion of single rooms. **Directors in the Acute Division have now completed risk assessments in relation to bed spacing in clinical wards which falls below 2.7metres.**	4	4	16	2	Continue to review year on year
	1.3	**ASD Chief Operating Officer/ Director of Facilities/ Medical Director**	**Failure to comply with national and EU regulations regarding decontamination**	**NHSGGC will evaluate impact of PCAT and implement action plans to meet recommendations** **Implement planned replacement programme for endoscopy services review documentation in relation to the updated Advisory Committee on Dangerous Pathogens guidance on "transmissible spongiform encephalopathy agents".** **Monitored via decontamination sub-group**	3	4	12	2	
Child Protection	2	[redacted]							

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CHP/CHCP	3.1	[redacted]							
	3.2	CHP/CHCP Directors	Local authority and NHS service objectives related to jointly provided services are not achieved on account of unclear levels of delegated authority combined with uncertainty regarding the impact of the Concordat agreed by the Scottish Government and COSLA.	CHCP Plan built upon corporate objectives and priorities; CHCP Plan agreed by parent organisations; Individual Performance objectives built upon agreed CHCP Plan; Mid year review of Objectives by Chief Executives in both organisations; Quarterly Performance Management results; The CHP Committee as a sub-committee of the NHS Board monitors through quarterly performance; Funding of any service change is agreed with appropriate parent organisation; Ongoing monitoring/review of CHCP performance by Joint Executive Group.	3	4	12	2	
	3.3	[redacted]							
Clinical	4.1	Medical Director	Compliance with all applicable clinical standards and protocols is not achieved, impacting on the delivery of safe, effective and patient-focused treatment for patients.	Well established dissemination arrangements for all SIGN and NHS QIS clinically related publications. Review and implementation of each product focused through planning and general management structures with links to local professional and clinical governance arrangements. Implementation tracking and exception reporting maintained with regular reports to ASD Strategic Management Group and CGIG. Independent scrutiny through periodic NHS QIS peer reviews or monitoring assessments in addition to Internal Audit reviews. Oversight maintained through role of Clinical Governance Committee. Continuous review and improvement of detail and quality of tracking information.	3	4	12	2	

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Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Clinical	4.2	[redacted]							
	4.3	[redacted]							
Communications	5	Director of Communications	Legislation and SGHD guidance on consultation/ engagement to involve patients in service change is not followed at all times. Possible consequences of failing to meet the obligation or not meeting guidance include: · Reputational damage · Legal challenge to NHS Board decisions on basis guidance was improperly followed · Censure by the Scottish Health Council (SHC) which may result in NHSGGC being instructed to repeat engagement or consultation resulting in potential delay or abandonment of service change or clinical development · Ministerial action/censure against NHSGGC · Not engaging with patients may result in services failing to meet their needs or address deficiencies	1) Individual consultation exercises are pre-planned to adhere to guidance – the SHC is normally involved in assessing these in advance of delivery 2) System-wide strategy for Patient Focused Public Involvement (PFPI) is formally reviewed by the SHC 3) Each CH(C)P Public Partnership Forum has an Executive Group and formal remit 4) Each service is responsible for ensuring PFPI process and best practice are embedded – this is overseen by the Communications and PFPI Group which comprises senior representation from all CHPs, Partnerships and Directorates 5) Ultimate review of methodologies and systems lies with the Board's Involving People Committee 6) Regular reporting to the PRG	3	4	12	2	

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Corporate Planning & Policy	6.1	[redacted]							
	6.2								
Finance	7								

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Health Information & Technology	9	[redacted]							
Human Resources	10								

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Public Health	11.1	[redacted]							
	11.2	[redacted]							

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Completed by	**Risk Management Steering Group**	**Date created/ updated**	**December 2010**

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PCAT - Primary Care Audit Tool

PFPI - Patient Focused Public Involvement

PODs - Patient's Own Drugs

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QIS - Quality Improvement Scotland

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SHC - Scottish Health Council

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NHS Greater Glasgow and Clyde
Corporate Risk Register - January 2011 (Draft)

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Acute	1.1	[redacted]							
	1.2	[redacted]							
	1.3	ASD Chief Operating Officer	Non-conformance with emerging guidance on the provision of bed spacing and single room accommodation for inpatients in new and refurbished projects. This impacts upon the number of beds available in existing wards on completion of refurbishment works, on the nursing workforce models and on appropriate patient selection in bed spaces.	Ongoing engagement and consultation with SGHD on practical application of the guidance. The new Southern General adult hospital is designed with 100% single rooms; the children's hospital with the recommended proportion of single rooms. Directors in the Acute Division have now completed risk assessments in relation to bed spacing in clinical wards which fall below 2.7m.	**4**	**4**	**16**	**2**	Continue to review year on year
	1.4	ASD Chief Operating Officer/ Director of Facilities/ Medical Director	Non-compliance with national and EU regulations regarding decontamination	NHSGGC will evaluate impact of PCAT and implement action plans to meet recommendations Implement planned replacement programme for endoscopy services Review documentation in relation to the updated Advisory Committee on Dangerous Pathogens guidance on "transmissible spongiform encephalopathy agents". Monitored via decontamination sub-group	**3**	**4**	**12**	**2**	

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NHS Greater Glasgow and Clyde
Corporate Risk Register - January 2011 (Draft)

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Child Protection	2	[redacted]							
CHP/CHCP	3								
Clinical	4.1	Medical Director	Compliance with all applicable clinical standards and protocols is not achieved, impacting on the delivery of safe, effective and patient-focused treatment for patients.	Well established dissemination arrangements for all SIGN and NHS QIS clinically related publications. Review and implementation of each product focused through planning and general management structures with links to local professional and clinical governance arrangements. Implementation tracking and exception reporting maintained with regular reports to ASD Strategic Management Group and CGIG. Independent scrutiny through periodic NHS QIS peer reviews or monitoring assessments in addition to Internal Audit reviews. Oversight maintained through role of Clinical Governance Committee. Continuous review and improvement of detail and quality of tracking information.	**3**	**4**	**12**	**2**	

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NHS Greater Glasgow and Clyde
Corporate Risk Register - January 2011 (Draft)

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Clinical	4.2	[redacted]							
	4.3								
	4.4								

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Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Communications	5	Director of Communications	Legislation and SGHD guidance on consultation/ engagement to involve patients in service change is not followed at all times. Possible consequences of failing to meet the obligation or not meeting guidance include: • Reputational damage • Legal challenge to NHS Board decisions on basis guidance was improperly followed • Censure by the Scottish Health Council (SHC) which may result in NHSGGC being instructed to repeat engagement or consultation resulting in potential delay or abandonment of service change or clinical development • Ministerial action/censure against NHSGGC • Not engaging with patients may result in services failing to meet their needs or address deficiencies	1. Individual consultation exercises are pre-planned to adhere to guidance – the SHC is normally involved in assessing these in advance of delivery 2. System-wide strategy for Patient Focused Public Involvement (PFPI) is formally reviewed by the SHC 3. Each CH(C)P Public Partnership Forum has an Executive Group and formal remit 4. Each service is responsible for ensuring PFPI process and best practice are embedded – this is overseen by the Communications and PFPI Group which comprises senior representation from all CHPs, Partnerships and Directorates 5. Ultimate review of methodologies and systems lies with the Board's Involving People Committee 6. Regular reporting to the PRG	**3**	**4**	**12**	**2**	
Corporate Planning & Policy	6	[redacted]							

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Finance	7	[redacted]							
Healthcare Acquired Infection	8	Medical Director	Emergence of outbreaks or incidence of infection that are indicative of a failure to ensure that all policies, protocols and procedures to support the effective Prevention and Control of Infection are developed and implemented within NHSGGC.	Annual Infection Control Programme which is aligned to National and Local priorities for the Prevention and Control of Infection and which is monitored through reports to Board Infection Control Committee, Clinical Governance Committee and NHS Board. Environmental audit exercise and ongoing monitoring arrangements Implementation of HAI action plan **Preparation and follow up to Healthcare Environment Inspectorate visits and independent scrutiny reports** **Senior infection control doctor and nurse on each directorate clinical governance committee.** **Monthly reporting from Infection Control Team to clinical governance committees.**	**3**	**4**	**12**	**2**	

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Health Information & Technology	9	[redacted]							
Human Resources	10.1								
	10.2	Director of HR	**Lack of integration between workforce planning and financial planning, impacting on resource availability and delivery of safe and effective services to patients.**	**Corporate cost savings plan is consolidated from Directorate/Divisional cost savings plans. Directorate/Divisional cost savings plans are specific plans, evidence based and developed following a proscribed approach using Project Initiation Documents (PIDs).** **Corporate Management Team monitors development of workforce plan and financial plan. regular reporting to Corporate Management Team and NHS Board.** **Scrutiny of workforce plan and financial plan by the Area Partnership Forum. Acute SMG, CH(C)P and MHP Management Teams oversee development of plan(s) and monitor implementation.**	**3**	**4**	**12**	**2**	

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Public Health	11.1	[redacted]							
	11.2	[redacted]							

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Summary of Changes to Corporate Risk Register

	Risk ref	Additions & Changes	Deletions
Acute	1.1	[redacted]	
Acute	1.2	No change since last year	
Acute	1.3	No change since last year	
Acute	1.4	No change since last year	
Child Protection	2	[redacted]	
CH(C)P	3.1	[redacted]	[redacted]
CH(C)P	3.2	[redacted]	
Clinical	4.1	No change since last year	
Clinical	4.2	[redacted]	
Clinical	4.3	Minor additions to text since last year	
Clinical	4.4	[redacted]	
Comms	5	No change since last year	
Corporate Planning	6	[redacted]	
Finance	7	[redacted]	
HAI	8	New controls in place that had been under "further action" last year	
HIT	9	[redacted]	
Human Resources	10.1	[redacted]	
Human Resources	10.2	New risk added following discussion at RMSG	
Public Health	11.1	Minor change since last year	Removal of reference to Exercise Coldplay
Public Health	11.2	[redacted]	

NHS Greater Glasgow and Clyde	***Corporate Risk Register***

Completed by	**Risk Management Steering Group**	**Date created/ updated**	**January 2011**

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Rare	1	Negligible	1			

The Corporate Risk Register comprises those risks that have been assessed as being high or very high.

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CHCP - Community Health & Care Partnership

CIT - Corporate Inequalities Team

HEAT - Health Improvement, Efficiency, Access, Treatment

LDP - Local Delivery Plan

MAPPA - Multi-Agency Public Protection Arrangements

MMC - Modernising Medical Careers

PCAT - Primary Care Audit Tool

PFPI - Patient Focused Public Involvement

PODs - Patient's Own Drugs

PPPG - Planning, Policy and Performance Group

PRG - Performance Review Group

QIS - Quality Improvement Scotland

RRL - Revenue Resource Limit

RTT - Referral to Treatment

SGHD - Scottish Government Health Directorates

SHC - Scottish Health Council

SIGN - Scottish Intercollegiate Guidelines Network

SMG - Strategic Management Group

SPSP - Scottish Patient Safety Programme

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NHS Greater Glasgow and Clyde
Corporate Risk Register - January 2011

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Acute	1.1	[redacted]							
	1.2	[redacted]							
	1.3	ASD Chief Operating Officer	Non-conformance with emerging guidance on the provision of bed spacing and single room accommodation for inpatients in new and refurbished projects. This impacts upon the number of beds available in existing wards on completion of refurbishment works, on the nursing workforce models and on appropriate patient selection in bed spaces.	Ongoing engagement and consultation with SGHD on practical application of the guidance. The new Southern General adult hospital is designed with 100% single rooms; the children's hospital with the recommended proportion of single rooms. Directors in the Acute Division have now completed risk assessments in relation to bed spacing in clinical wards which fall below 2.7m.	**4**	**4**	**16**	**2**	Continue to review year on year
	1.4	[redacted]							

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NHS Greater Glasgow and Clyde
Corporate Risk Register - January 2011

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Child Protection	2	[redacted]							
CHP/CHCP	3								
Clinical	4.1	Medical Director	Compliance with all applicable clinical standards and protocols is not achieved, impacting on the delivery of safe, effective and patient-focused treatment for patients.	Well established dissemination arrangements for all SIGN and NHS QIS clinically related publications. Review and implementation of each product focused through planning and general management structures with links to local professional and clinical governance arrangements. Implementation tracking and exception reporting maintained with regular reports to ASD Strategic Management Group and CGIG. Independent scrutiny through periodic NHS QIS peer reviews or monitoring assessments in addition to Internal Audit reviews. Oversight maintained through role of Clinical Governance Committee. Continuous review and improvement of detail and quality of tracking information.	**3**	**4**	**12**	**2**	

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Corporate Risk Register - January 2011

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Clinical	4.2	[redacted]							
	4.3	[redacted]							
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Corporate Planning & Policy	6	[redacted]							

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Finance	7	[redacted]							
		4. DoF	**4. Ability to meet cost of ongoing compliance with policy changes, statutory changes and updated guidance issued by SGHD.**	4. Regular finance outturn and performance review led by the CEO and DOF with all budget holders. 5. Ongoing review of development of financial plan by the **Corporate Management Team** and Board; quarterly review and discussion					
Healthcare Acquired Infection	8	Medical Director	Emergence of outbreaks or incidence of infection that are indicative of a failure to ensure that all policies, protocols and procedures to support the effective Prevention and Control of Infection are developed and implemented within NHSGGC.	Annual Infection Control Programme which is aligned to National and Local priorities for the Prevention and Control of Infection and which is monitored through reports to Board Infection Control Committee, Clinical Governance Committee and NHS Board. Environmental audit exercise and ongoing monitoring arrangements Implementation of HAI action plan **Preparation and follow up to Healthcare Environment Inspectorate visits and independent scrutiny reports** **Senior infection control doctor and nurse on each directorate clinical governance committee.** **Monthly reporting from Infection Control Team to clinical governance committees.**	**3**	**4**	**12**	**2**	

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Human Resources	10.1	[redacted]							
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Public Health	11.1	[redacted]							
	11.2								

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NHS Greater Glasgow and Clyde	***Corporate Risk Register***

Completed by	**Risk Management Steering Group**	**Date created/ updated**	**January 2012**

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The Corporate Risk Register comprises those risks that have been assessed as being high or very high.

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ASR - Acute Services Review

CEO - Chief Executive Officer

CGIG - Clinical Governance Implementation Group

CHP - Community Health Partnership

CHCP - Community Health & Care Partnership

CIT - Corporate Inequalities Team

CMT - Corporate Management Team

DoF - Director of Finance

HAI - Healthcare Acquired Infection

HEAT - Health Improvement, Efficiency, Access, Treatment

LDP - Local Delivery Plan

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PFPI - Patient Focused Public Involvement

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NHS Greater Glasgow and Clyde
Corporate Risk Register - January 2012

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Acute	1.1	[redacted]							
Acute	1.2	ASD Chief Operating Officer	Non-conformance with emerging guidance on the provision of bed spacing and single room accommodation for inpatients in new and refurbished projects. This impacts upon the number of beds available in existing wards on completion of refurbishment works, on the nursing workforce models and on appropriate patient selection in bed spaces.	Ongoing engagement and consultation with SGHD on practical application of the guidance. The new Southern General adult hospital is designed with 100% single rooms; the children's hospital with the recommended proportion of single rooms. Directors in the Acute Division have now completed risk assessments in relation to bed spacing in clinical wards which fall below 2.7m.	4	4	16	2	Continue to review year on year
Acute	1.3	[redacted]							
Child Protection	2								

NHS Greater Glasgow and Clyde
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CHP/CHCP	3.1	[redacted]							
CHP/CHCP	3.2	CH(C)P Directors	***Management of new integration process***						
Clinical	4.1	Medical Director	Compliance with all applicable clinical standards and protocols is not achieved, impacting on the delivery of safe, effective and patient-focused treatment for patients.	Well established dissemination arrangements for all SIGN and NHS Healthcare Scotland clinically related publications. Review and implementation of each product focused through planning and general management structures with links to local professional and clinical governance arrangements. Implementation tracking and exception reporting maintained with regular reports to ASD Strategic Management Group and CGIG. Independent scrutiny through periodic peer reviews or monitoring assessments in addition to Internal Audit reviews. Oversight maintained through role of Quality and Performance Committee. Continuous review and improvement of detail and quality of tracking information.	**3**	**4**	**12**	**2**	
Clinical	4.2	[redacted]							

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Clinical	4.3	[redacted]							
Clinical	4.4	[redacted]							

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Finance	5	[redacted]							
		4. DoF	4. Ability to meet cost of ongoing compliance with policy changes, statutory changes and updated guidance issued by SGHD.	4. Regular finance outturn and performance review led by the CEO and DOF with all budget holders. 5. Ongoing review of development of financial plan by the Corporate Management Team and Board; quarterly review and discussion					
Healthcare Acquired Infection	6	Medical Director	Emergence of outbreaks or incidence of infection that are indicative of a failure to ensure that all policies, protocols and procedures to support the effective Prevention and Control of Infection are developed and implemented within NHSGGC.	Annual Infection Control Programme which is aligned to National and Local priorities for the Prevention and Control of Infection and which is monitored through reports to Board Infection Control Committee, Quality & Performance Committee and NHS Board. Environmental audit exercise and ongoing monitoring arrangements Implementation of HAI action plan Preparation and follow up to Healthcare Environment Inspectorate visits and independent scrutiny reports Senior infection control doctor and nurse on each directorate clinical governance committee. Monthly reporting from Infection Control Team to clinical governance committees.	**3**	**4**	**12**	**2**	

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Health Information & Technology	7	[redacted]							
Human Resources	8.1								
Human Resources	8.2								
Human Resources	8.3								

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Public Health	9.	[redacted]							
Public Health	9.								
New South Glasgow Hospital	10								
Vale of Leven Inquiry	11		***Impact of inquiry findings*** **- far reaching recommendations** **- criticism of staff and management**						

Greater Glasgow and Clyde NHS Board

Corporate Management Team Meeting

15 March 2012

Director of Finance

DRAFT CORPORATE RISK REGISTER

Background

1. The NHS Board has an obligation to maintain and review a system of risk management, and as part of the process, a draft updated Corporate Risk Register (CRR) for 2012 is attached for CMT to review and approve.

2. After the register has been approved by CMT it will be presented at the Audit Committee for approval, and subsequently to the NHS Board for noting.

3. The Board's Risk Management Strategy is based on the principle that risk management arrangements are embedded within the organisation's management arrangements, supported by a hierarchy of risk registers established throughout the organisation, with, at an over-arching corporate level, the Corporate Risk Register.

4. The Board Director of Finance carries delegated responsibility to oversee the process of creating and maintaining the CRR, and to ensure that an appropriate hierarchy of risk registers is embedded within the operational processes of the organisation. The Director of Finance chairs the Risk Management Steering Group (RMSG).

5. The RMSG has carried out its annual review of the CRR, and of the processes followed within the wider organisation to use risk registers to inform the management of risk. A key outcome of this review is the attached, updated Corporate Risk Register.

Description of Review Process

6. Throughout NHSGGC, there is a full and comprehensive system for recording and managing risk, together with an escalation process for referring risks to a higher organisational level when the need arises.

7. In the course of the last 12 months each division, directorate and corporate service area has reviewed its own risk register and updated this to reflect an updated assessment of risk.

8. Updated risk registers were submitted to the RMSG which in turn reviewed the existing CRR to ensure that it continued to reflect key risks identified within the wider organisation by divisions, directorates and corporate service areas.

9. The RMSG reviewed each risk within the individual service registers, exercising judgement to ensure consistency of scoring and considered the appropriateness of the wording of the risks, controls described, and further actions required.

EMBARGOED UNTIL MEETING

10. Subsequent to the RMSG meeting, the CEO provided input to the CRR. He commented on some areas which he considered in particular should be debated by CMT –

    - Risk 1.2 - issue of bed spacing
    - [redacted]
    - Risk 5 - as above, the Board must meet financial targets, and has always previously done so.

Amendments from 2011 Corporate Risk Register

11. Significant additions/deletions are detailed below:-

Additions

- [redacted]
- Risk 10 - impact of Vale of Leven inquiry findings
- [redacted]

Deletions

The Steering Group considered that the scores of the following three risks should be reduced, thus taking them out of the range for inclusion in the Corporate Risk Register (they remain at local level):

- the risk of not following legislation and SGHD guidance on consultation/engagement to involve patients in service change;
- the risk of adequate policies, guidance, procedures and performance management not being in place to ensure that organisation is aware of content and implications of equalities legislation;
- the risk of lack of integration between workforce planning and financial planning, impacting on resource availability and delivery of safe and effective services to patients.

In addition, the risk around delays in the transfer of services from Stobhill to GRI affecting service delivery during and following service transfer is no longer applicable as the transfer has now taken place.

Paul James
Director of Finance
March 2012

NHS Greater Glasgow and Clyde — *Corporate Risk Register*

Completed by	**Risk Management Steering Group**	**Date created / updated**	**January 2012**

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Acute	1.3	[redacted]							
Child Protection	2	[redacted]							

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CHP/CHCP	3	[redacted]							
Clinical	4.1	Medical Director	Compliance with all applicable clinical standards and protocols is not achieved, impacting on the delivery of safe, effective and patient-focused treatment for patients.	Well established dissemination arrangements for all SIGN and NHS Healthcare Scotland clinically related publications. Review and implementation of each product focused through planning and general management structures with links to local professional and clinical governance arrangements. Implementation tracking and exception reporting maintained with regular reports to ASD Strategic Management Group and CGIG. Independent scrutiny through periodic peer reviews or monitoring assessments in addition to Internal Audit reviews. Oversight maintained through role of Quality and Performance Committee. Continuous review and improvement of detail and quality of tracking information.	3	4	12	2	
Clinical	4.2	[redacted]							
Clinical	4.3	ASD Chief Operating Officer CH(C)P Directors Director of Facilities	Reduction in capital funding and pressure on revenue resources impacts on premises improvements and maintenance programmes, leading to the possibility of non-compliance with applicable legislation and SGHD policies and guidance, and delays implementation of strategic change where capital investment is required.	Implementation of board-wide property management approach, including assessment of premisescompliance by applying a standard consistent methodology. Identificaion of priorities for improvment/maintenance by following standard approach, ensuringavailable resources are targeted at highest priorities. Regular reporting to Acute SMG, CH(C)P Management Teams, Capital Planning Group and Corporate Management Team to inform development of capital plan(s) and revenue budget setting.	3	4	12	2	

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	CORPORATE LEVEL RISK EXPOSURE Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Clinical	4.4	[redacted]							
Finance	5	[redacted]							
		4. DoF	4. Ability to meet cost of ongoing compliance with policy changes, statutory changes and updated guidance issued by SGHD.	4. Regular finance outturn and performance review led by the CEO and DOF with all budget holders. 5. Ongoing review of development of financial plan by the Corporate Management Team and Board; quarterly review and discussion					

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	CORPORATE LEVEL RISK EXPOSURE Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Healthcare Acquired Infection	6	[redacted]							
Health Information & Technology	7								
Human Resources	8.1								
[redacted]									

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Public Health	9.1	[redacted]							
Public Health	9.2								
Vale of Leven Inquiry	10	CEO	***Impact of inquiry findings - there may be far reaching recommendations leading to cost pressures and criticism of staff and management, which undermines confidence in the service and the Board's reputation***	***Measures already implemented have improved infection control rates throughout the organisation***	**5**	**3**	**15**	**2**	***Any additional recommendations will be considered thoroughly and implemented as appropriate. Reputational issues will be managed as they occur.***
New South Glasgow Hospital	11	[redacted]							

Risks shown in previous year no longer required

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Acute	1.1	[redacted]							
Communications	5	Director of Communications	Legislation and SGHD guidance on consultation/ engagement to involve patients in service change is not followed at all times. Possible consequences of failing to meet the obligation or not meeting guidance include: • Reputational damage • Legal challenge to NHS Board decisions on basis guidance was improperly followed • Censure by the Scottish Health Council (SHC) which may result in NHSGGC being instructed to repeat engagement or consultation resulting in potential delay or abandonment of service change or clinical development • Ministerial action/censure against NHSGGC • Not engaging with patients may result in services failing to meet their needs or address deficiencies	1. Individual consultation exercises are pre-planned to adhere to guidance – the SHC is normally involved in assessing these in advance of delivery 2. System-wide strategy for Patient Focused Public Involvement (PFPI) is formally reviewed by the SHC 3. Each CH(C)P Public Partnership Forum has an Executive Group and formal remit 4. Each service is responsible for ensuring PFPI process and best practice are embedded – this is overseen by the Communications and PFPI Group which comprises senior representation from all CHPs, Partnerships and Directorates 5. Ultimate review of methodologies and systems lies with the Board's Involving People Committee 6. Regular reporting to the PRG	**2**	**4**	**8**	**3**	**Considered likelihood reduced** **2011 risk 3x4 =12**
Corporate Planning & Policy	6	[redacted]							
Human Resources	10.2	Director of HR	Lack of integration between workforce planning and financial planning, impacting on resource availability and delivery of safe and effective services to patients.	Corporate cost savings plan is consolidated from Directorate/Divisional cost savings plans. Directorate/Divisional cost savings plans are specific plans, evidence based and developed following a proscribed approach using Project Initiation Documents (PIDs). Corporate Management Team monitors development of workforce plan and financial plan. regular reporting to Corporate Management Team and NHS Board. Scrutiny of workforce plan and financial plan by the Area Partnership Forum. Acute SMG, CH(C)P and MHP Management Teams oversee development of plan(s) and monitor implementation.	**3**	**3**	**9**	**3**	**Considered impact reduced** **2011 risk 3x4 =12**

Appendix

NHS Greater Glasgow and Clyde — Corporate Risk Register

Risk is the chance of something happening which will cause harm or detriment to the organisation, staff or patients. It is assessed in terms of likelihood of an event occurring and the severity of its impact upon the organisation, staff or patients.

NHS Greater Glasgow and Clyde has adopted, as illustrated below, a scoring system which enables the risks to be prioritised.

Likelihood (L)		Consequence (C)		Risk (LxC)	=	Priority
Almost certain	5	Extreme	5	20 - 25	=	Priority 1: VERY HIGH
Likely	4	Major	4	12 - 19	=	Priority 2: HIGH
Possible	3	Moderate	3	6 - 11	=	Priority 3: MEDIUM
Unlikely	2	Minor	2	1 - 5	=	Priority 4: LOW
Rare	1	Negligible	1			

The Corporate Risk Register comprises those risks that have been assessed as being high or very high.

NHS Greater Glasgow and Clyde — Glossary of Terms

ASD - Acute Services Division

CGIG - Clinical Governance Implementation Group

CHP - Community Health Partnership

CHCP - Community Health & Care Partnership

CIT - Corporate Inequalities Team

CMT - Corporate Management Team

HEAT - Health Improvement, Efficiency, Access, Treatment

LDP - Local Delivery Plan

MAPPA - Multi-Agency Public Protection Arrangements

MMC - Modernising Medical Careers

PCAT - Primary Care Audit Tool

PFPI - Patient Focused Public Involvement

Q&P - Quality and Performance Committee

QIS - Quality Improvement Scotland

RRL - Revenue Resource Limit

RTT - Referral to Treatment

SGHD - Scottish Government Health Directorates

SHC - Scottish Health Council

SIGN - Scottish Intercollegiate Guidelines Network

SMG - Strategic Management Group

SPSP - Scottish Patient Safety Programme

SUM - Safer Use of Medicines

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	CORPORATE LEVEL RISK EXPOSURE Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Acute	1.1	[redacted]							
Acute	1.2	ASD Chief Operating Officer and Director of Surgery & Anaesthetics	**Patient Rights (Scotland) Act 2012** **Failure to prepare staff to implement New Ways / failure to raise patient awareness of rules**	**Implementation of the RTT Guarantee and complaints aspects of the Act** **Group established to lead on implementation measures in ASD** **Regular reports to be provided to SMG**	**3**	**4**	**12**	**2**	
Acute	1.3	ASD Chief Operating Officer	Non-conformance with guidance on the provision of bed spacing and single room accommodation for inpatients in refurbished projects. This impacts upon the number of beds available in existing wards on completion of refurbishment works, on the nursing workforce models and on appropriate patient selection in bed spaces.	Ongoing engagement and consultation with SGHD on practical application of the guidance. The new Southern General adult hospital is designed with 100% single rooms; the children's hospital with the recommended proportion of single rooms. Directors in the Acute Division have now completed risk assessments in relation to bed spacing in clinical wards which fall below 2.7m.	**3**	**4**	**12**	**2**	Continue to review year on year
Child Protection	2	[redacted]							
CHP/CHCP	3								

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Clinical	4.1	[redacted]							
Clinical	4.2	ASD Chief Operating Officer CH(C)P Directors Director of Facilities	Reduction in capital funding and pressure on revenue resources impacts on premises improvements and maintenance programmes, leading to the possibility of non-compliance with applicable legislation and SGHD policies and guidance, and delays implementation of strategic change where capital investment is required.	Implementation of board-wide property management approach, including assessment of premises compliance by applying a standard consistent methodology. Identificaion of priorities for improvment/maintenance by following standard approach, ensuring available resources are targeted at highest priorities. Regular reporting to Acute SMG, CH(C)P Management Teams, Capital Planning Group and Corporate Management Team to inform development of capital plan(s) and revenue budget setting.	3	4	12	2	
Clinical	4.3	[redacted]							

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Communications	5	Director of Communications/ Board Nurse Director	Legislation and SGHD guidance on consultation/engagement to involve patients in service change is not followed at all times. Possible consequences of failing to meet the obligation or not meeting guidance include: - Reputational damage - Legal challenge to NHS Board decisions on basis guidance was improperly followed - Censure by the Scottish Health council (SHC) which may result in NHSGGC being instructed to repeat engagement or consultation resulting in potential delay or abandonment of service change or clinical development - Ministerial action/censure against NHSGGC - Not engaging with patients may result in services failing to meet their needs or address deficiencies.	1. Individual consultation exercises are pre-planned with community engagement and appropriate service leads to adhere to guidance - the SHC is normally involved is assessing these in advance of delivery. 2. System-wide strategy for Patient Focused Public Involvement (PFPI) is formally reviewed by SHC. 3. Each CH(C)P Public Partnership Forum has an Executive Group and formal remit. 4. Each service is responsible for ensuring PFPI process and best practice are embedded - this is overseen by Corporate Communications in partnership with the service lead director and the Board's community engagement team to ensure guidance is adhered to. 5.Ultimate review of methodologies and systems lies with the Board's Quality Policy Development Group. 6.Regular reporting to the Quality and Performance Committee.	3	4	12	2	
Finance	6	[redacted]							
		4. DoF	4. Ability to meet cost of ongoing compliance with policy changes, statutory changes and updated guidance issued by SGHD.	4. Regular finance outturn and performance review led by the CEO and DOF with all budget holders. 5. Ongoing review of development of financial plan by the Corporate Management Team and Board; quarterly review and discussion					

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	CORPORATE LEVEL RISK EXPOSURE Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Healthcare Acquired Infection	7	Medical Director	Emergence of outbreaks or incidence of infection that are indicative of a failure to ensure that all policies, protocols and procedures to support the effective Prevention and Control of Infection are developed and implemented within NHSGGC.	Annual Infection Control Programme which is aligned to National and Local priorities for the Prevention and Control of Infection and which is monitored through reports to Board Infection Control Committee, Quality & Performance Committee and NHS Board. Environmental audit exercise and ongoing monitoring arrangements Implementation of HAI action plan Preparation and follow up to Healthcare Environment Inspectorate visits and independent scrutiny reports Senior infection control doctor and nurse on each directorate clinical governance committee. Monthly reporting from Infection Control Team to clinical governance committees.	3	4	12	2	
Health Information & Technology	8	[redacted]							
Human Resources	9	[redacted]							

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Public Health	10.1	[redacted]							
Public Health	10.2	[redacted]							
Vale of Leven Inquiry	11	CEO	Impact of inquiry findings - there may be far reaching recommendations leading to cost pressures and criticism of staff and management, which undermines confidence in the service and the Board's reputation	Measures already implemented have improved infection control rates throughout the organisation	5	3	15	2	Any additional recommendations will be considered thoroughly and implemented as appropriate. Reputational issues will be managed as they occur.

NHS Greater Glasgow and Clyde — *Corporate Risk Register*

Risk is the chance of something happening which will cause harm or detriment to the organisation, staff or patients. It is assessed in terms of likelihood of an event occurring and the severity of its impact upon the organisation, staff or patients.

NHS Greater Glasgow and Clyde has adopted, as illustrated below, a scoring system which enables the risks to be prioritised.

Likelihood (L)		Consequence (C)		Risk (LxC)	=	Priority
Almost certain	5	Extreme	5	20 - 25	=	Priority 1: VERY HIGH
Likely	**4**	**Major**	**4**	**12 - 19**	**=**	**Priority 2: HIGH**
Possible	3	Moderate	3	6 - 11	=	Priority 3: MEDIUM
Unlikely	2	Minor	2	1 - 5	=	Priority 4: LOW
Rare	1	Negligible	1			

The Corporate Risk Register comprises those risks that have been assessed as being high or very high.

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	CORPORATE LEVEL RISK EXPOSURE Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Acute	1.1	[redacted]							
	1.2								
Child Protection	2								
CHP/CHCP	3								

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Clinical	4.1	[redacted]							
	4.2	ASD Chief Operating Officer CH(C)P Directors Director of Facilities	Reduction in capital funding and pressure on revenue resources impacts on premises improvements and maintenance programmes, leading to the possibility of non-compliance with applicable legislation and SGHD policies and guidance, and delays implementation of strategic change where capital investment is required.	Implementation of board-wide property management approach, including assessment of premises compliance by applying a standard consistent methodology. Identificaion of priorities for improvment/maintenance by following standard approach, ensuring available resources are targeted at highest priorities. Regular reporting to Acute SMG, CH(C)P Management Teams, Capital Planning Group and Corporate Management Team to inform development of capital plan(s) and revenue budget setting.	3	4	12	2	
	4.3	[redacted]							
Integration	5	**Interim Chief Officers**	**Failure to establish joint integration board, scheme of integration, Strategic plan and Joint Commisioning plan for the adult HSCP before 1st April 2015. This may result in requirements of the Act not being met.**	**Some Interim Chief Officers appointed and taking agenda forward**	**3**	**4**	**12**	**2**	**Agreement required between partners on the shadow and substantive governance arrangements for the NHS services. Extensive stakeholder involvement and engaement and communicaiton plans to be developed**

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Finance	6	[redacted]							
		4. DoF	4. Ability to meet cost of ongoing compliance with policy changes, statutory changes and updated guidance issued by SGHD.	4. Regular finance outturn and performance review led by the CEO and DOF with all budget holders. 5. Ongoing review of development of financial plan by the Director of Finance, Chief Executive and Board; quarterly review and discussion					
Healthcare Acquired Infection	7.1	Medical Director	Emergence of outbreaks or incidence of infection that are indicative of a failure to ensure that all policies, protocols and procedures to support the effective Prevention and Control of Infection are developed and implemented within NHSGGC.	Annual Infection Control Programme which is aligned to National and Local priorities for the Prevention and Control of Infection and which is monitored through reports to Board Infection Control Committee, Quality & Performance Committee and NHS Board. Environmental audit exercise and ongoing monitoring arrangements Implementation of HAI action plan Preparation and follow up to Healthcare Environment Inspectorate visits and independent scrutiny reports Senior infection control doctor and nurse on each directorate clinical governance committee. Monthly reporting from Infection Control Team to clinical governance committees.	**3**	**4**	**12**	**2**	
	7.2	**Medical Director/ Infection Control Manager**	**Decontamination - Where failure to comply with or provide appropriate clinical advice regarding current and development of EU and national regulations results in an outbreak of infection.**	**Monitored via the CJD Sub Group and Decontamination Sub Group. Head of Decontamination for NHSGGC sits on both groups.**	**3**	**4**	**12**	**2**	

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	CORPORATE LEVEL RISK EXPOSURE Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Healthcare Acquired Infection	7.3	Medical Director/Infection Control Manager	Failure to implement consistent systems and policies in relation to controlling emerging pathogens resulting in increased infection rates	A Multi-Drug Resistant Gram Negative Policy in place. Separate polices have been written for VHF etc. and controls are in place.	3	4	12	2	
Health Information & Technology	8	[redacted]							
Human Resources	9.1								
	9.2								

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Public Health	10.1	[redacted]							
	10.2								
Vale of Leven Inquiry	11	CEO	Impact of Vale of Leven inquiry findings - there may be far reaching recommendations leading to cost pressures and criticism of staff and management, which undermines confidence in the service and the Board's reputation	Measures already implemented have improved infection control rates throughout the organisation	5	3	15	2	Any additional recommendations will be considered thoroughly and implemented as appropriate. Reputational issues will be managed as they occur.
New SGH	12.1	**Project Director**	**Over development of SGH - concurrent activities, disruption to hospital project delivery. Lack of co-ordination of works. All resulting in disruptions to services.**	**Programme, management and methodology**	4	4	16	2	Additional PM support. Appropriate procurement plans
	12.2	[redacted]							

Appendix

NHS Greater Glasgow and Clyde — *Corporate Risk Register*

Risk is the chance of something happening which will cause harm or detriment to the organisation, staff or patients. It is assessed in terms of likelihood of an event occurring and the severity of its impact upon the organisation, staff or patients.

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MMC - Modernising Medical Careers

PCAT - Primary Care Audit Tool

PFPI - Patient Focused Public Involvement

Q&P - Quality and Performance Committee

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RTT - Referral to Treatment

SGHD - Scottish Government Health Directorates

SHC - Scottish Health Council

SIGN - Scottish Intercollegiate Guidelines Network

SMG - Strategic Management Group

SPSP - Scottish Patient Safety Programme

SUM - Safer Use of Medicines

NHS Greater Glasgow and Clyde
Corporate Risk Register - Oct 2014

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Acute	1.1	[redacted]							
Acute	1.2	Lead Director / Lead Director for Acute Medical Services / Interim Director of Facilities / Nurse Director	Failure to prevent or establish early detection and control for outbreaks or higher incidence of infection	Environmental audit exercise and ongoing monitoring arrangements Infection control policy, surveillance and reporting system Implementation of HAI action plans Preparation and follow up to HEI visits and independent scrutiny reports	3	4	12	2	
Acute	1.3	ASD Interim Director of Facilities/ ASD Director of Nursing	Non-conformance with guidance on the provision of bed spacing and single room accommodation for inpatients in refurbished projects. This impacts upon the number of beds available in existing wards on completion of refurbishment works, on the nursing workforce models and on appropriate patient selection in bed spaces.	Ongoing engagement and consultation with SGHD on practical application of the guidance. The new Southern General adult hospital is designed with 100% single rooms; the children's hospital with the recommended proportion of single rooms. Directors in the Acute Division have now completed risk assessments in relation to bed spacing in clinical wards which fall below 2.7m.	3	4	12	2	Continue to review year on year
Acute	1.4	[redacted]							
Child Protection	2								

NHS Greater Glasgow and Clyde
Corporate Risk Register - Oct 2014

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE		RISK RATING	RISK PRIORITY	FURTHER ACTION REQUIRED
					Likelihood (L)	Consequence (C)	(LxC)		
[redacted]									

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Clinical	4.2	ASD Chief Operating Officer CH(C)P Directors Director of Facilities	Reduction in capital funding and pressure on revenue resources impacts on premises improvements and maintenance programmes, leading to the possibility of non-compliance with applicable legislation and SGHD policies and guidance, and delays implementation of strategic change where capital investment is required.	Implementation of board-wide property management approach, including assessment of premises compliance by applying a standard consistent methodology. Identificaion of priorities for improvment/maintenance by following standard approach, ensuring available resources are targeted at highest priorities. Regular reporting to Acute SMG, CH(C)P Management Teams, Capital Planning Group and Corporate Management Team to inform development of capital plan(s) and revenue budget setting.	3	4	12	2	
Clinical	4.3	[redacted]							
Integration	5	Interim Chief Officers	Failure to establish joint integration board, scheme of integration, Strategic plan and Joing Commisioning plan for the adult HSCP before 1st April 2015.	Some Interim Chief Officers appointed and taking agenda forward	3	4	12	2	Agreement required between partners on the shadow and substantive governance arrangements for the NHS services. Extensive stakeholder involvement and engaement and communicaiton plans to be developed
Finance	6	[redacted]							

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
[redacted]									
Finance		4. DoF	4. Ability to meet cost of ongoing compliance with policy changes, statutory changes and updated guidance issued by SGHD.	4. Regular finance outturn and performance review led by the CEO and DOF with all budget holders. 5. Ongoing review of development of financial plan by the Corporate Management Team and Board; quarterly review and discussion					
Healthcare Acquired Infection	7.1	Medical Director	Emergence of outbreaks or incidence of infection that are indicative of a failure to ensure that all policies, protocols and procedures to support the effective Prevention and Control of Infection are developed and implemented within NHSGGC.	Annual Infection Control Programme which is aligned to National and Local priorities for the Prevention and Control of Infection and which is monitored through reports to Board Infection Control Committee, Quality & Performance Committee and NHS Board. Environmental audit exercise and ongoing monitoring arrangements Implementation of HAI action plan Preparation and follow up to Healthcare Environment Inspectorate visits and independent scrutiny reports Senior infection control doctor and nurse on each directorate clinical governance committee. Monthly reporting from Infection Control Team to clinical governance committees.	3	4	12	2	
Healthcare Acquired Infection	7.2	Medical Director/Infection Control Manager	Decontamination - Where failure to comply with or provide appropriate clinical advice regarding current and development of EU and national regulations	Monitored via the CJD Sub Group and Decontamination Sub Group. Head of Decontamination for NHSGGC sits on both groups.	3	4	12	2	
Healthcare Acquired Infection	7.3	Medical Director/ Infection Control Manager	Requirement to implement national infection control policy which may not be practical or appropriate for NHSGGC	Where appropriate have local addendums. Impact assessment for new national policy SICPs now live. Update Terms of Reference for BICC to reflect approval of policies/addendums and be presented to CGF.	3	4	12	2	
Healthcare Acquired Infection	7.4	[redacted]							

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE		RISK RATING	RISK PRIORITY	FURTHER ACTION REQUIRED
					Likelihood (L)	Consequence (C)	(LxC)		
Healthcare Acquired Infection	7.5	Medical Director/Infection Control Manager	Failure to implement consistent systems and policies in relation to controlling emerging pathogens	A Multi-Drug Resistant Gram Negative Policy in place. Separate polices have been written for VHF etc. and controls are in place.	3	4	12	2	
Health Information & Technology	8.1	[redacted]							
Health Information & Technology	8.2								
ources	9.1								
	9.2								

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Human Res	[redacted]								
		Director of Workforce	Failure to develop and implement suitable and sufficient HR arrangements and processes related to re-organisation and movement of staff within Acute Services, to new South Glasgow Hospitals.	HR plans developed and updated as required as part of 'on the move' strategy.	3	5	15	2	
	[redacted]								
Vale of Leven Inquiry	11	CEO	Impact of inquiry findings - there may be far reaching recommendations leading to cost pressures and criticism of staff and management, which undermines confidence in the service and the Board's reputation	Measures already implemented have improved infection control rates throughout the organisation	5	3	15	2	Any additional recommendations will be considered thoroughly and implemented as appropriate. Reputational issues will be managed as they occur.
New SGH	12.1	Project Director	Non-completion by 26th January 2015 - impact on migration, procurement	Monthly monitoring and weekly walkthrough to monitor situation	3	4	12	2	Continue regular monitoring

NHS Greater Glasgow and Clyde
Corporate Risk Register - Oct 2014

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE		RISK RATING	RISK PRIORITY	FURTHER ACTION REQUIRED
					Likelihood (L)	Consequence (C)	(LxC)		
New SGH	12.2	Project Director	Over development of SGH - concurrent activities, disruption to hospital project delivery. Lack of co-ordination of works	Programme, management and methodology	4	4	16	2	Additional PM support. Appropriate procurement plans
New SGH	12.3	Acute Division Directors	Disruption to services during transition to new hospitals. Higher than anticipated costs of move and transition.	Detailed planning process in place	3	4	12	2	Additional PM support. Appropriate procurement plans

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
	1	[redacted]							
	2								
	3	Lead Director / Lead Director for Acute Medical Services / Interim Director of Facilities / Nurse Director	Failure to prevent or establish early detection and control for outbreaks or higher incidence of infection	Environmental audit exercise and ongoing monitoring arrangements Infection control policy, surveillance and reporting system Implementation of HAI action plans Preparation and follow up to HEI visits and independent scrutiny reports	3	4	12	2	
	4	[redacted]							
	5								

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
	6	[redacted]							
	7	ASD Interim Director of Facilities/ ASD Director of Nursing	Non-conformance with guidance on the provision of bed spacing and single room accommodation for inpatients in refurbished projects. This impacts upon the number of beds available in existing wards on completion of refurbishment works, on the nursing workforce models and on appropriate patient selection in bed spaces.	Ongoing engagement and consultation with SGHD on practical application of the guidance. The new Southern General adult hospital is designed with 100% single rooms; the children's hospital with the recommended proportion of single rooms. Directors in the Acute Division have now completed risk assessments in relation to bed spacing in clinical wards which fall below 2.7m.	3	4	12	2	
	8	[redacted]							
	9								
	10								

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
	11	ASD Interim Director of Facilities	Reduction in Capital funding and pressure on revenue resources impacts on premises improvements and maintenance programmes, leading to the possibility of non compliance with applicable legislation and SGHD policies and guidance, and delays in implementation of strategic change where capital investment is required.	Implementation of Division wide property management approach including assessment of premises compliance with standard consistent methodologies. Regular reports to SMG / OMG on deployment of capital resources and investment priorities.	3	4	12	2	
	12	Project Director / Lead Director	Handover of New South Glasgow Hospital	Regular monitoring by On The Move Programme Board, MEG, CEG, ASSB, CMT, Q&P Committee and Board. Governed by a separate Risk Register.	3	4	12	2	

NHS Greater Glasgow and Clyde
Corporate Risk Register - Oct 2014

Ref	OWNER	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
5	[redacted]							
6	PM	Detrimental environmental impacts i.e. Noise disruption and pollution	All works to be assessed for noise disruption and/or pollution consequences Ecology report undertaken Contractors environmental policy implemented WRAP initiative implemented . Brookfield monitor vibration and noise automatically. Disruption to local residents during VIE construction, removal of tower cranes. Continue local liaison with residents	4	3	**12**	**2**	Ongoing review by PMG Regular meetings with local residents to discuss a series of environmental issues pre construction of the hospitals BCL WRAP on site Dust monitors installed around BMCL site to gather information - weekly report provided to NHS Team Dust screens erected in specific locations Acoustic barriers erected to minimise potential noise disruption Project Director reinforced that Brookfield must comply with GCC conditions. PPC application made and under review and project team in consultations with SEPA
14	IP	PPC Permits - Change to legislation Requirement to obtain permit to operate large scale combustion plant for purposes of commissioning. Not obtaining permit will delay BMCL commissioning	NHS GG&C are designated operators of the proposed energy centre & existing retained estate combustion plant and are therefore responsible to for the submission of permit application. Permit application was duly submitted on 3rd March 2014.	3	5	**15**	**2**	SEPA 5 month review process anticipated, (July commissioning programme). Post Public consultation notice (March 2014) . Installation of drainage oil seperator at EC fuel transfer station Production of management operating procedures in preparation for 1st audit under permit.

Ref	OWNER	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
17	PM	Non-compliance of completion criteria by BMCL	Meetings to be arranged. Criteria to be circulated	3	4	**12**	**2**	Completion criteria to be circulated to the group. Continue to monitor progress
19	[redacted]							
20	PM	Specialist Witness Testing - lack of availability of appropriate resources	Make arrangements with relevant specialist staff groups to prepare for work load	3	4	**12**	**2**	Commissioning programme required from BMCL to prepare and plan for this part of the process
21	DL	Non-completion by 26th January 2015 - impact on migration, procurement	Monthly monitoring and weekly walkthrough to monitor situation	3	4	**12**	**2**	Continue regular monitoring
29	DL	Loss of Key Resources (BMCL) - key staff moving onto new contracts	BMCL to confirm	4	3	**12**	**2**	Check BMCL position in relation to staff retention until job is completed
30	[redacted]							
34	DL	Over development of SGH - concurrent activities, disruption to hospital project delivery. Lack of co-ordination of works	Programme, management and methodology	4	4	**16**	**2**	Additional PM support. Appropriate procurement plans

NHS Greater Glasgow and Clyde
Corporate Risk Register - Oct 2014

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Child Protection	1	[redacted]							
	2								
	3								

NHS Greater Glasgow and Clyde
Corporate Risk Register - Oct 2014

Organisational area	Ref	OWNER	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	RISK EXPOSURE Likelihood (L)	RISK EXPOSURE Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Finance	1	[redacted]							
	2								
	3								
	4								
	5	ASD Chief Operating Officer	Underestimation of capital and revenue operating costs of new South Glasgow hospitals.	1. Operation of rigorous change control process led by COO, working through Executive Board and supporting project groups, involving all key stakeholders, and supported by an extensive network of professional advisers. 2. Routine and regular reporting of project progress to PRG and the NHS Board. 3. Close contact with SGHD	2	4	8	3	
	6	[redacted]							
	7								

Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	RISK EXPOSURE Likelihood (L)	RISK EXPOSURE Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
1	[redacted]							
2								
3								
4								

5

[redacted]

NHS Greater Glasgow and Clyde
Corporate Risk Register - Oct 2014

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
	1	Medical Director/Infection Control Manager	Decontamination - Where failure to comply with or provide appropriate clinical advice regarding current and development of EU and national regulations	Monitored via the CJD Sub Group and Decontamination Sub Group. Head of Decontamination for NHSGGC sits on both groups.	3	4	12	2	
	2	Medical Director/Infection Control Manager	Requirement to implement national infection control policy which may not be practical or appropriate for NHSGGC	Where appropriate have local addendums. Impact assessment for new national policy SICPs now live. Update Terms of Reference for BICC to reflect approval of policies/addendums and be presented to CGF.	3	4	12	2	
	3	[redacted]							
	5	Medical Director/Infection Control Manager	Failure to implement consistent systems and policies in relation to controlling emerging pathogens	A Multi-Drug Resistant Gram Negative Policy in place. Separate polices have been written for VHF etc. and controls are in place.	3	4	12	2	

NHS Greater Glasgow and Clyde
Corporate Risk Register - Oct 2014

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
	1								

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Health Information & Technology	8	[redacted]							
Health Information & Technology									
Health Information & Technology									

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Health Information & Technology	[redacted]								

Ref	OWNER	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	RISK EXPOSURE	RISK RATING Consequence (C)	(LxC)	RISK RANKIN	FURTHER
1	Medical Director	[redacted]						
2	Director of HR							
3	Head of Resourcing							

NHS Greater Glasgow and Clyde
Corporate Risk Register - Oct 2014

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	CORPORATE LEVEL RISK EXPOSURE Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Prescribing	1	[redacted]							
Medical Emergency	4								

NHS Greater Glasgow and Clyde
Corporate Risk Register - Oct 2014

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
[redacted]									

NHS Greater Glasgow and Clyde
Corporate Risk Register - Oct 2014

Ref	OWNER	THE RISK - what can happen and how it can	CONTROLS IN PLACE	RISK EXPOSURE Likelihood (L)	RISK EXPOSURE Consequence (C)	RISK RATING (LxC)	RISK RANKIN
1	[redacted]						
2							
3							

NHS Greater Glasgow and Clyde
Corporate Risk Register - Oct 2014

Ref	OWNER	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	RISK EXPOSURE Likelihood (L)	RISK EXPOSURE Consequence (C)	RISK RATING (LxC)	RISK RANKIN
1	Interim Chief Officer	Failure to establish joint integration board, scheme of integration, Strategic plan and Joing Commisioning plan for the adult HSCP before 1st April 2015.	Inerim Chief Officer appoionted February 2014 to lead process. Steering Group established to develop and agree draft partnership agreement. Project Plan in development to ensure all necessary activities to meet policy statements are progressed so that Shadow JIB can be established. Action learning set established to developm understanding of new arrangements and each parent organisations aspirations for the adult HSCP	4	4	16	2
2	[redacted]						
3							
4							
5							

Ref	OWNER	THE RISK - what can happen and how it can	CONTROLS IN PLACE	RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK RANKIN
6	[redacted]						
7							
8							

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE		RISK RATING	RISK PRIORITY	FURTHER ACTION REQUIRED
					Likelihood (L)	Consequence (C)	(LxC)		
[redacted]									

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE		RISK RATING	RISK PRIORITY	FURTHER ACTION REQUIRED
					Likelihood (L)	Consequence (C)	(LxC)		
Renfrewshire CHP	5	[redacted]							
Renfrewshire CHP	6								
	7								
Renfrewshire CHP	8								
HP			Non-compliance with all applicable policies, procedures, clinical and non-clinical standards and protocols, resulting in death or injury to staff, patients, visitors and the public.	Proactive controls arising from clinical and general management systems and processes including provision and uptake of relevant training, robust policy and procedures, Health & Safety Forum, Clinical and Care Governance Groups, Patient Safety Forum and Datix monitoring.					incidents, complaints and associated action plans. Proactive approach to falls prevention in EMI wards. Quarterly reports provided. Management of Aggression training - Adult Mental Health - EMI - Addictions - Quality Improvement Plans in place at

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE		RISK RATING	RISK PRIORITY	FURTHER ACTION REQUIRED
					Likelihood (L)	Consequence (C)	(LxC)		
Renfrewshire C	9	CHP Director / Heads of Service	Failure to comply with all clinical standards and protocols and appropriate clinical and environmental risk assessments could result in death or injury to staff; patients; visitors and the public arising from for eg: Suicide or Self Harm; Violent patients; Absconding patients; Accidental and Deliberate Overdose; Moving and Handling Incidents	Proactive controls arising from the mental health clinical and general management system and processes including specialised and supported workforce, ongoing training programmes, robust policy and procedures. Ongoing monitoring includes structured responsibility for detection and review of Critical Incidents with special emphasis on ensuring lessons learned from incidents are disseminated and applied across the Board. At a local level the consistent review of level of risk is assessed at MDT and if any significant change in the patients presentation occurs. This may be linked to an ongoing review and assessment of the level of observation required as described within the Clinical Observation Policy. Nurse Line Management supervision and ongoing core audit schedule alongside regular PDN review of policy appplications within clinical areas ensure robust governance and monitoring arrangements in place.	3	5	15	2	Monitoring through Care Governance Operational and Executive Group. Monitored through ongoing core audit schedule and nurse line management supervision at clinical level. Work underway which will ensure SMT have a role in governance and accountability.
Renfrewshire CHP	10	MH Snr Nurse / Head of Mental Health	HAI/HEI- Failure to meet HAI/HEI standards address areas of non compliance highlighted within clinical and environmental audit reports could result increased risk of infection, cross contamination and ability to deliver safe and sustainable services. Local HEI/HAI audits have highlighted areas requiring immediate attention around fabrics of building, furnishings and fittings	Regular audits in place with action planning to address findings. Regular & local HAI / HEI site meetings involving clinical & operational representatives, infection control shortcut in place in all clinical areas PC's and any updates highlighted to staff at staff meetings. Cleanliness Champions online training tracker in use; Cleanliness Champions in each clinical area and all inpatient nursing staff have a requirement to undertake infection control training as part of PDP. Joint reviews betwen clinical and facilities staff following each audit to identify action plans for improvemnet. Areas requiring immediate action and funding have been highlighted via capital funding projects and local SMT structure. Specifcially programme of works completed in AAU and ongoing in wards 37 /39 RAH to address issues raised as part of routine HEI/HAI standards audits. Source of funding now identified for programme of replacement furnishings and equipment and plan in place to address by end of financial year.	3	4	12	2	Further remedial work in clinical environments , particularly in relation to ensuite areas in AAU and remaining areas / sanitary ware in wards 37/39 to ensure compliance with standards and avoid red or amber fails in audit process. Funding bid developed for submission.
[redacted]									

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE		RISK RATING	RISK PRIORITY	FURTHER ACTION REQUIRED
					Likelihood (L)	Consequence (C)	(LxC)		
Renfrewshire CHP	12	[redacted]							
Renfrewshire CHP	13								
Renfrewshire CHP	14								
Renfrewshire CHP	15								
Renfrewshire CHP	16								

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE		RISK RATING	RISK PRIORITY	FURTHER ACTION REQUIRED
					Likelihood (L)	Consequence (C)	(LxC)		
Renfrewshire CHP	17	[redacted]							

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	CORPORATE LEVEL RISK EXPOSURE Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
	1	[redacted]							
	2								
	3								
	4	Head of Planning	Lack of consistency in commissioning or failure of key providers which could lead to varying costs, service quality and breaches of legislation, security or health and safety. In light of current financial situation there is an increased risk.of contractors business failure.	Contractors to adopt CHCP Policies and Procedures Violent Warning Marker Scheme Incident Reporting Quality monitoring Contract terms and conditions / SLA's Changing terms and conditions of contracts with assistance from Legal Services Up to date contracts and/or SLA's Quality monitoring	4	3	12	2	
	5	[redacted]							

Appendix

NHS Greater Glasgow and Clyde — *Corporate Risk Register*

Risk is the chance of something happening which will cause harm or detriment to the organisation, staff or patients. It is assessed in terms of likelihood of an event occurring and the severity of its impact upon the organisation, staff or patients.

NHS Greater Glasgow and Clyde has adopted, as illustrated below, a scoring system which enables the risks to be prioritised.

Likelihood (L)		Consequence (C)		Risk (LxC)	=	Priority
Almost certain	5	Extreme	5	20 - 25	=	Priority 1: VERY HIGH
Likely	4	Major	4	12 - 19	=	Priority 2: HIGH
Possible	3	Moderate	3	6 - 11	=	Priority 3: MEDIUM
Unlikely	2	Minor	2	1 - 5	=	Priority 4: LOW
Rare	1	Negligible	1			

The Corporate Risk Register comprises those risks that have been assessed as being high or very high.

NHS Greater Glasgow and Clyde — Glossary of Terms

ASD - Acute Services Division

CGIG - Clinical Governance Implementation Group

CHP - Community Health Partnership

CHCP - Community Health & Care Partnership

CIT - Corporate Inequalities Team

CMT - Corporate Management Team

HEAT - Health Improvement, Efficiency, Access, Treatment

LDP - Local Delivery Plan

MAPPA - Multi-Agency Public Protection Arrangements

MMC - Modernising Medical Careers

PCAT - Primary Care Audit Tool

PFPI - Patient Focused Public Involvement

Q&P - Quality and Performance Committee

QIS - Quality Improvement Scotland

RRL - Revenue Resource Limit

RTT - Referral to Treatment

SGHD - Scottish Government Health Directorates

SHC - Scottish Health Council

SIGN - Scottish Intercollegiate Guidelines Network

SMG - Strategic Management Group

SPSP - Scottish Patient Safety Programme

SUM - Safer Use of Medicines

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Acute	1.1	[redacted]							
Acute	1.2	Lead Director / Lead Director for Acute Medical Services / Interim Director of Facilities / Nurse Director	Failure to prevent or establish early detection and control for outbreaks or higher incidence of infection	Environmental audit exercise and ongoing monitoring arrangements Infection control policy, surveillance and reporting system Implementation of HAI action plans Preparation and follow up to HEI visits and independent scrutiny reports	3	4	12	2	
Acute	1.3	ASD Interim Director of Facilities/ ASD Director of Nursing	Non-conformance with guidance on the provision of bed spacing and single room accommodation for inpatients in refurbished projects. This impacts upon the number of beds available in existing wards on completion of refurbishment works, on the nursing workforce models and on appropriate patient selection in bed spaces.	Ongoing engagement and consultation with SGHD on practical application of the guidance. The new Southern General adult hospital is designed with 100% single rooms; the children's hospital with the recommended proportion of single rooms. Directors in the Acute Division have now completed risk assessments in relation to bed spacing in clinical wards which fall below 2.7m.	3	4	12	2	Continue to review year on year
Acute	1.4	[redacted]							
Child Protection	2								

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	CORPORATE LEVEL RISK EXPOSURE Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
CHP/CHCP	3	[redacted]							
Clinical	4.1								

NHS Greater Glasgow and Clyde
Corporate Risk Register - Dec 2014

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Clinical	4.2	ASD Chief Operating Officer CH(C)P Directors Director of Facilities	Reduction in capital funding and pressure on revenue resources impacts on premises improvements and maintenance programmes, leading to the possibility of non-compliance with applicable legislation and SGHD policies and guidance, and delays implementation of strategic change where capital investment is required.	Implementation of board-wide property management approach, including assessment of premises compliance by applying a standard consistent methodology. Identificaion of priorities for improvment/maintenance by following standard approach, ensuring available resources are targeted at highest priorities. Regular reporting to Acute SMG, CH(C)P Management Teams, Capital Planning Group and Corporate Management Team to inform development of capital plan(s) and revenue budget setting.	3	4	12	2	
Clinical	4.3	[redacted]							
Integration	5	Interim Chief Officers	Failure to establish joint integration board, scheme of integration, Strategic plan and Joing Commisioning plan for the adult HSCP before 1st April 2015.	Some Interim Chief Officers appointed and taking agenda forward	3	4	12	2	Agreement required between partners on the shadow and substantive governance arrangements for the NHS services. Extensive stakeholder involvement and engaement and communicaiton plans to be developed
Finance	6	[redacted]							

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Finance		[redacted]							
		4. DoF	4. Ability to meet cost of ongoing compliance with policy changes, statutory changes and updated guidance issued by SGHD.	4. Regular finance outturn and performance review led by the CEO and DOF with all budget holders. 5. Ongoing review of development of financial plan by the Corporate Management Team and Board; quarterly review and discussion					
Healthcare Acquired Infection	7.1	Medical Director	Emergence of outbreaks or incidence of infection that are indicative of a failure to ensure that all policies, protocols and procedures to support the effective Prevention and Control of Infection are developed and implemented within NHSGGC.	Annual Infection Control Programme which is aligned to National and Local priorities for the Prevention and Control of Infection and which is monitored through reports to Board Infection Control Committee, Quality & Performance Committee and NHS Board. Environmental audit exercise and ongoing monitoring arrangements Implementation of HAI action plan Preparation and follow up to Healthcare Environment Inspectorate visits and independent scrutiny reports Senior infection control doctor and nurse on each directorate clinical governance committee. Monthly reporting from Infection Control Team to clinical governance committees.	3	4	12	2	
Healthcare Acquired Infection	7.2	Medical Director/Infection Control Manager	Decontamination - Where failure to comply with or provide appropriate clinical advice regarding current and development of EU and national regulations	Monitored via the CJD Sub Group and Decontamination Sub Group. Head of Decontamination for NHSGGC sits on both groups.	3	4	12	2	
Healthcare Acquired Infection	7.3	Medical Director/ Infection Control Manager	Requirement to implement national infection control policy which may not be practical or appropriate for NHSGGC	Where appropriate have local addendums. Impact assessment for new national policy SICPs now live. Update Terms of Reference for BICC to reflect approval of policies/addendums and be presented to CGF.	3	4	12	2	
Healthcare Acquired Infection	7.4	[redacted]							

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE		RISK RATING	RISK PRIORITY	FURTHER ACTION REQUIRED
					Likelihood (L)	Consequence (C)	(LxC)		
Healthcare Acquired Infection	7.5	Medical Director/Infection Control Manager	Failure to implement consistent systems and policies in relation to controlling emerging pathogens	A Multi-Drug Resistant Gram Negative Policy in place. Separate polices have been written for VHF etc. and controls are in place.	3	4	12	2	
Health Information & Technology	8.1	[redacted]							
Health Information & Technology	8.2								
ources	9.1								
	9.2								

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Human Res	9.3	[redacted]							
	9.4	Director of Workforce	Failure to develop and implement suitable and sufficient HR arrangements and processes related to re-organisation and movement of staff within Acute Services, to new South Glasgow Hospitals.	HR plans developed and updated as required as part of 'on the move' strategy.	3	5	15	2	
	9.5	[redacted]							
Public Health	10.1	[redacted]							
Public Health	10.2	[redacted]							
Vale of Leven Inquiry	11	CEO	Impact of inquiry findings - there may be far reaching recommendations leading to cost pressures and criticism of staff and management, which undermines confidence in the service and the Board's reputation	Measures already implemented have improved infection control rates throughout the organisation	5	3	15	2	Any additional recommendations will be considered thoroughly and implemented as appropriate. Reputational issues will be managed as they occur.
New SGH	12.1	Project Director	Non-completion by 26th January 2015 - impact on migration, procurement	Monthly monitoring and weekly walkthrough to monitor situation	3	4	12	2	Continue regular monitoring

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE		RISK RATING	RISK PRIORITY	FURTHER ACTION REQUIRED
					Likelihood (L)	Consequence (C)	(LxC)		
New SGH	12.2	Project Director	Over development of SGH - concurrent activities, disruption to hospital project delivery. Lack of co-ordination of works	Programme, management and methodology	4	4	16	2	Additional PM support. Appropriate procurement plans
New SGH	12.3	Acute Division Directors	Disruption to services during transition to new hospitals. Higher than anticipated costs of move and transition.	Detailed planning process in place	3	4	12	2	Additional PM support. Appropriate procurement plans

NHS Greater Glasgow and Clyde — *Corporate Risk Register*

Risk is the chance of something happening which will cause harm or detriment to the organisation, staff or patients. It is assessed in terms of likelihood of an event occurring and the severity of its impact upon the organisation, staff or patients.

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Likely	4	Major	4	12 - 19	=	Priority 2: HIGH
Possible	3	Moderate	3	6 - 11	=	Priority 3: MEDIUM
Unlikely	2	Minor	2	1 - 5	=	Priority 4: LOW
Rare	1	Negligible	1			

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CHCP - Community Health & Care Partnership

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MMC - Modernising Medical Careers

PCAT - Primary Care Audit Tool

PFPI - Patient Focused Public Involvement

Q&P - Quality and Performance Committee

QIS - Quality Improvement Scotland

RRL - Revenue Resource Limit

RTT - Referral to Treatment

SGHD - Scottish Government Health Directorates

SHC - Scottish Health Council

SIGN - Scottish Intercollegiate Guidelines Network

SMG - Strategic Management Group

SPSP - Scottish Patient Safety Programme

SUM - Safer Use of Medicines

NHS Greater Glasgow and Clyde
Corporate Risk Register - Jan 2015

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Acute	1.1	[redacted]							
Acute	1.2	Lead Director / Lead Director for Acute Medical Services / Interim Director of Facilities / Nurse Director	Failure to prevent or establish early detection and control for outbreaks or higher incidence of infection	Environmental audit exercise and ongoing monitoring arrangements Infection control policy, surveillance and reporting system Implementation of HAI action plans Preparation and follow up to HEI visits and independent scrutiny reports	3	4	12	2	
Acute	1.3	ASD Interim Director of Facilities/ ASD Director of Nursing	Non-conformance with guidance on the provision of bed spacing and single room accommodation for inpatients in refurbished projects. This impacts upon the number of beds available in existing wards on completion of refurbishment works, on the nursing workforce models and on appropriate patient selection in bed spaces.	Ongoing engagement and consultation with SGHD on practical application of the guidance. The new Southern General adult hospital is designed with 100% single rooms; the children's hospital with the recommended proportion of single rooms. Directors in the Acute Division have now completed risk assessments in relation to bed spacing in clinical wards which fall below 2.7m.	3	4	12	2	Continue to review year on year
Acute	1.4	[redacted]							
Child Protection	2								

NHS Greater Glasgow and Clyde
Corporate Risk Register - Jan 2015

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
CHP/CHCP	3	[redacted]							
Clinical	4.1								

NHS Greater Glasgow and Clyde
Corporate Risk Register - Jan 2015

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Clinical	4.2	ASD Chief Operating Officer CH(C)P Directors Director of Facilities	Reduction in capital funding and pressure on revenue resources impacts on premises improvements and maintenance programmes, leading to the possibility of non-compliance with applicable legislation and SGHD policies and guidance, and delays implementation of strategic change where capital investment is required.	Implementation of board-wide property management approach, including assessment of premises compliance by applying a standard consistent methodology. Identificaion of priorities for improvment/maintenance by following standard approach, ensuring available resources are targeted at highest priorities. Regular reporting to Acute SMG, CH(C)P Management Teams, Capital Planning Group and Corporate Management Team to inform development of capital plan(s) and revenue budget setting.	3	4	12	2	
Clinical	4.3	[redacted]							
Integration	5	Interim Chief Officers	Failure to establish joint integration board, scheme of integration.	Some Interim Chief Officers appointed and taking agenda forward	3	4	12	2	Agreement required between partners on the shadow and substantive governance arrangements for the NHS services. Extensive stakeholder involvement and engaement and communicaiton plans to be developed
Finance	6	[redacted]							

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Finance		[redacted]							
Healthcare Acquired Infection	7.1	Medical Director	Emergence of outbreaks or incidence of infection that are indicative of a failure to ensure that all policies, protocols and procedures to support the effective Prevention and Control of Infection are developed and implemented within NHSGGC.	Annual Infection Control Programme which is aligned to National and Local priorities for the Prevention and Control of Infection and which is monitored through reports to Board Infection Control Committee, Quality & Performance Committee and NHS Board. Environmental audit exercise and ongoing monitoring arrangements Implementation of HAI action plan Preparation and follow up to Healthcare Environment Inspectorate visits and independent scrutiny reports Senior infection control doctor and nurse on each directorate clinical governance committee. Monthly reporting from Infection Control Team to clinical governance committees.	3	4	12	2	
Healthcare Acquired Infection	7.2	Medical Director/Infection Control Manager	Decontamination - Where failure to comply with or provide appropriate clinical advice regarding current and development of EU and national regulations	Monitored via the CJD Sub Group and Decontamination Sub Group. Head of Decontamination for NHSGGC sits on both groups.	3	4	12	2	
Healthcare Acquired Infection	7.3	Medical Director/ Infection Control Manager	Requirement to implement national infection control policy which may not be practical or appropriate for NHSGGC	Where appropriate have local addendums. Impact assessment for new national policy SICPs now live. Update Terms of Reference for BICC to reflect approval of policies/addendums and be presented to CGF.	3	4	12	2	
Healthcare Acquired Infection	7.4	[redacted]							

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE		RISK RATING	RISK PRIORITY	FURTHER ACTION REQUIRED
					Likelihood (L)	Consequence (C)	(LxC)		
Healthcare Acquired Infection	7.5	Medical Director/Infection Control Manager	Failure to implement consistent systems and policies in relation to controlling emerging pathogens	A Multi-Drug Resistant Gram Negative Policy in place. Separate polices have been written for VHF etc. and controls are in place.	3	4	12	2	
Health Information & Technology	8.1	[redacted]							
Health Information & Technology	8.2								
	9.1								
ources	9.2								

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Human Res	[redacted]								
Vale of Leven Inquiry	11	CEO	Impact of inquiry findings - there may be far reaching recommendations leading to cost pressures and criticism of staff and management, which undermines confidence in the service and the Board's reputation	Measures already implemented have improved infection control rates throughout the organisation	5	3	15	2	Any additional recommendations will be considered thoroughly and implemented as appropriate. Reputational issues will be managed as they occur.
New SGH	12.1	Project Director	Non-completion by 26th January 2015 - impact on migration, procurement	Monthly monitoring and weekly walkthrough to monitor situation	3	4	12	2	Continue regular monitoring

NHS Greater Glasgow and Clyde
Corporate Risk Register - Jan 2015

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE		RISK RATING	RISK PRIORITY	FURTHER ACTION REQUIRED
					Likelihood (L)	Consequence (C)	(LxC)		
New SGH	12.2	Project Director	Over development of SGH - concurrent activities, disruption to hospital project delivery. Lack of co-ordination of works	Programme, management and methodology	4	4	16	2	Additional PM support. Appropriate procurement plans
New SGH	12.3	Acute Division Directors	Disruption to services during transition to new hospitals. Higher than anticipated costs of move and transition.	Detailed planning process in place	3	4	12	2	Additional PM support. Appropriate procurement plans

NHS Greater Glasgow and Clyde — *Corporate Risk Register*

Risk is the chance of something happening which will cause harm or detriment to the organisation, staff or patients. It is assessed in terms of likelihood of an event occurring and the severity of its impact upon the organisation, staff or patients.

NHS Greater Glasgow and Clyde has adopted, as illustrated below, a scoring system which enables the risks to be prioritised.

Likelihood (L)		Consequence (C)		Risk (LxC)	=	Priority
Almost certain	5	Extreme	5	20 - 25	=	Priority 1: VERY HIGH
Likely	4	Major	4	12 - 19	=	Priority 2: HIGH
Possible	3	Moderate	3	6 - 11	=	Priority 3: MEDIUM
Unlikely	2	Minor	2	1 - 5	=	Priority 4: LOW
Rare	1	Negligible	1			

The Corporate Risk Register comprises those risks that have been assessed as being high or very high.

NHS Greater Glasgow and Clyde — Glossary of Terms

ASD - Acute Services Division

CGIG - Clinical Governance Implementation Group

CHP - Community Health Partnership

CHCP - Community Health & Care Partnership

CIT - Corporate Inequalities Team

CMT - Corporate Management Team

HEAT - Health Improvement, Efficiency, Access, Treatment

LDP - Local Delivery Plan

MAPPA - Multi-Agency Public Protection Arrangements

MMC - Modernising Medical Careers

PCAT - Primary Care Audit Tool

PFPI - Patient Focused Public Involvement

Q&P - Quality and Performance Committee

QIS - Quality Improvement Scotland

RRL - Revenue Resource Limit

RTT - Referral to Treatment

SGHD - Scottish Government Health Directorates

SHC - Scottish Health Council

SIGN - Scottish Intercollegiate Guidelines Network

SMG - Strategic Management Group

SPSP - Scottish Patient Safety Programme

SUM - Safer Use of Medicines

NHS Greater Glasgow and Clyde
Corporate Risk Register - Feb 2015 - Audit Committee

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Acute	1.1	[redacted]							
Acute	1.2	Lead Director / Lead Director for Acute Medical Services / Interim Director of Facilities / Nurse Director	Failure to prevent or establish early detection and control for outbreaks or higher incidence of infection	Environmental audit exercise and ongoing monitoring arrangements Infection control policy, surveillance and reporting system Implementation of HAI action plans Preparation and follow up to HEI visits and independent scrutiny reports	3	4	12	2	
Acute	1.3	ASD Interim Director of Facilities/ ASD Director of Nursing	Non-conformance with guidance on the provision of bed spacing and single room accommodation for inpatients in refurbished projects. This impacts upon the number of beds available in existing wards on completion of refurbishment works, on the nursing workforce models and on appropriate patient selection in bed spaces.	Ongoing engagement and consultation with SGHD on practical application of the guidance. The new Southern General adult hospital is designed with 100% single rooms; the children's hospital with the recommended proportion of single rooms. Directors in the Acute Division have now completed risk assessments in relation to bed spacing in clinical wards which fall below 2.7m.	3	4	12	2	Continue to review year on year
Child Protection	2	[redacted]							

NHS Greater Glasgow and Clyde
Corporate Risk Register - Feb 2015 - Audit Committee

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
CHP/CHCP	3.1	[redacted]							
	3.2								
	3.3								

NHS Greater Glasgow and Clyde
Corporate Risk Register - Feb 2015 - Audit Committee

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Clinical	4.1	[redacted]							
Clinical	4.2	ASD Chief Operating Officer CH(C)P Directors Director of Facilities	Reduction in capital funding and pressure on revenue resources impacts on premises improvements and maintenance programmes, leading to the possibility of non-compliance with applicable legislation and SGHD policies and guidance, and delays implementation of strategic change where capital investment is required.	Implementation of board-wide property management approach, including assessment of premises compliance by applying a standard consistent methodology. Identificaion of priorities for improvment/maintenance by following standard approach, ensuring available resources are targeted at highest priorities. Regular reporting to Acute SMG, CH(C)P Management Teams, Capital Planning Group and Corporate Management Team to inform development of capital plan(s) and revenue budget setting.	3	4	12	2	
Clinical	4.3	[redacted]							

NHS Greater Glasgow and Clyde
Corporate Risk Register - Feb 2015 - Audit Committee

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Integration	5	Interim Chief Officers	Failure to establish joint integration board, scheme of integration.	Some Interim Chief Officers appointed and taking agenda forward	3	4	12	2	The NHS Board has now approved all six JIB's, and all Chief Officers Designate are now in post.
Finance	6	[redacted]							
Finance									
Healthcare Acquired Infection	7.1	Medical Director	Emergence of outbreaks or incidence of infection that are indicative of a failure to ensure that all policies, protocols and procedures to support the effective Prevention and Control of Infection are developed and implemented within NHSGGC.	Annual Infection Control Programme which is aligned to National and Local priorities for the Prevention and Control of Infection and which is monitored through reports to Board Infection Control Committee, Quality & Performance Committee and NHS Board. Environmental audit exercise and ongoing monitoring arrangements Implementation of HAI action plan Preparation and follow up to Healthcare Environment Inspectorate visits and independent scrutiny reports Senior infection control doctor and nurse on each directorate clinical governance committee. Monthly reporting from Infection Control Team to clinical governance committees.	3	4	12	2	

NHS Greater Glasgow and Clyde
Corporate Risk Register - Feb 2015 - Audit Committee

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	CORPORATE LEVEL RISK EXPOSURE Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Healthcare Acquired Infection	7.2	Medical Director/Infection Control Manager	Decontamination - Where failure to comply with or provide appropriate clinical advice regarding current and development of EU and national regulations	Monitored via the CJD Sub Group and Decontamination Sub Group. Head of Decontamination for NHSGGC sits on both groups.	3	4	12	2	
Healthcare Acquired Infection	7.3	Medical Director/ Infection Control Manager	Requirement to implement national infection control policy which may not be practical or appropriate for NHSGGC	Where appropriate have local addendums. Impact assessment for new national policy SICPs now live. Update Terms of Reference for BICC to reflect approval of policies/addendums and be presented to CGF.	3	4	12	2	
Healthcare Acquired Infection	7.4	Medical Director/ Infection Control Manager	Failure to achieve reduction of MRSA/ MSSA bacteraemia to 24 cases per 100,000 occupied bed days.	* In areas with high incidents of MRSA/ MSSA bacteraemia produce action plans to reduce incidence, including use of care bundles. * Continue enhanced surveillance of MRSA/ MSSA. * Quarterly reports which include analysis of the incidents of device associated MRSA/MSSA. * Produce SPCs for MRSA/MSSA in areas with significant prevalence Develop systems to identify actionable issues in relation to “out of hospital” SABs. Develop quality improvement tools for prevention of SABs in Paediatrics. An Acute Directorate SAB steering group is set to convene every two to three months to enable local interventions and progress in reducing SAB acquisition to be shared across all aspects of Acute patient care delivery.	3	4	12	2	
Healthcare Acquired Infection	7.5	Medical Director/Infection Control Manager	Failure to implement consistent systems and policies in relation to controlling emerging pathogens	A Multi-Drug Resistant Gram Negative Policy in place. Separate polices have been written for VHF etc. and controls are in place.	3	4	12	2	

NHS Greater Glasgow and Clyde
Corporate Risk Register - Feb 2015 - Audit Committee

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	CORPORATE LEVEL RISK EXPOSURE Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Health Information & Technology	8.1	[redacted]							
Health Information & Technology	8.2								
	9.1								

NHS Greater Glasgow and Clyde
Corporate Risk Register - Feb 2015 - Audit Committee

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Human Resources	9.2	[redacted]							
	9.3								
	9.4	Director of Workforce	Failure to develop and implement suitable and sufficient HR arrangements and processes related to re-organisation and movement of staff within Acute Services, to new South Glasgow Hospitals.	HR plans developed and updated as required as part of 'on the move' strategy.	3	5	15	2	
	9.5	[redacted]							
Public Health	10.1								
Public Health	10.2								

NHS Greater Glasgow and Clyde
Corporate Risk Register - Feb 2015 - Audit Committee

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	FURTHER ACTION REQUIRED
Vale of Leven Inquiry	11	CEO	**The Scottish Government Health Directorate (SGHD) Implementation Group do not accept NHSGG&C's assessment of their position in relation to the 65 Scottish NHS Board Recommendations from the Vale of Leven Hospital Public Inquiry Report and require additional commitment from the Board to introduce measures which have not been taken account of in setting the allocations for 2015/16.**	**The Medical Director, Nurse Director, Director of Human Resources and Chief Officer – Acute Services drew up NHSHGG&C's position in relation to the 65 Scottish NHS Board Recommendations from the Vale of Leven Hospital Public Inquiry Report. They assessed the recommendations which had already been implemented on were ongoing from the previous reviews in relation to the incidence of C Diff at the Vale of Leven Hospital in 2007 and 2008 and identified the few recommendations which required additional action. Some were identified for further discussions with SGHD to see how compliance would be judged.** **The process included NHS Board Members reviewing NHSGG&C position prior to its submission to SGHD and the Quality & Performance Committee endorsed the NHS Board's response.**	**3**	**4**	**12**	**2**	**Implement the new recommendations and areas identified for ongoing/further work.** **Regular review by the SGHD Implementation Group.**
New SGH	12.1	Project Director	Continued development of SGH site.	Programme, management and methodology	**4**	**4**	**16**	**2**	Additional PM support. Appropriate procurement plans
New SGH	12.2	Acute Division Directors	Disruption to services during transition to new hospitals. Higher than anticipated costs of move and transition.	Detailed planning process in place	**3**	**4**	**12**	**2**	Additional PM support. Appropriate procurement plans
New SGH	12.3								

February 2015 - items deleted from previous Corporate Risk Register

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L)	CORPORATE LEVEL RISK EXPOSURE Consequence (C)	RISK RATING (LxC)	RISK PRIORITY	Reason for removal
Acute	1.4	[redacted]							
New SGH	12.1	Project Director	Non-completion by 26th January 2015 - impact on migration, procurement	Monthly monitoring and weekly walkthrough to monitor situation	3	4	12	2	New hospital handed over on schedule
Human Resources	9.2	[redacted]							

NHS Greater Glasgow and Clyde
Corporate Risk Register - August 2015

Ref	Organisational area	Date raised	Level 1 Category	Level 2 Category	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Impact (I)	Risk rating (LxI)	Risk priority	Risk status	Further action required	Action due date
1.1	Acute				Lead Director and Directors		[redacted]								
1.2	Acute				Lead Director / Lead Director for Acute Medical Services / Interim Director of Facilities / Nurse Director		Failure to prevent or establish early detection and control for outbreaks or higher incidence of infection	Environmental audit exercise and ongoing monitoring arrangements Infection control policy, surveillance and reporting system Implementation of HAI action plans Preparation and follow up to HEI visits and independent scrutiny reports	3	4	12	2			
1.3	Acute				ASD Interim Director of Facilities/ASD Director of Nursing		Non-conformance with guidance on the provision of bed spacing and single room accommodation for inpatients in refurbished projects. This impacts upon the number of beds available in existing wards on completion of refurbishment works, on the nursing workforce models and on appropriate patient selection in bed spaces.	Ongoing engagement and consultation with SGHD on practical application of the guidance. The new Southern General adult hospital is designed with 100% single rooms; the children's hospital with the recommended proportion of single rooms. Directors in the Acute Division have now completed risk assessments in relation to bed spacing in clinical wards which fall below 2.7m.	3	4	12	2		Continue to review year on year	
2	Child Protection				Nurse Director		[redacted]								
3.1	CHP/CHCP/IJB				[redacted]										
3.2	CHP/CHCP/IJB														

NHS Greater Glasgow and Clyde
Corporate Risk Register - August 2015

Ref	Organisational area	Date raised	Level 1 Category	Level 2 Category	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk priority	Risk status	Further action required	Action due date
3.3	CHP/CHCP/IJB				[redacted]										
4.1	Clinical														
4.2	Clinical				ASD Chief Operating Officer CH(C)P Directors Director of Facilities		Reduction in capital funding and pressure on revenue resources impacts on premises improvements and maintenance programmes, leading to the possibility of non-compliance with applicable legislation and SGHD policies and guidance, and delays implementation of strategic change where capital investment is required.	Implementation of board-wide property management approach, including assessment of premises compliance by applying a standard consistent methodology. Identificaion of priorities for improvment/maintenance by following standard approach, ensuring available resources are targeted at highest priorities. Regular reporting to Acute SMG, CH(C)P Management Teams, Capital Planning Group and Corporate Management Team to inform development of capital plan(s) and revenue budget setting.	3	4	12	2			
4.3	Clinical				[redacted]										

NHS Greater Glasgow and Clyde
Corporate Risk Register - August 2015

Ref	Organisational area	Date raised	Level 1 Category	Level 2 Category	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk priority	Risk status	Further action required	Action due date
5	Integration				Interim Chief Officers		Failure to establish joint integration board, scheme of integration.	Some Interim Chief Officers appointed and taking agenda forward	3	4	12	2		The NHS Board has now approved all six JIB's, and all Chief Officers Designate are now in post.	
6	Finance / Finance				[redacted]										
7.1	Healthcare Acquired Infection				Medical Director		Emergence of outbreaks or incidence of infection that are indicative of a failure to ensure that all policies, protocols and procedures to support the effective Prevention and Control of Infection are developed and implemented within NHSGGC.	Annual Infection Control Programme which is aligned to National and Local priorities for the Prevention and Control of Infection and which is monitored through reports to Board Infection Control Committee, Quality & Performance Committee and NHS Board. Environmental audit exercise and ongoing monitoring arrangements Implementation of HAI action plan Preparation and follow up to Healthcare Environment Inspectorate visits and independent scrutiny reports Senior infection control doctor and nurse on each directorate clinical governance committee. Monthly reporting from Infection Control Team to clinical governance committees.	3	4	12	2			
7.2	Healthcare Acquired Infection				Medical Director/Infection Control Manager		Decontamination - Where failure to comply with or provide appropriate clinical advice regarding current and development of EU and national regulations	Monitored via the CJD Sub Group and Decontamination Sub Group. Head of Decontamination for NHSGGC sits on both groups.	3	4	12	2			
7.3	Healthcare Acquired Infection				Medical Director/ Infection Control Manager		Requirement to implement national infection control policy which may not be practical or appropriate for NHSGGC	Where appropriate have local addendums. Impact assessment for new national policy SICPs now live. Update Terms of Reference for BICC to reflect approval of policies/addendums and be presented to CGF.	3	4	12	2			

NHS Greater Glasgow and Clyde
Corporate Risk Register - August 2015

Ref	Organisational area	Date raised	Level 1 Category	Level 2 Category	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk priority	Risk status	Further action required	Action due date
7.4	Healthcare Acquired Infection				[redacted]										
7.5	Healthcare Acquired Infection				Medical Director/Infection Control Manager		Failure to implement consistent systems and policies in relation to controlling emerging pathogens	A Multi-Drug Resistant Gram Negative Policy in place. Separate polices have been written for VHF etc. and controls are in place.	3	4	12	2			
8.1	Health Information & Technology				[redacted]										
8.2	Health Information & Technology														

NHS Greater Glasgow and Clyde
Corporate Risk Register - August 2015

Ref	Organisational area	Date raised	Level 1 Category	Level 2 Category	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk priority	Risk status	Further action required	Action due date
9.1	Human Resources				Medical Director		[redacted]								
9.2					[redacted]										
9.3					Head of Resourcing										
9.4					Director of Workforce		Failure to develop and implement suitable and sufficient HR arrangements and processes related to re-organisation and movement of staff within Acute Services, to new South Glasgow Hospitals.	HR plans developed and updated as required as part of 'on the move' strategy.	3	5	15	2			
9.5					[redacted]										
10.1					[redacted]										
10.2	Public Health				[redacted]										

NHS Greater Glasgow and Clyde
Corporate Risk Register - August 2015

Ref	Organisational area	Date raised	Level 1 Category	Level 2 Category	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Impact (I)	Risk rating (LxI)	Risk priority	Risk status	Further action required	Action due date
11	Vale of Leven Inquiry				CEO		The Scottish Government Health Directorate (SGHD) Implementation Group do not accept NHSGG&C's assessment of their position in relation to the 65 Scottish NHS Board Recommendations from the Vale of Leven Hospital Public Inquiry Report and require additional commitment from the Board to introduce measures which have not been taken account of in setting the allocations for 2015/16.	The Medical Director, Nurse Director, Director of Human Resources and Chief Officer – Acute Services drew up NHSHGG&C's position in relation to the 65 Scottish NHS Board Recommendations from the Vale of Leven Hospital Public Inquiry Report. They assessed the recommendations which had already been implemented on were ongoing from the previous reviews in relation to the incidence of C Diff at the Vale of Leven Hospital in 2007 and 2008 and identified the few recommendations which required additional action. Some were identified for further discussions with SGHD to see how compliance would be judged. The process included NHS Board Members reviewing NHSGG&C position prior to its submission to SGHD and the Quality & Performance Committee endorsed the NHS Board's response.	3	4	12	2		Implement the new recommendations and areas identified for ongoing/further work. Regular review by the SGHD Implementation Group.	
12.1	New SGH				Project Director		Continued development of SGH site.	Programme, management and methodology	4	4	16	2		Additional PM support. Appropriate procurement plans	
12.2	New SGH				Acute Division Directors		Disruption to services during transition to new hospitals. Higher than anticipated costs of move and transition.	Detailed planning process in place	3	4	12	2		Additional PM support. Appropriate procurement plans	
12.3	New SGH				CO Acute Services		Catastrophic event occurs causing inability to use South Glasgow University Hospital.	Revert to use of current facilities if in immediate future.	3	5	15	2		Contingency plans required for any catastrophic event after existing facilities can no longer be used.	

