Greater Glasgow and Clyde NHS Board

NHS Board Meeting
Tuesday, 25 June 2013 **Board Paper No. 13/27**

Director of Finance

Corporate Risk Register 2013

Recommendation

Members are asked to note the Corporate Risk Register (CRR), attached as an appendix, for 2013, which was approved by the Audit Committee at its meeting on 4 June 2013.

Background

1. 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.
2. 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).
3. 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 Corporate Risk Register. The CRR was also endorsed by CMT prior to being approved by the Audit Committee.

Paul James
Director of Finance
June 2013

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.

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
Draft Corporate Risk Register - April 2013

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	ASD Chief Operating Officer and Directors	Non-compliance with Waiting Time targets In patient / out patient and day case targets Emergency Access Standard Diagnostic targets Cancer targets Condition specific targets Bed days targets Care of the Elderly	Weekly monitoring against milestones and action plans Continuous cancer tracking and weekly review of cancer tracking reports Flexible working practice of clinicians Pooled pan-Glasgow waiting lists Routine reporting to Acute Division SMG, CMT and NHS Board	3	4	12	2	
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	Nurse Director	Inconsistent assessment and application of Child Protection procedures may result in poor identification of children at risk or children who have been harmed, and may also lead to legislative requirements not being complied with.	Robust policies and procedures are in place and have been communicated throughout NHSGGC. An ongoing comprehensive training programme is in place. Monitoring systems are established and all adverse events investigated and reported for learning outcomes at Child Health Steering Group and periodic reporting to the NHS Board. Audit availability of Child Protection information in all Clinical Areas. All appropriate NHSGGC staff complete Child Protection training and participate in audits, adverse event reviews and improvement plans.	3	4	12	2	
CHP/CHCP	3	ASD Chief Operating Officer, CH(C)P Directors	Increased delays in discharging patients from hospital and increased bed days due to pressures on local authority funding.	Regular monitoring of position and mechanisms for dialogue with all local authorities through the Acute Services Division organisational structure and CH(C)Ps. Regular reporting to CH(C)P Committees, Acute SMG, directorate management teams and the NHS Board. Regular liaison between NHS Board CEO and local authority CEOs.	5	4	20	1	

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Clinical	4.1	CH(C)P Directors	Compliance with all applicable clinical standards and protocols is not achieved within Mental Health Services resulting in death or harm to staff, patients, visitors, and the public arising from:- - suicide or deliberate self harm; - violent patients; - absconding patients; - hospital acquired infection outbreak; - Child protection and Vulnerable Adults - medication errors; - nutrition needs - confidentiality of data.	Proactive controls arising from the mental health clinical and general management system and processes including specialised and supported workforce, provision and uptake of relevant training, robust policy and procedures. Ongoing monitoring includes structured responsibility for detection and review of Significant Incidents with special emphasis on ensuring lessons learned from incidents are disseminated and applied across the board. Review of Control of Infection Procedures Monitoring and reporting through Care Governance structures Dissemination of lessons learned from incidents, and associated action plans	3	4	12	2	Conduct thorough review of current Care Governance Work Plan. Review training provision for violence and aggression Review of Control of Infection Procedures
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	Medical Director	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 support available to parts of the service. 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.

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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		Expenditure does not match available funds within context of Board's financial plan.						
		1. ASD Chief Operating Officer and other Service Directors	1. Service Directorates individually, or in combination, experience unplanned expenditure levels which exceed funding allocations and threaten achievement of Board's key financial objectives (i.e. RRL) due to: a) Pay growth, b) Prescribing and c) other major pressures	1. Monthly reporting and monitoring of all Division and Directorate budgets. Areas of increased expenditure identified and constrained by Directors, special areas of concern include drugs expenditure – costs associated with waiting times achievement. Areas of cost reduction identified and progressed by Directors with monitoring links through the Divisions Operational and Strategic Management Groups. Performance reviews with each Directorate. Overall monitoring links into Board through performance management and finance reporting arrangements.					
		2. DoF	2. General funding uplift over-estimated resulting in inability to implement planned commitments.	2. Close contact maintained with Scottish Government Health Finance Directorate. Robust financial planning and budgetary control systems. Corporate recovery plan.	3	4	12	2	
		3. DoF	3. Cost savings forecasts for major projects over-estimated, resulting in failure to achieve Board's financial objectives (i.e. RRL)	3. Robust project management arrangements in place. Service Managers agree deliverability of targets. Robust financial planning and budgetary control systems. Formal change control process in place to control scope change.					
		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					