Ref	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Impact (I)	Risk rating (LxI)	Risk priority	Further action required
1.1	Acute	[redacted]								
1.2	Acute									
2	Child Protection									
3.1	IJB									

Ref	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Impact (I)	Risk rating (LxI)	Risk priority	Further action required
3.2	IJB	IJB Chief Officers	Heads of Mental Health	[redacted]						
4.1	Clinical	IJB Chief Officers								
4.2	Clinical	Chief Officers, Director of Facilities		Reduction in capital funding and pressure on revenue resources impacts on premises improvements and maintenance programmes, leading to the possibility of non-compliance with applicable legislation and SGHD policies and guidance, and delays implementation of strategic change where capital investment is required.	Implementation of board-wide property management approach, including assessment of premises compliance by applying a standard consistent methodology. Identificaion of priorities for improvment/maintenance by following standard approach, ensuring available resources are targeted at highest priorities. Regular reporting to Acute SMG, IJB Management Teams, Capital Planning Group and Corporate Management Team to inform development of capital plan(s) and revenue budget setting.	3	4	12	2	

Ref	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk priority	Further action required
4.3	Clinical	Medical Director	Head of PPSU	[redacted]						
4.4	Clinical	Medical Director	Head of PPSU	[redacted]						

Ref	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Impact (I)	Risk rating (LxI)	Risk priority	Further action required
5	Finance	1. Acute services Chief Officer and other Sector/Service Directors 2. Director of Finance		[redacted]						
6.1	Infection Control	Medical Director	Consultant Microbiologist/ Nurse Consultant	Requirement to implement national policy which may not be practical or appropriate for NHSGGC	Where appropriate have local addendums. Impact assessment for new national policy TBP now live. Sub group of BICC to assess the impact on patients and practice.	3	4	12	2	
6.2	Infection Control	Medical Director	Consultant Microbiologist	Failure to implement consistent systems and policies in relation to controls around emerging pathogens.	Multi-Drug Resistant guidance issued by SGHD. However, unable to implement fully due to lack of patient engagement nationally (rectal swabs). With the opening of the QEUH, capacity has been increased to isolate patients. Most of the patients in new QEUH are in single rooms.	3	4	12	2	CPE screening implementation plan to be rolled out to ICUs. Exploring tagging of patients in Trakcare.

Ref	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Impact (I)	Risk rating (LxI)	Risk priority	Further action required
6.3	Infection Control	Medical Director	Infection Control Manager	Failure to achieve reduction of MRSA/ MSSA bacteraemia to 24 cases per 100,000 occupied bed days by 2016. Strong possibility have not met 2016 HEAT Target.	* In areas with high incidents of MRSA/ MSSA bacteraemia produce action plans to reduce incidence, including use of care bundles. * Continue enhanced surveillance of MRSA/ MSSA. * Quarterly reports which include analysis of the incidents of device associated MRSA/MSSA. * Produce SPCs for MRSA/MSSA in areas with significant prevalence. Develop quality improvement tools for prevention of SABs in Paediatrics. IPC Audit Tool will monitor all areas via the new tool.	3	4	12	2	An Acute Directorate SAB steering group to be reformed in light of the new structure. Nominations will be requested from Directors to enable local interventions and progress in reducing SAB acquisition to be shared across all aspects of Acute patient care delivery
7.1	Health Information & Technology	[redacted]								
7.2	Health Information & Technology									

Ref	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk priority	Further action required
7.3	Health Information & Technology	Director of Health Information Technology	[redacted]							
7.4	Health Information & Technology									
7.5	Health Information & Technology									

Ref	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Impact (I)	Risk rating (LxI)	Risk priority	Further action required
8.1	Human Resources	Medical Director		[redacted]						
8.2	Human Resources	[redacted]								
8.3	Human Resources	Director of HR & OD		Failure to develop and implement suitable and sufficient HR arrangements and processes related to re-organisation and movement of staff.	HR plans developed and updated as required.	3	5	15	2	
8.4	Human Resources	[redacted]								
8.5										

Ref	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Impact (I)	Risk rating (LxI)	Risk priority	Further action required
		[redacted]								
9.1	Public Health	Director of Public Health								
9.2	Public Health	Director of Public Health								

Ref	Organisational area	Date raised	Level 1 Category	Level 2 Category	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk level	Risk status	Further action/ comments
1.1	Acute				[redacted]									
1.2	Acute				Chief Officer - Acute Director of Facilities Nurse Director		Failure to prevent or establish early detection and control for outbreaks or higher incidence of infection	Environmental audit exercise and ongoing monitoring arrangements Infection control policy, surveillance and reporting system Implementation of HAI action plans Preparation and follow up to HEI visits and independent scrutiny reports	3	4	12	2		
1.3	Acute				Director of Facilities Director of Nursing		Non-conformance with guidance on the provision of bed spacing and single room accommodation for inpatients in refurbished projects. This impacts upon the number of beds available in existing wards on completion of refurbishment works, on the nursing workforce models and on appropriate patient selection in bed spaces.	Ongoing engagement and consultation with SGHD on practical application of the guidance. Directors in the Acute Division have now completed risk assessments in relation to bed spacing in clinical wards which fall below 2.7m.	3	4	12	2		Continue to review year on year
2	Child Protection				[redacted]									

Ref	Organisational area	Date raised	Level 1 Category	Level 2 Category	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk level	Risk status	Further action/ comments
3.1	[redacted]													
3.2														

Ref	Organisational area	Date raised	Level 1 Category	Level 2 Category	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk level	Risk status	Further action/ comments
3.3	[redacted]													
4.1	Clinical			[redacted]										

Ref	Organisational area	Date raised	Level 1 Category	Level 2 Category	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk level	Risk status	Further action/ comments
4.2	Clinical				Chief Officers - Acute & IJBs Director of Facilities		Reduction in capital funding and pressure on revenue resources impacts on premises improvements and maintenance programmes, leading to the possibility of non-compliance with applicable legislation and SGHD policies and guidance, and delays implementation of strategic change where capital investment is required.	Implementation of board-wide property management approach, including assessment of premises compliance by applying a standard consistent methodology. Identificaion of priorities for improvment/maintenance by following standard approach, ensuring available resources are targeted at highest priorities. Regular reporting to Acute SMG, IJB Management Teams, Capital Planning Group and Corporate Management Team to inform development of capital plan(s) and revenue budget setting.	3	4	12	2		
4.3	Clinical				Medical Director		[redacted]							

Ref	Organisational area	Date raised	Level 1 Category	Level 2 Category	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk level	Risk status	Further action/ comments
5.1	Finance				[redacted]									
5.2	Finance													
5.3	Finance													
5.4	Finance				DoF		Ability to meet cost of ongoing compliance with policy changes, statutory changes and updated guidance issued by SGHD.	Regular finance outturn and performance review led by the CEO and DOF with all budget holders. Ongoing review of development of financial plan by the Whole System Directors' Group and Board; quarterly review and discussion	3	4	12	2		

Ref	Organisational area	Date raised	Level 1 Category	Level 2 Category	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk level	Risk status	Further action/ comments
6.1	Healthcare Acquired Infection				Medical Director		Emergence of outbreaks or incidence of infection that are indicative of a failure to ensure that all policies, protocols and procedures to support the effective Prevention and Control of Infection are developed and implemented within NHSGGC.	Annual Infection Control Programme which is aligned to National and Local priorities for the Prevention and Control of Infection and which is monitored through reports to Board Infection Control Committee, Acute Services Committee and NHS Board. Environmental audit exercise and ongoing monitoring arrangements Implementation of HAI action plan Preparation and follow up to Healthcare Environment Inspectorate visits and independent scrutiny reports Senior infection control doctor and nurse on each directorate clinical governance committee. Monthly reporting from Infection Control Team to clinical governance committees.	3	4	12	2		
6.2	Healthcare Acquired Infection				Medical Director	Infection Control Manager	Decontamination - Where failure to comply with or provide appropriate clinical advice regarding current and development of EU and national regulations	Monitored via the CJD Sub Group and Decontamination Sub Group. Head of Decontamination for NHSGGC sits on both groups.	3	4	12	2		
6.3	Healthcare Acquired Infection				Medical Director	Infection Control Manager	Failure to achieve reduction of MRSA/ MSSA bacteraemia to 24 cases per 100,000 occupied bed days.	* In areas with high incidents of MRSA/ MSSA bacteraemia produce action plans to reduce incidence, including use of care bundles. * Continue enhanced surveillance of MRSA/ MSSA. * Quarterly reports which include analysis of the incidents of device associated MRSA/MSSA. * Produce SPCs for MRSA/MSSA in areas with significant prevalence. Develop systems to identify actionable issues in relation to "out of hospital" SABs. Develop quality improvement tools for prevention of SABs in Paediatrics. An Acute Directorate SAB steering group is set to convene every two to three months to enable local interventions and progress in reducing SAB acquisition to be shared across all aspects of Acute patient care delivery.	3	4	12	2		

Ref	Organisational area	Date raised	Level 1 Category	Level 2 Category	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk level	Risk status	Further action/ comments
6.4	Healthcare Acquired Infection				Medical Director	Infection Control Manager	Failure to implement consistent systems and policies in relation to controlling emerging pathogens	A Multi-Drug Resistant Gram Negative Policy in place. Separate polices have been written for VHF etc. and controls are in place.	3	4	12	2		
7.1	[redacted]													

Ref	Organisational area	Date raised	Level 1 Category	Level 2 Category	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk level	Risk status	Further action/ comments
7.2	Health Information & Technology				Director of Health Information Technology		[redacted]							
8.1	Human Resources				Medical Director									
8.2	Human Resources				Director of HR									

Ref	Organisational area	Date raised	Level 1 Category	Level 2 Category	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk level	Risk status	Further action/ comments
8.3	Human Resources				[redacted]									
8.4	Human Resources													
8.5	Human Resources													
9	Nursing													

Ref	Organisational area	Date raised	Level 1 Category	Level 2 Category	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk level	Risk status	Further action/ comments
10.1	Public Health				Director of Public Health		[redacted]							
10.2	Public Health				Director of Public Health									

Ref	Organisation -al area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Impact (I)	Risk rating (LxI)	Risk level	Further action/ comments
1	Acute	[redacted]								
2	Clinical									
3	Child Protection									
4	Acute/HSCP									
5	HSCP									

Ref	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk level	Further action/ comments
6	Clinical	HSCP Chief Officers	[redacted]							
7	Clinical	Chief Officers, Director of Facilities	Head of Finance for Capital Planning	Reduction in capital funding and pressure on revenue resources impacts on premises improvements and maintenance programmes, leading to the possibility of non-compliance with applicable legislation and SGHD policies and guidance, and delays implementation of strategic change where capital investment is required.	Implementation of board-wide property management approach, including assessment of premises compliance by applying a standard consistent methodology. Identificaion of priorities for improvment/maintenance by following standard approach, ensuring available resources are targeted at highest priorities. Regular reporting to Acute SMG, HSCP Management Teams, Capital Planning Group and Corporate Management Team to inform development of capital plan(s) and revenue budget setting.	4	4	16	2	
8	Clinical	Medical Director	Head of PPSU	Compliance with all applicable clinical standards, protocols and strategies to further improve value for money in prescribing is not achieved and balanced, so that patient medicines are not prescribed, dispensed or administered safely at all times, resulting in adverse events, patient harm and wasted resources.	Uni- and Multi-professional educational preparation and support for clinical staff. Policy, protocols and guidelines or other decision and practice support tools. Clinical and managerial supervision arrangements. Clinical Pharmacy review and pharmaceutical care provision is targeted to high risk patients identified at triage or referred by multidisciplinary team. Monitoring arrangements linked to Area Drugs and Therapeutic Committee and Clinical Governance structures. Ongoing use of pharmacy service redesign and engagement with senior management to extend the integration of clinical pharmacy within multidisciplinary teams. Improve information flow and controls including significant improved deployment of electronic applications. Within the Scottish Patient Safety Programme, enhance strategic commitment and implementation of Safer Use of Medicines Strategy and Actions. Business Continuity plans related to the Pharmacy Distribution Centre at Govan. Prescribing management information and controls relating to PMG in managing medicines expenditure within available resources.	3	4	12	2	Ongoing development and implementation of Board Medicines Strategy. Learning from SPSP pilot sites and spreading reliably tested processes and workstreams to more sites. Improving system and understanding at the interfaces of care.

Ref	Organisation -al area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Impact (I)	Risk rating (LxI)	Risk level	Further action/ comments
9	Clinical	Medical Director	Head of PPSU	[redacted]						
10	Finance	[redacted]								
11	Finance									
12	Finance									
13	Finance	DoF		Ability to meet cost of ongoing compliance with policy changes, statutory changes and updated guidance issued by SGHD.	Regular finance outturn and performance review led by the CEO and DOF with all budget holders. Ongoing review of development of financial plan by the Whole System Directors' Group and Board; quarterly review and discussion	4	4	16	2	
14	Healthcare Acquired Infection	Medical Director	Infection Control Manager	Failure to implement consistent systems and policies in relation to controlling emerging pathogens	Multi-Drug Resistant guidance issued by SGHD. However, unable to implement fully due to lack of patient engagement nationally (rectal swabs). With the opening of the QEUH, capacity has been increased to isolate patients. Most of the patients in QEUH are in single rooms.	3	4	12	2	

Ref	Organisation -al area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Impact (I)	Risk rating (LxI)	Risk level	Further action/ comments
15	Healthcare Acquired Infection	Medical Director	Infection Control Manager	Failure to achieve reduction of MRSA/ MSSA/C-Diff bacteraemia to 24 cases per 100,000 occupied bed days by 2016.	* In areas with high incidents of MRSA/ MSSA bacteraemia produce action plans to reduce incidence, including use of care bundles. * Continue enhanced surveillance of MRSA/ MSSA. * Quarterly reports which include analysis of the incidents of device associated MRSA/MSSA. * Produce SPCs for MRSA/MSSA in areas with significant prevalence. Develop systems to identify actionable issues in relation to "out of hospital" SABs. Develop quality improvement tools for prevention of SABs in Paediatrics. An Acute Directorate SAB steering group is set to convene every two to three months to enable local interventions and progress in reducing SAB acquisition to be shared across all aspects of Acute patient care delivery.	3	4	12	2	
16	Organisational	[redacted]								
17	Health Information & Technology	Director of Health Information Technology		[redacted]						

Ref	Organisation-al area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk level	Further action/ comments
18	Organisational	[redacted]								
19	Organisational									
20	Human Resources	Medical Director								
21	Human Resources	Head of Resourcing								

Ref	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure		Risk rating	Risk level	Further action/ comments
						Likelihood (L)	Impact (I)	(LxI)		
22	Organisational	Director of HR & OD	[redacted]							
23	Human Resources	Director of HR								
24	Organisational	Nurse Director								
25	Organisational	Director of HR & OD								
26	Nursing	[redacted]								

Ref	Organisation-al area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk level	Further action/ comments
27	Public Health	Director of Public Health		[redacted]						
28	Public Health	Director of Public Health								

Items deleted from previous Corporate Risk Register

Ref	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Impact (I)	Risk rating (LxI)	Revised Risk level	Further action/ comments
6.1	Healthcare Acquired Infection	Medical Director	Consultant Microbiologist/ Nurse Consultant	Requirement to implement national policies for infection control/decontamination which may not be practical or appropriate for NHSGGC	Where appropriate have local addendums. Impact assessment for new national policy Transmission Based Precautions now live. Sub group of Board Infection Control Committee to assess the impact on patients and practice. Decontamination Sub Group meets.	2	4	8	3	**RATING NOW REDUCED FROM 3/4**
7.4	Organisational	Director of Health Information Technology	Director of Health Information Technology	[redacted]						

Ref	Organisation-al area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk level	Further action/ comments
1	Acute	[redacted]								
2	Clinical	Acute Services Chief Officer	Sector Directors							
3	[redacted]									
4	Acute/HSCP	[redacted]								
5	HSCP									

Ref	Organisation -al area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk level	Further action/ comments
6	Clinical	HSCP Chief Officers		[redacted]						
7	Clinical	Chief Officers, Director of Facilities	Head of Finance for Capital Planning	Reduction in capital funding and pressure on revenue resources impacts on premises improvements and maintenance programmes, leading to the possibility of non-compliance with applicable legislation and SGHD policies and guidance, and delays implementation of strategic change where capital investment is required.	Implementation of board-wide property management approach, including assessment of premises compliance by applying a standard consistent methodology. Identificaion of priorities for improvment/maintenance by following standard approach, ensuring available resources are targeted at highest priorities. Regular reporting to Acute SMG, HSCP Management Teams, Capital Planning Group and Corporate Management Team to inform development of capital plan(s) and revenue budget setting.	4	4	16	2	
8	[redacted]									

Ref	Organisation-al area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk level	Further action/ comments
9	Clinical	[redacted]								
10	[redacted]									
11	Finance	[redacted]								
12	Finance	[redacted]								
13	Finance									
14	Healthcare Acquired Infection	Medical Director	Infection Control Manager	Failure to implement consistent systems and policies in relation to controlling emerging pathogens	Multi-Drug Resistant guidance issued by SGHD. However, unable to implement fully due to lack of patient engagement nationally (rectal swabs). With the opening of the QEUH, capacity has been increased to isolate patients. Most of the patients in QEUH are in single rooms.	3	4	12	2	

Ref	Organisation -al area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk level	Further action/ comments
15	Healthcare Acquired Infection	Medical Director	Infection Control Manager	Failure to achieve reduction of MRSA/ MSSA/C-Diff bacteraemia to 24 cases per 100,000 occupied bed days by 2016.	* In areas with high incidents of MRSA/ MSSA bacteraemia produce action plans to reduce incidence, including use of care bundles. * Continue enhanced surveillance of MRSA/ MSSA. * Quarterly reports which include analysis of the incidents of device associated MRSA/MSSA. * Produce SPCs for MRSA/MSSA in areas with significant prevalence. Develop systems to identify actionable issues in relation to "out of hospital" SABs. Develop quality improvement tools for prevention of SABs in Paediatrics. An Acute Directorate SAB steering group is set to convene every two to three months to enable local interventions and progress in reducing SAB acquisition to be shared across all aspects of Acute patient care delivery.	3	4	12	2	
16	[redacted]									
17	Health Information & Technology	Director of Health Information Technology		[redacted]						

Ref	Organisation-al area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk level	Further action/ comments
18	Organisational	Director of Health Information Technology	[redacted]							
19	Organisational	Director of Health Information Technology								
20	Human Resources	Medical Director								
21	Human Resources	Head of Resourcing								

Ref	Organisation-al area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk level	Further action/ comments
22	Organisational	Director of HR & OD	[redacted]							
23	Human Resources	Director of HR								
24	Organisational	Nurse Director								
25	Organisational	Director of HR & OD								
26	Nursing	[redacted]								

Ref	Organisation -al area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Corporate level risk exposure Impact (I)	Risk rating (LxI)	Risk level	Further action/ comments
27	Public Health	Director of Public Health		[redacted]						
28	Public Health	Director of Public Health								

Items deleted from previous Corporate Risk Register

Ref	Organisation-al area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate level risk exposure Likelihood (L)	Impact (I)	Risk rating (LxI)	Revised Risk level	Further action/ comments
6.1	Healthcare Acquired Infection	Medical Director	Consultant Microbiologist/ Nurse Consultant	Requirement to implement national policies for infection control/decontamination which may not be practical or appropriate for NHSGGC	Where appropriate have local addendums. Impact assessment for new national policy Transmission Based Precautions now live. Sub group of Board Infection Control Committee to assess the impact on patients and practice. Decontamination Sub Group meets.	2	4	8	3	**RATING NOW REDUCED FROM 3/4**
7.4	Organisational	[redacted]								

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NHS Greater Glasgow and Clyde
Risk Management Steering Group

Tuesday 9 August 2016

Risk Registers

The Corporate Risk Registers is attached.

The Corporate Risk Register shows the risks that were previously identified, but has not yet been updated based on the latest local risk registers.

The RMSG is asked to scrutinise the register and consider any updates that might be necessary to the Corporate Risk Register

CRR Ref	Dir Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Directorate level risk exposure Likelihood (L)	Directorate level risk exposure Impact (I)	Corporate Risk Register level risk Likelihood (L)	Corporate Risk Register level risk Impact (I)	CRR Risk rating (LxI)	CRR Risk level	Further action/ comments
CRR1	AS6	Acute	Operational	[redacted]										
CRR2	AS8	Acute	Clinical											
CRR3	AS5	Acute/ HSCPs	Operational											
CRR4	AS10	Acute/ HSCPs	Operational/ Financial	Chief Officers, Director of Facilities & Capital Planning	Director of Facilities & Capital Planning	Capital funding Reduction in Capital funding and pressure on revenue resources impacts on premises improvements and maintenance programmes, leading to the possibility of non compliance with applicable legislation and SGHD policies and guidance, and delays in implementation of strategic change where capital investment is required.	Implementation of Division wide property management approach including assessment of premises compliance with standard consistent methodologies. Regular reports to SMG / OMG on deployment of capital resources and investment priorities.	*3*	*4*	**4**	**4**	**16**	**2**	

CRR Ref	Dir Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Directorate level risk exposure		Corporate Risk Register level risk		CRR Risk rating	CRR Risk level	Further action/ comments
								Likelihood (L)	Impact (I)	Likelihood (L)	Impact (I)	(LxI)		
CRR5	NURS1 INV6 REN6 GLA7	Nursing/ HSCPs	Child Protection	[redacted]										
CRR6	NURS2 INV5 ED2 REN6 GLA8	Nursing/ HSCPs	Adult Protection											

CRR Ref	Dir Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Directorate level risk exposure		Corporate Risk Register level risk		CRR Risk rating	CRR Risk level	Further action/ comments
								Likelihood (L)	Impact (I)	Likelihood (L)	Impact (I)	(LxI)		
[redacted]														

CRR Ref	Dir Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Directorate level risk exposure		Corporate Risk Register level risk		CRR Risk rating	CRR Risk level	Further action/ comments
								Likelihood (L)	Impact (I)	Likelihood (L)	Impact (I)	(LxI)		
CRR10	FIN1 AS1 INV1 ED8 GLA2 WD3 ER2 REN11	[redacted]												
CRR11	FIN2													
CRR12	FIN3													
CRR13	FIN4	Finance	Finance	DoF		Ability to meet cost of ongoing compliance with policy changes, statutory changes and updated guidance issued by SGHD.	Regular finance outturn and performance review led by the CEO and DOF with all budget holders. Ongoing review of development of financial plan by the Whole System Directors' Group and Board; quarterly review and discussion	*4*	*4*	**4**	**4**	**16**	**2**	
CRR14	IC1	Medical	Infection Control	Medical Director	Infection Control Manager	Failure to implement consistent systems and policies in relation to control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE, VHF and MERS	*3*	*4*	**3**	**4**	**12**	**2**	

CRR Ref	Dir Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Directorate level risk exposure		Corporate Risk Register level risk		CRR Risk rating	CRR Risk level	Further action/ comments
								Likelihood (L)	Impact (I)	Likelihood (L)	Impact (I)	(LxI)		
CRR15	IC2	Medical	Infection Control	Medical Director	Infection Control Manager	Failure to achieve reduction of MRSA/ MSSA/C-Diff bacteraemia to 24 cases per 100,000 occupied bed days by 2016.	* In areas with high incidents of MRSA/ MSSA bacteraemia produce action plans to reduce incidence, including use of care bundles. * Continue enhanced surveillance of MRSA/ MSSA. * Quarterly reports which include analysis of the incidents of device associated MRSA/MSSA. * Produce SPCs for MRSA/MSSA in areas with significant prevalence. Develop systems to identify actionable issues in relation to "out of hospital" SABs. Develop quality improvement tools for prevention of SABs in Paediatrics. An Acute Directorate SAB steering group is set to convene every two to three months to enable local interventions and progress in reducing SAB acquisition to be shared across all aspects of Acute patient care delivery.	*4*	*4*	**3**	**4**	**12**	**2**	

[redacted]

CRR Ref	Dir Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Directorate level risk exposure		Corporate Risk Register level risk		CRR Risk rating	CRR Risk level	Further action/ comments
								Likelihood (L)	Impact (I)	Likelihood (L)	Impact (I)	(LxI)		

[redacted]

CRR Ref	Dir Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Directorate level risk exposure Likelihood (L)	Directorate level risk exposure Impact (I)	Corporate Risk Register level risk Likelihood (L)	Corporate Risk Register level risk Impact (I)	CRR Risk rating (LxI)	CRR Risk level	Further action/ comments
CRR19	EH5	[redacted]												
CRR20	HR1													
CRR21	HR3													
CRR22		Human Resources	Organisational	Director of HR &OD	Director of HR&OD	Failure to develop and implement suitable and sufficient HR arrangements and processes related to re-organisation and movement of staff.	HR plans developed and updated as required.	*No longer on HR register*		**3**	**5**	**15**	**2**	
[redacted]														

CRR Ref	Dir Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Directorate level risk exposure		Corporate Risk Register level risk		CRR Risk rating	CRR Risk level	Further action/ comments
								Likelihood (L)	Impact (I)	Likelihood (L)	Impact (I)	(LxI)		
CRR24	HR7	[redacted]												
CRR25	NURS1 GLA24 HR6													

CRR Ref	Dir Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Directorate level risk exposure		Corporate Risk Register level risk		CRR Risk rating	CRR Risk level	Further action/ comments
								Likelihood (L)	Impact (I)	Likelihood (L)	Impact (I)	(LxI)		
[redacted]														

CRR Ref	Dir Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Directorate level risk exposure		Corporate Risk Register level risk		CRR Risk rating	CRR Risk level	Further action/ comments
								Likelihood (L)	Impact (I)	Likelihood (L)	Impact (I)	(LxI)		
[redacted]														

CRR Ref	X-Ref to Directorate Register	Directorate/ Partnership Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate Risk Register level risk Likelihood (L)	Corporate Risk Register level risk Impact (I)	CRR Risk rating (LxI)	CRR Risk level	Further action/ comments
CRR1	AS6	[redacted]									
CRR2	AS8										
CRR3	AS5										

CRR Ref	X-Ref to Directorate Register	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate Risk Register level risk Likelihood (L)	Corporate Risk Register level risk Impact (I)	CRR Risk rating (LxI)	CRR Risk level	Further action/ comments
CRR4	AS10	Acute/ HSCPs	Operational/ Financial	Chief Officers, Director of Facilities & Capital Planning	Director of Facilities & Capital Planning	Capital funding Reduction in Capital funding and pressure on revenue resources impacts on premises improvements and maintenance programmes, leading to the possibility of non compliance with applicable legislation and SGHD policies and guidance, and delays in implementation of strategic change where capital investment is required.	Implementation of Division wide property management approach including assessment of premises compliance with standard consistent methodologies. Regular reports to SMG / OMG on deployment of capital resources and investment priorities. Property asset management strategy in place.	4	4	16	2	**Further action** **Comments**
CRR5	NURS1 INV6 REN6 GLA7	[redacted]										

CRR Ref	X-Ref to Directorate Register	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate Risk Register level risk		CRR Risk rating	CRR Risk level	Further action/ comments
								Likelihood (L)	Impact (I)	(LxI)		
CRR7	RMSG1	[redacted]										
CRR8	PPSU											

CRR Ref	X-Ref to Directorate Register	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate Risk Register level risk		CRR Risk rating	CRR Risk level	Further action/ comments
								Likelihood (L)	Impact (I)	(LxI)		
[redacted]												

CRR Ref	X-Ref to Directorate Register	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate Risk Register level risk Likelihood (L)	Corporate Risk Register level risk Impact (I)	CRR Risk rating (LxI)	CRR Risk level	Further action/ comments
CRR12	FIN3	[redacted]										
CRR14	IC1	Medical	Infection Control	Medical Director	Infection Control Manager	Failure to implement consistent systems and policies in relation to control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE, VHF and MERS. Reports to Board/ASC.	3	4	12	2	**Further action** **Comments**

CRR Ref	X-Ref to Directorate Register	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate Risk Register level risk Likelihood (L)	Corporate Risk Register level risk Impact (I)	CRR Risk rating (LxI)	CRR Risk level	Further action/ comments
CRR15	IC2	Medical	Infection Control	Medical Director	Infection Control Manager	Failure to achieve reduction of MRSA/ MSSA/C-Diff bacteraemia to 24 cases per 100,000 occupied bed days by 2016.	* In areas with high incidents of MRSA/ MSSA bacteraemia produce action plans to reduce incidence, including use of care bundles. * Continue enhanced surveillance of MRSA/ MSSA. * Quarterly reports which include analysis of the incidents of device associated MRSA/MSSA. * Produce SPCs for MRSA/MSSA in areas with significant prevalence. Develop systems to identify actionable issues in relation to "out of hospital" SABs. Develop quality improvement tools for prevention of SABs in Paediatrics. An Acute Directorate SAB steering group is set to convene every two to three months to enable local interventions and progress in reducing SAB acquisition to be shared across all aspects of Acute patient care delivery. Reports to Board/ASC.	3	4	12	2	**Further action** **Comments**
CRR16	EH1	[redacted]										

CRR Ref	X-Ref to Directorate Register	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate Risk Register level risk		CRR Risk rating	CRR Risk level	Further action/ comments
								Likelihood (L)	Impact (I)	(LxI)		
CRR17	EH3	[redacted]										

CRR Ref	X-Ref to Directorate Register	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate Risk Register level risk		CRR Risk rating	CRR Risk level	Further action/ comments
								Likelihood (L)	Impact (I)	(LxI)		
CRR19	EH5	[redacted]										
CRR20	HR1											
CRR21	HR3											
CRR23	HR4											

CRR Ref	X-Ref to Directorate Register	Directorate/ Partnership	rganisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate Risk Register level risk		CRR Risk rating	CRR Risk level	Further action/ comments
								Likelihood (L)	Impact (I)	(LxI)		
CRR24	HR7	[redacted]										
CRR25	NURS1 GLA24 HR6											
CRR26	NURS3											

CRR Ref	X-Ref to Directorate Register	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate Risk Register level risk Likelihood (L)	Corporate Risk Register level risk Impact (I)	CRR Risk rating (LxI)	CRR Risk level	Further action/ comments
CRR27	PH1 ED7	[redacted]										f s
CRR28	PH2											
[redacted]												

CRR Ref	X-Ref to Directorate Register	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate Risk Register level risk Likelihood (L) Impact (I)	CRR Risk rating (LxI)	CRR Risk level	Further action/ comments
CRR1	AS6	[redacted]									
CRR2	AS8										
CRR3	AS5										

CRR Ref	X-Ref to Directorate Register	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate Risk Register level risk Likelihood (L)	Corporate Risk Register level risk Impact (I)	CRR Risk rating (LxI)	CRR Risk level	Further action/ comments
CRR4	AS10	Acute/ HSCPs	Operational/ Financial	Chief Officers, Director of Facilities & Capital Planning	Director of Facilities & Capital Planning	Capital funding Reduction in Capital funding and pressure on revenue resources impacts on premises improvements and maintenance programmes, leading to the possibility of non compliance with applicable Health and Safety legislation and SGHD policies and guidance, and delays in implementation of strategic change where capital investment is required.	Implementation of Division wide property management approach including assessment of premises compliance with standard consistent methodologies. Regular reports to SMG / OMG on deployment of capital resources and investment priorities. Property asset management strategy in place.	4	4	16	2	**Further action** **Comments**
[redacted]												

CRR Ref	X-Ref to Directorate Register	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate Risk Register level risk Likelihood (L) Impact (I)	CRR Risk rating (LxI)	CRR Risk level	Further action/ comments
[redacted]											

CRR Ref	X-Ref to Directorate Register	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate Risk Register level risk Likelihood (L)	Corporate Risk Register level risk Impact (I)	CRR Risk rating (LxI)	CRR Risk level	Further action/ comments
CRR10	FIN1	[redacted]										
CRR11	FIN2											
CRR12	FIN3											
CRR14	IC1	Medical	Infection Control	Medical Director	Infection Control Manager	Failure to implement consistent systems and policies in relation to control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE, VHF and MERS. Reports to Board/ASC.	3	4	12	2	**Further action** **Comments**

CRR Ref	X-Ref to Directorate Register	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate Risk Register level risk Likelihood (L)	Corporate Risk Register level risk Impact (I)	CRR Risk rating (LxI)	CRR Risk level	Further action/ comments
CRR15	IC2	Medical	Infection Control	Medical Director	Infection Control Manager	Failure to achieve reduction of MRSA/ MSSA/C-Diff bacteraemia to 24 cases per 100,000 occupied bed days by 2016.	* In areas with high incidents of MRSA/ MSSA bacteraemia produce action plans to reduce incidence, including use of care bundles. * Continue enhanced surveillance of MRSA/ MSSA. * Quarterly reports which include analysis of the incidents of device associated MRSA/MSSA. * Produce SPCs for MRSA/MSSA in areas with significant prevalence. Develop systems to identify actionable issues in relation to "out of hospital" SABs. Develop quality improvement tools for prevention of SABs in Paediatrics. An Acute Directorate SAB steering group is set to convene every two to three months to enable local interventions and progress in reducing SAB acquisition to be shared across all aspects of Acute patient care delivery. Reports to Board/ASC.	**3**	**4**	**12**	**2**	**Further action** **Comments**
CRR17	EH3	[redacted]										

CRR Ref	X-Ref to Directorate Register	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate Risk Register level risk Likelihood (L) Impact (I)	CRR Risk rating (LxI)	CRR Risk level	Further action/ comments
CRR20	HR1	[redacted]									
CRR21	HR3										
CRR24	HR7										

CRR Ref	X-Ref to Directorate Register	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate Risk Register level risk Likelihood (L)	Corporate Risk Register level risk Impact (I)	CRR Risk rating (LxI)	CRR Risk level	Further action/ comments
CRR25	NURS10 GLA24 HR6	[redacted]										
CRR26	NURS3											

CRR Ref	X-Ref to Directorate Register	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate Risk Register level risk Likelihood (L)	Corporate Risk Register level risk Impact (I)	CRR Risk rating (LxI)	CRR Risk level	Further action/ comments
CRR27	PH1 ED7	[redacted]										
CRR28	PH2											

CRR Ref	X-Ref to Directorate Register	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Description of risk	Controls in place	Corporate Risk Register level risk Likelihood (L) Impact (I)	CRR Risk rating (LxI)	CRR Risk level	Further action/ comments
[redacted]											

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Date Risk Identified	Risk type	Description of risk	Controls in place	Corporate Risk Register level risk Likelihood (L)	Corporate Risk Register level risk Impact (I)	CRR Risk rating (LxI)	CRR Risk level	Change in risk rating	Treat/ Tolerate/ Transfer/ Terminate	Further action/ comments
CR/0801	Acute	[redacted]													
CR/0802	[redacted]														
CR/0804	Acute / HSCPs	Operational/ Financial	Chief Officers, Director of Facilities & Capital Planning	Director of Facilities & Capital Planning	2008	Strategic	Reduction in Capital funding and pressure on revenue resources impacts on backlog maintenance and Health and Safety obligation leading to the possibility of non compliance with applicable Health and Safety legislation and SGHD policies and guidance.	Implementation of Division wide property management approach including assessment of premises compliance with standard consistent methodologies. Regular reports to SMG / OMG on deployment of capital resources and investment priorities. Property asset management strategy in place.	**4**	**4**	**16**	**2**	No change	**Tolerate**	**Further action** **Comments**

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Date Risk Identified	Risk type	Description of risk	Controls in place	Corporate Risk Register level risk Likelihood (L)	Corporate Risk Register level risk Impact (I)	CRR Risk rating (LxI)	CRR Risk level	Change in risk rating	Treat/ Tolerate/ Transfer/ Terminate	Further action/ comments
CR/0805	[redacted]														
CR/0806															
CR/0807															
CR/1501															

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Date Risk Identified	Risk type	Description of risk	Controls in place	Corporate Risk Register level risk Likelihood (L)	Corporate Risk Register level risk Impact (I)	CRR Risk rating (LxI)	CRR Risk level	Change in risk rating	Treat/ Tolerate/ Transfer/ Terminate	Further action/ comments
CR/1502	[redacted]														

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
CR/0801	Acute	Operational	[redacted]						
CR/0802	Acute	Clinical							

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
CR/0803	[redacted]								
CR/0804	Acute/ HSCPs	Operational/ Financial	Chief Officers, Director of Facilities & Capital Planning	Director of Facilities & Capital Planning	Strategic	Reduction in Capital funding and pressure on revenue resources impacts on backlog maintenance and Health and Safety obligation leading to the possibility of non compliance with applicable Health and Safety legislation and SGHD policies and guidance.	***Inherent Risk*** *Likelihood* / *Impact* / *Score* Implementation of Division wide property management approach including assessment of premises compliance with standard consistent methodologies. Regular reports to SMG / OMG on deployment of capital resources and investment priorities. Property asset management strategy in place.	***Residual Risk*** *Likelihood* ***4*** / *Impact* ***4*** / *Score* ***16***	
CR/0805	[redacted]								

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
							[redacted]		
CR/0806	[redacted]								
CR/0807									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
I							[redacted]		

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
[redacted]									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
[redacted]									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
CR/1701	[redacted]								

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
OP/0801	[redacted]								
OP/0802									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
OP/0803	[redacted]								

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
OP/0804	[redacted]								

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
OP/0805	[redacted]								
OP/0806									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
OP/1001	Medical	Infection Control	Medical Director	Infection Control Manager	Operational	Failure to implement consistent systems and policies in relation to control.	***Inherent Risk*** *Likelihood* *Impact* *Score* Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE, VHF and MERS. Reports to Board/ASC.	***Residual Risk*** *Likelihood* *Impact* *Score* ***3*** ***4*** ***12***	
OP/1002	Medical	Infection Control	Medical Director	Infection Control Manager	Operational	Failure to achieve reduction of MRSA/ MSSA/C-Diff bacteraemia to 24 cases per 100,000 occupied bed days by 2016.	***Inherent Risk*** *Likelihood* *Impact* *Score* * In areas with high incidents of MRSA/ MSSA bacteraemia produce action plans to reduce incidence, including use of care bundles. * Continue enhanced surveillance of MRSA/ MSSA. * Quarterly reports which include analysis of the incidents of device associated MRSA/MSSA. * Produce SPCs for MRSA/MSSA in areas with significant prevalence. Develop systems to identify actionable issues in relation to "out of hospital" SABs. Develop quality improvement tools for prevention of SABs in Paediatrics. An Acute Directorate SAB steering group is set to convene every two to three months to enable local interventions and progress in reducing SAB acquisition to be shared across all aspects of Acute patient care delivery. Reports to Board/ASC.	***Residual Risk*** *Likelihood* *Impact* *Score* ***3*** ***4*** ***12***	

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
OP/1101	[redacted]								
OP/1401									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
OP/1402	[redacted]								
OP/1501									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
OP/1502	[redacted]								
OP/1601	eHealth	Infrastructure	Director of eHealth/ Director of Property, Procurement & Facilities Management/ Director of Diagnostics		Operational	Node 12 at the QEUH in the retained estate and contains Telephone services for the Maternity and New Labs buildings and VOIP for the estate. This Node in IT Terms provides services into Southern Management Building and Podiatry for and also at the rear of the area are the PACS Servers for the Adult Services for that Campus. Due to Building works that neither Telecoms, eHealth or Diagnostics were aware of, the security and water / weather tightness of the Node is now in question, meaning that this area is vulnerable to Vandalism / Theft or loss of service due to water ingress or dampness in the electronics.	***Inherent Risk*** *Likelihood* *Impact* *Score* Telecomms, IT and PACS have reviewed the area and we have sent concerns to Property, Procurement & Facilities Management. There are no other immediate measures that can be put in place. Property, Procurement & Facilities Management have re-visited the area and are looking to make the area more secure with security barriers and look at reducing likelihood of water / damp ingress to the area.	***Residual Risk*** *Likelihood* *Impact* *Score* ***3*** ***4*** ***12*** Property, Procurement & Facilities Management are taking steps to progress the final repairs which are tied into the facia repair of the building due to Building status with planning etc and are to keep Calum Morison up to date with dates and progress (currently outstanding end of Nov)	

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of risk	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review committee
CR/0801	[redacted]								
CR/0802									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of risk	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review committee
[redacted]									
CR/0804	Acute/ HSCPs	Operational/ Financial	Chief Officers, Director of Facilities & Capital Planning	Director of Facilities & Capital Planning	Strategic	Reduction in Capital funding and pressure on revenue resources impacts on backlog maintenance and Health and Safety obligation leading to the possibility of non compliance with applicable Health and Safety legislation and SGHD policies and guidance. *Inherent risk (before mitigating controls)* *Likelihood* 5 *Impact* 4 *Score* 20	Implementation of Division wide property management approach including assessment of premises compliance with standard consistent methodologies. Regular reports to SMG / OMG on deployment of capital resources and investment priorities. Property asset management strategy in place. *Residual risk (after mitigating controls)* *Likelihood* 4 *Impact* 4 *Score* 16		**Finance & Planning Committee**
[redacted]									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of risk	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review committee
CR/0806	[redacted]								

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of risk	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review committee
CR/1501	[redacted]								
CR/1502									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of risk	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review committee
[redacted]									

Ref	Directorate/ Partnership	rganisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of risk	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review committee
[redacted]									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
OP/0801	[redacted]								
OP/0802									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
OP/0803	[redacted]								

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
[redacted]									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
[redacted]									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
OP/1001	Medical	Infection Control	Medical Director	Infection Control Manager	Operational	Failure to implement consistent systems and policies in relation to control.	***Inherent Risk*** ***Likelihood*** ***Impact*** ***Score*** ***4*** ***4*** ***16*** Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE, VHF and MERS. Reports to Board/ASC.	***Residual Risk*** ***Likelihood*** ***Impact*** ***Score*** ***3*** ***4*** ***12***	
OP/1002	Medical	Infection Control	Medical Director	Infection Control Manager	Operational	Failure to achieve reduction of MRSA/ MSSA/C-Diff bacteraemia to 24 cases per 100,000 occupied bed days by 2016.	***Inherent Risk*** ***Likelihood*** ***Impact*** ***Score*** ***4*** ***4*** ***16*** * In areas with high incidents of MRSA/ MSSA bacteraemia produce action plans to reduce incidence, including use of care bundles. * Continue enhanced surveillance of MRSA/ MSSA. * Quarterly reports which include analysis of the incidents of device associated MRSA/MSSA. * Produce SPCs for MRSA/MSSA in areas with significant prevalence. Develop systems to identify actionable issues in relation to "out of hospital" SABs. Develop quality improvement tools for prevention of SABs in Paediatrics. An Acute Directorate SAB steering group is set to convene every two to three months to enable local interventions and progress in reducing SAB acquisition to be shared across all aspects of Acute patient care delivery. Reports to Board/ASC.	***Residual Risk*** ***Likelihood*** ***Impact*** ***Score*** ***3*** ***4*** ***12***	

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
[redacted]									
OP/1401	[redacted]								

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
[redacted]									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
		O					[redacted]		

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Controls in place	Further mitigating action to reduce, eliminate or transfer risk	Governance/ review Committee
OP/1601	eHealth	Infrastructure	Director of eHealth/ Director of Property, Procurement & Facilities Management/ Director of Diagnostics		Operational	Node 12 at the QEUH in the retained estate and contains Telephone services for the Maternity and New Labs buildings and VOIP for the estate. This Node in IT Terms provides services into Southern Management Building and Podiatry for and also at the rear of the area are the PACS Servers for the Adult Services for that Campus. Due to Building works that neither Telecoms, eHealth or Diagnostics were aware of, the security and water / weather tightness of the Node is now in question, meaning that this area is vulnerable to Vandalism / Theft or loss of service due to water ingress or dampness in the electronics.	***Inherent Risk*** ***Likelihood*** ***4*** ***Impact*** ***4*** ***Score*** ***16*** Telecomms, IT and PACS have reviewed the area and we have sent concerns to Property, Procurement & Facilities Management. There are no other immediate measures that can be put in place. Property, Procurement & Facilities Management have re-visited the area and are looking to make the area more secure with security barriers and look at reducing likelihood of water / damp ingress to the area.	***Residual Risk*** ***Likelihood*** ***3*** ***Impact*** ***4*** ***Score*** ***12*** Property, Procurement & Facilities Management are taking steps to progress the final repairs which are tied into the facia repair of the building due to Building status with planning etc and are to keep Calum Morison up to date with dates and progress (currently outstanding end of Nov)	

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
CR/0801	[redacted]								
CR/0802									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
CR/0803	[redacted]								
CR/0804	Acute/ HSCPs	Operational/ Financial	Chief Officers, Director of Facilities & Capital Planning	Director of Facilities & Capital Planning	Strategic	Expected reduction in capital funding and pressure on revenue resources impacts on backlog maintenance and Health and Safety obligations leading to the possibility of non compliance with applicable Health and Safety legislation and SGHD policies and guidance. *Inherent risk (before mitigating controls)* *Likelihood* 5 *Impact* 4 *Score* 20	Implementation of Board wide property management approach including assessment of premises compliance with standard consistent methodologies. Regular reports to CPG/SMG / OMG on deployment of capital resources and investment priorities. Investment Priorities are based on PAMS data. Property asset management strategy in place. *Residual risk (after mitigating controls)* *Likelihood* 4 *Impact* 4 *Score* 16	Consideration should be given to an annual recurrent revenue budget for statutory compliance works in addition to the capital budget.	**Finance & Planning Committee**

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
CR/0805	[redacted]								
CR/0806									
CR/0806									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
CR/1502	[redacted]								

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Ref	Directorate/ Partnership	rganisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
CR/1702	Property, Procurement and Facilities Management	Fire safety	Director of PPFM	Director of PPFM	Operational	The probabibility of Queen Elizabeth University Hospital being at high risk due to the incorpration of Aluminium Composite Materials (ACMs) similar but not the same to those used in Grenfell Tower, leading to an increased likelihood of a fire ocurring.	The QEUH has been designed and engineered to meet Building and Fire Safety Regulations. Health Facilities Scotland and their National Fire Advisor have given assurances that the hospital is an extremely safe building. Firm assurances have also been given by the main contractor and their design team and the Board's technical advisers that the regulatory process has been followed and that the appropriate Building Standards Completion Certificates are in place. As a precautionary measure, and to make sure the public, patients and staff have full confidence in the safety of the QEUH, the NHS Board officers took the decision to remove the panels from the three external sections of the hospital where these panels are located. Officers worked with contractors and technical advisers in assessing how to proceed this work at the earliest possible opportunity.	It has been decided that the ACM panels are to be removed and replaced. Planning work is underway to with an objective to compelete the works as quickly as possible bearing in mind the need to satisfy public sector test of value for money.	**NHS Board**

Inherent risk (before mitigating controls)			*Residual risk (after mitigating controls)*		
Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
2	*3*	**6**	*2*	*3*	**6**

Ref	[redacted]
CR/1703	[redacted]

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Ref	Directorate/ Partnership Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]								

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
OP/1001	Medical	Infection Control	Medical Director	Infection Control Manager	Operational	Failure to implement consistent systems and policies in relation to control. *Inherent Risk* *Likelihood* 4 *Impact* 4 *Score* 16	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE, VHF and MERS. Reports to Board/ASC. *Residual Risk* *Likelihood* 3 *Impact* 4 *Score* 12		
OP/1002	Medical	Infection Control	Medical Director	Infection Control Manager	Operational	Failure to achieve reduction of MRSA/ MSSA/C-Diff bacteraemia to 24 cases per 100,000 occupied bed days. *Inherent Risk* *Likelihood* 4 *Impact* 4 *Score* 16	* In areas with high incidents of MRSA/ MSSA bacteraemia produce action plans to reduce incidence, including use of care bundles. * Continue enhanced surveillance of MRSA/ MSSA. * Quarterly reports which include analysis of the incidents of device associated MRSA/MSSA. * Produce SPCs for MRSA/MSSA in areas with significant prevalence. Develop systems to identify actionable issues in relation to “out of hospital” SABs. Develop quality improvement tools for prevention of SABs in Paediatrics. An Acute Directorate SAB steering group is set to convene every two to three months to enable local interventions and progress in reducing SAB acquisition to be shared across all aspects of Acute patient care delivery. Reports to Board/ASC. *Residual Risk* *Likelihood* 3 *Impact* 4 *Score* 12		

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Ref	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									
OP/1601		Infrastructure	Director of eHealth/ Director of Property, Procurement & Facilities Management/ Director of Diagnostics		Operational	Node 12 at the QEUH in the retained estate and contains Telephone services for the Maternity and New Labs buildings and VOIP for the estate. This Node in IT Terms provides services into Southern Management Building and Podiatry for and also at the rear of the area are the PACS Servers for the Adult Services for that Campus. Due to Building works that neither Telecoms, eHealth or Diagnostics were aware of, the security and water / weather tightness of the Node is now in question, meaning that this area is vulnerable to Vandalism / Theft or loss of service due to water ingress or dampness in the electronics. *Inherent Risk* *Likelihood* 4 *Impact* 4 *Score* 16	Telecomms, IT and PACS have reviewed the area and we have sent concerns to Property, Procurement & Facilities Management. There are no other immediate measures that can be put in place. Property, Procurement & Facilities Management have re-visited the area and are looking to make the area more secure with security barriers and look at reducing likelihood of water / damp ingress to the area. *Residual Risk* *Likelihood* 3 *Impact* 4 *Score* 12	Property, Procurement & Facilities Management are taking steps to progress the final repairs which are tied into the facia repair of the building due to Building status with planning etc and are to keep Calum Morison up to date with dates and progress (currently outstanding end of Nov)	

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Datix ID	Directorate/ Partnership	rganisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
2057	Acute/ HSCPs	Operational/ Financial	Chief Officers, Director of Facilities & Capital Planning	Director of Facilities & Capital Planning	Strategic	Expected reduction in capital funding and pressure on revenue resources impacts on backlog maintenance and Health and Safety obligations leading to the possibility of non compliance with applicable Health and Safety legislation and SGHD policies and guidance.	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure. The system has risk assessment criteria that 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. Regular reports to CPG/SMG / OMG on deployment of capital resources and investment priorities. Investment Priorities are based on PAMS data. 3. A revenue allocation of [redacted] 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. 4. Property Asset Management Strategy in place.		**Finance & Planning Committee**

Current score			*Risk score (after mitigating controls)*		
Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
4	*4*	*16*			

[redacted]

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									
2021	Finance	Finance	[redacted]						

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
2063	[redacted]								

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
2064	Property, Procurement and Facilities Management	Fire safety	Director of PPFM	Director of PPFM	Operational	The probability of Queen Elizabeth University Hospital being at high risk due to the incorporation of Aluminium Composite Materials (ACMs) similar but not the same to those used in Grenfell Tower, leading to an increased likelihood of a fire occurring. Update November 2017 - as part of the inspection work on cladding, a further issue has been uncovered regarding a section of cladding on the RHC. HFS have conducted an inspection and deemed the building safe.	The QEUH has been designed and engineered to meet Building and Fire Safety Regulations. Health Facilities Scotland and their National Fire Advisor have given assurances that the hospital is an extremely safe building. Firm assurances have also been given by the main contractor and their design team and the Board's technical advisers that the regulatory process has been followed and that the appropriate Building Standards Completion Certificates are in place. As a precautionary measure, and to make sure the public, patients and staff have full confidence in the safety of the QEUH, the NHS Board officers took the decision to remove the panels from the three external sections of the hospital where these panels are located. Officers worked with contractors and technical advisers in assessing how to proceed this work at the earliest possible opportunity.	It has been decided that the ACM panels are to be removed and replaced. Planning work is underway to with an objective to complete the works as quickly as possible bearing in mind the need to satisfy public sector test of value for money. In terms of the RHC, discussions are on-going with Multiplex around replacing the affected areas.	**NHS Board**

Current score			*Risk score (after mitigating controls)*		
Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
2	*3*	*6*			

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									
2082	[redacted]								

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
2086	[redacted]								
2087	Medical	Infection Control	Medical Director	Infection Control Manager	Operational	Failure to implement consistent systems and policies in relation to control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. The impact of these pathogens on different patients and in different healthcare systems can be variable, so we have to be prepared to modify local guidance to fit the needs of local services. This can be complicated and open to interpretation especially as these will sometimes require whole system changes, e.g. wearing of FFP3 masks for patients with query MERS. Any change also need to be supported by local guidance and training. IPCT are a limited resource so ensuring that any changes are applied across the whole system in a consistent manner is challenging. Emerging pathogens represent a risk because often the epidemiology and routes of transmission are not fully understood. The consequences are cross transmission and outbreaks.		

Current score			*Risk score (after mitigating controls)*		
Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
4	*4*	*16*			

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
2088	Medical	Infection Control	Medical Director	Infection Control Manager	Operational	Failure to achieve reduction of MRSA/ MSSA bacteraemia to 24 cases per 100,000 occupied bed days by 2018. Pending any updated changes to target at national level.	* Continue enhanced surveillance of MRSA/ MSSA. * Quarterly reports which include analysis of the incidence of device associated MRSA/MSSA. * Produce SPCs for MRSA/MSSA in areas with significant prevalence. Avoidable SAB related devices will be referred for clinical significant incident review. *Current score* *Likelihood* 4 *Impact* 4 *Score* 16	AICC will implement and monitor the SAB Action Plan. Screening of renal patients for MSSA prior to line insertion. IPCT to monitor compliance with PVC/CVC bundles via IPCAT. *Risk score (after mitigating controls)* *Likelihood* *Impact* *Score*	
2089	[redacted]								

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

NHS Greater Glasgow and Clyde Corporate Risk Register

Measurement Tools - Likelihood

1 – Rare - can't believe it would happen
2 – Unlikely - do not expect it to happen
3 – Possible - may occur occasionally
4 – Likely - will probably occur, but not a persistent issue
5 – Almost certain - will undoubtedly occur/is happening

Measurement Tools - Impact

1 – Insignificant
2 – Minor
3 – Moderate
4 – Major
5 – Extreme

Measurement Tools - Consequence

Likelihood	***Impact/Consequence***				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	**Medium 5**	**High 10**	**High 15**	**Very High 20**	**Very High 25**
Likely	**Medium 4**	**Medium 8**	**High 12**	**High 16**	**Very High 20**
Possible	**Low 3**	**Medium 6**	**Medium 9**	**High 12**	**High 15**
Unlikely	**Low 2**	**Medium 4**	**Medium 6**	**Medium 8**	**High 10**
Rare	**Low 1**	**Low 2**	**Low 3**	**Medium 4**	**Medium 5**

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
2054	Acute	[redacted]							

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
2055	[redacted]								

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
2056	[redacted]								
2057	Acute/ HSCPs	Operational/ Financial	Chief Officers, Director of Facilities & Capital Planning	Director of Facilities & Capital Planning	Strategic	Expected reduction in capital funding and pressure on revenue resources impacts on backlog maintenance and Health and Safety obligations leading to the possibility of non compliance with applicable Health and Safety legislation and SGHD policies and guidance.	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure. The system has risk assessment criteria that 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. Regular reports to CPG/SMG / OMG on deployment of capital resources and investment priorities. Investment Priorities are based on PAMS data. 3. A revenue allocation of [redacted] 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. 4. Property Asset Management Strategy in place. *Current score* — *Likelihood* 3, *Impact* 4, *Score* 12	There will be a need to ensure that the annual capital and revenue funding for PPFM takes cognisance of the statutory obligations applied to the NHS Board. Prioritisation will be informed by EAMs and the PAMS data. *Risk score (after further actions)* — *Likelihood* 3, *Impact* 3, *Score* 9	**Finance & Planning Committee**

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
2059	[redacted]								

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
2060	[redacted]								
2021									

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
2061	[redacted]								

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
2063	[redacted]								

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
2064	Property, Procurement and Facilities Management	Fire safety	Director of PPFM	Director of PPFM	Operational	The probability of Queen Elizabeth University Hospital being at high risk due to the incorporation of Aluminium Composite Materials (ACMs) similar but not the same to those used in Grenfell Tower, leading to an increased likelihood of a fire occurring. Update November 2017 - as part of the inspection work on cladding, a further issue has been uncovered regarding a section of cladding on the RHC. HFS have conducted an inspection and deemed the building safe.	The QEUH has been designed and engineered to meet Building and Fire Safety Regulations. Health Facilities Scotland and their National Fire Advisor have given assurances that the hospital is an extremely safe building. Firm assurances have also been given by the main contractor and their design team and the Board's technical advisers that the regulatory process has been followed and that the appropriate Building Standards Completion Certificates are in place. As a precautionary measure, and to make sure the public, patients and staff have full confidence in the safety of the QEUH, the NHS Board officers took the decision to remove the panels from the three external sections of the hospital where these panels are located. Officers worked with contractors and technical advisers in assessing how to proceed this work at the earliest possible opportunity.	It has been decided that the ACM panels are to be removed and replaced with non-combustible panels . Planning work is underway to with an objective to complete the works as quickly as possible bearing in mind the need to satisfy public sector test of value for money. In terms of the RHC, discussions are on-going with Multiplex around replacing the affected areas.	**NHS Board**

Current score			*Risk score (after further actions)*		
Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
2	*3*	**6**	*1*	*3*	**3**

[redacted]

Datix ID	Directorate/ Partnership	rganisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
2087	Medical	Infection Control	Medical Director	Infection Control Manager	Operational	Failure to comply with recognised policies and procedures in relation to infection control. Emerging pathogens represent a risk because often the epidemiology and routes of transmission are not fully understood. The consequences are cross transmission and outbreaks.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. *Current score* — *Likelihood* 4 × *Impact* 4 = *Score* 16	The impact of these pathogens on different patients and in different healthcare systems can be variable, so we have to be prepared to modify local guidance to fit the needs of local services. This can be complicated and open to interpretation especially as these will sometimes require whole system changes, e.g. wearing of FFP3 masks for patients with query MERS. Any change also need to be supported by local guidance and training. IPCT are a limited resource so ensuring that any changes are applied across the whole system in a consistent manner is challenging. *Risk score (after further actions)* — *Likelihood* 3 × *Impact* 4 = *Score* 12	**Clinical Governance Committee**

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
2088	Medical	Infection Control	Medical Director	Infection Control Manager	Operational	Failure to achieve reduction of MRSA/ MSSA bacteraemia to 24 cases per 100,000 occupied bed days by 2018. Pending any updated changes to target at national level.	* Continue enhanced surveillance of MRSA/ MSSA. * Quarterly reports which include analysis of the incidence of device associated MRSA/MSSA. * Produce SPCs for MRSA/MSSA in areas with significant prevalence. Avoidable SAB related devices will be referred for clinical significant incident review. *Current score* *Likelihood* 4 *Impact* 4 *Score* 16	AICC will implement and monitor the SAB Action Plan. Screening of renal patients for MSSA prior to line insertion. IPCT to monitor compliance with PVC/CVC bundles via IPCAT. *Risk score (after further actions)* *Likelihood* 3 *Impact* 4 *Score* 12	**Clinical Governance Committee**

[redacted]

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Likelihood

1 – **Rare -** can't believe it would happen
2 – **Unlikely -** do not expect it to happen
3 – **Possible -** may occur occasionally
4 – **Likely -** will probably occur, but not a persistent issue
5 – **Almost certain -** will undoubtedly occur/is happening

Impact

1 – **Negligible**
2 – **Minor**
3 – **Moderate**
4 – **Major**
5 – **Extreme**

Consequence

Likelihood	*Impact/Consequence*				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	**Medium 5**	**High 10**	**High 15**	**Very High 20**	**Very High 25**
Likely	**Medium 4**	**Medium 8**	**High 12**	**High 16**	**Very High 20**
Possible	**Low 3**	**Medium 6**	**Medium 9**	**High 12**	**High 15**
Unlikely	**Low 2**	**Medium 4**	**Medium 6**	**Medium 8**	**High 10**
Rare	**Low 1**	**Low 2**	**Low 3**	**Medium 4**	**Medium 5**

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
2055	[redacted]								

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									
2057	Acute/ HSCPs	Operational/ Financial	Chief Officers, Director of Facilities & Capital Planning	Director of Facilities & Capital Planning	Strategic	Expected reduction in capital funding and pressure on revenue resources impacts on backlog maintenance and Health and Safety obligations leading to the possibility of non compliance with applicable Health and Safety legislation and SGHD policies and guidance.	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure. The system has risk assessment criteria that 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. Regular reports to CPG/SMG / OMG on deployment of capital resources and investment priorities. Investment Priorities are based on PAMS data. 3. A revenue allocation of [redacted] 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. 4. Property Asset Management Strategy in place. *Current score*: *Likelihood* 3, *Impact* 4, *Score* 12	There will be a need to ensure that the annual capital and revenue funding for PPFM takes cognisance of the statutory obligations applied to the NHS Board. Prioritisation will be informed by EAMs and the PAMS data. *Risk score (after further actions)*: *Likelihood* 3, *Impact* 3, *Score* 9	**Finance & Planning Committee**

Datix ID	Directorate/ Partnership	rganisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
2061	[redacted]								

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
2064	Property, Procurement and Facilities Management	Fire safety	Director of PPFM	Director of PPFM	Operational	The probability of Queen Elizabeth University Hospital being at high risk due to the incorporation of Aluminium Composite Materials (ACMs) similar but not the same to those used in Grenfell Tower, leading to an increased likelihood of a fire occurring. Update November 2017 - as part of the inspection work on cladding, a further issue has been uncovered regarding a section of cladding on the RHC. HFS have conducted an inspection and deemed the building safe.	The QEUH has been designed and engineered to meet Building and Fire Safety Regulations. Health Facilities Scotland and their National Fire Advisor have given assurances that the hospital is an extremely safe building. Firm assurances have also been given by the main contractor and their design team and the Board's technical advisers that the regulatory process has been followed and that the appropriate Building Standards Completion Certificates are in place. As a precautionary measure, and to make sure the public, patients and staff have full confidence in the safety of the QEUH, the NHS Board officers took the decision to remove the panels from the three external sections of the hospital where these panels are located. Officers worked with contractors and technical advisers in assessing how to proceed this work at the earliest possible opportunity.	It has been decided that the ACM panels are to be removed and replaced with non-combustible panels . Planning work is underway to with an objective to complete the works as quickly as possible bearing in mind the need to satisfy public sector test of value for money. In terms of the RHC, discussions are on-going with Multiplex around replacing the affected areas.	**NHS Board**

Current score			*Risk score (after further actions)*		
Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
2	*3*	**6**	*1*	*3*	**3**

2065	[redacted]

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
2087	Medical	Infection Control	Medical Director	Infection Control Manager	Operational	Failure to comply with recognised policies and procedures in relation to infection control. Emerging pathogens represent a risk because often the epidemiology and routes of transmission are not fully understood. The consequences are cross transmission and outbreaks.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. *Current score* — *Likelihood* 4 / *Impact* 4 / *Score* 16	The impact of these pathogens on different patients and in different healthcare systems can be variable, so we have to be prepared to modify local guidance to fit the needs of local services. This can be complicated and open to interpretation especially as these will sometimes require whole system changes, e.g. wearing of FFP3 masks for patients with query MERS. Any change also need to be supported by local guidance and training. IPCT are a limited resource so ensuring that any changes are applied across the whole system in a consistent manner is challenging. *Risk score (after further actions)* — *Likelihood* 3 / *Impact* 4 / *Score* 12	**Clinical Governance Committee**
2103	[redacted]								

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
			[redacted]						

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
2088	Medical	Infection Control	Medical Director	Infection Control Manager	Operational	Failure to achieve reduction of MRSA/ MSSA bacteraemia to 24 cases per 100,000 occupied bed days by 2018. Pending any updated changes to target at national level.	* Continue enhanced surveillance of MRSA/ MSSA. * Quarterly reports which include analysis of the incidence of device associated MRSA/MSSA. * Produce SPCs for MRSA/MSSA in areas with significant prevalence. Avoidable SAB related devices will be referred for clinical significant incident review. *Current score*: Likelihood 4, Impact 4, Score 16	AICC will implement and monitor the SAB Action Plan. Screening of renal patients for MSSA prior to line insertion. IPCT to monitor compliance with PVC/CVC bundles via IPCAT. *Risk score (after further actions)*: Likelihood 3, Impact 4, Score 12	**Clinical Governance Committee**
2089	[redacted]								

Datix ID	Directorate/ Partnership	Organisational area	Accountable owner	Risk manager	Risk type	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further mitigating action to reduce, eliminate or transfer residual risk	Governance/ review committee
[redacted]									

ID	Title	Manager	RR Type	Review date	Risk level (initial)	Risk level (current)	Risk level (Target)	Description	Controls in place	RR Status
301	MRSA Screening Programme	Walsh, Tom	Corporate Risk	30/03/2012	Moderate	Moderate	Low	Failure to implement the National Policy for screening for MRSA	Project team in place.	Live/Active
[redacted]										
	Projects				Moderate	Moderate	Moderate	resourced e.g. HUB initiative, Capital projects	projections	
[redacted]										

ID	Title	Manager	RR Type	Review date	Risk level (initial)	Risk level (current)	Risk level (Target)	Description	Controls in place	RR Status

ID	Title	Manager	RR Type	Review date	Risk level (initial)	Risk level (current)	Risk level (Target)	Description	Controls in place	RR Status

Likelihood

1 – **Rare -** can't believe it would happen
2 – **Unlikely -** do not expect it to happen
3 – **Possible -** may occur occasionally
4 – **Likely -** will probably occur, but not a persistent issue
5 – **Almost certain -** will undoubtedly occur/is happening

Impact

1 – **Negligible**
2 – **Minor**
3 – **Moderate**
4 – **Major**
5 – **Extreme**

Consequence

Likelihood	*Impact/Consequence*				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	**Medium 5**	**High 10**	**High 15**	**Very High 20**	**Very High 25**
Likely	**Medium 4**	**Medium 8**	**High 12**	**High 16**	**Very High 20**
Possible	**Low 3**	**Medium 6**	**Medium 9**	**High 12**	**High 15**
Unlikely	**Low 2**	**Medium 4**	**Medium 6**	**Medium 8**	**High 10**
Rare	**Low 1**	**Low 2**	**Low 3**	**Medium 4**	**Medium 5**

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further actions to mitigate, reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2054	[redacted]						
2055							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further actions to mitigate, reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2056	[redacted]						
2057	Acute/ HSCPs	Chief Officers, Director of Facilities & Capital Planning	Expected reduction in capital funding and pressure on revenue resources impacts on backlog maintenance and Health and Safety obligations leading to the possibility of non compliance with applicable Health and Safety legislation and SGHD policies and guidance.	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure. The system has risk assessment criteria that 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. Regular reports to CPG/SMG / OMG on deployment of capital resources and investment priorities. Investment Priorities are based on PAMS data. 3. A revenue allocation of [redacted] 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. 4. Property Asset Management Strategy in place.	There will be a need to ensure that the annual capital and revenue funding for PPFM takes cognisance of the statutory obligations applied to the NHS Board. Prioritisation will be informed by EAMs and the PAMS data.		**Finance & Planning Committee**

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		3	*4*	*12*	*3*	*3*	*9*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further actions to mitigate, reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2059	Public Health	[redacted]					
2060	Public Health						

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further actions to mitigate, reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2061	Finance	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further actions to mitigate, reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further actions to mitigate, reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2063	Human Resources	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further actions to mitigate, reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2064	PPFM	Director of PPFM	The probability of Queen Elizabeth University Hospital being at high risk due to the incorporation of Aluminium Composite Materials (ACMs) similar but not the same to those used in Grenfell Tower, leading to an increased likelihood of a fire occurring. As part of the inspection work on cladding, a further issue has been uncovered regarding a section of cladding on the RHC. HFS have conducted an inspection and deemed the building safe.	The QEUH has been designed and engineered to meet Building and Fire Safety Regulations. Health Facilities Scotland and their National Fire Advisor have given assurances that the hospital is an extremely safe building. Firm assurances have also been given by the main contractor and their design team and the Board's technical advisers that the regulatory process has been followed and that the appropriate Building Standards Completion Certificates are in place. As a precautionary measure, and to make sure the public, patients and staff have full confidence in the safety of the QEUH, the NHS Board officers took the decision to remove the panels from the three external sections of the hospital where these panels are located. Officers worked with contractors and technical advisers in assessing how to proceed this work at the earliest possible opportunity.	It has been decided that the ACM panels are to be removed and replaced with non-combustible panels. It is planned that work will begin in June/July 2018 to replace the panels		**NHS Board**
		Risk level and scores	***Corporate level risk***	***Current risk score***			***Target risk score (after further actions)***				
				Likelihood	***Impact***	***Score***	***Likelihood***	***Impact***	***Score***		
				2	*3*	6	*1*	*3*	3		
2065	[redacted]										
2082											

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further actions to mitigate, reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2083	[redacted]						
2085							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further actions to mitigate, reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2087	Medical	Medical Director	Failure to comply with recognised policies and procedures in relation to infection control. Emerging pathogens represent a risk because often the epidemiology and routes of transmission are not fully understood. The consequences are cross transmission and outbreaks.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS.	The impact of these pathogens on different patients and in different healthcare systems can be variable, so we have to be prepared to modify local guidance to fit the needs of local services. This can be complicated and open to interpretation especially as these will sometimes require whole system changes, e.g. wearing of FFP3 masks for patients with query MERS. Any change also need to be supported by local guidance and training. IPCT are a limited resource so ensuring that any changes are applied across the whole system in a consistent manner is challenging.		**Clinical & Care Governance Committee**
		Risk level and scores	***Corporate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood ***Impact*** ***Score***	***Likelihood*** ***Impact*** ***Score***		
				4 ***4*** ***16***	***3*** ***4*** ***12***		
2103	[redacted]						

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further actions to mitigate, reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further actions to mitigate, reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2199	[redacted]						

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further actions to mitigate, reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2084 2086	[redacted]						
2088	Medical	Medical Director	Failure to achieve reduction of MRSA/ MSSA bacteraemia to 24 cases per 100,000 occupied bed days by 2018. Pending any updated changes to target at national level.	* Continue enhanced surveillance of MRSA/ MSSA. * Quarterly reports which include analysis of the incidence of device associated MRSA/MSSA. * Produce SPCs for MRSA/MSSA in areas with significant prevalence. Avoidable SAB related devices will be referred for clinical significant incident review.	AICC is implementing and will monitor the SAB Action Plan. Screening of renal patients for MSSA prior to line insertion. IPCT to monitor compliance with PVC/CVC bundles via IPCAT.		**Clinical & Care Governance Committee**
		Risk level and scores	***Directorate level risk***	***Current risk score***			***Target risk score (after further actions)***				
				Likelihood	***Impact***	***Score***	***Likelihood***	***Impact***	***Score***		
				4	***4***	***16***	***3***	***4***	***12***		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Further actions to mitigate, reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Likelihood

1 – **Rare -** can't believe it would happen
2 – **Unlikely -** do not expect it to happen
3 – **Possible -** may occur occasionally
4 – **Likely -** will probably occur, but not a persistent issue
5 – **Almost certain -** will undoubtedly occur/is happening

Impact

1 – **Negligible**
2 – **Minor**
3 – **Moderate**
4 – **Major**
5 – **Extreme**

Consequence

Likelihood	*Impact/Consequence*				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	**Medium 5**	**High 10**	**High 15**	**Very High 20**	**Very High 25**
Likely	**Medium 4**	**Medium 8**	**High 12**	**High 16**	**Very High 20**
Possible	**Low 3**	**Medium 6**	**Medium 9**	**High 12**	**High 15**
Unlikely	**Low 2**	**Medium 4**	**Medium 6**	**Medium 8**	**High 10**
Rare	**Low 1**	**Low 2**	**Low 3**	**Medium 4**	**Medium 5**

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2057	Acute/ HSCPs	Chief Officers, Director of Facilities & Capital Planning	Expected reduction in capital funding and pressure on revenue resources impacts on backlog maintenance and Health and Safety obligations leading to the possibility of non compliance with applicable Health and Safety legislation and SGHD policies and guidance.	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure. The system has risk assessment criteria that 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. Regular reports to CPG/SMG / OMG on deployment of capital resources and investment priorities. Investment Priorities are based on PAMS data. 3. A revenue allocation of [redacted] 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. 4. Property Asset Management Strategy in place.	There will be a need to ensure that the annual capital and revenue funding for PPFM takes cognisance of the statutory obligations applied to the NHS Board. Prioritisation will be informed by EAMs and the PAMS data.		**Finance & Planning Committee**
		Risk level and scores	***Corporate level risk***	***Current risk score***			
				Likelihood	***Impact***	***Score***	
				3	*4*	*12*	
				Target risk score (after further actions)			
				Likelihood	***Impact***	***Score***	
				3	*3*	*9*	

[redacted]

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2063	[redacted]						
2064	PPFM	Director of PPFM	The probability of Queen Elizabeth University Hospital being at high risk due to the incorporation of Aluminium Composite Materials (ACMs) similar but not the same to those used in Grenfell Tower, leading to an increased likelihood of a fire occurring. As part of the inspection work on cladding, a further issue has been uncovered regarding a section of cladding on the RHC. HFS have conducted an inspection and deemed the building safe.	The QEUH has been designed and engineered to meet Building and Fire Safety Regulations. Health Facilities Scotland and their National Fire Advisor have given assurances that the hospital is an extremely safe building. Firm assurances have also been given by the main contractor and their design team and the Board's technical advisers that the regulatory process has been followed and that the appropriate Building Standards Completion Certificates are in place. As a precautionary measure, and to make sure the public, patients and staff have full confidence in the safety of the QEUH, the NHS Board officers took the decision to remove the panels from the three external sections of the hospital where these panels are located. Officers worked with contractors and technical advisers in assessing how to proceed this work at the earliest possible opportunity.	It has been decided that the ACM panels are to be removed and replaced with non-combustible panels. It is planned that work will begin in June/July 2018 to replace the panels		**NHS Board**

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		2	*3*	*6*	*1*	*3*	*3*		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2065	[redacted]						
2082							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2188	Medical	Medical Director	Failure to comply with recognised policies and procedures in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. The impact of these pathogens on different patients and in different healthcare systems can be variable, so we have to be prepared to modify local guidance to fit the needs of local services. This can be complicated and open to interpretation especially as these will sometimes require whole system changes, e.g. wearing of FFP3 masks for patients with query MERS. Any change also need to be supported by local guidance and training. IPCT are a limited resource so ensuring that any changes are applied across the whole system in a consistent manner is challenging. Emerging pathogens represent a risk because often the epidemiology and routes of transmission are not fully understood. The consequences are cross transmission and outbreaks.	SOPs to support the management of environmental and drug resistant organisms is underway. Targeted education re the use of Respiratory Protective Equipment will also be rolled out.	**Ongoing**	**Clinical & Care Governance Committee**
		Risk level and scores	***Corporate level risk***	***Current risk score*** *Likelihood* 4 *Impact* *Score* 2	***Target risk score (after further actions)*** *Likelihood* 4 *Impact* *Score* 2		
2103	[redacted]						

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2325	[redacted]						
2324							
2199							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							
2086							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							
2190	Medical	Medical Director	Failure to implement national guidance, systems and policies in relation to water safety.	Water safety Group Water safety Policy Pseudomonas risk assessment. Water safety group reports to BICC. Sampling in response to clinical cases. Review of controls if required for individual sites or high risk units			
		Risk level and scores	*Directorate level risk*	*Current risk score*	*Target risk score (after further actions)*		
				Likelihood 4 / *Impact* 3 / *Score* 12	*Likelihood* 3 / *Impact* 3 / *Score* 9		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2192	Medical	Medical Director	Failure to achieve reduction of MRSA/ MSSA bacteraemia Target has yet to be issued but this data will now be presented split into Healthcare Associated and Community cases*. Healthcare Associated will be presented as cases per total occupied bed days and the Community cases which will be presented as cases per head of population. * cases where the origin is unknown are included in the Community figures	Continue enhanced surveillance of MRSA/ MSSA. Quarterly reports which include analysis of the incidence of device associated MRSA/MSSA. Produce SPCs for MRSA/MSSA in areas with significant prevalence. Avoidable SAB related devices will be referred for clinical significant incident review. IPCT to monitor compliance with PVC/CVC bundles via IPCAT. Review by Antimicrobial Pharmacists – Commenced 2017 All new SABs are referred to the antimicrobial pharmacists for review. This will ensure that all patients have the optimum type of antimicrobial for the correct length of time. Review of "unknown source" of Bacteraemia cases by Infection Control Doctors 2018 SAB Steering Group reconvened and will report to AICC and BICC	SAB Stering Group to monitor via an action plan which is presented to the acute infection control committee.		

Risk level and scores	*Directorate level risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		5	*3*	*15*	*4*	*2*	*8*

Likelihood

1 – **Rare -** is unlikely to happen
2 – **Unlikely -** not expected to happen
3 – **Possible -** may occur occasionally
4 – **Likely -** will probably occur, but not a persistent issue
5 – **Almost certain -** will undoubtedly occur/is happening

Impact

1 – **Negligible**
2 – **Minor**
3 – **Moderate**
4 – **Major**
5 – **Extreme**

Consequence

Likelihood	*Impact/Consequence*				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	**Medium 5**	**High 10**	**High 15**	**Very High 20**	**Very High 25**
Likely	**Medium 4**	**Medium 8**	**High 12**	**High 16**	**Very High 20**
Possible	**Low 3**	**Medium 6**	**Medium 9**	**High 12**	**High 15**
Unlikely	**Low 2**	**Medium 4**	**Medium 6**	**Medium 8**	**High 10**
Rare	**Low 1**	**Low 2**	**Low 3**	**Medium 4**	**Medium 5**

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							
2057	Acute/ HSCPs	Chief Officers, Director of Facilities & Capital Planning	Reduction in capital funding and pressure on revenue resources impacts on backlog maintenance and Health and Safety obligations leading to the possibility of non compliance with applicable Health and Safety legislation and SG policies and guidance.	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure. The system has risk assessment criteria that 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 [redacted] 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 PPFM takes cognisance of the statutory obligations applied to the NHS Board.*** ***Prioritisation is informed by EAMs and the PAMS data.***	***The risk is tolerated at this level; no further actions are considered necessary at this time.*** ***Tolerated***	**N/a**	**Finance & Planning Committee**
		Risk level and scores	***Corporate level risk***	***Current risk score***			***Target risk score (after further actions)***		
				Likelihood	***Impact***	***Score***	***Likelihood***	***Impact***	***Score***
				3	***4***	***12***	***3***	***4***	***12***

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2063	Human Resources	[redacted]					
2064	PPFM	Director of PPFM	The probability of Queen Elizabeth University Hospital being at high risk due to the incorporation of Aluminium Composite Materials (ACMs) similar but not the same to those used in Grenfell Tower, leading to an increased likelihood of a fire occurring. As part of the inspection work on cladding, a further issue was uncovered regarding a section of cladding on the RHC. HFS conducted an inspection and deemed the building safe.	The QEUH has been designed and engineered to meet Building and Fire Safety Regulations. Health Facilities Scotland and their National Fire Advisor have given assurances that the hospital is an extremely safe building. Firm assurances have also been given by the main contractor and their design team and the Board's technical advisers that the regulatory process has been followed and that the appropriate Building Standards Completion Certificates are in place. As a precautionary measure, and to make sure the public, patients and staff have full confidence in the safety of the QEUH, the NHS Board officers took the decision to remove the panels from the three external sections of the hospital where these panels are located. Officers worked with contractors and technical advisers in assessing how to proceed this work. ***As a result, the original building contractor (Brookfield) will replace the panels. Work has commenced.***	It has been decided that the ACM panels are to be removed and replaced with non-combustible panels. ***Building warrants and engineering certificates have been secured. Work is underway, and is due for completion February 2019. The works should not affect any patient care within the building.***	***February 2019***	**Finance & Planning Committee**

Risk level and scores	***Corporate level risk***	***Current risk score***			***Target risk score (after further actions)***		
		Likelihood	***Impact***	***Score***	***Likelihood***	***Impact***	***Score***
		2	***3***	***6***	***1***	***3***	***3***

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2083	Nursing	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2085	Medical	[redacted]					
2188	Medical	Medical Director	Failure to comply with recognised policies and procedures in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. The impact of these pathogens on different patients and in different healthcare systems can be variable, so we have to be prepared to modify local guidance to fit the needs of local services. This can be complicated and open to interpretation especially as these will sometimes require whole system changes, e.g. wearing of FFP3 masks for patients with query MERS. Any change also need to be supported by local guidance and training. IPCT are a limited resource so ensuring that any changes are applied across the whole system in a consistent manner is challenging. ***Emerging pathogens represent a risk because often the epidemiology and routes of transmission are not fully understood. The consequences are cross transmission and outbreaks.*** ***SOPs to support the management of environmental and drug resistant organisms is underway.*** ***Targeted education re the use of Respiratory Protective Equipment will also be rolled out.***	***The risk is tolerated at this level; no further actions are considered necessary at this time.*** ***Tolerated***	**N/a**	**Clinical & Care Governance Committee**
		Risk level and scores	***Corporate level risk***	***Current risk score***			***Target risk score (after further actions)***				
				Likelihood	***Impact***	***Score***	***Likelihood***	***Impact***	***Score***		
				4	***3***	***12***	***4***	***3***	***12***		

Datix ID	Directorate/ artnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2103	eHealth	[redacted]					
2199	Public Health						

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2190	Facilities and Estates	Director of Facilities and Estates	Failure to implement national guidance, systems and policies in relation to water safety.	Water safety Group Water safety Policy Pseudomonas risk assessment. Water safety group reports to BICC. Sampling in response to clinical cases. Review of controls if required for individual sites or high risk units		**Ongoing**	**Acute Services Committee**
		Risk level and scores	***Directorate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood / ***Impact*** / ***Score***	***Likelihood*** / ***Impact*** / ***Score***		
				4 / ***3*** / ***12***	***4*** / ***3*** / ***12***		
2192	Medical	Medical Director	Failure to achieve reduction of MRSA/ MSSA bacteraemia Target has yet to be issued but this data will now be presented split into Healthcare Associated and Community cases*. Healthcare Associated will be presented as cases per total occupied bed days and the Community cases which will be presented as cases per head of population. * cases where the origin is unknown are included in the Community figures	Continue enhanced surveillance of MRSA/ MSSA. Quarterly reports which include analysis of the incidence of device associated MRSA/MSSA. Produce SPCs for MRSA/MSSA in areas with significant prevalence. Avoidable SAB related devices will be referred for clinical significant incident review. IPCT to monitor compliance with PVC/CVC bundles via IPCAT. Review by Antimicrobial Pharmacists – Commenced 2017 All new SABs are referred to the antimicrobial pharmacists for review. This will ensure that all patients have the optimum type of antimicrobial for the correct length of time. Review of “unknown source” of Bacteraemia cases by Infection Control Doctors 2018 SAB Steering Group reconvened and will report to AICC and BICC	SAB Steering Group to monitor via an action plan which is presented to the acute infection control committee.	**Ongoing**	**Clinical & Care Governance Committee**
		Risk level and scores	***Directorate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood / ***Impact*** / ***Score***	***Likelihood*** / ***Impact*** / ***Score***		
				5 / ***3*** / ***15***	***4*** / ***2*** / ***8***		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	irectorate/ artnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

[redacted]

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

[redacted]

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

[redacted]

Datix ID	Directorate/ partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2063	[redacted]						
2064	Estates & Facilities	Director of Estates & Facilities	The probability of Queen Elizabeth University Hospital being at high risk due to the incorporation of Aluminium Composite Materials (ACMs) similar but not the same to those used in Grenfell Tower, leading to an increased likelihood of a fire occurring. As part of the inspection work on cladding, a further issue was uncovered regarding a section of cladding on the RHC. HFS conducted an inspection and deemed the building safe.	The QEUH has been designed and engineered to meet Building and Fire Safety Regulations. Health Facilities Scotland and their National Fire Advisor have given assurances that the hospital is an extremely safe building. Firm assurances have also been given by the main contractor and their design team and the Board's technical advisers that the regulatory process has been followed and that the appropriate Building Standards Completion Certificates are in place. As a precautionary measure, and to make sure the public, patients and staff have full confidence in the safety of the QEUH, the NHS Board officers took the decision to remove the panels from the three external sections of the hospital where these panels are located. Officers worked with contractors and technical advisers in assessing how to proceed this work. ***As a result, the original building contractor (Brookfield) will replace the panels. Work has commenced.***	It has been decided that the ACM panels are to be removed and replaced with non-combustible panels. ***Building warrants and engineering certificates have been secured. Work is underway, and is due for completion February 2019. The works should not affect any patient care within the building.***	***February 2019***	**Finance & Planning Committee**

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		2	*3*	*6*	*1*	*3*	*3*		

Datix ID	Directorate/Partnership	Score	Risk level	Governance/ review committee
2064	Estates & Facilities	6	Corporate level risk	Finance & Planning Committee
2064	Estates & Facilities	6	Corporate level risk	Finance & Planning Committee
2064	Estates & Facilities	6	Corporate level risk	Finance & Planning Committee
2064	Estates & Facilities	6	Corporate level risk	Finance & Planning Committee
2064	Estates & Facilities	6	Corporate level risk	Finance & Planning Committee
2064	Estates & Facilities	6	Corporate level risk	Finance & Planning Committee

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/Partnership	Score	Risk level	Governance/ review committee
[redacted]				

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee

[redacted]

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2188	Medical	Medical Director	Failure to comply with recognised policies and procedures in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. The impact of these pathogens on different patients and in different healthcare systems can be variable, so we have to be prepared to modify local guidance to fit the needs of local services. This can be complicated and open to interpretation especially as these will sometimes require whole system changes, e.g. wearing of FFP3 masks for patients with query MERS. Any change also need to be supported by local guidance and training. IPCT are a limited resource so ensuring that any changes are applied across the whole system in a consistent manner is challenging. ***Emerging pathogens represent a risk because often the epidemiology and routes of transmission are not fully understood. The consequences are cross transmission and outbreaks.*** ***SOPs to support the management of environmental and drug resistant organisms is underway.***	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. ***Targeted education re the use of Respiratory Protective Equipment will also be rolled out.***	**Ongoing**	**Clinical & Care Governance Committee**
		Risk level and scores	***Corporate level risk***	***Current risk score*** *Likelihood* *Impact* ***Score***	***Target risk score (after further actions)*** *Likelihood* *Impact* ***Score***		
2103	eHealth	[redacted]					

Datix ID	Directorate/Partnership	Score	Risk level	Governance/ review committee
2188	Medical	12	Corporate level risk	Clinical & Care Governance Committee
2188	Medical	12	Corporate level risk	Clinical & Care Governance Committee
2188	Medical	12	Corporate level risk	Clinical & Care Governance Committee
2188	Medical	12	Corporate level risk	Clinical & Care Governance Committee
2188	Medical	12	Corporate level risk	Clinical & Care Governance Committee
2188	Medical	12	Corporate level risk	Clinical & Care Governance Committee
[redacted]				

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Likelihood

1 – **Rare -** is unlikely to happen
2 – **Unlikely -** not expected to happen
3 – **Possible -** may occur occasionally
4 – **Likely -** will probably occur, but not a persistent issue
5 – **Almost certain -** will undoubtedly occur/is happening

Impact

1 – **Negligible**
2 – **Minor**
3 – **Moderate**
4 – **Major**
5 – **Extreme**

Consequence

Likelihood	*Impact/Consequence*				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	**Medium 5**	**High 10**	**High 15**	**Very High 20**	**Very High 25**
Likely	**Medium 4**	**Medium 8**	**High 12**	**High 16**	**Very High 20**
Possible	**Low 3**	**Medium 6**	**Medium 9**	**High 12**	**High 15**
Unlikely	**Low 2**	**Medium 4**	**Medium 6**	**Medium 8**	**High 10**
Rare	**Low 1**	**Low 2**	**Low 3**	**Medium 4**	**Medium 5**

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2055	Acute	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							
2057	Acute/ HSCPs	Chief Officers, Director of Estates & Facilities	Reduction in capital funding and pressure on revenue resources impacts on backlog maintenance and Health and Safety obligations leading to the possibility of non compliance with applicable Health and Safety legislation and SG policies and guidance.	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure. The system has risk assessment criteria that 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 [redacted] enables the sector estates teams to undertake Statutory operational maintenance and repair. These requirements have set maintenance, inspection and testing levels as detailed within Statutory Compliance legislation. 5. Property Asset Management Strategy in place. ***6. The annual capital and revenue funding for Estates & Facilities takes cognisance of the statutory obligations applied to the NHS Board. Prioritisation is informed by EAMs and the PAMS data.***	***A review of NHSGGC's EAM system is being undertakenin orsder to review the accuracyof data and to change the presentation of information. The outcome of this will provide management with more understandable data, and inform us where we have risk, and, therefore, enable us to mitigate risks. The asset management review will lay out details of areas which require investment, and risk assess those areas.***	**Jul-19**	**Finance & Planning Committee**

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		3	*3*	*9*	*2*	*3*	*6*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2059	[redacted]						
2060							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2063	Human Resources	[redacted]					
2064	Estates & Facilities	Director of Estates & Facilities	The probability of Queen Elizabeth University Hospital being at high risk due to the incorporation of Aluminium Composite Materials (ACMs) similar but not the same to those used in Grenfell Tower, leading to an increased likelihood of a fire occurring. As part of the inspection work on cladding, a further issue was uncovered regarding a section of cladding on the RHC. HFS conducted an inspection and deemed the building safe.	The QEUH has been designed and engineered to meet Building and Fire Safety Regulations. Health Facilities Scotland and their National Fire Advisor have given assurances that the hospital is an extremely safe building. Firm assurances have also been given by the main contractor and their design team and the Board's technical advisers that the regulatory process has been followed and that the appropriate Building Standards Completion Certificates are in place. As a precautionary measure, and to make sure the public, patients and staff have full confidence in the safety of the QEUH, the NHS Board officers took the decision to remove the panels from the three external sections of the hospital where these panels are located. Officers worked with contractors and technical advisers in assessing how to proceed this work. As a result, the original building contractor (Brookfield) will replace the panels. ***Work on the Children's Hospital has been completed and the building has been reclad.***	It has been decided that the ACM panels are to be removed and replaced with non-combustible panels. Building warrants and engineering certificates have been secured. ***Work is due to commence in February 2019, with completion esimated for June/July 2019. The works should not affect any patient care within the building.***	***July 2019***	**Finance & Planning Committee**

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		2	*3*	*6*	*1*	*3*	*3*		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2065	[redacted]						
2082							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2188	Medical	Medical Director	Failure to comply with recognised policies and procedures in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. The impact of these pathogens on different patients and in different healthcare systems can be variable, so we have to be prepared to modify local guidance to fit the needs of local services. This can be complicated and open to interpretation especially as these will sometimes require whole system changes, e.g. wearing of FFP3 masks for patients with query MERS. Any change also need to be supported by local guidance and training. IPCT are a limited resource so ensuring that any changes are applied across the whole system in a consistent manner is challenging. Emerging pathogens represent a risk because often the epidemiology and routes of transmission are not fully understood. The consequences are cross transmission and outbreaks. SOPs to support the management of environmental and drug resistant organisms is underway.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. Targeted education re the use of Respiratory Protective Equipment will also be rolled out.	**Ongoing**	**Clinical & Care Governance Committee**

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		4	*3*	*12*	*4*	*3*	*12*		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
	Acute		*There is a reputational risk in respect of the recent issues and concerns expressed relating to the QEUH and RHC, including:* *• facilities and environmental issues* *• capacity flow across the south sector* *• intense media scrutiny regarding patient care*	*• Robust escalation process in place to proactively manage any issue to ensure patient and staff safety in respect of the Board's facilities* *• Clinical focus remains on patient safety, with extensive reporting and monitoring, e.g. robust infection control procedures* *• Significant senior management capacity allocated to addressing recent incidents.* *• Proactive media handling*	*A programme board, chaired by the Chief Executive, will be established to oversee the following work:* *• An internal review of the facilities and environmental issues in respect of the QEUH and RHC* *• A review of capacity and flow to assess the present position against the original model and planning assumptions* *• A review of clinical outcomes over the period to provide assurance* *An independent external review of the QEUH, ordered by the Cabinet Secretary, will also be carried out, as well as a Scotland-wide inquiry launched by the Scottish Parliament Health and Sport Committee on Health Hazards in the Healthcare Environment.*		

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		4	*5*	*20*	*3*	*3*	*9*		

Datix ID	irectorate/ artnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

NHS Greater Glasgow and Clyde - Corporate Risk Register *April 2019*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							
2057	Acute/ HSCPs	Chief Officers, Director of Estates & Facilities	Reduction in capital funding and pressure on revenue resources impacts on backlog maintenance and Health and Safety obligations leading to the possibility of non compliance with applicable Health and Safety legislation and SG policies and guidance.	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure. The system has risk assessment criteria that 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 [redacted] enables the sector estates teams to undertake Statutory operational maintenance and repair. These requirements have set maintenance, inspection and testing levels as detailed within Statutory Compliance legislation. 5. Property Asset Management Strategy in place. ***6. The annual capital and revenue funding for Estates & Facilities takes cognisance of the statutory obligations applied to the NHS Board. Prioritisation is informed by EAMs and the PAMS data.***	***A review of NHSGGC's EAM system is being undertaken in orsder to review the accuracyof data and to change the presentation of information. The outcome of this will provide management with more understandable data, and inform us where we have risk, and, therefore, enable us to mitigate risks. The asset management review will lay out details of areas which require investment, and risk assess those areas.***	**Jul-19**	**Finance & Planning Committee**

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		3	*3*	*9*	*2*	*3*	*6*

NHS Greater Glasgow and Clyde - Corporate Risk Register *April 2019*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

NHS Greater Glasgow and Clyde - Corporate Risk Register *April 2019*

Datix ID	irectorate/ artnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

NHS Greater Glasgow and Clyde - Corporate Risk Register *April 2019*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2061	Finance	[redacted]					

NHS Greater Glasgow and Clyde - Corporate Risk Register *April 2019*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

NHS Greater Glasgow and Clyde - Corporate Risk Register ***April 2019***

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2063	[redacted]						
2064	Estates & Facilities	Director of Estates & Facilities	The probability of Queen Elizabeth University Hospital being at high risk due to the incorporation of Aluminium Composite Materials (ACMs) similar but not the same to those used in Grenfell Tower, leading to an increased likelihood of a fire occurring. As part of the inspection work on cladding, a further issue was uncovered regarding a section of cladding on the RHC. HFS conducted an inspection and deemed the building safe.	The QEUH has been designed and engineered to meet Building and Fire Safety Regulations. Health Facilities Scotland and their National Fire Advisor have given assurances that the hospital is an extremely safe building. Firm assurances have also been given by the main contractor and their design team and the Board's technical advisers that the regulatory process has been followed and that the appropriate Building Standards Completion Certificates are in place. As a precautionary measure, and to make sure the public, patients and staff have full confidence in the safety of the QEUH, the NHS Board officers took the decision to remove the panels from the three external sections of the hospital where these panels are located. Officers worked with contractors and technical advisers in assessing how to proceed this work. As a result, the original building contractor (Brookfield) will replace the panels. ***Work on the Children's Hospital has been completed and the building has been reclad.***	It has been decided that the ACM panels are to be removed and replaced with non-combustible panels. Building warrants and engineering certificates have been secured. ***Work is due to commence in February 2019, with completion esimated for June/July 2019. The works should not affect any patient care within the building.***	***July 2019***	**Finance & Planning Committee**

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		2	*3*	*6*	*1*	*3*	*3*		

NHS Greater Glasgow and Clyde - Corporate Risk Register *April 2019*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2065	[redacted]						
2082							

NHS Greater Glasgow and Clyde - Corporate Risk Register *April 2019*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

NHS Greater Glasgow and Clyde - Corporate Risk Register *April 2019*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

NHS Greater Glasgow and Clyde - Corporate Risk Register ***April 2019***

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2188	Medical	Medical Director	Failure to comply with recognised policies and procedures in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. The impact of these pathogens on different patients and in different healthcare systems can be variable, so we have to be prepared to modify local guidance to fit the needs of local services. This can be complicated and open to interpretation especially as these will sometimes require whole system changes, e.g. wearing of FFP3 masks for patients with query MERS. Any change also need to be supported by local guidance and training. IPCT are a limited resource so ensuring that any changes are applied across the whole system in a consistent manner is challenging. Emerging pathogens represent a risk because often the epidemiology and routes of transmission are not fully understood. The consequences are cross transmission and outbreaks. SOPs to support the management of environmental and drug resistant organisms is underway.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. Targeted education re the use of Respiratory Protective Equipment will also be rolled out.	**Ongoing**	**Clinical & Care Governance Committee**

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		4	*3*	*12*	*4*	*3*	*12*

NHS Greater Glasgow and Clyde - Corporate Risk Register *April 2019*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

NHS Greater Glasgow and Clyde - Corporate Risk Register *April 2019*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

NHS Greater Glasgow and Clyde - Corporate Risk Register *April 2019*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2190	Facilities and Estates	Director of Facilities and Estates	*Impact of failure to implement national guidance, systems and policies in relation to:* ** the bulit environment* ** patient safety* ** reputational risk* ** business continuity* ** system efficiency*	*Close working with clinical teams.* *Maximising current control measures to expedite actions.* *Additional managerial and frontline staff in place to ensure action in key areas.*	*Asset base survey underway* *Review of current structures and interface between departments* *Review of assurance processes* *Review actions from external advisors and assessors* *Infection Control and Built Environment Group being established*		Acute Services Committee

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		4	*3*	*12*	*3*	*3*	*9*		

Likelihood

1 – **Rare -** is unlikely to happen
2 – **Unlikely -** not expected to happen
3 – **Possible -** may occur occasionally
4 – **Likely -** will probably occur, but not a persistent issue
5 – **Almost certain -** will undoubtedly occur/is happening

Impact

1 – **Negligible**
2 – **Minor**
3 – **Moderate**
4 – **Major**
5 – **Extreme**

Consequence

Likelihood	*Impact/Consequence*				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	**Medium 5**	**High 10**	**High 15**	**Very High 20**	**Very High 25**
Likely	**Medium 4**	**Medium 8**	**High 12**	**High 16**	**Very High 20**
Possible	**Low 3**	**Medium 6**	**Medium 9**	**High 12**	**High 15**
Unlikely	**Low 2**	**Medium 4**	**Medium 6**	**Medium 8**	**High 10**
Rare	**Low 1**	**Low 2**	**Low 3**	**Medium 4**	**Medium 5**

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2057	Acute/ HSCPs	Chief Officers, Director of Estates & Facilities	Reduction in capital funding and pressure on revenue resources impacts on backlog maintenance and Health and Safety obligations leading to the possibility of non compliance with applicable Health and Safety legislation and SG policies and guidance.	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure. The system has risk assessment criteria that 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 [redacted] enables the sector estates teams to undertake Statutory operational maintenance and repair. These requirements have set maintenance, inspection and testing levels as detailed within Statutory Compliance legislation. 5. Property Asset Management Strategy in place. 6. The annual capital and revenue funding for Estates & Facilities takes cognisance of the statutory obligations applied to the NHS Board. Prioritisation is informed by EAMs and the PAMS data.	A review of NHSGGC's EAM system is being undertaken in orsder to review the accuracy of data and to change the presentation of information. The outcome of this will provide management with more understandable data, and inform us where we have risk, and, therefore, enable us to mitigate risks. The asset management review will lay out details of areas which require investment, and risk assess those areas.	**Jul-19**	**Finance & Planning Committee**

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		3	*3*	*9*	*2*	*3*	*6*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2188	Medical	Medical Director	Failure to comply with recognised policies and procedures in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. The impact of these pathogens on different patients and in different healthcare systems can be variable, so we have to be prepared to modify local guidance to fit the needs of local services. This can be complicated and open to interpretation especially as these will sometimes require whole system changes, e.g. wearing of FFP3 masks for patients with query MERS. Any change also need to be supported by local guidance and training. IPCT are a limited resource so ensuring that any changes are applied across the whole system in a consistent manner is challenging. Emerging pathogens represent a risk because often the epidemiology and routes of transmission are not fully understood. The consequences are cross transmission and outbreaks. SOPs to support the management of environmental and drug resistant organisms is underway. ***The requirement to complete the MRSA CRA was published as a "Hot Topic" on StaffNet (NHSGGC intranet) on 14 March 2019 and this message has also been conveyed to all Chief Nurses within the Acute Adult Sectors / Directorates.***	***Improvement actions include the following:*** ***PVC Care Plan*** ***The PVC care plan has been approved by Chiefs of Nursing and Medicine and is currently being rolled out throughout NHSGGC. This plan now focuses on the removal of the device as soon as possible, rather than the maintenance of it and increases the number of daily checks from once to twice per day. It also promotes the switch from IV to oral antibiotics which is a key message from the antimicrobial management team. IPCT will monitor the impact of this initiative during 2019.*** ***PVC Packs*** ***Samples of this pack are currently being evaluated. If clinical areas approve it is possible that this could be available for use by May 2019.*** ***A further SAB group meeting in which to explore any other areas for improvement is scheduled for 28th May 2019.*** ***PVC poster*** ***A poster has been developed by the clinical team in one of the wards in Glasgow Royal Infirmary (North Glasgow Sector) which is displayed on the medical case note trolley. This acts as a simple and visual aide memoire to remind medical and nursing staff to ensure:*** ***- Unnecessary PVCs are removed promptly.*** ***- Review of IV antibiotics and consider the switch from intravenous to oral medications daily.*** ***- Documentation for all PVCs is present in the clinical notes.*** ***This has been approved, in principle, by the Chief Nurses and will be cascaded for use throughout the Acute Sector.*** ***MRSA*** ***Patients in high-risk areas are all routinely screened for MRSA and the CRA is an additional precaution. Ward compliance rates are returned to the Sector / Directorate Senior Management Teams to identify areas that require support/education in relation to improved screening. This information is contained within the Sector / Directorate IPC Monthly Report which is tabled at the Sector / Directorate governance meetings. The updated My Assessment Record (MAR) is in the process of being rolled out. In the meantime during their weekly visits, the IPC Nurses (IPCNs) will check three patient admission documents and report any poor compliance with the completion of the assessment to the Nurse in Charge, the Lead and Chief Nurses. Chief Nurses will immediately instruct Lead Nurses to address this with Senior Charge Nurses and determine any actions which will be taken to improve compliance, e.g. safety briefs, education. Compliance rates are also reported to the Acute Services Division Clinical Governance Forum. IPCT will continue to monitor this.***	**Ongoing**	**Clinical & Care Governance Committee**

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		5	*4*	*20*	*5*	*4*	*20*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2190	Facilities and Estates	**Director of Facilities and Estates**	Impact of failure to implement national guidance, systems and policies in relation to: * the bulit environment * patient safety * reputational risk * business continuity * system efficiency	Close working with clinical teams. Maximising current control measures to expedite actions. Additional managerial and frontline staff in place to ensure action in key areas.	Asset base survey underway Review of current structures and interface between departments Review of assurance processes Review actions from external advisors and assessors Infection Control and Built Environment Group being established	**Sep-19** **Aug-19** **Jun-19** **Sep-19** **Jun-19**	**Acute Services Committee**
		Risk level and scores	***Corporate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood ***4*** / ***Impact*** ***3*** / ***Score*** ***12***	***Likelihood*** ***3*** / ***Impact*** ***3*** / ***Score*** ***9***		
	Acute		***There is a reputational risk in respect of the recent issues and concerns expressed relating to the QEUH and RHC, including:*** ***• facilities and environmental issues*** ***• capacity flow across the south sector*** ***• intense media scrutiny regarding patient care***	***• Robust escalation process in place to proactively manage any issue to ensure patient and staff safety in respect of the Board's facilities*** ***• Clinical focus remains on patient safety, with extensive reporting and monitoring, e.g. robust infection control procedures*** ***• Significant senior management capacity allocated to addressing recent incidents.*** ***• Proactive media handling***	***A programme board, chaired by the Chief Executive, will be established to oversee the following work:*** ***• An internal review of the facilities and environmental issues in respect of the QEUH and RHC*** ***• A review of capacity and flow to assess the present position against the original model and planning assumptions*** ***• A review of clinical outcomes over the period to provide assurance*** ***An independent external review of the QEUH, ordered by the Cabinet Secretary, will also be carried out, as well as a Scotland-wide inquiry launched by the Scottish Parliament Health and Sport Committee on Health Hazards in the Healthcare Environment.***	**Dec-19**	
		Risk level and scores	***Corporate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood ***4*** / ***Impact*** ***5*** / ***Score*** ***20***	***Likelihood*** ***3*** / ***Impact*** ***3*** / ***Score*** ***9***		
	Human Resources	**Learning and Education Lead, Head of OD - Acute and Corporate**	***Failure of managers/ leaders to effectively engage with staff. Lack of engagement can create a workplace climate where staff are unable to perform to their best which can in turn can impact upon patient care and service delivery.***	***Annual iMatter staff survey schedule in place as the national tool to measure engagement by providing all staff with the opportunity to provide feedback to their manager and the organisation. A 60% return rate of surveys is required to provide a Team/ Board report to then inform local staff engagement action plans . iMatter Operational Lead meets with local iMatter Leads for each iMatter run, monthly/ as required, to review plan and discuss timescales, actions and how to overcome identified barriers for engagement. There are also significant levels of investment in management and leadership development, development of team based working and the development of a GGC Culture Framework to inform culture developments actions at CMT level and below.***	***Continue to work with local Leads and senior managers to identify area specific barriers to implementation and develop solutions using learning from previous iMatter runs. Agree and implement a plan for culture development informed by outPuts from focus groups and monitoring tools such as iMatter.***	**Dec-19**	**Staff Governance Committee**
		Risk level and scores	***Corporate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood ***3*** / ***Impact*** ***4*** / ***Score*** ***12***	***Likelihood*** ***1*** / ***Impact*** ***5*** / ***Score*** ***5***		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							
	Human Resources	Head of Health & Safety	*Risk of Non-compliance with enforcement agency requirements leading to enforcement action eg. fines, prosecution*	*Enforcement agency requirements are the responsibility of the relevant Director to ensure that the appropriate action is taken. This action is co-ordinated by the Head of Health and Safety. Only the Head of HS and senior staff will deal directly with enforcement agencies. Potential issues of non-compliance will be discussed at the earliest stage with the appropriare Director and dialogue entered into with Enforcement Agency - Health and Safety Executive for health and safety issues.*	*Further engagement with Health and Safety Executive on a regular basis to ensure that statutory requirements are discussed in advance of any inspection visits to ensure compliance can be demonstrated in advance of visits.*	Aug-19	Staff Governance Committee

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		3	*4*	*12*	*2*	*4*	*8*

[redacted]

Likelihood

1 – Rare - is unlikely to happen
2 – Unlikely - not expected to happen
3 – Possible - may occur occasionally
4 – Likely - will probably occur, but not a persistent issue
5 – Almost certain - will undoubtedly occur/is happening

Impact

1 – Negligible
2 – Minor
3 – Moderate
4 – Major
5 – Extreme

Consequence

Likelihood	*Impact/Consequence*				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	**Medium 5**	**High 10**	**High 15**	**Very High 20**	**Very High 25**
Likely	**Medium 4**	**Medium 8**	**High 12**	**High 16**	**Very High 20**
Possible	**Low 3**	**Medium 6**	**Medium 9**	**High 12**	**High 15**
Unlikely	**Low 2**	**Medium 4**	**Medium 6**	**Medium 8**	**High 10**
Rare	**Low 1**	**Low 2**	**Low 3**	**Medium 4**	**Medium 5**

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2055	Acute	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2057	Acute/ HSCPs	Chief Officers, Director of Estates & Facilities	Reduction in capital funding and pressure on revenue resources impacts on backlog maintenance and Health and Safety obligations leading to the possibility of non compliance with applicable Health and Safety legislation and SG policies and guidance.	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure. The system has risk assessment criteria that 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 [redacted] enables the sector estates teams to undertake Statutory operational maintenance and repair. These requirements have set maintenance, inspection and testing levels as detailed within Statutory Compliance legislation. 5. Property Asset Management Strategy in place. 6. The annual capital and revenue funding for Estates & Facilities takes cognisance of the statutory obligations applied to the NHS Board. Prioritisation is informed by EAMs and the PAMS data.	A review of NHSGGC's EAM system is being undertaken in orsder to review the accuracy of data and to change the presentation of information. The outcome of this will provide management with more understandable data, and inform us where we have risk, and, therefore, enable us to mitigate risks. The asset management review will lay out details of areas which require investment, and risk assess those areas.	**Jul-19**	**Finance & Planning Committee**
		Risk level and scores	***Corporate level risk***	***Current risk score***			***Target risk score (after further actions)***				
				Likelihood	***Impact***	***Score***	***Likelihood***	***Impact***	***Score***		
				3	***3***	***9***	***2***	***3***	***6***		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2059	Public Health	[redacted]					
2060	Public Health						

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2188	Medical	Medical Director	Failure to comply with recognised policies and procedures in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. Continue to support education for all staff including novel models, e.g information café, ward based training and scenario based training. Training initiatives need to be flexible to address the needs of a 24/7 workforce. This is in place in NHSGGC. Training available for staff who are likely to encounter infections of high consequence. PVC care plan has now been rolled out to all of GGC. SOPs to support the management of environmental and drug resistant organisms is now in place. The requirement to complete the MRSA & CPE CRA was published as a "Hot Topic" on StaffNet (NHSGGC intranet) on 14 March 2019 and this message has also been conveyed to all Chief Nurses within the Acute Adult Sectors / Directorates	***Improvement actions include the following:*** ***PVC Packs*** ***Samples of this pack are currently being evaluated. If clinical areas approve it is possible that this could be available for use by July 2019.*** ***IPC App*** ***Feasibility/cost currently being explored. This would facilitate access to information at all times. An evaluation of this should be completed by August 2109.*** ***MRSA/CPE Screening*** ***Continue to participate in the NHS Scotland screening initiative and feedback within agreed timescales. This should help to imbed screening for resistant organisms into practice with a system proposed for local reporting.*** ***Assurance re Policy Implementation*** ***Update the IPCAT audit process and criteria in order to facilitate the implementation of not only audit for assurance but audit for improvement.*** ***Outbreak and Incident Debriefs*** ***Use the output from the outbreak and incident debriefs to improve processes where appropriate. These are currently ongoing.***	**July 2019** **August 2019** **TBD by SGHD** **July 2109** **August 2019**	**Clinical & Care Governance Committee**

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		5	*4*	*20*	*4*	*4*	*16*		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2190	Facilities and Estates	**Director of Facilities and Estates**	Impact of failure to implement national guidance, systems and policies in relation to: * the bulit environment * patient safety * reputational risk * business continuity * system efficiency	Close working with clinical teams. Maximising current control measures to expedite actions. Additional managerial and frontline staff in place to ensure action in key areas.	Asset base survey underway Review of current structures and interface between departments Review of assurance processes Review actions from external advisors and assessors Infection Control and Built Environment Group being established	**Sep-19** **Aug-19** **Jun-19** **Sep-19** **Jun-19**	**Acute Services Committee**
		Risk level and scores	***Corporate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood ***Impact*** ***Score*** ***4*** ***3*** ***12***	***Likelihood*** ***Impact*** ***Score*** ***3*** ***3*** ***9***		
To be added 1	Acute	**Chief Operating Officer - Acute**	***There is a reputational risk in respect of the recent issues and concerns expressed relating to the QEUH and RHC, including:*** ***• facilities and environmental issues*** ***• capacity flow across the south sector*** ***• intense media scrutiny regarding patient care***	***• Robust escalation process in place to proactively manage any issue to ensure patient and staff safety in respect of the Board's facilities*** ***• Clinical focus remains on patient safety, with extensive reporting and monitoring, e.g. robust infection control procedures*** ***• Significant senior management capacity allocated to addressing recent incidents.*** ***• Proactive media handling***	***A programme board, chaired by the Chief Executive, will be established to oversee the following work:*** ***• An internal review of the facilities and environmental issues in respect of the QEUH and RHC*** ***• A review of capacity and flow to assess the present position against the original model and planning assumptions*** ***• A review of clinical outcomes over the period to provide assurance*** ***An independent external review of the QEUH, ordered by the Cabinet Secretary, will also be carried out, as well as a Scotland-wide inquiry launched by the Scottish Parliament Health and Sport Committee on Health Hazards in the Healthcare Environment.***	**Dec-19**	**Acute Serices Committee**
		Risk level and scores	***Corporate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood ***Impact*** ***Score*** ***4*** ***5*** ***20***	***Likelihood*** ***Impact*** ***Score*** ***3*** ***3*** ***9***		
To be added 2	Human Resources	**Director of HR & OD**	***Failure of managers/ leaders to effectively engage with staff. Lack of engagement can create a workplace climate where staff are unable to perform to their best which can in turn can impact upon patient care and service delivery.***	***Annual iMatter staff survey schedule in place as the national tool to measure engagement by providing all staff with the opportunity to provide feedback to their manager and the organisation. A 60% return rate of surveys is required to provide a Team/ Board report to then inform local staff engagement action plans . iMatter Operational Lead meets with local iMatter Leads for each iMatter run, monthly/ as required, to review plan and discuss timescales, actions and how to overcome identified barriers for engagement. There are also significant levels of investment in management and leadership development, development of team based working and the development of a GGC Culture Framework to inform culture developments actions at CMT level and below.***	***Continue to work with local Leads and senior managers to identify area specific barriers to implementation and develop solutions using learning from previous iMatter runs. Agree and implement a plan for culture development informed by outPuts from focus groups and monitoring tools such as iMatter.***	**Dec-19**	**Staff Governance Committee**
		Risk level and scores	***Corporate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood ***Impact*** ***Score*** ***3*** ***4*** ***12***	***Likelihood*** ***Impact*** ***Score*** ***1*** ***5*** ***5***		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
To be added 3	Human Resources	Director of HR & OD	*Risk of Non-compliance with enforcement agency requirements leading to enforcement action eg. fines, prosecution*	*Enforcement agency requirements are the responsibility of the relevant Director to ensure that the appropriate action is taken. This action is co-ordinated by the Head of Health and Safety. Only the Head of HS and senior staff will deal directly with enforcement agencies. Potential issues of non-compliance will be discussed at the earliest stage with the appropriare Director and dialogue entered into with Enforcement Agency - Health and Safety Executive for health and safety issues.*	*Further engagement with Health and Safety Executive on a regular basis to ensure that statutory requirements are discussed in advance of any inspection visits to ensure compliance can be demonstrated in advance of visits.*	Aug-19	Staff Governance Committee
		Risk level and scores	*Corporate level risk*	*Current risk score* Likelihood: *3* Impact: *4* Score: *12*	*Target risk score (after further actions)* Likelihood: *2* Impact: *4* Score: *8*		
To be added 4	Nursing	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2054	Acute	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2055	Acute	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2056	Acute/	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2057	Acute/ HSCPs	Chief Officers, Director of Estates & Facilities	Reduction in capital funding and pressure on revenue resources impacts on backlog maintenance and Health and Safety obligations leading to the possibility of non compliance with applicable Health and Safety legislation and SG policies and guidance.	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure. The system has risk assessment criteria that 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 [redacted] enables the sector estates teams to undertake Statutory operational maintenance and repair. These requirements have set maintenance, inspection and testing levels as detailed within Statutory Compliance legislation. 5. Property Asset Management Strategy in place. 6. The annual capital and revenue funding for Estates & Facilities takes cognisance of the statutory obligations applied to the NHS Board. Prioritisation is informed by EAMs and the PAMS data.	A review of NHSGGC's EAM system is being undertaken in orsder to review the accuracy of data and to change the presentation of information. The outcome of this will provide management with more understandable data, and inform us where we have risk, and, therefore, enable us to mitigate risks. The asset management review will lay out details of areas which require investment, and risk assess those areas.	Jul-19	**Finance & Planning Committee**

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		3	*3*	*9*	*2*	*3*	*6*		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2082	Nursing	[redacted]					

Datix ID	irectorate/ artnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2188	Medical	Medical Director	Failure to comply with recognised policies and procedures in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. Continue to support education for all staff including novel models, e.g information café, ward based training and scenario based training. Training initiatives need to be flexible to address the needs of a 24/7 workforce. This is in place in NHSGGC. Training available for staff who are likely to encounter infections of high consequence. PVC care plan has now been rolled out to all of GGC. SOPs to support the management of environmental and drug resistant organisms is now in place. The requirement to complete the MRSA & CPE CRA was published as a "Hot Topic" on StaffNet (NHSGGC intranet) on 14 March 2019 and this message has also been conveyed to all Chief Nurses within the Acute Adult Sectors / Directorates	Improvement actions include the following: PVC Packs Samples of this pack are currently being evaluated. If clinical areas approve it is possible that this could be available for use by July 2019. IPC App Feasibility/cost currently being explored. This would facilitate access to information at all times. An evaluation of this should be completed by August 2109. MRSA/CPE Screening Continue to participate in the NHS Scotland screening initiative and feedback within agreed timescales. This should help to imbed screening for resistant organisms into practice with a system proposed for local reporting. Assurance re Policy Implementation Update the IPCAT audit process and criteria in order to facilitate the implementation of not only audit for assurance but audit for improvement. Outbreak and Incident Debriefs Use the output from the outbreak and incident debriefs to improve processes where appropriate. These are currently ongoing.	Trial complete and successful. Recommendation to take forward sent for approval to SAB group in August Cost of app prohibitive at this time. IPC audit updated to include KPIs position recovered reporting compliance of 92% and 94% for MRSA and CPE IPCAT updated tested and framework developed this will be in place by September	Clinical & Care Governance Committee

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		5	*4*	*20*	*4*	*4*	*16*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2103	eHealth	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2199	Public Health	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2190	Facilities and Estates	**Director of Facilities and Estates**	Impact of failure to implement national guidance, systems and policies in relation to: * the built environment * patient safety * reputational risk * business continuity * system efficiency	Close working with clinical teams. Maximising current control measures to expedite actions. Additional managerial and frontline staff in place to ensure action in key areas.	Asset base survey underway Review of current structures and interface between departments Review of assurance processes Review actions from external advisors and assessors Infection Control and Built Environment Group being established	Mar-20 Oct-19 Complete Complete Complete	**Acute Services Committee**
		Risk level and scores	***Corporate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood / ***Impact*** / ***Score*** ***4*** / ***3*** / ***12***	***Likelihood*** / ***Impact*** / ***Score*** ***3*** / ***3*** / ***9***		
To be added 1 (Last Meeting)	Acute	Chief Operating Officer - Acute	There is a reputational risk in respect of the recent issues and concerns expressed relating to the QEUH and RHC, including: • facilities and environmental issues • capacity flow across the south sector • intense media scrutiny regarding patient care	• Robust escalation process in place to proactively manage any issue to ensure patient and staff safety in respect of the Board's facilities • Clinical focus remains on patient safety, with extensive reporting and monitoring, e.g. robust infection control procedures • Significant senior management capacity allocated to addressing recent incidents. • Proactive media handling	A programme board, chaired by the Chief Executive, will be established to oversee the following work: • An internal review of the facilities and environmental issues in respect of the QEUH and RHC • A review of capacity and flow to assess the present position against the original model and planning assumptions • A review of clinical outcomes over the period to provide assurance An independent external review of the QEUH, ordered by the Cabinet Secretary, will also be carried out, as well as a Scotland-wide inquiry launched by the Scottish Parliament Health and Sport Committee on Health Hazards in the Healthcare Environment. In August 2019 The Health and Safety Executive commenced a review into the issues related to the management of risks associated with ventilation and water systems within the QEUH, in particular related to wards 6A, 4B and 4C.	Dec-19	Acute Services Committee
		Risk level and scores	***Corporate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood / ***Impact*** / ***Score*** ***4*** / ***5*** / ***20***	***Likelihood*** / ***Impact*** / ***Score*** ***3*** / ***3*** / ***9***		
To be added 2 (Last Meeting)	Human Resources	Director of HR & OD	Failure of managers/ leaders to effectively engage with staff. Lack of engagement can create a workplace climate where staff are unable to perform to their best which can in turn can impact upon patient care and service delivery.	Annual iMatter staff survey schedule in place as the national tool to measure engagement by providing all staff with the opportunity to provide feedback to their manager and the organisation. A 60% return rate of surveys is required to provide a Team/ Board report to then inform local staff engagement action plans . iMatter Operational Lead meets with local iMatter Leads for each iMatter run, monthly/ as required, to review plan and discuss timescales, actions and how to overcome identified barriers for engagement. There are also significant levels of investment in management and leadership development, development of team based working and the development of a GGC Culture Framework to inform culture developments actions at CMT level and below.	Continue to work with local Leads and senior managers to identify area specific barriers to implementation and develop solutions using learning from previous iMatter runs. Agree and implement a plan for culture development informed by outPuts from focus groups and monitoring tools such as iMatter.'Further review of Directorate Succession Planning activity and check what further support may be required from OD. Create a Directorate self assessment template to help this. To be integrated into local OD annual action plans.	Dec-19	Board and Staff Governance Committee
		Risk level and scores	***Corporate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood / ***Impact*** / ***Score*** ***3*** / ***4*** / ***12***	***Likelihood*** / ***Impact*** / ***Score*** ***1*** / ***5*** / ***5***		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
To be added 3 (Last Meeting)	Human Resources	Director of HR & OD	Risk of Non-compliance with enforcement agency requirements leading to enforcement action eg. fines, prosecution	Enforcement agency requirements are the responsibility of the relevant Director to ensure that the appropriate action is taken. This action is co-ordinated by the Head of Health and Safety. Only the Head of HS and senior staff will deal directly with enforcement agencies. Potential issues of non-compliance will be discussed at the earliest stage with the appropriate Director and dialogue entered into with Enforcement Agency - Health and Safety Executive for health and safety issues.	Further engagement with Health and Safety Executive on a regular basis to ensure that statutory requirements are discussed in advance of any inspection visits to ensure compliance can be demonstrated in advance of visits.	Aug-19	Staff Governance Committee
		Risk level and scores	***Corporate level risk***	***Current risk score***		***Target risk score (after further actions)***		
				Likelihood	***Impact***	***Score***	***Likelihood***	***Impact***	***Score***
				3	***4***	***12***	***2***	***4***	***8***
To be added 4 (Last Meeting)	Nursing	[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
To be added 5 (Last meeting)	Nursing	Nurse Director	Safe Staffing Legislation: There is a risk that NHSGGC will not be in full operational readiness for the planned Safe Staffing Legislation, especially in areas where there is limited detail regarding change and impact over the workforce and a range of broader legislation issues with the potential to adversely unsettle continuity of delivery of healthcare services across NHSGGC.	1. Robust governance structures in place to support safe, effective and efficient use of Nursing, Midwifery and Allied Health Professional (NMAHP) resources. 2. Rostering Policy and Monitoring and Escalation Guidance in place and regularly monitored. 3. Robust education and training of staff in use of workload tools. 4. Local workload tool runs are timeously scheduled and outcomes reported by service. 5. National Board allocation received for the introduction of a NHSGGC Safe Staffing Team 6. Hospital Huddles to identify and mitigate critical safety information in relation service delivery to patients and also wider situational awareness issues. 7. Huddles utilised as a process using prediction to support safety and flow, input from all clinical areas on activity, safety to inform prediction on position for the day and escalation of any issues for action. 8.	1. National procedure for identification of risk caused by staffing which affects the health, wellbeing or safety of patients or the quality of care by any member of staff 2. Where risk is identified national procedure for mitigation of such risks so far as possible by clinical leader 3. Raising awareness amongst staff of the agreed national procedures 4. Arrangements for escalation of risk which have not been mitigated in assessment process 5. Provision of clinical advice where decision maker is not a clinician. 6. Procedure for onward escalation of risk from Point of Care to the Board. 7. Monitoring and review of common staffing method. 8. Test out the newly developed WOS NMAHP Workforce Planning, Assessment and Prioritisation Tool to identify the current NMAHP Workforce pressures.	Apr-20	NMAHP WWP Group; Staff Governance Group and Clinical and Care Governance Groups
		Risk level and scores	***Corporate level risk***	***Current risk score***			***Target risk score (after further actions)***				
				Likelihood	***Impact***	***Score***	***Likelihood***	***Impact***	***Score***		
				4	***4***	***16***	***4***	***4***	***16***		
To be added 6	Governance	[redacted]									

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2054	Acute	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

[redacted]

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2057	Acute/ HSCPs	Chief Officers, Director of Estates & Facilities	Reduction in capital funding and pressure on revenue resources impacts on backlog maintenance and Health and Safety obligations leading to the possibility of non compliance with applicable Health and Safety legislation and SG policies and guidance.	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure. The system has risk assessment criteria that 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 [redacted] enables the sector estates teams to undertake Statutory operational maintenance and repair. These requirements have set maintenance, inspection and testing levels as detailed within Statutory Compliance legislation. 5. Property Asset Management Strategy in place. 6. The annual capital and revenue funding for Estates & Facilities takes cognisance of the statutory obligations applied to the NHS Board. Prioritisation is informed by EAMs and the PAMS data.	A review of NHSGGC's EAM system is being undertaken in orsder to review the accuracy of data and to change the presentation of information. The outcome of this will provide management with more understandable data, and inform us where we have risk, and, therefore, enable us to mitigate risks. The asset management review will lay out details of areas which require investment, and risk assess those areas.	Complete	**Finance & Planning Committee**

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		3	*3*	*9*	*2*	*3*	*6*		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2059	Public Health	[redacted]					
2060	Public Health						

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2082	Nursing	[redacted]					

Datix ID	irectorate/ artnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2188	Medical	Medical Director	Failure to comply with recognised policies and procedures in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. Continue to support education for all staff including novel models, e.g information café, ward based training and scenario based training. Training initiatives need to be flexible to address the needs of a 24/7 workforce. This is in place in NHSGGC. Training available for staff who are likely to encounter infections of high consequence. PVC care plan has now been rolled out to all of GGC. SOPs to support the management of environmental and drug resistant organisms is now in place. The requirement to complete the MRSA & CPE CRA was published as a "Hot Topic" on StaffNet (NHSGGC intranet) on 14 March 2019 and this message has also been conveyed to all Chief Nurses within the Acute Adult Sectors / Directorates	Improvement actions include the following: PVC Packs – These pack are now available for clinical areas and they have been promoted via the Chief Nurses and Chiefs of Medicine/ MRSA/CPE Screening Continue to participate in the NHS Scotland screening initiative and feedback within agreed timescales. This should help to imbed screening for resistant organisms into practice with a system proposed for local reporting. Results from recent audit confirm that compliance has returned to normal levels. Assurance re Policy Implementation. New IPCAT audit methodology has been circulated to Chief Nurses. It is anticipated that this new process will begin on the 1 January 2019. Outbreak and Incident Debriefs Use the output from the outbreak and incident debriefs to improve processes where appropriate. These are currently ongoing.	Jan 20	Clinical & Care Governance Committee

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		5	*4*	*20*	*4*	*4*	*16*		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2103	eHealth	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2190	Facilities and Estates	**Director of Facilities and Estates**	Impact of failure to implement national guidance, systems and policies in relation to: * the built environment * patient safety * reputational risk * business continuity * system efficiency	Close working with clinical teams. Maximising current control measures to expedite actions. Additional managerial and frontline staff in place to ensure action in key areas.	Asset base survey underway Review of current structures and interface between departments Review of assurance processes Review actions from external advisors and assessors Infection Control and Built Environment Group being established	Mar-20 Mar-20 Complete Complete Complete	**Acute Services Committee**
		Risk level and scores	***Corporate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood / ***Impact*** / ***Score*** ***4*** / ***3*** / ***12***	***Likelihood*** / ***Impact*** / ***Score*** ***3*** / ***3*** / ***9***		
To be added 1 (Last Meeting)	Acute	Chief Operating Officer - Acute	There is a reputational risk in respect of the recent issues and concerns expressed relating to the QEUH and RHC, including: • facilities and environmental issues • capacity flow across the south sector • intense media scrutiny regarding patient care design, build and commissions	• Robust escalation process in place to proactively manage any issue to ensure patient and staff safety in respect of the Board's facilities • Clinical focus remains on patient safety, with extensive reporting and monitoring, e.g. robust infection control procedures • Significant senior management capacity allocated to addressing recent incidents. • Proactive media handling • Programme Board established to oversee the reviews • Steering Group estabilised and meeting to collate review and supply the documents and information required for the inquiries. • Programme Management Office being established at Board HQ. • Clinical Management Team Established to liaise directly with the Scottish Government Oversight Board	A programme board, chaired by the Chief Executive, will be established to oversee the following work: • An internal review of the facilities and environmental issues in respect of the QEUH and RHC • A review of capacity and flow to assess the present position against the original model and planning assumptions • A review of clinical outcomes over the period to provide assurance An independent external review of the QEUH, ordered by the Cabinet Secretary is currently progressing and a Scotland-wide inquiry was launched by the Scottish Parliament Health and Sport Committee on Health Hazards in the Healthcare Environment. In August 2019 The Health and Safety Executive have conducted a review into the issues related to the management of risks associated with ventilation and water systems within the QEUH, in particular related to wards 6A, 4B and 4C. The report is awaited. A Public Inquiry into issues at the Queen Elizabeth University Hospital in Glasgow and the Royal Hospital for Children and Young People in Edinburgh was announced by the Cabinet Secretary on 17th October 2019. Terms of Reference are still to be confirmed. On 25th November the Board was escalated to stage 4 of the NHS Board Escalation Framework. An Oversight Board chaired by the CNO is being introduced to strengthen current measures relating to Infection Prevention Management and Control at QEUH and RHC	Dec-19	Acute Services Committee
		Risk level and scores	***Corporate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood / ***Impact*** / ***Score*** ***5*** / ***4*** / ***20***	***Likelihood*** / ***Impact*** / ***Score*** ***5*** / ***4*** / ***20***		
To be added 2 (Last Meeting)	Human Resources	Director of HR & OD	Failure of managers/ leaders to effectively engage with staff. Lack of engagement can create a workplace climate where staff are unable to perform to their best which can in turn can impact upon patient care and service delivery.	Annual iMatter staff survey schedule in place as the national tool to measure engagement by providing all staff with the opportunity to provide feedback to their manager and the organisation. A 60% return rate of surveys is required to provide a Team/ Board report to then inform local staff engagement action plans . iMatter Operational Lead meets with local iMatter Leads for each iMatter run, monthly/ as required, to review plan and discuss timescales, actions and how to overcome identified barriers for engagement. There are also significant levels of investment in management and leadership development, development of team based working and the development of a GGC Culture Framework to inform culture developments actions at CMT level and below.	Continue to work with local Leads and senior managers to identify area specific barriers to implementation and develop solutions using learning from previous iMatter runs. Agree and implement a plan for culture development informed by outPuts from focus groups and monitoring tools such as iMatter.'Further review of Directorate Succession Planning activity and check what further support may be required from OD. Create a Directorate self assessment template to help this. To be integrated into local OD annual action plans.	Feb-20	Board and Staff Governance Committee

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk			Mitigating action to further reduce, eliminate or transfer residual risk			Target dates for actions	Governance /review committee
		Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
				Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
				3	*4*	*12*	*2*	*3*	*6*		
To be added 4 (Last Meeting)	Nursing	[redacted]									

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
To be added 5 (Last meeting)	Nursing	Nurse Director	Safe Staffing Legislation: There is a risk that NHSGGC will not be in full operational readiness for the planned Safe Staffing Legislation, especially in areas where there is limited detail regarding change and impact over the workforce and a range of broader legislation issues with the potential to adversely unsettle continuity of delivery of healthcare services across NHSGGC.	1. Robust governance structures in place to support safe, effective and efficient use of Nursing, Midwifery and Allied Health Professional (NMAHP) resources. 2. Rostering Policy and Monitoring and Escalation Guidance in place and regularly monitored. 3. Robust education and training of staff in use of workload tools. 4. Local workload tool runs are timeously scheduled and outcomes reported by service. 5. National Board allocation received for the introduction of a NHSGGC Safe Staffing Team 6. Hospital Huddles to identify and mitigate critical safety information in relation service delivery to patients and also wider situational awareness issues. 7. Huddles utilised as a process using prediction to support safety and flow, input from all clinical areas on activity, safety to inform prediction on position for the day and escalation of any issues for action.	1. National procedure for identification of risk caused by staffing which affects the health, wellbeing or safety of patients or the quality of care by any member of staff 2. Where risk is identified national procedure for mitigation of such risks so far as possible by clinical leader 3. Raising awareness amongst staff of the agreed national procedures 4. Arrangements for escalation of risk which have not been mitigated in assessment process 5. Provision of clinical advice where decision maker is not a clinician. 6. Procedure for onward escalation of risk from Point of Care to the Board. 7. Monitoring and review of common staffing method. 8. Test out the newly developed WOS NMAHP Workforce Planning, Assessment and Prioritisation Tool to identify the current NMAHP Workforce pressures.	Apr-20	NMAHP WWP Group; Staff Governance Group and Clinical and Care Governance Groups
		Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
				Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
To be added 6	Governance	[redacted]									
To Be Added 7	Human Resources	*Risk level and scores*	*Directorate level risk*	*Current risk score*			*Target risk score (after further actions)*				
				Current risk score	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
				4	*4*	**16**	*3*	*4*	**12**		
To be Added 8	Human Resources	Director of Human Resources and Organisational Development	Risk of personal injury to patients, staff and others related to non-compliance with legislative requirements . This can also led to enforcement action eg. fines, prosecution through the relevant Enforcement Agency eg. Health and Safety Executive.	Legislative requirements are the responsibility of the relevant Director to ensure that the appropriate action is taken to minimise risk of injury to staff, patients, visitors and others. A management system is in place to promote safe working practices and compliance with relevant legislation. Only the Head of Health and Safety and senior staff will deal directly with enforcement agencies. Potential issues of non-compliance will be discussed at the earliest stage with the appropriate Director and dialogue entered into with Enforcement Agency - Health and Safety Executive for health and safety issues.			Further engagement with HSE on a regular basis to ensure that stutory requirements are discussed in advance of any inspection visits to ensure compliance can be demonstrated in advance of visits.			**Feb-20**	**Health and Safety Forum**
		Risk level and scores	*Departmental risk*	*Current risk score*			*Target risk score (after further actions)*				
				Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
				3	*4*	**12**	*3*	*4*	**12**		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
To be Added 9	Medical	Medical Director	NHSGGC services fail to deliver high quality care to patients that results in poor outcomes or unintended harm, which significantly reduces patient health and well being	NHS GG&C Healthcare Quality Strategy & Clinical Governance Policy/Guidance Framework Mechanisms to support all clinical staff apply evidence based practice. Quality monitoring via the Clinical Governance arrangements, which are in place at Board, Divisional and Local Levels which are reviewed regularly Clinical Quality Improvement programme and projects Clinical Risk Management arrangements Clinical leadership, support and review systems such as revalidation and M&Ms	Annual implementation plan for the NHSGGC Healthcare Quality Strategy:- • Clinical Informatice strategic implementation plan • Improve Safety and effectiveness medicines via HEPMA implementation • QI programme to improving care for patients at risk of acute deterioration • QI programme to improve care for women in labour • Pilot implementation of Value Management Model	**Year one actions March 2020**	**Clinical & Care Governance Committee**

Risk level and scores	*Directorate level risk*	*Current risk score*			*Likelihood*	*Impact*	*Score*		
		Current risk score	*Impact*	*Score*					
		4	*5*	**20**	*3*	*5*	**15**		

To be added 10	Nursing	Nurse Director	NHS GG&C fails to meet the legislative, mandatory, professional and ethical obligations to provide person centred care, which will reduce patient and public confidence in services, affect the therapeutic relationship, create waste from additional management burdens in resolving deficiencies and negatively impact on staff experience.	NHS GG&C Healthcare Quality Strategy, with the related policy and guidance framework. There are multiple methods to support patients, families and the public in providing feedback on their experience. There is a network of formal responsibilities (including Executive lead) and personal leadership (including NHS staff commitment) for person centred care. There are multiple education, training, development and supervision opportunities provided by NHS GG&C to enhance staff skills and behaviours. There are internal governance arrangements to ensure collection analysis and response to feedback is leading to improvement in services and care experience. Person centred competencies embedded in staff recruitment, support and development arrangements.	NHS GG&C Healthcare Quality Strategy implementation plan will lead to; • Further improvement in the governance arrangements • Further development and integration of feedback mechanisms • Development of indicators which will facilitate monitoring and improvement in person centred care Further implementation of person centred visiting Further development of person centred care planning Review and develop mechanisms to support staff in taking pride and joy in their work Enhance public awareness in the importance of feedback, how we listen to care experience and how this helps to monitor the quality and safety of care.	**Year one actions March 2020**	**Clinical & Care Governance Committee**

Risk level and scores	*Departmental risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		5	*3*	**15**	*4*	*3*	**12**		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2054	Acute	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2055	Acute	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2056	Acute/	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2057	Acute/ HSCPs	Chief Officers, Director of Estates & Facilities	Reduction in capital funding and pressure on revenue resources impacts on backlog maintenance and Health and Safety obligations leading to the possibility of non compliance with applicable Health and Safety legislation and SG policies and guidance.	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure. The system has risk assessment criteria that 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 [redacted] enables the sector estates teams to undertake Statutory operational maintenance and repair. These requirements have set maintenance, inspection and testing levels as detailed within Statutory Compliance legislation. 5. Property Asset Management Strategy in place. 6. The annual capital and revenue funding for Estates & Facilities takes cognisance of the statutory obligations applied to the NHS Board. Prioritisation is informed by EAMs and the PAMS data.	A review of NHSGGC's EAM system is being undertaken in orsder to review the accuracy of data and to change the presentation of information. The outcome of this will provide management with more understandable data, and inform us where we have risk, and, therefore, enable us to mitigate risks. The asset management review will lay out details of areas which require investment, and risk assess those areas.	Complete	**Finance & Planning Committee**

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		3	*3*	*9*	*2*	*3*	*6*		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2059	Public Health	[redacted]					
2060	Public Health						

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2188	Medical	Medical Director	Failure to comply with recognised policies and procedures in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. Continue to support education for all staff including novel models, e.g information café, ward based training and scenario based training. Training initiatives need to be flexible to address the needs of a 24/7 workforce. This is in place in NHSGGC. Training available for staff who are likely to encounter infections of high consequence. PVC care plan has now been rolled out to all of GGC. SOPs to support the management of environmental and drug resistant organisms is now in place. The requirement to complete the MRSA & CPE CRA was published as a "Hot Topic" on StaffNet (NHSGGC intranet) on 14 March 2019 and this message has also been conveyed to all Chief Nurses within the Acute Adult Sectors / Directorates	Improvement actions include the following: PVC Packs – These pack are now available for clinical areas and they have been promoted via the Chief Nurses and Chiefs of Medicine/ MRSA/CPE Screening Continue to participate in the NHS Scotland screening initiative and feedback within agreed timescales. This should help to imbed screening for resistant organisms into practice with a system proposed for local reporting. Results from recent audit confirm that compliance has returned to normal levels. Assurance re Policy Implementation. New IPCAT audit methodology has been circulated to Chief Nurses. It is anticipated that this new process will begin on the 1 January 2019. Outbreak and Incident Debriefs Use the output from the outbreak and incident debriefs to improve processes where appropriate. These are currently ongoing.	Jan 20	Clinical & Care Governance Committee

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		5	*4*	*20*	*4*	*4*	*16*		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2199	Public Health	[redacted]					
2325	Governance						

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2190	Facilities and Estates	**Director of Facilities and Estates**	Impact of failure to implement national guidance, systems and policies in relation to: * the built environment * patient safety * reputational risk * business continuity * system efficiency	Close working with clinical teams. Maximising current control measures to expedite actions. Additional managerial and frontline staff in place to ensure action in key areas.	Asset base survey underway Review of current structures and interface between departments Review of assurance processes Review actions from external advisors and assessors Infection Control and Built Environment Group being established	Mar-20 Mar-20 Complete Complete Complete	**Acute Services Committee**
		Risk level and scores	***Corporate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood / ***Impact*** / ***Score***	***Likelihood*** / ***Impact*** / ***Score***		
				4 / ***3*** / ***12***	***3*** / ***3*** / ***9***		
To be added 1 (Last Meeting)	Acute	Chief Operating Officer - Acute	There is a reputational risk in respect of the recent issues and concerns expressed relating to the QEUH and RHC, including: • facilities and environmental issues • capacity flow across the south sector • intense media scrutiny regarding patient care design, build and commissions	• Robust escalation process in place to proactively manage any issue to ensure patient and staff safety in respect of the Board's facilities • Clinical focus remains on patient safety, with extensive reporting and monitoring, e.g. robust infection control procedures • Significant senior management capacity allocated to addressing recent incidents. • Proactive media handling • Programme Board established to oversee the reviews • Steering Group estabilised and meeting to collate review and supply the documents and information required for the inquiries. • Programme Management Office being established at Board HQ. • Clinical Management Team Established to liaise directly with the Scottish Government Oversight Board	A programme board, chaired by the Chief Executive, will be established to oversee the following work: • An internal review of the facilities and environmental issues in respect of the QEUH and RHC • A review of capacity and flow to assess the present position against the original model and planning assumptions • A review of clinical outcomes over the period to provide assurance An independent external review of the QEUH, ordered by the Cabinet Secretary is currently progressing and a Scotland-wide inquiry was launched by the Scottish Parliament Health and Sport Committee on Health Hazards in the Healthcare Environment. In August 2019 The Health and Safety Executive have conducted a review into the issues related to the management of risks associated with ventilation and water systems within the QEUH, in particular related to wards 6A, 4B and 4C. The report is awaited. A Public Inquiry into issues at the Queen Elizabeth University Hospital in Glasgow and the Royal Hospital for Children and Young People in Edinburgh was announced by the Cabinet Secretary on 17th October 2019. Terms of Reference are still to be confirmed. On 25th November the Board was escalated to stage 4 of the NHS Board Escalation Framework. An Oversight Board chaired by the CNO is being introduced to strengthen current measures relating to Infection Prevention Management and Control at QEUH and RHC	Dec-19	Acute Services Committee
		Risk level and scores	***Corporate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood / ***Impact*** / ***Score***	***Likelihood*** / ***Impact*** / ***Score***		
				5 / ***4*** / ***20***	***5*** / ***4*** / ***20***		
To be added 2 (Last Meeting)	Human Resources	Director of HR & OD	Failure of managers/ leaders to effectively engage with staff. Lack of engagement can create a workplace climate where staff are unable to perform to their best which can in turn can impact upon patient care and service delivery.	Annual iMatter staff survey schedule in place as the national tool to measure engagement by providing all staff with the opportunity to provide feedback to their manager and the organisation. A 60% return rate of surveys is required to provide a Team/ Board report to then inform local staff engagement action plans . iMatter Operational Lead meets with local iMatter Leads for each iMatter run, monthly/ as required, to review plan and discuss timescales, actions and how to overcome identified barriers for engagement. There are also significant levels of investment in management and leadership development, development of team based working and the development of a GGC Culture Framework to inform culture developments actions at CMT level and below.	Continue to work with local Leads and senior managers to identify area specific barriers to implementation and develop solutions using learning from previous iMatter runs. Agree and implement a plan for culture development informed by outPuts from focus groups and monitoring tools such as iMatter.'Further review of Directorate Succession Planning activity and check what further support may be required from OD. Create a Directorate self assessment template to help this. To be integrated into local OD annual action plans.	Feb-20	Board and Staff Governance Committee

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk			Mitigating action to further reduce, eliminate or transfer residual risk			Target dates for actions	Governance /review committee
		Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
				Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
				3	*4*	*12*	*2*	*3*	*6*		
To be added 4 (Last Meeting)	Nursing	[redacted]									

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
To be added 5 (Last meeting)	Nursing	Nurse Director	Safe Staffing Legislation: There is a risk that NHSGGC will not be in full operational readiness for the planned Safe Staffing Legislation, especially in areas where there is limited detail regarding change and impact over the workforce and a range of broader legislation issues with the potential to adversely unsettle continuity of delivery of healthcare services across NHSGGC.	1. Robust governance structures in place to support safe, effective and efficient use of Nursing, Midwifery and Allied Health Professional (NMAHP) resources. 2. Rostering Policy and Monitoring and Escalation Guidance in place and regularly monitored. 3. Robust education and training of staff in use of workload tools. 4. Local workload tool runs are timeously scheduled and outcomes reported by service. 5. National Board allocation received for the introduction of a NHSGGC Safe Staffing Team 6. Hospital Huddles to identify and mitigate critical safety information in relation service delivery to patients and also wider situational awareness issues. 7. Huddles utilised as a process using prediction to support safety and flow, input from all clinical areas on activity, safety to inform prediction on position for the day and escalation of any issues for action.	1. National procedure for identification of risk caused by staffing which affects the health, wellbeing or safety of patients or the quality of care by any member of staff 2. Where risk is identified national procedure for mitigation of such risks so far as possible by clinical leader 3. Raising awareness amongst staff of the agreed national procedures 4. Arrangements for escalation of risk which have not been mitigated in assessment process 5. Provision of clinical advice where decision maker is not a clinician. 6. Procedure for onward escalation of risk from Point of Care to the Board. 7. Monitoring and review of common staffing method. 8. Test out the newly developed WOS NMAHP Workforce Planning, Assessment and Prioritisation Tool to identify the current NMAHP Workforce pressures.	Apr-20	NMAHP WWP Group; Staff Governance Group and Clinical and Care Governance Groups
		Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
				Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
				4	*4*	*16*	*4*	*4*	*16*		
To be added 6	Governance	[redacted]									
To Be Added 7	Human Resources	[redacted]									
To be Added 8	Human Resources	Director of Human Resources and Organisational Development	Risk of personal injury to patients, staff and others related to non-compliance with legislative requirements . This can also led to enforcement action eg. fines, prosecution through the relevant Enforcement Agency eg. Health and Safety Executive.	Legislative requirements are the responsibility of the relevant Director to ensure that the appropriate action is taken to minimise risk of injury to staff, patients, visitors and others. A management system is in place to promote safe working practices and compliance with relevant legislation. Only the Head of Health and Safety and senior staff will deal directly with enforcement agencies. Potential issues of non-compliance will be discussed at the earliest stage with the appropriate Director and dialogue entered into with Enforcement Agency - Health and Safety Executive for health and safety issues.	Further engagement with HSE on a regular basis to ensure that stutory requirements are discussed in advance of any inspection visits to ensure compliance can be demonstrated in advance of visits.	**Feb-20**	**Health and Safety Forum**				
		Risk level and scores	*Departmental risk*	*Current risk score*			*Target risk score (after further actions)*				
				Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
				3	*4*	**12**	*3*	*4*	**12**		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
To be Added 9	Medical	Medical Director	NHSGGC services fail to deliver high quality care to patients that results in poor outcomes or unintended harm, which significantly reduces patient health and well being	NHS GG&C Healthcare Quality Strategy & Clinical Governance Policy/Guidance Framework Mechanisms to support all clinical staff apply evidence based practice. Quality monitoring via the Clinical Governance arrangements, which are in place at Board, Divisional and Local Levels which are reviewed regularly Clinical Quality Improvement programme and projects Clinical Risk Management arrangements Clinical leadership, support and review systems such as revalidation and M&Ms	Annual implementation plan for the NHSGGC Healthcare Quality Strategy:- • Clinical Informatice strategic implementation plan • Improve Safety and effectiveness medicines via HEPMA implementation • QI programme to improving care for patients at risk of acute deterioration • QI programme to improve care for women in labour • Pilot implementation of Value Management Model	**Year one actions March 2020**	**Clinical & Care Governance Committee**

Risk level and scores	*Directorate level risk*	*Current risk score*			*Likelihood*	*Impact*	*Score*		
		Current risk score	*Impact*	*Score*					
		4	*5*	**20**	*3*	*5*	**15**		

To be added 10	Nursing	Nurse Director	NHS GG&C fails to meet the legislative, mandatory, professional and ethical obligations to provide person centred care, which will reduce patient and public confidence in services, affect the therapeutic relationship, create waste from additional management burdens in resolving deficiencies and negatively impact on staff experience.	NHS GG&C Healthcare Quality Strategy, with the related policy and guidance framework. There are multiple methods to support patients, families and the public in providing feedback on their experience. There is a network of formal responsibilities (including Executive lead) and personal leadership (including NHS staff commitment) for person centred care. There are multiple education, training, development and supervision opportunities provided by NHS GG&C to enhance staff skills and behaviours. There are internal governance arrangements to ensure collection analysis and response to feedback is leading to improvement in services and care experience. Person centred competencies embedded in staff recruitment, support and development arrangements.	NHS GG&C Healthcare Quality Strategy implementation plan will lead to; • Further improvement in the governance arrangements • Further development and integration of feedback mechanisms • Development of indicators which will facilitate monitoring and improvement in person centred care Further implementation of person centred visiting Further development of person centred care planning Review and develop mechanisms to support staff in taking pride and joy in their work Enhance public awareness in the importance of feedback, how we listen to care experience and how this helps to monitor the quality and safety of care.	**Year one actions March 2020**	**Clinical & Care Governance Committee**

Risk level and scores	*Departmental risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		5	*3*	**15**	*4*	*3*	**12**		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2054	Acute	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2055	Acute	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2056	Acute/ HSCPs	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2057	Acute/ HSCPs	Chief Officers, Director of Estates & Facilities	Non compliance with applicable Health and Safety legislation and SG policies and guidance.	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure. The system has risk assessment criteria that 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 [redacted] enables the sector estates teams to undertake Statutory operational maintenance and repair. These requirements have set maintenance, inspection and testing levels as detailed within Statutory Compliance legislation. 5. Property Asset Management Strategy in place. 6. The annual capital and revenue funding for Estates & Facilities takes cognisance of the statutory obligations applied to the NHS Board. Prioritisation is informed by EAMs and the PAMS data.	A review of NHSGGC's EAM system is being undertaken in order to review the accuracy of data and to change the presentation of information. The outcome of this will provide management with more understandable data, and inform us where we have risk, and, therefore, enable us to mitigate risks. The asset management review will lay out details of areas which require investment, and risk assess those areas.	Complete	Finance & Planning Committee

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		3	*3*	*9*	*2*	*3*	*6*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2059	Public Health	[redacted]					
2060	Public Health						

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	irectorate/ artnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	irectorate/ artnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2188	Medical	Professor Marion Bain	Failure to comply with recognised policies and procedures in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS and COVID 19. Continue to support education for all staff including novel models, e.g. information café, ward based training and scenario based training. Training initiatives need to be flexible to address the needs of the 24/7 workforce. This is in place of NHSGGC. Training available for staff who are likely to encounter infections of high consequence. PVC car plan has now been rolled out to all of GGC. SOPs to support the management of environmental and drug resistant organisms is now in place. The requirement to complete the MRSA & CPE CRA was published as a 'Hot Topic' on Staffnet (NHSGGC intranet) on 14 March 2019 and this message has also been conveyed to all Chief Nurses within the Acute Adult Sectors/Directorates. Implement any recommendations from the IPC SG Sub Group when issued. Implement any recommendations from the independent enquiry into QEUH and RHC Continue to implement standard policies in light of possible pandemic	Improvement actions include the following: PVC Packs –procurement issues have meant that these packs are not available yet. MRSA/CPE Screening Continue to participate in the NHS Scotland screening initiative and feedback within agreed timescales. The most recent results indicate that the compliance with both screening programmes is above 90%. Assurance re Policy Implementation. New IPCAT audit was implemented in February 2020. This will be evaluated in 6 months. Outbreak and Incident Debriefs Use the output from the outbreak and incident debriefs to improve processes where appropriate. These are currently ongoing. Each hot debrief will be resubmitted to committees 6 months after original report in order to provide assurance that the actions and recommendations have been achieved. Recommendations from IPC SG subgroup and Independent review of QEUH and RHC. These will be evaluated in terms of impact on services and current reso	Jun-20	Clinical & Care Governance Committee

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		5	*4*	*20*	*4*	*4*	*16*		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2190	Facilities and Estates	**Director of Facilities and Estates**	Impact of failure to implement national guidance, systems and policies in relation to: • the built environment • patient safety • reputational risk • business continuity • system efficiency	Close working with clinical teams. Maximising current control measures to expedite actions. Additional managerial and frontline staff in place to ensure action in key areas.	Asset base survey underway Review of current structures and interface between departments Review of assurance processes Review actions from external advisors and assessors Infection Control and Built Environment Group being established	Mar-20 Mar-20 Complete Complete Complete	Acute Services Committee
		Risk level and scores	***Corporate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood / ***Impact*** / ***Score***	***Likelihood*** / ***Impact*** / ***Score***		
				4 / ***3*** / ***12***	***3*** / ***3*** / ***9***		
To be added 1	Acute	Chief Operating Officer - Acute	There is a reputational risk in respect of public confidence related to recent issues and concerns expressed regarding the QEUH & RHC including :- • facilities and environmental issues • capacity flow across the south sector • intense media scrutiny regarding patient care design, build and commissions.	• Robust escalation process in place to proactively manage any issue to ensure patient and staff safety in respect of the Board's facilities • Clinical focus remains on patient safety, with extensive reporting and monitoring, e.g. robust infection control procedures • Significant senior management capacity allocated to addressing recent incidents. • Proactive media handling • Programme Board established to oversee the reviews • Steering Group established and meeting to collate review and supply the documents and information required for the inquiries. • Programme Management Office being established at Board HQ. • Clinical Management Team Established to liaise directly with the Scottish Government Oversight Board	An internal process has been undertaken, overseen by the programme board chaired by the Chief Executive, to review facilities and environmental issues, capacity and flow, and clinical outcomes at the QEUH and RHC. These internal processes have reported to Board Governance Committees and to the NHS Board. An external independent review is being carried out and is being fully supported by the Board. The Project Management Office (PMO) with the Board Administration service is overseeing provision of information to the external review team. Visits for the external review team to the relevant sites have also been provided, and opportunities for the review team to engage directly with relevant nursing and infection control staff have been arranged. The public inquiry Terms of Reference (ToR) remain to be published, though Lord Brodie has been announced as the Chair. Support for the Board's engagement with the inquiry has been formalised within the NHS Central Legal Office, and regular meetings between the CLO team and the PMO have been arranged to support information provision to the inquiry. The Board has instigated a claim against the principle contractors on the QEUH and RHC design and build, having identified eleven broad areas of shortfall in the facilities. The Board has made the summons publicly available as well as a short overview document setting out the ground of claim. Two Oversight Boards have been established, with the Board having escalated to level 4 of the NHS Scotland Board Escalation Framework. These Oversight Boards will work to support the Board to rebuild public confidence. The Board is engaging at senior levels with the Oversight Boards, and working alongside additional support provided by the Scottish Government, focussed on strategic and operational infection control roles, and the appointed Turnaround Director	Jun-20	Acute Services Committee
		Risk level and scores	***Corporate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood / ***Impact*** / ***Score***	***Likelihood*** / ***Impact*** / ***Score***		
				5 / ***4*** / ***20***	***5*** / ***4*** / ***20***		
To be added 2	Human Resources	Director of Human Resources and Organisational Development	Failure of managers/ leaders to effectively engage with staff. Lack of engagement can create a workplace climate where staff are unable to perform to their best which can in turn can impact upon patient care and service delivery.	Annual iMatter staff survey schedule in place as the national tool to measure engagement by providing all staff with the opportunity to provide feedback to their manager and the organisation. A 60% return rate of surveys is required to provide a Team/ Board report to then inform local staff engagement action plans. iMatter Operational Lead meets with local iMatter Leads for each iMatter run, monthly/ as required, to review plan and discuss timescales, actions and how to overcome identified barriers for engagement. There are also significant levels of investment in management and leadership development, development of team based working and the development of a GGC Culture Framework to inform culture developments actions at CMT level and below. The GGC Culture Framework is now approved and an action plan to support our activity around Staff Engagement/Experience and Collective Leadership is underway.	2019 saw an increase in imatter returns to 59%. Activities to promote imatter in 2020 are underway. The Board at its February 2020 agreed the introduction of Investors in People to help staff engagement and experience. The Sturrock shortlife working group have identified key actions as part of the Engagement Action Plan in particular Employee Voice and improving feedback from staff at all levels of the Board. Action Plans will be finalised and presented to the Corporate Management Team and the Staff Governance Committee in May 2020.	**Aug-20**	**NHS Board Staff Governance Committee**
		Risk level and scores	**Corporate level risk**	**Current risk score**	**Act**		
				Likelihood / **Impact** / **Score**	**Likelihood** / **Impact** / **Score**		
				3 / **4** / ***12***	**2** / **3** / ***6***		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
To be added 5	Nursing	Nurse Director	There is a risk that NHSGGC will not be in full operational readiness to fulfil the 10 duties of the Health and Care Staffing (Scotland) Act 2019. This is especially relevant in areas where there is limited detail regarding the impact on the workforce and a range of broader legislation issues.	1. Robust governance structures in place to support safe, effective and efficient use of Nursing, Midwifery and Allied Health Professional (NMAHP) resources. 2. Rostering Policy and Monitoring and Escalation Guidance in place and regularly monitored. 3. Robust education and training of staff in use of workload tools where available. 4. Local workload tool runs are timeously scheduled and outcomes reported by service. 5. National Board allocation received for the introduction of a NHSGGC Health and Care Staffing Team 6. Hospital Huddles to identify and mitigate critical safety information and also wider situational awareness issues in relation to service delivery to patients. 7. Huddles utilised as a process using prediction to support safety and flow, input from all clinical areas on activity, safety to inform prediction on position for the day and escalation of any issues for action.	1. National guidance and procedural escalation will be provided by Scottish Government to cover all 10 duties. 2. draft guidance is being prepared for 12IC (Duty to have real-time staffing assessment in place), 12ID (Duty to have risk escalation process in place) and 12IE (Duty to have arrangements to address severe and recurrent risks) caused by staffing which affects the health, wellbeing or safety of patients or the quality of care by any member of staff 2. Identified risk will result in the national procedure being executed to mitigate such risks by a clinical leader 3. Awareness of risk escalation and agreed national procedures will be shared amongst staff and implemented locally from Point of Care to the Board. 4. Monitoring and review of common staffing method and develop a Common Staffing Method Outcome Generator (COG) to support service to report on workload tool outcomes. 8. Test the newly developed WOS NMAHP Workforce Planning, Assessment and Prioritisation Tool to identify the current NMAHP Workforce pressures.	Aug-20	Health and Care Staffing Programme Board; Staff Governance and Clinical and Care Governance Groups

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		4	*4*	*16*	*4*	*4*	*16*		

To be added 6	Governance	[redacted]					
To Be Added 7	Human Resources						
To be Added 8	Human Resources	Director of Human Resources and Organisational Development	Risk of personal injury to patients, staff and others related to non-compliance with legislative requirements . This can also led to enforcement action e.g.. fines, prosecution through the relevant Enforcement Agency e.g.. Health and Safety Executive.	Legislative requirements are the responsibility of the relevant Director to ensure that the appropriate action is taken to minimise risk of injury to staff, patients, visitors and others. A management system is in place to promote safe working practices and compliance with relevant legislation. Only the Head of Health and Safety and senior staff will deal directly with enforcement agencies. Potential issues of non-compliance will be discussed at the earliest stage with the appropriate Director and dialogue entered into with Enforcement Agency - Health and Safety Executive for health and safety issues.	Further engagement with HSE on a regular basis to ensure that statutory requirements are discussed in advance of any inspection visits to ensure compliance can be demonstrated in advance of visits. There are two current HSE activities within the Board and they are being overseen by Directors . All matters raised are included in transparent action plans with clear timescales agreed ultimately with HSE.Matters are discussed at the Corporate Management Team, the Health and Safety Forum and at the Staff Governance Committee as appropriate.	Feb-20	Staff Governance Committee

Risk level and scores	*Departmental risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		3	*4*	**12**	*3*	*4*	**12**		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
To be Added 9	Medical	Medical Director	NHSGGC services fail to deliver high quality care to patients that results in poor outcomes or unintended harm, which significantly reduces patient health and well being	NHS GG&C Healthcare Quality Strategy & Clinical Governance Policy/Guidance Framework Mechanisms to support all clinical staff apply evidence based practice. Quality monitoring via the Clinical Governance arrangements, which are in place at Board, Divisional and Local Levels which are reviewed regularly Clinical Quality Improvement programme and projects Clinical Risk Management arrangements Clinical leadership, support and review systems such as revalidation and M&Ms	Annual implementation plan for the NHSGGC Healthcare Quality Strategy:- • Clinical Informatics strategic implementation plan • Improve Safety and effectiveness medicines via HEPMA implementation • QI programme to improving care for patients at risk of acute deterioration • QI programme to improve care for women in labour • Pilot implementation of Value Management Model	Year one actions March 2020	Clinical & Care Governance Committee

Risk level and scores	*Directorate level risk*	*Current risk score*			*Current risk score*		
		Current risk score	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		4	*5*	**20**	*3*	*5*	**15**

To be added 10	Nursing	Nurse Director	NHS GG&C fails to meet the legislative, mandatory, professional and ethical obligations to provide person centred care, which will reduce patient and public confidence in services, affect the therapeutic relationship, create waste from additional management burdens in resolving deficiencies and negatively impact on staff experience.	NHS GG&C Healthcare Quality Strategy, with the related policy and guidance framework. There are multiple methods to support patients, families and the public in providing feedback on their experience. There is a network of formal responsibilities (including Executive lead) and personal leadership (including NHS staff commitment) for person centred care. There are multiple education, training, development and supervision opportunities provided by NHS GG&C to enhance staff skills and behaviours. There are internal governance arrangements to ensure collection analysis and response to feedback is leading to improvement in services and care experience. Person centred competencies embedded in staff recruitment, support and development arrangements.	NHS GG&C Healthcare Quality Strategy implementation plan will lead to; • Further improvement in the governance arrangements • Further development and integration of feedback mechanisms • Development of indicators which will facilitate monitoring and improvement in person centred care Further implementation of person centred visiting Further development of person centred care planning Review and develop mechanisms to support staff in taking pride and joy in their work Enhance public awareness in the importance of feedback, how we listen to care experience and how this helps to monitor the quality and safety of care.	**Year one actions March 2020**	**Clinical & Care Governance Committee**

Risk level and scores	*Departmental risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		5	*3*	**15**	*4*	*3*	**12**

To be added 11 (Feb 2020)	Acute	[redacted]

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2054	Acute	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2055	Acute	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2056	Acute/ HSCPs	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2057	Acute/ HSCPs	Chief Officers, Director of Estates & Facilities	Non compliance with applicable Health and Safety legislation and SG policies and guidance. [redacted]	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure. The system has risk assessment criteria that 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 [redacted] 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. [redacted]	A review of NHSGGC's EAM system is being undertaken in order to review the accuracy of data and to change the presentation of information. The outcome of this will provide management with more understandable data, and inform us where we have risk, and, therefore, enable us to mitigate risks. The asset management review will lay out details of areas which require investment, and risk assess those areas.	Complete	Finance & Planning Committee

		Current risk score			Target risk score (after further actions)				
Risk level and scores	*Corporate level risk*	*Likelihood*	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		3	*3*	*9*	*2*	*3*	*6*		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2059	Public Health	[redacted]					
2060	Public Health						

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2063	Human Resources	[redacted]					
2083	Nursing						

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2082	Nursing	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2188	Medical	Professor Angela Wallace	Failure to comply with recognised policies and procedures in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS and COVID 19. Continue to support education for all staff including novel models, e.g. information café, ward based training and scenario based training. Training initiatives need to be flexible to address the needs of the 24/7 workforce. This is in place of NHSGGC. Training available for staff who are likely to encounter infections of high consequence. PVC car plan has now been rolled out to all of GGC. SOPs to support the management of environmental and drug resistant organisms is now in place. The requirement to complete the MRSA & CPE CRA was published as a 'Hot Topic' on Staffnet (NHSGGC intranet) on 14 March 2019 and this message has also been conveyed to all Chief Nurses within the Acute Adult Sectors/Directorates. Implement any recommendations from the IPC SG Sub Group when issued. Implement any recommendations from the independent enquiry into QEUH and RHC Continue to implement standard policies in light of -pandemic [redacted] **Ensure that there are educational tools available to staff to ensure that they follow guidelines.** **Use core brief to update staff in 'real time' to changes in the guidance** **Ensure IPCT have access to all available guidance and literature as this is a new and emerging pathogen** **Ensure that IPCT website is up to date and accessible.**	Improvement actions include the following: PVC Packs –procurement issues have meant that these packs are not available yet. MRSA/CPE Screening Continue to participate in the NHS Scotland screening initiative and feedback within agreed timescales. The most recent results indicate that the compliance with both screening programmes is above 90%. Assurance re Policy Implementation. New IPCAT audit was implemented in February 2020. This will be evaluated in 6 months. Outbreak and Incident Debriefs Use the output from the outbreak and incident debriefs to improve processes where appropriate. These are currently ongoing. Each hot debrief will be resubmitted to committees 6 months after original report in order to provide assurance that the actions and recommendations have been achieved. Recommendations from IPC SG subgroup and Independent review of QEUH and RHC. These will be evaluated in terms of impact on services and current resources. **Guidance will continue to be advocated and changes highlighted via core brief and educational materials. This is available to all staff via the IPCT on line site.** [redacted]	Jun-20	Clinical & Care Governance Committee

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		5	*4*	*20*	*4*	*4*	*16*		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2103	eHealth	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2190	Facilities and Estates	Director of Facilities and Estates	Impact of failure to implement national guidance, systems and policies in relation to: • the built environment • patient safety • reputational risk • business continuity • system efficiency	Close working with clinical teams. Maximising current control measures to expedite actions. Additional managerial and frontline staff in place to ensure action in key areas.	Asset base survey underway Review of current structures and interface between departments Review of assurance processes Review actions from external advisors and assessors Infection Control and Built Environment Group being established	Mar-20 Mar-20 Complete Complete Complete	Acute Services Committee

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		4	*3*	*12*	*3*	*3*	*9*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
To be added 1	Acute	Chief Operating Officer - Acute	There is a reputational risk in respect of public confidence related to recent issues and concerns expressed regarding the QEUH & RHC including :- • facilities and environmental issues • capacity flow across the south sector • intense media scrutiny regarding patient care design, build and commissions.	• Robust escalation process in place to proactively manage any issue to ensure patient and staff safety in respect of the Board's facilities • Clinical focus remains on patient safety, with extensive reporting and monitoring, e.g. robust infection control procedures • Significant senior management capacity allocated to addressing recent incidents. • Proactive media handling • Programme Board established to oversee the reviews • Steering Group established and meeting to collate review and supply the documents and information required for the inquiries. • Programme Management Office being established at Board HQ. • Clinical Management Team Established to liaise directly with the Scottish Government Oversight Board	An internal process has been undertaken, overseen by the programme board chaired by the Chief Executive, to review facilities and environmental issues, capacity and flow, and clinical outcomes at the QEUH and RHC. These internal processes have reported to Board Governance Committees and to the NHS Board. Paused [redacted] An external independent review is being carried out and is being fully supported by the Board. The Project Management Office (PMO) with the Board Administration service is overseeing provision of information to the external review team. Visits for the external review team to the relevant sites have also been provided, and opportunities for the review team to engage directly with relevant nursing and infection control staff have been arranged. The public inquiry Terms of Reference (ToR) remain to be published, though Lord Brodie has been announced as the Chair. Support for the Board's engagement with the inquiry has been formalised within the NHS Central Legal Office, and regular meetings between the CLO team and the PMO have been arranged to support information provision to the inquiry. The Board has instigated a claim against the principle contractors on the QEUH and RHC design and build, having identified eleven broad areas of shortfall in the facilities. The Board has made the summons publicly available as well as a short overview document setting out the ground of claim. Two Oversight Boards have been established, with the Board having escalated to level 4 of the NHS Scotland Board Escalation Framework. These Oversight Boards will work to support the Board to rebuild public confidence. The Board is engaging at senior levels with the Oversight Boards, and working alongside additional support provided by the Scottish Government, focussed on strategic and operational infection control roles, and the appointed Turnaround Director. **Process paused during COVID however work ongoing at Board level.**	Jun-20	Acute Services Committee