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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	Director of Health Information Technology	Inappropriate release/use of data/patient records; inability to meet national Information Governance Standards and appropriate sharing of information by partner organisations.	Procedures are in place on all sites for use/release of data, including Multi-Agency Public Protection Arrangements (MAPPA) related information, monitoring of Information Governance Standards and Security Policy, Caldicott Guardian responsibilities, Information Sharing Protocols, NHSGGC-wide Information Governance Steering Group. All laptops (now including University equipment) encrypted. Information Sharing Protocol (endorsed by the Information Commissioner) in place. New information governance policies approved. New e-mail policy in place. Extended use of electronic records. A programme of work re the systematic audit of access to electronic records is being extended beyond the Emergency Care Summary. Access is controlled via a role based access protocol signed off by senior clinicians and the Caldicott Guardian. An ongoing programme of awareness and training will continue.	3	4	12	2	Continue to follow up recommendations highlighted in audits by both internal and external auditors. The awareness education of this agenda to all staff remains a priority.
Human Resources	9	Medical Director	The reduction in numbers of specialty trainees as part of the Government's Reshaping the Medical Workforce policy could make some rotas in acute specialties difficult to staff. When added to the risks of failure to recruit enough adequately qualified medical staff, increasing numbers of trainee staff involved in out of hours work, less than full time work and maternity and paternity leave, this could lead to a reduction in available doctors for direct patient care.	1. Continue to review with the Deanery the implications of junior doctor vacancies. 2. Work with Medical Staffing to monitor high risk rotas. 3. Report to Head of Medical Staffing Regional Workforce Director and SGHD on high risk rotas if necessary. 4. Service Managers will identify mitigation measures and take appropriate action. 5. Identify replacement staffing either temporary or permanent to fill the gaps.	4	4	16	2	Work with the Regional Workforce group and the new National Reshaping Working Group to develop plans to ensure service is not disrupted.

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Public Health	10.1	Director of Public Health	There is a Major Incident/Pandemic in the Greater Glasgow and Clyde area, the NHS are unable to respond adequately. We do not fully meet the requirements of the Civil Contingencies (Scotland) Act 2005.	Major incident plans and associate guidelines; Control of Major Accident Hazard Plans; Regular testing and updating of emergency plans (multi-agency response); Business Continuity Plans; Comprehensive plans for a Pandemic outbreak; Formal meetings and co-ordination between CHCP and CHPs; Strategic planning meetings; Acute Division Civil Contingencies meetings; Comprehensive exercise programme. In the event of a pandemic: - CEO chairs weekly meeting of Pandemic Executive Group; - Daily conference call on Pandemic Flu; - Daily sickness monitoring; - Regular reports to the NHS Board.	3	4	12	2	Constant monitoring and exercising of plans, updating as required. Tabletops developed to meet specific risks.
Public Health	10.2	Director of Public Health	Screening programmes: Systems for identifying/ inviting or follow up of eligible population for the following screening programmes - breast; bowel; cervical; diabetic retinopathy; pregnancy and newborn; communicable diseases in pregnancy, Down's Syndrome and Neural Tube Defects; newborn bloodspot; newborn hearing; pre-school vision - do not function as intended	Experienced staff to closely monitor failsafe mechanisms. Ensure regular quality assurance monitoring and feedback. Use of Critical Incident Reporting tool. Look back exercises and remedial action. Automatic recall of individuals after set time period has elapsed. Suspend programmes in case of Force Majeur. Quarterly reports on screening Annual Report to NHS Board	3	4	12	2	On going awareness advice
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.