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		5	*4*	*20*	*5*	*4*	*20*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
To be added 2	Human Resources	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
To be added 4	Nursing	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
To be added 5	Nursing	Director of Nursing	There is a risk that NHSGGC will not be in full operational readiness to fulfil the 10 duties of the Health and Care Staffing (Scotland) Act 2019. This is especially relevant in areas where there is limited detail regarding the impact on the workforce and a range of broader legislation issues. **(The preparation for the Health and Care Staffing Scotland Act risk has been suspended due to COID-19 and will be reviewed again in Aug 2020)**	1. Robust governance structures in place to support safe, effective and efficient use of Nursing, Midwifery and Allied Health Professional (NMAHP) resources. 2. Rostering Policy and Monitoring and Escalation Guidance in place and regularly monitored. 3. Robust education and training of staff in use of workload tools where available. 4. Local workload tool runs are timeously scheduled and outcomes reported by service. 5. National Board allocation received for the introduction of a NHSGGC Health and Care Staffing Team 6. Hospital Huddles to identify and mitigate critical safety information and also wider situational awareness issues in relation to service delivery to patients. 7. Huddles utilised as a process using prediction to support safety and flow, input from all clinical areas on activity, safety to inform prediction on position for the day and escalation of any issues for action.	1. National guidance and procedural escalation will be provided by Scottish Government to cover all 10 duties. 2. draft guidance is being prepared for 12IC (Duty to have real-time staffing assessment in place), 12ID (Duty to have risk escalation process in place) and 12IE (Duty to have arrangements to address severe and recurrent risks) caused by staffing which affects the health, wellbeing or safety of patients or the quality of care by any member of staff 2. Identified risk will result in the national procedure being executed to mitigate such risks by a clinical leader 3. Awareness of risk escalation and agreed national procedures will be shared amongst staff and implemented locally from Point of Care to the Board. 4. Monitoring and review of common staffing method and develop a Common Staffing Method Outcome Generator (COG) to support service to report on workload tool outcomes. 8. Test the newly developed WOS NMAHP Workforce Planning, Assessment and Prioritisation Tool to identify the current NMAHP Workforce pressures.	Aug-20	Health and Care Staffing Programme Board; Staff Governance and Clinical and Care Governance Groups

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*

To be added 6	Governance	[redacted]

To Be Added 7	Human Resources	[redacted]

To be Added 8	Human Resources	Director of Human Resources and Organisational Development	Risk of personal injury to patients, staff and others related to non-compliance with legislative requirements . This can also led to enforcement action e.g.. fines, prosecution through the relevant Enforcement Agency e.g.. Health and Safety Executive.	Legislative requirements are the responsibility of the relevant Director to ensure that the appropriate action is taken to minimise risk of injury to staff, patients, visitors and others. A management system is in place to promote safe working practices and compliance with relevant legislation. Only the Head of Health and Safety and senior staff will deal directly with enforcement agencies. Potential issues of non-compliance will be discussed at the earliest stage with the appropriate Director and dialogue entered into with Enforcement Agency - Health and Safety Executive for health and safety issues.	Further engagement with HSE on a regular basis to ensure that statutory requirements are discussed in advance of any inspection visits to ensure compliance can be demonstrated in advance of visits. There are two current HSE activities within the Board and they are being overseen by Directors . All matters raised are included in transparent action plans with clear timescales agreed ultimately with HSE.Matters are discussed at the Corporate Management Team, the Health and Safety Forum and at the Staff Governance Committee as appropriate. [redacted].		Staff Governance Committee

Risk level and scores	*Departmental risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		3	*4*	12	*3*	*4*	12

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
To be Added 9	Medical	Medical Director	NHSGGC services fail to deliver high quality care to patients that results in poor outcomes or unintended harm, which significantly reduces patient health and well being	NHS GG&C Healthcare Quality Strategy & Clinical Governance Policy/Guidance Framework Mechanisms to support all clinical staff apply evidence based practice. Quality monitoring via the Clinical Governance arrangements, which are in place at Board, Divisional and Local Levels which are reviewed regularly Clinical Quality Improvement programme and projects Clinical Risk Management arrangements Clinical leadership, support and review systems such as revalidation and M&Ms [redacted]	Annual implementation plan for the NHSGGC Healthcare Quality Strategy:- • Clinical Informatics strategic implementation plan • Improve Safety and effectiveness medicines via HEPMA implementation **(ON HOLD)** • QI programme to improving care for patients at risk of acute deterioration • QI programme to improve care for women in labour • Pilot implementation of Value Management Model [redacted]	Year one actions March 2020	Clinical & Care Governance Committee

Risk level and scores	*Directorate level risk*	*Current risk score*			*Current risk score*		
		Current risk score	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		4	*5*	20	*3*	*5*	15

To be added 10	Nursing	Director of Nursing	NHS GG&C fails to meet the legislative, mandatory, professional and ethical obligations to provide person centred care, which will reduce patient and public confidence in services, affect the therapeutic relationship, create waste from additional management burdens in resolving deficiencies and negatively impact on staff experience.	NHS GG&C Healthcare Quality Strategy, with the related policy and guidance framework. There are multiple methods to support patients, families and the public in providing feedback on their experience. There is a network of formal responsibilities (including Executive lead) and personal leadership (including NHS staff commitment) for person centred care. There are multiple education, training, development and supervision opportunities provided by NHS GG&C to enhance staff skills and behaviours. There are internal governance arrangements to ensure collection analysis and response to feedback is leading to improvement in services and care experience. Person centred competencies embedded in staff recruitment, support and development arrangements. [redacted]	NHS GG&C Healthcare Quality Strategy implementation plan will lead to; • Further improvement in the governance arrangements • Further development and integration of feedback mechanisms • Development of indicators which will facilitate monitoring and improvement in person centred care Further implementation of person centred visiting Further development of person centred care planning Review and develop mechanisms to support staff in taking pride and joy in their work Enhance public awareness in the importance of feedback, how we listen to care experience and how this helps to monitor the quality and safety of care. [redacted]	**Year one actions March 2020**	**Clinical & Care Governance Committee**

Risk level and scores	*Departmental risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		5	*3*	15	*4*	*3*	12

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
To be added 11 (Feb 2020)	Acute	[redacted]					

NHS Greater Glasgow and Clyde
Breakdown of Corporate Risks as at 12 August 2020

	Total	Very high	High	Moderate
Clinical/Infection Control	7	4	2	1
Acute	3	3		
eHealth	2			2
Board Administration	2		1	1
Public Health	3		2	1
Finance	1	1		
Human Resources/H&S	4		3	1
Facilities and Estates	2		1	1
	24	**8**	**9**	**7**

Current Risks with Actions
Corporate Risks
12-Aug-20

ID	Risk level	Manager	Description	Controls in place	RR Type	RR Status	Rating (current)	Rating (Target)	Responsibility ('To')	Actions	Progress	Start date	Due date	Done date

[redacted]

Title: Failure to implement national guidance, systems and policies																
2746	High	Steele, Tom	Impact of failure to implement national guidance, systems and policies in relation to: • the built environment • patient safety • reputational risk • business continuity • system efficiency	Close working with clinical teams. Maximising current control measures to expedite actions. Additional managerial and frontline staff in place to ensure action in key areas.	Corporate Risk	Live/Active	12	9		Asset base survey underway Review of current structures and interface between departments Review of assurance processes Review actions from external advisors and assessors Infection Control and Built Environment Group being established						
Title: Failure to meet the requirements of the Civil Contingencies (Scotland) Act																
[redacted]			Failure to fully meet the requirements of the Civil Contingencies (Scotland) Act	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]						
Title: Financial challenge																
2021	Very High	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]						
Title: GDPR AND DATA PROTECTION COMPLIANCE																

[redacted]

2056	Very High	[redacted]												
Title: Infection control														
2188	Very High	Devine, Sandra	Failure to comply with recognised policies and procedures in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS and COVID 19. Continue to support education for all staff including novel models, e.g. information café, ward based training and scenario based training. Training initiatives need to be flexible to address the needs of the 24/7 workforce. This is in place of NHSGGC. Training available for staff who are likely to encounter infections of high consequence. PVC car plan has now been rolled out to all of GGC. SOPs to support the management of environmental and drug resistant organisms is now in place. The requirement to complete the MRSA & CPE CRA was published as a 'Hot Topic' on Staffnet (NHSGGC intranet) on 14 March 2019 and this message has also been conveyed to all Chief Nurses within the Acute Adult Sectors/Directorates. Implement any recommendations from the IPC SG Sub Group when issued. Implement any recommendations from the independent enquiry into QEUH and RHC Continue to implement standard policies in light of pandemic Use remote access tools to ensure that the team are up to date with the rapidly chaging guidance in relation to COVID 19 Ensure that there are educational tools available to staff to ensure that they follow guidelines. Use core brief to update staff in 'real time' to changes in the guidance Ensure IPCT have access to all available guidance and literature as this is a new and emerging pathogen Ensure that IPCT website is up to date and accessible.	Corporate Risk	Live/Active	20	16	Devine, Sandra	Improvement actions include the following: PVC Packs –procurement issues have meant that these packs are not available yet. MRSA/CPE Screening Continue to participate in the NHS Scotland screening initiative and feedback within agreed timescales. The most recent results indicate that the compliance with both screening programmes is above 90%. Assurance re Policy Implementation. New IPCAT audit was implemented in February 2020. This will be evaluated in 6 months. Outbreak and Incident Debriefs Use the output from the outbreak and incident debriefs to improve processes where appropriate. These are currently ongoing. Each hot debrief will be resubmitted to committees 6 months after original report in order to provide assurance that the actions and recommendations have been achieved. Recommendations from IPC SG subgroup and Independent review of QEUH and RHC. These will be evaluated in terms of impact on services and current resources. Guidance will continue to be advocated and changes highlighted via core brief and educational materials. This is available to all staff via the IPCT on line site. [redacted]		### ### ### ###	### ### ### ###	
[redacted]														

2057	Moderate	Riddell, Mark	Non compliance with applicable Health and Safety legislation and SG policies and guidance [redacted]	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure. The system has risk assessment criteria that 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 [redacted] 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. [redacted]	Corporate Risk	Live/Active	9	6		A review of NHSGGC's EAM system is being undertaken in order to review the accuracy of data and to change the presentation of information. The outcome of this will provide management with more understandable data, and inform us where we have risk, and, therefore, enable us to mitigate risks. The asset management review will lay out details of areas which require investment, and risk assess those areas.				
Title: Pandemic														
2199	High	[redacted]												
Title: Readiness for Health and Care Staffing (Scotland) Act 2019														
2733	High	Mcguire, Margaret	There is a risk that NHSGGC will not be in full operational readiness to fulfil the 10 duties of the Health and Care Staffing (Scotland) Act 2019. This is especially relevant in areas where there is limited detail regarding the impact on the workforce and a range of broader legislation issues. (The preparation for the Health and Care Staffing Scotland Act risk has been suspended due to COID-19 and will be reviewed again in Aug 2020)	1. Robust governance structures in place to support safe, effective and efficient use of Nursing, Midwifery and Allied Health Professional (NMAHP) resources. 2. Rostering Policy and Monitoring and Escalation Guidance in place and regularly monitored. 3. Robust education and training of staff in use of workload tools where available. 4. Local workload tool runs are timeously scheduled and outcomes reported by service. 5. National Board allocation received for the introduction of a NHSGGC Health and Care Staffing Team 6. Hospital Huddles to identify and mitigate critical safety information and also wider situational awareness issues in relation to service delivery to patients. 7. Huddles utilised as a process using prediction to support safety and flow, input from all clinical areas on activity, safety to inform prediction on position for the day and escalation of any issues for action.	Corporate Risk	Live/Active	16	16		1. National guidance and procedural escalation will be provided by Scottish Government to cover all 10 duties. 2. draft guidance is being prepared for 12IC (Duty to have real-time staffing assessment in place), 12ID (Duty to have risk escalation process in place) and 12IE (Duty to have arrangements to address severe and recurrent risks) caused by staffing which affects the health, wellbeing or safety of patients or the quality of care by any member of staff 3. Identified risk will result in the national procedure being executed to mitigate such risks by a clinical leader 4. Awareness of risk escalation and agreed national procedures will be shared amongst staff and implemented locally from Point of Care to the Board. 5. Monitoring and review of common staffing method and develop a Common Staffing Method Outcome Generator (COG) to support service to report on workload tool outcomes. 6. Test the newly developed WOS NMAHP Workforce Planning, Assessment and Prioritisation Tool to identify the current NMAHP Workforce pressures.			### ### ### ###	
[redacted]														
2730	Very High	Best, Jonathan	There is a reputational risk in respect of public confidence related to recent issues and concerns expressed regarding the QEUH & RHC including :- • facilities and environmental issues • capacity flow across the south sector • intense media scrutiny regarding patient care design, build and commissions.	• Robust escalation process in place to proactively manage any issue to ensure patient and staff safety in respect of the Board's facilities • Clinical focus remains on patient safety, with extensive reporting and monitoring, e.g. robust infection control procedures • Significant senior management capacity allocated to addressing recent incidents. • Proactive media handling • Programme Board established to oversee the reviews • Steering Group established and meeting to collate review and supply the documents and information required for the inquiries. • Programme Management Office being established at Board HQ. • Clinical Management Team Established to liaise directly with the Scottish Government Oversight Board	Corporate Risk	Live/Active	20	20		An internal process has been undertaken, overseen by the programme board chaired by the Chief Executive, to review facilities and environmental issues, capacity and flow, and clinical outcomes at the QEUH and RHC. These internal processes have reported to Board Governance Committees and to the NHS Board. [redacted] An external independent review is being carried out and is being fully supported by the Board. The Project Management Office (PMO) with the Board Administration service is overseeing provision of information to the external review team. Visits for the external review team to the relevant sites have also been provided, and opportunities for the review team to engage directly with relevant nursing and infection control staff have been arranged. The public inquiry Terms of Reference (ToR) remain to be published, though Lord Brodie has been announced as the Chair. Support for the Board's engagement with the inquiry has been formalised within the NHS Central Legal Office, and regular meetings between the CLO team and the PMO have been arranged to support information provision to the inquiry. The Board has instigated a claim against the principle contractors on the QEUH and RHC design and build, having identified eleven broad areas of shortfall in the facilities. The Board has made the summons publicly available as well as a short overview document setting out the ground of claim. Two Oversight Boards have been established, with the Board having escalated to level 4 of the NHS Scotland Board Escalation Framework. These Oversight Boards will work to support the Board to rebuild public confidence. The Board is engaging at senior levels with the Oversight Boards, and working alongside additional support provided by the Scottish Government, focussed on strategic and operational infection control roles, and the appointed Turnaround Director. Process paused during COVID however work ongoing at Board level.				
Title: Risk of personal injury to due to non-compliance with legislative requirements.														
2736	High	MacPherson, Anne	Risk of personal injury to patients, staff and others related to non-compliance with legislative requirements. This can also led to enforcement action e.g.. fines, prosecution through the relevant Enforcement Agency e.g.. Health and Safety Executive.	Legislative requirements are the responsibility of the relevant Director to ensure that the appropriate action is taken to minimise risk of injury to staff, patients, visitors and others. A management system is in place to promote safe working practices and compliance with relevant legislation. Only the Head of Health and Safety and senior staff will deal directly with enforcement agencies. Potential issues of non-compliance will be discussed at the earliest stage with the appropriate Director and dialogue entered into with Enforcement Agency - Health and Safety Executive for health and safety issues.	Corporate Risk	Live/Active	16	9		Further engagement with HSE on a regular basis to ensure that statutory requirements are discussed in advance of any inspection visits to ensure compliance can be demonstrated in advance of visits. There are two current HSE activities within the Board and they are being overseen by Directors . All matters raised are included in transparent action plans with clear timescales agreed ultimately with HSE.Matters are discussed at the Corporate Management Team, the Health and Safety Forum and at the Staff Governance Committee as appropriate. [redacted]				

NHS Greater Glasgow and Clyde - Corporate Risk Register Overview - September 2020

	Datix ID	Risk	Division/ Directorate	Risk Owner	Risk level	Risk score as at		Length of time risk score has been the same					Governance Committee
						Mar-20	Sep-20	>12 mths	9-12 mths	6-9 mths	3-6 mths	<3 mths	
1	[redacted]												
2													
3	2730	Reputational risks around facilities and environmental issues and capacity flow	Acute	Chief Operating Officer	Corporate	20	20	●					Acute Services Committee
4	[redacted]												
	[redacted]												
6	2057	Non-compliance with applicable Health and Safety legislation and SG policies and guidance.	Acute/HSCPs	Chief Officers, Director of Facilities & Estates	Corporate	9	9	●					Finance and Planning Committee
7	2746	Implemention of national guidance, systems and policies *(renumbered from 2190)*	Facilities and Estates	Director of Facilities & Estates	Corporate	12	12	●					Finance and Planning Committee
8	[redacted]												
9													
10													
11													
12	2736	Risk of personal injury to due to non-compliance with legislative requirements.	Human Resources	Director of HR & OD	Directorate	12	16					●	Staff Governance Committee
13	[redacted]												
14													
15													
16													
17	[redacted]												
18													
19	2085	Compliance with clinical standards, protocols and strategies in place to ensure safe and effective use of medicines	Medical	Medical Director	Corporate	9	9	●					Clinical & Care Governance Committee
20	2188	Infection prevention and control	Medical	Medical Director	Corporate	20	20	●					Clinical & Care Governance Committee
21	2765	Failure to deliver high quality care to patients	Medical	Medical Director	Directorate	20	20		●				Clinical & Care Governance Committee
22	[redacted]												
23													

	Datix ID	Risk	Division/ Directorate	Risk Owner	Risk level	Risk score as at		Length of time risk score has been the same					Governance Committee
						Mar-20	Sep-20	>12 mths	9-12 mths	6-9 mths	3-6 mths	<3 mths	
24	[redacted]												
25													
26	2733	Readiness for Health and Care Staffing (Scotland) Act 2019	Nursing	Nurse Director	Corporate	16	16	●					Clinical & Care Governance Committee
27	2766	Failure to meet obligations to provide person centred care	Nursing	Nurse Director	Directorate	15	15		●				Clinical & Care Governance Committee
28	[redacted]												
29													
30													

[redacted]

Datix ID	irectorate/ artnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2730	Acute	Chief Operating Officer - Acute	There is a reputational risk in respect of public confidence related to recent issues and concerns expressed regarding the QEUH & RHC including :- • facilities and environmental issues • capacity flow across the south sector • intense media scrutiny regarding patient care design, build and commissions.	• Robust escalation process in place to proactively manage any issue to ensure patient and staff safety in respect of the Board's facilities • Clinical focus remains on patient safety, with extensive reporting and monitoring, e.g. robust infection control procedures • Significant senior management capacity allocated to addressing recent incidents. • Proactive media handling • Programme Board established to oversee the reviews • Steering Group established and meeting to collate review and supply the documents and information required for the inquiries. • Programme Management Office being established at Board HQ. • Clinical Management Team Established to liaise directly with the Scottish Government Oversight Board	An internal process has been undertaken, overseen by the programme board chaired by the Chief Executive, to review facilities and environmental issues, capacity and flow, and clinical outcomes at the QEUH and RHC. These internal processes have reported to Board Governance Committees and to the NHS Board. [redacted] An external independent review is being carried out and is being fully supported by the Board. The Project Management Office (PMO) with the Board Administration service is overseeing provision of information to the external review team. Visits for the external review team to the relevant sites have also been provided, and opportunities for the review team to engage directly with relevant nursing and infection control staff have been arranged. **The public inquiry being chaired by Lord Brodie QC will examine issues at the Queen Elizabeth University Hospital campus, with the "overarching aim" to consider the "planning, design, construction, commissioning and, where appropriate, maintenance" of the hospitals. It will determine how ventilation and water contamination issues affected patient safety and care - and whether these issues could have been prevented. The inquiry will also seek to recommend how "past mistakes" can be avoided in future NHS projects. Other areas that the inquiry team will investigate include the management of the project by NHS Greater Glasgow and Clyde, and whether the "organisational culture" at the health boards encouraged staff to raise concerns. The inquiry will also consider whether individuals or bodies "deliberately concealed or failed to disclose evidence of wrongdoing or failures" during the projects.** Support for the Board's engagement with the inquiry has been formalised within the NHS Central Legal Office, and regular meetings between the CLO team and the PMO have been arranged to support information provision to the inquiry. The Board has instigated a claim against the principle contractors on the QEUH and RHC design and build, having identified eleven broad areas of shortfall in the facilities. The Board has made the summons publicly available as well as a short overview document setting out the ground of claim. Two Oversight Boards have been established, with the Board having escalated to level 4 of the NHS Scotland Board Escalation Framework. These Oversight Boards will work to support the Board to rebuild public confidence. The Board is engaging at senior levels with the Oversight Boards, and working alongside additional support provided by the Scottish Government, focussed on strategic and operational infection control roles, and the appointed Turnaround Director. **Process paused during COVID however work ongoing at Board level.**	Jun-20	Acute Services Committee

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		5	*4*	*20*	*5*	*4*	*20*		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2057	Acute/ HSCPs	Chief Officers, Director of Estates & Facilities	Non compliance with applicable Health and Safety legislation and SG policies and guidance. [redacted]	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure. The system has risk assessment criteria that 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 [redacted] 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. [redacted]	A review of NHSGGC's EAM system is being undertaken in order to review the accuracy of data and to change the presentation of information. The outcome of this will provide management with more understandable data, and inform us where we have risk, and, therefore, enable us to mitigate risks. The asset management review will lay out details of areas which require investment, and risk assess those areas.	Complete	Finance & Planning Committee

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		3	*3*	*9*	*2*	*3*	*6*		

2746 *(renumbered from 2190)*	Facilities and Estates	Director of Facilities and Estates	Impact of failure to implement national guidance, systems and policies in relation to: • the built environment • patient safety • reputational risk • business continuity • system efficiency	Close working with clinical teams. Maximising current control measures to expedite actions. Additional managerial and frontline staff in place to ensure action in key areas.	Asset base survey underway Review of current structures and interface between departments Review of assurance processes Review actions from external advisors and assessors Infection Control and Built Environment Group being established	Mar-20 Mar-20 Complete Complete Complete	Acute Services Committee

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		4	*3*	*12*	*3*	*3*	*9*		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2021	Finance	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2063	Human Resources	[redacted]					
2731	Human Resources	Director of Human Resources and Organisational Development	Failure of managers/ leaders to effectively engage with staff. Lack of engagement can create a workplace climate where staff are unable to perform to their best which can in turn can impact upon patient care and service delivery.	Annual iMatter staff survey schedule in place as the national tool to measure engagement by providing all staff with the opportunity to provide feedback to their manager and the organisation. A 60% return rate of surveys is required to provide a Team/ Board report to then inform local staff engagement action plans. iMatter Operational Lead meets with local iMatter Leads for each iMatter run, monthly/ as required, to review plan and discuss timescales, actions and how to overcome identified barriers for engagement. There are also significant levels of investment in management and leadership development, development of team based working and the development of a GGC Culture Framework to inform culture developments actions at CMT level and below. The GGC Culture Framework is now approved and an action plan to support our activity around Staff Engagement/Experience and Collective Leadership is underway. [redacted]	[redacted]	Oct-20	NHS Board Staff Governance Committee

Risk level and scores	Corporate level risk	Current risk score			Act				
		Likelihood	Impact	Score	Likelihood	Impact	Score		
		3	4	*12*	2	3	*6*		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2735	Human Resources	[redacted]					
2736	Human Resources	Director of Human Resources and Organisational Development	Risk of personal injury to patients, staff and others related to non-compliance with legislative requirements . This can also led to enforcement action e.g.. fines, prosecution through the relevant Enforcement Agency e.g.. Health and Safety Executive.	Legislative requirements are the responsibility of the relevant Director to ensure that the appropriate action is taken to minimise risk of injury to staff, patients, visitors and others. A management system is in place to promote safe working practices and compliance with relevant legislation. Only the Head of Health and Safety and senior staff will deal directly with enforcement agencies. Potential issues of non-compliance will be discussed at the earliest stage with the appropriate Director and dialogue entered into with Enforcement Agency - Health and Safety Executive for health and safety issues.	Further engagement with HSE on a regular basis to ensure that statutory requirements are discussed in advance of any inspection visits to ensure compliance can be demonstrated in advance of visits. There are two current HSE activities within the Board and they are being overseen by Directors . All matters raised are included in transparent action plans with clear timescales agreed ultimately with HSE.Matters are discussed at the Corporate Management Team, the Health and Safety Forum and at the Staff Governance Committee as appropriate. [redacted]	Sep-20	Staff Governance Committee
		Risk level and scores	***Departmental risk***	***Current risk score*** ***Likelihood*** 4 ***Impact*** 4 ***Score*** 16	***Target risk score (after further actions)*** ***Likelihood*** 3 ***Impact*** 3 ***Score*** 9		
2768	Human Resources	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2059	Public Health	[redacted]					
2060	Public Health						

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2199	Public Health	[redacted]					
		Risk level and scores	*Corporate level risk*	*Likelihood* 3 / *Impact* 4 / *Score* 12	*Target risk score (after further actions)* — *Likelihood* 3 / *Impact* 4 / *Score* 12		
2325	Governance	[redacted]					
2712	Governance	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2085	Medical	[redacted]					
2188	Medical	Professor Angela Wallace	Failure to comply with recognised policies and procedures in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS and COVID 19. Continue to support education for all staff including novel models, e.g. information café, ward based training and scenario based training. Training initiatives need to be flexible to address the needs of the 24/7 workforce. This is in place of NHSGGC. Training available for staff who are likely to encounter infections of high consequence. PVC car plan has now been rolled out to all of GGC. SOPs to support the management of environmental and drug resistant organisms is now in place. The requirement to complete the MRSA & CPE CRA was published as a 'Hot Topic' on Staffnet (NHSGGC intranet) on 14 March 2019 and this message has also been conveyed to all Chief Nurses within the Acute Adult Sectors/Directorates. Implement any recommendations from the IPC SG Sub Group when issued. Implement any recommendations from the independent enquiry into QEUH and RHC Continue to implement standard policies in light of pandemic **Use remote access tools to ensure that the team are up to date with the rapidly chaging guidance in relation to COVID 19** **Ensure that there are educational tools available to staff to ensure that they follow guidelines.** **Use core brief to update staff in 'real time' to changes in the guidance** **Ensure IPCT have access to all available guidance and literature as this is a new and emerging pathogen** **Ensure that IPCT website is up to date and accessible.**	Improvement actions include the following: PVC Packs –procurement issues have meant that these packs are not available yet. MRSA/CPE Screening Continue to participate in the NHS Scotland screening initiative and feedback within agreed timescales. The most recent results indicate that the compliance with both screening programmes is above 90%. Assurance re Policy Implementation. New IPCAT audit was implemented in February 2020. This will be evaluated in 6 months. Outbreak and Incident Debriefs Use the output from the outbreak and incident debriefs to improve processes where appropriate. These are currently ongoing. Each hot debrief will be resubmitted to committees 6 months after original report in order to provide assurance that the actions and recommendations have been achieved. Recommendations from IPC SG subgroup and Independent review of QEUH and RHC. These will be evaluated in terms of impact on services and current resources. **Guidance will continue to be advocated and changes highlighted via core brief and educational materials. This is available to all staff via the IPCT on line site.** [redacted]	Jun-20	Clinical & Care Governance Committee

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		5	*4*	*20*	*4*	*4*	*16*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2765	Medical	Medical Director	NHSGGC services fail to deliver high quality care to patients that results in poor outcomes or unintended harm, which significantly reduces patient health and well being	NHS GG&C Healthcare Quality Strategy & Clinical Governance Policy/Guidance Framework Mechanisms to support all clinical staff apply evidence based practice. Quality monitoring via the Clinical Governance arrangements, which are in place at Board, Divisional and Local Levels which are reviewed regularly Clinical Quality Improvement programme and projects Clinical Risk Management arrangements Clinical leadership, support and review systems such as revalidation and M&Ms [redacted]	Annual implementation plan for the NHSGGC Healthcare Quality Strategy:- • Clinical Informatics strategic implementation plan • Improve Safety and effectiveness medicines via HEPMA implementation (ON HOLD) • QI programme to improving care for patients at risk of acute deterioration • QI programme to improve care for women in labour • Pilot implementation of Value Management Model [redacted]	Jun-20	Clinical & Care Governance Committee
			Risk level and scores	*Directorate level risk*	*Current risk score* — *Impact* / *Score*	*Likelihood* / *Impact* / *Score*	
2056	Acute/ HSCPs	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2082	Nursing	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2733	Nursing	Director of Nursing	There is a risk that NHSGGC will not be in full operational readiness to fulfil the 10 duties of the Health and Care Staffing (Scotland) Act 2019. This is especially relevant in areas where there is limited detail regarding the impact on the workforce and a range of broader legislation issues. **The preparation for the Health and Care Staffing Scotland Act risk has been suspended due to COID-19 and will be reviewed again in Aug 2020.**	1. Robust governance structures in place to support safe, effective and efficient use of Nursing, Midwifery and Allied Health Professional (NMAHP) resources. 2. Rostering Policy and Monitoring and Escalation Guidance in place and regularly monitored. 3. Robust education and training of staff in use of workload tools where available. 4. Local workload tool runs are timeously scheduled and outcomes reported by service. 5. National Board allocation received for the introduction of a NHSGGC Health and Care Staffing Team 6. Hospital Huddles to identify and mitigate critical safety information and also wider situational awareness issues in relation to service delivery to patients. 7. Huddles utilised as a process using prediction to support safety and flow, input from all clinical areas on activity, safety to inform prediction on position for the day and escalation of any issues for action.	1. National guidance and procedural escalation will be provided by Scottish Government to cover all 10 duties. 2. draft guidance is being prepared for 12IC (Duty to have real-time staffing assessment in place), 12ID (Duty to have risk escalation process in place) and 12IE (Duty to have arrangements to address severe and recurrent risks) caused by staffing which affects the health, wellbeing or safety of patients or the quality of care by any member of staff 2. Identified risk will result in the national procedure being executed to mitigate such risks by a clinical leader 3. Awareness of risk escalation and agreed national procedures will be shared amongst staff and implemented locally from Point of Care to the Board. 4. Monitoring and review of common staffing method and develop a Common Staffing Method Outcome Generator (COG) to support service to report on workload tool outcomes. 8. Test the newly developed WOS NMAHP Workforce Planning, Assessment and Prioritisation Tool to identify the current NMAHP Workforce pressures.	Aug-20	Health and Care Staffing Programme Board; Staff Governance and Clinical and Care Governance Groups

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		4	*4*	*16*	*4*	*3*	*12*		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2766	Nursing	Director of Nursing	NHS GG&C fails to meet the legislative, mandatory, professional and ethical obligations to provide person centred care, which will reduce patient and public confidence in services, affect the therapeutic relationship, create waste from additional management burdens in resolving deficiencies and negatively impact on staff experience.	NHS GG&C Healthcare Quality Strategy, with the related policy and guidance framework. There are multiple methods to support patients, families and the public in providing feedback on their experience. There is a network of formal responsibilities (including Executive lead) and personal leadership (including NHS staff commitment) for person centred care. There are multiple education, training, development and supervision opportunities provided by NHS GG&C to enhance staff skills and behaviours. There are internal governance arrangements to ensure collection analysis and response to feedback is leading to improvement in services and care experience. Person centred competencies embedded in staff recruitment, support and development arrangements. [redacted] **o Incident reporting, Significant Clinical Incident and Duty of Candour processes are being maintained, with the SCIs provided on a revised basis to reflect diminished capacity for investigation** **o Patient feedback and complaints continue to be monitored with responses to critical feedback maintained** **o Where clinical governance forums are suspended key issues are taken forward through multidisciplinary management team meetings**	NHS GG&C Healthcare Quality Strategy implementation plan will lead to; • Further improvement in the governance arrangements • Further development and integration of feedback mechanisms • Development of indicators which will facilitate monitoring and improvement in person centred care Further implementation of person centred visiting Further development of person centred care planning Review and develop mechanisms to support staff in taking pride and joy in their work Enhance public awareness in the importance of feedback, how we listen to care experience and how this helps to monitor the quality and safety of care. [redacted]	Oct-20	Clinical & Care Governance Committee

Risk level and scores	*Departmental risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		5	*3*	*15*	*4*	*3*	*12*		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

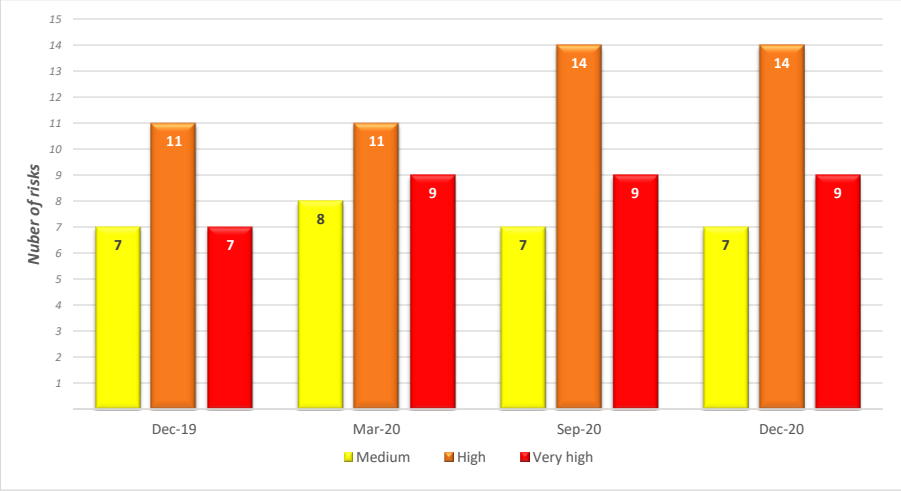
Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

	Datix ID	Risk	Division/ Directorate	Risk Owner	Risk level	Risk score Sep-20	Risk score Dec-20	Length of time risk score has been at the current level >12 mths	9-12 mths	6-9 mths	3-6 mths	<3 mths	Governance Committee
1	[redacted]												
2													
3	2730	Reputational risks around facilities and environmental issues and capacity flow	Acute	Chief Operating Officer	Corporate	20	20	●					Acute Services Committee
4	[redacted]												
5													
6													
7	2746	Implemention of national guidance, systems and policies	Facilities and Estates	Director of Facilities & Estates	Corporate	12	12	●					Finance and Planning Committee
8	2057	Non-compliance with applicable Health and Safety legislation and SG policies and guidance.	Acute/HSCPs	Chief Officers, Director of Facilities & Estates	Corporate	9	9	●					Finance and Planning Committee
9	[redacted]												
10													
11													
12	2736	Risk of personal injury to due to non-compliance with legislative requirements.	Human Resources	Director of HR & OD	Directorate	16	16				●		Staff Governance Committee
13	[redacted]												
14	2059	Compliance with Civil Contingencies (Scotland) Act	Public Health	Director of Public Health	Corporate	9	9	●					Acute Services Committee
15	[redacted]												
16													
17	[redacted]												
18													
19													
20	[redacted]												
21	2188	Infection prevention and control	Medical	Medical Director	Corporate	20	20	●					Clinical & Care Governance Committee
22	2765	Failure to deliver high quality care to patients	Medical	Medical Director	Directorate	20	20	●					Clinical & Care Governance Committee
23	[redacted]												

	Datix ID	Risk	Division/ Directorate	Risk Owner	Risk level	Risk score Sep-20	Risk score Dec-20	Length of time risk score has been at the current level >12 mths	9-12 mths	6-9 mths	3-6 mths	<3 mths	Governance Committee
24	[redacted]												
25													
26													
27	2733	Readiness for Health and Care Staffing (Scotland) Act 2019	Nursing	Nurse Director	Corporate	16	16	●					Clinical & Care Governance Committee
28	2766	Failure to meet obligations to provide person centred care	Nursing	Nurse Director	Directorate	15	15	●					Clinical & Care Governance Committee
29	[redacted]												
30													

Risk profile

The profile of risks reported over previous quarters is shown below:



Risk score

The number of risks where the score has been the same over time is shown below:

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	irectorate/ artnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2730	Acute	Chief Operating Officer - Acute	There is a reputational risk in respect of public confidence related to recent issues and concerns expressed regarding the QEUH & RHC including :- • facilities and environmental issues • capacity flow across the south sector • intense media scrutiny regarding patient care design, build and commissions.	• Robust escalation process in place to proactively manage any issue to ensure patient and staff safety in respect of the Board's facilities • Clinical focus remains on patient safety, with extensive reporting and monitoring, e.g. robust infection control procedures • Significant senior management capacity allocated to addressing recent incidents. • Proactive media handling • Programme Board established to oversee the reviews • Steering Group established and meeting to collate review and supply the documents and information required for the inquiries. • Programme Management Office being established at Board HQ. • Clinical Management Team Established to liaise directly with the Scottish Government Oversight Board	An internal process has been undertaken, overseen by the programme board chaired by the Chief Executive, to review facilities and environmental issues, capacity and flow, and clinical outcomes at the QEUH and RHC. These internal processes have reported to Board Governance Committees and to the NHS Board. [redacted] An external independent review is being carried out and is being fully supported by the Board. The Project Management Office (PMO) with the Board Administration service is overseeing provision of information to the external review team. Visits for the external review team to the relevant sites have also been provided, and opportunities for the review team to engage directly with relevant nursing and infection control staff have been arranged. The public inquiry being chaired by Lord Brodie QC will examine issues at the Queen Elizabeth University Hospital campus, with the "overarching aim" to consider the "planning, design, construction, commissioning and, where appropriate, maintenance" of the hospitals. It will determine how ventilation and water contamination issues affected patient safety and care - and whether these issues could have been prevented. The inquiry will also seek to recommend how "past mistakes" can be avoided in future NHS projects. Other areas that the inquiry team will investigate include the management of the project by NHS Greater Glasgow and Clyde, and whether the "organisational culture" at the health boards encouraged staff to raise concerns. The inquiry will also consider whether individuals or bodies "deliberately concealed or failed to disclose evidence of wrongdoing or failures" during the projects. Support for the Board's engagement with the inquiry has been formalised within the NHS Central Legal Office, and regular meetings between the CLO team and the PMO have been arranged to support information provision to the inquiry. The Board has instigated a claim against the principle contractors on the QEUH and RHC design and build, having identified eleven broad areas of shortfall in the facilities. The Board has made the summons publicly available as well as a short overview document setting out the ground of claim. Two Oversight Boards have been established, with the Board having escalated to level 4 of the NHS Scotland Board Escalation Framework. These Oversight Boards will work to support the Board to rebuild public confidence. The Board is engaging at senior levels with the Oversight Boards, and working alongside additional support provided by the Scottish Government, focussed on strategic and operational infection control roles, and the appointed Turnaround Director. **The independent report highlighted 63 recommendations, with work being led by the COO on the 40 required to be addressed directly within NHSCCC. Corporate Directors who have responsibility for groups of recommendations with common themes will designate owners responsible for full implementation.** Process paused during COVID however work ongoing at Board level.	Mar-21	Acute Services Committee

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		5	*4*	*20*	*4*	*4*	*16*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2057	Acute/ HSCPs	Chief Officers, Director of Estates & Facilities	Non compliance with applicable Health and Safety legislation and SG policies and guidance. [redacted]	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure. The system has risk assessment criteria that 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 [redacted] enables the sector estates teams to undertake Statutory operational maintenance and repair. These requirements have set maintenance, inspection and testing levels as detailed within Statutory Compliance legislation. 5. Property Asset Management Strategy in place. 6. The annual capital and revenue funding for Estates & Facilities takes cognisance of the statutory obligations applied to the NHS Board. Prioritisation is informed by EAMs and the PAMS data. A Board wide PPE Sub Group has been established that meets daily and includes representation from Procurement, Infection Control, Health and Safety, Community and Acute nursing and the Assistant Medical Director (Acute). The Groups task is to assess current legislation and guidance, oversee supplies, deal with issues and manage comms. There is also a National Procurement leads call twice a week attended by the Director of Finance and the Interim Head of Procurement. [redacted]	A review of NHSGGC's EAM system is being undertaken in order to review the accuracy of data and to change the presentation of information. The outcome of this will provide management with more understandable data, and inform us where we have risk, and, therefore, enable us to mitigate risks. The asset management review will lay out details of areas which require investment, and risk assess those areas. As of 1st September 2020, the PPE sub group was stood down to reflect the reduced risk around the supply, distribution and use of PPE - which is now considered BAU.	Complete	Finance & Planning Committee

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		3	*3*	*9*	*2*	*3*	*6*		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2746	Facilities and Estates	Director of Facilities and Estates	Impact of failure to implement national guidance, systems and policies in relation to: • the built environment • patient safety • reputational risk • business continuity • system efficiency	Close working with clinical teams. Maximising current control measures to expedite actions. Additional managerial and frontline staff in place to ensure action in key areas.	Asset base survey underway Review of current structures and interface between departments Review of assurance processes Review actions from external advisors and assessors Infection Control and Built Environment Group being established	Complete	Acute Services Committee

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*				
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*		
		4	*3*	*12*	*3*	*3*	*9*		

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							
2731	Human Resources	Director of Human Resources and Organisational Development	Failure of managers/ leaders to effectively engage with staff. Lack of engagement can create a workplace climate where staff are unable to perform to their best which can in turn can impact upon patient care and service delivery.	Annual iMatter staff survey schedule in place as the national tool to measure engagement by providing all staff with the opportunity to provide feedback to their manager and the organisation. A 60% return rate of surveys is required to provide a Team/ Board report to then inform local staff engagement action plans. iMatter Operational Lead meets with local iMatter Leads for each iMatter run, monthly/ as required, to review plan and discuss timescales, actions and how to overcome identified barriers for engagement. There are also significant levels of investment in management and leadership development, development of team based working and the development of a GGC Culture Framework to inform culture developments actions at CMT level and below. The GGC Culture Framework is now approved and an action plan to support our activity around Staff Engagement/Experience and Collective Leadership is underway. [redacted]	[redacted]	Oct-20	NHS Board Staff Governance Committee

Risk level and scores	Corporate level risk	Current risk score			Act		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		3	4	*12*	2	3	*6*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							
2736	Human Resources	Director of Human Resources and Organisational Development	Risk of personal injury to patients, staff and others related to non-compliance with legislative requirements . This can also led to enforcement action e.g.. fines, prosecution through the relevant Enforcement Agency e.g.. Health and Safety Executive.	Legislative requirements are the responsibility of the relevant Director to ensure that the appropriate action is taken to minimise risk of injury to staff, patients, visitors and others. A management system is in place to promote safe working practices and compliance with relevant legislation. Only the Head of Health and Safety and senior staff will deal directly with enforcement agencies. Potential issues of non-compliance will be discussed at the earliest stage with the appropriate Director and dialogue entered into with Enforcement Agency - Health and Safety Executive for health and safety issues.	Further engagement with HSE on a regular basis to ensure that statutory requirements are discussed in advance of any inspection visits to ensure compliance can be demonstrated in advance of visits. Establish a Safety Culture Group and develop a supporting strategy and framework to promote a positive Safety Culture across GGC .	Feb-21	Staff Governance Committee

Risk level and scores	*Departmental risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2199	Public Health	[redacted]					
		Risk level and scores	*Corporate level risk*	*Likelihood* 3 / *Impact* 4 / *Score* 12	*Target risk score (after further actions)* *Likelihood* 3 / *Impact* 4 / *Score* 12		
2325	Governance	[redacted]					

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2712	Governance	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2188	Medical	Professor Angela Wallace	Failure to comply with recognised policies and procedures in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS and COVID 19. MRSA/CPE Screening Continue to participate in the NHS Scotland screening initiative and feedback within agreed timescales. The most recent results indicate that the compliance with both screening programmes is above 90%. Continue to support education for all staff including novel models, e.g. information café, ward based training and scenario based training. Training initiatives need to be flexible to address the needs of the 24/7 workforce. This is in place of NHSGGC. SOPs to support the management of environmental and drug resistant organisms is now in place. Implement any recommendations from the IPC SG Sub Group when issued. The action plan developed in response to the recommendations from the independent enquiry is in progress with time scales agreed to implement. [redacted]	MRSA/CPE Screening Continue to participate in the NHS Scotland screening initiative and feedback within agreed timescales. The most recent results indicate that the compliance with both screening programmes is above 90%. Assurance re Policy Implementation. New IPCAT audit was implemented in February 2020. This is currently being evaluated. Outbreak and Incident Debriefs and Action Plans Use the output from the outbreak and incident debriefs to improve processes where appropriate. These are currently ongoing. Each hot debrief will be resubmitted to committees 6 months after original report in order to provide assurance that the actions and recommendations have been achieved. **In addition action plans will be returned to the service to ensure action are completed. This will be summaries for the IPC committees and added as an addendum in the HAIRT document which is submitted to the BGCF and NHS Board.** Recommendations from IPC SG subgroup and Independent review of QEUH and RHC. These will be evaluated in terms of impact on services and current resources. **Service redesign will commence. Staff turnover will allow a review of existing posts and a design for the IPCT which will be fit for the future. The impact of the requirement for IPC in nursing homes is still largely undefined but will also feed into this review.** [redacted]	Mar-21	Clinical & Care Governance Committee

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		5	*4*	*20*	*4*	*4*	*16*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2765	Medical	Medical Director	NHSGGC services fail to deliver high quality care to patients that results in poor outcomes or unintended harm, which significantly reduces patient health and well being	NHS GG&C Healthcare Quality Strategy & Clinical Governance Policy/Guidance Framework Mechanisms to support all clinical staff apply evidence based practice. Quality monitoring via the Clinical Governance arrangements, which are in place at Board, Divisional and Local Levels which are reviewed regularly Clinical Quality Improvement programme and projects Clinical Risk Management arrangements Clinical leadership, support and review systems such as revalidation and M&Ms [redacted]	Annual implementation plan for the NHSGGC Healthcare Quality Strategy:- • Clinical Informatics strategic implementation plan • Improve Safety and effectiveness medicines via HEPMA implementation (ON HOLD) • QI programme to improving care for patients at risk of acute deterioration • QI programme to improve care for women in labour • Pilot implementation of Value Management Model [redacted]	Jun-20	Clinical & Care Governance Committee

Risk level and scores	*Directorate level risk*	*Current risk score*	*Current risk score*			*Current risk score*		
		Current risk score	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*	
		4	*5*	*20*	*3*	*5*	*15*	

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	irectorate/ artnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2733	Nursing	Director of Nursing	There is a risk that NHSGGC will not be in full operational readiness to fulfil the 10 duties of the Health and Care Staffing (Scotland) Act 2019. This is especially relevant in areas where there is limited detail regarding the impact on the workforce and a range of broader legislation issues. [redacted]	1. Robust governance structures in place to support safe, effective and efficient use of Nursing, Midwifery and Allied Health Professional (NMAHP) resources. 2. Rostering Policy and Monitoring and Escalation Guidance in place and regularly monitored. 3. Robust education and training of staff in use of workload tools where available. 4. Local workload tool runs are timeously scheduled and outcomes reported by service. 5. National Board allocation received for the introduction of a NHSGGC Health and Care Staffing Team 6. Hospital Huddles to identify and mitigate critical safety information and also wider situational awareness issues in relation to service delivery to patients. 7. Huddles utilised as a process using prediction to support safety and flow, input from all clinical areas on activity, safety to inform prediction on position for the day and escalation of any issues for action.	1. National guidance and procedural escalation will be provided by Scottish Government to cover all 10 duties. 2. draft guidance is being prepared for 12IC (Duty to have real-time staffing assessment in place), 12ID (Duty to have risk escalation process in place) and 12IE (Duty to have arrangements to address severe and recurrent risks) caused by staffing which affects the health, wellbeing or safety of patients or the quality of care by any member of staff 3. Identified risk will result in the national procedure being executed to mitigate such risks by a clinical leader 4. Awareness of risk escalation and agreed national procedures will be shared amongst staff and implemented locally from Point of Care to the Board. 5. Monitoring and review of common staffing method and develop a Common Staffing Method Outcome Generator (COG) to support service to report on workload tool outcomes. 6. Test the newly developed WOS NMAHP Workforce Planning, Assessment and Prioritisation Tool to identify the current NMAHP Workforce pressures.	Aug-20	Health and Care Staffing Programme Board Staff Governance Committee Clinical and Care Governance Committee

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		4	*4*	*16*	*4*	*3*	*12*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2766	Nursing	Director of Nursing	NHS GG&C fails to meet the legislative, mandatory, professional and ethical obligations to provide person centred care, which will reduce patient and public confidence in services, affect the therapeutic relationship, create waste from additional management burdens in resolving deficiencies and negatively impact on staff experience.	NHS GG&C Healthcare Quality Strategy, with the related policy and guidance framework. There are multiple methods to support patients, families and the public in providing feedback on their experience. There is a network of formal responsibilities (including Executive lead) and personal leadership (including NHS staff commitment) for person centred care. There are multiple education, training, development and supervision opportunities provided by NHS GG&C to enhance staff skills and behaviours. There are internal governance arrangements to ensure collection analysis and response to feedback is leading to improvement in services and care experience. Person centred competencies embedded in staff recruitment, support and development arrangements. [redacted]	NHS GG&C Healthcare Quality Strategy implementation plan will lead to; • Further improvement in the governance arrangements • Further development and integration of feedback mechanisms • Development of indicators which will facilitate monitoring and improvement in person centred care Further implementation of person centred visiting Further development of person centred care planning Review and develop mechanisms to support staff in taking pride and joy in their work Enhance public awareness in the importance of feedback, how we listen to care experience and how this helps to monitor the quality and safety of care. [redacted]	Oct-20	Clinical & Care Governance Committee

Risk level and scores	*Departmental risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		5	*3*	*15*	*4*	*3*	*12*

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Ref	Risk	Risk Area	Risk Owner	Risk score at Jun-20	Risk score at Dec-20	Length of time risk score has been at the current level: 6-9 mths	3-6 mths	<3 mths	Governance Committee
1.1	[redacted]								
1.2	There is a risk that routine processes for ensuring quality and safety through clinical governance become overwhelmed.	Governance	Chief Executive	20	20	●			SEG/Interim Board
2.1	[redacted]								
2.2									
2.3									
2.4									
3.1									
4.1									
4.2	[redacted]								
4.3									
4.4									
4.5									
4.6	Negative impact on staff wellbeing	Workforce	Director of HR & OD	20	20	●			SEG/Interim Board
4.7	Lack of corporate management capacity and resilience to co-ordinate organisational response.	Workforce	Director of HR & OD	20	20	●			SEG/Interim Board
4.8	Lack of clinical management capacity and resilience ensuring safe staffing.	Workforce	Director of HR & OD	20	20	●			SEG/Interim Board
4.9	[redacted]								
4.10									
4.11									
4.12									
4.13									
5.0.1									
5.1.1									

Ref	Risk	Risk Area	Risk Owner	Risk score at Jun-20	Risk score at Dec-20	Length of time risk score has been at the current level 6-9 mths	Length of time risk score has been at the current level 3-6 mths	Length of time risk score has been at the current level <3 mths	Governance Committee
6.1	[redacted]								
6.2									
6.3									
6.4									
7.1.1									
7.2.1									
7.2.2									
7.3.1									
7.4.1									
8.1									
9.1									
9.2									
9.3									
9.4									
10.1									
10.2									
10.3									
10.4									
11.1									
11.2									
11.3									

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
1.1	Governance	[redacted]					
1.2	Governance	Chief Executive	• 1.2 There is a risk that routine processes for ensuring quality and safety through clinical governance become overwhelmed.	• Arrangements to support the tactical groups in maintaining governance over newly approved/adapted clinical guidelines • Focus continues on routine infection control monitoring and reporting across all sites • Review undertaken of duty of candour/SCI actions to ensure support and consistency and ethical decision making considered by SEG. • Ethics Forum established for use as required to support ethical decision making.	• Fortnightly Clinical Governance monitoring report for SEG and CMT established – update to Interim Board 2nd June.		
		Risk level and scores	*Corporate level risk*	*Current risk score* *Likelihood* *Impact* *Score*	*Target risk score (after further actions)* *Likelihood* *Impact* *Score*		
2.1	Acute Capacity	[redacted]					
2.2	Acute Capacity						
2.3	Acute Capacity						

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2.4	Acute Capacity	[redacted]					
3.1	Equipment						
4.1	Workforce						
4.2	Workforce						
4.3	Workforce						

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
4.4	Workforce	[redacted]					
4.5	Workforce						
4.6	Workforce						
4.7	Workforce						
4.8	Workforce						
4.9	Workforce						
4.10	Workforce						
4.11	Workforce						

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
4.12	Workforce	[redacted]					
4.13	Workforce						
5.0.1	Staff Testing						
5.1.1	Community Testing						

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Likelihood

1 – **Rare -** is unlikely to happen
2 – **Unlikely -** not expected to happen
3 – **Possible -** may occur occasionally
4 – **Likely -** will probably occur, but not a persistent issue
5 – **Almost certain -** will undoubtedly occur/is happening

Impact

1 – **Negligible**
2 – **Minor**
3 – **Moderate**
4 – **Major**
5 – **Extreme**

Consequence

Likelihood	*Impact/Consequence*				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	**Medium 5**	**High 10**	**High 15**	**Very High 20**	**Very High 25**
Likely	**Medium 4**	**Medium 8**	**High 12**	**High 16**	**Very High 20**
Possible	**Low 3**	**Medium 6**	**Medium 9**	**High 12**	**High 15**
Unlikely	**Low 2**	**Medium 4**	**Medium 6**	**Medium 8**	**High 10**
Rare	**Low 1**	**Low 2**	**Low 3**	**Medium 4**	**Medium 5**

Datix ID	Risk	Area of Risk	Risk Owner	Risk level	Current Score	Target Score	Number of months risk score has been at the current level					Governance Committee
							>12	9-12	6-9	3-6	<=3	

23	**New 7 2822**	[redacted]											
24	**New 12 2827**												
25	2054												
26	2055												
27	2745												
28	2056												
29	2188	Infection prevention and control	Clinical Risks - Infection control	Medical Director	Corporate	**20**	**16**	●					Clinical & Care Governance Committee
30	2085	[redacted]											
31	2730												
32	2746	Implementation of national guidance, systems and policies	Reputation - QEUH	Director of Facilities & Estates	Corporate	**12**	**9**	●					Finance, Planning and Performance Committee
33	2059	Compliance with Civil Contingencies (Scotland) Act	Reputation - BCP	Director of Public Health	Corporate	**9**	**6**	●					Acute Services Committee
34	2021	[redacted]											
35	**New 4 2819**	**There is a risk that inadequate capital funding in will adversely affect the Board's ability to achieve its key objectives**	**Financial Sustainability - Capital**	**Director of Finance**	**Corporate**	**20**	**16**					●	Finance, Planning and Performance Committee
36	[redacted]	[redacted]											
37	[redacted]												
38	2325												
39	**New 6 2821**												
40	[redacted]												
41	2765												Committee
42	2199	[redacted]											
43	2736	Risk of personal injury to due to non-compliance with legislative requirements.	Other	Director of HR & OD	Directorate	**12**	**8**			●			Staff Governance Committee
44	2057	Non-compliance with applicable Health and Safety legislation and SG policies and guidance.	Other	Chief Officers, Director of Facilities & Estates	Corporate	**9**	**6**	●					Finance, Planning and Performance Committee

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]									

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]									

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]									

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2733	**Workforce - training**	Director of Nursing	There is a risk that NHSGGC will not be in full operational readiness to fulfil the 10 duties of the Health and Care Staffing (Scotland) Act 2019. This is especially relevant in areas where there is limited detail regarding the impact on the workforce and a range of broader legislation issues. [redacted]	• Robust governance structures in place to support safe, effective and efficient use of Nursing, Midwifery and Allied Health Professional (NMAHP) resources. • Rostering Policy and Monitoring and Escalation Guidance in place and regularly monitored. • Robust education and training of staff in use of workload tools where available. • Local workload tool runs are timeously scheduled and outcomes reported by service. • National Board allocation received for the introduction of a NHSGGC Health and Care Staffing Team • Hospital Huddles to identify and mitigate critical safety information and also wider situational awareness issues in relation to service delivery to patients. • Huddles utilised as a process using prediction to support safety and flow, input from all clinical areas on activity, safety to inform prediction on position for the day and escalation of any issues for action.	**High**	**High**	• National guidance and procedural escalation will be provided by Scottish Government to cover all 10 duties. • Draft guidance is being prepared for 12IC (Duty to have real-time staffing assessment in place), 12ID (Duty to have risk escalation process in place) and 12IE (Duty to have arrangements to address severe and recurrent risks) caused by staffing which affects the health, wellbeing or safety of patients or the quality of care by any member of staff • Identified risk will result in the national procedure being executed to mitigate such risks by a clinical leader • Awareness of risk escalation and agreed national procedures will be shared amongst staff and implemented locally from Point of Care to the Board. • Monitoring and review of common staffing method and develop a Common Staffing Method Outcome Generator (COG) to support service to report on workload tool outcomes. • Test the newly developed WOS NMAHP Workforce Planning, Assessment and Prioritisation Tool to identify the current NMAHP Workforce pressures.	Aug-20	Health and Care Staffing Programme Board Staff Governance Committee Clinical and Care Governance Committee

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2766	**Workforce - training**	Director of Nursing	NHSGGC fails to meet the legislative, mandatory, professional and ethical obligations to provide person centred care, which will reduce patient and public confidence in services, affect the therapeutic relationship, create waste from additional management burdens in resolving deficiencies and negatively impact on staff experience.	NHSGGC Healthcare Quality Strategy, with the related policy and guidance framework. There are multiple methods to support patients, families and the public in providing feedback on their experience. There is a network of formal responsibilities (including Executive lead) and personal leadership (including NHS staff commitment) for person centred care. There are multiple education, training, development and supervision opportunities provided by NHSGGC to enhance staff skills and behaviours. There are internal governance arrangements to ensure collection analysis and response to feedback is leading to improvement in services and care experience. Person centred competencies embedded in staff recruitment, support and development arrangements. [redacted]	**High**	**High**	NHSGGC Healthcare Quality Strategy implementation plan will lead to: • Further improvement in the governance arrangements • Further development and integration of feedback mechanisms • Development of indicators which will facilitate monitoring and improvement in person centred car • Further implementation of person centred visiting • Further development of person centred care planning Review and develop mechanisms to support staff in taking pride and joy in their work [redacted]	Oct-20	Clinical & Care Governance Committee

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]									

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]									

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
New 19	Workforce - Health and safety	[redacted]							

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for	Governanc e /review
[redacted]									

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]									

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]									

2822 (new 7)	**Change management - remobilisation**	

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
				[redacted]					

2827 (new 12)	**Service delivery - escalation**	Chief Executive	The Board is at level 4 of the NHS Scotland Board Performance Escalation Framework in respect of scheduled care, unscheduled care, GP out of hours, and culture and leadership. There is a risk that the Board is delayed in moving out of this framework.	An Oversight Board was appointed, and considered unscheduled care, scheduled care and GP OOHs. It also considered the culture and leadership within the organisation. [redacted] • Further work continues internally to address the issues associated with the Performance Escalation. An internal Oversight Board continues to meet regularly to oversee progress with GP OOHs, Unscheduled Care and Scheduled Care. • The culture and leadership work continues to progress, with positive feedback received from the Turnaround Director **Review of GP Out of Hours** The NHSGGC GP OOHs service was placed into business continuity arrangements in response to a number of significant issues facing the sustainability of the service. The service was moved into a temporary business continuity model to consolidate the GP OOH service and it was anticipated that these arrangements would continue for 18-24 months, to complete the long-term stabilisation and transformation of the service. Actions taken to date: • A Chief Officer was seconded to the GP OOH service in January 2020 along with an Interim Deputy Medical Director for Primary Care • Consolidation of the services onto fewer sites • A workforce plan was agreed by the Escalation Delivery Group. • The recruitment of salaried GPs and ANPs to the service is continuing. Consideration is also being given to the input of pharmacy, AHP and Scottish Ambulance Paramedic Service staff. • Further measures include improvements to the environmental conditions for staff and action to stabilise and equalise GP pay. **Culture and Leadership** The NHS Board agreed its Culture Framework and its approach to collective leadership. Through the Director of Human Resources and OD and the Head of Organisational Development there remains a focus with good progress been made on key areas. Key priorities: • Actions to support staff as they respond to the pandemic. Our Mental Health and Wellbeing Group has delivered an action plan with a wide range of supports being made available. This has also included focus groups supported by our BAME network which has captured a wealth of information to develop specific support for the BAME workforce.	**High**	**High**	• The post of Deputy Medical Director for Primary Care has now been advertised on a substantive basis. Redesign work • Work has been progressing around service redesign in order to support the staff working in the service to provide appropriate care to patients. Further work is ongoing to consider the feasibility of re-establishing a GP OOH service presence in Inverclyde and increase the cover in the Vale of Leven area. • "Walk-in" attendances were ceased and an appointment system, via NHS24, was launched throughout the service. In addition, the service has launched "Near Me" video consultations to support patient assessment. • The rollout of the Investors in People Standard commenced at Inverclyde Royal Hospital in October 2020 and the learning from this pilot site will inform a wider rollout across NHSGGC in a three-year implementation programme. Preparations in relation to the other key development activities in this important initiative are underway and these will be progressed early in 2021.	Mar-21	Finance, Planning and Performance Committee

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
				• Regular communication with our Area and Local Partnership Forums and Area Clinical Forum. • The NHS Scotland Everyone Matters Staff Pulse Survey providing detailed and valuable feedback. • Our 90-minute Leadership programme has been adjusted and enhanced for online delivery, again with a focus on mental health and wellbeing and has over 100 leaders attending each session. • Our Ready to Lead development programme has been converted to online delivery and is progressing well.					

2054	**Service delivery - scheduled care**	Chief Officer - Acuteand Directors	[redacted]	The Cabinet Secretary for Health and Sport has escalated NHSGGC to level 4 for specific issues relating to performance including Scheduled Care. An Oversight Board has been established and is chaired by NHS Scotland's Chief Performance Officer. • [redacted] • The NHSGGC Scopes Improvement Plan is under implementation, bi-monthly meetings with the Scottish Government in place to monitor progress. [redacted] • A Performance Review Group framework is in place providing regular scrutiny of Sector/Directorate performance. [redacted]	**Very high**	**High**	At the NHSGGC Performance Oversight Board on the 19th March 2020, the group reviewed the Escalation Level 2 Recovery Programme and were updated on progress made to date. The Performance Oversight Board were assured that significant progress had been made across all workstreams; however, in response to the COVID-19 pandemic the Board decided that both the Planned Care and the Unscheduled Care work would be paused until further notice. As a consequence, the Core Groups were stood down under the Turnaround Director and it was agreed that NHSGGC will restart governance arrangements under the direction of the Chief Operating Officer as soon as the current COVID-19 position allows.In response to the COVID-19 pandemic, on 19th March NHSGGC postponed all routine outpatient and elective treatment/surgery including non-urgent cancer treatment. [redacted]		Acute Services Committee

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
							[redacted]		

2055

[redacted]

Acute Services Committee

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]									
2745									

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2056	[redacted]								

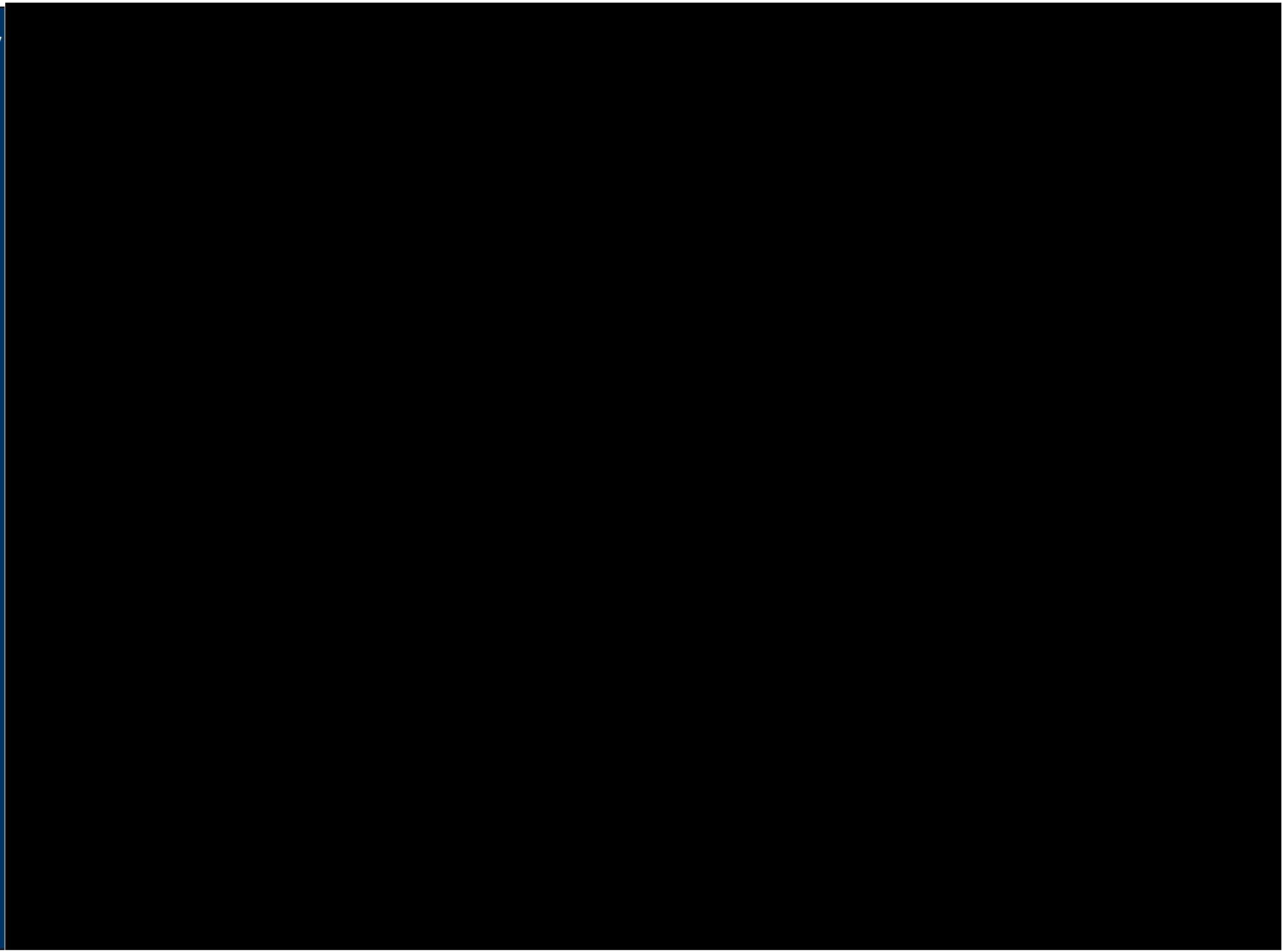
Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2188	Clinical Risks - infection control	Professor Angela Wallace	Failure to comply with recognised policies and procedures in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS and COVID 19. MRSA/CPE Screening Continue to participate in the NHS Scotland screening initiative and feedback within agreed timescales. The most recent results indicate that the compliance with both screening programmes is above 90%. Continue to support education for all staff including novel models, e.g., information café, ward-based training and scenario-based training. Training initiatives need to be flexible to address the needs of the 24/7 workforce. This is in place of NHSGGC. SOPs to support the management of environmental and drug resistant organisms is now in place. Implement any recommendations from the IPC SG Sub Group when issued. The action plan developed in response to the recommendations from the independent enquiry is in progress with time scales agreed to implement. Continue to implement standard policies in light of pandemic and be aware of other risks due to COVID 19 controls e.g. use of additional PPE, proning patients, increased use of antimicrobials. Surveillance of all required infections is ongoing in real time and incidents and outbreaks out with those related to COVID continue to be managed and reported as normal. [redacted]	Very high	High	MRSA/CPE Screening Continue to participate in the NHS Scotland screening initiative and feedback within agreed timescales. The most recent results indicate that the compliance with both screening programmes is above 90%. Assurance re Policy Implementation. New IPCAT audit was implemented in February 2020. This is currently being evaluated. Outbreak and Incident Debriefs and Action Plans Use the output from the outbreak and incident debriefs to improve processes where appropriate. These are currently ongoing. Each hot debrief will be resubmitted to committees 6 months after original report in order to provide assurance that the actions and recommendations have been achieved. In addition, action plans will be returned to the service to ensure action are completed. This will be summaries for the IPC committees and added as an addendum in the HAIRT document which is submitted to the BGCF and NHS Board. Recommendations from IPC SG subgroup and Independent review of QEUH and RHC. These will be evaluated in terms of impact on services and current resources. Service redesign will commence. Staff turnover will allow a review of existing posts and a design for the IPCT which will be fit for the future. The impact of the requirement for IPC in nursing homes is still largely undefined but will also feed into this review. [redacted]	Mar-21	Clinical & Care Governance Committee

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2085	[redacted]								

2730	**Reputational - QEUH**	Chief Operating Officer - Acute	There is a reputational risk in respect of public confidence related to recent issues and concerns expressed regarding the QEUH & RHC including:- • facilities and environmental issues • capacity flow across the south sector • intense media scrutiny regarding patient care design, build and commissions.	• Robust escalation process in place to proactively manage any issue to ensure patient and staff safety in respect of the Board's facilities • Clinical focus remains on patient safety, with extensive reporting and monitoring, e.g. robust infection control procedures • Significant senior management capacity allocated to addressing recent incidents. • Proactive media handling • Programme Board established to oversee the reviews • Steering Group established and meeting to collate review and supply the documents and information required for the inquiries. • Programme Management Office being established at Board HQ. • Clinical Management Team Established to liaise directly with the Scottish Government Oversight Board In response to concerns raised, the Board commissioned three internal reviews covering areas central to the delivery of safe, high quality healthcare on the QEUH Campus. The key findings from the reviews were: • Facilities and Environmental Impact Review - An external advisor was appointed to examine eleven areas where issues had arisen with the building since the hospitals opened in 2015. In light of their conclusions, the Board took legal advice and were advised that legal proceedings should be raised. The Board accepted that advice and instructed MacRoberts LLP to act on its behalf. The Board has also taken remedial action to address all the issues raised. • Capacity and Flow Review - This review found the QEUH to be treating considerably higher numbers of patients than originally anticipated in the Full Business Case. An improvement programme was developed to address the issues identified to further improve the patient flows, including the introduction of a separate, dedicated Minor Injuries unit at the hospital. • The Clinical Outcomes Review concluded that NHS GGC has maintained an appropriate set of clinical governance arrangements within services responsible for patient care in the QEUH and the RHC. Whilst the internal review reached positive conclusions on the clinical outcomes at the QEUH and the RHC, it recognised the considerable public concern about the management of infection prevention and control on the QEUH Campus, with further work being undertaken internally and through the Oversight Board work. An Independent Review of the QEUH Campus was commissioned by the Cabinet Secretary for Health & Sport, to address concerns about patient safety; the key findings of this Review were:	**Very high**	**High**	An internal process has been undertaken, overseen by the programme board chaired by the Chief Executive, to review facilities and environmental issues, capacity and flow, and clinical outcomes at the QEUH and RHC. These internal processes have reported to Board Governance Committees and to the NHS Board. [redacted] The public inquiry being chaired by Lord Brodie QC will examine issues at the Queen Elizabeth University Hospital campus, with the "overarching aim" to consider the "planning, design, construction, commissioning and, where appropriate, maintenance" of the hospitals. It will determine how ventilation and water contamination issues affected patient safety and care - and whether these issues could have been prevented. The inquiry will also seek to recommend how "past mistakes" can be avoided in future NHS projects. Other areas that the inquiry team will investigate include the management of the project by NHS Greater Glasgow and Clyde, and whether the "organisational culture" at the health boards encouraged staff to raise concerns. The inquiry will also consider whether individuals or bodies "deliberately concealed or failed to disclose evidence of wrongdoing or failures" during the projects. Support for the Board's engagement with the inquiry has been formalised within the NHS Central Legal Office, and regular meetings between the CLO team and the PMO have been arranged to support information provision to the inquiry. The Board has instigated a claim against the principle contractors on the QEUH and RHC design and build, having identified eleven broad areas of shortfall in the facilities. The Board has made the summons publicly available as well as a short overview document setting out the ground of claim. Two Oversight Boards have been established, with the Board having escalated to level 4 of the NHS Scotland Board Escalation Framework. These Oversight Boards will work to support the Board to rebuild public confidence. The Board is engaging at senior levels with the Oversight Boards, and working alongside additional support provided by the Scottish Government, focussed on strategic and operational infection control roles, and the appointed Turnaround Director. The independent report has highlighted 63 recommendations, with work being led by the COO on the 40 required to be addressed directly within NHSCCC. Corporate Directors who have responsibility for groups of recommendations with common themes will designate owners responsible for full implementation. Process paused during COVID however work ongoing at Board level.	Mar-24	Acute Services Committee

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
				• No sound evidential basis was established for asserting that avoidable deaths have resulted from failures in the design, build, commissioning or maintenance of the QEUH and RHC. • The QEUH and RHC now have in place the modern safety features and systems that we would expect of a hospital of this type. The general population of patients, staff and visitors can have confidence that the QEUH and RHC offer a setting for high quality healthcare.					
2746	**Reputational - QEUH**	Director of Facilities and Estates	Impact of failure to implement national guidance, systems and policies in relation to: • the built environment • patient safety • reputational risk • business continuity • system efficiency	Close working with clinical teams. Maximising current control measures to expedite actions. Additional managerial and frontline staff in place to ensure action in key areas.	**High**	**Medium**	Asset base survey underway Review of current structures and interface between departments Review of assurance processes Review actions from external advisors and assessors Infection Control and Built Environment Group being established	Complete	Acute Services Committee

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2059	[redacted]								

2021	**Financial sustainability - revenue**	

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2819 (new 4)	[redacted]								

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2082	[redacted]								

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2060	[redacted]								

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2325	[redacted]								

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2821 (new 6)	[redacted]								

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]									

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2765	Other	Medical Director	NHSGGC services fail to deliver high quality care to patients that results in poor outcomes or unintended harm, which significantly reduces patient health and well being	NHSGGC Healthcare Quality Strategy & Clinical Governance Policy/Guidance Framework Mechanisms to support all clinical staff apply evidence-based practice. Quality monitoring via the Clinical Governance arrangements, which are in place at Board, Divisional and Local Levels which are reviewed regularly Clinical Quality Improvement programme and projects Clinical Risk Management arrangements Clinical leadership, support and review systems such as revalidation and M&Ms [redacted]	Very high	High	Annual implementation plan for the NHSGGC Healthcare Quality Strategy: - • Clinical Informatics strategic implementation plan • Improve Safety and effectiveness medicines via HEPMA implementation (ON HOLD) • QI programme to improving care for patients at risk of acute deterioration • QI programme to improve care for women in labour • Pilot implementation of Value Management Model [redacted]	Completion of in-year actions by March 2021	Clinical & Care Governance Committee

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2199	[redacted]								
2736	Other	Director of HR & OD	Risk of personal injury to patients, staff and others related to non-compliance with legislative requirements. This can also lead to enforcement action e.g., fines, prosecution through the relevant Enforcement Agency e.g., Health and Safety Executive.	Legislative requirements are the responsibility of the relevant Director to ensure that the appropriate action is taken to minimise risk of injury to staff, patients, visitors and others. A management system is in place to promote safe working practices and compliance with relevant legislation. Only the Head of Health and Safety and senior staff will deal directly with enforcement agencies. Potential issues of non-compliance will be discussed at the earliest stage with the appropriate Director and dialogue entered into with Enforcement Agency - Health and Safety Executive for health and safety issues.	**High**	**Medium**	Further engagement with HSE on a regular basis to ensure that statutory requirements are discussed in advance of any inspection visits to ensure compliance can be demonstrated in advance of visits. Establish a Safety Culture Group and develop a supporting strategy and framework to promote a positive Safety Culture across GGC.	Mar-21	Health and Safety Forum

Datix ID	Category of risk	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Current score	Target score	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2057	Other	Chief Officers, Director of Estates & Facilities	Non-compliance with applicable Health and Safety legislation and SG policies and guidance. [redacted]	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure. The system has risk assessment criteria that 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 [redacted] 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. [redacted]	**Medium**	**Medium**	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. As of 1st September 2020, the PPE sub group was stood down to reflect the reduced risk around the supply, distribution and use of PPE - which is now considered BAU.	Complete	Finance, Planning and Performance Committee

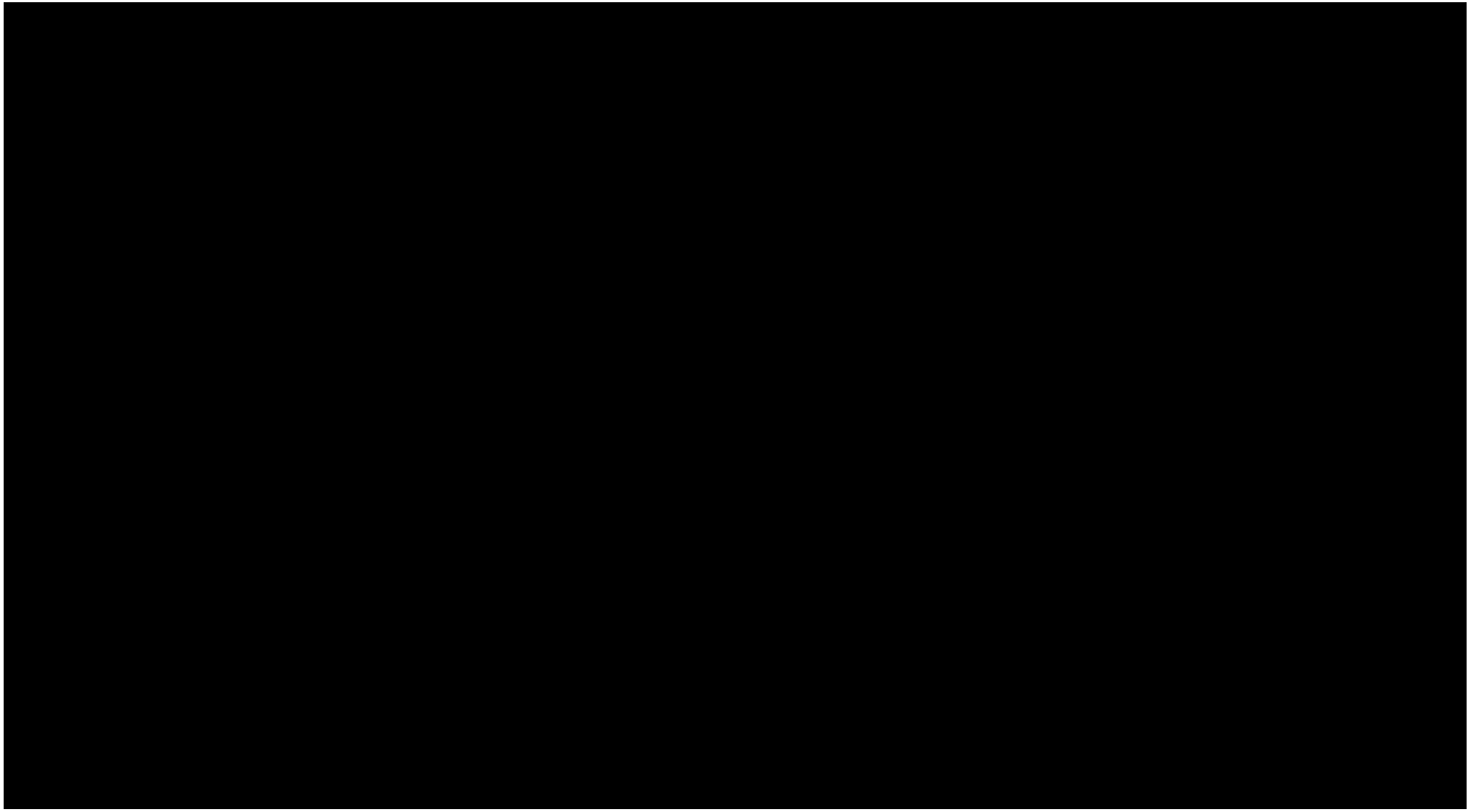
Datix ID	irectorate/ artnership	ategory of Risk	NEXT ACTION	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Curent Likelihood	Current Impact	Current Score	Residual Liklieh od	residual Impact	Residual Score	Target dates for actions	Risk Level	Corporate Objective - Level 1	Corporate Objective - Level 2	Governance /review committee
[redacted]																		

[redacted]

202	Acute HSCP	Othe	To be Close	Estates & Facilities	Safety legislation and SG policies and guidance.	existing estate and assess the physical condition of the buildings & Infrastructure. The system has risk assessment criteria that 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 [redacted] 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.	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.											

[redacted]

2056	Acute/ HSCPs	Service Delivery - delayed discharge	To be downgraded to Operational Risk Register	[redacted]														
2732	Nursing	Workforce - Succession planning/sustainability	To be downgraded to Operational Risk Register															
2733	Nursing	Workforce - Training	To be downgraded to Operational Risk Register	Director of Nursing	There is a risk that NHSGGC will not be in full operational readiness to fulfil the 10 duties of the Health and Care Staffing (Scotland) Act 2019. This is especially relevant in areas where there is limited detail regarding the impact on the workforce and a range of broader legislation issues. [redacted]	1. Robust governance structures in place to support safe, effective and efficient use of Nursing, Midwifery and Allied Health Professional (NMAHP) resources. 2. Rostering Policy and Monitoring and Escalation Guidance in place and regularly monitored. 3. Robust education and training of staff in use of workload tools where available. 4. Local workload tool runs are timeously scheduled and outcomes reported by service. 5. National Board allocation received for the introduction of a NHSGGC Health and Care Staffing Team 6. Hospital Huddles to identify and mitigate critical safety information and also wider situational awareness issues in relation to service delivery to patients. 7. Huddles utilised as a process using prediction to support safety and flow, input from all clinical areas on activity, safety to inform prediction on position for the day and escalation of any issues for action.	1. National guidance and procedural escalation will be provided by Scottish Government to cover all 10 duties. 2. draft guidance is being prepared for 12IC (Duty to have real-time staffing assessment in place), 12ID (Duty to have risk escalation process in place) and 12IE (Duty to have arrangements to address severe and recurrent risks) caused by staffing which affects the health, wellbeing or safety of patients or the quality of care by any member of staff 3. Identified risk will result in the national procedure being executed to mitigate such risks by a clinical leader 4. Awareness of risk escalation and agreed national procedures will be shared amongst staff and implemented locally from Point of Care to the Board. 5. Monitoring and review of common staffing method and develop a Common Staffing Method Outcome Generator (COG) to support service to report on workload tool outcomes. 6. Test the newly developed WOS NMAHP Workforce Planning, Assessment and Prioritisation Tool to identify the current NMAHP Workforce pressures.	*4*	*4*	*16*	*4*	*3*	*12*	Aug-20	Corporate	BVCO	CO14	**Health and Care Staffing Programme Board Staff Governance Committee Clinical and Care Governance Committee**



New - ref not yet assigne	Medical	Clinical Risks - Clinical gaps	To be Closed	New 6 - 2021	[redacted]
	Care Homes	Care Homes	To be closed		
	Remobilisation	Change Management - Remobilisation	To be closed	New 7 - 2022	

Datix ID	Directorate/ Partnership	Category of Risk	Status	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Curent Likelihood	Current Impact	Current Score	Residual Liklieh od	residual Impact	Residual Score	Target dates for actions	Risk Level	Corporate Objective - Level 1	Corporate Objective - Level 2	Governance /review committee
New 2827	Corporate	Service Delivery - Escalation	Open	Chief Executive	The Board is at level 4 of the NHS Scotland Board Performance Escalation Framework in respect of scheduled care, unscheduled care, GP out of hours, and culture and leadership. There is a risk that the Board is delayed in moving out of this framework.	An Oversight Board was appointed, and considered unscheduled care, scheduled care and GP OOHs. It also considered the culture and leadership within the organisation. • The Board was on course to achieve the revised targets set for 31st March 2020; however, the process was paused due to the outbreak of COVID-19. • Further work continues internally to address the issues associated with the Performance Escalation. An internal Oversight Board continues to meet regularly to oversee progress with GP OOHs, Unscheduled Care and Scheduled Care. The Board have largely met the relevant targets in the RMP2 and RMP3 and the Scottish Government have acknowledged the efforts made by NHSGGC to remobilise activity. • The culture and leadership work continues to progress - agreeing its Culture Framework and its approach to collective leadership.	• The post of Deputy Medical Director for Primary Care has now been advertised on a substantive basis. Redesign work • Work has been progressing around service redesign in order to support the staff working in the service to provide appropriate care to patients. Further work is ongoing to consider the feasibility of re-establishing a GP OOH service presence in Inverclyde and increase the cover in the Vale of Leven area. • "Walk-in" attendances were ceased and an appointment system, via NHS24, was launched throughout the service. In addition the service has launched "Near Me" video consultations to support patient assessment. • The rollout of the Investors in People Standard commenced at Inverclyde Royal Hospital in October 2020 and the learning from this pilot site will inform a wider rollout across NHSGGC in a three year implementation programme. Preparations in relation to the other key development activities in this important initiative are underway and these will be progressed early in 2021.	4	4	16	3	4	12	Jun-21	Corporate	BVCO	CO14	Finance, Planning and Performance Committee
[redacted]																		
2188	Medical	Clinical Risks - Infection control	Open	Dir Infection Control	Failure to comply with recognised policies and procedures in relation to infection control.	NIPC Manual is accessible on the desktop of every PC in GGC. IPC webiste is continually updated with summary SOP with links to theNIPCM. IPCT education is manditory with yearly updates for many topics as standard. IPCT present on each main site; all sites are have access to a designated IPCT. All patients with infection included in appendix 13 of the NIPCM are referred to the IPCT and a process of review is initiated to impliment controls as per NIPCM. Surveillance of surgical site infection is ongoing as per SG policy. Surveillance of blood stream infections with S. aureus bacteraemia and E. coli bacteraemia is ongoing. COVID 19 cases are reported daily to SG and are monitored via ARHAI weekly report. Electronic system ICNet pulls a feed from laboratory systems every 15 minutes and referrals go directly to the infection prevention and control team who then visit the ward and give infomation to clinical staff to ensure that control are in place for patients with organisms with the potential to spread to others. Patient are given infomation on why they are in isolation and daily check list with ongoing controls is left with clinical staff. IPCT work with collegues in the antimicrobial managment team to promote antimicrobial policy compliance. If any outbreaks or incidents occur an IMT process is initiated. Key learning from these is reported at the IPC governance committees with a 'hot debrief' submitted to these same committees at the end of the incident with specific reference to implications for other area across the board.	Programme of audit for key policies linked to CAS framework. Improvement collaborative has been initiated and is firmly linked to the GGC quality strategy which vision is 'healthcare without preventable infection' the aim is to promote key objectives for GGC around reducing harm due to avoidable infections. Monthly HH audits are ongoing. IPCT support local teams in implementing national policy into practice using improvement methodology. All patient are assessed on admission for the possibility that they have CPE/MRSA/CJD this is recoded in the nursing documentation. Lessons from incidents and outbreaks are shared with governance committees to ensure orgnasational learning. When patients are referred process of initial and ongoing review in put in place to ensure key control are consistently applied. Promotion of antimicrobial stewardship. IPCT participate in new builds and renovation projects to ensue that the patients environment promotes the prevention of infection.	5	4	20	4	4	16	Mar-22	Corporate	BCCO	CO6	Clinical & Care Governance Committee
[redacted]																		
2021	Finance	[redacted]																

2766	Nursing	Medical	Open	Director of Nursing	Failure to comply with legistlation and obligations in regards to patient rights, patient feedback and person centred care	Implementation of the NHSGGC Healthcare Quality Strategy and stakeholder communications and engagement strategy and associated work streams for both. Implementation of person centred care boardwide work plan. Multiple methods from ward to board level to gain feedback from and support patients, families, and the public in regard to care experience. Network of explicit formal responsibilities including Executive leads and professional local leadership for the person centred care agenda. A range of education, training, development and supervision opportunities provided by NHSGGC to enhance staff skills and behaviours. Internal governance arrangements to ensure collection, analysis including identification of themes and learning across the organisation. Person centred competencies embedded in staff recruitment, support, and development arrangements.	NHSGGC Healthcare Quality Strategy implementation plan will lead to; • Deliver on the Board's commitments described in both stratgey documents. • Expansion of data collection assurance and outcomes linked to feedback and person centred care • Work with public partners to develop easily streamlined mechanisms to improve and enhance collaboration with our population.	*3*	*3*	*9*	*3*	*3*	*9*	Oct-21	Corporate	BVCO	CO14	Clinical & Care Governance Committee
[redacted]																				
Ref to be assigned	Acute HSCP	Nursing	[redacted]																	

[redacted]

2730	Acute	Corporate	Open	Chief Officer - Acute	Failure to implement the recommendations published in respect of the QEUH and RHC; The External Review, The Oversight Board Report, The Case Note Review Report, impacting on patient care, staff resilience, the reputation of the Board and public confidence in services provided.	• Robust escalation process in place to proactively manage any issue to ensure patient and staff safety in respect of the Board's facilities • Clinical focus remains on patient safety, with extensive reporting and monitoring, e.g. robust infection control procedures • Significant senior management capacity allocated to addressing recent incidents. • Proactive media handling • Programme Board established to oversee the reviews • Steering Group established and meeting to collate review and supply the documents and information required for the inquiries. • Programme Management Office being established at Board HQ. • Clinical Management Team Established to liaise directly with the Scottish Government Oversight Board In response to concerns raised, the Board commissioned three internal reviews covering areas central to the delivery of safe, high quality healthcare on the QEUH Campus.The key findings from the reviews were: • Facilities and Environmental Impact Review - An external advisor was appointed to examine eleven areas where issues had arisen with the building. • Capacity and Flow Review - This review found the QEUH to be treating considerably higher numbers of patients than originally anticipated in the Full Business Case. An improvement programme was developed to address the issues. • The Clinical Outcomes Review concluded that NHS GGC has maintained an appropriate set of clinical governance arrangements within services responsible for patient care in the QEUH and the RHC.	*Creation of a robust Action Plan against all recommendations across the reports. Monitor through Gold and Silver Command, CMT and upwards to respective governance committees, over seen by the Finance Planning and performance Committee. *Work with the Scottish Government and the newly established Action and Assurance Review Group (AARG) to provide Assurance around progress and delivery.	5	4	20	4	4	16	Sep-21	Corporate	BVCO	CO12	Acute Services Committee
Ref to be assigned	Acute/ HSCPs	Other	Open	Director of Estates & Facilities	The RMP3 relies upon infrastructure, much of which requires significant investment. Particular elements of concern include but are not limited to; Ventilation Systems, High & Low Voltage infrastructure, Domestic Hot & Cold Water systems, Medical Gas Systems (particulary oxygen capacity), Building Fabric Condition	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure andidentifies the areas of the estate at high risk of failure and therefore of highest priority for repair. 2. Implementation of Board wide property management approach including assessment of premises compliance with standard consistent methodologies. 3. Regular reports to CMT/ CPG/SMG / OMG on deployment of capital resources and investment priorities. Investment Priorities are based on PAMS data. 4. A revenue allocation of [redacted] enables the sector estates teams to undertake Statutory operational maintenance and repair. These requirements have set maintenance, inspection and testing levels as detailed within Statutory Compliance legislation. 5. Property Asset Management Strategy in place. 6. The annual capital and revenue funding for Estates & Facilities takes cognisance of the statutory obligations applied to the NHS Board. Prioritisation is informed by EAMs and the PAMS data.	A review of NHSGGC's EAM system was undertaken in order to review the accuracy of data and to change the presentation of information. The outcome of this provided management with more understandable data, and informed us where we have risk, and, therefore, enable us to mitigate risks. The asset management review details areas which require investment, and risk assess those areas. The Statutory Compliance Audit and Risk Tool (SCART) Steering Group meets quarterly to monitor SCART performance and to ensure all necessary records and other forms of evidence to support compliance are readily available and in date.	4	4	16	3	3	9	Sep-21	Corporate	BVCO	CO14	Finance, Planning and Performance Committee
Ref to be assigned	Acute/ HSCPs	Corporate	Open	Director of Estates & Facilities	Actions taken by a regulatory body (e.g HSE, SEPA, Fire) in regards to statutory compliance and impact of the Boards Estate and its activities on the: health, safety and wellbeing of staff, patients and the general public as well as the surrounding environment.	Control measure sin plce include: 1. Fire risk assessments 2. Environmental PPC Permits in place at two facilities namely, GRI & QEUH. Environmental Authorisations (Scotland) Regulations (EASR) Permits in place across seven sites for nuclear waste. 3. High level Environmental Legal Register in place to monitor relevant environmental legislation applicable to the Board. 4.Estate Asset Management System (EAMs) 5. Statutory Compliance Audit and Risk Tool (SCART) 6. Topic specific Authorised Persons (AP) and Authorised Engineer oversight and audit	1. Development of whole building risk assessments. Risk assessments will be conducted across the Estate with risk assessment for the QEUH already completed. 2. Authorised Engineer audits conducted for specialist areas i.e. water, ventialtion and LV. 3. Authorised person training and competence 4. Regular internal and external (SEPA) audits for PPC Permits. Permits currently sitting at "Excellent".	4	4	16	3	3	9	Sep-21	Corporate	BVCO	CO14	Finance, Planning and Performance Committee

[redacted]

Ref to be assigned	Medical	Corporate	Open	Medical Director	Failure to deliver the Remobilisation Plan in respect of co-ordination, capacity and resources.	Recovery Tactical Group (RTG) established. Weekly meetings held to monitor implementation with Executive Leads aligned to each action. Paper presented to SEG in May 2021 outlining monitoring arrangements for RMP3 and future role of RTG. RMP3 Action Tracker developed identifying 400+ actions and commitments from RMP3. Monthly tracker updates presented to RTG and SEG. Internal Audit Report of RMP3 Planning has been completed in April 2021	1. Robust programme management controls and processes in place to drive RMP3. 2. Ongoing review of RMP3 tracking tool as part of continous improvement and learning. 3. Implement actions from Internal Audit report RMP3 from April 2021. 4. Produce a closure report for the previous re-mobilisation tracker actions (RMP2).	*3*	*3*	*9*	*2*	*3*	*6*	Sep-21	Corporate	BCCO	CO7	Finance, Planning and Performance Committee

[redacted]

Corporate Risk Register - summary **31 August 2021**

Corporate Risk Register - movement in risk numbers	
No. of risks at June 2021	19
New risks escalated (2819)	1
No. of risks at August 2021	**20**

Datix ID	Risk title	Division/ Directorate	Accountable owner	Category of Risk	Status	Current Score	Risk Level	Corporate Objective - Level 1	Corporate Objective - Level 2	Governance /review committee
[redacted]										
2188	Infection prevention and control	Medical	Dir Infection Control	Clinical Risks - Infection control	Open	20	Corporate	BCCO	CO6	Clinical & Care Governance Committee
[redacted]										
2766	Failure to meet obligations to provide person centred care	Nursing	Director of Nursing	Workforce - Training	Open	9	Corprorate	BVCO	CO14	Clinical & Care Governance Committee
[redacted]										
3051	RMP3 - ageing infrastructure	Acute/HSCPs	Director of Estates & Facilities	Other	Open	16	Corporate	BVCO	CO14	Finance, Planning and Performance Committee
3052	Actions taken by a regulatory body	Acute/HSCPs	Director of Estates & Facilities	Other	Open	16	Corporate	BVCO	CO14	Finance, Planning and Performance Committee
[redacted]										
3054	Remobilisation Plan - co-ordination, capacity and resources	Medical	Medical Director	Clinical Risks - Clinical gaps	Open	9	Corprorate	BCCO	CO7	Finance, Planning and Performance Committee
[redacted]										
3060	Positive, engaging and diverse culture	Human Resources	Director of HR & OD		Open	16	Corporate	BWCO	CO15	Staff Governance Committee
3062	Continual development of clinical standards, protocols and strategies	Medical	Medical Director	Clinical Risks - Clinical gaps	Open	9	Corporate	BCCO	CO6	Clinical & Care Governance Committee

Datix ID	Directorate/ Partnership	Category of Risk	Status	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Curent Likelihood	Current Impact	urrent Score	Residual Likliehood	Residual Impact	Residual Score	Target dates for actions	Risk Level	Corporate Objective - Level 1	Corporate Objective - Level 2	Governance /review committee
[redacted]																		
2188	Medical	Clinical Risks - Infection control	Open	Dir Infection Control	Failure to comply with recognised policies and procedures in relation to infection control.	NIPC Manual is accessible on the desktop of every PC in GGC. IPC webiste is continually updated with summary SOP with links to theNIPCM. IPCT education is manditory with yearly updates for many topics as standard. IPCT present on each main site; all sites are have access to a designated IPCT. All patients with infection included in appendix 13 of the NIPCM are referred to the IPCT and a process of review is initiated to impliment controls as per NIPCM. Surveillance of surgical site infection is ongoing as per SG policy. Surveillance of blood stream infections with S. aureus bacteraemia and E. coli bacteraemia is ongoing. COVID 19 cases are reported daily to SG and are monitored via ARHAI weekly report. Electronic system ICNet pulls a feed from laboratory systems every 15 minutes and referrals go directly to the infection prevention and control team who then visit the ward and give infomation to clinical staff to ensure that control are in place for patients with organisms with the potential to spread to others. Patient are given infomation on why they are in isolation and daily check list with ongoing controls is left with clinical staff. IPCT work with collegues in the antimicrobial managment team to promote antimicrobial policy compliance. If any outbreaks or incidents occur an IMT process is initiated. Key learning from these is reported at the IPC governance committees with a 'hot debrief' submitted to these same committees at the end of the incident with specific reference to	Programme of audit for key policies linked to CAS framework. Improvement collaborative has been initiated and is firmly linked to the GGC quality strategy which vision is 'healthcare without preventable infection' the aim is to promote key objectives for GGC around reducing harm due to avoidable infections. Monthly HH audits are ongoing. IPCT support local teams in implementing national policy into practice using improvement methodology. All patient are assessed on admission for the possibility that they have CPE/MRSA/CJD this is recoded in the nursing documentation. Lessons from incidents and outbreaks are shared with governance committees to ensure orgnasational learning. When patients are referred process of initial and ongoing review in put in place to ensure key control are consistently applied. Promotion of antimicrobial stewardship. IPCT participate in new builds and renovation projects to ensue that the patients environment promotes the prevention of infection.	*5*	*4*	*20*	*4*	*4*	*16*	Mar-22	Corporate	BCCO	CO6	Clinical & Care Governance Committee

Datix ID	Directorate/ Partnership	Category of Risk	Status	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Target date for actions	Risk Level	Corporate Objective - Level 1	Corporate Objective - Level 2	Governance /review committee
[redacted]																		
2730	Acute	Corporate	Open	Chief Operating Officer	Failure to implement the recommendations published in respect of the QEUH and RHC; The External Review, The Oversight Board Report, The Case Note Review Report, impacting on patient care, staff resilience, the reputation of the Board and public confidence in services provided.	• Robust escalation process in place to proactively manage any issue to ensure patient and staff safety in respect of the Board's facilities • Clinical focus remains on patient safety, with extensive reporting and monitoring, e.g. robust infection control procedures • Significant senior management capacity allocated to addressing recent incidents. • Proactive media handling • Programme Board established to oversee the reviews • Steering Group established and meeting to collate review and supply the documents and information required for the inquiries. • Programme Management Office being established at Board HQ. • Clinical Management Team Established to liaise directly with the Scottish Government Oversight Board In response to concerns raised, the Board commissioned three internal reviews covering areas central to the delivery of safe, high quality healthcare on the QEUH Campus.The key findings from the reviews were: • Facilities and Environmental Impact Review - An external advisor was appointed to examine eleven areas where issues had arisen with the building • Capacity and Flow Review - This review found the QEUH to be treating considerably higher numbers of patients than originally anticipated in the Full Business Case. An improvement programme was developed to	Creation of a robust Action Plan against all recommendations across the reports. Monitor through Gold and Silver Command, CMT and upwards to respective governance committees, over seen by the Finance Planning and Performance Committee. Work with the Scottish Government and the newly established Action and Assurance Review Group (AARG) to provide assurance around progress and delivery.	5	4	20	4	4	16	Sep-21	Corporate	BVCO	CO12	Acute Services Committee
[redacted]																		
2768	Nursing	Medica	Open	Director of Nursing	Failure to comply with legislation and obligations in regards to patient rights, patient feedback and person centred care	Implementation of the NHSGGC Healthcare Quality Strategy and stakeholder communications and engagement strategy and associated work streams for both. Implementation of person centred care boardwide work plan. Multiple methods from ward to board level to gain feedback from and support patients, families, and the public in regard to care experience. Network of explicit formal responsibilities including Executive leads and professional local leadership for the person centred care agenda. A range of education, training, development and supervision opportunities provided by NHSGGC to enhance staff skills and behaviours. Internal governance arrangements to ensure collection, analysis including identification of themes and learning across the organisation. Person centred competencies embedded in staff recruitment, support, and development arrangements.	NHSGGC Healthcare Quality Strategy implementation plan will lead to: • Deliver on the Board's commitments described in both stratgey documents. • Expansion of data collection assurance and outcomes linked to feedback and person centred care • Work with public partners to develop easily streamlined mechanisms to improve and enhance collaboration with our population.	3	3	9	3	3	9	Oct-21	Corporate	BVCO	CO14	Clinical & Care Governance Committee
[redacted]																		
2827	Corporate	Service Delivery - Escalation	Open	Chief Executive	The Board is at level 4 of the NHS Scotland Board Performance Escalation Framework in respect of scheduled care, unscheduled care, GP out of hours, and culture and leadership. There is a risk that the Board is delayed in moving out of this framework.	An Oversight Board was appointed, and considered unscheduled care, scheduled care and GP OOHs. It also considered the culture and leadership within the organisation. • The Board was on course to achieve the revised targets set for 31st March 2020; however, the process was paused due to the outbreak of COVID-19. • Further work continues internally to address the issues associated with the Performance Escalation. An internal Oversight Board continues to meet regularly to oversee progress with GP OOHs, Unscheduled Care and Scheduled Care. The Board have largely met the relevant targets in the RMP2 and RMP3 and the Scottish Government have acknowledged the efforts made by NHSGGC to remobilise activity. • The culture and leadership work continues to progress - agreeing its Culture Framework and its approach to collective leadership.	• The post of Deputy Medical Director for Primary Care has now been advertised on a substantive basis. Redesign work • Work has been progressing around service redesign in order to support the staff working in the service to provide appropriate care to patients. Further work is ongoing to consider the feasibility of re-establishing a GP OOH service presence in Inverclyde and increase the cover in the Vale of Leven area. • "Walk-in" attendances were ceased and an appointment system, via NHS24, was launched throughout the service. In addition the service has launched "Near Me" video consultations to support patient assessment. • The rollout of the Investors in People Standard commenced at Inverclyde Royal Hospital in October 2020 and the learning from this pilot site will inform a wider rollout across NHSGGC in a three year implementation programme. Preparations in relation to the other key development activities in this important initiative are underway and these will be progressed early in 2021.	4	4	16	3	4	12	Jun-21	Corporate	BVCO	CO14	Finance, Planning and Performance Committee

Datix ID	Directorate/ Partnership	Category of Risk	Status	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Curent Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Target date for actions	Risk Level	Corporate Objective - Level 1	Corporate Objective - Level 2	Governance /review committee
3057	Acute/ HSCPs	Partnerships/Acute	Open	[redacted]														
3058	Acute/ HSCPs	Nursing	Open															
3059	Human Resources	Workforce (HR)	Open															
3060	Human Resources	Workforce (HR)	Open	Director of HR & OD	Failure to cultivate, promote and enhance a positive, engaging and diverse culture.	Workforce Strategy. Leadership development programmes, culture framework and initiatives. Succession Planning Framework. Equality Action Plan.	Promotion of culture framework and associated programmes and initiatives. Medical Managment programme introduced. Executive and non-executive development programme. Review of Ready to Lead programme underway. Development of Equality Action Plan to support activity and initatives across NHSGGC.	4	4	16	3	4	12	Dec-21	Corporate	BVCO	CO17	Staff Governance Committee
3051	Acute/ HSCPs	Other	Open	Director of Estates & Facilities	The RMP3 relies upon infrastructure, much of which requires significant investment. Particular elements of concern include but are not limited to; Ventilation Systems, High & Low Voltage infrastructure, Domestic Hot & Cold Water systems, Medical Gas Systems (particularly oxygen capacity), Building Fabric Condition	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure andidentifies the areas of the estate at high risk of failure and therefore of highest priority for repair. 2. Implementation of Board wide property management approach including assessment of premises compliance with standard consistent methodologies. 3. Regular reports to CMT/ CPG/SMG / OMG on deployment of capital resources and investment priorities. Investment Priorities are based on PAMS data. 4. A revenue allocation of [redacted] enables the sector estates teams to undertake Statutory operational maintenance and repair. These requirements have set maintenance, inspection and testing levels as detailed within Statutory Compliance legislation. 5. Property Asset Management Strategy in place. 6. The annual capital and revenue funding for Estates & Facilities takes cognisance of the statutory obligations applied to the NHS Board. Prioritisation is informed by EAMs and the PAMS data.	A review of NHSGGC's EAM system was undertaken in order to review the accuracy of data and to change the presentation of information. The outcome of this provided management with more understandable data, and informed us where we have risk, and, therefore, enable us to mitigate risks. The asset management review details areas which require investment, and risk assess those areas. The Statutory Compliance Audit and Risk Tool (SCART) Steering Group meets quarterly to monitor SCART performance and to ensure all necessary records and other forms of evidence to support compliance are readily available and in date.	4	4	16	3	3	9	Sep-21	Corporate	BVCO	CO14	Finance, Planning and Performance Committee
3052	Acute/ HSCPs	Corporate	Open	Director of Estates & Facilities	Actions taken by a regulatory body (e.g HSE, SEPA, Fire) in regards to statutory compliance and impact of the Boards Estate and its activities on the: health, safety and wellbeing of staff, patients and the general public as well as the surrounding environment.	Control measure sin place include: 1. Fire risk assessments 2. Environmental PPC Permits in place at two facilities namely, GRI & QEUH. Environmental Authorisations (Scotland) Regulations (EASR) Permits in place across seven sites for nuclear waste. 3. High level Environmental Legal Register in place to monitor relevant environmental legislation applicable to the Board. 4.Estate Asset Management System (EAMs) 5. Statutory Compliance Audit and Risk Tool (SCART) 6. Topic specific Authorised Persons (AP) and Authorised Engineer oversight and audit	1. Development of whole building risk assessments. Risk assessments will be conducted across the Estate with risk assessment for the QEUH already completed. 2. Authorised Engineer audits conducted for specialist areas i.e. water, ventialtion and LV. 3. Authorised person training and competence 4. Regular internal and external (SEPA) audits for PPC Permits. Permits currently sitting at "Excellent".	4	4	16	3	3	9	Sep-21	Corporate	BVCO	CO14	Finance, Planning and Performance Committee
3062	Medical	Clinical Risks - Clinical gaps	Open	[redacted]														

Datix ID	Directorate/ Partnership	Category of Risk	Status	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Target date for actions	Risk Level	Corporate Objective - Level 1	Corporate Objective - Level 2	Governance /review committee
3054	Medical	Corporate	Open	Medical Director	Failure to deliver the Remobilisation Plan in respect of co-ordination, capacity and resources.	Recovery Tactical Group (RTG) established. Weekly meetings held to monitor implementation with Executive Leads aligned to each action. Paper presented to SEG in May 2021 outlining monitoring arrangements for RMP3 and future role of RTG. RMP3 Action Tracker developed identifying 400+ actions and commitments from RMP3. Monthly tracker updates presented to RTG and SEG. Internal Audit Report of RMP3 Planning has been completed in April 2021 and shared with SEG	1. Robust programme management controls and processes in place to drive RMP3. 2. Ongoing review of RMP3 tracking tool as part of continous improvement and learning. 3. Implement actions from Internal Audit report RMP3 from April 2021. 4. Produce a closure report for the previous re-mobilisation tracker actions (RMP2).	3	3	9	2	3	6	Sep-21	Corporate	BCCO	CO7	Finance, Planning and Performance Committee

Extract from current CRR (Aug-21) **Changes/updates since the CRR as at 22/06/2021**

Datix ID	Directorate/ Partnership	Category of Risk	Status	Accountable owner	Description of risk	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Curent Likelihood	Current Impact	Current Score	Residual Impact	Residual Score	Target dates for actions	Corporate Objective - Level 2	Governance /review committee
2021	Finance	Financial Sustainability - Revenue	[redacted]													
[redacted]																
3060	Human Resources	Workforce (HR	Open	Director of HR & OD	Failure to cultivate, promote and enhance a positive, engaging and diverse culture.			Actions narrative updated by the Accountable Owner							Level 2 objective updated by the Accountable Owner - was CO15, now CO17	

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

1. Purpose

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

2. Executive Summary

The paper can be summarised as follows:

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

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

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

3. Recommendations

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

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

4. Response Required

This paper is presented for assurance

5. Engagement & Communications

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

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

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

6. Impact Assessment

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

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

7. Governance Route

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

As above

8. Date Prepared & Issued

Date Prepared: 19/10/21

Date Issued: 19/10/21

Appendix 1

Corporate Risk Register - summary **October 2021**

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

Datix ID	Risk title	Division/ Directorate	Accountable owner	Category of Risk	Status	Current Score	Risk Level	Corporate Objective	Governance /review committee
[redacted]									
2188	Infection prevention and control	Medical	Dir Infection Control	Clinical Risks - Infection control	Open	20	Corporate	BCCO CO6	Clinical & Care Governance Committee
3062	Continual development of clinical standards, protocols and strategies	Medical	Medical Director	Clinical Risks - Clinical gaps	Open	9	Corporate	BCCO CO6	Clinical & Care Governance Committee
2199	Pandemic	Public Health	Director of Public Health	Other	Open	12	Corporate	BCCO CO7	Public Health Committee
[redacted]									
2730	Reputational risks around facilities and environmental issues and capacity flow	Acute	Chief Operating Officer - Acute	Reputational - QEUH	Open	20	Corporate	BVCO CO12	Acute Services Committee
2021	Financial sustainability - revenue	Finance	Director of Finance	Financial Sustainability - Revenue	Open	20	Corporate	BVCO CO11	Finance, Planning and Performance Committee
[redacted]									
2766	Failure to meet obligations to provide person centred care	Nursing	Director of Nursing	Workforce - Training	Open	9	Corprorate	BVCO CO14	Clinical & Care Governance Committee
2827	Moving out of NHS Scotland Board Performance Escalation Level 4 Framework	Escalation	Chief Executive	Service Delivery - Escalation	Closed	4	Corporate	BVCO CO14	Finance, Planning and Performance Committee
3051	RMP3 - ageing infrastructure	Acute/HSCPs	Director of Estates & Facilities	Other	Open	16	Corporate	BVCO CO14	Finance, Planning and Performance Committee
3052	Actions taken by a regulatory body	Acute/HSCPs	Director of Estates & Facilities	Other	Open	16	Corporate	BVCO CO14	Finance, Planning and Performance Committee
3060	Positive, engaging and diverse culture	Human Resources	Director of HR & OD		Open	16	Corporate	BWCO CO15	Staff Governance Committee
3059	Staff training and development	Human Resources	Director of HR & OD		Open	20	Corporate	BWCO CO17	Staff Governance Committee
[redacted]									

Datix ID	Directorate/ Partnership	Category of Risk	Status	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Curent Likelihood	Current Impact	Current Score	Residual Likliehood	Residual Impact	Residual Score	Target dates for actions	Risk Level	Corporate Objectives	Governance /review committee
[redacted]																	
2188	Medical	Clinical Risks - Infection control	Open	Dir Infection Control	Failure to comply with recognised policies and procedures in relation to infection control.	NIPC Manual is accessible on the desktop of every PC in GGC. IPC webiste is continually updated with summary SOP with links to theNIPCM. IPCT education is manditory with yearly updates for many topics as standard. IPCT present on each main site; all sites are have access to a designated IPCT. All patients with infection included in appendix 13 of the NIPCM are referred to the IPCT and a process of review is initiated to impliment controls as per NIPCM. Surveillance of surgical site infection is ongoing as per SG policy. Surveillance of blood stream infections with S. aureus bacteraemia and E. coli bacteraemia is ongoing. COVID 19 cases are reported daily to SG and are monitored via ARHAI weekly report. Electronic system ICNet pulls a feed from laboratory systems every 15 minutes and referrals go directly to the infection prevention and control team who then visit the ward and give infomation to clinical staff to ensure that control are in place for patients with organisms with the potential to spread to others. Patient are given infomation on why they are in isolation and daily check list with ongoing controls is left with clinical staff. IPCT work with collegues in the antimicrobial managment team to promote antimicrobial policy compliance. If any outbreaks or incidents occur an IMT process is initiated. Key learning from these is reported at the IPC governance committees with a 'hot debrief' submitted to these same committees at the end of the incident with specific reference to implications for other area across the board.	Programme of audit for key policies linked to CAS framework. Improvement collaborative has been initiated and is firmly linked to the GGC quality strategy which vision is 'healthcare without preventable infection' the aim is to promote key objectives for GGC around reducing harm due to avoidable infections. Monthly HH audits are ongoing. IPCT support local teams in implementing national policy into practice using improvement methodology. All patient are assessed on admission for the possibility that they have CPE/MRSA/CJD this is recoded in the nursing documentation. Lessons from incidents and outbreaks are shared with governance committees to ensure orgnasational learning. When patients are referred process of initial and ongoing review in put in place to ensure key control are consistently applied. Promotion of antimicrobial stewardship. IPCT participate in new builds and renovation projects to ensue that the patients environment promotes the prevention of infection.	*5*	*4*	*20*	*4*	*4*	*16*	Mar-22	Corporate	BCCO CO6	Clinical & Care Governance Committee

Datix ID	Directorate/ Partnership	Category of Risk	Status	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Curent Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Target date for action	Risk Level	Corporate Objectives	Governance /review committee
3054	Medical HSCPs	Corporate	Open	Medical Director	Failure to deliver the Remobilisation Plan in respect of co-ordination, capacity and resources.	Recovery Tactical Group (RTG) established. Weekly meetings held to monitor implementation with Executive Leads aligned to each action. Paper presented to SEG in May 2021 outlining monitoring arrangements for RMP3 and future role of RTG. RMP3 Action Tracker developed identifying 400+ actions and commitments from RMP3. Monthly tracker updates presented to RTG and SEG. Internal Audit Report of RMP3 Planning has been completed in April 2021 and shared with SEG	1. Robust programme management controls and processes in place to drive RMP3. 2. Ongoing review of RMP3 tracking tool as part of continous improvement and learning. 3. Implement actions from Internal Audit report RMP3 from April 2021. 4. Produce a closure report for the previous re-mobilisation tracker actions (RMP2).	3	3	9	2	3	6	Sep-21	Corporate	BCCO CO7	Finance, Planning and Performance Committee
[redacted]																	
3058	Acute/	Nursing															
2060	Public Health	Related (UB/Third Party) risks - Screening															
2730	Acute	Corporate	Open	Chief Operating Officer	Failure to implement the recommendations published in respect of the QEUH and RHC; The External Review, The Oversight Board Report, The Case Note Review Report, impacting on patient care, staff resilience, the reputation of the Board and public confidence in services provided.	• Robust escalation process in place to proactively manage any issue to ensure patient and staff safety in respect of the Board's facilities • Clinical focus remains on patient safety, with extensive reporting and monitoring, e.g. robust infection control procedures • Significant senior management capacity allocated to addressing recent incidents. • Proactive media handling • Programme Board established to oversee the reviews • Steering Group established and meeting to collate review and supply the documents and information required for the inquiries. • Programme Management Office being established at Board HQ. • Clinical Management Team Established to liaise directly with the Scottish Government Oversight Board In response to concerns raised, the Board commissioned three internal reviews covering areas central to the delivery of safe, high quality healthcare on the QEUH Campus.The key findings from the reviews were: • Facilities and Environmental Impact Review - An external advisor was appointed to examine eleven areas where issues had arisen with the building • Capacity and Flow Review - This review found the QEUH to be treating considerably higher numbers of patients than originally anticipated in the Full Business Case. An improvement programme was developed to address the issues. • The Clinical Outcomes Review concluded that NHS GGC has maintained an appropriate set of clinical governance arrangements within services responsible for patient care in the QEUH and the RHC.	Creation of a robust Action Plan against all recommendations across the reports. Monitor through Gold and Silver Command, CMT and upwards to respective governance committees, over seen by the Finance Planning and Performance Committee. Work with the Scottish Government and the newly established Action and Assurance Review Group (AARG) to provide assurance around progress and delivery.	5	4	20	4	4	16	Sep-21	Corporate	BVCO C012	Acute Services Committee

Datix ID	Directorate/ Partnership	Category of Risk	Status	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Curent Likelihood	urrent Impact	urrent Score	Residual Likelihood	Residual Impact	esidual Score	Target date for action	Risk Level	Corporate Objectives	Governance /review committee
[redacted]																	
2766	Nursing	Medical	Open	Director of Nursing	Failure to comply with legistlation and obligations in regards to patient rights, patient feedback and person centred care	Implementation of the NHSGGC Healthcare Quality Strategy and stakeholder communications and engagement strategy and associated work streams for both. Implementation of person centred care boardwide work plan. Multiple methods from ward to board level to gain feedback from and support patients, families, and the public in regard to care experience. Network of explicit formal responsibilities including Executive leads and professional local leadership for the person centred care agenda. A range of education, training, development and supervision opportunities provided by NHSGGC to enhance staff skills and behaviours. Internal governance arrangements to ensure collection, analysis including identification of themes and learning across the organisation. Person centred competencies embedded in staff recruitment, support, and development arrangements.	NHSGGC Healthcare Quality Strategy implementation plan will lead to: • Deliver on the Board's commitments described in both stratgey documents. • Expansion of data collection assurance and outcomes linked to feedback and person centred care • Work with public partners to develop easily streamlined mechanisms to improve and enhance collaboration with our population.	3	3	9	3	3	9	Oct-21	Corporate	BVCO CO14	Clinical & Care Governance Committee
[redacted]																	
282	Corporate Acute/HSCPs	Service Delivery - Escalation	Closed	Chief Executive	The Board is at level 4 of the NHS Scotland Board Performance Escalation Framework in respect of scheduled care, unscheduled care, GP out of hours, and culture and leadership. There is a risk that the Board is delayed in moving out of this framework.	An Oversight Board was appointed, and considered unscheduled care, scheduled care and GP OOHs. It also considered the culture and leadership within the organisation. • [redacted] • Further work continues internally to address the issues associated with the Performance Escalation. An internal Oversight Board continues to meet regularly to oversee progress with GP OOHs, Unscheduled Care and Scheduled Care. The Board have largely met the relevant targets in the RMP2 and RMP3 and the Scottish Government have acknowledged the efforts made by NHSGGC to remobilise activity. • The culture and leadership work continues to progress - agreeing its Culture Framework and its approach to collective leadership.	• The post of Deputy Medical Director for Primary Care has now been advertised on a substantive basis. Redesign work • Work has been progressing around service redesign in order to support the staff working in the service to provide appropriate care to patients. Further work is ongoing to consider the feasibility of re-establishing a GP OOH service presence in Inverclyde and increase the cover in the Vale of Leven area. • "Walk-in" attendances were ceased and an appointment system, via NHS24, was launched throughout the service. In addition the service has launched "Near Me" video consultations to support patient assessment. • The rollout of the Investors in People Standard commenced at Inverclyde Royal Hospital in October 2020 and the learning from this pilot site will inform a wider rollout across NHSGGC in a three year implementation programme. Preparations in relation to the other key development activities in this important initiative are underway and these will be progressed early in 2021.							Jun-21	Corporate	BVCO CO14	Finance, Planning and Performance Committee
3051	Acute/HSCPs	Other	Open	Director of Estates & Facilities	The RMP3 relies upon infrastructure, much of which requires significant investment. Particular elements of concern include but are not limited to; Ventilation Systems, High & Low Voltage infrastructure, Domestic Hot & Cold Water systems, Medical Gas Systems (particularly oxygen capacity), Building Fabric Condition	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure andidentifies the areas of the estate at high risk of failure and therefore of highest priority for repair. 2. Implementation of Board wide property management approach including assessment of premises compliance with standard consistent methodologies. 3. Regular reports to CMT/ CPG/SMG / OMG on deployment of capital resources and investment priorities. Investment Priorities are based on PAMS data. 4. A revenue allocation of [redacted] enables the sector estates teams to undertake Statutory operational maintenance and repair. These requirements have set maintenance, inspection and testing levels as detailed within Statutory Compliance legislation. 5. Property Asset Management Strategy in place. 6. The annual capital and revenue funding for Estates & Facilities takes cognisance of the statutory obligations applied to the NHS Board. Prioritisation is informed by EAMs and the PAMS data.	A review of NHSGGC's EAM system was undertaken in order to review the accuracy of data and to change the presentation of information. The outcome of this provided management with more understandable data, and informed us where we have risk, and, therefore, enable us to mitigate risks. The asset management review details areas which require investment, and risk assess those areas. The Statutory Compliance Audit and Risk Tool (SCART) Steering Group meets quarterly to monitor SCART performance and to ensure all necessary records and other forms of evidence to support compliance are readily available and in date.	4	4	16	3	3	9	Sep-21	Corporate	BVCO CO14	Finance, Planning and Performance Committee
3052	Acute/HSCPs	Corporate	Open	Director of Estates & Facilities	Actions taken by a regulatory body (e.g HSE, SEPA, Fire) in regards to statutory compliance and impact of the Boards Estate and its activities on the: health, safety and wellbeing of staff, patients and the general public as well as the surrounding environment.	Control measure sin plce include: 1. Fire risk assessments 2. Environmental PPC Permits in place at two facilities namely, GRI & QEUH. Environmental Authorisations (Scotland) Regulations (EASR) Permits in place across seven sites for nuclear waste. 3. High level Environmental Legal Register in place to monitor relevant environmental legislation applicable to the Board. 4.Estate Asset Management System (EAMs) 5. Statutory Compliance Audit and Risk Tool (SCART) 6. Topic specific Authorised Persons (AP) and Authorised Engineer oversight and audit	1. Development of whole building risk assessments. Risk assessments will be conducted across the Estate with risk assessment for the QEUH already completed. 2. Authorised Engineer audits conducted for specialist areas i.e. water, ventialtion and LV. 3. Authorised person training and competence 4. Regular internal and external (SEPA) audits for PPC Permits. Permits currently sitting at "Excellent".	4	4	16	3	3	9	Sep-21	Corporate	BVCO CO14	Finance, Planning and Performance Committee
3060	Human Resources	Workforce (HR)	Open	Director of HR & OD	Failure to cultivate, promote and enhance a positive, engaging and diverse culture.	Workforce Strategy. Leadership development programmes, culture framework and initiatives. Succession Planning Framework. Equality Action Plan.	Promotion of culture framework and associated programmes and initiatives. Medical Managment programme introduced. Executive and non-executive development programme. Review of Ready to Lead programme underway. Development of Equality Action Plan to support activity and initatives across NHSGGC.	4	4	16	3	4	12	Dec-21	Corporate	BWCO CO17	Staff Governance Committee

Datix ID	Directorate/ Partnership	Category of Risk	Status	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Curent Likelihood	urrent Impact	urrent Score	Residual Likelihood	Residual Impact	esidual Score	Target date for actions	Risk level	Corporate Objectives	Governance /review committee
[redacted]																	
3059	Human Resources	Workforce (HR)	Open	Director of HR & OD	Failure to train and develop staff members to deliver role, or key competencies not identified and developed.	Annual Reviews (Turas/KSF). Statutory and Mandatory Training. Performance targets and KPIs.	Annual reviews for all staff to discuss PDP and objectives and agree support linked to the Knowledge and Skills Framework (KSF) to agreed competencies for AFC staff, and medical staff monitoring and appraisal process. Monitoring of Statutory and Mandatory Training compliance, agreed KPIs and performance target trajectories in place for all Sectors and reviewed at Performance Review Groups (PRGs) and Acute Services Committee and Finance Planning and Performance Committee. Development and enhancement of online learning and training through Turas Learn.	5	4	20	3	3	9	44440	Corporate	BWCO CO20	Staff Governance Committee

Appendix 3

Extract from current CRR (Oct-21)

Datix ID	Directorate/ HSCPs	Category of Risk	Status	Accountable owner	Description of risk	Changes since last CRR (Y/N)	Change approved by	Status	Curent Likelihood	Current Score	Residual Likelihood	Residual Score	Corporate Objective - Level 1	Corporate Objective - Level 2	Corporate Objective	Governance /review committee
3057	Acute/HSCPs	Partnerships/Acute	Open													
2827	Corporate	Service Delivery - Escalation	Closed	Chief Executive	The Board is at level 4 of the NHS Scotland Board Performance Escalation Framework in respect of scheduled care, unscheduled care, GP out of hours, and culture and leadership. There is a risk that the Board is delayed in moving out of this framework.	Y	FPP	Status updated	-3	-12	-2	-8				

Datix ID	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Score	Residual Likelihood	Residual Impact	Residual Score	Target dates for actions	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
[redacted]													
2188	Dir Infection Control	Failure to comply with recognised policies and procedures in relation to infection control. Potential Impact(s) Risk of outbreaks linked to clinical settings, detrimental impact on patient experience and outcomes, higher risk for staff and patients. Risk of reputational damage.	NIPC Manual is accessible on the desktop of every PC in GGC. IPC website is continually updated with summary SOP or guidance documents with links to the NIPCM. IPCT education is mandatory with yearly updates for many topics as standard. IPCT present on each main site; all sites are have access to a designated IPCT. All patients with infection included in appendix 13 of the NIPCM are referred to the IPCT and a process of review is initiated to implement controls as per NIPCM. Surveillance of surgical site infection is ongoing as per SG policy. Surveillance of blood stream infections with S. aureus bacteraemia and E. coli bacteraemia is ongoing. COVID 19 cases are reported daily to SG and are monitored via ARHAI weekly report. Electronic system ICNet pulls a feed from laboratory systems every 15 minutes and referrals go directly to the infection prevention and control team who then visit the ward and give information to clinical staff to ensure that control are in place for patients with organisms with the potential to spread to others. Patient are given information on why they are in isolation and daily check list with ongoing controls is left with clinical staff. IPCT work with colleagues in the antimicrobial management team to promote antimicrobial policy compliance. If any outbreaks or incidents occur an IMT process is initiated. Key learning from these is reported at the IPC governance committees with a 'hot debrief' submitted to these same committees at the end of the incident with specific reference to implications for other area across the board.	Programme of audit for key policies linked to CAS framework eg Hand Hygiene and SCIPS. Improvement collaborative has been initiated and is firmly linked to the GGC quality strategy which vision is 'healthcare without preventable infection' the aim is to promote key objectives for GGC around reducing harm due to avoidable infections. Monthly HH audits are ongoing. IPCT support local teams in implementing national policy into practice using improvement methodology. All patient are assessed on admission for the possibility that they have CPE/MRSA/CJD this is recoded in the nursing documentation. Lessons from incidents and outbreaks are shared with governance committees to ensure organisational learning. When patients are referred process of initial and ongoing review in put in place to ensure key control are consistently applied. Promotion of antimicrobial stewardship. IPCT participate in new builds and renovation projects to ensure that the patients environment promotes the prevention of infection.	*20*	*4*	*4*	*16*	Mar-22	BCCO CO 6	Clinical	1 - Minimal	Clinical & Care Governance Committee
3062	[redacted]												

Datix ID	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Score	Residual Likelihood	Residual Impact	Residual Score	Target date for actions	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
[redacted]													

Datix ID	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	urrent Score	Residual Likelihood	Residual Impact	Residual Score	Target date for actions	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
3057	[redacted]												
2055													
2060													
3058													

Datix ID	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Score	Residual Likelihood	Residual Impact	Residual Score	Target date for actions	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
2730	Chief Operating Officer	Failure to implement the recommendations published in respect of the QEUH and RHC; The External Review, The Oversight Board Report, The Case Note Review Report, Potential Impact(s) Impact on patient care, staff resilience, the reputation of the Board and public confidence in services provided.	• Robust escalation process in place to proactively manage any issue to ensure patient and staff safety in respect of the Board's facilities • Clinical focus remains on patient safety, with extensive reporting and monitoring, e.g. robust infection control procedures • Significant senior management capacity allocated to addressing recent incidents. • Proactive media handling • Programme Board established to oversee the reviews • Steering Group established and meeting to collate review and supply the documents and information required for the inquiries. • Programme Management Office being established at Board HQ. • Clinical Management Team Established to liaise directly with the Scottish Government Oversight Board In response to concerns raised, the Board commissioned three internal reviews covering areas central to the delivery of safe, high quality healthcare on the QEUH Campus. The key findings from the reviews were: • Facilities and Environmental Impact Review - An external advisor was appointed to examine eleven areas where issues had arisen with the building • Capacity and Flow Review - This review found the QEUH to be treating considerably higher numbers of patients than originally anticipated in the Full Business Case. An improvement programme was developed to address the issues. • The Clinical Outcomes Review concluded that NHS GGC has maintained an appropriate set of clinical governance arrangements within services responsible for patient care in the QEUH and the RHC. A robust Action plan has been developed to implement all recommendations across the reports. This action plan is being actively monitored by CMT and FP&P	Continue to work with the Scottish Government and the newly established Action and Assurance Review Group (AARG) to provide assurance around progress and delivery.	20	4	4	16	Mar-22	BVCO C012	Clinical	1 - Minimal	Acute Services Committee
3066	[redacted]												
2766	Director of Nursing	Failure to comply with legislation and obligations in regards to patient rights, patient feedback and person centred care Potential Impact(s) Detrimental impact on patient care, experience, outcomes and safety. Risk of financial penalty and reputational damage	Implementation of the NHSGGC Healthcare Quality Strategy and stakeholder communications and engagement strategy and associated work streams for both. Implementation of person centred care boardwide work plan. Multiple methods from ward to board level to gain feedback from and support patients, families, and the public in regard to care experience. Network of explicit formal responsibilities including Executive leads and professional local leadership for the person centred care agenda. A range of education, training, development and supervision opportunities provided by NHSGGC to enhance staff skills and behaviours. Internal governance arrangements to ensure collection, analysis including identification of themes and learning across the organisation. Person centred competencies embedded in staff recruitment, support, and development arrangements.	NHSGGC Healthcare Quality Strategy implementation plan will lead to: • Deliver on the Board's commitments described in both strategy documents. • Expansion of data collection assurance and outcomes linked to feedback and person centred care • Work with public partners to develop easily streamlined mechanisms to improve and enhance collaboration with our population.	9	3	3	9	Mar-22	BVCO CO 14	Clinical	1 - Minimal	Clinical & Care Governance Committee

Datix ID	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Score	Residual Likelihood	Residual Impact	Residual Score	Target date for actions	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
3044	[redacted]												
3052	Director of Estates & Facilities	Failure to ensure statutory compliance through regulatory bodies Potential Impact(s) Actions taken by a regulatory body (e.g HSE, SEPA, Fire) in regards to statutory compliance and impact of the Boards Estate and its activities on the: health, safety and wellbeing of staff, patients and the general public as well as the surrounding environment.	Control measure sin place include: 1. Fire risk assessments 2. Environmental PPC Permits in place at two facilities namely, GRI & QEUH. Environmental Authorisations (Scotland) Regulations (EASR) Permits in place across seven sites for nuclear waste. 3. High level Environmental Legal Register in place to monitor relevant environmental legislation applicable to the Board. 4.Estate Asset Management System (EAMs) 5. Statutory Compliance Audit and Risk Tool (SCART) 6. Topic specific Authorised Persons (AP) and Authorised Engineer oversight and audit	1. Development of whole building risk assessments. Risk assessments will be conducted across the Estate with risk assessment for the QEUH already completed. 2. Authorised Engineer audits conducted for specialist areas i.e. water, ventilation and LV. 3. Authorised person training and competence 4. Regular internal and external (SEPA) audits for PPC Permits. Permits currently sitting at "Excellent".	*16*	*3*	*3*	*9*	Mar-22	BVCO CO 14	Legal	1 - Minimal	Finance, Planning and Performance Committee
3060	Director of HR & OD	Failure to cultivate, promote and enhance a positive, engaging and diverse culture. Potential Impact(s) Increased staff turnover, demotivated, unhappy workforce, higher risk of industrial dispute, services not delivered effectively	Workforce Strategy. Leadership development programmes, culture framework and initiatives. Succession Planning Framework. Equality Action Plan.	Promotion of culture framework and associated programmes and initiatives. Medical Management programme introduced. Executive and non-executive development programme. Review of Ready to Lead programme underway. Development of Equality Action Plan to support activity and initiatives across NHSGGC.	*16*	*3*	*4*	*12*	Dec-21	BWCO CO 17	People/ Workforce	2 - Cautious	Staff Governance Committee

Datix ID	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Score	Residual Likelihood	Residual Impact	Residual Score	Target date for actions	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
3110	[redacted]												

Definitions

Appendix 3

Corporate Objective - Level 1	
BVCO	Better Value
BCCO	Better Care
BHCO	Better Health
BWCO	Better workplace

Corporate Objective - Level 2			
CO1	To reduce the burden of disease on the population through health improvement programmes that deliver a measurable shift to prevention rather than treatment	CO11	To ensure effective financial planning across the healthcare system that supports financial sustainability and balance budgets
CO2	To reduce health inequalities through advocacy and community planning	CO12	To reduce cost variation, improve productivity and eliminate waste through a robust system of efficiency savings management
CO3	To reduce the premature mortality rate of the population and the variance in this between communities	CO13	To exploit the potential for research, digital technology and innovation to reform service delivery and reduce costs
CO4	To ensure the best start for children with a focus on developing good health and wellbeing in their early years	CO14	To utilise and improve our capital assets to support the reform of healthcare
CO5	To promote and support good mental health and wellbeing at all ages	CO15	To ensure our people are treated fairly and consistently, with dignity and respect and work in a n environment where diversity is valued
CO6	To provide a safe environment and appropriate working practices that minimise the risk of injury or harm to our patients and our people	CO16	To ensure our people are well informed
CO7	To ensure services are timely and accessible to all parts of the community we serve	CO17	To ensure our people are appropriately trained and developed
CO8	To deliver person centred care through a partnership approach built on respect compassion and shared decision making	CO18	To ensure our people are involved in decisions that affect them
CO9	To continuously improve the quality of care engaging with our patients and our people to ensure healthcare services meet their needs	CO19	To promote the health and well-being of our people
CO10	To shift the reliance on hospital care towards proactive and coordinated care and support in the community	CO20	To provide a continuously improving and safe working environment

Risk Type	Risk Appetite
Operating Risks arising from inadequate, poorly designed or ineffective/inefficient internal processes resulting in fraud, error, impaired customer service (quality, quantity and/or access to service), non-compliance and/or poor value for money.	3 – Open – in relation to innovation and change which supports the effective delivery of corporate objectives.
Legal Risks arising from a defective transaction, a claim being made (including a defence to a claim or a counterclaim) or some other legal event occurring that results in a liability or other loss, or a failure to take appropriate measures to meet legal or regulatory requirements or to protect assets (for example, intellectual property).	1 – Minimal - vital to ensure the board fully meets all legal and regulatory requirements, including adherence to internal Standing Financial Instructions.
Financial/Commercial Risks arising from not managing finances in accordance with requirements and financial constraints resulting in poor returns from investments, failure to manage assets/liabilities or to obtain value for money from the resources deployed, and/or non-compliant financial reporting. Risks arising from weaknesses in the management of commercial partnerships, supply chains and contractual requirements, resulting in poor performance, inefficiency, poor value for money, fraud, and /or failure to meet business requirements/objectives.	3 - Open - prepared to accept the possibility of some limited financial loss. Value for money is still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.
Clinical Risks arising from weaknesses in the clinical processes, resulting in poor performance in terms of clinical outcomes, patient safety, wellbeing and patient experience. Failure to deliver services that are, clinically effective, safe, efficient and person centred. Failure to meet compliance and regulatory requirements.	1 - Minimal – core services - preference for delivery options of a safe nature with a low degree of inherent risk.
People/Workforce Risks arising from ineffective leadership and engagement, suboptimal culture, inappropriate behaviours, the unavailability of sufficient capacity and capability, industrial action and/or non-compliance with relevant employment legislation/HR policies resulting in negative impact on performance.	2 – Cautious - defined as willing to accept a higher degree of risk however still being within a cautious approach.
Reputational Risks arising from adverse events, including ethical violations, a lack of sustainability, systemic or repeated failures or poor quality or a lack of innovation, leading to damages to reputation and or destruction of trust and relations.	2 – Cautious - defined as willing to accept a higher degree of risk however still being within a cautious approach.

NHS GGC Corporate Risk Register

Appendix B

Vers		Date	16/02/2022

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	urrent Impact	Current Score	Residual Likelihood	Residual Impact	esidual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee

[redacted]

CURRENT RISKS

2188	Medical	Open		Dir Infection Control	**Risk Title** Infection prevention and control **Risk:** Non-compliance with established policies and procedures leading to an increase of outbreaks in clinical settings **Cause:** 1. Lack of awareness and training and knowledge on infection control 2. Lack of oversight on implementation of established policies and procedures **Impact:** 1. Unsatisfactory patient experience /clinical outcome - long term effects 2. Adverse publicity / reputation - local media adverse publicity 3. Staffing and competence - Major error due to ineffective training / lack of implementation of training. Late delivery of key objective / service due to lack of staff.	NIPC Manual is accessible on the desktop of every PC in GGC. IPC website is continually updated with summary SOP or guidance documents with links to the NIPCM. IPCT education is mandatory with yearly updates for many topics as standard. IPCT present on each main site; all sites are have access to a designated IPCT. All patients with infection included in appendix 13 of the NIPCM are referred to the IPCT and a process of review is initiated to implement controls as per NIPCM. Surveillance of surgical site infection is ongoing as per SG policy. Surveillance of blood stream infections with S. aureus bacteraemia and E. coli bacteraemia is ongoing. COVID 19 cases are reported daily to SG and are monitored via ARHAI weekly report. Electronic system ICNet pulls a feed from laboratory systems every 15 minutes and referrals go directly to the infection prevention and control team who then visit the ward and give information to clinical staff to ensure that control are in place for patients with organisms with the potential to spread to others. Patient are given information on why they are in isolation and daily check list with ongoing controls is left with clinical staff. IPCT work with colleagues in the antimicrobial management team to promote antimicrobial policy compliance. If any outbreaks or incidents occur an IMT process is initiated. Key learning from these is reported at the IPC governance committees with a 'hot debrief' submitted to these same committees at the end of the incident with specific reference to implications for other area across the board.	Programme of audit for key policies linked to CAS framework eg Hand Hygiene and SCIPS. Improvement collaborative has been initiated and is firmly linked to the GGC quality strategy which vision is 'healthcare without preventable infection' the aim is to promote key objectives for GGC around reducing harm due to avoidable infections. Monthly HH audits are ongoing. IPCT support local teams in implementing national policy into practice using improvement methodology. All patient are assessed on admission for the possibility that they have CPE/MRSA/CJD this is recoded in the nursing documentation. Lessons from incidents and outbreaks are shared with governance committees to ensure organisational learning. When patients are referred process of initial and ongoing review in put in place to ensure key control are consistently applied. Promotion of antimicrobial stewardship. IPCT participate in new builds and renovation projects to ensure that the patients environment promotes the prevention of infection.	5	4	20	4	4	16	'Static. Risk description, cause and impact reviewed and updated	Mar-22	Corporate	BCCO CO 6	Clinical	1 - Minimal	Clinical & Care Governance Committee

[redacted]

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	urrent Impact	urrent Score	Residual Likelihood	Residual Impact	esidual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
2055	Acute	Open		Chief Operating Officer	[redacted]	[redacted]	[redacted]													
3058	Acute/HSCPs	Open		[redacted]																
2730	Acute	Open		Chief Operating Officer	**Risk Title** Reputational risks around facilities, environmental issues and capacity flow **Risk:** Failure to implement the recommendations published in respect of the QEUH and RHC; The External Review; The Oversight Board Report and the Case Note Review Report **Cause:** 1. Lack of available resources 2. Lack of appropriate focus and oversight **Impact:** 1. Patient Experience - impact on patient care resulting in unsatisfactory patient experience 2. Adverse Publicity / Reputation - National media / adverse publicity. Public confidence in the organisation undermined. MSP / MP concern / questions in parliament. Effect on staff resilience	• Robust escalation process in place to proactively manage any issue to ensure patient and staff safety in respect of the Board's facilities • Clinical focus remains on patient safety, with extensive reporting and monitoring, e.g. robust infection control procedures • Significant senior management capacity allocated to addressing recent incidents. • Proactive media handling • Programme Board established to oversee the reviews • Steering Group established and meeting to collate review and supply the documents and information required for the inquiries. • Programme Management Office being established at Board HQ. • Clinical Management Team Established to liaise directly with the Scottish Government Oversight Board In response to concerns raised, the Board commissioned three internal reviews covering areas central to the delivery of safe, high quality healthcare on the QEUH Campus. The key findings from the reviews were: • Facilities and Environmental Impact Review - An external advisor was appointed to examine eleven areas where issues had arisen with the building • Capacity and Flow Review - This review found the QEUH to be treating considerably higher numbers of patients than originally anticipated in the Full Business Case. An improvement programme was developed to address the issues. • The Clinical Outcomes Review concluded that NHS GGC has maintained an appropriate set of clinical governance arrangements within services responsible for patient care in the QEUH and the RHC. A robust Action plan has been developed to implement all recommendations across the reports. This	Continue to work with the Scottish Government and the newly established Action and Assurance Review Group (AARG) to provide assurance around progress and delivery.	5	4	**20**	4	4	**16**	'Static. Risk controls have been reviewed and are still current and current risk score remains 16.	Mar-22	Corporate	BVCO C012	Clinical	1 - Minimal	Acute Services Committee
3066	Finance	Open		Director of Finance	[redacted]															

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
3110	Human Resources	Open		[redacted]																
3059	Human Resources	Open																		
3044	Finance	Open																		
3051	Acute/HSCPs	Open	26/06/2021	Director of Estates & Facilities	**Risk Title** Remobilisation Plan - ageing infrastructure **Risk:** [redacted] **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 [redacted] enables the sector estates teams to undertake Statutory operational maintenance and repair. These requirements have set maintenance, inspection and testing levels as detailed within Statutory Compliance legislation. 5. Property Asset Management Strategy in place. 6. The annual capital and revenue funding for Estates & Facilities takes cognisance of the statutory obligations applied to the NHS Board. Prioritisation is informed by EAMs and the PAMS data.	A review of NHSGGC's EAM system was undertaken in order to review the accuracy of data and to change the presentation of information. The outcome of this provided management with more understandable data, and informed us where we have risk, and, therefore, enable us to mitigate risks. The asset management review details areas which require investment, and risk assess those areas. The Statutory Compliance Audit and Risk Tool (SCART) Steering Group meets quarterly to monitor SCART performance and to ensure all necessary records and other forms of evidence to support compliance are readily available and in date.	4	4	**16**	3	3	**9**	Static. Work is currently ongoing to assess current compliance and subsequent requirements to improve compliance to a statutory level where necessary.	Mar-23	Corporate	BVCO CO 14	Operating	3 - Open	Finance, Planning and Performance Committee
3052	Acute/HSCPs	Open	26/06/2021	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	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 and LV. 3. Authorised person training and competence 4. Regular internal and external (SEPA) audits for PPC Permits. Permits currently sitting at "Excellent".	4	4	**16**	3	3	**9**	Work remains ongoing new funding to the amount of [redacted] 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-22	Corporate	BVCO CO 14	Legal	1 - Minimal	Finance, Planning and Performance Committee

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
3060	Human Resources	Open		Director of HR & OD	**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	Workforce Strategy. Leadership development programmes, culture framework and initiatives. Succession Planning Framework. Equality Action Plan.	Promotion of culture framework and associated programmes and initiatives. Medical Management programme introduced. Executive and non-executive development programme. Review of Ready to Lead programme underway. Development of Equality Action Plan to support activity and initiatives across NHSGGC.	4	4	**16**	3	4	**12**	'Static. Risk description, cause and impact reviewed and updated	Dec-21	Corporate	BWCO CO 17	People / Workforce	2 - Cautious	Staff Governance Committee
	Medical	Open		[redacted]																
2199	Public Health	Open		[redacted]																
2060	Public Health	Open																		
3062	Medical	Open																		
3054	Medical	Open																		

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
2766	Nursing	Open		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	Implementation of the NHSGGC Healthcare Quality Strategy and stakeholder communications and engagement strategy and associated work streams for both. Implementation of person centred care boardwide work plan. Multiple methods from ward to board level to gain feedback from and support patients, families, and the public in regard to care experience. Network of explicit formal responsibilities including Executive leads and professional local leadership for the person centred care agenda. A range of education, training, development and supervision opportunities provided by NHSGGC to enhance staff skills and behaviours. Internal governance arrangements to ensure collection, analysis including identification of themes and learning across the organisation. Person centred competencies embedded in staff recruitment, support, and development arrangements.	NHSGGC Healthcare Quality Strategy implementation plan will lead to: • Deliver on the Board's commitments described in both strategy documents. -Work underway to review corporate feedback mechanisms and associated processes for reflection, learning, improvement and reporting. -Phased recovery plan in place for return to full person-centred visiting. -Project plan for person-centred care planning is underway - main engagement phase is completed, testing and improvement design phase commenced. -Board Patient Story Development processes and coordination have been reviewed with a greater focus on reflection, learning and improvement. - 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. - A toolkit for Realistic Medicine is in development which includes person-centred care resources, education material etc. - The Care Experience Improvement Model will recommence Feb/Mar in a small cohort of five teams whih is underpinned by the Excellence in Care Standard for Person-centred Care. • Expansion of data collection assurance and outcomes linked to feedback and person centred care	3	3	9	3	3	9	Static. Risk description, cause and impact updated. Current and further controls reviewed and updated	Mar-22	Corporate	BVCO CO 14	Clinical	1 - Minimal	Clinical & Care Governance Committee

NHS Greater Glasgow and Clyde	**Paper No. 22/08**
Meeting:	**Audit & Risk Committee**
Meeting Date:	**15 March 2022**
Title:	**Corporate Risk Register**
Sponsoring Director/Manager	**Mark White, Director of Finance**
Report Author:	**Andrew Gibson, Chief Risk Officer**

1. Purpose

The purpose of the attached paper is to:

Update members on the current Corporate Risk Register (CRR).

2. Executive Summary

The paper can be summarised as follows:

The Corporate Risk Register, was presented to the Audit and Risk Committee on 14 December 2021. At that meeting the Committee agreed, that in addition to risk descriptions detailing clear "impact", each risk description should also articulate underlying risk cause(s).

All risk descriptions have subsequently been updated to include:

- Risk Cause
- Risk Description
- Risk Impact

Risk owners have also reviewed the risks for any other updates and amendments. The following changes are proposed for submission to the Audit & Risk Committee:

- NEW RISK: Succession Planning. Risk Score 9 (Medium). Proposed and approved by Staff Governance Committee on 1st February 2022

- CLOSED RISK: Delayed Discharges. Risk Score 16 (High). Risk was discussed at Finance Planning and Performance Committee on 15th February 2022 and it

was proposed for closure as Delayed Discharges is now an issue rather than a risk.

- DECREASE: Medicines Costs Funding Availability. Proposed reduction from 12 (High) to 8 (Medium). The forecast year end position for the medicines FIP is [redacted] and [redacted] which exceeds the target of [redacted]. The proposal is therefore to reduce the likelihood from 3 to 2, bring the risk down to Medium. The risk still remains on the CRR and will continue to be monitored, particularly in the context of wider economic constraints nationally, e.g. inflation rises.

The Corporate Risk Register report is enclosed at Appendix A in a new format, with a fully copy of the risk register enclosed as Appendix B.

3. Recommendations

The Audit & Risk Committee is asked to consider the following recommendations:

- Approve changes to the Corporate Risk Register included in the enclosed report
- Approve the new Corporate Risk Register report format for use at future Audit & Risk Committee meetings

4. Response Required

This paper is presented for <u>approval</u>

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: *(Provide a high-level assessment of whether the paper increases the likelihood of these being achieved.)*

- **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:

- Risk Management Steering Group
- CMT
- Standing Committees

7. Governance Route

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

- As Above

8. Date Prepared & Issued

Date Prepared: March 2022
Date Issued: 8 March 2022

Appendix A

Corporate Risk Register Review

March 2022

Reporting Period: February 2022

Audit & Risk Committee 15th March 2022

Contents

1. Summary and Key Messages

2. Risk Dashboard

3. Corporate Risks in Focus

4. Risk Trend Analysis

Summary and Key Messages

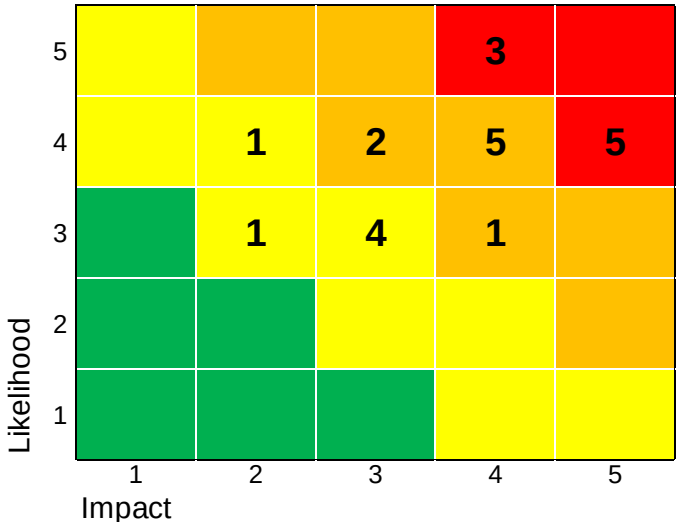
- Summary of changes:
  - 1 new risk:
    - Succession Planning (refer to page 5)
  - 1 risk proposed for closure:
    - 3057: Delayed Discharges (refer to page 6)
  - 1 risk reducing in score:
    - 3053: Medicines Costs and Funding Availability (refer to page 7)

- Key Messages:
  - All risk descriptions have been reviewed and updated to include risk cause and risk impact
  - Work ongoing to review single repository for all risk registers and enhanced reporting / insight (Datix)
  - Chief Risk Officer engaging with Directorate and Service stakeholders to inform Corporate Risk Forward Plan

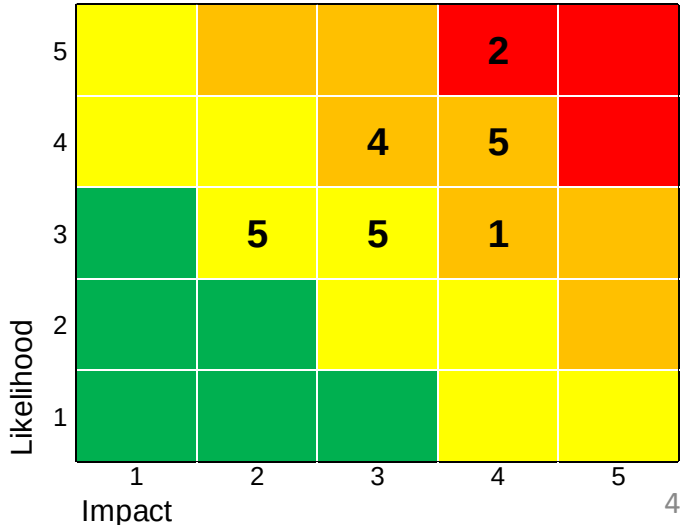
Corporate Risk Dashboard

Datix Ref	Risk Title	Previous Risk Scores Q1	Q2	Q3	Current Risk Score	Residual Risk Score	Risk Movement
NEW RISKS							
[redacted]							
RISKS REDUCING IN SCORE							
[redacted]							↓
RISKS PROPOSED FOR CLOSURE							
[redacted]							↔
CURRENT RISKS							
2188	Infection Prevention and Control	20	20	20	**20**	16	↔
[redacted]							↔
[redacted]							↔
[redacted]							↔
2730	Reputational Risks Around Facilities and Environmental Issues and Capacity Flow	20	20	20	**20**	16	↔
[redacted]							↔
[redacted]							↔
[redacted]							↔
[redacted]							↔
3051	Remobilisation Plans - Ageing Infrastructure	16	16	16	**16**	9	↔
3052	Regulatory Body Compliance	16	16	16	**16**	9	↔
3060	Positive, Engaging and Diverse Culture	16	16	16	**16**	12	↔
	Delivery of Quality Training Standards			12	**12**	9	↔
[redacted]		12	12	12	**12**	12	↔
[redacted]							↔
[redacted]							↔
3054	Remobilisation Plan - Co-ordination, Capacity and Resources	9	9	9	**9**	6	↔
2766	Failure to Meet Obligations to Provide Person Centred Care	9	9	9	**9**	9	↔
[redacted]							↔

Current Score



Residual Score



Corporate Risk Register – New Risks

Risk Title	[redacted]
[redacted]	

Risk Description	Risk Owner	Governance Committee
[redacted]		

[redacted]

[redacted]

Corporate Risk Register – Risks Proposed for Closure

Risk Title	[redacted]
[redacted]	

Risk Description	Risk Owner	Governance Committee
[redacted]		

[redacted]	[redacted]

[redacted]

Corporate Risk Register – Risks Reducing in Score

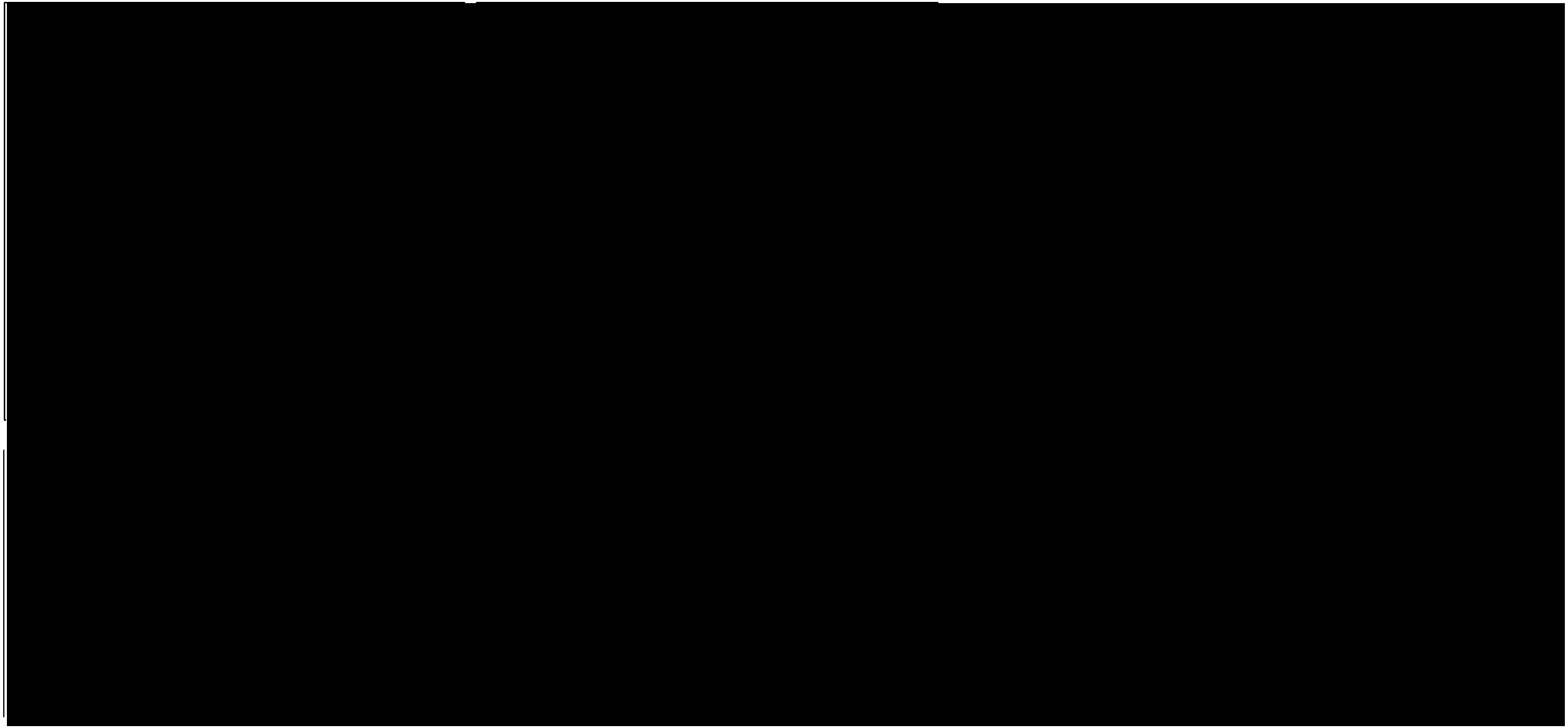
Risk Title	[redacted]
[redacted]	

Risk Description	Risk Owner	Governance Committee
[redacted]		

[redacted]
[redacted]

[redacted]

Corporate Risk Register – Analysis



NHS GGC Corporate Risk Register

Appendix B

Vers		Date	16/02/2022

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
NEW RISKS																				
[redacted]	Human Resources	New																		
RISKS PROPOSED																				
3057	Acute/HSCPs	Open																		
RISKS REDUCING I																				
3053	Medical	Open																		
CURRENT RISKS																				
2188	Medical	Open		Dir Infection Control	**Risk Title** Infection prevention and control **Risk:** Non-compliance with established policies and procedures leading to an increase of outbreaks in clinical settings **Cause:** 1. Lack of awareness and training and knowledge on infection control 2. Lack of oversight on implementation of established policies and procedures **Impact:** 1. Unsatisfactory patient experience /clinical outcome - long term effects 2. Adverse publicity / reputation - local media adverse publicity 3. Staffing and competence - Major error due to ineffective training / lack of implementation of training. Late delivery of key objective / service due to lack of staff.	NIPC Manual is accessible on the desktop of every PC in GGC. IPC website is continually updated with summary SOP or guidance documents with links to the NIPCM. IPCT education is mandatory with yearly updates for many topics as standard. IPCT present on each main site; all sites are have access to a designated IPCT. All patients with infection included in appendix 13 of the NIPCM are referred to the IPCT and a process of review is initiated to implement controls as per NIPCM. Surveillance of surgical site infection is ongoing as per SG policy. Surveillance of blood stream infections with S. aureus bacteraemia and E. coli bacteraemia is ongoing. COVID 19 cases are reported daily to SG and are monitored via ARHAI weekly report. Electronic system ICNet pulls a feed from laboratory systems every 15 minutes and referrals go directly to the infection prevention and control team who then visit the ward and give information to clinical staff to ensure that control are in place for patients with organisms with the potential to spread to others. Patient are given information on why they are in isolation and daily check list with ongoing controls is left with clinical staff. IPCT work with colleagues in the antimicrobial management team to promote antimicrobial policy compliance. If any outbreaks or incidents occur an IMT process is initiated. Key learning from these is reported at the IPC governance committees with a 'hot debrief' submitted to these same committees at the end of the incident with specific reference to implications for other area across the board.	Programme of audit for key policies linked to CAS framework eg Hand Hygiene and SCIPS. Improvement collaborative has been initiated and is firmly linked to the GGC quality strategy which vision is 'healthcare without preventable infection' the aim is to promote key objectives for GGC around reducing harm due to avoidable infections. Monthly HH audits are ongoing. IPCT support local teams in implementing national policy into practice using improvement methodology. All patient are assessed on admission for the possibility that they have CPE/MRSA/CJD this is recoded in the nursing documentation. Lessons from incidents and outbreaks are shared with governance committees to ensure organisational learning. When patients are referred process of initial and ongoing review in put in place to ensure key control are consistently applied. Promotion of antimicrobial stewardship. IPCT participate in new builds and renovation projects to ensure that the patients environment promotes the prevention of infection.	5	4	20	4	4	16	'Static. Risk description, cause and impact reviewed and updated	Mar-22	Corporate	BCCO CO 6	Clinical	1 - Minimal	Clinical & Care Governance Committee
2054	Acute	Open	[redacted]																	

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
2055	Acute	Open		[redacted]																
3058	Acute/HSCPs	Open		[redacted]																
2730	Acute	Open		Chief Operating Officer	**Risk Title** Reputational risks around facilities, environmental issues and capacity flow **Risk:** Failure to implement the recommendations published in respect of the QEUH and RHC; The External Review; The Oversight Board Report and the Case Note Review Report **Cause:** 1. Lack of available resources 2. Lack of appropriate focus and oversight **Impact:** 1. Patient Experience - impact on patient care resulting in unsatisfactory patient experience 2. Adverse Publicity / Reputation - National media / adverse publicity. Public confidence in the organisation undermined. MSP / MP concern / questions in parliament. Effect on staff resilience	• Robust escalation process in place to proactively manage any issue to ensure patient and staff safety in respect of the Board's facilities • Clinical focus remains on patient safety, with extensive reporting and monitoring, e.g. robust infection control procedures • Significant senior management capacity allocated to addressing recent incidents. • Proactive media handling • Programme Board established to oversee the reviews • Steering Group established and meeting to collate review and supply the documents and information required for the inquiries. • Programme Management Office being established at Board HQ. • Clinical Management Team Established to liaise directly with the Scottish Government Oversight Board In response to concerns raised, the Board commissioned three internal reviews covering areas central to the delivery of safe, high quality healthcare on the QEUH Campus. The key findings from the reviews were: • Facilities and Environmental Impact Review - An external advisor was appointed to examine eleven areas where issues had arisen with the building • Capacity and Flow Review - This review found the QEUH to be treating considerably higher numbers of patients than originally anticipated in the Full Business Case. An improvement programme was developed to address the issues. • The Clinical Outcomes Review concluded that NHS GGC has maintained an appropriate set of clinical governance arrangements within services responsible for patient care in the QEUH and the RHC. A robust Action plan has been developed to implement all recommendations across the reports. This action plan is being actively monitored by CMT and FP&P	Continue to work with the Scottish Government and the newly established Action and Assurance Review Group (AARG) to provide assurance around progress and delivery.	5	4	**20**	4	4	**16**	'Static. Risk controls have been reviewed and are still current and current risk score remains 16.	Mar-22	Corporate	BVCO C012	Clinical	1 - Minimal	Acute Services Committee
3066	Finance	Open		[redacted]																

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
3110	Human Resources	Open		[redacted]																
3059	Human Resources	Open		Director of HR & OD	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.		Knowledge and Skills Framework (KSF) to agreed competencies for AFC staff, and medical staff monitoring and appraisal process. Monitoring of Statutory and Mandatory Training compliance, agreed KPIs and performance target trajectories in place for all Sectors and reviewed at Performance Review Groups (PRGs) and Acute Services Committee and Finance Planning and Performance Committee. Development and enhancement of online learning and training through Turas Learn.	5	4	20	3	3	9	and further controls reviewed and updated	Dec-21	Corporate	BWCO CO 20	People / Workforce	2 - Cautious	Staff Governance Committee
3044	Finance	Open		[redacted]																
3051	Estates & Facilities	Open	26/06/2021	[redacted]																
3052	Estates & Facilities	Open	26/06/2021	Director of Estates & Facilities	**<u>Risk Title</u>** 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	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 and LV. 3. Authorised person training and competence 4. Regular internal and external (SEPA) audits for PPC Permits. Permits currently sitting at "Excellent".	4	4	16	3	3	9	Work remains ongoing new funding to the amount of [redacted] 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-22	Corporate	BVCO CO 14	Legal	1 - Minimal	Finance, Planning and Performance Committee

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
3060	Human Resources	Open		Director of HR & OD	**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	Workforce Strategy. Leadership development programmes, culture framework and initiatives. Succession Planning Framework. Equality Action Plan.	Promotion of culture framework and associated programmes and initiatives. Medical Management programme introduced. Executive and non-executive development programme. Review of Ready to Lead programme underway. Development of Equality Action Plan to support activity and initiatives across NHSGGC.	4	4	16	3	4	12	'Static. Risk description, cause and impact reviewed and updated	Dec-21	Corporate	BWCO CO 17	People / Workforce	2 - Cautious	Staff Governance Committee
	Medical	Open		[redacted]																
2199	Public Health	Open		[redacted]																
2060	Public Health	Open																		
3062	Medical	Open																		
3054	Medical	Open																		

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
2766	Nursing	Open		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	Implementation of the NHSGGC Healthcare Quality Strategy and stakeholder communications and engagement strategy and associated work streams for both. Implementation of person centred care boardwide work plan. Multiple methods from ward to board level to gain feedback from and support patients, families, and the public in regard to care experience. Network of explicit formal responsibilities including Executive leads and professional local leadership for the person centred care agenda. A range of education, training, development and supervision opportunities provided by NHSGGC to enhance staff skills and behaviours. Internal governance arrangements to ensure collection, analysis including identification of themes and learning across the organisation. Person centred competencies embedded in staff recruitment, support, and development arrangements.	NHSGGC Healthcare Quality Strategy implementation plan will lead to: • Deliver on the Board's commitments described in both strategy documents. -Work underway to review corporate feedback mechanisms and associated processes for reflection, learning, improvement and reporting. -Phased recovery plan in place for return to full person-centred visiting. -Project plan for person-centred care planning is underway - main engagement phase is completed, testing and improvement design phase commenced. -Board Patient Story Development processes and coordination have been reviewed with a greater focus on reflection, learning and improvement. - 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. - A toolkit for Realistic Medicine is in development which includes person-centred care resources, education material etc. - The Care Experience Improvement Model will recommence Feb/Mar in a small cohort of five teams whih is underpinned by the Excellence in Care Standard for Person-centred Care. • Expansion of data collection assurance and outcomes linked to feedback and person centred care	3	3	9	3	3	9	Static. Risk description, cause and impact updated. Current and further controls reviewed and updated	Mar-22	Corporate	BVCO CO 14	Clinical	1 - Minimal	Clinical & Care Governance Committee

NHS GGC Corporate Risk Register

Appendix B

Vers		Date	25/05/2022

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
RISKS INCREASING IN SCORE																				
3066	Finance	Open	[redacted]																	
2199	Public Health	Open																		
RISK DESCRIPTION REVIE																				
3057	Acute/HSCPs	Open																		
STATIC RISKS																				
2188	Medical	Open		Dir Infection Control	**Risk Title** Infection prevention and control **Risk:** Non-compliance with established policies and procedures leading to an increase of outbreaks in clinical settings **Cause:** 1. Lack of awareness and training and knowledge on infection control 2. Lack of oversight on implementation of established policies and procedures **Impact:** 1. Unsatisfactory patient experience /clinical outcome - long term effects 2. Adverse publicity / reputation - local media adverse publicity 3. Staffing and competence - Major error due to ineffective training / lack of implementation of training. Late delivery of key objective / service due to lack of staff.	NIPC Manual is accessible on the desktop of every PC in GGC. IPC website is continually updated with summary SOP or guidance documents with links to the NIPCM. IPCT education is mandatory with yearly updates for many topics as standard. IPCT present on each main site; all sites are have access to a designated IPCT. All patients with infection included in appendix 13 of the NIPCM are referred to the IPCT and a process of review is initiated to implement controls as per NIPCM. Surveillance of surgical site infection is ongoing as per SG policy. Surveillance of blood stream infections with S. aureus bacteraemia and E. coli bacteraemia is ongoing. COVID 19 cases are reported daily to SG and are monitored via ARHAI weekly report. Electronic system ICNet pulls a feed from laboratory systems every 15 minutes and referrals go directly to the infection prevention and control team who then visit the ward and give information to clinical staff to ensure that control are in place for patients with organisms with the potential to spread to others. Patient are given information on why they are in isolation and daily check list with ongoing controls is left with clinical staff. IPCT work with colleagues in the antimicrobial management team to promote antimicrobial policy compliance. If any outbreaks or incidents occur an IMT process is initiated. Key learning from these is reported at the IPC governance committees with a 'hot debrief' submitted to these same committees at the end of the incident with specific reference to implications for other area across the board.	Programme of audit for key policies linked to CAS framework eg Hand Hygiene and SCIPS. Improvement collaborative has been initiated and is firmly linked to the GGC quality strategy which vision is 'healthcare without preventable infection' the aim is to promote key objectives for GGC around reducing harm due to avoidable infections. Monthly HH audits are ongoing. IPCT support local teams in implementing national policy into practice using improvement methodology. All patient are assessed on admission for the possibility that they have CPE/MRSA/CJD this is recoded in the nursing documentation. Lessons from incidents and outbreaks are shared with governance committees to ensure organisational learning. When patients are referred process of initial and ongoing review in put in place to ensure key control are consistently applied. Promotion of antimicrobial stewardship. IPCT participate in new builds and renovation projects to ensure that the patients environment promotes the prevention of infection.	5	4	20	4	4	16	'Static.	Aug-22	Corporate	BCCO CO 6	Clinical	1 - Minimal	Clinical & Care Governance Committee

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	urrent Impact	Current Score	Residual Likelihood	Residual Impact	esidual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
2954	Acute	Open		Chief Operating Officer	[redacted]															
2055	Acute	Open			[redacted]															
3058	Acute/HSCPs	Open			[redacted]															
2730	Acute	Open		Chief Operating Officer	**Risk Title** Reputational risks around facilities, environmental issues and capacity flow **Risk:** Failure to implement the recommendations published in respect of the QEUH and RHC; The External Review; The Oversight Board Report and the Case Note Review Report **Cause:** 1. Lack of available resources 2. Lack of appropriate focus and oversight **Impact:** 1. Patient Experience - impact on patient care resulting in unsatisfactory patient experience 2. Adverse Publicity / Reputation - National media / adverse publicity. Public confidence in the organisation undermined. MSP / MP concern / questions in parliament. Effect on staff resilience	• Robust escalation process in place to proactively manage any issue to ensure patient and staff safety in respect of the Board's facilities • Clinical focus remains on patient safety, with extensive reporting and monitoring, e.g. robust infection control procedures • Significant senior management capacity allocated to addressing recent incidents. • Proactive media handling • Programme Board established to oversee the reviews • Steering Group established and meeting to collate review and supply the documents and information required for the inquiries. • Programme Management Office being established at Board HQ. • Clinical Management Team Established to liaise directly with the Scottish Government Oversight Board In response to concerns raised, the Board commissioned three internal reviews covering areas central to the delivery of safe, high quality healthcare on the QEUH Campus. The key findings from the reviews were: • Facilities and Environmental Impact Review - An external advisor was appointed to examine eleven areas where issues had arisen with the building • Capacity and Flow Review - This review found the QEUH to be treating considerably higher numbers of patients than originally anticipated in the Full Business Case. An improvement programme was developed to address the issues. • The Clinical Outcomes Review concluded that NHS GGC has maintained an appropriate set of clinical governance arrangements within services responsible for patient care in the QEUH and the RHC. A robust Action plan has been developed to implement all recommendations across the reports. This action plan is being actively monitored by CMT and FP&P	Continue to work with the Scottish Government. Action and Assurance Review Group (AARG) Action Plan complete. Regular monitoring, review and audit planning and reporting in place for Case Note Review, Independent Review and Oversight Board	5	4	20	3	3	9	'Positive movement". Residual Risk controls have been reviewed and the residual risks core has reduced from 4x4=16 (High) to 3x3=9 (Medium). Actions outlined in the AARG Action Plan have been completed with regular feedback from monitoring and audit processes discussed at senior management teams and Executive Oversight Group. Though all actions are completed there remains the need to maintain scrutiny and oversight through the ongoing audit process.	Jun-22	Corporate	BVCO C012	Clinical	1 - Minimal	Acute Services Committee

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3110	Human Resources	Open		[redacted]																
3059	Human Resources	Open		Director of HR & OD	**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.	Annual Reviews (Turas/KSF). Statutory and Mandatory Training. Performance targets and KPIs.	Annual reviews for all staff to discuss PDP and objectives and agree support - linked to Knowledge and Skills Framework (KSF) to agreed competencies, and medical staff monitoring and appraisal process. Monitoring of Statutory and Mandatory Training compliance, agreed KPIs and performance target trajectories in place for all Sectors and reviewed at Performance Review Groups (PRGs) and Acute Services Committee and Finance Planning and Performance Committee. Development and enhancement of online learning and training through Turas Learn. Progress the development of profession based career pathways with these areas incorporated as key elements. Automated HR Notifications email alert being introduced in May to staff to highlight action to maintain a current KSF PDP&R.	5	4	20	3	3	9	Static. Current and further controls reviewed and updated.	Aug-22	Corporate	BWCO CO 20	People / Workforce	2 - Cautious	Staff Governance Committee
3044	Finance	Open		[redacted]																
3051	Estates & Facilities	Open	26/06/202	[redacted]																
3052	Estates & Facilities	Open	26/06/2021	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	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 and LV. 3. Authorised person training and competence 4. Regular internal and external (SEPA) audits for PPC Permits. Permits currently sitting at "Excellent".	4	4	16	3	3	9	Static. Work remains ongoing new funding to the amount of [redacted] 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.	Jun-22	Corporate	BVCO CO 14	Legal	1 - Minimal	Finance, Planning and Performance Committee
3060	Human Resources	Open		Director of HR & OD	**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	Workforce Strategy. Leadership development programmes, culture framework and initiatives. Succession Planning Framework. Equality Action Plan.	Promotion of culture framework and associated programmes and initiatives. Medical Management programme introduced. Executive and non-executive development programmes. Review of Ready to Lead programme underway. Development of Equality Action Plan to support activity and initiatives across NHSGGC. iMatter response and results, focus on action planning and success stories across teams. Application of Investors in People Standard, and development plans on each site agreed by site workforce groups. Continued facilitation of Collaborative Conversations. Collaborative development of Internal Communication and Employee Engagement Strategy.	4	4	16	3	4	12	Static. Current and further controls reviewed and updated.	Aug-22	Corporate	BWCO CO 17	People / Workforce	2 - Cautious	Staff Governance Committee

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
[redacted]	Medical	Open																		
2060	Public Health	Open																		
[redacted]	Human Resources	Open	01/02/202																	
3062	Medical	Open																		
3054	Medical	Open																		
2766	Nursing	Open		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. Multiple methods from ward to board level to gain feedback from and support patients, families, and the public in regard to care experience. 4. Network of explicit formal responsibilities including Executive leads and professional local leadership for the person centred care agenda. 5. A range of education, training, development and supervision opportunities provided by NHSGGC to enhance staff skills and behaviours. 6. Internal governance arrangements to ensure collection, analysis including identification of themes and learning across the organisation. 7. Person centred competencies embedded in staff recruitment, support, and development arrangements.	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 (D Connelly, PEPI Team) 3. Visiting Review Team meet every 1 -2 weeks to assess scope for return to person-centred visiting. PCV remobilised on 23/05/2022 with maximum of two visitors at a time (J Rodgers/AcLinton, PCHC Team). 4. Project plan for person-centred care planning is in place - main engagement phase is completed, testing and improvement design phase commenced.(A McLinton, PCHC Team) 5. Board Patient Story Development processes and coordination have been reviewed with a greater focus on reflection, learning and improvement.(J Rodgers/D Connelly/A McLinton) 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 (A McLinton, PCHC Team) 7. A Realistic Medicine Toolkit has been launched which includes person-centred care resources, education material etc.(A Ireland/Breeda Ojo, Realistic Medicine Team)) 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.(A McLinton, PCHC Team) 9. Expansion of data collection assurance and outcomes linked to feedback and person centred care (D Connelly, PEPI Team)	3	3	9	3	3	9	Static. Current and further controls reviewed and updated	Mar-23	Corporate	BVCO CO 14	Clinical	1 - Minimal	Clinical & Care Governance Committee

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
3053	Medical	Open																		

NHS GGC Corporate Risk Register

Appendix B

Vers		Date	30.06.2022

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
RISKS DECREASING IN SCORE																				
2730	Acute	Open		Chief Operating Officer	**Risk Title** QEUH & RHC Independent Review, Oversight Board and Case Note Review Recommendations **Risk:** Evidence based practice and change does not continue to be embedded across functions and sites following completion of all recommendations outlined across the Independent Review, Oversight Board Report and Case Note review. **Cause:** 1. Lack of available resources 2. Lack of appropriate focus, oversight and monitoring **Impact:** 1. Patient Experience - impact on patient care resulting in unsatisfactory patient experience 2. Adverse Publicity / Reputation - National media / adverse publicity. Public confidence in the organisation undermined. MSP / MP concern / questions in parliament. Effect on staff resilience	Of the 108 recommendations outlined across the Independent Review, Oversight Board Report and Case Note Review ; all have been completed. This presents a substantial Board wide programme of work between clinical, managerial and support staff. Structures and systems have been put in place.	Oversight and monitoring continues with the Scottish Government Action and Assurance Review Group (AARG). Regular monitoring, review and audit planning and reporting is in place for Case Note Review, Independent Review and Oversight Board. GGC was de-escalated from level 4 to level 2 of the Scottish Government Performance Framework in June 2022. Evidence based audits continue.	3	3	9	3	3	9	'Risk score has been reduced from 5x4 = 20 to 3x3 = 9 due to all actions being completed across the AARG action plan and GGC being de-escalated from the SG Performance Framework from 4 to 2. Members of Acute Strategic Management Group and the Chief Operating Officer agreed that due to the sensitivities around the QEUH to keep the risk on the Corporate Risk Register to monitor for a period of 6 months. The group noted feedback from the Acute Services Committee and agreed that the risk should not be split into 2 risks. SMG 30-6-2022	Dec-22	Corporate	BVCO C012	Clinical	1 - Minimal	Acute Services Committee
STATIC RISKS																				
3066	Finance	Open		[redacted]																
2188	Medical	Open		Dir Infection Control	**Risk Title** Infection prevention and control **Risk:** Non-compliance with established policies and procedures leading to an increase of outbreaks in clinical settings **Cause:** 1. Lack of awareness and training and knowledge on infection control 2. Lack of oversight on implementation of established policies and procedures **Impact:** 1. Unsatisfactory patient experience /clinical outcome - long term effects 2. Adverse publicity / reputation - local media adverse publicity 3. Staffing and competence - Major error due to ineffective training / lack of implementation of training. Late delivery of key objective / service due to lack of staff.	NIPC Manual is accessible on the desktop of every PC in GGC. IPC website is continually updated with summary SOP or guidance documents with links to the NIPCM. IPCT education is mandatory with yearly updates for many topics as standard. IPCT present on each main site; all sites are have access to a designated IPCT. All patients with infection included in appendix 13 of the NIPCM are referred to the IPCT and a process of review is initiated to implement controls as per NIPCM. Surveillance of surgical site infection is ongoing as per SG policy. Surveillance of blood stream infections with S. aureus bacteraemia and E. coli bacteraemia is ongoing. COVID 19 cases are reported daily to SG and are monitored via ARHAI weekly report. Electronic system ICNet pulls a feed from laboratory systems every 15 minutes and referrals go directly to the infection prevention and control team who then visit the ward and give information to clinical staff to ensure that control are in place for patients with organisms with the potential to spread to others. Patient are given information on why they are in isolation and daily check list with ongoing controls is left with clinical staff. IPCT work with colleagues in the antimicrobial management team to promote antimicrobial policy compliance. If any outbreaks or incidents occur an IMT process is initiated. Key learning from these is reported at the IPC governance committees with a 'hot debrief' submitted to these same committees at the end of the incident with specific reference to implications for other area across the board.	Programme of audit for key policies linked to CAS framework eg Hand Hygiene and SCIPS. Improvement collaborative has been initiated and is firmly linked to the GGC quality strategy which vision is 'healthcare without preventable infection' the aim is to promote key objectives for GGC around reducing harm due to avoidable infections. Monthly HH audits are ongoing. IPCT support local teams in implementing national policy into practice using improvement methodology. All patient are assessed on admission for the possibility that they have CPE/MRSA/CJD this is recoded in the nursing documentation. Lessons from incidents and outbreaks are shared with governance committees to ensure organisational learning. When patients are referred process of initial and ongoing review in put in place to ensure key control are consistently applied. Promotion of antimicrobial stewardship. IPCT participate in new builds and renovation projects to ensure that the patients environment promotes the prevention of infection.	5	4	20	4	4	16	'Static.	Aug-22	Corporate	BCCO CO 6	Clinical	1 - Minimal	Clinical & Care Governance Committee
2054	Acute	Open		[redacted]																

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
2055	Acute	Open			[redacted]															
3058	Acute/HSCPs	Open																		
3110	Human Resources	Open																		
3059	Human Resources	Open		Director of HR & OD	**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.	Annual Reviews (Turas/KSF). Statutory and Mandatory Training. Performance targets and KPIs.	Annual reviews for all staff to discuss PDP and objectives and agree support - linked to Knowledge and Skills Framework (KSF) to agreed competencies, and medical staff monitoring and appraisal process. Monitoring of Statutory and Mandatory Training compliance, agreed KPIs and performance target trajectories in place for all Sectors and reviewed at Performance Review Groups (PRGs) and Acute Services Committee and Finance Planning and Performance Committee. Development and enhancement of online learning and training through Turas Learn. Progress the development of profession based career pathways with these areas incorporated as key elements.	5	4	20	3	3	9	Static. Current and further controls reviewed and updated.	Aug-22	Corporate	BWCO CO 20	People / Workforce	2 - Cautious	Staff Governance Committee

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
2199	Public Health	Open	[redacted]																	th
3057	Acute/HSCPs	Open																		e
3044	Finance	Open																		e
3051	Estates & Facilities	Open	26/06/2021	[redacted]																
3052	Estates & Facilities	Open	26/06/2021	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	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".	4	4	16	3	3	9	Static. Work remains ongoing new funding to the amount of [redacted] 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	Corporate	BVCO CO 14	Legal	1 - Minimal	Finance, Planning and Performance Committee
3060	Human Resources	Open		Director of HR & OD	**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	Workforce Strategy. Leadership development programmes, culture framework and initiatives. Succession Planning Framework. Equality Action Plan.	Promotion of culture framework and associated programmes and initiatives. Medical Management programme introduced. Executive and non-executive development programmes. Review of Ready to Lead programme underway. Development of Equality Action Plan to support activity and initiatives across NHSGGC. iMatter response and results, focus on action planning and success stories across teams. Application of Investors in People Standard, and development plans on each site agreed by site workforce groups. Continued facilitation of Collaborative Conversations. Collaborative development of Internal Communication and Employee Engagement Strategy.	4	4	16	3	4	12	Static. Current and further controls reviewed and updated.	Aug-22	Corporate	BWCO CO 17	People / Workforce	2 - Cautious	Staff Governance Committee

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	urrent Impact	urrent Score	Residual Likelihood	Residual Impact	esidual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	isk Appetite	Governance /review committee
	Medical	Open			[redacted]															
2060	Public Health	Open																		
	Human Resources	Open	01/02/202																	
3062	Medical	Open																		
3054	Medical	Open																		
2766	Nursing	Open		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. Multiple methods from ward to board level to gain feedback from and support patients, families, and the public in regard to care experience. 4. Network of explicit formal responsibilities including Executive leads and professional local leadership for the person centred care agenda. 5. A range of education, training, development and supervision opportunities provided by NHSGGC to enhance staff skills and behaviours. 6. Internal governance arrangements to ensure collection, analysis including identification of themes and learning across the organisation. 7. Person centred competencies embedded in staff recruitment, support, and development arrangements.	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 (D Connelly, PEPI Team) 3. Visiting Review Team meet every 1 -2 weeks to assess scope for return to person-centred visiting. PCV remobilised on 23/05/2022 with maximum of two visitors at a time (J Rodgers/AcLinton, PCHC Team). 4. Project plan for person-centred care planning is in place - main engagement phase is completed, testing and improvement design phase commenced.(A McLinton, PCHC Team) 5. Board Patient Story Development processes and coordination have been reviewed with a greater focus on reflection, learning and improvement.(J Rodgers/D Connelly/A McLinton) 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 (A McLinton, PCHC Team) 7. A Realistic Medicine Toolkit has been launched which includes person-centred care resources, education material etc.(A Ireland/Breeda Ojo, Realistic Medicine Team)) 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.(A McLinton, PCHC Team) 9. Expansion of data collection assurance and outcomes linked to feedback and person centred care (D Connelly, PEPI Team)	3	3	9	3	3	9	Static. Current and further controls reviewed and updated	Mar-23	Corporate	BVCO CO 14	Clinical	1 - Minimal	Clinical & Care Governance Committee

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current likelihood	rrent Impact	rrent Score	Residual likelihood	Residual Impact	idual Score	Review Notes	Target dates for actions	Risk Level	orporate bjectives	Risk Type	sk Appetite	Governance /review committee
3053	Medical	Open		Medical Director	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

NHS GGC Corporate Risk Register

Appendix B

Vers		Date	28.07.2022

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
DE-ESCALATED RISKS																				
2730	Acute	Open		Chief Operating Officer	**Risk Title** QEUH & RHC Independent Review, Oversight Board and Case Note Review Recommendations **Risk:** Evidence based practice and change does not continue to be embedded across functions and sites following completion of all recommendations outlined across the Independent Review, Oversight Board Report and Case Note review. **Cause:** 1. Lack of available resources 2. Lack of appropriate focus, oversight and monitoring **Impact:** 1. Patient Experience - impact on patient care resulting in unsatisfactory patient experience 2. Adverse Publicity / Reputation - National media / adverse publicity. Public confidence in the organisation undermined. MSP / MP concern / questions in parliament. Effect on staff resilience	Of the 108 recommendations outlined across the Independent Review, Oversight Board Report and Case Note Review ; all have been completed. This presents a substantial Board wide programme of work between clinical, managerial and support staff. Structures and systems have been put in place.	Oversight and monitoring continues with the Scottish Government Action and Assurance Review Group (AARG). Regular monitoring, review and audit planning and reporting is in place for Case Note Review, Independent Review and Oversight Board. GGC was de-escalated from level 4 to level 2 of the Scottish Government Performance Framework in June 2022. Evidence based audits continue.	3	3	9	3	3	9	De-escalate. Risk score reduced from 5x4 = 20 to 3x3 = 9 in June due to all actions being completed across the AARG action plan and GGC being de-escalated from the SG Performance Framework from 4 to 2. It is proposed that due to ongoing cycle of audits that the risk should be de-escalated to Acute South Sector Risk Register (this was discussed at Acute Services Committee in July) Executive Oversight Group will monitor audit compliance.	Dec-22	Corporate	BVCO CO12	Clinical	1 - Minimal	Acute Services Committee
STATIC RISKS																				
3066	Finance	Open		[redacted]																
2188	Medical	Open		Dir Infection Control	**Risk Title** Infection prevention and control **Risk:** Non-compliance with established policies and procedures leading to an increase of outbreaks in clinical settings **Cause:** 1. Lack of awareness and training and knowledge on infection control 2. Lack of oversight on implementation of established policies and procedures **Impact:** 1. Unsatisfactory patient experience /clinical outcome - long term effects 2. Adverse publicity / reputation - local media adverse publicity 3. Staffing and competence - Major error due to ineffective training / lack of implementation of training. Late delivery of key objective / service due to lack of staff.	NIPC Manual is accessible on the desktop of every PC in GGC. IPC website is continually updated with summary SOP or guidance documents with links to the NIPCM. IPCT education is mandatory with yearly updates for many topics as standard. IPCT present on each main site; all sites are have access to a designated IPCT. All patients with infection included in appendix 13 of the NIPCM are referred to the IPCT and a process of review is initiated to implement controls as per NIPCM. Surveillance of surgical site infection is ongoing as per SG policy. Surveillance of blood stream infections with S. aureus bacteraemia and E. coli bacteraemia is ongoing. COVID 19 cases are reported daily to SG and are monitored via ARHAI weekly report. Electronic system ICNet pulls a feed from laboratory systems every 15 minutes and referrals go directly to the infection prevention and control team who then visit the ward and give information to clinical staff to ensure that control are in place for patients with organisms with the potential to spread to others. Patient are given information on why they are in isolation and daily check list with ongoing controls is left with clinical staff. IPCT work with colleagues in the antimicrobial management team to promote antimicrobial policy compliance. If any outbreaks or incidents occur an IMT process is initiated. Key learning from these is reported at the IPC governance committees with a 'hot debrief' submitted to these same committees at the end of the incident with specific reference to implications for other area across the board.	Programme of audit for key policies linked to CAS framework eg Hand Hygiene and SCIPS. Improvement collaborative has been initiated and is firmly linked to the GGC quality strategy which vision is 'healthcare without preventable infection' the aim is to promote key objectives for GGC around reducing harm due to avoidable infections. Monthly HH audits are ongoing. IPCT support local teams in implementing national policy into practice using improvement methodology. All patient are assessed on admission for the possibility that they have CPE/MRSA/CJD this is recoded in the nursing documentation. Lessons from incidents and outbreaks are shared with governance committees to ensure organisational learning. When patients are referred process of initial and ongoing review in put in place to ensure key control are consistently applied. Promotion of antimicrobial stewardship. IPCT participate in new builds and renovation projects to ensure that the patients environment promotes the prevention of infection.	5	4	20	4	4	16	'Static.	Aug-22	Corporate	BCCO CO 6	Clinical	1 - Minimal	Clinical & Care Governance Committee
2054	Acute	Open		[redacted]																

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	urrent Impact	Current Score	Residual Likelihood	Residual Impact	esidual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
2055	Acute	Open			[redacted]															
3058	Acute/HSCPs	Open																		
3110	Human Resources	Open																		
3059	Human Resources	Open		Director of Human Resources & Organisational Development	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.		Knowledge and Skills Framework (KSF) to agreed competencies, and medical staff monitoring and appraisal process. Monitoring of Statutory and Mandatory Training compliance, agreed KPIs and performance target trajectories in place for all Sectors and reviewed at Performance Review Groups (PRGs) and Acute Services Committee and Finance Planning and Performance Committee. Development and enhancement of online learning and training through Turas Learn. Progress the development of profession based career pathways with these areas incorporated as key elements.	5	4	20	3	3	9		Aug-22	Corporate	BWCO CO 20	People / Workforce	2 - Cautious	Staff Governance Committee

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	urrent Impact	Current Score	Residual Likelihood	Residual Impact	esidual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
2199	Public Health	Open			[redacted]															
3057	Acute/HSCPs	Open																		
3044	Finance	Open																		
3051	Estates & Facilities	Open	26/06/2021																	
3052	Estates & Facilities	Open	26/06/2021	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	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".	4	4	**16**	3	3	**9**	Static. Work remains ongoing new funding to the amount of [redacted] 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	Corporate	BVCO CO 14	Legal	1 - Minimal	Finance, Planning and Performance Committee

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
3060	Human Resources	Open		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	Workforce Strategy. Leadership development programmes, culture framework and initiatives. Succession Planning Framework. Workforce Equality Action Plan.	Promotion of culture framework and associated programmes and initiatives. Medical Management programme introduced. Executive and non-executive development programmes. Review of Ready to Lead programme underway. Development of Workforce Equality Action Plan to support activity and initiatives across NHSGGC. iMatter response and results; analysis of NHSGGC Board Report; and focus on action planning and sharing success stories across teams. Application of Investors in People Standard, and development plans on each site agreed by site workforce groups. Continued facilitation of Collaborative Conversations. Collaborative development of Internal Communication and Employee Engagement Strategy.	4	4	**16**	3	4	**12**	Static. Updated 25.07.2022 with comments from Diana Hudson re iMatters - iMatter response and results; analysis of NHSGGC Board Report; and focus on action planning and sharing success stories across teams.	Aug-22	Corporate	BWCO CO 17	People / Workforce	2 - Cautious	Staff Governance Committee
[redacted]																				
[redacted]																				
[redacted]																				
[redacted]																				
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Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
2766	Nursing	Open		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. Multiple methods from ward to board level to gain feedback from and support patients, families, and the public in regard to care experience. 4. Network of explicit formal responsibilities including Executive leads and professional local leadership for the person centred care agenda. 5. A range of education, training, development and supervision opportunities provided by NHSGGC to enhance staff skills and behaviours. 6. Internal governance arrangements to ensure collection, analysis including identification of themes and learning across the organisation. 7. Person centred competencies embedded in staff recruitment, support, and development arrangements.	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 (D Connelly, PEPI Team) 3. Visiting Review Team meet every 1 -2 weeks to assess scope for return to person-centred visiting. PCV remobilised on 23/05/2022 with maximum of two visitors at a time (J Rodgers/AcLinton, PCHC Team). 4. Project plan for person-centred care planning is in place - main engagement phase is completed, testing and improvement design phase commenced.(A McLinton, PCHC Team) 5. Board Patient Story Development processes and coordination have been reviewed with a greater focus on reflection, learning and improvement.(J Rodgers/D Connelly/A McLinton) 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 (A McLinton, PCHC Team) 7. A Realistic Medicine Toolkit has been launched which includes person-centred care resources, education material etc.(A Ireland/Breeda Ojo, Realistic Medicine Team)) 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.(A McLinton, PCHC Team) 9. Expansion of data collection assurance and outcomes linked to feedback and person centred care (D Connellly, PEPI Team)	3	3	**9**	3	3	**9**	Static	Mar-23	Corporate	BVCO CO 14	Clinical	1 - Minimal	Clinical & Care Governance Committee
3053	Medical	Open			[redacted]															

NHS GGC Corporate Risk Register

Appendix B

Vers		Date	25.08.2022

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
RISKS PROPOSED FOR DE-ESCALATION																				
2188	Medical	Open		Dir Infection Control	**'Risk Title** Infection prevention and control Risk: Failure to deliver IPC Service to support clinical services' compliance with recognised policies and procedures in relation to infection control **Cause:** 1. Lack of awareness and training and knowledge on infection control 2. Lack of oversight or non-compliance on implementation of established policies and procedures **Impact:** 1. Risk of outbreaks linked to clinical settings, 2. detrimental impact on patient experience and outcomes, 3. higher risk for staff and patients. 4. Risk of reputational damage.	1. NIPC Manual is accessible on the desktop of every PC in GGC. 2. IPC website is continually updated with summary SOP with links to the NIPCM. IPCT education is mandatory with yearly updates for many topics as standard. 3. IPCT continue to advise services on national policy and best practice 4. IPCT present on each main site; all sites and have access to a designated IPCT. 5. All patients suspected or confirmed to have an alert organism listed in appendix 13 of the NIPCM are referred to the IPCT and a process of review is initiated to implement controls as per NIPCM. 6. Surveillance of surgical site infection is ongoing as per SG policy. Surveillance of blood stream infections with S. aureus bacteraemia and E. coli bacteraemia is ongoing. 7. COVID 19 cases are reported daily to SG and are monitored via ARHAI weekly report. COVID 19 closed wards report is issued to senior managers daily. The number of incidents is also reported via the HAIRT to NHS Board and the Clinical Care Governance Group. A separate report with ward closures and bed days lost is submitted to Acute Clinical Governance Forum. 8. Electronic system ICNet pulls a feed from laboratory systems every 15 minutes and referrals go directly to the infection prevention and control team who then visit the ward and give information to clinical staff to ensure that control are in place for patients with organisms with the potential to spread to others. Patient are given information on why they are in isolation and daily check list with ongoing controls is left with clinical staff. 9. IPCT work with colleagues in the antimicrobial management team to promote antimicrobial policy compliance. 10. As per Chapter 3 of the National Infection Prevention Control Manual If any outbreaks or incidents occur an IMT process is initiated. Key learning from these is reported at the IPC governance committees with a 'hot debrief' submitted to these same committees at the end of the incident with specific reference to implications for other area across the board. 11. Development of the IPCT Workforce Plan which includes succession planning. 12. Programme of audit for key policies linked to CAS framework. SICPs audits done on a 6 monthly basis by senior charge nurses and IPCT Audit 20% of areas to provide the Board with assurance. 13. Improvement collaborative has been initiated and is firmly linked to the GGC quality strategy which vision is 'healthcare without preventable infection' the aim is to promote key objectives for GGC around reducing harm due to avoidable infections. 14. Monthly HH audits are ongoing. Programme of audit for key policies linked to CAS framework. SICPs audits done on a 6 monthly basis by senior charge nurses and IPCT Audit 20% of areas to provide the Board with assurance. 15. Improvement collaborative has been initiated and is firmly linked to the GGC quality strategy which vision is 'healthcare without preventable infection' the aim is to promote key objectives for GGC around reducing harm due to avoidable infections. 16. Monthly HH audits are ongoing. 17. All patient are assessed on admission for the possibility that they have CPE/MRSA/CJD this is recorded in the nursing documentation.	1. IPCT will continue to support local teams in implementing new national policy into practice using improvement methodology. (Target Date: on release of new policies) (Owner: IPC Nurse Consultant). 2. Lessons from incidents and outbreaks are shared with governance committees to ensure organisational learning. (Target Date: following every incident investigation) (Owner: Sector IPC Lead Nurse). 3. IPCT participate in new builds and renovation projects to ensure that the patients are cared for in a safe healthcare environment. (Target Date: Dec 2023) (Owner: Director of Infection Prevention and Control).	2	5	**10**	2	4	**8**	Following the Water Incident and the subsequent External Enquiry, Oversight Board Report and Case Note Review many actions have been put in place which are a first for Scotland, The recommendations from the Scottish Hospitals Public Inquiry will also be put in place when issued however, we will continue to identify themes and where able implement actions before these are issued. We continue to learn and implement recommendations from any HIS Inspections and will continue to review the new HIS standards in order to anticipate expectations and put in place systems and processes to support patient safety and clinical practice. The risk has been reviewed in the light of developments made and with the current effective control measures in place, the likelihood has been reduced and as a result the risk score is reduced too. The IPCT have a plan in place to continue supporting services in implementing new policies as they are released and sharing lessons learned from every incident/outbreak with a HIIAT scoring of amber or red as mitigation actions and will be involved in every new build in future to ensure Infection Prevention and Control measures are considered and applied where appropriate and with that plan in place the residual risk impact and likelihood is also reduced resulting in a lower risk score. Taking the above into consideration, the current risk score has reduced from 20 to 10 and it would be appropriate to de-escalate this Risk from the Corporate level as it is now manageable within service level Risk Register.	Dec-23	Corporate	BCCO CO 6	Clinical	1 - Minimal	Clinical & Care Governance Committee
CURRENT RISKS																				
3066	Finance	Open	[redacted]																	
2054	Acute	Open																		
2055	Acute	Open																		

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
3058	Acute/HSCPs	Open	[redacted]																	
3110	Human Resources	Open																		
3059	Human Resources	Open		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. 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. (All managers within designated directorates are leading on their activities to address and improve the preformance.)	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. (Lead TBC; Target Date TBC)	5	4	20	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.	Aug-22	Corporate	BWCO CO 20	People / Workforce	2 - Cautious	Staff Governance Committee
2199	Public Health	Open		Director of Public Health	[redacted]															
3057	Acute/HSCPs	Open			[redacted]															

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	Current Impact	Current Score	Residual Likelihood	Residual Impact	Residual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
3044	Finance	Open		[redacted]																
3051	Estates & Facilities	Open	26/06/2021	[redacted]																
3052	Estates & Facilities	Open	26/06/2021	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	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".	4	4	16	3	3	9	Static. Work remains ongoing new funding to the amount of [redacted] 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	Corporate	BWCO CO 14	Legal	1 - Minimal	Finance, Planning and Performance Committee
3060	Human Resources	Open		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.	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. (Head of Organisation Developement - 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 (Liam Head of People Engagement - Target Date is????) 4. Collaborative development of Internal Communication and Employee Engagement Strategy. Currently with CMT and been through the Staff Governence Committee. (Liam - Head of People engagement - Target date)	4	4	16	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	Corporate	BWCO CO 17	People / Workforce	2 - Cautious	Staff Governance Committee
	Medical	Open		[redacted]																
2060	Public Health	Open																		
	Human Resources	Open	01/02/2022																	

Datix ID	Directorate/ Partnership	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Current Likelihood	arent Impact	urrent Score	Residual Likelihood	Residual Impact	sidual Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	isk Appetite	Governance /review committee
3062	Medical	Open																		
3054	Medical	Open																		
2766	Nursing	Open		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. Multiple methods from ward to board level to gain feedback from and support patients, families, and the public in regard to care experience. 4. Network of explicit formal responsibilities including Executive leads and professional local leadership for the person centred care agenda. 5. A range of education, training, development and supervision opportunities provided by NHSGGC to enhance staff skills and behaviours. 6. Internal governance arrangements to ensure collection, analysis including identification of themes and learning across the organisation. 7. Person centred competencies embedded in staff recruitment, support, and development arrangements.	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 (D Connelly, PEPI Team) 3. Visiting Review Team meet every 1 -2 weeks to assess scope for return to person-centred visiting. PCV remobilised on 23/05/2022 with maximum of two visitors at a time (J Rodgers/AcLinton, PCHC Team). 4. Project plan for person-centred care planning is in place - main engagement phase is completed, testing and improvement design phase commenced.(A McLinton, PCHC Team) 5. Board Patient Story Development processes and coordination have been reviewed with a greater focus on reflection, learning and improvement.(J Rodgers/D Connelly/A McLinton) 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 (A McLinton, PCHC Team) 7. A Realistic Medicine Toolkit has been launched which includes person-centred care resources, education material etc.(A Ireland/Breeda Ojo, Realistic Medicine Team)) 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.(A McLinton, PCHC Team) 9. Expansion of data collection assurance and outcomes linked to feedback and person centred care (D Connellly, PEPI Team)	3	3	9	3	3	9	Static. Current and further controls reviewed and updated	Mar-23	Corporate	BV/CO CO 14	Clinical	1 - Minimal	Clinical & Care Governance Commitee
3053	Medical	Open																		

NHS GGC Corporate Risk Register

Appendix B

Vers		Date	23.09.22

Datix ID	Directorate/ Partnership	Status	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Residual Likelihood	Residual Impact	Residual Score	Target Likelihood	Target Impact	Target Score	Review Notes	Target dates for actions	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
NEW RISKS																		
	Human Resources	NEW	[redacted]															
	Nursing	NEW	Director of Infection Control	**Risk Title** Infection Prevention and Control support to New Builds and Renovations. **Risk:** Failure to support the delivery of the New Build/Renovations in line with NHS Assure requirements **Cause:** 1. Insufficient capacity within IPCT to absorb or distribute the required support for the NHS Assure oversight process through existing resources. 2. Insufficient IPC Doctor and IPC Nurse resource to support INS capital programme and other major and minor projects at an early stage and throughout the different stages **Impact:** 1. Risk of outbreaks linked to New Build settings, 2. detrimental impact on patients' care, experience and outcomes. 3. higher risk for staff and patients. 4. Risk of reputational and Financial damage.	1. Offering Water and Ventilation training to all IPCT. 2. Raising issues nationally via ICM Network. 3. SBAR completed re ICD Resource to HAI Executive Lead, Chief Operating Officer and the Director of Diagnosis.	1. Looking into getting additional ICD/ICN Resource - (Target Date: Dec 22) (Owner: Sandra Devine/Rob Gardner). 2. Reviewing the work of the IPC Clinical Scientist to support IPCDs - (Target Date: Dec 22)(Owner: Sandra Devine). 3. Explore the possibility of dedicated ICN resource for HAI SCRIBE - (Target Date: Mar 23) (Owner: Sandra Devine). 4. Work with colleagues in Estates to develop a system to simplify the SCRIBE Process - (Target Date: March 23) (Owner: Sandra Devine/ Mark Riddell)	5	4	20	2	4	8	NHS Scotland Assure's core purpose is to deliver and co-ordinate a diverse range of effective expert advice and support services in relation to national IPC, construction, equipping and technical matters which support and improve health and well-being services. This will be done via the KSARs process which will deliver an independent "peer review" in which NHS Scotland Assure staff from outside the Health Board's programme / project use their experience and expertise to examine the progress and likelihood of successful delivery, with a particular emphasis on the safety of the patients, staff and visitors using the facility. This will also have a resource implication for IPCT teams to fulfil the requirement of this oversight. The Institute of Neurological Sciences Capital Programme and other New Build or renovation programmes require dedicate support from an IPC doctor and nurse to progress with their business case. The current enhanced support and the ongoing requirements for input cannot be sustained within the available resources without impact on other key areas of the Infection Prevention and Control and Microbiology workload. As the IPCD are managed by different Directorate (Diagnostic), it is difficult for IPC to influence any decisions made in allocating further resources. This is therefore considered a very high risk for IPC Directorate and due to dependencies across multiple Directorates cannot be mitigated at the IPC Directorate level Risk Register and therefore it is proposed for escalation to the Corporate level Risk Register.	May-23	BCCO CO 6	Clinical	1 - Minimal	Clinical & Care Governance Committee
REVIEWED RISKS																		
2054	Acute	Open	[redacted]															
	Acute	Open																

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CURRENT RISKS																		
3066	Finance	Open	[redacted]															
2055	Acute	Open																
3058	Acute/HSCPs	Open																
3110	Human Resources	Open																

Datix ID	Directorate/ Partnership	Status	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Residual Likelihood	Residual Impact	Residual Score	Target Likelihood	Target Impact	Target Score	Review Notes	Target dates for actions	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
3059	Human Resources	Open	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.	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. (Owner TBC; 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 (Owner: Head of Staff Experience; Target Date TBC)	5	4	20	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
2199	Public Health	Open	Director of Public Health	[redacted]														
3057	Acute/HSCPs	Open	Director of Nursin															
3044	Finance	Open	Director of Financ															
3051	Estates & Facilities	Open	[redacted]															

Datix ID	Directorate/ Partnership	Status	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Residual Likelihood	Residual Impact	Residual Score	Target Likelihood	Target Impact	Target Score	Review Notes	Target dates for actions	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
3052	Estates & Facilities	Open	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	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".	4	4	16	3	3	9	Static. Work remains ongoing new funding to the amount of [redacted] 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	Finance, Planning and Performance Committee
3060	Human Resources	Open	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.	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. (Head of Organisation Developement - 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 Head of Staff Experience - 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. (Head of Staff Experience - October 2022)	4	4	16	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
[redacted]																		
[redacted]																		
[redacted]																		
[redacted]																		

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3054	Medical	Open	[redacted]															
2766	Nursing	Open	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.	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 (D Connelly, PEPI Team) 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 (J Rodgers/AcLinton, PCHC Team). 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.(A McLinton, PCHC Team) 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. (J Rodgers/D Connelly/A McLinton) 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 (A McLinton, PCHC Team) 7. A Realistic Medicine Toolkit has been launched which includes person-centred care resources, education material etc.(A Ireland/Breeda Ojo, Realistic Medicine Team)) 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.(A McLinton, PCHC Team) 9. Expansion of data collection assurance and outcomes linked to feedback and person centred care (D Connellly, PEPI Team) 10. Ensure the needs of those with protected characteristics are mainstreamed into all workstreams (Jac Ross, EHRT and PCC Steering Group)	3	3	9	3	3	9	Static. Current and further controls reviewed and updated	Mar-23	BVCO CO 14	Clinical	1 - Minimal	Clinical & Care Governance Committee
3053	Medical	Open	[redacted]															

NHS GGC Corporate Risk Register

Appendix B

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	esidual 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
[redacted]															

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	esidual Impact	esidual 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
[redacted]															

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	esidual Impact	esidual 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
[redacted]															

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
[redacted]															
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
[redacted]															

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	sidual Impact	esidual Score	Mitigating action to further reduce, eliminate or transfer residual risk	Target Likelihood	arget Impact	arget Score	Review Notes	Target dates for actions	Corporate Objectives	Risk Type	isk Appetite	Governance /review committee
Director of Nursing	[redacted]														

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
[redacted]															
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 [redacted] 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	Finance, 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

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	esidual Impact	esidual 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
[redacted]															

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
[redacted]															

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 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

[redacted]

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			Mitigating action to further reduce, eliminate or transfer residual risk	Forecast score following mitigation			Review Notes	Target dates for actions	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
			Residual Likelihood	Residual Impact	Residual Score		Target Likelihood	Target Impact	Target Score						
	[redacted]														[redacted]

NHS GGC Corporate Risk Register

Appendix B

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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
RISKS REDUCING IN SCORE															
[redacted]															
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.	3	3	9	1. Contribute to the development of learning pathways designed to enhance workforce skills and capabilities in digital and specialist care within the NHSGGC Digital Strategy. WFS 2.4 Target Date March 2023. (Head of Learning & Education) 2. Confirm internal profession based career pathways with these areas incorporated as key elements ensuring principles of fairness and accessibility . WFS 4.12 Target Date March 2023. (Head of Learning & Education) 2. 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 from March 2023. (Head of Staff Experience)	3	2	6	Risk score reduced from 5x4 = 20 to 3x3 = 9. An additional 2 mitigating actions have now been fully implemented and are now current controls, resulting in 5 out of a total 8 mitigating actions now implemented. This risk reduces to Medium and reflects the range of controls implemented. The 3 remaining actions are on track	Mar-23	BWCO CO 20	People / Workforce	Moderate	Staff Governance 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. 9. Collaborative development of Internal Communication and Employee Engagement Strategy. Presented to CMT, Staff Governence Committee and was presented to NHS Board on 25/10/22	3	4	12	1. Executive and non-executive development programmes. (Head of Organisation Development - Target Date is ongoing) 2. Application of Investors in People Standard, and development plans on each site agreed by site workforce groups. (Head of Organisation Development 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 (Head of Staff Experience. Target Date for agreeing programme is Dec-22, target date for deployment TBC)	2	3	6	Risk score reduced from 4x4 = 16 to 3x4 = 12. An additional 4 mitigating actions have now been fully implemented and are now current controls, resulting in 9 out of a total 11 mitigating actions now implemented. The Internal Communication and Employee Engagement Strategy was presented to NHS Board on 25/10/2022. This risk remains High, however reflects the range of controls implemented. The 3 remaining actions are on track.	Mar-23	BWCO CO 17	People / Workforce	Moderate	Staff Governance Committee
[redacted]															
CURRENT RISKS															
[redacted]															
Director of Human Resources & Organisational Development	[redacted]														

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Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Score based on current controls			Mitigating action to further reduce, eliminate or transfer residual risk	Forecast score following mitigation			Review Notes	Target dates for actions	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
			Residual Likelihood	Residual Impact	Residual Score		Target Likelihood	Target Impact	Target Score						
[redacted]															

28.10.22

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
[redacted]															
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 [redacted] 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	Cautious	Finance, Planning and Performance Committee
[redacted]															

28.10.22

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
[redacted]															
[redacted]															
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 (D Connelly, PEPI Team) 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 (J Rodgers/AcLinton, PCHC Team). 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.(A McLinton, PCHC Team) 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. (J Rodgers/D Connelly/A McLinton) 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 (A McLinton, PCHC Team) 7. A Realistic Medicine Toolkit has been launched which includes person-centred care resources, education material etc (A Ireland/Breeda Ojo, Realistic Medicine Team)) 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.(A McLinton, PCHC Team) 9. Expansion of data collection assurance and outcomes linked to feedback and person centred care (D Connellly, PEPI Team) 10. Ensure the needs of those with protected characteristics are mainstreamed into all workstreams (Jac Ross, EHRT and PCC Steering Group)	2	2	**4**	Current and further controls reviewed and updated, target score decreased based on plannd mitigation to further reduce, eliminate or transfer residual risk.	Mar-23	BVCO CO 14	Clinical	Moderate	Clinical & Care Governance Committee
[redacted]															
[redacted]															

NHS GGC Corporate Risk Register

Appendix B

17.11.2022

			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	Risk Level	Corporate Objective - Level 1	Corporate Objective - Level 2	Corporate Objectives	Risk Type	Risk Appetite	Governance review committee
[redacted]																			

17.11.2022

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	Risk Level	Corporate Objective - Level 1	Corporate Objective - Level 2	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
[redacted]																		
[redacted]																		
[redacted]																		

17.11.2022

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	Risk Level	Corporate Objective - Level 1	Corporate Objective - Level 2	Corporate Objectives	Risk Type	Risk Appetite	Governance /review 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. 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.	3	4	12	1. Senior, middle, and medical manager leadership programmes have all been reviewed and are currently being delivered. The Executive Leadership Programme is completed and the Non-executive development framework is pending Scottish Govt. guidance to all Boards. 2. Application of IIP is underway and includes assessment and development plans for each site cluster. Target Date is end of March 2023 for initial assessment of all clusters 3. 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. 4. 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. 5. 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.	2	3	6	Risk score reduced from 4x4 = 16 to 3x4 = 12. An additional 4 mitigating actions have now been fully implemented and are now current controls, resulting in 9 out of a total 11 mitigating actions now implemented. The Internal Communication and Employee Engagement Strategy was presented to NHS Board on 25/10/2022. This risk remains High, however reflects the range of controls implemented. The 2 remaining actions are on track.	Mar-23	Corporate	BWCO CO	17	BWCO CO 17	People / Workforce	Moderate	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.	3	3	9	1. Embedding educational governance throughout learning pathways, developing learning with partners and in line with national standards to ensure these support workforce skills and capabilities outlined in the Workforce Strategy. (Head of Learning & Education) 2. Review and develop key internal profession based career pathways as identified in the workforce plan, incorporating key principles of fairness and accessibility. WFS 4.12 Target Date March 2023. (Head of Learning & Education) 3. Putting in place Directorate/ HSCP performance trajectories so that we are working to achieve compliance targets for Core Statutory and Mandatory learning and recording of PDP&Rs on Turas Appraisal by March 2023. Trajectories will allow us to target support and actions through the Learning and Education Team over that period. (Head of Learning & Educaiton) 4. 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 from March 2023. (Head of Staff Experience)	3	2	6	Risk score reduced from 5x4 = 20 to 3x3 = 9. An additional 2 mitigating actions have now been fully implemented and are now current controls, resulting in 5 out of a total 8 mitigating actions now implemented. This risk reduces to Medium and reflects the range of controls implemented. The 3 remaining actions are on track	Mar-23	Corporate	BWCO CO	20	BWCO CO 20	People / Workforce	Moderate	Staff Governance Committee

17.11.2022

			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	Risk Level	Corporate Objective - Level 1	Corporate Objective - Level 2	Corporate Objectives	Risk Type	Risk Appetite	Governance /review committee
[redacted]																			
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 (D Connelly, PEPI Team) 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 (J Rodgers/AcLinton, PCHC Team). 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.(A McLinton, PCHC Team) 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. (J Rodgers/D Connelly/A McLinton) 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 (A McLinton, PCHC Team) 7. A Realistic Medicine Toolkit has been launched which includes person-centred care resources, education material etc.(A Ireland/Breeda Ojo, Realistic Medicine Team)) 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.(A McLinton, PCHC Team) 9. Expansion of data collection assurance and outcomes linked to feedback and person centred care (D Connelly, PEPI Team) 10. Ensure the needs of those with protected characteristics are mainstreamed into all workstreams (Jac Ross, EHRT and PCC Steering Group)	2	2	4	Current and further controls reviewed and updated, target score decreased based on plannd mitigation to further reduce, eliminate or transfer residual risk.	Mar-23	Corporate	BVCO CO	14	BVCO CO 14	Clinical	Moderate	Clinical & Care Governance Committee
[redacted]																			

NHS GGC Corporate Risk Register

Appendix B

Vers			Date	01.12.2022

							Score based on current controls				Forecast score following mitigation									
Datix ID	Directorate/ Partnership	ategory of Risk	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Residual Likelihood	esidual 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	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance Forum committee
[redacted]																				

Vers			Date	01.12.2022

							Score based on current controls				Forecast score following mitigation										
Datix ID	Directorate/ Partnership	Category of Risk	Status	ID Date	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	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance Committee committee
2199	Public Health	Public Health	Open		[redacted]																
3057	Acute/HSCPs	Partnerships/Acute	Open																		
2819	Finance	Financial Sustainability - Capital	Open																		
3061	Estates & Facilities	Other	Open	26/06/2021																	
3052	Estates & Facilities	Corporate	Open	26/06/2021	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 [redacted] 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	Corporate	BVCO CO 14	Legal	Cautious	Finance, Planning and Performance Committee
3110	Human Resources	Workforce (HR)	Open																		

Vers			Date	01.12.2022

								Score based on current controls					Forecast score following mitigation										
Date ID	Directorate/ Partnership	Category of Risk	Status	ID Date	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	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance Committee
3060	Human Resources	Workforce (HR)	Open		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. 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.	3	4	12	1. Senior, middle, and medical manager leadership programmes have all been reviewed and are currently being delivered. The Executive Leadership Programme is completed and the Non-executive development framework is pending Scottish Govt. guidance to all Boards. 2. Application of IIP is underway and includes assessment and development plans for each site cluster. Target Date is end of March 2023 for initial assessment of all clusters 3. 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. 4. 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. 5. 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.	2	3	6	Risk score reduced from 4x4 = 16 to 3x4 = 12. An additional 4 mitigating actions have now been fully implemented and are now current controls, resulting in 9 out of a total 11 mitigating actions now implemented. The Internal Communication and Employee Engagement Strategy was presented to NHS Board on 25/10/2022. This risk remains High, however reflects the range of controls implemented. The 2 remaining actions are on track.	Mar-23	Corporate	BWCO CO 17	People / Workforce	Moderate	Staff Governance Committee
	Medical	Clinical Risks - Clinical gaps	Open		[redacted]																	
2060	Public Health	Related (IJB/Third Party) risks - Screening	Open																			
3059	Human Resources	Workforce (HR)	Open		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.	3	3	9	1. Embedding educational governance throughout learning pathways, developing learning with partners and in line with national standards to ensure these support workforce skills and capabilities outlined in the Workforce Strategy. (Head of Learning & Education) 2. Review and develop key internal profession based career pathways as identified in the workforce plan, incorporating key principles of fairness and accessibility. WFS 4.12 Target Date March 2023. (Head of Learning & Education) 3. Putting in place Directorate/ HSCP performance trajectories so that we are working to achieve compliance targets for Core Statutory and Mandatory learning and recording of PDP&Rs on Turas Appraisal by March 2023. Trajectories will allow us to target support and actions through the Learning and Education Team over that period. (Head of Learning & Educaiton) 4. 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 from March 2023. (Head of Staff Experience)	3	2	6	Risk score reduced from 5x4 = 20 to 3x3 = 9. An additional 2 mitigating actions have now been fully implemented and are now current controls, resulting in 5 out of a total 8 mitigating actions now implemented. This risk reduces to Medium and reflects the range of controls implemented. The 3 remaining actions are on track	Mar-23	Corporate	BWCO CO 20	People / Workforce	Moderate	Staff Governance Committee
3062	Medical	Clinical Risks - Clinical gaps	Open		[redacted]																	
3054	Medical	Corporate	Open																			
2766	Nursing	Medical	Open		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 (D Connelly, PEPI Team) 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 (J Rodgers/AcLinton, PCHC Team). 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.(A McLinton, PCHC Team) 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. (J Rodgers/D Connelly/A McLinton) 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 (A McLinton, PCHC Team) 7. A Realistic Medicine Toolkit has been launched which includes person-centred care resources, education material etc.(A Ireland/Breeda Ojo, Realistic Medicine Team)) 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.(A McLinton, PCHC Team) 9. Expansion of data collection assurance and outcomes linked to feedback and person centred care (D Connellly, PEPI Team) 10. Ensure the needs of those with protected characteristics are mainstreamed into all workstreams (Jac Ross, EHRT and PCC Steering Group)	2	2	4	Current and further controls reviewed and updated, target score decreased based on plannd mitigation to further reduce, eliminate or transfer residual risk.	Mar-23	Corporate	BWCO CO 14	Clinical	Moderate	Clinical & Care Governance Committee

Vers			Date	01.12.2022

Datix ID	Directorate/ Partnership	Category of Risk	Status	ID Date	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Score based on current controls: Residual Likelihood	Score based on current controls: esidual Impact	Score based on current controls: Residual Score	Mitigating action to further reduce, eliminate or transfer residual risk	Forecast score following mitigation: Target Likelihood	Forecast score following mitigation: Target Impact	Forecast score following mitigation: Target Score	Review Notes	Target dates for actions	Risk Level	Corporate Objectives	Risk Type	Risk Appetite	Governance review committee
3053	Medical	Medical	Open		[redacted]																
3433	Human Resources	Tolerated Risks	Open	01/02/2022																	

Corporate Risk Register **Report Date: 23.12.2022**

						Risk Score - Initial					Risk Score -Current					Risk Score -Target																		
ID	Opened	Title	Description	Cause	Impact	Likelih-ood	Impact	Rating	Risk Level	Controls in place	Likelih-ood	Impact	Rating	Risk Level	Further Controls Required	Action Owner	Due date	Done date	Likelih-ood	Impact	Rating	Risk Level	Last Review Date	Review Notes	Risk Owner	Risk Lead	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Managemen t Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governanc e Committee	Status
Decreased Risks																																					

[redacted]

Corporate Risk Register **Report Date: 23.12.2022**

ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial: Prood	Joint	Rsg	Level	Controls in place	Risk Score -Current: Prood	Joint	Rsg	Level	Further Controls Required	Action	Due date	Done date	Risk Score -Target: Prood	Joint	Rsg	Level	Last Review Date	Review Notes	Risk	Risk	Next Review	Corporate	Risk Type	Risk Appetite	Managemen	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governanc	Status
[redacted]																																					
		body compliance	**maintain statutory compliance through regulatory bodies**	staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance	and psychological); Inspection / Audit; Adverse publicity / reputation					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 (API and Authorised Engineer oversight					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".	Mark								across the 4 main geographical areas to improve compliance in statutory issues such as fire damper testing, PAT testing and fixed wire testing.	Tom	Mark		To utilise and improve our capital assets to support the reform of healthcare									Planning and Performance Committee	
[redacted]															[redacted] Programme Manager Adult Screening. Continuous"									"Static. The 'Mitigation actions to further reduce, eliminate or transfer residual risk' [redacted] cle, which flows into/ already undergirds the ut can never entirely eliminate these. Hence the ctions is the same. reviewed on a regular basis at screening programme steering groups "														
[redacted]																																					
3060	01/06/2021	**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	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 Mann, Douglas Mann, Douglas Spence, Liam	31/03/2023 28/02/2023 31/03/2023 30/12/2022		2	3	6	Medium	20/12/2022	'Risk score reduced from 4x4 = 16 to 3x4 = 12. An additional 4 mitigating actions have now been fully implemented and are now current controls, resulting in 10 out of a total 15 mitigating actions now implemented. The Internal Communication and Employee Engagement Strategy was presented to NHS Board on 25/10/2022. This risk remains High, however reflects the range of controls implemented. The 5 remaining actions are on track.	MacPherson, Anne	Spence, Liam	10/01/2023	Better Workplace - To ensure our people are appropriately trained and developed	People / Workforce	Moderate	Corporate	Board/Corporate	Human Resources	Not Required			Staff Governance Committee	Live/Active
[redacted]																																					
[redacted]																																					
3059	01/06/2021	**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 . 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	MacDonald, Moira MacDonald, Moira MacDonald, Moira MacDonald, Moira	31/03/2023 31/03/2023 31/03/2023 31/03/2023		3	2	6	Medium	20/12/2022	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. Any slippage in target dates should be referenced here and rationale as to why. Any completed actions (and the total number) since last review should be mentioned here, as well as a general narrative progress update. 7/10 mitigating actions are now current controls. 3 Remaining mitigating actions are on track.	MacPherson, Anne	MacDonald, Moira	16/01/2023	Better Workplace - To provide a continuously improving and safe working environment	People / Workforce	Moderate	Corporate	Board/Corporate	Human Resources	Learning and Education			Staff Governance Committee	Live/Active
2766	28/02/2020	**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.	3	3	9	Medium	Deliver on the Board's commitments described in the strategy documents. Workplan implemented with rigorous review of objectives, milestones and timelines. 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.	Rodgers, Jennifer Rodgers, Jennifer Rodgers, Jennifer	31/03/2023 31/03/2023 28/02/2023		2	2	4	Medium	02/12/2022	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, PCHC 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 Djp, Realistic Medicine Team). - 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.(A	Wallace, Angela	Rodgers, Jennifer	09/01/2023	Better Care - To deliver person centred care through a partnership approach built on respect compassion and shared decision making	Clinical	Moderate	Corporate	Board/Corporate	Corporate Services/Nursing	Not Required			Clinical and Care Governance Committee	Live/Active

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Corporate Risk Register **Report Date: 23.12.2022**

						Risk Score - Initial					Risk Score -Current					Risk Score -Target																				
ID	Opened	Title	Description	Cause	Impact	Likelih-ood	Impact	Rating	Risk Level	Controls in place	Likelih-ood	Impact	Rating	Risk Level	Further Controls Required	Action Owner	Due date	Done date	Likelih-ood	Impact	Rating	Risk Level	Last Review Date	Review Notes	Risk Owner	Risk Lead	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Managemen t Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governanc e Committee	Status
[redacted]																																					

Corporate Risk Register Report Date: 26.01.23

ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial				Controls in place	Risk Score - Current				Further Controls Required	Action Owner	Due date	Risk Score - Target				Last Review Date	Review Notes	Risk Owner	Risk Lead	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
						Likelihood	Impact	Rating	Risk level		Likelihood	Impact	Rating	Risk level				Likelihood	Impact	Rating	Risk Level																	
Decreased Risks																																					

Corporate Risk Register — Report Date: 26.01.23

ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial: Likelihood	Impact	Rating	Risk level	Controls in place	Risk Score - Current: Likelihood	Impact	Rating	Risk level	Further Controls Required	Action Owner	Due date	Risk Score - Target: Likelihood	Impact	Risk Level	Last Review Date	Review Notes	Risk Owner	Risk Lead	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
[redacted]																																				
3052	22/06/2021	**Regulatory body compliance**	Failure to achieve and maintain statutory compliance through regulatory bodies	1. Inadequate / inadequate programme of staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance 3. Insufficient authorising persons within the board to sufficiently provide the required two AP's per specialty to ensure	Adverse publicity / reputation, Injury: physical and psychological, Inspection / Audit	4	4	16	High	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	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".	Rosales, Mark	31/03/2023	3	3	9	Medium		across the 4 main geographical areas to improve compliance in statutory issues such as fire damper testing, PAT testing and fixed wire testing.		Mark		To utilise and improve our capital assets to support the reform of healthcare									Planning and Performance Committee	
[redacted]																																			
3060	01/08/2021	**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.	3	4	12	High	12. Application of HP 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 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.	Mackie, Douglas Mann, Douglas Mann, Douglas Spence, Liam	31/07/2023 28/02/2023 31/03/2023 31/03/2023	2	3	6	Medium	04/01/2023	Updated the action in collaborative conversations.	Mann/Henderson, Anne	Spence, Liam	14/04/2023	Better Workplace - To ensure our people are appropriately trained and developed	People / Workforce	Moderate	Corporate	Strategic/Corporate	Human Resources	Not Required					Staff Governance Committee	Under Review
[redacted]																																			
3029	21/06/2021	**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	Refreshed approach to PDP and Personal Development 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. Continuing to develop and promote work with partners in learning and planning, ensuring 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 MacDonald, Moira MacDonald, Moira MacDonald, Moira	31/03/2023 31/03/2023 31/03/2023 31/03/2023	3	2	6	Medium	04/01/2023	Proofreading actions have been reviewed and now part of BAU and removed from the 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.	Mann/Henderson, Anne	Hill, Moira	04/04/2023	Better Workplace - To provide a continuously improving and safe working environment	People / Workforce	Moderate	Corporate	Strategic/Corporate	Human Resources	Learning and Education					Staff Governance Committee	Under Review
[redacted]																																			

Corporate Risk Register Report Date: 26.01.23

ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial				Controls in place	Risk Score - Current				Further Controls Required	Action Owner	Due date	Risk Score - Target				Last Review Date	Review Notes	Risk Owner	Risk Lead	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
						Likelihood	Impact	Rating	Risk level		Likelihood	Impact	Rating	Risk level				Likelihood	Impact	Rating	Risk Level																
2766	28/02/2020	**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.	3	3	9	Medium	Deliver on the Board's commitments described in the strategy documents.	Rodgers, Jennifer	31/01/2023	2	2	4	Medium	24/01/2023	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, PCHC 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 Dp, Realistic Medicine Team).	Wallace, Angela	Rodgers Jennifer	13/02/2023	Better Care - To deliver person centred care through a partnership approach built on respect compassion and shared decision making	Clinical	Moderate	Corporate	Board/Corporate	Corporate Services/Nursing	Not Required			Clinical and Care Governance Committee	Live/Active
										Workplan implemented with rigorous review of objectives, milestones and timelines.						Rodgers, Jennifer	31/02/2023																			
										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.						Rodgers, Jennifer	28/02/2023																			

[redacted]

Corporate Risk Register **Report Date: 26.01.23**

						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 Owner	Risk Lead	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
3433	01/02/2022	**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**	Identification of all career upward individuals in each directorate as potential successors to director and SMT roles. OD support to career upward individuals listed in each directorate for director and SMT positions.	Davies, Nareen Mann, Douglas	30/12/2022 28/02/2023	2	1	2	**Low**	15/12/2022	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	Mann, Douglas	19/01/2023	Better Workplace - To ensure our people are appropriately trained and developed	People / Workforce	Moderate	Corporate	Board/Corporate	Human Resources	Organisational Development	Organisational development	West Glasgow ACH - Yorkhill	Staff Governance Committee	Live/Active

Appendix B - Corporate Risk Register

| | | | | | | Risk Score - Initial | | | | | Risk Score - Current | | | | | Risk Score - Target | | | | | |

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| | | | | | | Risk Score - Initial | | | | | Risk Score - Current | | | | | Risk Score - Target | | | | | |

Appendix B - Corporate Risk Register

ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial: Likelihood	Impact	Rating	Risk level	Controls in place	Risk Score - Current: Likelihood	Impact	Rating	Risk level	Further Controls Required	Action Owner	Due date	Risk Score - Target: Likelihood	Impact	Rating	Risk Level	Last Review Date	Review Notes	Risk Movement	Risk Owner	Risk Lead	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
2766	28/02/2020	**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	14/02/2023	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, PCHC 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 remobilised 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, PCHC Team)	↔	Wallace, Angela	Rodgers, Jennifer	14/03/2023	Better Care - To deliver person centred care through a partnership approach built on respect compassion and shared decision making	Clinical	Moderate	Corporate	Board/Corporate	Corporate Services/Nursing	Not Required			Clinical and Care Governance Committee	Live/Active
[redacted]																																						
3052	22/06/2021	**Regulatory body compliance**	Failure to achieve and maintain statutory compliance through regulatory bodies	1. Insufficient or inadequate programme of staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance 3. Insufficient authorising persons within the board to sufficiently provide the required two AP's per specialty to ensure sign off of permits and provide resilience.	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	31/03/2023	3	3	9	Medium	26/01/2023	Static. Work remains ongoing new funding to the amount of [redacted] 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	Riddell, Mark	26/04/2023	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Legal	Cautious	Corporate	Board/Corporate	Facilities/Estates	Not Required			Finance, Planning and Performance Committee	Live/Active
3060	01/06/2021	**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. Identification of career upward individuals and OD support to these individuals will be complete in Feb 2023	3	4	12	High	12. Application of IP 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 Mann, Douglas Mann, Douglas Spence, Liam	31/03/2023 28/02/2023 31/03/2023 31/03/2023	2	3	6	Medium	10/01/2023	Updated the action in collaborative conversations.	↔	MacPherson, Anne	Spence, Liam	14/03/2023	Better Workplace - To ensure our people are appropriately trained and developed	People / Workforce	Moderate	Corporate	Board/Corporate	Human Resources	Not Required			Staff Governance Committee	Live/Active
3059	01/06/2021	**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 MacDonald, Moira MacDonald, Moira MacDonald, Moira	31/03/2023 31/03/2023 31/03/2023 31/03/2023	3	2	6	Medium	25/01/2022	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	MacDonald, Moira	16/03/2023	Better Workplace - To provide a continuously improving and safe working environment	People / Workforce	Moderate	Corporate	Board/Corporate	Human Resources	Learning and Education			Staff Governance Committee	Live/Active
[redacted]																																						

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	Risk Lead	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
																																					Live/Active

Report Date: 30/03/2023 CMT Date: 06/04/2023

ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial: Likelihood	Impact	Rating	Risk level	Controls in place	Risk Score - Current: Likelihood	Impact	Rating	Risk level	Further Controls Required	Action Owner	Due date	Risk Score - Target: Likelihood	Impact	Rating	Risk Level	Last Review Date	Review Notes	Risk Owner	Risk Lead	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
Risks Proposed for Closure																																				
[redacted]																																				
Risks Proposed for De-escalation																																				
2766	28/02/2020	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 April 2023. Full implementation will commence in late Spring 2023. 12. Values based recruitment now standard in all recruitment.	3	3	9	Medium	The Care Experience Improvement Model is currently under review - going forward this will be target in areas identified to be high risk from review of complaints, care experience feedback received, Sub-optimal Internal and Extrnal Inspection Visits/Audits results - improvement will continue to be guided and underpinned by the Excellence in Care Standard for Person-centred Care.	Rodgers, Jennifer	31/08/2023	2	2	4	Medium	30/03/2023	A range of additional controls are now in place and this risk is currently scored as Medium. It is therefore proposed to de-escalate this risk, with the following actions in place support the reduction in the risk scoring and risk de-escalation: - 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 Group, BCGC 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' - Excellence in Care Standard for PCC is being updated and will be a core board wide standard across all the EIC Families and will be monitor via the CCAAT process in individual areas - Increased resource within the PCHC Team to support continued delivery of workplan: undertaking recruitment to replace two posts both fixed term for two years - Band 7 (0.6 WTE) and Band 3 (0.4 WTE). - Patient story is delivered bi-monthly at each board meeting. Process being progressed to share the story wider across all services. - Lived Experience Volunteers have now been recruited to join the 'What Matters to You' Group - A Realistic Medicine Toolkit has been launched which includes person-centred care resources, education material etc.	Wallace, Angela	Rodgers, Jennifer	20/04/2023	Better Care - To deliver person centred care through a partnership approach built on respect compassion and shared decision making	Clinical	Moderate	Corporate	Board/Corporate	Corporate Services/Nursing	Not Required			Clinical and Care Governance Committee	
Decreased Risks																																				
[redacted]																																				

Report Date: 30/03/2023 CMT Date: 06/04/2023

ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial				Controls in place	Risk Score - Current				Further Controls Required	Action Owner	Due date	Risk Score - Target				Last Review Date	Review Notes	Risk Owner	Risk Lead	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
						Likelihood	Impact	Rating	Risk level		Likelihood	Impact	Rating	Risk level				Likelihood	Impact	Rating	Risk Level																	
					psychological, Patient experience, Service / Business interruption, Staffing and competence					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. 6. Patient discharge transport service commenced and in place. 7. Steering group now in place. Focus on reducing bed days lost to delayed discharge, improving the percentage of patients discharged without delay and discharge over 7 days.																										
2819	0																																			
2054	0																																			
3343	2																																			
3082	22/06/2021	Regulatory body compliance	Failure to achieve and maintain statutory compliance through regulatory bodies	1. Insufficient or inadequate programme of staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance 3. Insufficient authorising persons within the board to sufficiently provide the required two AP's per specialty to ensure sign off of permits and provide resilience.	Adverse publicity / reputation, Injury: physical and psychological, Inspection / Audit	4	4	16	High	Control measure in 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	30/06/2023	3	3	9	Medium	24/03/2023	Static. Work remains ongoing now funding to the amount of [redacted] 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. 24.03.23 No change at this time a further review will be conducted on 26.04.23 (Update by AP on behalf of Mark Riddell)	Steele, Tom	Riddell, Mark	26/06/2023	Better Value To utilise and improve our capital assets to support the reform of healthcare	Legal	Cautious	Corporate	Board/Corporate	Facilities/Estates	Not required			Finance, Planning and Performance Committee	
		engaging and diverse culture	and enhance a positive, engaging and diverse culture.	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	interruption					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					plans for each site cluster. Initial assessments of all acute and corporate clusters will be complete by end of March 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.	Douglas Mann, Douglas Spence, Liam	 31/03/2023 31/03/2023						the 31/03/2023	n, Anne	Liam		Workplace - To ensure our people are appropriately trained and developed	Workforce								Governance Committee	

Report Date: 30/03/2023 CMT Date: 06/04/2023

						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 Owner	Risk Lead	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
[redacted]																																			
3059	01/06/2021	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 MacDonald, Moira MacDonald, Moira MacDonald, Moira	31/03/2023 31/03/2023 31/03/2023 31/03/2023	3	2	6	Medium	10/03/2023	Five Mitigating actions have been reviewed and now part of BAU and moved into the Current Control column. 5/9 mitigating actions are now current controls. 4 Remaining mitigating actions are on track to be delivered by 31/03/2023	MacPherson, Anne	MacDonald, Moira	20/04/2023	Better Workplace - To provide a continuously improving and safe working environment	People / Workforce	Moderate	Corporate	Board/Corporate	Human Resources	Learning and Education			Staff Governance Committee	
[redacted]																																			

Report Date: 27/04/2023 CMT Date: 04/05/2023

						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	Synopsis	Action Owner	Due date	Done date	Likelihood	Impact	Rating	Risk level	Last Review Date	Review Notes	Risk Owner	Risk Lead	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
Decreased Risks																																					
[redacted]																																					
Current Risks																																					
[redacted]																																					

Report Date: 27/04/2023 CMT Date: 04/05/2023

| | | | | | | Risk Score - Initial | | | | | | Risk Score - Current | | | | | | Risk Score - Target | | | | | |

Report Date: 27/04/2023 CMT Date: 04/05/2023

						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	Synopsis	Action Owner	Due date	Done date	Likelihood	Impact	Rating	Risk level	Last Review Date	Review Notes	Risk Owner	Risk Lead	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
[redacted]																																							
3059	01/06/2021	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.) 6. Embedded educational governance throughout learning pathways, developing learning with partners and in line with national standards to ensure pathways support workforce skills and capabilities outlined in the Workforce Strategy	3	3	9	Medium	3.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	MacDonald, Moira	31/03/2023		3	2	6	Medium	27/04/2023	8/9 mitigating actions are now current controls. 1 Remaining mitigating action to be delivered	MacPherson, Anne	MacDonald, Moira	23/05/2023	Better Workplace - To provide a continuously improving and safe working environment	People / Workforce	Moderate	Corporate	Board/Corporate	Human Resources	Learning and Education			Staff Governance Committee	Live/Active
[redacted]																																							

Master Corporate Risk Register Report Date: 22.05.23

ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial				Controls in place	Risk Score - Current				Further Controls Required	Action Owner	Due date	Risk Score - Target				Last Review Date	Review Notes	Risk Owner	Risk Lead	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
						Likelihood	Impact	Rating	Risk level		Likelihood	Impact	Rating	Risk level				Likelihood	Impact	Rating	Risk level																
De-escalated Risks																																				
[redacted]																																				

Master Corporate Risk Register Report Date: 22.05.23

ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial				Controls in place	Risk Score - Current				Further Controls Required	Action Owner	Due date	Risk Score - Target				Last Review Date	Review Notes	Risk Owner	Risk Lead	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
						Likelihood	Impact	Rating	Risk level		Likelihood	Impact	Rating	Risk level				Likelihood	Impact	Rating	Risk level																
[redacted]																																				
3052	22/06/2021	Regulatory body compliance	Failure to achieve and maintain statutory compliance through regulatory bodies	1. Insufficient or inadequate programme of staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance 3. Insufficient authorising persons within the board to sufficiently provide the required two AP's per specialty to ensure sign off of permits and provide resilience.	Adverse publicity / reputation, Injury: physical and psychological, Inspection / Audit	4	4	16	High	1. Fire risk assessments. 2. Environmental PPC Permits in place at two facilities namely, GRI & QEUH. Environmental Authorisations (Scotland) Regulations (EASR) Permits in place across seven sites for nuclear waste. 3. High level Environmental Legal Register in place to monitor relevant environmental legislation applicable to the Board. 4.Estate Asset Management System (EAMs) 5. Statutory Compliance Audit and Risk Tool (SCART) 6. Topic specific Authorised Persons (AP) and Authorised Engineer oversight and audit. 7. Asbestos compliance team use contractors to manage ACM's on sites.	4	4	16	High	Single building fire risk assessments to be conducted across the entire NHSGGC estate. Authorised Engineer audits conducted for specialist areas i.e. water, ventilation, LV, HV and pressure systems. 1. Sufficient authorised persons to be trained and competency assessed to ensure compliance. 2. Sufficient responsible persons (Water) to be trained and competency assessed to ensure compliance. 3. Competence persons training for technicians. Regular internal and external (SEPA) audits for PPC Permits. Permits currently sitting at "Excellent".	Cowley, David Riddell, Mark Riddell, Mark Riddell, Mark	29/03/2024 29/03/2024 29/03/2024 29/03/2024	3	3	9	Medium	10/05/2023	24.03.23 No change at this time a further review will be conducted on 25.04.23 Risk remains unchanged estates colleagues continue to review and monitor (Updated by AP on behalf of MR) 10.05.23 Actions assigned to risk in order to develop mitigations in collaboration with risk manager.	Steele, Tom	Riddell, Mark	09/06/2023	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Legal	Cautious	Corporate	Board/Corporate	Facilities/Estates	Not Required			Finance, Planning and Performance Committee	Live/Active
[redacted]																																				
3060	01/06/2021	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. 12. Application of IIP is underway and includes assesment and development plans for each site cluster. Initial assessments of all acute and corporate clusters have been completed with improvement plans in place or under development. 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. 14. First two phases of Collaborative Conversations complete. As part of newly approved staff internal communications and employee engagement strategy, a third phase is now underway from March 2023.	3	4	12	High	Development of our approach to 'Civility Saves Lives' is underway, target completion end October. Development of a Success Register approach that both acknowledges and celebrates good practice initiatives but then also provides the ability to share learning across NHSGGC.	Mann, Douglas Mann, Douglas	27/10/2023 27/10/2023	2	3	6	Medium	22/05/2023	We are on track to deliver the last two outstanding actions with the success register due to launch from May 2023 and Civility Saves Lives continuing to roll out, with our training package being tested with Civility Saves Lives Champions in May 2023.	MacPherson, Anne	Spence, Liam	20/06/2023	Better Workplace - To ensure our people are appropriately trained and developed	People / Workforce	Moderate	Corporate	Board/Corporate	Human Resources	Not Required			Staff Governance Committee	Live/Active

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Master Corporate Risk Register Report Date: 22.05.23

ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial: Likelihood	Impact	Rating	Risk level	Controls in place	Risk Score - Current: Likelihood	Impact	Rating	Risk level	Further Controls Required	Action Owner	Due date	Risk Score - Target: Likelihood	Impact	Rating	Risk level	Last Review Date	Review Notes	Risk Owner	Risk Lead	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
[redacted]																																					
3059	01/06/2021	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.) 6. Embedded educational governance throughout learning pathways, developing learning with partners and in line with national standards to ensure pathways support workforce skills and capabilities outlined in the Workforce Strategy 7. Key internal profession based career pathways developed as identified in the workforce plan, incorporating key principles of fairness and accessibility	3	3	9	Medium	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	MacDonald, Moira	31/03/2023	3	2	6	Medium	22/05/2023	Internal Communications & Employee Engagement Strategy approved by the board which sets out the overall shape and direction of our employee engagement programme. A series of collaborative conversations are now under development, aligned with the Corporate Clusters and to underpin our IJP re-accreditation programme for 2023/4.	MacPherson, Anne	MacDonald, Moira	20/06/2023	Better Workplace - To provide a continuously improving and safe working environment	People / Workforce	Moderate	Corporate	Board/Corporate	Board/Corporate	Human Resources	Learning and Education			Staff Governance Committee	Live/Active
[redacted]																																					
		obligations to provide person centred care	legislation related to patient rights; patient feedback; person centred care.	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	reputation, Financial: including damage / loss / Fraud, Patient experience	5	3	15	High	2. Implementation of person centred care board wide work plan. 3. Implementation of NHSGGC 2020 – 24 Quality 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 April 2023. Full implementation will commence in late Spring 2023. 12. Values based recruitment now standard in all recruitment. 13. Person centred visiting is now fully in place with evaluation underway and learning and improvement plans in place.	3	3	9	Medium	forward this will be target in areas identified to be high risk from review of complaints, care experience feedback received, Sub-optimal Internal and Extrnal Inspection Visits/Audits results - improvement will continue to be guided and underpinned by the Excellence in Care Standard for Person-centred Care.	Jennifer		2	2	4	Medium		is therefore proposed to de-escalate this risk, with the following actions in place support the reduction in the risk scoring and risk de-escalation: 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 Group, BCGC 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' - Excellence in Care Standard for PCC is being updated and will be a core board wide standard across all the EIC Families and will be monitor via the CCAAT process in individual areas Increased resource within the PCHC Team to support continued delivery of workplan undertaking recruitment to replace two posts both fixed term for two years - Band 7 (0.6 WTE) and Band 3 (0.4 WTE). Patient story is delivered bi-monthly at each board meeting. Process being progressed to share the story wider across all services. - Lived Experience Volunteers have now been recruited to join the 'What Matters to You' Group - A Realistic Medicine Toolkit has been launched which includes person-centred care resources, education material etc.(Jude Marshal, Malcolm Wason, Realistic Medicine Team. Please note that this risk was approved for de-escalation by CMT in March 2023. The final	Angela			deliver person centred care through a partnership approach built on respect compassion and shared decision making					Services/Nursing			Care Governance Committee	
[redacted]																																					

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Master Corporate Risk Register - 18.06.2023

ID	Opened	Title		Description	Cause		Impact	Risk Score- Initial				Controls in place	Risk Score- Current				Further Controls Required	Action Owner	Due date	Risk Score- Target				Last Review Date	Review Notes	Risk Owner	Risk Lead	Next Review Date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
								Likelihood	Impact	Rating	Risk level		Likelihood	Impact	Rating	Risk level				Likelihood	Impact	Rating	Risk level																

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Master Corporate Risk Register- 18/07/2023

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ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial				Controls in place	Risk Score - Current				Further Controls Required	Action Owner	Due date	Risk Score - Target				Last Review Date	Review Notes	Risk Owner	Risk Lead	Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
						Likelihood	Consequence	Rating	Risk level		Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level																	
[redacted]																																				

ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial				Controls in place	Risk Score - Current				Further Controls Required	Action Owner	Due date	Risk Score - Target				Last Review Date	Review Notes	Risk Owner	Risk Lead	Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
						Likelihood	Consequence	Rating	Risk level		Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level																
[redacted]																																				
		engaging and diverse culture	and enhance a positive, engaging and diverse culture.	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	Interruption					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. 12. Application of IIP is underway and includes assessment and development plans for each site cluster. Initial assessments of all acute and corporate clusters have been completed with improvement plans in place or under development. 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. 14. First two phases of Collaborative Conversations complete. As part of newly approved staff internal communications and employee engagement strategy, a third phase is now underway from March 2023.					target completion end October. Development of a Success Register approach that both acknowledges and celebrates good practice initiatives but then also provides the ability to share learning across NHSGGC.	Douglas Mann, Douglas	 27/10/23				register due to launch from May 2023 and Civility Saves Lives continuing to roll out, with our training package being tested with Civility Saves Lives Champions in May 2023. To support the deployment a new action called Success Register has been created with a target date of 27/10/2023.	n, Anne			Workplace - To ensure our people are appropriately trained and developed	Workforce	e								Governance Committee	
3052	22/06/21	Regulatory body compliance	Failure to achieve and maintain statutory compliance through regulatory bodies	1. Insufficient or inadequate programme of staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance 3. Insufficient authorising persons within the board to sufficiently provide the required two AP's per specialty to ensure sign off of permits and provide resilience.	Adverse publicity / reputation, Injury: physical and psychological, Inspection / Audit	4	4	16	High	1. Fire risk assessments 2. Environmental PPC Permits in place at two facilities namely, GRI & QEUH. Environmental Authorisations (Scotland) Regulations (EASR) Permits in place across seven sites for nuclear waste. 3. High level Environmental Legal Register in place to monitor relevant environmental legislation applicable to the Board. 4.Estate Asset Management System (EAMs) 5. Statutory Compliance Audit and Risk Tool (SCART) 6. Topic specific Authorised Persons (AP) and Authorised Engineer oversight and audit. 7. Asbestos compliance team use contractors to manage ACM's on sites.	4	4	16	High	Single building fire risk assessments to be conducted across the entire NHSGGC estate. Authorised Engineer audits conducted for specialist areas i.e. water, ventilation, LV, HV and pressure systems. 1. Sufficient authorised persons to be trained and competency assessed to ensure compliance. 2. Sufficient responsible persons (Water) to be trained and competency assessed to ensure compliance. 3. Competence persons training for technicians. Regular internal and external (SEPA) audits for PPC Permits. Permits currently sitting at "Excellent".	Cowley, David Riddell, Mark Riddell, Mark Martin Johnstone	29/03/24 29/03/24 29/03/24 29/03/24	3	3	9	Medium	24/07/23	24.03.23 No change at this time a further review will be conducted on 25.04.23 Risk remains unchanged estates colleagues continue to review and monitor 10.05.23 Actions assigned to risk in order to develop mitigations in collaboration with risk manager. 24.07.23 Work ongoing on identified actions	Steele, Tom	Riddell, Mark	31/08/23	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Legal	Cautious	Corporate	Board/Corporate	Facilities/Estates	Not Required				Finance, Planning and Performance Committee	Live/Active
[redacted]																																				
3059	01/09/21	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.) 6. Embedded educational governance throughout learning pathways, developing learning with partners and in line with national standards to ensure pathways support workforce skills and capabilities outlined in the Workforce Strategy 7. Key internal profession based career pathways developed as identified in the workforce plan, incorporating key principles of fairness and accessibility	3	3	9	Medium	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	Spence, Liam	31/03/23	3	2	6	Medium	24/08/23	Internal Communications & Employee Engagement Strategy approved by the board which sets out the overall shape and direction of our employee engagement programme. A series of collaborative conversations are now under development, aligned with the Corporate Clusters and to underpin our IIP re-accreditation programme for 2023/4.	MacPherson, Anne	MacDonald, Moira	30/08/23	Better Workplace - To provide a continuously improving and safe working environment	People / Workforce	Moderate	Corporate	Board/Corporate	Human Resources	Learning and Education				Staff Governance Committee	Live/Active
[redacted]																																				

Master Corporate Risk Register - 29/08/2023

ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial			Controls in place	Risk Score - Current			Further Controls Required	Action Owner	Due date	Risk Score - Target			Last Review Date	Review Notes	Risk Owner	Risk Lead	Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
						Likelihood	Consequence	Risk level		Likelihood	Consequence	Risk level				Likelihood	Consequence	Risk level																
Current Risk's																																		
[redacted]																2	2	4	Medium	21/05/23		Wallace, Angela	Love, Elaine	31/08/23	Better Health - To ensure the best start for children with a focus on developing good health and wellbeing in their early years	Clinical	Moderate	Corporate	Board/Corporate	Corporate Services/Nursing	Public Protection			Clinical and Care Governance Committee	Live/Active
[redacted]																																		

ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial				Controls in place	Risk Score - Current				Further Controls Required	Action Owner	Due date	Risk Score - Target				Last Review Date	Review Notes	Risk Owner	Risk Lead	Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
						Likelihood	Consequence	Rating	Risk level		Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level																	
3410	[redacted]																											Moderate	Corporate		Board/Corporate	Corporate Services/Nursing	Medical Education			Staff Governance Committee	Live/Active
3110	[redacted]																						MacPherson, Anne	Munce, Steven	30/08/23	Better	People / Workforce	[redacted]								Staff Governance Committee	Live/Active
3036	[redacted]									• 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 [redacted] ted.				Very High				to SG, highlighting recurring and non-recurring spend.	Mcllwain, Fiona	14/08/24				[redacted]			Neil, Colin	McIlwan, Fiona	30/09/23	[redacted]	Financial / Commercial	[redacted]								Finance, Planning and Performance Committee	Live/Active

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ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial				Controls in place	Risk Score - Current				Further Controls Required	Action Owner	Due date	Risk Score - Target				Last Review Date	Review Notes	Risk Owner	Risk Lead	Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
						Likelihood	Consequence	Rating	Risk level		Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level																
[redacted]																																				
3010	01/06/21	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. 12. Application of IIP is underway and includes assessment and development plans for each site cluster. Initial assessments of all acute and corporate clusters have been completed with improvement plans in place or under development. 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. 14. First two phases of Collaborative Conversations complete. As part of newly approved staff internal communications and employee engagement strategy, a third phase is now underway from March 2023.	3	4	12	High	14. Development of our approach to 'Civility Saves Lives' is underway, target completion end October.	Mann, Douglas	27/10/23	2	3	6	Medium	22/05/23	We are on track to deliver the last two outstanding actions with the success register due to launch from May 2023 and Civility Saves Lives continuing to roll out, with our training package being tested with Civility Saves Lives Champions in May 2023. To support the deployment a new action called Success Register has been created with a target date of 27/10/2023.	MacPherson, Anne	Spence, Liam	30/08/23	Better Workplace - To ensure our people are appropriately trained and developed	People / Workforce	Moderate	Corporate	Board/Corporate	Human Resources	Not Required			Staff Governance Committee	Live/Active
															Development of a Success Register approach that both acknowledges and celebrates good practice initiatives but then also provides the ability to share learning across NHSGGC.	Mann, Douglas	27/10/23																					
3052	22/06/21	Regulatory body compliance	Failure to achieve and maintain statutory compliance through regulatory bodies	1. Insufficient or inadequate programme of staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance 3. Insufficient authorising persons within the board to sufficiently provide the required two AP's per specialty to ensure sign off of permits and provide resilience.	Adverse publicity / reputation, injury: physical and psychological, Inspection / Audit	4	4	16	High	1. Fire risk assessments 2. Environmental PPC Permits in place at two facilities namely, GRI & QEUH. Environmental Authorisations (Scotland) Regulations (EASR) Permits in place across seven sites for nuclear waste. 3. High level Environmental Legal Register in place to monitor relevant environmental legislation applicable to the Board. 4.Estate Asset Management System (EAMs) 5. Statutory Compliance Audit and Risk Tool (SCART) 6. Topic specific Authorised Persons (AP) and Authorised Engineer oversight and audit. 7. Asbestos compliance team use contractors to manage ACM's on sites.	4	4	16	High	Single building fire risk assessments to be conducted across the entire NHSGGC estate.	Cowley, David	29/03/24	3	3	9	Medium	24/07/23	24.03.23 No change at this time a further review will be conducted on 25.04.23 Risk remains unchanged estates colleagues continue to review and monitor 10.05.23 Actions assigned to risk in order to develop mitigations in collaboration with risk manager. 24.07.23 Work ongoing on identified actions	Steele, Tom	Riddell, Mark	31/08/23	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Legal	Cautious	Corporate	Board/Corporate	Facilities/Estates	Not Required			Finance, Planning and Performance Committee	Live/Active
															Authorised Engineer audits conducted for specialist areas i.e. water, ventilation, LV, HV and pressure systems.	Riddell, Mark	29/03/24																					
															1. Sufficient authorised persons to be trained and competency assessed to ensure compliance. 2. Sufficient responsible persons (Water) to be trained and competency assessed to ensure compliance. 3. Competence persons training for technicians.	Riddell, Mark	29/03/24																					
															Regular internal and external (SEPA) audits for PPC Permits. Permits currently sitting at "Excellent".	Martin Johnstone	29/03/24																					
[redacted]																																				
3059	01/06/21	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.) 6. Embedded educational governance throughout learning pathways, developing learning with partners and in line with national standards to ensure pathways support workforce skills and capabilities outlined in the Workforce Strategy 7. Key internal profession based career pathways developed as identified in the workforce plan, incorporating key principles of fairness and accessibility	3	3	9	Medium	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	Spence, Liam	31/03/23	3	2	6	Medium	22/05/23	Internal Communications & Employee Engagement Strategy approved by the board which sets out the overall shape and direction of our employee engagement programme. A series of collaborative conversations are now under development, aligned with the Corporate Clusters and to underpin our IIP re-accreditation programme for 2023/4.	MacPherson, Anne	MacDonald, Moira	30/08/23	Better Workplace - To provide a continuously improving and safe working environment	People / Workforce	Moderate	Corporate	Board/Corporate	Human Resources	Learning and Education			Staff Governance Committee	Live/Active
[redacted]																																				

Master Corporate Risk Register- for Sept 2023 ARC

ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial			Controls in place	Risk Score - Current			Further Controls Required	Action Owner	Due date	Risk Score - Target			Last Review Date	Review Notes	Risk Owner	Risk Lead	Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
						Likelihood	Consequence	Risk level		Likelihood	Consequence	Risk level				Likelihood	Consequence	Risk level																

[redacted]

ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial				Controls in place	Risk Score - Current				Further Controls Required	Action Owner	Due date	Risk Score - Target				Last Review Date	Review Notes	Risk Owner	Risk Lead	Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
						Likelihood	Consequence	Rating	Risk level		Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level																	

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						Likelihood	Consequence	Rating	Risk level		Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level																
[redacted]																																				
3060	01/06/21	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. 12. Application of IIP is underway and includes assessment and development plans for each site cluster. Initial assessments of all acute and corporate clusters have been completed with improvement plans in place or under development. 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. 14. First two phases of Collaborative Conversations complete. As part of newly approved staff internal communications and employee engagement strategy, a third phase is now underway from March 2023.	3	4	12	High	14. Development of our approach to 'Civility Saves Lives' is underway, target completion end October.	Mann, Douglas	27/10/23	2	3	6	Medium	22/05/23	We are on track to deliver the last two outstanding actions with the success register due to launch from May 2023 and Civility Saves Lives continuing to roll out, with our training package being tested with Civility Saves Lives Champions in May 2023. To support the deployment a new action called Success Register has been created with a target date of 27/10/2023.	MacPherson, Anne	Spence, Liam	30/08/23	Better Workplace - To ensure our people are appropriately trained and developed	People / Workforce	Moderate	Corporate	Board/Corporate	Human Resources	Not Required			Staff Governance Committee	Live/Active
															Development of a Success Register approach that both acknowledges and celebrates good practice initiatives but then also provides the ability to share learning across NHSGGC.	Mann, Douglas	27/10/23																					
3052	22/06/21	Regulatory body compliance	Failure to achieve and maintain statutory compliance through regulatory bodies	1. Insufficient or inadequate programme of staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance 3. Insufficient authorising persons within the board to sufficiently provide the required two AP's per specialty to ensure sign off of permits and provide resilience.	Adverse publicity / reputation, injury: physical and psychological, Inspection / Audit	4	4	16	High	1. Fire risk assessments 2. Environmental PPC Permits in place at two facilities namely, GRI & QEUH. Environmental Authorisations (Scotland) Regulations (EASR) Permits in place across seven sites for nuclear waste. 3. High level Environmental Legal Register in place to monitor relevant environmental legislation applicable to the Board. 4.Estate Asset Management System (EAMs) 5. Statutory Compliance Audit and Risk Tool (SCART) 6. Topic specific Authorised Persons (AP) and Authorised Engineer oversight and audit. 7. Asbestos compliance team use contractors to manage ACM's on sites.	4	4	16	High	Single building fire risk assessments to be conducted across the entire NHSGGC estate.	Cowley, David	29/03/24	3	3	9	Medium	29/07/23	24.03.23 No change at this time a further review will be conducted on 25.04.23 Risk remains unchanged estates colleagues continue to review and monitor 10.05.23 Actions assigned to risk in order to develop mitigations in collaboration with risk manager. 24.07.23 Work ongoing on identified actions	Steele, Tom	Riddell, Mark	31/08/23	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Legal	Cautious	Corporate	Board/Corporate	Facilities/Estates	Not Required			Finance, Planning and Performance Committee	Live/Active
															Authorised Engineer audits conducted for specialist areas i.e. water, ventilation, LV, HV and pressure systems.	Riddell, Mark	29/03/24																					
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[redacted]																																				

Master Coporate Risk Register 19/10/23

						Risk Score - Initial					Risk Score - Current								Risk Score - Target										
ID	Opened	Title	Description	Cause	Impact	Likelihood	onsequence	Rating	Risk level	Controls in place	Likelihood	onsequence	Rating	Risk level	Further Controls Required	Action Owner	Due date	Action Completed Date	Likelihood	onsequence	Rating	Risk level	Last Review Date	Review Notes	Risk Owner	Review date	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
[redacted]																														

ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial				Controls in place	Risk Score - Current				Further Controls Required	Action Owner	Due date	Action Completed Date	Risk Score - Target				Last Review Date	Review Notes	Risk Owner	Review date	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
						Likelihood	Consequence	Rating	Risk level		Likelihood	Consequence	Rating	Risk level					Likelihood	Consequence	Rating	Risk level								

[redacted]

[redacted]

ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial: Likelihood	Risk Score - Initial: Consequence	Risk Score - Initial: Rating	Risk Score - Initial: Risk level	Controls in place	Risk Score - Current: Likelihood	Risk Score - Current: Consequence	Risk Score - Current: Rating	Risk Score - Current: Risk level	Further Controls Required	Action Owner	Due date	Action Completed Date	Risk Score - Target: Likelihood	Risk Score - Target: Consequence	Risk Score - Target: Rating	Risk Score - Target: Risk level	Last Review Date	Review Notes	Risk Owner	Review date	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
[redacted]																													
3060	01/06/2021	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	Service / Business interruption	4	4	16	High	1. Workforce Strategy. 2. Leadership development programmes. New programme for Senior Managers has started. 3. Succession Planning Framework. 4. Equality Action Plan. 5. Medical Management programme introduced. New approach to start by end November. 6. Review of Ready to Lead programme underway. New programme commencing March 2024. 7. iMatter response and results; analysis of NHSGGC Board Report; and focus on action planning and sharing success stories across teams. 8. Promotion of culture framework and associated programmes and initiatives. This is now part of the Workforce Strategy and action plan which is BAU. 9. Internal Communication and Employee Engagement Strategy, now approved by NHSGGC Board as at 25/10/22 10. Additional modules on Equalities & Diversity are now part of our leadership programmes. 11. Senior, middle, and medical manager leadership programmes have all been reviewed and are currently being delivered. The Executive Leadership Programme is completed. 12. Application of IIP is underway and includes assessment and development plan	2	3	6	Medium	completed.	Douglas	31/03/2023	31/03/2023													
															12. Application of IIP is underway and includes assessment and development plans for each site cluster. Initial assessments of all acute and corporate clusters have been completed with improvement plans in place or under development.	Mann, Douglas	31/03/2023	31/03/2023													
															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	Mann, Douglas	28/02/2023	28/02/2023													
															14. Development of our approach to 'Civility Saves Lives' is underway, target completion end October.	Mann, Douglas	27/10/2023	03/10/2023	2	3	6	Medium	03/10/2023	Training package now ready for first cohort of Civility Leads in November 2023. The Success Register has now been launched. Early evaluation indicates that search engine facility is already useable in current system.	MacPherson, Anne	31/01/2024	Better Workplace - To ensure our people are appropriately trained and developed	People / Workforce	Moderate	Staff Governance Committee

						Risk Score - Initial					Risk Score - Current					Risk Score - Target											
ID	Opened	Title	Description	Cause	Impact	Likelihood	Consequence	Rating	Risk level	Controls in place	Likelihood	Consequence	Rating	Risk level	Further Controls Required	Action Owner	Due date	Action Completed Date	Likelihood	Consequence	Rating	Risk level	Last Review Date	Review Notes	Risk Owner	Review date	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
				with available training, instruction and support packages						for each site cluster. Initial assessments of all acute and corporate clusters have been completed with improvement plans in place. IRH and Corporate Cluster now accredited. Summative assessments for remaining clusters running from October 2023 to April 2024. 13. Refreshed approach to Succession Planning now in place. Prioritisation at this stage for Directors and SMT members. Career conversations as part of mid term reviews of PDPs will complete end November. 14. First two phases of Collaborative Conversations complete. As part of newly approved staff internal communications and employee engagement strategy, a third phase is now underway from March 2023. 15. Success Register has now been implemented and being used to share good practice and show appreciation between staff for excellent work. 16. Civility Saves Lives initiative underway. Champions groups in each IJP Cluster. Civility Leads training starting November 2023.					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 underway from March 2023.	Spence, Liam	31/03/2023	31/03/2023											
															Development of a Success Register approach that both acknowledges and celebrates good practice initiatives but then also provides the ability to share learning across NHSGGC.	Mann, Douglas	27/10/2023	03/10/2023											
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3052	22/06/2021	Regulatory body compliance	Failure to achieve and maintain statutory compliance through regulatory bodies	1. Insufficient or inadequate programme of staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance 3. Insufficient authorising persons within the board to sufficiently provide the required two AP's per specialty to ensure sign off of permits and provide resilience.	Adverse publicity / reputation, Injury: physical and psychological, Inspection / Audit	4	4	16	High	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 environment legislation applicable to the Board. 4.Estate Asset Management System (EAMs) 5. Statutory Compliance Audit and Risk Tool (SCART) 6. Topic specific Authorised Persons (AP) and Authorised Engineer oversight and audit. 7. Asbestos compliance team use contractors to manage ACM's on sites.	4	4	16	High	Single building fire risk assessments to be conducted across the entire NHSGGC estate. Authorised Engineer audits conducted for specialist areas i.e. water, ventilation, LV, HV and pressure systems. 1. Sufficient authorised persons to be trained and competency assessed to ensure compliance. 2. Sufficient responsible persons (Water) to be trained and competency assessed to ensure compliance. 3. Competence persons training for technicians. Regular internal and external (SEPA) audits for PPC Permits. Permits currently sitting at "Excellent".	David Riddell, Mark Riddell, Mark Riddell, Mark Riddell, Mark	29/03/2024 29/03/2024 29/03/2024 29/03/2024		3	3	9	Medium	10/05/2023	24.03.23 No change at this time a further review will be conducted on 25.04.23 Risk remains unchanged estates colleagues continue to review and monitor (Updated by AP on behalf of MR) 10.05.23 Actions assigned to risk in order to develop mitigations in collaboration with risk manager.	Steele, Tom	09/06/2023	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Legal	Cautious	Finance, Planning and Performance Committee
[redacted]																													
3059	01/06/2021	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.) 6. Embedded educational governance throughout learning pathways, developing learning with partners and in line with national standards to ensure pathways support workforce skills and capabilities outlined in the Workforce Strategy 7. Key internal profession based career pathways developed as identified in the workforce plan, incorporating key principles of fairness and accessibility	2	2	4	Medium	6. Embedded educational governance throughout learning pathways, developing learning with partners and in line with national standards to ensure pathways support workforce skills and capabilities outlined in the Workforce Strategy. 7. 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 MacDonald, Moira Spence, Liam MacDonald, Moira	31/03/2023 31/03/2023 31/03/2023 31/03/2023	31/03/2023 31/03/2023 08/08/2023 31/03/2023	3	2	6	Medium	03/08/2023	03.08.2023 Internal Communications & Employee Engagement Strategy approved by the board sets out the overall shape and direction of our employee engagement programme.collaborative conversations are now implemented, aligned with the Corporate Clusters to underpin our IIP re-accreditation programme for 2023/4.	MacPherson, Anne	03/08/2023	Better Workplace - To provide a continuously improving and safe working environment	People / Workforce	Moderate	Staff Governance Committee
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ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial				Controls in place	Risk Score - Current				Further Controls Required	Action Owner	Due date	Action Completed Date	Risk Score - Target				Last Review Date	Review Notes	Risk Owner	Review date	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
						Likelihood	Consequence	Rating	Risk level		Likelihood	Consequence	Rating	Risk level					Likelihood	Consequence	Rating	Risk level								

[redacted]

Master Corporate Risk Register- 21/09/2023

ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial				Controls in place	Risk Score - Current				Further Controls Required	Responsibility (To)	Due date	Risk Score - Target				Last Review Date	Review Notes	Risk Owner	Review date	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
						Likelihood	Consequence	Rating	Risk level		Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level								

[redacted]

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

[redacted]

[redacted]

3060	01/06/21	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	3	3	9	Medium	14. Development of our approach to 'Civility Saves Lives' is underway, target completion end October. Development of a Success Register approach that both acknowledges and celebrates good practice initiatives but then also provides the ability to share learning across NHSGGC.	Mann, Douglas Mann, Douglas	27/10/2023 27/10/2023	2	3	6	Medium	22/05/23	We are on track to deliver the last two outstanding actions with the success register due to launch from May 2023 and Civility Saves Lives continuing to roll out, with our training package being tested with Civility Saves Lives Champions in May 2023. To support the deployment a new action called Success Register has been created with a target date of 27/10/2023.	MacPherson, Anne	30/06/23	Better Workplace - To ensure our people are appropriately trained and developed	People / Workforce	Moderate	Staff Governance Committee
3052	22/06/21	Regulatory body compliance	Failure to achieve and maintain statutory compliance through regulatory bodies	1. Insufficient or inadequate programme of staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance 3. Insufficient authorising persons within the board to sufficiently provide the required two AP's per specialty to ensure sign off of permits and provide resilience.	Adverse publicity / reputation, Injury: physical and psychological, Inspection / Audit	4	4	16	High	1. Fire risk assessments 2. Environmental PPC Permits in place at two facilities namely, GRI & QEUH. Environmental Authorisations (Scotland) Regulations (EASR) Permits in place across seven sites for nuclear waste. 3. High level Environmental Legal Register in place to monitor relevant environmental legislation applicable to the Board. 4.Estate Asset Management System (EAMs) 5. Statutory Compliance Audit and Risk Tool (SCART) 6. Topic specific Authorised Persons (AP) and Authorised Engineer oversight and audit. 7. Asbestos compliance team use contractors to manage ACM's on sites.	4	4	16	High	Single building fire risk assessments to be conducted across the entire NHSGGC estate. Authorised Engineer audits conducted for specialist areas i.e. water, ventilation, LV, HV and pressure systems. 1. Sufficient authorised persons to be trained and competency assessed to ensure compliance. 2. Sufficient responsible persons (Water) to be trained and competency assessed to ensure compliance. 3. Competance persons training for technicians. Regular internal and external (SEPA) audits for PPC Permits. Permits currently sitting at "Excellent".	Cowley, David Riddell, Mark Riddell, Mark Riddell, Mark	29/03/2024 29/03/2024 29/03/2024 29/03/2024	3	3	9	Medium	24/07/23	24.03.23 No change at this time a further review will be conducted on 25.04.23 Risk remains unchanged estates colleagues continue to review and monitor (Updated by AP on behalf of MB) 10.05.23 Actions assigned to risk in order to develop mitigations in collaboration with risk manager. 24.07.23 Work ongoing on identified actions	Steele, Tom	31/08/23	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Legal	Cautious	Finance, Planning and Performance Committee

[redacted]

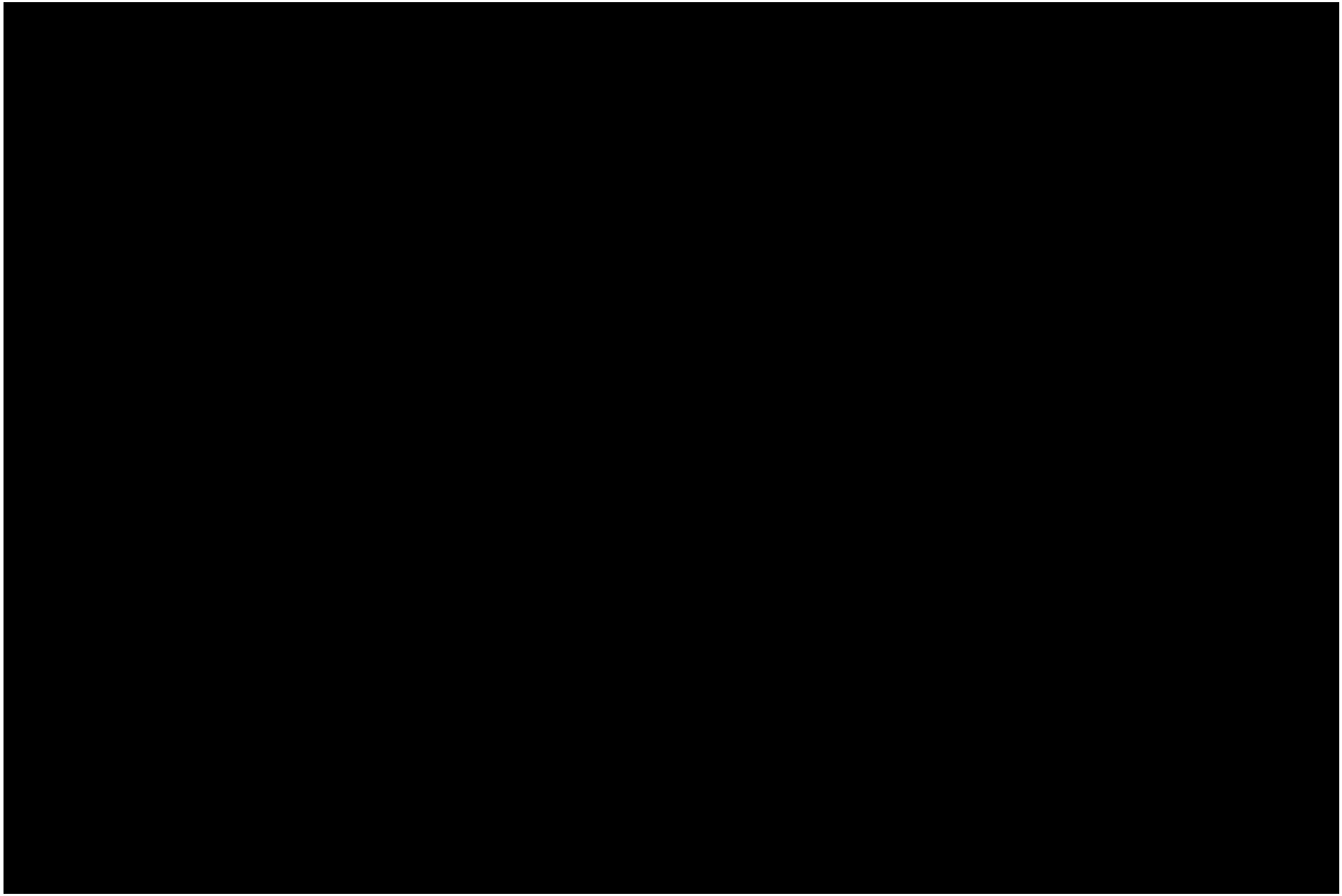
[redacted]

3059	01/06/21	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	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	3	3	9	Medium	6.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	Spence, Liam	31/03/23	3	2	6	Medium	22/05/23	Internal Communications & Employee Engagement Strategy approved by the board which sets out the overall shape and direction of our employee engagement programme. A series of collaborative conversations are now under development, aligned with the Corporate Clusters and to underpin our IIP re-accreditation programme for 2023/4.	MacPherson, Anne	MacDonald, Moira	30/06/23	Better Workplace - To provide a continuously improving and safe working environment	People / Workforce	Moderate	Board/Corporate	Human Resources	Learning and Education			Staff Governance Committee	Staff Governance Committee

[redacted]

CRR as at 23/11/23

						Risk Score - Initial					Risk Score - Current					Risk Score - Target												
ID	Opened	Title	Description	Cause	Impact	Likelihood	Consequence	Rating	Risk level	Controls in place	Likelihood	Consequence	Rating	Risk level	Further Controls Required	Responsibility (Tier)	Due date	Likelihood	Consequence	Rating	Risk level	Last Review Date	Review Notes	Manager	Review date	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
[redacted]																													



[redacted]

3060	01/06/2021	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. New programme for Senior Managers has started. 3. Succession Planning Framework. 4. Equality Action Plan. 5. Medical Management programme introduced. New approach to start by end November. 6. Review of Ready to Lead programme underway. New programme commencing March 2024. 7. iMatter response and results; analysis of NHSGGC Board Report; and focus on action planning and sharing success stories across teams. 8. Promotion of culture framework and associated programmes and initiatives. This is now part of the Workforce Strategy and action plan which is BAU. 9. Internal Communication and Employee Engagement Strategy, now approved by NHSGGC Board as at 25/10/22 10. Additional modules on Equalities & Diversity are now part of our leadership programmes. 11. Senior, middle, and medical manager leadership programmes have all been reviewed and are currently being delivered. The Executive Leadership Programme is completed. 12. Application of IIP is underway and includes assessment and development plans for each site cluster. Initial assessments of all acute and corporate clusters have been completed with improvement plans in place. RHI and Corporate Cluster now accredited. Summative assessments for remaining clusters running from October 2023 to April 2024. 13. Refreshed approach to Succession Planning now in place. Prioritisation at this stage for Directors and SMT members. Career conversations as part of mid term reviews of PDPs will complete end November. 14. First two phases of Collaborative Conversations complete. As part of newly approved staff internal communications and employee engagement strategy, a third phase is now underway from March 2023. 15. Succes Register has now been implemented and being used to share good practice and show appreciation between staff for excellent work. 16. Civility Saves Lives initiative underway. Champions groups in each IJP Cluster. Civility Leads training starting November 2023.	2	3	6	Medium				2	3	6	Medium	17/10/2023	The range of mitigations and culture change programmes are now all underway and being implemented across the organisation, with our target risk score reached. Going forward, we will gain assurance through the EP assessment programme taking place in our acute services from November 2023 to May 2024 that these programmes are delivering real change throughout NHSGGC. Key changes since the last update to the Committee include the training package now ready for first cohort of Civility Leads in November 2023 and the Succes Register has now been launched.	MacPherson, Anne	30/11/2023	Better Workplace - To ensure our people are appropriately trained and developed	People / Workforce	Moderate	Staff Governance Committee
3052	22/06/2021	Regulatory body compliance	Failure to achieve and maintain statutory compliance through regulatory bodies	1. Insufficient or inadequate programme of staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance 3. Insufficient authorising persons within the board to sufficiently provide the required two AP's per specialty to ensure sign off of permits and provide resilience.	Adverse publicity / reputation, injury: physical and psychological, Inspection / Audit	4	4	16	High	1. Fire risk assessments. 2. Environmental PPC Permits in place at two facilities namely, GRI & QEUH. Environmental Authorisations (Scotland) Regulations (EASR) Permits in place across seven sites for nuclear waste. 3. High level Environmental Legal Register in place to monitor relevant environmental legislation applicable to the Board. 4.Estate Asset Management System (EAMs) 5. Statutory Compliance Audit and Risk Tool (SCART) 6. Topic specific Authorised Persons (AP) and Authorised Engineer oversight and audit. 7. Asbestos compliance team use contractors to manage ACM's on sites.	4	4	16	High	Single building fire risk assessments to be conducted across the entire NHSGGC estate. Authorised Engineer audits conducted for specialist areas i.e. water, ventilation, LV, HV and pressure systems. 1. Sufficient authorised persons to be trained and competency assessed to ensure compliance. 2. Sufficient responsible persons (Water) to be trained and competency assessed to ensure compliance. 3. Competence persons training for technicians. Regular internal and external (SEPA) audits for PPC Permits. Permits currently sitting at "Excellent".	Cowley, David Riddell, Mark Riddell, Mark Riddell, Mark	20/03/2024 20/03/2024 20/03/2024 20/03/2024	3	3	9	Medium	10/05/2023	24.03.23 No change at this time a further review will be conducted on 25.04.23 Risk remains unchanged estates colleagues continue to review and monitor (Updated by AP on behalf of MR) 10.05.23 Actions assigned to risk in order to develop mitigations in collaboration with risk manager.	Steele, Tom	09/06/2023	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Legal	Cautious	Finance, Planning and Performance Committee

[redacted]

3059	01/06/2021	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.) 6. Embedded educational governance throughout learning pathways, developing learning with partners and in line with national standards to ensure pathways support workforce skills and capabilities outlined in the Workforce Strategy 7. Key internal profession based career pathways developed as identified in the workforce plan, incorporating key principles of fairness and accessibility	2	2	4	Medium				2	2	4	Medium	17/10/2023	All actions closed and Risk Score Target reached. Ensuring the agreed actions are having the required impact, we continue to monitor the uptake of our key learning and education programmes, including statutory and mandatory training. While we are on an improvement trajectory, if we do not meet our targets this year we will review the associated risk controls and put in place revised mitigations	MacPherson, Anne	30/11/2023	Better Workplace - To provide a continuously improving and safe working environment	People / Workforce	Moderate	Staff Governance Committee

Risk Register Template - 19/12/23

[redacted]

3080	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. New programme for Senior Managers has started. 3. Succession Planning Framework. 4. Equality Action Plan. 5. Medical Management programme introduced. New approach to start by end November. 6. Review of Ready to Lead programme underway. New programme commencing March 2024. 7. iMatter response and results; analysis of NHSGGC Board Report; and focus on action planning and sharing success stories across teams. 8. Promotion of culture framework and associated programmes and initiatives. This is now part of the Workforce Strategy and action plan which is BAU. 9. Internal Communication and Employee Engagement Strategy, now approved by NHSGGC Board as at 25/10/22 10. Additional modules on Equalities & Diversity are now part of our leadership programmes. 11. Senior, middle, and medical manager leadership programmes have all been reviewed and are currently being delivered. The Executive Leadership Programme is completed. 12. Application of IIP is underway and includes assessment and development plans for each site cluster. Initial assessments of all acute and corporate clusters have been completed with improvement plans in place. RH and Corporate Cluster now accredited. Summative assessments for remaining clusters running from October 2023 to April 2024. 13. Refreshed approach to Succession Planning now in place. Prioritisation at this stage for Directors and SMT members. Career conversations as part of mid term reviews of PDPs will complete end November. 14. First two phases of Collaborative Conversations complete. As part of newly approved staff internal communications and employee engagement strategy, a third phase is now underway from March 2023. 15. Success Register has now been implemented and being used to share good practice and show appreciation between staff for excellent work. 16. Civility Saves Lives initiative underway. Champions groups in each IIP Cluster. Civility Leads training starting November 2023.	2	3	6	Medium				2	3	6	Medium	04/12/2023	The range of mitigations and culture change programmes are now all underway and being implemented across the organisation, with our target risk score reached. Going forward, we will gain assurance through the IIP assessment programme taking place in our acute services from November 2023 to May 2024 that these programmes are delivering real change throughout NHSGGC. Key changes since the last update to the Committee include the training package now ready for first cohort of Civility Leads in November 2023 and the Success Register has now been launched. 2024 Internal Comms Employee Engagement Plan (ICEE) is under development and will be reported through our governance in early 2024.	MacPherson, Anne	Better Workplace - To ensure our people are appropriately trained and developed	People / Workforce	Moderate	Staff Governance Committee
3052	Regulatory body compliance	Failure to achieve and maintain statutory compliance through regulatory bodies	1. Insufficient or inadequate programme of staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance 3. Insufficient authorising persons within the board to sufficiently provide the required two AP's per specialty to ensure sign off of permits and provide resilience.	Adverse publicity / reputation. Injury: physical and psychological. Inspection / Audit	4	4	16	High	1. Fire risk assessments 2. Environmental PPC Permits in place at two facilities namely, GRI & QEUH. Environmental Authorisations (Scotland) Regulations (EASR) Permits in place across seven sites for nuclear waste. 3. High level Environmental Legal Register in place to monitor relevant environmental legislation applicable to the Board. 4.Estate Asset Management System (EAMs) 5. Statutory Compliance Audit and Risk Tool (SCART) 6. Topic specific Authorised Persons (AP) and Authorised Engineer oversight and audit. 7. Asbestos compliance team use contractors to manage ACM's on sites.	4	4	16	High	Single building fire risk assessments to be conducted across the entire NHSGGC estate. Authorised Engineer audits conducted for specialist areas i.e. water, ventilation, LV, HV and pressure systems. 1. Sufficient authorised persons to be trained and competency assessed to ensure compliance. 2. Sufficient responsible persons (Water) to be trained and competency assessed to ensure compliance. 3. Competence persons training for technicians. Regular internal and external (SEPA) audits for PPC Permits. Permits currently sitting at "Excellent".	Cowley, David Riddell, Mark Riddell, Mark Riddell, Mark	29/03/2024 29/03/2024 29/03/2024 29/03/2024	3	3	9	Medium	10/05/2023	10.05.23 Actions assigned to risk in order to develop mitigations in collaboration with risk manager.	Steele, Tom	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Legal	Cautious	Finance, Planning and Performance Committee
3059	Staff training and development	Failure to appropriately train and develop NHSGGC staff to enable individuals to deliver their role and responsibilities, or where requirements for key competencies are not identified, developed and achieved.	1. Organisation wide training & development programme(s)that are do not meet identified need/ or are fit for purpose 2. Training & development provision is not effectively implemented and monitored 3. Increased levels of demand for the acquisition of knowledge and skills reduce the available protected time for training 4. Lack of awareness for managers and staff of the availability of training and development opportunities 5. Staff not engaging / taking up available training opportunities	Service / Business interruption	5	4	20	Very High	on the appropriate system for job family to enable data to be available for corporate recording and performance monitoring. 2. Identification of training that is agreed as statutory and mandatory for the organisation. 3. Completion of core statutory and mandatory training is recorded on learning management systems that enable data to be available for corporate reporting and performance monitoring via Microstrategy Monitoring of Statutory and Mandatory Training compliance, 4. Agreement of performance targets and KPIs for PDP&R and Statutory and Mandatory training. 5. Agreed KPIs and performance target trajectories in place for all areas for review at Performance Review Groups (PRGs), Acute Services Committee and HR Commissioning Meetings. (All service managers are responsible for leading activities to address and improve local performance.) 6. Embedded educational governance throughout learning pathways, developing learning with partners and in line with national standards to ensure pathways support workforce skills and capabilities outlined in the Workforce Strategy 7. Key internal profession based career pathways developed as identified in the workforce plan, incorporating key principles of fairness and accessibility	2	2	4	Medium				2	2	4	Medium	17/10/2023	All actions closed and Risk Score Target reached. Ensuring the agreed actions are having the required impact, we continue to monitor the uptake of our key learning and education programmes, including statutory and mandatory training. While we are on an improvement trajectory, if we do not meet our targets this year we will review the associated risk controls and put in place revised mitigations	MacPherson, Anne	Better Workplace - To provide a continuously improving and safe working environment	People / Workforce	Moderate	Staff Governance Committee

[redacted]

Corporate Risk Register

Report Date: 26.03.20

ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial				Controls in place	Risk Score - Current				Further Controls Required	Action Owner	Due date	Risk Score - Target				Last Review Date	Review Notes	Risk Owner	Risk Lead	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
						Likelihood	Impact	Rating	Risk level		Likelihood	Impact	Rating	Risk level				Likelihood	Impact	Rating	Risk Level																	
Decreased Risks																																					
[redacted]																																					

Corporate Risk Register

Report Date: 26.03.20

| | | | | | | Risk Score - Initial | | | | | Risk Score - Current | | | | | | | Risk Score - Target | | | | | | |

Corporate Risk Register

Report Date: 26.03.20

						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 Owner	Risk Lead	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
[redacted]																																			

Corporate Risk Register

Report Date: 26.03.20

ID	Opened	Title	Description	Cause	Impact	Risk Score - Initial				Controls in place	Risk Score - Current				Further Controls Required	Action Owner	Due date	Risk Score - Target				Last Review Date	Review Notes	Risk Owner	Risk Lead	Next Review date	Corporate Objectives	Risk Type	Risk Appetite	Management Level	Division	Directorate admitted	Clin. Group	Specialty	Unit	Assigned Governance Committee	Status
						Likelihood	Impact	Rating	Risk level		Likelihood	Impact	Rating	Risk level				Likelihood	Impact	Rating	Risk Level																	
[redacted]																																				

					Risk Score Initial					Risk Score Current					Risk Score Target											
ID	Title	Description	Cause	Impact	Likelihood	Consequence	Rating	Risk level	Controls in place	Likelihood	Consequence	Rating	Risk level	Further Action Required	Action Owner	Due date	Likelihood	Consequence	Rating	Risk level	Last Review Date	Review Notes	Manager	Next Review Date	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
3051	Ageing infrastructure	The ageing infrastructure across the estate could raise operational and financial issues which could result in service disruption and impact on patient care	1. Lack of funding to invest in improvements to the building estate, such as Ventilation Systems, High & Low Voltage infrastructure, Domestic Hot & Cold Water systems, Medical Gas Systems (particularly oxygen capacity), Building Fabric Condition 2. Lack of sufficient staff resource to identify, plan and manage the required investment works 3. Recent findings in relation to RAAC concrete may pose a risk to buildings within GGC.	Adverse publicity / reputation, Financial: including damage / loss / fraud, Injury: physical and psychological, Patient experience	4	4	16	High	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & infrastructure and identifies the areas of the estate at high risk of failure and therefore of highest priority for repair. A review of NHSGGC's EAM system was undertaken in order to review the accuracy of data and to change the presentation of information. The outcome of this provided management with more understandable data, and informed us where we have risk, and, therefore, enable us to mitigate risks. The asset management review details areas which require investment, and risk assess those areas. This system is managed and maintained by the Property & Capital Planning department. This system supports the development of the a Property & Asset Management Strategy (PAMS) and also the annual NHS Scotland Assets & Facilities Report (SAFR) which is submitted to SG. Property & Asset Strategy Group review the Estates Review Report and monitor it along with the Capital Planning Group. 2. Implementation of Board wide property management approach including assessment of premises compliance with standard consistent methodologies. Property compliance is measured via SCART, which is managed by the Corporate Estates Team. 3. Regular reports to CMT/ CPG/SMG / OMG on deployment of capital resources and investment priorities. Prioritisation is informed by EAMs and the PAMS data. It is for this group to review the report and monitor it along with the Capital Planning Group. 4. A revenue allocation of [redacted] 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. 7. The Statutory Compliance Audit and Risk Tool (SCART) Steering Group meets quarterly to monitor SCART performance and to ensure all necessary records and other forms of evidence to support compliance are readily available and in date. 8. RAAC HFS are currently undertaking surveys and sampling to determine current risk if any to GGC until these findings have been shared no further mitigations can be implemented.Surveys co-ordinated via NHS Assure and started on 13th November 2023. No RAAC was identified at any of the high or medium likelihood properties.	4	4	16	High	Repairs to AHU highlighted in the annual validation report in terms of maintenance and lighting should be undertaken asap.	Kole, debdeep	31/01/2024	3	3	9	Medium	15/01/2024	15.01.24 RAAC surveys, instructed by NHS Scotland Assure, carried out in Nov and Dec 23 have identified no RAAC in any of the High or Medium Risk Properties. Surveys of low likelihood properties will commence in 2024, earliest date for commencing survey work will be March.	Steele, Tom	15/02/2024	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	31/01/2024												

[redacted]

305	[redacted]														2	3	6	Medium	14/12/2023	Dec 23 - ADP guidance received and work commenced on content development.	Armstrong, Jennifer	10/01/2024	Better Care - To ensure services are timely and accessible to all parts of the community we serve	Operating	Open	Finance, Planning and Performance Committee
[redacted]																					Edwards, William	18/01/2024	Better Care - To ensure services are timely and accessible to all parts of the community we serve	Operating	Open	Acute Services Committee
[redacted]																										opulation Health and ellbeing Committee
3060	Positive, engaging and diverse culture	Failure to cultivate, promote and enhance a positive, engaging and diverse culture.	1. Lack of overarching workforce strategy and associated policies, procedures and initiatives 2. Strategy not fully implemented 3. Lack of appropriate training, information, instruction and support for staff 4. Lack of sufficient staff engagement with available training, instruction and support packages	Service / Business interruption	4	4	16	High	1. Workforce Strategy. 2. Leadership development programmes. New programme for Senior Managers has started. 3. Succession Planning Framework. 4. Equality Action Plan. 5. Medical Management programme introduced. New approach to start by end November. 6. Review of Ready to Lead programme underway. New programme commencing March 2024. 7. iMatter response and results; analysis of NHSGGC Board Report; and focus on action planning and sharing success stories across teams. 8. Promotion of culture framework and associated programmes and initiatives. This is now part of the Workforce Strategy and action plan which is BAU. 9. Internal Communication and Employee Engagement Strategy, now approved by NHSGGC Board as at 25/10/22 10. Additional modules on Equalities & Diversity are now part of our leadership programmes. 11. Senior, middle, and medical manager leadership programmes have all been reviewed and are currently being delivered. The Executive Leadership Programme is completed. 12. Application of IIP is underway and includes assessment and development plans for each site cluster. Initial assessments of all acute and corporate clusters have been completed with improvement plans in place. IRH and Corporate Cluster now accredited. Summative assessments for remaining clusters running from October 2023 to April 2024. 13. Refreshed approach to Succession Planning now in place. Prioritisation at this stage for Directors and SMT members. Career conversations as part of mid term reviews of PDPs will complete end November. 14. First two phases of Collaborative Conversations complete. As part of newly approved staff internal communications and employee engagement strategy, a third phase is now underway from March 2023. 15. Success Register has now been implemented and being used to share good practice and show appreciation between staff for excellent work. 16. Civility Saves Lives initiative underway. Champions groups in each IIP Cluster. Civility Leads training starting November 2023.	2	3	6	Medium					2	3	6	Medium	04/12/2023	The range of mitigations and culture change programmes are now all underway and being implemented across the organisation, with our target risk score reached. Going forward, we will gain assurance through the IIP assessment programme taking place in our acute services from November 2023 to May 2024 that these programmes are delivering real change throughout NHSGGC. Key changes since the last update to the Committee include the training package now ready for first cohort of Civility Leads in November 2023 and the Success Register has now been launched. 2024 Internal Comms Employee Engagement Plan (ICEE) is under development and will be reported through our governance in early 2024.	MacPherson, Anne	08/01/2024	Better Workplace - To ensure our people are appropriately trained and developed	People / Workforce	Moderate	Staff Governance Committee
3052	Regulatory body compliance	Failure to achieve and maintain statutory compliance through regulatory bodies	1. Insufficient or inadequate programme of staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance 3. Insufficient authorising persons within the board to sufficiently provide the required two AP's per specialty to ensure sign off of permits and provide resilience.	Adverse publicity / reputation, Injury: physical and psychological, Inspection / Audit	4	4	16	High	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.15.01.24 Mark Riddell Update: Topics covered are LV, HV, Ventilation, Water MGPS and Pressure Systems, independently reviewed on an annual basis. All audits are sent to the Compliance team for recording in the first instance and an action plan is then developed with local teams to address any issues relating to the audit. 7. Asbestos compliance team use contractors to manage ACM's on sites. All training is co-ordinated via the compliance team who monitor numbers as well as organise training as and when required, a significant spend in 2022/2023 has seen a significant rise in numbers across all disciplines from CPs, APs, RPs etc	4	4	16	High	Single building fire risk assessments to be conducted across the entire NHSGGC estate. Authorised Engineer audits conducted for specialist areas i.e. water, ventilation, LV, HV and pressure systems. 1. Sufficient authorised persons to be trained and competency assessed to ensure compliance. 2. Sufficient responsible persons (Water) to be trained and competency assessed to ensure compliance. 3. Competence persons training for technicians. Regular internal and external (SEPA) audits for PPC Permits. Permits currently sitting at "Excellent".	Cowley, David Riddell, Mark Riddell, Mark Riddell, Mark	29/03/2024 29/03/2024 29/03/2024 29/03/2024	3	3	9	Medium	15/01/2024	24.03.23 No change at this time a further review will be conducted on 25.04.23 Risk remains unchanged estates colleagues continue to review and monitor (Updated by AP on behalf of MR) 10.05.23 Actions assigned to risk in order to develop mitigations in collaboration with risk manager. 15.01.24 AP and Linden Magee updated on behalf of Mark Riddell.	Steele, Tom	15/02/2024	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Legal	Cautious	Finance, Planning and Performance Committee
[redacted]																													
3059	Staff training and development	Failure to appropriately train and develop NHSGGC staff to enable individuals to deliver their role and responsibilities, or where requirements for key competencies are not identified, developed and achieved.	1. Organisation wide training & development programme(s)that are do not meet identified need/ or are fit for purpose 2. Training & development provision is not effectively implemented and monitored 3. Increased levels of demand for the acquisition of knowledge and skills reduce the available protected time for training 4. Lack of awareness for managers and staff of the availability of training and development opportunities 5. Staff not engaging / taking up available training opportunities	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.) 6. Embedded educational governance throughout learning pathways, developing learning with partners and in line with national standards to ensure pathways support workforce skills and capabilities outlined in the Workforce Strategy 7. Key internal profession based career pathways developed as identified in the workforce plan, incorporating key principles of fairness and accessibility	2	2	4	Medium					2	2	4	Medium	17/10/2023	All actions closed and Risk Score Target reached. Ensuring the agreed actions are having the required impact, we continue to monitor the uptake of our key learning and education programmes, including statutory and mandatory training. While we are on an improvement trajectory, if we do not meet our targets this year we will review the associated risk controls and put in place revised mitigations	MacPherson, Anne	30/11/2023	Better Workplace - To provide a continuously improving and safe working environment	People / Workforce	Moderate	Staff Governance Committee

[redacted]

Appendix B - Corporate Risk Register

						Risk Score - Current							Risk Score - Target							
ID	Title	Description	Cause	Impact	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 Owner	Risk Type	Risk Appetite
3051	Ageing infrastructure	The ageing infrastructure across the estate could raise operational and financial issues which could result in service disruption and impact on patient care	1. Lack of funding to invest in improvements to the building estate, such as Ventilation Systems, High & Low Voltage infrastructure, Domestic Hot & Cold Water systems, Medical Gas Systems (particularly oxygen capacity), Building Fabric Condition 2. Lack of sufficient staff resource to identify, plan and manage the required investment works 3. Recent findings in relation to RAAC concrete may pose a risk to buildings within GGC.	Adverse publicity / reputation, Financial: including damage / loss / fraud, Injury: physical and psychological, Patient experience	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure and identifies the areas of the estate at high risk of failure and therefore of highest priority for repair. A review of NHSGGC's EAM system was undertaken in order to review the accuracy of data and to change the presentation of information. The outcome of this provided management with more understandable data, and informed us where we have risk, and, therefore, enable us to mitigate risks. The asset management review details areas which require investment, and risk assess those areas. This system is managed and maintained by the Property & Capital Planning department. This system supports the development of the a Property & Asset Management Strategy (PAMS) and also the annual NHS Scotland Assets & Facilities Report (SAFR) which is submitted to SG. Property & Asset Strategy Group review the Estates Review Report and monitor it along with the Capital Planning Group. 2. Implementation of Board wide property management approach including assessment of premises compliance with standard consistent methodologies. Property compliance is measured via SCART, which is managed by the Corporate Estates Team. 3. Regular reports to CMT/ CPG/SMG / OMG on deployment of capital resources and investment priorities. Prioritisation is informed by EAMs and the PAMS data. It is for this group to review the report and monitor it along with the Capital Planning Group. 4. A revenue allocation of [redacted] 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. 7. The Statutory Compliance Audit and Risk Tool (SCART) Steering Group meets quarterly to monitor SCART performance and to ensure all necessary records and other forms of evidence to support compliance are readily available and in date. 8. RAAC HFS are currently undertaking surveys and sampling to determine current risk if any to GGC until these findings have been shared no further mitigations can be implemented.Surveys co-ordinated via NHS Assure and started on 13th November 2023. No RAAC was identified at any of the high or medium likelihood properties.	4	4	16	High	Repairs to AHU highlighted in the annual validation report in terms of maintenance and lighting should be undertaken asap. Business case to be produced on CDU AHU identifying a solution to replacing the ageing AHU.	Kole, debdeep Riddell, Mark	31/01/2024 31/01/2024	3	3	9	Medium	15/01/2024	RAAC surveys, instructed by NHS Scotland Assure, carried out in Nov and Dec 23 have identified no RAAC in any of the High or Medium Risk Properties. Surveys of low likelihood properties will commence in 2024, earliest date for commencing survey work will be March.	Steele, Tom	Operating	Open

[redacted]

Appendix B - Corporate Risk Register

ID	Title	Description	Cause	Impact	Controls in place	Risk Score - Current				Further Controls Required	Action Owner	Due date	Risk Score - Target				Last Review Date	Review Notes	Risk Owner	Risk Type	Risk Appetite
						Likelihood	Impact	Rating	Risk level				Likelihood	Impact	Rating	Risk Level					

[redacted]

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ID	Title	Description	Cause	Impact	Controls in place	Risk Score - Current				Further Controls Required	Action Owner	Due date	Risk Score - Target				Last Review Date	Review Notes	Risk Owner	Risk Type	Risk Appetite
						Likelihood	Impact	Rating	Risk level				Likelihood	Impact	Rating	Risk Level					
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ID	Title	Description	Cause	Impact	Controls in place	Risk Score - Current				Further Controls Required	Action Owner	Due date	Risk Score - Target				Last Review Date	Review Notes	Risk Owner	Risk Type	Risk Appetite
						Likelihood	Impact	Rating	Risk level				Likelihood	Impact	Rating	Risk Level					
[redacted]																					
3060	Positive, engaging and diverse culture	Failure to cultivate, promote and enhance a positive, engaging and diverse culture.	1. Lack of overarching workforce strategy and associated policies, procedures and initiatives 2. Strategy not fully implemented 3. Lack of appropriate training, information, instruction and support for staff 4. Lack of sufficient staff engagement with available training, instruction and support packages	Service / Business interruption	'1. Workforce Strategy. 2. Leadership development programmes. New programme for Senior Managers has started. 3. Succession Planning Framework. 4. Equality Action Plan. 5. Medical Management programme introduced. New approach to start by end November. 6. Review of Ready to Lead programme underway. New programme commencing March 2024. 7. iMatter response and results; analysis of NHSGGC Board Report; and focus on action planning and sharing success stories across teams. 8. Promotion of culture framework and associated programmes and initiatives. This is now part of the Workforce Strategy and action plan which is BAU. 9. Internal Communication and Employee Engagement Strategy, now approved by NHSGGC Board as at 25/10/22 10. Additional modules on Equalities & Diversity are now part of our leadership programmes. 11. Senior, middle, and medical manager leadership programmes have all been reviewed and are currently being delivered. The Executive Leadership Programme is completed. 12. Application of IIP is underway and includes assessment and development plans for each site cluster. Initial assessments of all acute and corporate clusters have been completed with improvement plans in place. IRH and Corporate Cluster now accredited. Summative assessments for remaining clusters running from October 2023 to April 2024. 13. Refreshed approach to Succession Planning now in place. Prioritisation at this stage for Directors and SMT members. Career conversations as part of mid term reviews of PDPs will complete end November. 14. First two phases of Collaborative Conversations complete. As part of newly approved staff internal communications and employee engagement strategy, a third phase is now underway from March 2023. 15. Success Register has now been implemented and being used to share good practice and show appreciation between staff for excellent work. 16. Civility Saves Lives initiative underway. Champions groups in each IiP Cluster. Civility Leads training starting November 2023.	2	3	6	Medium				2	3	6	Medium	09/02/2024	The range of mitigations and culture change programmes are now all underway and being implemented across the organisation, with our target risk score reached. Going forward, we will gain assurance through the IIP assessment programme taking place in our acute services from November 2023 to May 2024 that these programmes are delivering real change throughout NHSGGC. Key changes since the last update to the Committee include the training package now ready for first cohort of Civility Leads in November 2023 and the Success Register has now been launched. 2024 Internal Comms Employee Engagement Plan (ICEE) is under development and will be reported through our governance in early 2024.	MacPherson, Anne	People / Workforce	Moderate
3052	Regulatory body compliance	Failure to achieve and maintain statutory compliance through regulatory bodies	1. Insufficient or inadequate programme of staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance 3. Insufficient authorising persons within the board to sufficiently provide the required two AP's per specialty to ensure sign off of permits and provide resilience.	Adverse publicity / reputation, Injury: physical and psychological, Inspection / Audit	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. Topics covered are LV, HV, Ventilation, Water MGPS and Pressure Systems, independently reviewed on an annual basis. All audits are sent to the Compliance team for recording in the first instance and an action plan is then developed with local teams to address any issues relating to the audit. 7. Asbestos compliance team use contractors to manage ACM's on sites. All training is co-ordinated via the compliance team who monitor numbers as well as organise training as and when required, a significant spend in 2022/2023 has seen a significant rise in numbers across all disciplines from CPs, APs, RPs etc	4	4	16	High	Single building fire risk assessments to be conducted across the entire NHSGGC estate. Authorised Engineer audits conducted for specialist areas i.e. water, ventilation, LV, HV and pressure systems. 1. Sufficient authorised persons to be trained and competency assessed to ensure compliance. 2. Sufficient responsible persons (Water) to be trained and competency assessed to ensure compliance. 3. Competence persons training for technicians. Regular internal and external (SEPA) audits for PPC Permits. Permits currently sitting at "Excellent".	Cowley, David Riddell, Mark Riddell, Mark Riddell, Mark	29/03/2024 29/03/2024 29/03/2024 29/03/2024	3	3	9	Medium	15/01/2024	No change to risk.	Steele, Tom	Legal	Cautious
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Appendix B - Corporate Risk Register

						Risk Score - Current							Risk Score - Target							
ID	Title	Description	Cause	Impact	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 Owner	Risk Type	Risk Appetite
3059	Staff training and development	Failure to appropriately train and develop NHSGGC staff to enable individuals to deliver their role and responsibilities, or where requirements for key competencies are not identified, developed and achieved.	1. Organisation wide training & development programme(s)that are do not meet identified need/ or are fit for purpose 2. Training & development provision is not effectively implemented and monitored 3. Increased levels of demand for the acquisition of knowledge and skills reduce the available protected time for training 4. Lack of awareness for managers and staff of the availability of training and development opportunities 5. Staff not engaging / taking up available training opportunities	Service / Business interruption	1. Annual Reviews for all staff to discuss PDP, objectives and agree support. Conversations to be agreed and recorded on the appropriate system for job family to enable data to be available for corporate recording and performance monitoring. 2. Identification of training that is agreed as statutory and mandatory for the organisation. 3. Completion of core statutory and mandatory training is recorded on learning management systems that enable data to be available for corporate reporting and performance monitoring via Microstrategy Monitoring of Statutory and Mandatory Training compliance, 4. Agreement of performance targets and KPIs for PDP&R and Statutory and Mandatory training. 5. Agreed KPIs and performance target trajectories in place for all areas for review at Performance Review Groups (PRGs), Acute Services Committee and HR Commissioning Meetings. (All service managers are responsible for leading activities to address and improve local performance.) 6. Embedded educational governance throughout learning pathways, developing learning with partners and in line with national standards to ensure pathways support workforce skills and capabilities outlined in the Workforce Strategy 7. Key internal profession based career pathways developed as identified in the workforce plan, incorporating key principles of fairness and accessibility	2	2	4	Medium				2	2	4	Medium	09/02/2024	All actions closed and Risk Score Target reached. Ensuring the agreed actions are having the required impact, we continue to monitor the uptake of our key learning and education programmes, including statutory and mandatory training. While we are on an improvement trajectory, if we do not meet our targets this year we will review the associated risk controls and put in place revised mitigations	MacPherson, Anne	People / Workforce	Moderate

[redacted]

Risk Register Template

ID	Title	Description	Cause	Controls in place	Risk Score - Current			Further Controls Required	Action Owner	Due date	Risk Score - Target				Review Notes	Risk Owner	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
					Likelihood	Consequence	Rating / Risk level				Likelihood	Consequence	Rating / Risk level	Last Review Date						

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					Likelihood	Consequence	Risk level				Likelihood	Consequence	Risk level							

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					Risk Score - Current						Risk Score - Target									
ID	Title	Description	Cause	Controls in place	Likelihood	Consequence	Rating	Risk level	Further Controls Required	Action Owner	Due date	Likelihood	Consequence	Rating	Risk level	Last Review Date	Review Notes	Risk Owner	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
[redacted]																					

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ID	Title	Description	Cause	Controls in place	Likelihood	Consequence	Rating	Risk level	Further Controls Required	Action Owner	Due date	Likelihood	Consequence	Rating	Risk level	Last Review Date	Review Notes	Risk Owner	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
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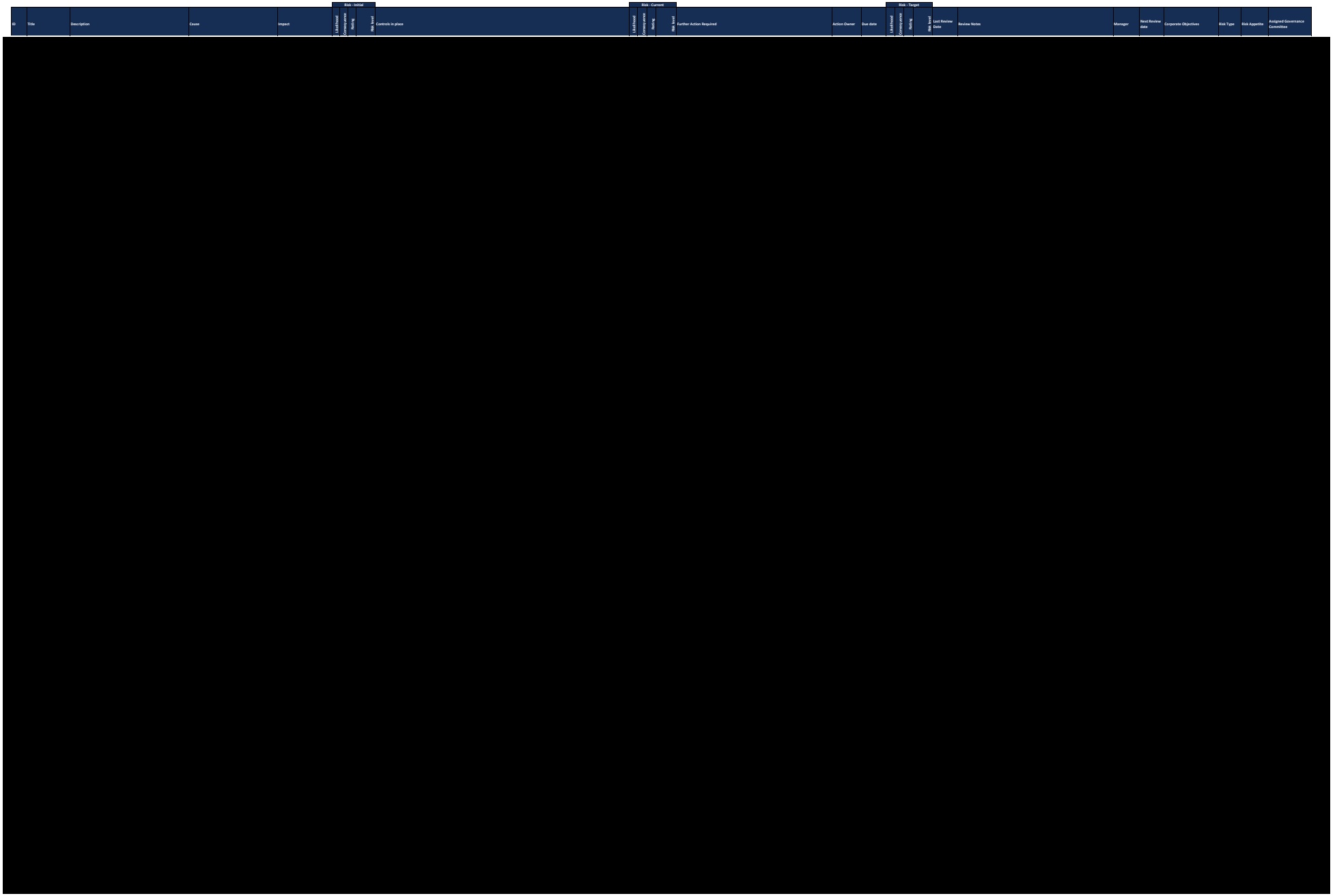
Risk - Initial
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Risk level
Further Action Required
Action Owner
Due date
Likelihood
Consequence
Rating
Risk level
Last Review Date
Review Notes
Manager
Next Review date
Corporate Objectives
Risk Type
Risk Appetite
Assigned Governance Committee

[redacted]

3066	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. New programme for Senior Managers has started. 3. Succession Planning Framework. 4. Equality Action Plan. 5. Medical Management programme introduced. New approach to start by end November. 6. Ready to Lead programme. 7. iMatter response and results; analysis of NHSGGC Board Report; and focus on action planning and sharing success stories across teams. 8. Promotion of culture framework and associated programmes and initiatives. This is now part of the Workforce Strategy and action plan which is BAU. 9. Internal Communication and Employee Engagement Strategy, now approved by NHSGGC Board as at 25/10/22 10. Additional modules on Equalities & Diversity are now part of our leadership programmes. 11. Senior, middle, and medical manager leadership programmes have all been reviewed and are currently being delivered. The Executive Leadership Programme is completed. 12. Application of IIP is underway and includes assessment and development plans for each site cluster. Summative assessments for all clusters running from October 2023 to April 2024. 13. Refreshed approach to Succession Planning now in place. Prioritisation at this stage for Directors and SMT members. Career conversations as part of mid term reviews of PDPs will complete end November. 14. Programme of Collaborative Conversations delivered in 2023 to underpin Investors in People accreditation, with further Conversations taking place in the first quarter of 2024 to better understand iMatter feedback. 15. Success Register has now been implemented and being used to share good practice and show appreciation between staff for excellent work. 16. Civility Saves Lives initiative underway. Champions groups in each IJP Cluster. Civility Leads training starting November 2023.	2	3	6	Medium				2	3	6	Medium	11/04/2024	The range of mitigations and culture change programmes are now all underway and being implemented across the organisation, with our target risk score reached. Going forward, we will gain assurance through the IIP assessment programme taking place in our acute services from November 2023 to May 2024 that these programmes are delivering real change throughout NHSGGC. Key changes since the last update to the Committee include the training package now ready for first cohort of Civility Leads in November 2023 and the Success Register has now been launched. 2024 Internal Comms Employee Engagement Plan (ICEE) is under development and will be reported through our governance in early 2024.	MacPherson, Anne	31/05/2024	Better Workplace - To ensure our people are appropriately trained and developed	People / Workforce	Moderate	Staff Governance Committee
3052	Regulatory body compliance	Failure to achieve and maintain statutory compliance through regulatory bodies	1. Insufficient or inadequate programme of staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance 3. Insufficient authorising persons within the board to sufficiently provide the required two AP's per specialty to ensure sign off of permits and provide resilience.	Adverse publicity / reputation, injury: physical and psychological, Inspection / Audit	4	4	16	High	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.All audits are sent to the Compliance team for recording in the first instance and an action plan is then developed with local teams to address any issues relating to the audit. 7. Asbestos compliance team use contractors to manage ACM's on sites. Risk has been reviewed and no further action required at present.	4	4	16	High	Single building fire risk assessments to be conducted across the entire NHSGGC estate. Authorised Engineer audits conducted for specialist areas i.e. water, ventilation, LV, HV and pressure systems. 1. Sufficient authorised persons to be trained and competency assessed to ensure compliance. 2. Sufficient responsible persons (Water) to be trained and competency assessed to ensure compliance. 3. Competence persons training for technicians.	Cowley, David Riddell, Mark Riddell, Mark	29/03/2024 29/03/2024 29/03/2024	3	3	9	Medium	09/04/2024	Risk has been reviewed and no further action at present time	Steele, Tom	08/04/2024	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Legal	Cautious	Finance, Planning and Performance Committee
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3050	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 FOI&A and Statutory and Mandatory training. 5. Agreed KPIs and performance target trajectories in place for all areas for review at Performance Review Groups (PRGs), Acute Services Committee and HR Commissioning Meetings. (All service managers are responsible for leading activities to address and improve local performance.) 6. Embedded educational governance throughout learning pathways, developing learning with partners and in line with national standards to ensure pathways support workforce skills and capabilities outlined in the Workforce Strategy 7. Key internal profession based career pathways developed as identified in the workforce plan, incorporating key principles of fairness and accessibility	2	2	4	Medium				2	2	4	Medium	11/04/2024	All actions closed and Risk Score Target reached. No further update from last month due to annual leave. Ensuring the agreed actions are having the required impact, we continue to monitor the uptake of our key learning and education programmes, including statutory and mandatory training. While we are on an improvement trajectory, if we do not meet our targets this year we will review the associated risk controls and put in place revised mitigations	MacPherson, Anne	31/05/2024	Better Workplace - To provide a continuously improving and safe working environment	People / Workforce	Moderate	Staff Governance Committee
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Risk Score - Current
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ID
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Description
Cause
Impact
Likelihood
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Rating
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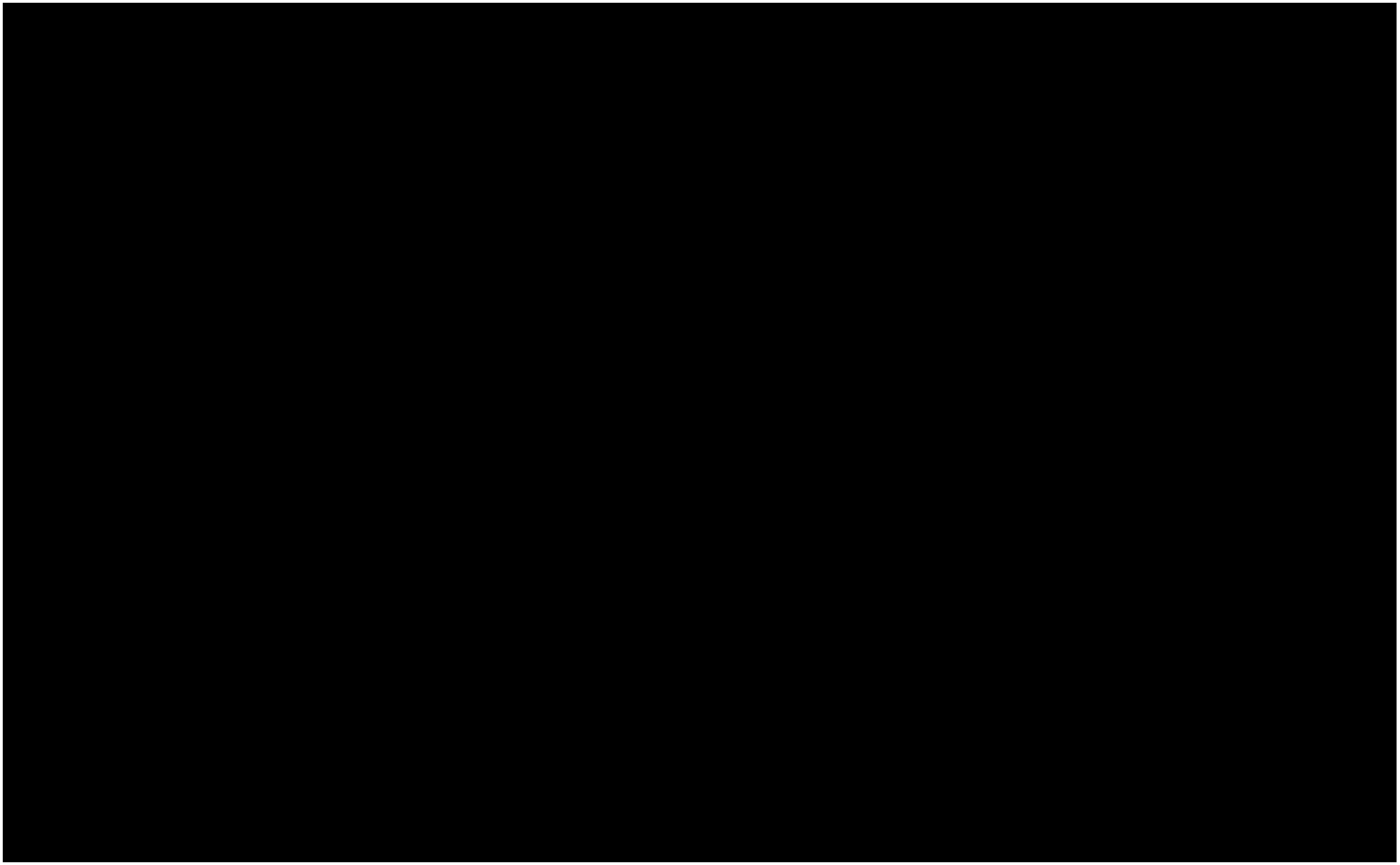
Rating
Risk level
Further Actions Required
Action Owner
Due date
Likelihood
Consequence
Rating
Risk level
Last Review Date
Review Notes
Manager
Corporate Objectives
Risk Type
Risk Appetite
Assigned Governance Committee



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3060	Positive, engaging and diverse culture	Failure to cultivate, promote and enhance a positive, engaging and diverse culture.	1. Lack of overarching workforce strategy and associated policies, procedures and initiatives 2. Strategy not fully implemented 3. Lack of appropriate training, information, instruction and support for staff 4. Lack of sufficient staff engagement with available training, instruction and support packages	Service / Business interruption	4	4	16	High	1. Workforce Strategy. 2. Leadership development programmes. New programme for Senior Managers has started. 3. Succession Planning Framework. 4. Equality Action Plan. 5. Medical Management programme introduced. New approach to start by end November. 6. Review of Ready to Lead programme underway. New programme commencing March 2024. 7. iMatter response and results; analysis of NHSGGC Board Report; and focus on action planning and sharing success stories across teams. 8. Promotion of culture framework and associated programmes and initiatives. This is now part of the Workforce Strategy and action plan which is BAU. 9. Internal Communication and Employee Engagement Strategy, now approved by NHSGGC Board as at 25/10/22 10. Additional modules on Equalities & Diversity are now part of our leadership programmes. 11. Senior, middle, and medical manager leadership programmes have all been reviewed and are currently being delivered. The Executive Leadership Programme is completed. 12. Application of IIP is underway and includes assessment and development plans for each site cluster. Initial assessments of all acute and corporate clusters have been completed with improvement plans in place. IRH and Corporate Cluster now accredited. Summative assessments for remaining clusters running from October 2023 to April 2024. 13. Refreshed approach to Succession Planning now in place. Prioritisation at this stage for Directors and SMT members. Career conversations as part of mid term reviews of PDPs will complete end November. 14. First two phases of Collaborative Conversations complete. As part of newly approved staff internal communications and employee engagement strategy, a third phase is now underway from March 2023. 15. Success Register has now been implemented and being used to share good practice and show appreciation between staff for excellent work. 16. Civility Saves Lives initiative underway. Champions groups in each IJP Cluster. Civility Leads training starting November 2023.	2	3	6	Medium				2	3	6	Medium	13/03/2024	The range of mitigations and culture change programmes are now all underway and being implemented across the organisation, with our target risk score reached. 2024 Internal Comms Employee Engagement Plan (ICEE) is under development and will be reported through our governance in early 2024.	MacPherson, Anne	Better Workplace - To ensure our people are appropriately trained and developed	People / Workforce	Moderate	Staff Governance Committee
3052	Regulatory body compliance	Failure to achieve and maintain statutory compliance through regulatory bodies	1. Insufficient or inadequate programme of staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance 3. Insufficient authorising persons within the board to sufficiently provide the required two AP's per specialty to ensure sign off of permits and provide resilience.	Adverse publicity / reputation, Injury: physical and psychological, Inspection / Audit	4	4	16	High	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. Topics covered are LV, HV, Ventilation, Water MGPS and Pressure Systems, independently reviewed on an annual basis. All audits are sent to the Compliance team for recording in the first instance and an action plan is then developed with local teams to address any issues relating to the audit. 7. Asbestos compliance team use contractors to manage ACM's on sites. All training is co-ordinated via the compliance team who monitor numbers as well as organise training as and when required, a significant spend in 2022/2023 has seen a significant rise in numbers across all disciplines from CPs, APs, RPs etc	4	4	16	High	Single building fire risk assessments to be conducted across the entire NHSGGC estate. Authorised Engineer audits conducted for specialist areas i.e. water, ventilation, LV, HV and pressure systems. 1. Sufficient authorised persons to be trained and competency assessed to ensure compliance. 2. Sufficient responsible persons (Water) to be trained and competency assessed to ensure compliance. 3. Competence persons training for technicians.	Cowley, David Riddell, Mark Riddell, Mark	29/03/2024 29/03/2024 29/03/2024	3	3	9	Medium	13/03/2024	No change to risk.	Steele, Tom	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Legal	Cautious	Finance, Planning and Performance Committee
3059	Staff training and development	Failure to appropriately train and develop NHSGGC staff to enable individuals to deliver their role and responsibilities, or where requirements for key competencies are not identified, developed and achieved.	1. Organisation wide training & development programme(s)that are do not meet identified need/ or are fit for purpose 2. Training & development provision is not effectively implemented and monitored 3. Increased levels of demand for the acquisition of knowledge and skills reduce the available protected time for training 4. Lack of awareness for managers and staff of the availability of training and development opportunities 5. Staff not engaging / taking up available training opportunities	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.) 6. Embedded educational governance throughout learning pathways, developing learning with partners and in line with national standards to ensure pathways support workforce skills and capabilities outlined in the Workforce Strategy 7. Key internal profession based career pathways developed as identified in the workforce plan, incorporating key principles of fairness and accessibility	2	2	4	Medium				2	2	4	Medium	13/03/2024	All actions closed and Risk Score Target reached. Ensuring the agreed actions are having the required impact, we continue to monitor the uptake of our key learning and education programmes, including statutory and mandatory training. While we are on an improvement trajectory, if we do not meet our targets this year we will review the associated risk controls and put in place revised mitigations	MacPherson, Anne	Better Workplace - To provide a continuously improving and safe working environment	People / Workforce	Moderate	Staff Governance Committee

[redacted]

ID	Title	Description	Cause	Impact	Controls in place	Risk - Current				Further Action Requierd	Action Owner	Due date	Risk - Target				Last Review Date	Review Notes	Manager	Review date	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
						Likelihood	Consequence	Rating	Risk Level				Likelihood	Consequence	Rating	Risk Level								
[redacted]																			Crighton, Emilia	10/07/2024	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			Population Health and Wellbeing Committee

[redacted]

					requirements																			
3060	Positive, engaging and diverse culture	Failure to cultivate, promote and enhance a positive, engaging and diverse culture.	1. Lack of overarching workforce strategy and associated policies, procedures and initiatives 2. Strategy not fully implemented 3. Lack of appropriate training, information, instruction and support for staff 4. Lack of sufficient staff engagement with available training, instruction and support packages	Service / Business interruption	1. Workforce Strategy. 2. Leadership development programmes. New programme for Senior Managers has started. 3. Succession Planning Framework. 4. Equality Action Plan. 5. Medical Management programme introduced. New approach to start by end November. 6. Ready to Lead programme. 7. iMatter response and results; analysis of NHSGGC Board Report; and focus on action planning and sharing success stories across teams. 8. Promotion of culture framework and associated programmes and initiatives. This is now part of the Workforce Strategy and action plan which is BAU. 9. Internal Communication and Employee Engagement Strategy, now approved by NHSGGC Board as at 25/10/22 10. Additional modules on Equalities & Diversity are now part of our leadership programmes. 11. Senior, middle, and medical manager leadership programmes have all been reviewed and are currently being delivered. The Executive Leadership Programme is completed. 12. Application of IIP is underway and includes assessment and development plans for each site cluster. Summative assessments for all clusters running from October 2023 to April 2024. 13. Refreshed approach to Succession Planning now in place. Prioritisation at this stage for Directors and SMT members. Career conversations as part of mid term reviews of PDPs will complete end November. 14. Programme of Collaborative Conversations delivered in 2023 to underpin Investors In People accreditation, with further Conversations taking place in the first quarter of 2024 to better understand iMatter feedback. 15. Success Register has now been implemented and being used to share good practice and show appreciation between staff for excellent work. 16. Civility Saves Lives initiative underway. Champions groups in each IiP Cluster. Civility Leads training starting November 2023.	2	3	6	Medium				2	3	6	Medium	10/06/2024	The range of mitigations and culture change programmes are now all underway and being implemented across the organisation, with our target risk score reached. Going forward, we will gain assurance through the IIP assessment programme taking place in our acute services from November 2023 to May 2024 that these programmes are delivering real change throughout NHSGGC. Key changes since the last update to the Committee include the training package now ready for first cohort of Civility Leads in November 2023 and the Success Register has now been launched. 2024 Internal Comms Employee Engagement Plan (ICEE) is under development and will be reported through our governance in early 2024.	MacPherson, Anne	28/06/2024	Better Workplace - To ensure our people are appropriately trained and developed	People / Workforce	Moderate	Staff Governance Committee
[redacted]																								
3052	Regulatory body compliance	Failure to achieve and maintain statutory compliance through regulatory bodies	1. Insufficient or inadequate programme of staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance 3. Insufficient authorising persons within the board to sufficiently provide the required two AP's per specialty to ensure sign off of permits and provide resilience.	Adverse publicity / reputation, Injury: physical and psychological, Inspection / Audit	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.Topics covered are LV, HV, Ventilation, Water MGPS and Pressure Systems, independently reviewed on an annual basis. All audits are sent to the Compliance team for recording in the first instance and an action plan is then developed with local teams to address any issues relating to the audit. 7. Asbestos compliance team use contractors to manage ACM's on sites. All training is co-ordinated via the compliance team who monitor numbers as well as organise training as and when required, a significant spend in 2022/2023 has seen a significant rise in numbers across all disciplines from CPs, APs, RPs etc Risk has been reviewed and no further action required at present.	4	4	16	High	across the entire NHSGGC estate. Authorised Engineer audits conducted for specialist areas i.e. water, ventilation, LV, HV and pressure systems. 1. Sufficient authorised persons to be trained and competency assessed to ensure compliance. 2. Sufficient responsible persons (Water) to be trained and competency assessed to ensure compliance. 3. Competence persons training for technicians. Regular internal and external (SEPA) audits for PPC Permits. Permits currently sitting at "Excellent".	Cowley, David Riddell, Mark Riddell, Mark Riddell, Mark	29/03/2024 29/03/2024 29/03/2024 29/03/2024	3	3	9	Medium	19/06/2024	Detailed risk review ongoing	Steele, Tom	12/07/2024	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Legal	Cautious	Finance, Planning and Performance Committee

[redacted]

New	Public Inquiries, Police Investigations, Fatal Accident Inquiries and other Reviews and Inspections	Public Inquiries, Police Investigations, Fatal Accident Inquiries and other Reviews and Inspections results in an impact on staff wellbeing, public confidence and service delivery.	1. Inquiries including Public Inquiries, Fatal Accident Inquiries, Police / PF Investigations and HIS Inspections (including unannounced) that require significant investment of time amongst a wide range of Clinical and Managerial staff. 2. Significant investment of time required by Staff to participate in processes, which impacts Service Delivery. 3. Challenge of concurrent processes and timing of investigations and inquiries. Volume and quantity of information requests and associated activity is dictated by the Inquiry and is therefore reactive. 4. Timing of investigations and inquiries often involving same Clinical and Corporate staff. 5. Participation in legal process impact on Staff Wellbeing. 6. Public Communications can be issued to external website, without GGC knowledge of release of information.	• Patient Experience • Adverse Publicity/ Reputation • Service / Business Interruption • Financial damage/loss	1. Robust Governance arrangements in place for Public Inquiries (currently 4 ongoing - UK COVID, Scottish COVID Inquiry, Scottish Child Abuse Inquiry, Scottish Hospitals) and FAI (currently 8 ongoing), this includes - a. Dedicated PMO function in place to project manage response to public inquiries, reducing additional responsibilities for existing staff. b. Dedicated governance arrangements in place via EWG, EOG to CMT and upwards. c. Core planning groups established for each discretionary FAI ensuring correct clinical and managerial input, including input from the CLO. This includes close working relationship with Press Office for Communications. d. Focus on Staff welfare - Standard Operating Procedures and guidance in place including online website (Staf Net) which explains the Public Inquiry and FAI process to Staff. e. Unannounced HiS Inspection, (including 3 in April), are managed on a reactive approach and Executive Team provide support to minimise disruption to staff. Work is reprioritised to support with inspection and follow up communication and action. 2. Early planning and early identification of key participants required to support investigations. 3. Regular Liaison with CLO for notification of external issues out with GGC control. Regular updates of changes to FAI dates provided to IFDs in order flex support to meet changing timescales. Planned review meetings where external reports are expected in order to ensure staff availability for review and response. 4.Staff Welfare - Full-time Witness Support function now available to staff, provided by temporary funding support to increase capacity in witness support for staff, who wish to access this support. HR provide Health and Wellbeing guidance. Staff Union Support available. 5. GGC Team (including Comms) review press release and external websites for documentation/communication released in order to provide GGC response and associated Staff comms required. Press team are given advanced notice of known Court and Inquiry dates to inform their events planner.	4	5	20	Very High	1. Review resource required for support in relation to ongoing Inquiries and Investigations. 2. Workload Prioritisation of Corporate Objectives/Key Deliverables within key areas of staff participation to be carried out. 3. Staff - regular review of actions required to support staff and service delivery. 4. Provide regular communications to staff following External Publications in respect of press releases. 5. Provide external support through the Association of Clinical Psychologists UK to Staff. 6. Review options to move to Governance Light structure.	1. Elaine Vanhegan 2. Jane Grant 3. Elaine Vanhegan 4. Sandra Bustillo 5. Anne MacPherson 6. Elaine Vanhegan	1. Jan 2025 2. End June 2024 3. Weekly 4. Monthly, as required - until end of December 2024. 5. June 2024 6. August 2024	3	5	15	High	13/06/2024	Risk review notes - New risk created to reflect impact from ongoing Investigations and Inquiries.	Elaine Vanhegan	10/07/2024	Better Care - To ensure services are timely and accessible to all parts of the community we serve	Reputational	Moderate	Finance, Planning and Performance Committee

Revised Risk

						Risk - Current					Risk - Target										
ID	Title	Description	Cause	Impact	Controls in place	Likelihood	Consequence	Rating	Risk level	Further Action Requierd	Action Owner	Due date	Likelihood	Consequence	Rating	Risk level	Last Review Date	Review Notes	Manager	Review date	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
[redacted]																								

						Risk - Current						Risk - Target										
ID	Title	Description	Cause	Impact	Controls in place	Likelihood	Consequence	Rating	Risk level	Further action required	Responsibility ('To')	Due date	Likelihood	Consequence	Rating	Risk level	Last Review Date	Review Notes	Manager	Review date	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
[redacted]																								

ID	Title	Description	Cause	Impact	Controls in place	Risk - Current				Further Action Requierd	Action Owner	Due date	Risk - Target				Last Review Date	Review Notes	Manager	Review date	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
						Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level								
[redacted]																								

ID	Title	Description	Cause	Impact	Controls in place	Risk Score - Current				Further Controls Required	Action Owner	Due date	Risk Score - Target				Last Review Date	Review Notes	Manager	Review Date	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
						Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level								
[redacted]																								

ID	Title	Description	Cause	Impact	Controls in place	Risk - Current				Further Action Requierd	Action Owner	Due date	Risk Score - Target				Last Review Date	Review Notes	Manager	Review date	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
						Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level								
[redacted]																								

ID	Title	Description	Cause	Impact	Controls in place	Risk Score - Current				Further Controls Required	Action Owner	Due date	Risk Score - Target				Last Review Date	Review Notes	Manager	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
						Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level							
[redacted]																							

ID	Title	Further Action Requierd	Action Owner	Due date
[redacted]				

ID	Title	Further Action Requierd	Action Owner	Due date
[redacted]				
New	Public Inquiries, Police Investigations, Fatal Accident Inquiries and other Reviews and Inspections	1. Review resource required for support in relation to ongoing Inquiries and Investigations.	1. Elaine Vanhegan	1. Jan 2025
		2. Workload Prioritisation of Corporate Objectives/Key Deliverables within key areas of staff participation to be carried out.	2. Jane Grant	2. End June 2024
		3. Staff - regular review of actions required to support staff and service delivery.	3. Elaine Vanhegan	3. Weekly
		4. Provide regular communications to staff following External Publications in respect of press releases.	4. Sandra Bustillo	4. Monthly, as required until end of December
		5. Provide external support through the Association of Clinical Psychologists UK to Staff.	5. Anne MacPherson	5. June 2024
		6. Review options to move to Governance Light structure.	6. Elaine Vanhegan	6. August 2024

ID	Title	Description	Cause	Impact	Risk - Initial				Controls in place	Risk - Current				Further Action Required	Action Owner	Due date	Risk - Target				Last Review Date	Review Notes	Manager	Review date	Corporate Objectives	Risk Type	Risk Appetite	Directorate admitted	Assigned Governance Committee
					Likelihood	nsequence	Rating	Risk level		Likelihood	nsequence	Rating	Risk level				Likelihood	nsequence	Rating	Risk level									
[redacted]																													
[redacted]																													
[redacted]																													

[redacted]

																				Monitor and deliver the Non-Pay PID for 24/25	Thomson, John	31/03/2025								

[redacted]

3060	Positive, engaging and diverse culture	Failure to cultivate, promote and enhance a positive, engaging and diverse culture.	1. Lack of overarching workforce strategy and associated policies, procedures and initiatives 2. Strategy not fully implemented 3. Lack of appropriate training, information, instruction and support for staff 4. Lack of sufficient staff engagement with available training, instruction and support packages	Service / Business interruption	4	4	16	High	1. Workforce Strategy. 2. Leadership development programmes. New programme for Senior Managers has started. 3. Succession Planning Framework. 4. Equality Action Plan. 5. Medical Management programme introduced. New approach to start by end November. 6. Ready to Lead programme. 7. Matter response and results; analysis of NHSGGC Board Report; and focus on action planning and sharing success stories across teams. 8. Promotion of culture framework and associated programmes and initiatives. This is now part of the Workforce Strategy and action plan which is BAU. 9. Internal Communication and Employee Engagement Strategy, now approved by NHSGGC Board as at 25/10/22 10. Additional modules on Equalities & Diversity are now part of our leadership programmes. 11. Senior, middle, and medical manager leadership programmes have all been reviewed and are currently being delivered. The Executive Leadership Programme is completed. 12. Application of IIP is underway and includes assessment and development plans for each site cluster. Summative assessments for all clusters running from October 2023 to April 2024. 13. Refreshed approach to Succession Planning now in place. Prioritisation at this stage for Directors and SMT members. Career conversations as part of mid term reviews of PDPs will complete end November.	2	3	6	Medium				2	3	6	Medium	######	The range of mitigations and culture change programmes are now all underway and being implemented across the organisation, with our target risk score reached. Going forward, we will gain assurance through the IIP assessment programme taking place in our acute services from November 2023 to May 2024 that these programmes are delivering real change throughout NHSGGC. Civility Leads are rolling out and the Success Register has now been launched. 2024 Internal Comms Employee Engagement Plan (ICEE) has been approved and is being implemented across 2024.	MacPherson, Anne	######	Better Workplace - To ensure our people are appropriately trained and developed	People / Workforce	Moderate	Human Resources	Staff Governance Committee

										14. Programme of Collaborative Conversations delivered in 2023 to underpin investors in People accreditation, with further Conversations taking place in the first quarter of 2024 to better understand iMatter feedback. 15. Success Register has now been implemented and being used to share good practice and show appreciation between staff for excellent work.																	
3816	Public Inquiries, Police Investigations, Fatal Accident Inquiries and other Reviews and Inspections	Public Inquiries, Police Investigations, Fatal Accident Inquiries and other Reviews and Inspections impacts on staff wellbeing, public confidence and service delivery.	1. Inquiries including Public Inquiries, Fatal Accident Inquiries, Police / PF Investigations and HIS Inspections (including unannounced) that require significant investment of time amongst a wide range of Clinical and Managerial staff. 2. Significant investment of time required by Staff to participate in processes, which impacts Service Delivery. 3. Challenge of concurrent processes and timing of investigations and inquiries. Volume and quantity of information requests and associated activity is dictated by the Inquiry and is therefore reactive. 4. Timing of investigations and inquiries often involving same Clinical and Corporate staff. 5. Participation in legal process impact on Staff Wellbeing. 6. Public Communications can be issued to external website, without GGC knowledge of release of information.	Adverse publicity / reputation, Financial: including damage / loss / fraud, Patient experience, Service / Business interruption	5	5	25	Very High	1. Robust Governance arrangements in place for Public Inquiries (currently 4 ongoing - UK COVID, Scottish COVID Inquiry, Scottish Child Abuse Inquiry, Scottish Hospitals) and FAI (currently 8 ongoing), this includes - a. Dedicated PMO function in place to project manage response to public inquiries, reducing additional responsibilities for existing staff. b. Dedicated governance arrangements in place via EWG, EOG to CMT and upwards. c. Core planning groups established for each discretionary FAI ensuring correct clinical and managerial input, including input from the CLO. This includes close working relationship with Press Office for Communications. d. Focus on Staff welfare - Standard Operating Procedures and guidance in place including online website (Staff Net) which explains the Public Inquiry and FAI process to Staff. e. Unannounced HIS Inspection, (including 3 in April), are managed on a reactive approach and Executive Team provide support to minimise disruption to staff. Work is reprioritised to support with inspection and follow up communication and action. 2. Early planning and early identification of key participants required to support investigations. 3. Regular Liaison with CLO for notification of external issues out with GGC control. Regular updates of changes to FAI dates provided to IFDs in order flex support to meet changing timescales. Planned review meetings where external reports are expected in order to ensure staff availability for review and response. 4.Staff Welfare - Full-time Witness Support function now available to staff, provided by temporary funding support to increase capacity in witness support for staff, who wish to access this support. HR provide Health and Wellbeing guidance. Staff Union Support available. 5. GGC Team (including Comms) review press release and external websites for documentation/communication released in order to provide GGC response and associated Staff comms required. Press team are given advanced notice of known Court and Inquiry dates to inform their events planner.	4	5	20	Very High	1. Review resource required for support in relation to ongoing Inquiries and Investigations. 2. Workload Prioritisation of Corporate Objectives/Key Deliverables within key areas of staff participation to be carried out. 3. Staff - regular review of actions required to support staff and service delivery. 4. Provide regular communications to staff following External Publications in respect of press releases. 5. Provide external support through the Association of Clinical Psychologists UK to Staff.	Vanhegan, Elaine Vanhegan, Elaine Vanhegan, Elaine Vanhegan, Elaine Vanhegan, Elaine	31/01/2025 30/06/2024 20/12/2024 20/12/2024 30/06/2024	3	5	15	High	######	New risk created in May 2024 to reflect impact from ongoing Investigations and Inquiries.	Vanhegan, Elaine	######	Better Care - To ensure services are timely and accessible to all parts of the community we serve	Reputational	Moderate	Corporate Services/Nursing	Finance, Planning and Performance Committee
[redacted]																												
3052	Regulatory body compliance	Failure to achieve and maintain statutory compliance through regulatory bodies	1. Insufficient or inadequate programme of staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance 3. Insufficient authorising persons within the board to sufficiently provide the required two AP's per specialty to ensure sign off of permits and provide resilience.	Adverse publicity / reputation, Injury: physical and psychological, Inspection / Audit	4	4	16	High	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.15.01.24 Mark Riddell Update: Topics covered are LV, HV, Ventilation, Water MGPS and Pressure Systems, independently reviewed on an annual basis. All audits are sent to the Compliance team for recording in the first instance and an action plan is then developed with local teams to address any issues relating to the audit. 7. Asbestos compliance team use contractors to manage ACM's on sites.15.01.24 Mark Riddell Update: Nicholas Elliott and John Conroy both have P405 training along with a number of Estates personnel, Nick has the S301 also and is classed as a Competent Certified Person. All training is co-ordinated via the compliance team who monitor numbers as well as organise training as and when required, a significant spend in 2022/2023 has seen a significant rise in numbers across all disciplines from CPs, APs, RPs etc Risk has been reviewed and no further action required at present.	4	4	16	High	Single building fire risk assessments to be conducted across the entire NHSGGC estate. Authorised Engineer audits conducted for specialist areas i.e. water, ventilation, LV, HV and pressure systems. 1. Sufficient authorised persons to be trained and competency assessed to ensure compliance. 2. Sufficient responsible persons (Water) to be trained and competency assessed to ensure compliance. 3. Competence persons training for technicians. Regular internal and external (SEPA) audits for PPC Permits. Permits currently sitting at "Excellent".	Cowley, David Riddell, Mark Riddell, Mark Riddell, Mark	29/03/2024 29/03/2024 29/03/2024 29/03/2024	3	3	9	Medium	######	Risk has been reviewed and no further action at present time	Steele, Tom	######	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Legal	Cautious	Facilities/Estates	Finance, Planning and Performance Committee
[redacted]																												
3052	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	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.) 6. Embedded educational governance throughout learning pathways, developing learning with partners and in line with national standards to ensure pathways support workforce skills and capabilities outlined in the Workforce Strategy 7. Key internal profession based career pathways developed as identified in the workforce plan, incorporating key principles of fairness	2	2	4	Medium			2	2	4	Medium	######	All actions closed and Risk Score Target reached. No further update from last month. Ensuring the agreed actions are having the required impact, we continue to monitor the uptake of our key learning and education programmes, including statutory and mandatory training. While we are on an improvement trajectory, if we do not meet our targets this year we will review the associated risk controls and put in place revised mitigations	Macpherson, Anne	######	Better Workplace - To provide a continuously improving and safe working environment	People / Workforce	Moderate	Human Resources	Staff Governance Committee
[redacted]																												

ID	Title	Description	Cause	Impact	Controls in place	Risk - Current				Further Action Required	Action Owner	Due date	Risk - Target				Last Review Date	Review Notes	Manager	Review date
						Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level				
[redacted]																				

ID	Title	Description	Cause	Impact	Controls in place	Risk - Current				Further Action Required	Action Owner	Due date	Risk - Target				Last Review Date	Review Notes	Manager	Review date
						Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level				
[redacted]																				

ID	Title	Further Action Required	Action Owner	Due date	Notes
[redacted]					

ID	Title	Further Action Required	Action Owner	Due date	Notes
[redacted]					
3816	Public Inquiries, Police Investigations, Fatal Accident Inquiries and other Reviews and Inspections	1. Review resource required for support in relation to ongoing Inquiries and Investigations.	Vanhegan, Elaine	31/01/2025	
		2. Workload Prioritisation of Corporate Objectives/Key Deliverables within key areas of staff participation to be carried out.	Vanhegan, Elaine	30/06/2024	
		3. Staff - regular review of actions required to support staff and service delivery.	Vanhegan, Elaine	20/12/2024	
		4. Provide regular communications to staff following External Publications in respect of press releases.	Vanhegan, Elaine	20/12/2024	
		5. Provide external support through the Association of Clinical Psychologists UK to Staff.	Vanhegan, Elaine	30/06/2024	
		6. Review options to move to Governance Light structure.	Vanhegan, Elaine	30/08/2024	
[redacted]					

ID	Title	Further Action Required	Action Owner	Due date	Notes
		[redacted]			

Key:	
	Action Complete
	Action overdue <1month
	Action overdue >1 month
	Action due date change request

ID	Title	Description	Cause	Impact	Controls in place	Risk - Current				Further Action Required	Action Owner	Due date	Risk - Target				Last Review Date	Review Notes	Risk Owner	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
						Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level							
3051	Ageing infrastructure	The ageing infrastructure across the estate will continue to raise operational and financial issues which could result in service disruption and impact on patient care	1. Lack of risk based business continuity plan identifying priority areas for investment in order to maintain business as usual in the current estate 2. Lack of sufficient 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 and pressure systems. 3. Current delivery model is based upon reactive maintenance of assets and not asset lifecycle. 4. Increased reactive maintenance results in additional financial costs and additional risks associated with ageing infrastructure. 5. Aged infrastructure unable to meet ongoing changes to clinical requirements that results in additional and unplanned financial impact and non-compliance e.g. reduced-ligature. 6. Building structures unable to flex/modify (due to structure/fabric) to suit modern treatment methods without extensive modification incurring excessive cost. 7. New and emerging change to building conditions results in additional investigations/surveys and subsequent repair. 8. Changes to SHTM (Scottish Health Technical Memorandum) that results in additional and unplanned financial impact and non-compliance. 9. Lack of sufficient staff resource to identify, plan and manage the required investment works. Potential for skills gap to emerge through aged assets in relation to apprentice training. Staff retention is an area with hard requirement	Adverse publicity / reputation, Financial: including damage / loss / fraud, Injury: physical and psychological, Patient experience, Service / Business interruption, Staffing and competence	1. Allocation of funding is prioritised focussing on statutory maintenance, service contracts, and reactive maintenance. Reactive model based upon run to fail, repair is assessed upon impact of failure. Statutory maintenance is reported through FM first and AE (Authorised Engineer) audits. Purchasing is through pecos against Delegation of Authorities. Cross boundary maintenance team support is in place. 2. Minor works support mechanism is in place to allocate funding for backlog maintenance/emergency works based upon risk, on a Board wide approach. 3. Aged infrastructure is discussed at forums/Governance Structures highlighting identified risks e.g. BICC, AICC, BVSG. 4. Strategic Asset Management System SAMS identifies building and condition surveys and associated risk. Quarterly meeting between SAMS Team and local Estates Team, where this information is discussed and confirmed and a High Risk report is created. This information is shared with Estates Team for action management. Property and asset team carry out an annual review of SAMS. The output of SAMS is then transferred into an annual NHS Scotland Assets & Facilities Report (Fleet, medical equipment and office accommodation) (SAFR) which is submitted to SG. 5. SAMS inspection capture defects through building condition surveys through 3rd party contractors. Management surveys are carried out for asbestos surveys, this is managed through Compliance estates for pre 2000 buildings. IPC carry out review and audits of estate. HIS Audits for compliance against Clinical Standards, with actions identified to drive compliance e.g. room layout. Enhanced supervision within high risk areas. 6. Escalation process is in place for AIPF (Asset Investment Prioritisation Forum)/Capital Planning Group (CPG) to assess priority based upon submitted requests. This only deals with requests submitted and does not capture a holistic approach. output of AIPF includes reports provided to Governance Committees on spend. The backlog of maintenance tasks are reviewed and prioritised on a regular basis via AIPF and is delivered within budget constraints. 7. Critical spares in place for a selection of high priority assets. 8. An estates review report to the Property & Asset Strategy Group was completed in 2019 as a status report on work completed. 9. Asset disposal /derelict buildings - GGC risk assessed list to prioritise asset disposal and demolition of buildings to reduce costs. 10. Current plan in place for RAAC - high risk areas have been completed and no RAAC had been identified. 11. Prioritised list from SRDG (Suicide Risk Design Group) of reduced-ligature actions plans to be implemented. 12. External Contractors carry out service and condition based reports, that identify actions required and risk level. Authorised engineer on specialist subject (water, pressure, medical gas, HV, LV, decontamination and ventilation) will make recommendations on suitability on plant (no costs included), based upon requirements of SHTM. 13. Visibility of any changes to SHTM that are being proposed, through engagement at NHS Assure SHTM meetings, via various forums. AE audits of SHTM are assigned to smart sheets, this is then prioritised through a risk based approach to assign funding. 14. Training is monitored on an ongoing basis through Estates Compliance Team. Staff development is currently in place through Estates career pathway including apprentices. In-house training in place. Robust recruitment is in place. Additional 3rd party contractor support for maintenance in addition to on call maintenance teams.	4	5	20	Very High	1. Data - review data from systems and processes and how they are prioritised for decision making. Process/Hierarchy to be developed and rolled out. (Capital and Operational Estates). 3. Maintenance plan to be reviewed based upon funding plan for 2024. (Capital and Minor Works) 4. Maintenance investment strategy (SG) - Maintenance Business continuity plan (EAMS prioritisation) to be produced (Oct to Board 24 ,Jan to 2025 to SG) based on Boards infrastructure to mitigate inherent risk 5. Review of Estates workforce structure to deliver ongoing Estates strategy (Capital, Property and Estates) based upon funding levels. 6. Whole system planning (SG) - Review maintenance investment strategy in line with MFT (Moving Forward Together). 7. Review options for additional cross boundary working of maintenance teams 8. Implement recommendations from annual prioritised plan for ligature reduction to be completed. (annual rolling plan). 9. Review of Governance Structures following development of Maintenance BCP. 10. Complete RAAC surveys for low and medium risk areas.	Riddell, Mark Steele, Tom Love, Gordon Riddell, Mark Riddell, Mark Bain, Donald Huddleston, James Riddell, Mark Love, Gordon	31/10/2024 30/04/2024 30/08/2024 30/09/2024 28/02/2025 30/09/2024 31/03/2025 28/06/2024 30/04/2024	3	3	9	Medium	06/08/2024	Risk has been reviewed and no further action at present time	Steele, Tom	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Operating	Open	Finance, Planning and Performance Committee
[redacted]										Develop BCP (Capital and Current Infrastructure) plans across NHS GGC inline with Moving Forward Together	Steele, Tom	31/01/2025	3	4	12	High							

ID	Title	Description	Cause	Impact	Controls in place	Risk - Current				Further Action Required	Action Owner	Due date	Risk - Target				Last Review Date	Review Notes	Risk Owner	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
						Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level							
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ID	Title	Description	Cause	Impact	Controls in place	Risk - Current				Further Action Required	Action Owner	Due date	Risk - Target				Last Review Date	Review Notes	Risk Owner	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
						Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level							
[redacted]																							
3060	Positive, engaging and diverse culture	Failure to cultivate, promote and enhance a positive, engaging and diverse culture.	1. Lack of overarching workforce strategy and associated policies, procedures and initiatives 2. Strategy not fully implemented 3. Lack of appropriate training, information, instruction and support for staff 4. Lack of sufficient staff engagement with available training, instruction and support packages	Service / Business interruption	1. Workforce Strategy. 2. Leadership development programmes. New programme for Senior Managers has started. 3. Succession Planning Framework. 4. Equality Action Plan. 5. Medical Management programme introduced. New approach to start by end November. 6. Ready to Lead programme. 7. iMatter response and results; analysis of NHSGGC Board Report; and focus on action planning and sharing success stories across teams. 8. Promotion of culture framework and associated programmes and initiatives. This is now part of the Workforce Strategy and action plan which is BAU. 9. Internal Communication and Employee Engagement Strategy, now approved by NHSGGC Board as at 25/10/22 10. Additional modules on Equalities & Diversity are now part of our leadership programmes. 11. Senior, middle, and medical manager leadership programmes have all been reviewed and are currently being delivered. The Executive Leadership Programme is completed. 12. Application of IIP is underway and includes assessment and development plans for each site cluster. Summative assessments for all clusters running from October 2023 to April 2024. 13. Refreshed approach to Succession Planning now in place. Prioritisation at this stage for Directors and SMT members. Career conversations as part of mid term reviews of PDPs will complete end November. 14. Programme of Collaborative Conversations delivered in 2023 to underpin Investors In People accreditation, with further Conversations taking place in the first quarter of 2024 to better understand iMatter feedback. 15. Success Register has now been implemented and being used to share good practice and show appreciation between staff for excellent work. 16. Civility Saves Lives initiative underway. Champions groups in each IIP Cluster. Civility Leads training started November 2023.	2	3	6	Medium				2	3	6	Medium	15/08/2024	2024 Internal Comms Employee Engagement Plan (ICEE) has been approved and is being implemented across 2024.	MacPherson, Anne	Better Workplace - To ensure our people are appropriately trained and developed	People / Workforce	Moderate	Staff Governance Committee
[redacted]																							

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						Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level							
[redacted]																							
3052	Regulatory body compliance	Failure to achieve and maintain statutory compliance through regulatory bodies	1. Insufficient or inadequate programme of staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance 3. Insufficient authorising persons within the board to sufficiently provide the required two AP's per specialty to ensure sign off of permits and provide resilience.	Adverse publicity / reputation, Injury: physical and psychological, Inspection / Audit	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.15.01.24 Mark Riddell Update: Topics covered are LV, HV, Ventilation, Water MGPS and Pressure Systems, independently reviewed on an annual basis. All audits are sent to the Compliance team for recording in the first instance and an action plan is then developed with local teams to address any issues relating to the audit. 7. Asbestos compliance team use contractors to manage ACM's on sites.15.01.24 Mark Riddell Update: Nicholas Elliott and John Conroy both have P405 training along with a number of Estates personnel, Nick has the S301 also and is classed as a Competent Certified Person. All training is co-ordinated via the compliance team who monitor numbers as well as organise training as and when required, a significant spend in 2022/2023 has seen a significant rise in numbers across all disciplines from CPs, APs, RPs etc Risk has been reviewed and no further action required at present.	4	4	16	High	Single building fire risk assessments to be conducted across the entire NHSGGC estate. Authorised Engineer audits conducted for specialist areas i.e. water, ventilation, LV, HV and pressure systems. 1. Sufficient authorised persons to be trained and competency assessed to ensure compliance. 2. Sufficient responsible persons (Water) to be trained and competency assessed to ensure compliance. 3. Competence persons training for technicians. Regular internal and external (SEPA) audits for PPC Permits. Permits currently sitting at "Excellent".	Cowley, David Riddell, Mark Riddell, Mark Riddell, Mark	29/03/2024 29/03/2024 29/03/2024 29/03/2024	3	3	9	Mediu m	06/08/2024	Risk has been reviewed and no further action at present time	Steele, Tom	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Legal	Cautious	Finance, Planning and Performance Committee
[redacted]																							
	development	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.	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	interruption	for job family to enable data to be available for corporate recording and performance monitoring. 2. Identification of training that is agreed as statutory and mandatory for the organisation. 3. Completion of core statutory and mandatory training is recorded on learning management systems that enable data to be available for corporate reporting and performance monitoring via Microstrategy Monitoring of Statutory and Mandatory Training compliance, 4. Agreement of performance targets and KPIs for PDP&R and Statutory and Mandatory training. 5. Agreed KPIs and performance target trajectories in place for all areas for review at Performance Review Groups (PRGs), Acute Services Committee and HR Commissioning Meetings. (All service managers are responsible for leading activities to address and improve local performance.) 6. Embedded educational governance throughout learning pathways, developing learning with partners and in line with national standards to ensure pathways support workforce skills and capabilities outlined in the Workforce Strategy 7. Key internal profession based career pathways developed as identified in the workforce plan, incorporating key principles of fairness and accessibility				m						m		month. Ensuring the agreed actions are having the required impact, we continue to monitor the uptake of our key learning and education programmes, including statutory and mandatory training. While we are on an improvement trajectory, if we do not meet our targets this year we will review the associated risk controls and put in place revised mitigations	Anne	provide a continuously improving and safe working environment	Workforce		Governance Committee
[redacted]																							

Risk ID	Title	Synopsis	Action Owner	Due date
[redacted]				
3816	Public Inquiries, Police Investigations, Fatal Accident Inquiries and other Reviews and Inspections	1. Review resource required for support in relation to ongoing Inquiries and Investigations.	Vanhegan, Elaine	31/01/2025
		2. Workload Prioritisation of Corporate Objectives/Key Deliverables within key areas of staff participation to be carried out.	Vanhegan, Elaine	30/06/2024
		3. Staff - regular review of actions required to support staff and service delivery.	Vanhegan, Elaine	20/12/2024
		4. Provide regular communications to staff following External Publications in respect of press releases.	Vanhegan, Elaine	20/12/2024
		5. Provide external support through the Association of Clinical Psychologists UK to Staff.	Vanhegan, Elaine	30/06/2024
		6. Review options to move to Governance Light structure.	Vanhegan, Elaine	30/08/2024
[redacted]				

Key:
- Action Complete
- Action overdue <1month
- Action overdue >1 month
- Action due date change request

Revised wording

ID	Title	Description	Cause	Impact	Controls in place	Risk - Current				Further Controls Required
						Likelihood	Consequence	Rating	Risk level	
[redacted]										

Original Text

ID	Title	Description	Cause	Impact	Controls in place	Likelihood	onsequence	Rating	Risk level	Further Controls Required
[redacted]										

			Risk - Target						
Action owner	Action Due date	Action Completed Date	Likelihood	Consequence	Rating	Risk level	Last Review Date	Review Notes	Manager
[redacted]									

Action owner	Action Due date	Action Completed Date	Likelihood	Consequence	Rating	Risk level	Last Review Date	Review Notes	Manager
[redacted]									

						Risk - Current								Risk - Target										
ID	Title	Description	Cause	Impact	Controls in place	Likelihood	Consequence	Rating	Risk level	Further Action Required	Action Owner	Due date	Likelihood	Consequence	Rating	Risk level	Last Review Date	Review Notes	Risk Owner	Corporate Objectives	Risk Type	Risk Appetite	Directorate admitted	Assigned Governance Committee
3051	Ageing infrastructure	The ageing infrastructure across the estate will continue to raise operational and financial issues which could result in service disruption and impact on patient care	1. Lack of risk based business continuity plan identifying priority areas for investment in order to maintain business as usual in the current estate 2. Lack of sufficient 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 and pressure systems. 3. Current delivery model is based upon reactive maintenance of assets and not asset lifecycle. 4. Increased reactive maintenance results in additional financial costs and additional risks associated with ageing infrastructure. 5. Aged infrastructure unable to meet ongoing changes to clinical requirements that results in additional and unplanned financial impact and non-compliance e.g. reduced-ligature. 6. Building structures unable to flex/modify (due to structure/fabric) to suit modern treatment methods without extensive modification incurring excessive cost. 7. New and emerging change to building conditions results in additional investigations/surveys and subsequent repair. 8. Changes to SHTM (Scottish Health Technical Memorandum) that results in additional and unplanned financial impact and non-compliance. 9. Lack of sufficient staff resource to identify, plan and manage the required investment works. Potential for skills gap to emerge through aged assets in relation to apprentice training. Staff retention in an area with aged environment.	Adverse publicity / reputation, Financial: including damage / loss / fraud, Injury: physical and psychological, Patient experience, Service / Business interruption, Staffing and competence	1. Allocation of funding is prioritised focussing on statutory maintenance, service contracts, and reactive maintenance. Reactive model based upon run to fail, repair is assessed upon impact of failure. Statutory maintenance is reported through FM first and AE (Authorised Engineer) audits. Purchasing is through pecos against Delegation of Authorities. Cross boundary maintenance team support is in place. 2. Minor works support mechanism is in place to allocate funding for backlog maintenance/emergency works based upon risk, on a Board wide approach. 3. Aged infrastructure is discussed at forums/Governance Structures highlighting identified risks e.g. BICC, AICC, BVSG. 4. Strategic Asset Management System SAMS identifies building and condition surveys and associated risk. Quarterly meeting between SAMS Team and local Estates Team, where this information is discussed and confirmed and a High Risk report is created. This information is shared with Estates Team for action management. Property and asset team carry out an annual review of SAMS. The output of SAMS is then transferred into an annual NHS Scotland Assets & Facilities Report (Fleet, medical equipment and office accommodation) (SAFR) which is submitted to SG. 5. SAMS inspection capture defects through building condition surveys through 3rd party contractors. Management surveys are carried out for asbestos surveys, this is managed through Compliance estates for pre 2000 buildings. IPC carry out review and audits of estate. HIS Audits for compliance against Clinical Standards, with actions identified to drive compliance e.g. room layout. Enhanced supervision within high risk areas. 6. Escalation process is in place for AIPF (Asset Investment Prioritisation Forum)/Capital Planning Group (CPG) to assess priority based upon submitted requests. This only deals with requests submitted and does not capture a holistic approach. output of AIPF includes reports provided to Governance Committees on spend. The backlog of maintenance tasks are reviewed and prioritised on a regular basis via AIPF and is delivered within budget constraints. 7. Critical spares in place for a selection of high priority assets. 8. An estates review report to the Property & Asset Strategy Group was completed in 2019 as a status report on work completed. 9. Asset disposal /derelict buildings - GGC risk assessed list to prioritise asset disposal and demolition of buildings to reduce costs. 10. Current plan in place for RAAC - high risk areas have been completed and no RAAC had been identified. 11. Prioritised list from SRDG (Suicide Risk Design Group) of reduced-ligature actions plans to be implemented. 12. External Contractors carry out service and condition based reports, that identify actions required and risk level. Authorised engineer on specialist subject (water, pressure, medical gas, HV, LV, decontamination and ventilation) will make recommendations on suitability on plant (no costs included), based upon requirements of SHTM. 13. Visibility of any changes to SHTM that are being proposed, through engagement at NHS Assure SHTM meetings, via various forums. AE audits of SHTM are assigned to smart sheets, this is then prioritised through a risk based approach to assign funding. 14. Training is monitored on an ongoing basis through Estates Compliance Team. Staff development is currently in place through Estates career pathway including apprentices. In-house training in place. Robust recruitment is in place. Additional 3rd party contractor support for maintenance in addition to on call maintenance teams.	4	5	20	Very High	1. Data - review data from systems and processes and how they are prioritised for decision making. Process/Hierarchy to be developed and rolled out. (Capital and Operational Estates).	Riddell, Mark	31/10/2024	3	3	9	Medium	10/09/2024	10.09.24 Risk has been reviewed and currently no action required however works are progressing at pace on the Business Continuity Plan.	Steele, Tom	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Operating	Open	Facilities/Estates	Finance, Planning and Performance Committee
										3. Maintenance plan to be reviewed based upon funding plan for 2024. (Capital and Minor Works)	Steele, Tom	30/04/2024												
										4. Maintenance investment strategy (SG) - Maintenance Business continuity plan (EAMS prioritisation) to be produced (Oct to Board 24 ,Jan to 2025 to SG) based on Boards infrastructure to mitigate inherent risk	Love, Gordon	30/09/2024												
										5. Review of Estates workforce structure to deliver ongoing Estates strategy (Capital, Property and Estates) based upon funding levels.	Riddell, Mark	30/09/2024												
										6. Whole system planning (SG) - Review maintenance investment strategy in line with MFT (Moving Forward Together).	Riddell, Mark	28/02/2025												
										7. Review options for additional cross boundary working of maintenance teams	Bain, Donald	30/09/2024												
										8. Implement recommendations from annual prioritised plan for ligature reduction to be completed. (annual rolling plan).	Huddleston, James	31/03/2025												
										9. Review of Governance Structures following development of Maintenance BCP.	Riddell, Mark	28/06/2024												
										10. Complete RAAC surveys for low and medium risk areas.	Love, Gordon	30/04/2024												

[redacted]

ID	Title	Description	Cause	Impact	Controls in place	Risk - Current				Further Action Required	Action Owner	Due date	Risk - Target				Last Review Date	Review Notes	Risk Owner	Corporate Objectives	Risk Type	Risk Appetite	Directorate admitted	Assigned Governance Committee
						Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level								
[redacted]																								

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						Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level								
3060	Positive, engaging and diverse culture	Failure to cultivate, promote and enhance a positive, engaging and diverse culture.	1. Lack of overarching workforce strategy and associated policies, procedures and initiatives 2. Strategy not fully implemented 3. Lack of appropriate training, information, instruction and support for staff 4. Lack of sufficient staff engagement with available training, instruction and support packages	Service / Business interruption	*1. Workforce Strategy. 2. Leadership development programmes including programme for Senior Managers. 3. Succession Planning Framework. 4. Equality Action Plan. 5. Medical Management programme introduced. 6. Ready to Lead programme. 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, approved by NHSGGC Board on 25/10/22 10. Additional modules on Equalities & Diversity are now part of our leadership programmes. 11. Senior, middle, and medical manager leadership programmes have all been reviewed and are currently being delivered. The Executive Leadership Programme is completed. 12. IIP accreditation achieved June 2024, with Cluster groups driving forward improvements. 13. Refreshed approach to Succession Planning now in place. 14. Programme of Collaborative Conversations delivered in 2023 to underpin Investors In People accreditation, with further Conversations taking place over 2024 to better understand iMatter feedback. 15. Success Register has now been implemented and being used to share good practice and show appreciation between staff for excellent work. 16. Civility Saves Lives initiative underway. Champions groups in each IIP Cluster with a network of Civility Leads now in place and growing.	2	3	6	Medium				2	3	6	Medium	12/09/2024	The range of mitigations and culture change programmes are now all underway and being implemented across the organisation, with our target risk score reached. We have additional assurance through the IIP assessment programme which took place in our acute services from November 2023 to May 2024 - that these programmes are delivering real change throughout NHSGGC. Recommendations from the assessments will form action plans being taken forward by the Cluster Groups. Civility Leads are rolling out and the Success Register has now been launched. 2024 Internal Comms Employee Engagement Plan (ICEE) has been approved and is being implemented across 2024.	MacPherson, Anne	Better Workplace - To ensure our people are appropriately trained and developed	People / Workforce	Moderate	Human Resources	Staff Governance Committee

						Risk - Current					Risk - Target												
ID	Title	Description	Cause	Impact	Controls in place	Likelihood	Consequence	Rating	Risk level	Further Action Required	Action Owner	Due date	Likelihood	Consequence	Rating	Risk level	Last Review Date	Review Notes	Risk Owner	Corporate Objectives	Risk Type	Risk Appetite	Directorate admitted	Assigned Governance Committee
3816	Public Inquiries, Police Investigations, Fatal Accident Inquiries and other Reviews and Inspections	Public Inquiries, Police Investigations, Fatal Accident Inquiries and other Reviews and Inspections impacts on staff wellbeing, public confidence and service delivery.	1. Inquiries including Public Inquiries, Fatal Accident Inquiries, Police / PF Investigations and HIS Inspections (including unannounced) that require significant investment of time amongst a wide range of Clinical and Managerial staff. 2. Significant investment of time required by Staff to participate in processes, which impacts Service Delivery. 3. Challenge of concurrent processes and timing of investigations and inquiries. Volume and quantity of information requests and associated activity is dictated by the Inquiry and is therefore reactive. 4. Timing of investigations and inquiries often involving same Clinical and Corporate staff. 5. Participation in legal process impact on Staff Wellbeing. 6. Public Communications can be issued to external website, without GGC knowledge of release of information.	Adverse publicity / reputation, Financial: including damage / loss / fraud, Patient experience, Service / Business interruption	1. Robust Governance arrangements in place for Public Inquiries (currently 4 ongoing - UK COVID, Scottish COVID Inquiry, Scottish Child Abuse Inquiry, Scottish Hospitals) and FAI (currently 8 ongoing), this includes - a. Dedicated PMO function in place to project manage response to public inquiries, reducing additional responsibilities for existing staff. b. Dedicated governance arrangements in place via EWG, EOG to CMT and upwards. c. Core planning groups established for each discretionary FAI ensuring correct clinical and managerial input, including input from the CLO. This includes close working relationship with Press Office for Communications. d. Focus on Staff welfare - Standard Operating Procedures and guidance in place including online website (Staff Net) which explains the Public Inquiry and FAI process to Staff. e. Unannounced HIS Inspection, (including 3 in April), are managed on a reactive approach and Executive Team provide support to minimise disruption to staff. Work is reprioritised to support with inspection and follow up communication and action. 2. Early planning and early identification of key participants required to support investigations. 3. Regular Liaison with CLO for notification of external issues out with GGC control. Regular updates of changes to FAI dates provided to IFDs in order flex support to meet changing timescales. Planned review meetings where external reports are expected in order to ensure staff availability for review and response. 4.Staff Welfare - Full-time Witness Support function now available to staff, provided by temporary funding support to increase capacity in witness support for staff, who wish to access this support. HR provide Health and Wellbeing guidance. Staff Union Support available. 5. GGC Team (including Comms) review press release and external websites for documentation/communication released in order to provide GGC response and associated Staff comms required. Press team are given advanced notice of known Court and Inquiry dates to inform their events planner.	4	5	20	Very High	1. Review resource required for support in relation to ongoing Inquiries and Investigations.	Vanhegan, Elaine	31/01/2025	3	5	15	High	11/09/2024	Sept 24- No changes to risk, controls remain in place. Glasgow III Hearing has commenced and will run until mid November 2024.	Vanhegan, Elaine	Better Care - To ensure services are timely and accessible to all parts of the community we serve	Reputational	Moderate	Corporate Services/Nursing	Finance, Planning and Performance Committee
										2. Workload Prioritisation of Corporate Objectives/Key Deliverables within key areas of staff participation to be carried out.	Vanhegan, Elaine	30/06/2024												
										3. Staff - regular review of actions required to support staff and service delivery.	Vanhegan, Elaine	20/12/2024												
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										6. Review options to move to Governance Light structure.	Vanhegan, Elaine	30/08/2024												
[redacted]																								
3052	Regulatory body compliance	Failure to achieve and maintain statutory compliance through regulatory bodies	1. Insufficient or inadequate programme of staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance 3. Insufficient authorising persons within the board to sufficiently provide the required two AP's per specialty to ensure sign off of permits and provide resilience.	Adverse publicity / reputation, Injury: physical and psychological, Inspection / Audit	1. Fire risk assessments 2. Environmental PPC Permits in place at two facilities namely, GRI & QEUH. Environmental Authorisations (Scotland) Regulations (EASR) Permits in place across seven sites for nuclear waste. 3. High level Environmental Legal Register in place to monitor relevant environmental legislation applicable to the Board. 4.Estate Asset Management System (EAMs) 5. Statutory Compliance Audit and Risk Tool (SCART) 6. Topic specific Authorised Persons (AP) and Authorised Engineer oversight and audit. 7. Asbestos compliance team use contractors to manage ACM's on sites All training is co-ordinated via the compliance team who monitor numbers as well as organise training as and when required, a significant spend in 2022/2023 has seen a significant rise in numbers across all disciplines from CPs, APs, RPs etc Risk has been reviewed and no further action required at present.	4	4	16	High	Single building fire risk assessments to be conducted across the entire NHSGGC estate.	Cowley, David	29/03/2024	3	3	9	Medium	10/09/2024	10.09.24 risk has been reviewed and no further action at present time.	Steele, Tom	Better Value - To utilise and improve our capital assets to support the reform of healthcare	Legal	Cautious	Facilities/Estates	Finance, Planning and Performance Committee
										Authorised Engineer audits conducted for specialist areas i.e. water, ventilation, LV, HV and pressure systems.	Riddell, Mark	29/03/2024												
										1. Sufficient authorised persons to be trained and competency assessed to ensure compliance. 2. Sufficient responsible persons (Water) to be trained and competency assessed to ensure compliance. 3. Competence persons training for technicians.	Riddell, Mark	29/03/2024												
[redacted]																								
3059	Staff training and development	Failure to appropriately train and develop NHSGGC staff to enable individuals to deliver their role and responsibilities, or where requirements for key competencies are not identified, developed and achieved.	1. Organisation wide training & development programme(s)that are do not meet identified need/ or are fit for purpose 2. Training & development provision is not effectively implemented and monitored 3. Increased levels of demand for the acquisition of knowledge and skills reduce the available protected time for training 4. Lack of awareness for managers and staff of the availability of training and development opportunities 5. Staff not engaging / taking up available training opportunities	Service / Business interruption	1. Annual Reviews for all staff to discuss PDP, objectives and agree support. Conversations to be agreed and recorded on the appropriate system for job family to enable data to be available for corporate recording and performance monitoring. 2. Identification of training that is agreed as statutory and mandatory for the organisation. 3. Completion of core statutory and mandatory training is recorded on learning management systems that enable data to be available for corporate reporting and performance monitoring via Microstrategy Monitoring of Statutory and Mandatory Training compliance, 4. Agreement of performance targets and KPIs for PDP&R and Statutory and Mandatory training. 5. Agreed KPIs and performance target trajectories in place for all areas for review at Performance Review Groups (PRGs), Acute Services Committee and HR Commissioning Meetings. (All service managers are responsible for leading activities to address and improve local performance.) 6. Embedded educational governance throughout learning pathways, developing learning with partners and in line with national standards to ensure pathways support workforce skills and capabilities outlined in the Workforce Strategy 7. Key internal profession based career pathways developed as identified in the workforce plan, incorporating key principles of fairness and accessibility	2	2	4	Medium				2	2	4	Medium	16/08/2024	All actions closed and Risk Score Target reached. No further update from last month. Ensuring the agreed actions are having the required impact, we continue to monitor the uptake of our key learning and education programmes, including statutory and mandatory training. While we are on an improvement trajectory, if we do not meet our targets this year we will review the associated risk controls and put in place revised mitigations	MacPherson, Anne	Better Workplace - To provide a continuously improving and safe working environment	People / Workforce	Moderate	Human Resources	Staff Governance Committee
[redacted]																								

ID	Title	Description	Cause	Impact	Controls in place	Risk - Current				Further Action Required	Action Owner	Due date	Risk - Target				Last Review Date	Review Notes	Risk Owner	Corporate Objectives	Risk Type	Risk Appetite	Directorate admitted	Assigned Governance Committee
						Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level								
					[redacted]																			

Revised Wording

ID	Title	Description	Cause	Impact	Controls in place	Risk - Current				Further Action Required	Action Owner	Due date	Risk - Target				Last Review Date	Review Notes	Risk Owner	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
						Likelihood	onsequence	Rating	Risk level				Likelihood	onsequence	Rating	Risk level							
[redacted]																							

Original Wording

ID	Title	Description	Cause	Impact	Controls in place	Risk - Current				Further Action Required	Action Owner	Due date	Risk - Target				Last Review Date	Review Notes	Risk Owner	Corporate Objectives	Risk Type	Risk Appetite	Assigned Governance Committee
						Likelihood	Consequence	Rating	Risk level				Likelihood	Consequence	Rating	Risk level							
[redacted]																							

Risk ID	Title	Further Action Required	Action Owner	Due date	Comments
[redacted]					
		1. Confirmation of Non-recurring Funding /Capital funding - confirmation of 15 actions pending and development of agreed way forward, working with Executive Leads [redacted]	MacArthur, Claire [redacted]	28/06/2024 [redacted]	[redacted]
[redacted]					

[redacted]

3816	Public Inquiries, Police Investigations, Fatal Accident Inquiries and other Reviews and Inspections	1. Review resource required for support in relation to ongoing Inquiries and Investigations	Vanhegan, Elaine	31/01/2025	
		2. Workload Prioritisation of Corporate Objectives/Key Deliverables within key areas of staff participation to be carried out	Vanhegan, Elaine	30/06/2024	
		3. Staff - regular review of actions required to support staff and service delivery.	Vanhegan, Elaine	20/12/2024	
		4. Provide regular communications to staff following External Publications in respect of press releases	Vanhegan, Elaine	20/12/2024	
		5. Provide external support through the Association of Clinical Psychologists UK to Staff	Vanhegan, Elaine	30/06/2024	
		6. Review options to move to Governance Light structure.	Vanhegan, Elaine	30/08/2024	Governance light was agreed at the June Board meaning cancelled (population health and wellbeing and acute serv back BAUb

[redacted]

ID	Title	Description	Cause	Controls in place	Risk Score - Current				Risk Score - Target				Last Review Date	Review Notes	Manager	Risk Appetite	Assigned Governance Committee
					Likelihood	Consequence	Rating	Risk level	Likelihood	Consequence	Rating	Risk level					
[redacted]																	

ID	Title	Description	Cause	Controls in place	Risk Score - Current				Risk Score - Target				Last Review Date	Review Notes	Manager	Risk Appetite	Assigned Governance Committee
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ID	Title	Description	Cause	Controls in place	Risk Score - Current				Risk Score - Target				Last Review Date	Review Notes	Manager	Risk Appetite	Assigned Governance Committee
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ID	Title	Description	Cause	Controls in place	Risk Score - Current				Risk Score - Target				Last Review Date	Review Notes	Manager	Risk Appetite	Assigned Governance Committee
					Likelihood	Consequence	Rating	Risk level	Likelihood	Consequence	Rating	Risk level					
[redacted]																	
3060	Positive, engaging and diverse culture	Failure to develop and maintain a positive, engaging and diverse culture in which staff are treated fairly, consistently with dignity and respect, inline with NHS Scotland values.	1. Lack of overarching strategies and associated policies, procedures and initiatives 2. Strategies/policies, procedures and initiatives not fully implemented across all areas. 3. Lack of appropriate training, information, instruction and support for staff 4. Insufficient staff engagement with available training, instruction and support packages, through non-attendance. 5. Behaviours not inline with NHS Scotland values and GGC Policies. 6. Ineffective reporting mechanisms or willingness to report workforce issues (e.g. psychological safety). 7. Action not taken following issues identified 8. Complexity of GGC organisation leading to inconsistent leadership and messages. 9. Equality, Diversity and Inclusivity not embedded in all practices	1. Strategies - Overarching MFT (Moving Forward Together) Strategy which is underpinned by a suite of Corporate Strategies, which inform NHS GGC Policies, Plans and Development programmes. 2. Strategy implementation - Strategies are accompanied by an action plan which are translated into the Corporate Delivery Plan. Deliverables are then communicated as Objectives for Executives and Senior Managers as part of annual objective setting and appraisal process. • HSE Stress Tool communicated to teams for use. • Achieved IIP accreditation in June 2024 • Annual Workforce Equality Action Plan, monitored via the Workforce Equality Group. 3. Training - • Suite of online and tutor led training available to all staff. • Statutory and Mandatory Training manged via LeanPro - including Equalities Training. Completion is tracked and monitored. • GMC Medical Training is in place. • Leadership Development Programmes and resources are in place through TURAS and LearnPro, which are assigned via PDP or through Self Learning. New programme for Senior Managers commenced 2024. Feedback gathered from delegates has been used to inform further development required. • Ready to Lead programme has been in place and revised version is planned to commence in 24/25. 4. Training attendance - • Statutory and Mandatory training is monitored, and managed through PDP review and 1-2-1. • Additional training initiatives are tracked to ensure attendance. • Protected learning time is in place for staff to attend mandatory training. 5. Behaviours - • Policies and processes in place - Conduct Policy, Bullying and Harassment Policy. Grievance policy • Civility Saves Lives initiative commenced which involves a Champions groups in each IiP Cluster. • Civility Leads training commenced November 2023.. • HR Support and advice Unit with bullying and harassment dedicated line. • Success register to formally thank staff to support a culture of appreciation for good work is now in place and subject to regular review. • Cut it Out - Sexual Harrassment Campaign rolled out in 2024 including posters, training session to drive a zero tolerance culture on sexual harrassment. 6. Reporting Mechanisms - • Line Manager support is available for issues to be identified and managed. Escalation process is available via Line Manager's Manager. • A number of options are available for escalation of concerns - Speak Up, Civility Leads for all staff, Trade Unions, Occupational Health, Staff Partnership, Trade Union, Confidential Contacts, Whistleblowing, and Peer Support. The output from these are tracked for themes and reported through Governance Committees. • imatter, IIP, collaborative conversation , staff led equality forums and through trade union and p[partnership - outputs drive strategy. Themes and data emerging from collaborative conversations and IiP assessment are used to determine future strategy. • Escalation route for Site or Board wide issues from iMatter results. • Consolidated development plan for iMatter and IIP plans for Directorates, through IIP cluster workforce groups ensuring all issues are captured in one plan. 7. Once for Scotland Policies and escalation routes for staff to raise issues as noted in control above. Confidential contacts or whistleblowing in addition to the escalation routes above are additional routes for staff to raise complaints where issues raised have not been addressed and have exhausted previous routes. 8. Leadership programmes are in place that support a consistency of culture and leadership behaviours for example New Medical Management programme in place • Communication - Core briefs, Corporate comms provide consistent information to all Staff. • Internal Communication and Employee Engagement Strategy has been developed. • Senior Management Programme 2023 and 2024 to develop consistent Leadership approaches across GGC. 9. Equalities, Diversity and Inclusivity are now part of our leadership programmes. Annual workforce equality group action plan in place, which includes training and awareness. A number of groups have been created to embed EDI in all practices, these include - . Staff led equality groups, Non-Executive equality champions, Staff Experience Team. Equalities Human Rights Team. • Mandatory Learnpro Training for all staff for EDI	2	4	8	Medium	2	3	6	Medium	09/10/2024	Risk has undergone a full review including description, causes, control, score and actions. The impact was reassessed and increased from 2 x 3 = 6 to 2 x 4 = 8. The likelihood remains at 2 due to the current controls in place, including the recent Cut It Out Sexual Harrassment Campaign.	MacPherson, Anne	Moderate	Staff Governance Committee
3816	Public Inquiries, Police Investigations, Fatal Accident Inquiries and other Reviews and Inspections	Public Inquiries, Police Investigations, Fatal Accident Inquiries and other Reviews and Inspections impacts on staff wellbeing, public confidence and service delivery.	1. Inquiries including Public Inquiries, Fatal Accident Inquiries, Police / PF Investigations and HIS Inspections (including unannounced) that require significant investment of time amongst a wide range of Clinical and Managerial staff. 2. Significant investment of time required by Staff to participate in processes, which impacts Service Delivery. 3. Challenge of concurrent processes and timing of investigations and inquiries. Volume and quantity of information requests and associated activity is dictated by the Inquiry and is therefore reactive. 4. Timing of investigations and inquiries often involving same Clinical and Corporate staff. 5. Participation in legal process impact on Staff Wellbeing. 6. Public Communications can be issued to external website, without GGC knowledge of release of information.	1. Robust Governance arrangements in place for Public Inquiries (currently 4 ongoing - UK COVID, Scottish COVID Inquiry, Scottish Child Abuse Inquiry, Scottish Hospitals) and FAI (currently 8 ongoing), this includes - a. Dedicated PMO function in place to project manage response to public inquiries, reducing additional responsibilities for existing staff. b. Dedicated governance arrangements in place via EWG, ECG to CMT and upwards. c. Core planning groups established for each discretionary FAI ensuring correct clinical and managerial input, including input from the CLO. This includes close working relationship with Press Office for Communications. d. Focus on Staff welfare - Standard Operating Procedures and guidance in place including online website (Staff Net) which explains the Public Inquiry and FAI process to Staff. e. Unannounced HIS Inspection, (including 3 in April), are managed on a reactive approach and Executive Team provide support to minimise disruption to staff. Work is reprioritised to support with inspection and follow up communication and action. 2. Early planning and early identification of key participants required to support investigations. 3. Regular Liaison with CLO for notification of external issues out with GGC control. Regular updates of changes to FAI dates provided to IFDs in order flex support to meet changing timescales. Planned review meetings where external reports are expected in order to ensure staff availability for review and response. 4.Staff Welfare - Full-time Witness Support function now available to staff, provided by temporary funding support to increase capacity in witness support for staff, who wish to access this support. HR provide Health and Wellbeing guidance. Staff Union Support available. 5. GGC Team (including Comms) review press release and external websites for documentation/communication released in order to provide GGC response and associated Staff comms required. Press team are given advanced notice of known Court and Inquiry dates to inform their events planner. 6. Chief Operating Officer has been identified as lead to support the ED review.	4	5	20	Very High	3	5	15	High	10/10/2024	Oct 24- Risk reviewed and noted at FP&P Committee that controls remain in place and effective. Additional control (No6) added to note that lead identified for ED review.	Vanhegan, Elaine	Moderate	Finance, Planning and Performance Committee
[redacted]																	

ID	Title	Description	Cause	Controls in place	Risk Score - Current				Risk Score - Target				Last Review Date	Review Notes	Manager	Risk Appetite	Assigned Governance Committee
					Likelihood	Consequence	Rating	Risk level	Likelihood	Consequence	Rating	Risk level					
[redacted]																	
3052	Regulatory body compliance	Failure to achieve and maintain statutory compliance through regulatory bodies	1. Insufficient or inadequate programme of staff training instruction and information 2. Inadequate internal control and oversight processes to prevent and detect instances of non-compliance 3. Insufficient authorising persons within the board to sufficiently provide the required two AP's per specialty to ensure sign off of permits and provide resilience.	1. Fire risk assessments 2. Environmental PPC Permits in place at two facilities namely, GRI & QEUH. Environmental Authorisations (Scotland) Regulations (EASR) Permits in place across seven sites for nuclear waste. 3. High level Environmental Legal Register in place to monitor relevant environmental legislation applicable to the Board. 4.Estate Asset Management System (EAMs) 5. Statutory Compliance Audit and Risk Tool (SCART) 6. Topic specific Authorised Persons (AP) and Authorised Engineer oversight and audit.15.01.24 Mark Riddell Update: Topics covered are LV, HV, Ventilation, Water MGPS and Pressure Systems, independently reviewed on an annual basis. All audits are sent to the Compliance team for recording in the first instance and an action plan is then developed with local teams to address any issues relating to the audit. 7. Asbestos compliance team use contractors to manage ACM's on sites.15.01.24 Mark Riddell Update: Nicholas Elliott and John Conroy both have P405 training along with a number of Estates personnel, Nick has the S301 also and is classed as a Competent Certified Person. All training is co-ordinated via the compliance team who monitor numbers as well as organise training as and when required, a significant spend in 2022/2023 has seen a significant rise in numbers across all disciplines from CPs, APs, RPs etc Risk has been reviewed and no further action required at present.	4	4	16	High	3	3	9	Medium	01/10/2024	Risk has been reviewed and currently no action required.	Steele, Tom	Cautious	Finance, Planning and Performance Committee
[redacted]																	

ID	Title	Further Action Required	Action Owner	Due date	Completed	Comments
[redacted]						

ID	Title	Further Action Required	Action Owner	Due date	Completed Date	Comments
		[redacted]	[redacted]	[redacted]		
3060	Positive, engaging and diverse culture	1. Implementation of 2024 Internal Comms Employee Engagement Plan (ICEE)	1. Liam Spence,	1. 01/03/2025		
		2. Commence Middle Management Leadership Programme to replace (Ready To Lead) Leadership accelerator (May 25).	2. Doug Mann	2. 01/04/2025		
		3. Launch of Team Talk communication process	3. Neil, McSeveny	3. 01/11/2024		
		4. Workforce Strategy for 2025 - 30 to be developed	4. Anne MacPherson	4. 01/02/2025		
		5. Introduction of Board Subcommittee for overseeing EDI	5. Elaine Vanhegan	5. 28/02/2025		
		6. Commence roll out EDI Tutor led programme for all Managers (2 year plan)	6. Liam Spence	6. 31/12/2024		
3816	Public Inquiries, Police Investigations, Fatal Accident Inquiries and other Reviews and Inspections	1. Review resource required for support in relation to ongoing Inquiries and Investigations.	Vanhegan, Elaine	31/01/2025		
		2. Workload Prioritisation of Corporate Objectives/Key Deliverables within key areas of staff participation to be carried out.	Vanhegan, Elaine	30/06/2024		
		3. Staff - regular review of actions required to support staff and service delivery.	Vanhegan, Elaine	20/12/2024		
[redacted]						
3059	Mandatory Staff training and development	1. Deliver Governance Review Structure and core modules process	1. MacDonald, Moira.	1. 30/03/2025		
		2. Review Process for Monitoring and management of Training -	2. MacDonald, Moira	2. 30/03/2025		
[redacted]						
3052	Regulatory body compliance	Single building fire risk assessments to be conducted across the entire NHSGGC estate.	Cowley, David	29/03/2024		QEUH SBFRA has been drafted in Sept 2024. Five SBFRA remain to be completed on new system which are Labs, Neonatal, Podiatry, Neuro and new Victoria Hospital. Two are planned for October/November. Delay to action completion due to 6month delay in Fire Safety Management System. Note - detailed review ongoing which includes all actions, therefore actions have not been included in action KPI's this month.
		Authorised Engineer audits conducted for specialist areas i.e. water, ventilation, LV, HV and pressure systems.	Riddell, Mark	29/03/2024		
		1. Sufficient authorised persons to be trained and competency assessed to ensure compliance. 2. Sufficient responsible persons (Water) to be trained and competency assessed to ensure compliance. 3. Competence persons training for technicians.	Riddell, Mark	29/03/2024		
		Regular internal and external (SEPA) audits for PPC Permits.	Riddell, Mark	29/03/2024		

Key:
- Action Complete
- Action overdue <1month
- Action overdue >1 month
- Action due date change request

Revised Wording

ID	Title	Description	Cause	Impact	Controls in place	Risk Score - C		
						Likelihood	Consequence	Rating
3059	Mandatory Staff training and development	Failure to appropriately train and develop NHSGGC staff to enable individuals to deliver their role and responsibilities safely.	1. Organisation wide mandatory training & development programme(s) that do not meet identified need/ or are fit for purpose - • Roles and responsibilities are not clearly defined. • key competencies are not defined. • Training & development provision is not effectively implemented. • Mandatory training is not defined for all levels. 2. Monitoring of training is not effective across GGC. 3. Training is not accessible for all staff. 4. Staff fail to attend available training opportunities. 5. Lack of awareness for managers and staff of the availability of training and development opportunities	Service / Business interruption, Injury, Staffing & Competence	1. Core Statutory and Mandatory training for all GGC staff is agreed by the CMT and monitored by the Statutory and Mandatory Training Group • Completion of core statutory and mandatory training is recorded on learning management systems. • Direct notifications are issued monthly to the member of staff, line manager and service of any outstanding training. Staff members are notified via email for any overdue training or training due within the next 3 months. Line Manager is provided with a report for all direct reports training status by module. • Source data also provides workforce story boards and is incorporated into monthly reports provided to multiple forums (H&S Forum, SMT's and CMT) for review and action • KPIs and performance target trajectories are in place for all staff 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.) • Subject Matter Experts (SME's) design and review training content to ensure material meets legislative requirement and criteria in each profession where appropriate • Core content is made available online through Learnpro learning management system. This is designed to ensure disability accessibility options are adhered to. Digital access is available through onsite libraries should direct access to PC or other digital devices not be available. Face to face training is available should digital access not be available or is required to meet service logistics. Digital access and literacy support is noted within the Board Digital Strategy. • Clear Trajectories set for Compliance with Statutory and Mandatory Training. 2. Monitoring of Training - • The H&S Policy clearly identifies the Safety, Health and Wellbeing (SHaW) roles and responsibilities for Directors, Managers and Staff. This is to ensure that individuals and teams respond to SHaW priorities, are trained and understand requirements. • Monthly tasks covering audit and training are alerted to managers for action via the SHaW task calendar • Personal Development Plans form part of the 3 appraisal systems in place to cover all staff: Agenda for Change staff (system: Turas Appraisal AfC), Medical & Dental staff (system: SOAR) and Executives & Senior managers (system: Turas Appraisal ESM). • Turas Appraisal provides a comprehensive real time dashboard for reviewers and managers. • Performance for Medical & Dental is monitored by Medical Director and Executives and Senior Managers through the Remuneration Committee. 3. Accessibility of Training - • The Induction Portal identifies steps for all staff and then by profession. • Core statutory and mandatory training is assigned to all roles in learnpro at the point of joining the organisation. • Doctors in training are directly supported through Medical Education and access to training is provided to new trainees in FY1 posts prior to their start date (Preparation for Practice) 4. Attendance at Training • Business Conduct Code - states requirement and consequences for non-attendance and following of training. • Staff PDP is in place and includes review of Training. 5. Awareness of Training - • There are pages on HR Connect, Induction Portal, Statutory and Mandatory Training, SHaW which outline training requirements. • Target core briefs are used for SHaW or subject specific training. Staff Net Hub is new and work underway with eHealth to explore how best to use this site for internal staff information and communications.	3	4	12

Original Wording

ID	Title	Description	Cause	Impact	Controls in place	Risk Score - C		
						Likelihood	Consequence	Rating
3059	Staff training and development	Failure to appropriately train and develop NHSGGC staff to enable individuals to deliver their role and responsibilities, or where requirements for key competencies are not identified, developed and achieved.	1. Organisation wide training & development programme(s)that are do not meet identified need/ or are fit for purpose 2. Training & development provision is not effectively implemented and monitored 3. Increased levels of demand for the acquisition of knowledge and skills reduce the available protected time for training 4. Lack of awareness for managers and staff of the availability of training and development opportunities 5. Staff not engaging / taking up available training opportunities	Service / Business interruption	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 Micro strategy Monitoring of Statutory and Mandatory Training compliance, 4. Agreement of performance targets and KPIs for PDP&R and Statutory and Mandatory training. 5. Agreed KPIs and performance target trajectories in place for all areas for review at Performance Review Groups (PRGs), Acute Services Committee and HR Commissioning Meetings. (All service managers are responsible for leading activities to address and improve local performance.) 6. Embedded educational governance throughout learning pathways, developing learning with partners and in line with national standards to ensure pathways support workforce skills and capabilities outlined in the Workforce Strategy 7. Key internal profession based career pathways developed as identified in the workforce plan, incorporating key principles of fairness and accessibility	2	2	4

urrent				Risk Score - Target							
Risk level	Futher Action required	Action Owner	Due date	Likelihood	Consequence	Rating	Risk level	Review Notes	Manager	Corporate Objectives	Assigned Governance Committee
High	1. Deliver Governance Review Structure and core modules process	1. MacDonald, Moira.	1. 30/03/2025	2	2	4	Medium	Risk has been fully reviewed including all causes, controls and actions. Risk has been rescored and has been increased from a 2 (Likelihood) x 3 (Impact) = 6 (Medium) to a 3 (likelihood) x 4 (impact) = 12 (High) - this takes into account the focus on stat mandatory training. There is a current focus to have 90% achieved and this is being progressed by each Director.	MacPherson, Anne	Better Workplace - To provide a continuously improving and safe working environment	Staff Governance Committee
	2. Review Process for Monitoring and Management of Training.	2. MacDonald, Moira	2. 30/03/2025								

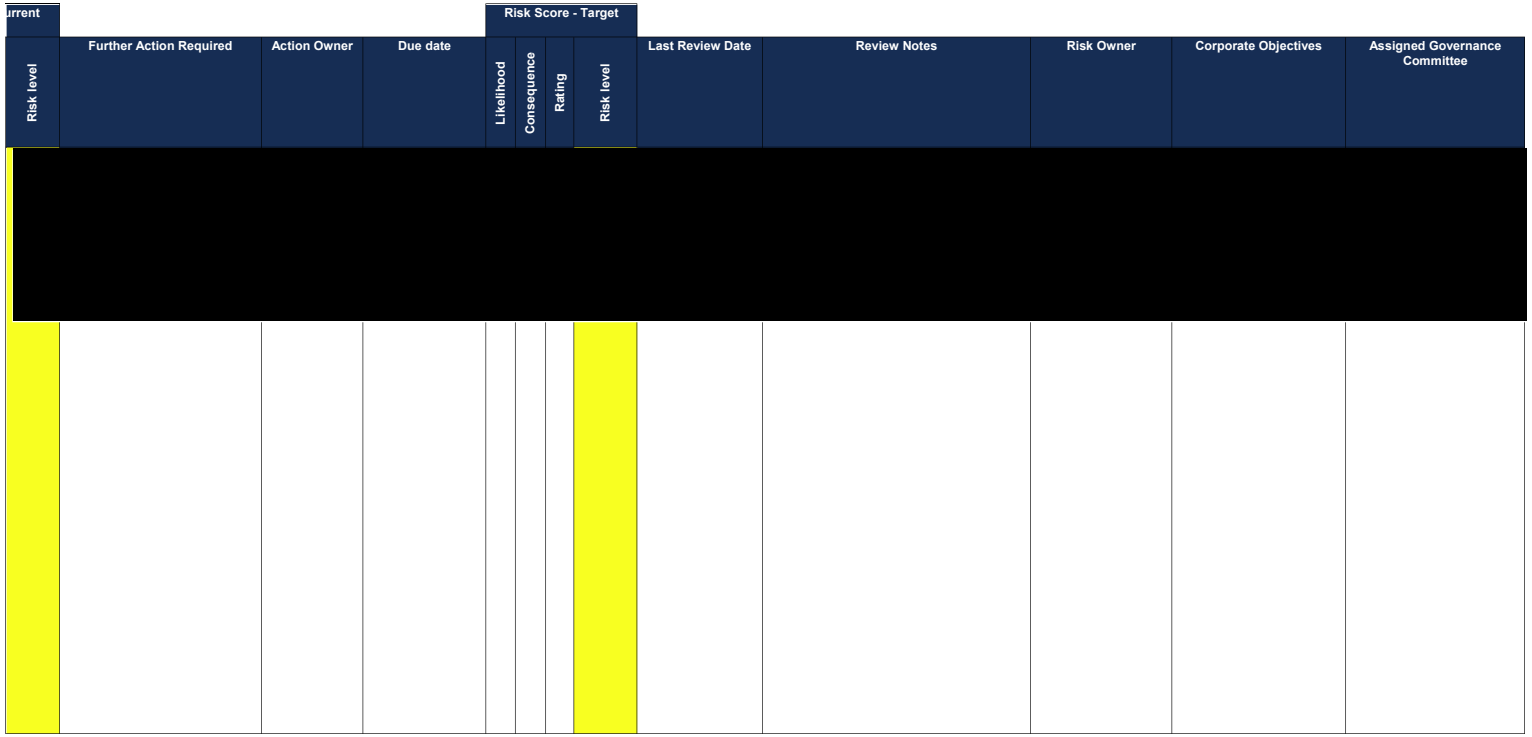
urrent				Risk Score - Target							
Risk level	Futher Action required	Action Owner	Due date	Likelihood	Consequence	Rating	Risk level	Review Notes	Manager	Corporate Objectives	Assigned Governance Committee
Medium				2	2	4	Medium	All actions closed and Risk Score Target reached. No further update from last month. Ensuring the agreed actions are having the required impact, we continue to monitor the uptake of our key learning and education programmes, including statutory and mandatory training. While we are on an improvement trajectory, if we do not meet our targets this year we will review the associated risk controls and put in place revised mitigations	MacPherson, Anne	Better Workplace - To provide a continuously improving and safe working environment	Staff Governance Committee

Revised Wording

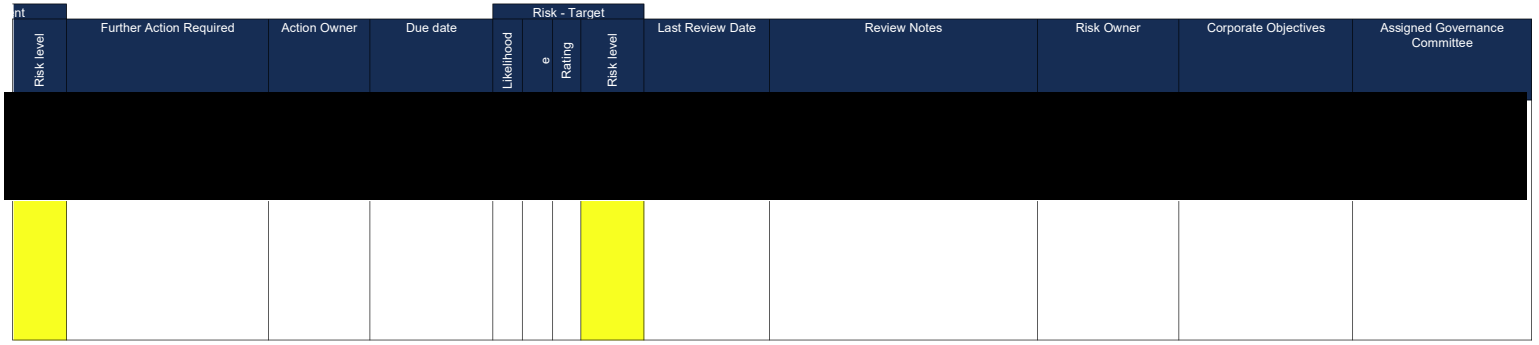
ID	Title	Description	Cause	Controls in place	Risk Score - C		
					Likelihood	onsequence	Rating
[redacted]							

Original Wording

ID	Title	Description	Cause	Controls in place	Risk - Curre		
					ikelihood	onsequenc e	Rating
[redacted]							



urrent				Risk Score - Target								
Risk level	Further Action Required	Action Owner	Due date	Likelihood	Consequence	Rating	Risk level	Last Review Date	Review Notes	Risk Owner	Corporate Objectives	Assigned Governance Committee
[redacted]												



nt				Risk - Target								
Risk level	Further Action Required	Action Owner	Due date	Likelihood	e	Rating	Risk level	Last Review Date	Review Notes	Risk Owner	Corporate Objectives	Assigned Governance Committee
[redacted]												

Revised Wording

ID	Title	Description	Cause	Impact	Controls in place	Risk Score - Current			
						Likelihood	Consequence	Rating	Risk level
3060	Positive, engaging and diverse culture	Failure to develop and maintain a positive, engaging and diverse culture in which staff are treated fairly, consistently with dignity and respect, inline with NHS Scotland values.	1. Lack of overarching strategies and associated policies, procedures and initiatives 2. Strategies/policies, procedures and initiatives not fully implemented across all areas. 3. Lack of appropriate training, information, instruction and support for staff 4. Insufficient staff engagement with available training, instruction and support packages, through non-attendance. 5. Behaviours not inline with NHS Scotland values and GGC Policies. 6. Ineffective reporting mechanisms or willingness to report workforce issues (e.g. psychological safety). 7. Action not taken following issues identified 8. Complexity of GGC organisation leading to inconsistent leadership and messages. 9. Equality, Diversity and Inclusivity not embedded in all practices	Service / Business interruption, Complaints/Claims, Staffing and Competence, Adverse/Publicity	1. Strategies - Overarching MFT (Moving Forward Together) Strategy which is underpinned by a suite of Corporate Strategies, which inform NHS GGC Policies, Plans and Development programmes. 2. Strategy implementation - Strategies are accompanied by an action plan which are translated into the Corporate Delivery Plan. Deliverables are then communicated as Objectives for Executives and Senior Managers as part of annual objective setting and appraisal process. • HSE Stress Tool communicated to teams for use. • Achieved IIP accreditation in June 2024 • Annual Workforce Equality Action Plan, monitored via the Workforce Equality Group. 3. Training - • Suite of online and tutor led training available to all staff. • Statutory and Mandatory Training manged via LeanPro - including Equalities Training. Completion is tracked and monitored. • GMC Medical Training is in place. • Leadership Development Programmes and resources are in place through TURAS and LearnPro, which are assigned via PDP or through Self Learning. New programme for Senior Managers commenced 2024. Feedback gathered from delegates has been used to inform further development required. • Ready to Lead programme has been in place and revised version is planned to commence in 24/25. 4. Training attendance - • Statutory and Mandatory training is monitored, and managed through PDP review and 1-2-1. • Additional training initiatives are tracked to ensure attendance. • Protected learning time is in place for staff to attend mandatory training. 5. Behaviours - • Policies and processes in place - Conduct Policy, Bullying and Harassment Policy. Grievance policy • Civility Saves Lives initiative commenced which involves a Champions groups in each IiP Cluster. • Civility Leads training commenced November 2023.. • HR Support and advice Unit with bullying and harassment dedicated line. • Success register to formally thank staff to support a culture of appreciation for good work is now in place and subject to regular review. • Cut it Out - Sexual Harrassment Campaign rolled out in 2024 including posters, training session to drive a zero tolerance culture on sexual harrassment. 6. Reporting Mechanisms - • Line Manager support is available for issues to be identified and managed. Escalation process is available via Line Manager's Manager. • A number of options are available for escalation of concerns - Speak Up, Civility Leads for all staff, Trade Unions, Occupational Health, Staff Partnership, Trade Union, Confidential Contacts, Whistleblowing, and Peer Support. The output from these are tracked for themes and reported through Governance Committees. • imatter, IIP, collaborative conversation , staff led equality forums and through trade union and p[partnership - outputs drive strategy. Themes and data emerging from collaborative conversations and IiP assessment are used to determine future strategy. • Escalation route for Site or Board wide issues from iMatter results. • Consolidated development plan for iMatter and IIP plans for Directorates, through IIP cluster workforce groups ensuring all issues are captured in one plan. 7. Once for Scotland Policies and escalation routes for staff to raise issues as noted in control above. Confidential contacts or whistleblowing in addition to the escalation routes above are additional routes for staff to raise complaints where issues raised have not been addressed and have exhausted previous routes. 8. Leadership programmes are in place that support a consistency of culture and leadership behaviours for example New Medical Management programme in place • Communication - Core briefs, Corporate comms provide consistent information to all Staff. • Internal Communication and Employee Engagement Strategy has been developed. • Senior Management Programme 2023 and 2024 to develop consistent Leadership approaches across GGC. 9. Equalities, Diversity and Inclusivity are now part of our leadership programmes. Annual workforce equality group action plan in place, which includes training and awareness. A number of groups have been created to embed EDI in all practices, these include - . Staff led equality groups, Non-Executive equality champions, Staff Experience Team. Equalities Human Rights Team. • Mandatory Learnpro Training for all staff for EDI	2	4	8	Medium

Original Wording

ID	Title	Description	Cause	Impact	Controls in place	Risk Score - Current			
						Likelihood	Consequence	Rating	Risk level
3060	Positive, engaging and diverse culture	Failure to cultivate, promote and enhance a positive, engaging and diverse culture.	1. Lack of overarching workforce strategy and associated policies, procedures and initiatives 2. Strategy not fully implemented 3. Lack of appropriate training, information, instruction and support for staff 4. Lack of sufficient staff engagement with available training, instruction and support packages	Service / Business interruption	'1. Workforce Strategy. 2. Leadership development programmes. New programme for Senior Managers has started. 3. Succession Planning Framework. 4. Equality Action Plan. 5. Medical Management programme introduced. New approach to start by end November. 6. Ready to Lead programme. 7. iMatter response and results; analysis of NHSGGC Board Report; and focus on action planning and sharing success stories across teams. 8. Promotion of culture framework and associated programmes and initiatives. This is now part of the Workforce Strategy and action plan which is BAU. 9. Internal Communication and Employee Engagement Strategy, now approved by NHSGGC Board as at 25/10/22 10. Additional modules on Equalities & Diversity are now part of our leadership programmes. 11. Senior, middle, and medical manager leadership programmes have all been reviewed and are currently being delivered. The Executive Leadership Programme is completed. 12. Application of IIP is underway and includes assessment and development plans for each site cluster. Summative assessments for all clusters running from October 2023 to April 2024. 13. Refreshed approach to Succession Planning now in place. Prioritisation at this stage for Directors and SMT members. Career conversations as part of mid term reviews of PDPs will complete end November. 14. Programme of Collaborative Conversations delivered in 2023 to underpin Investors In People accreditation, with further Conversations taking place in the first quarter of 2024 to better understand iMatter feedback. 15. Success Register has now been implemented and being used to share good practice and show appreciation between staff for excellent work. 16. Civility Saves Lives initiative underway. Champions groups in each IiP Cluster. Civility Leads training started November 2023.	2	3	6	Medium

Further Action Required	Action Owner	Due date	Risk Score - Target				Last Review Date	Review Notes	Manager	Corporate Objectives	Assigned Governance Committee
			Likelihood	Consequence	Rating	Risk level					
[redacted]											

Synopsis	Responsibility ('To')	Due date	Risk Score - Target				Last Review Date	Review Notes	Manager	Corporate Objectives	Assigned Governance Committee
			Likelihood	Consequence	Rating	Risk level					
			[redacted]								

Likelihood

1 – Rare - is unlikely to happen
2 – Unlikely - not expected to happen
3 – Possible - may occur occasionally
4 – Likely - will probably occur, but not a persistent issue
5 – Almost certain - will undoubtedly occur/is happening

Impact

1 – Negligible
2 – Minor
3 – Moderate
4 – Major
5 – Extreme

Consequence

Likelihood	*Impact/Consequence*				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	**Medium 5**	**High 10**	**High 15**	**Very High 20**	**Very High 25**
Likely	**Medium 4**	**Medium 8**	**High 12**	**High 16**	**Very High 20**
Possible	**Low 3**	**Medium 6**	**Medium 9**	**High 12**	**High 15**
Unlikely	**Low 2**	**Medium 4**	**Medium 6**	**Medium 8**	**High 10**
Rare	**Low 1**	**Low 2**	**Low 3**	**Medium 4**	**Medium 5**

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee

Datix ID	Directorate/Partnership	Score	Risk level	Governance/ review committee

[redacted]

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee

Datix ID	Directorate/Partnership	Score	Risk level	Governance/ review committee

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

NHS Greater Glasgow and Clyde - Corporate Risk Register *April 2025*

Datix ID	Directorate/ artnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2059	Public Health	[redacted]					

[redacted]

Datix ID	Directorate/Partnership	Score	Risk level	Governance/ review committee
2059	Public Health	9	Corporate level risk	Acute Services Committee

[redacted]

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee

[redacted]

Datix ID	Directorate/Partnership	Score	Risk level	Governance/ review committee

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/Partnership	Score	Risk level	Governance/ review committee
2085	Medical	9	Corporate level risk	Clinical & Care Governance Committee

[redacted]

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2168	Medical	Medical Director	Failure to comply with recognised policies and procedures in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. Continue to support education for all staff including novel models, e.g information café, ward based training and scenario based training. Training initiatives need to be flexible to address the needs of a 24/7 workforce. This is in place in NHSGGC. Training available for staff who are likely to encounter infections of high consequence. PVC care plan has now been rolled out to all of GGC. SOPs to support the management of environmental and drug resistant organisms is now in place. The requirement to complete the MRSA & CPE CRA was published as a "Hot Topic" on StaffNet (NHSGGC intranet) on 14 March 2019 and this message has also been conveyed to all Chief Nurses within the Acute Adult Sectors / Directorates	***Improvement actions include the following:*** ***PVC Packs*** ***Samples of this pack are currently being evaluated. If clinical areas approve it is possible that this could be available for use by July 2019.*** ***IPC App*** ***Feasibility/cost currently being explored. This would facilitate access to information at all times. An evaluation of this should be completed by August 2109.*** ***MRSA/CPE Screening*** ***Continue to participate in the NHS Scotland screening initiative and feedback within agreed timescales. This should help to imbed screening for resistant organisms into practice with a system proposed for local reporting.*** ***Assurance re Policy Implementation*** ***Update the IPCAT audit process and criteria in order to facilitate the implementation of not only audit for assurance but audit for improvement.*** ***Outbreak and Incident Debriefs*** ***Use the output from the outbreak and incident debriefs to improve processes where appropriate. These are currently ongoing.***	**July 2019** **August 2019** **TBD by SGHD** **July 2109** **August 2019**	**Clinical & Care Governance Committee**

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		5	*4*	*20*	*4*	*4*	*16*

Datix ID	Directorate/Partnership	Score	Risk level	Governance/ review committee
2188	Medical	20	Corporate level risk	Clinical & Care Governance Committee
2188	Medical	20	Corporate level risk	Clinical & Care Governance Committee
2188	Medical	20	Corporate level risk	Clinical & Care Governance Committee
2188	Medical	20	Corporate level risk	Clinical & Care Governance Committee
2188	Medical	20	Corporate level risk	Clinical & Care Governance Committee
2188	Medical	20	Corporate level risk	Clinical & Care Governance Committee

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2103	eHealth	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Datix ID	Directorate/Partnership	Score	Risk level	Governance/ review committee
[redacted]		6	Corporate level risk	Information Governance Steering Group

[redacted]

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2199	Public Health	[redacted]					
2325	Governance						

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2190	Facilities and Estates	**Director of Facilities and Estates**	Impact of failure to implement national guidance, systems and policies in relation to: * the bulit environment * patient safety * reputational risk * business continuity * system efficiency	Close working with clinical teams. Maximising current control measures to expedite actions. Additional managerial and frontline staff in place to ensure action in key areas.	Asset base survey underway Review of current structures and interface between departments Review of assurance processes Review actions from external advisors and assessors Infection Control and Built Environment Group being established	**Sep-19** **Aug-19** **Jun-19** **Sep-19** **Jun-19**	**Acute Services Committee**
		Risk level and scores	***Corporate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood / ***Impact*** / ***Score***	***Likelihood*** / ***Impact*** / ***Score***		
				4 / ***3*** / ***12***	***3*** / ***3*** / ***9***		
To be added 1	Acute	**Chief Operating Officer - Acute**	***There is a reputational risk in respect of the recent issues and concerns expressed relating to the QEUH and RHC, including:*** ***• facilities and environmental issues*** ***• capacity flow across the south sector*** ***• intense media scrutiny regarding patient care***	***• Robust escalation process in place to proactively manage any issue to ensure patient and staff safety in respect of the Board's facilities*** ***• Clinical focus remains on patient safety, with extensive reporting and monitoring, e.g. robust infection control procedures*** ***• Significant senior management capacity allocated to addressing recent incidents.*** ***• Proactive media handling***	***A programme board, chaired by the Chief Executive, will be established to oversee the following work:*** ***• An internal review of the facilities and environmental issues in respect of the QEUH and RHC*** ***• A review of capacity and flow to assess the present position against the original model and planning assumptions*** ***• A review of clinical outcomes over the period to provide assurance*** ***An independent external review of the QEUH, ordered by the Cabinet Secretary, will also be carried out, as well as a Scotland-wide inquiry launched by the Scottish Parliament Health and Sport Committee on Health Hazards in the Healthcare Environment.***	**Dec-19**	**Acute Serices Committee**
		Risk level and scores	***Corporate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood / ***Impact*** / ***Score***	***Likelihood*** / ***Impact*** / ***Score***		
				4 / ***5*** / ***20***	***3*** / ***3*** / ***9***		
To be added 2	Human Resources	**Director of HR & OD**	***Failure of managers/ leaders to effectively engage with staff. Lack of engagement can create a workplace climate where staff are unable to perform to their best which can in turn can impact upon patient care and service delivery.***	***Annual iMatter staff survey schedule in place as the national tool to measure engagement by providing all staff with the opportunity to provide feedback to their manager and the organisation. A 60% return rate of surveys is required to provide a Team/ Board report to then inform local staff engagement action plans . iMatter Operational Lead meets with local iMatter Leads for each iMatter run, monthly/ as required, to review plan and discuss timescales, actions and how to overcome identified barriers for engagement. There are also significant levels of investment in management and leadership development, development of team based working and the development of a GGC Culture Framework to inform culture developments actions at CMT level and below.***	***Continue to work with local Leads and senior managers to identify area specific barriers to implementation and develop solutions using learning from previous iMatter runs. Agree and implement a plan for culture development informed by outPuts from focus groups and monitoring tools such as iMatter.***	**Dec-19**	**Staff Governance Committee**
		Risk level and scores	***Corporate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood / ***Impact*** / ***Score***	***Likelihood*** / ***Impact*** / ***Score***		
				3 / ***4*** / ***12***	***1*** / ***5*** / ***5***		

Datix ID	Directorate/Partnership	Score	Risk level	Governance/ review committee
2190	Facilities and Estates	12	Corporate level risk	Acute Services Committee
2190	Facilities and Estates	12	Corporate level risk	Acute Services Committee
2190	Facilities and Estates	12	Corporate level risk	Acute Services Committee
2190	Facilities and Estates	12	Corporate level risk	Acute Services Committee
2190	Facilities and Estates	12	Corporate level risk	Acute Services Committee
2190	Facilities and Estates	12	Corporate level risk	Acute Services Committee
To be added 1	Acute	20	Corporate level risk	Acute Serices Committee
To be added 1	Acute	20	Corporate level risk	Acute Serices Committee
To be added 1	Acute	20	Corporate level risk	Acute Serices Committee
To be added 1	Acute	20	Corporate level risk	Acute Serices Committee
To be added 1	Acute	20	Corporate level risk	Acute Serices Committee
To be added 2	Human Resources	12	Corporate level risk	Staff Governance Committee
To be added 2	Human Resources	12	Corporate level risk	Staff Governance Committee
To be added 2	Human Resources	12	Corporate level risk	Staff Governance Committee
To be added 2	Human Resources	12	Corporate level risk	Staff Governance Committee
To be added 2	Human Resources	12	Corporate level risk	Staff Governance Committee

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
To be added 3	Human Resources	Director of HR & OD	*Risk of Non-compliance with enforcement agency requirements leading to enforcement action eg. fines, prosecution*	*Enforcement agency requirements are the responsibility of the relevant Director to ensure that the appropriate action is taken. This action is co-ordinated by the Head of Health and Safety. Only the Head of HS and senior staff will deal directly with enforcement agencies. Potential issues of non-compliance will be discussed at the earliest stage with the appropriare Director and dialogue entered into with Enforcement Agency - Health and Safety Executive for health and safety issues.*	*Further engagement with Health and Safety Executive on a regular basis to ensure that statutory requirements are discussed in advance of any inspection visits to ensure compliance can be demonstrated in advance of visits.*	Aug-19	Staff Governance Committee

Risk level and scores	*Corporate level risk*	*Current risk score*			*Target risk score (after further actions)*		
		Likelihood	*Impact*	*Score*	*Likelihood*	*Impact*	*Score*
		3	*4*	*12*	*2*	*4*	*8*

[redacted]

Datix ID	Directorate/Partnership	Score	Risk level	Governance/ review committee
To be added 3	Human Resources	12	Corporate level risk	Staff Governance Committee
To be added 3	Human Resources	12	Corporate level risk	Staff Governance Committee
To be added 3	Human Resources	12	Corporate level risk	Staff Governance Committee
To be added 3	Human Resources	12	Corporate level risk	Staff Governance Committee
To be added 3	Human Resources	12	Corporate level risk	Staff Governance Committee
To be added 3	Human Resources	12	Corporate level risk	Staff Governance Committee

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
To be added 5	Nursing	Nurse Director	*Safe Staffing Legislation: There is a risk that NHSGGC will not be in full operational readiness for the planned Safe Staffing Legislation, especially in areas where there is limited detail regarding change and impact over the workforce and a range of broader legislation issues with the potential to adversely unsettle continuity of delivery of healthcare services across NHSGGC.*	*1. Robust governance structures in place to support safe, effective and efficient use of Nursing, Midwifery and Allied Health Professional (NMAHP) resources. 2. Rostering Policy and Monitoring and Escalation Guidance in place and regularly monitored. 3. Robust education and training of staff in use of workload tools. 4. Local workload tool runs are timeously scheduled and outcomes reported by service. 5. National Board allocation received for the introduction of a NHSGGC Safe Staffing Team 6. Hospital Huddles to identify and mitigate critical safety information in relation service delivery to patients and also wider situational awareness issues. 7. Huddles utilised as a process using prediction to support safety and flow, input from all clinical areas on activity, safety to inform prediction on position for the day and escalation of any issues for action. 8.*	*1. National procedure for identification of risk caused by staffing which affects the health, wellbeing or safety of patients or the quality of care by any member of staff 2. Where risk is identified national procedure for mitigation of such risks so far as possible by clinical leader 3. Raising awareness amongst staff of the agreed national procedures 4. Arrangements for escalation of risk which have not been mitigated in assessment process 5. Provision of clinical advice where decision maker is not a clinician. 6. Procedure for onward escalation of risk from Point of Care to the Board. 7. Monitoring and review of common staffing method. 8. Test out the newly developed WOS NMAHP Workforce Planning, Assessment and Prioritisation Tool to identify the current NMAHP Workforce pressures.*	Apr-20	NMAHP WWP Group; Staff Governance Group and Clinical and Care Governance Groups
		Risk level and scores	*Corporate level risk*	*Current risk score*			
				Likelihood	*Impact*	*Score*	
				4	*4*	*16*	
				Target risk score (after further actions)			
				Likelihood	*Impact*	*Score*	
				4	*4*	*16*	

22	22	22		22						22	22

Acute Services Committee	5
Finance & Planning Committee	2
Public Health Committee	2
Clinical & Care Governance Committee	4
Staff Governance Committee	2
Audit Committee	1
NHS Board	0
	16

Datix ID	Directorate/Partnership	Score	Risk level	Governance/ review committee

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2324	[redacted]						

Datix ID	Directorate/Partnership	Score	Risk level	Governance/ review committee

Datix ID	irectorate/ artnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

	Datix ID	Directorate/Partnership	Score	Risk level	Governance/ review committee
	2084	Medical	16	Directorate level risk	Clinical & Care Governance Committee
	[redacted]				

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

Datix ID	Directorate/Partnership	Score	Risk level	Governance/ review committee
2089	Nursing	16	Directorate level risk	Clinical & Care Governance Committee
[redacted]				

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

	Datix ID	Directorate/Partnership	Score	Risk level	Governance/ review committee
[redacted]	0	Human Resources	16	Directorate level risk	Staff Governance Committee

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2190	Facilities and Estates	Director of Facilities and Estates	Impact of failure to implement national guidance, systems and policies in relation to the bulit environment. * patient safety * reputational risk * business continuity risk * system efficiency	Close working with clinical teams Maximising current control measures to expedite actions Additional managerial and frontline staff in place to ensure action in key areas	Asset base survey underway Review of current systems and interface between departments Review of assurance process Review actions from external advisors and assessors Infection Control and Built Environment Group being established	**Ongoing**	**Acute Services Committee**
		Risk level and scores	***Directorate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood / ***Impact*** / ***Score***	***Likelihood*** / ***Impact*** / ***Score***		
				4 / ***3*** / ***12***	***4*** / ***3*** / ***12***		
2192	Medical	Medical Director	Failure to achieve reduction of MRSA/ MSSA bacteraemia Target has yet to be issued but this data will now be presented split into Healthcare Associated and	Continue enhanced surveillance of MRSA/ MSSA. Quarterly reports which include analysis of the incidence of device associated MRSA/MSSA. Produce SPCs for MRSA/MSSA in areas with significant prevalence.	SAB steering group set up to implement policy and strategies to reduce the number of patients with SAB. ***This group will produce an action plan which will be presented to the Acute Infection Control Committee to assess progress with regards to each action planned.***	**Ongoing**	**Clinical & Care Governance Committee**
		Risk level and scores	***Directorate level risk***	***Current risk score***	***Target risk score (after further actions)***		
				Likelihood / ***Impact*** / ***Score***	***Likelihood*** / ***Impact*** / ***Score***		
				5 / ***3*** / ***15***	***4*** / ***2*** / ***8***		

Datix ID	Directorate/Partnership	Score	Risk level	Governance/ review committee
2190	Facilities and Estates	12	Directorate level risk	Acute Services Committee
2190	Facilities and Estates	12	Directorate level risk	Acute Services Committee
2190	Facilities and Estates	12	Directorate level risk	Acute Services Committee
2190	Facilities and Estates	12	Directorate level risk	Acute Services Committee
2190	Facilities and Estates	12	Directorate level risk	Acute Services Committee
2190	Facilities and Estates	12	Directorate level risk	Acute Services Committee
2192	Medical	15	Directorate level risk	Clinical & Care Governance Committee
2192	Medical	15	Directorate level risk	Clinical & Care Governance Committee
2192	Medical	15	Directorate level risk	Clinical & Care Governance Committee
2192	Medical	15	Directorate level risk	Clinical & Care Governance Committee
2192	Medical	15	Directorate level risk	Clinical & Care Governance Committee
2192	Medical	15	Directorate level risk	Clinical & Care Governance Committee

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

[redacted]

Datix ID	Directorate/Partnership	Score	Risk level	Governance/ review committee
0	Director of Finance	9	Directorate level risk	CMT
[redacted]				

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
2325	Governance	[redacted]					
	PPFM						

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							
2324							

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk	Mitigating action to further reduce, eliminate or transfer residual risk	Target dates for actions	Governance /review committee
[redacted]							

ID	Title	Manager	RR Type	Review date	Risk level (initial)	Risk level (current)	Risk level (Target)	Description of risk	Controls in place	RR Status

Current Risks Detailed Report 15/02/2018

ID	Title	Manager	Corporate Risk	RR Type	Review date	Risk level (initial)	Risk level (current)	Risk level (Target)	Description	Controls in place	RR Status

ID	Title	Manager	Corporate Risk	RR Type	Review date	Risk level (initial)	Risk level (current)	Risk level (Target)	Description	Controls in place	RR Status

ID	Title	Manager	Corporate Risk	RR Type	Review date	Risk level (initial)	Risk level (current)	Risk level (Target)	Description	Controls in place	RR Status
2064	Risk of fire at QEUH due to the incorpration of Aluminium Composite Materials	Young, Scott	P	Corporate Risk	29/11/2017	**Moderate**	**Moderate**	**Low**	The probability of Queen Elizabeth University Hospital being at high risk due to the incorporation of Aluminium Composite Materials (ACMs) similar but not the same to those used in Grenfell Tower, leading to an increased likelihood of a fire occurring.	The QEUH has been designed and engineered to meet Building and Fire Safety Regulations. Health Facilities Scotland and their National Fire Advisor have given assurances that the hospital is an extremely safe building. Firm assurances have also been given by the main contractor and their design team and the Board's technical advisers that the regulatory process has been followed and that the appropriate Building Standards Completion Certificates are in place. As a precautionary measure, and to make sure the public, patients and staff have full confidence in the safety of the QEUH, the NHS Board officers took the decision to remove the panels from the three external sections of the hospital where these panels are located. Officers worked with contractors and technical advisers in assessing how to proceed this work at the earliest possible	Live/Active
[redacted]											
2087	Infection control systems	Walsh, Tom	P	Corporate Risk	31/12/2017	**High**	**High**	**High**	Failure to implement consistent systems and policies in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE, VHF and MERS. Reports to Board/ASC.	Live/Active

ID	Title	Manager	Corporate Risk	RR Type	Review date	Risk level (initial)	Risk level (current)	Risk level (Target)	Description	Controls in place	RR Status
301	MRSA Screening Programme	Walsh, Tom		Corporate Risk	30/03/2012	**Moderate**	**Moderate**	**Low**	Failure to implement the National Policy for screening for MRSA	Project team in place.	Live/Active

ID	Title	Manager	Corporate Risk	RR Type	Review date	Risk level (initial)	Risk level (current)	Risk level (Target)	Description	Controls in place	RR Status

ID	Title	Manager	Corporate Risk	RR Type	Review date	Risk level (initial)	Risk level (current)	Risk level (Target)	Description	Controls in place	RR Status
[redacted]											

ID	Title	Manager	RR Type	Review date	Risk level (initial)	Risk level (current)	Risk level (Target)	Description	Controls in place	RR Status

SCOTTISH HOSPITALS INQUIRY

Bundle of documents for Oral hearings commencing from 16 September 2025 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Bundle 45 – NHS Greater Glasgow and Clyde Corporate Risk Register

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