NHS Golden Jubilee

**Meeting: NHS GJ Board**

**Meeting date: 29 May 2025**

**Title: Strategic Risk Register**

**Responsible Executive: Jonny Gamble, Director of Finance**

**Report Author: Kevin McMahon, Head of Risk & Clinical Governance**

# Purpose

## 

## This is presented to NHS GJ Board for:

* Approval

## This report relates to a:

* Effective decision making in NHS Golden Jubilee.

## This aligns to the following NHS Scotland quality ambition(s):

* Safe
* Effective
* Person Centred

**This aligns to the following NHSGJ Corporate Objectives:**

* Leadership, Strategy and Risk
* High Performing Organisation
* Optimal Workforce
* Facilities Expansion and Use
* Centre for Sustainable Delivery
* NHS Scotland Academy and Strategic Partnerships
* Culture, Wellbeing and Values

# Report summary

The Strategic Risk Register reports on material changes across each of the portfolio areas within NHS Golden Jubilee. This report is intended to provide a summary of any significant changes to risks including scoring, new risks or closed risks since the last period of reporting. Section 2.1 outlines the current activity to support corporate risk management.

# Situation

The Head of Risk and Clinical Governance is working with the Executive Leadership Team (ELT) to ensure the strategic risks reflect the current strategic position of NHS GJ. To support ongoing management of strategic risk and links to strategic planning, NHS GJ have established an ELT Risk management group that will meet on a quarterly basis commencing in May 2025.

As NHS GJ move towards implement the new strategy, work is ongoing to align strategic planning activity and corporate risk management to ensure a risk aware approach to strategy implementation and objectives.

There are 20 risks currently included within the Strategic Risk Register, compared to 23 previously reported. The risk movement in the strategic risk register are outlined below.

# Assessment

* + 1. **New Risks**

There is one new risk added to the Strategic Risk Register since last review relating to the SACCS service post-operative outcomes.

Further new risks for 2025/26 are being identified through the approach outlined in section 2.1.

## 2.2.2 Risks Closed

Since previously reported to the Committee there has been 3 strategic risks closed:

R-034 - Lack of Clinical Perfusionists/trainees to develop appropriate succession planning.

F8 Financial Planning - If we fail to maximise effective use of the Boards resources and assets, then we will not deliver the financial plan. This risk has been closed for the financial year 2024/25. NHS GJ are currently assessing and validating the risks associated to the Financial Plan 2025/26.

O23 eHealth Resources **-** Due to insufficient resources within e-Health, in relation to the expectation on the service, certain activities i.e. major incident response, project or programme activity may be delayed or de-scoped to operate within available staffing levels and maintain staff wellbeing.

S13 National and Regional working impacts delivery of the GJ Strategy leading to a potential impact on funding allocation, delivery of the annual delivery plan and GJ Strategy resulting in a negative impact on the reputation and engagement with NHS Boards. This risk as it falls in line with the Boards risk appetite and has been closed due to effective stakeholder engagement and strategic planning.

**2.2.3 Risks Increased**

There have been no risks increased since the last review.

## 2.2.4 Risks Reduced

S10 - If there is a cyber-incident/attack then this will lead to a failure of digital systems and loss of critical clinical information systems resulting in a significant negative impact on patient care, adverse publicity, loss of public confidence and financial impact.

In light of the current NIS-R audit report and assurance of controls in place the cyber security risk S10 has been reduced from high to medium.

DR-207 - Unavailability of IABP due to inability to deliver mandated safety maintenance.

The assurances provided to the Clinical Governance Committee on the management of risk DR 207, the risk has now reduced to low with the supply chain issues largely resolved. The supplier has confirmed the equipment lifetime of the device is 12 years. This places the next scheduled replacement into 2026. It is hoped that the issues will be resolved by this point.

## 2.2.5 Equality and Diversity, including health inequalities

There are no specific issues that require to be noted.

## Communication, involvement, engagement and consultation

The Strategic Risk Register is presented to Executive Leadership Team, with further engagement throughout the organisation on any escalation required.

## Route to the Meeting

The Strategic Risk Register has been prepared for this meeting taking account of any changes or amendments since the last review. This has been presented to the April Executive Leadership Team for discussion and review.

# Recommendation

NHS GJ Board is asked to discuss the steps required to ensure strategic risk continues to support effective decision making and approve the Strategic Risk Register.

# 3 List of appendices

The following appendices are included with this report:

Appendix 1, List of Committees and associated risks linked to corporate objectives

Appendix 2, At a Glance View Strategic Risk Register

Appendix 3, Full details of the Strategic Risk Register

**APPENDIX 1 – List of Committees and associated risks linked to corporate objectives**

|  |  |  |
| --- | --- | --- |
| **Committee** | **Risks** | **\*\*Corporate Objective** |
| Staff Governance & Person Centred Committee | SR-241 - Organisational Change  SR-242 - Recruitment and Retention  230 – Fixed Term Contracts  SR-243 - Staff Wellbeing and Absence  B003/22 - Retention and recruitment to senior positions | 2, 3  1, 2, 3, 6, 7  3  7  1 |
| Finance & Performance Committee | SR-244 - Capital Infrastructure  O9 – Waiting Times Management  S11 – Expansion Programme  S10 – Cyber Security  S22 – Site Masterplan  B004/22 – Centre for Sustainable Delivery  departments  SR-245 - Health & Safety  SR-246 – SNAHFS Funding  DR-232 NORS Retrieval Service - on call rota  B001/22 – Ability to provide full Lab Services | 1  1  4  2  4  1, 5, 6  2  1  1  1 |
| Clinical Governance Committee | S6 – Healthcare Associated Infections  DR-207 – Unavailability of Intra-Aortic Balloon Pumps  DR-220 Cardiac Surgery Waiting List Harm  250 - SACCS Mortality rates | 2  2, 4  1  1 2 |

## \*\*Corporate Objectives Key:

* + - 1. Leadership, Strategy & Risk
      2. High Performing Organisation
      3. Optimal Workforce
      4. Facilities Expansion & Use
      5. Centre for Sustainable Delivery
      6. NHS Scotland Academy and Strategic Partnerships
      7. Culture, Wellbeing & Values

## APPENDIX 2 - At a Glance View Strategic Risk Register

| **Risk ID** | **Committee** | **Title** | **Risk Description** | **Target** | **Sept**  **24** | **Oct**  **24** | **Nov**  **24** | **Jan**  **25** | **Mar 25** | **Apr**  **25** | **Trend** | **Exec Lead** | **Opened** | **Last review** | **Next review** | **Corporate Objective** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 250 | CGC | SACCS Post Operative Outcomes | If surgical outcomes continue to deteriorate, then SACCS patients undergoing surgery will come to harm, and this may be avoidable.  Rising mortality over the last three years, which appears to exceed statistical thresholds (2SD) compared to rUK for both adjusted and unadjusted mortality. All clinical risk indicators are being reviewed, including morbidity. | **8**  **(Med)** | **-** | **-** | **-** | **-** | **-** | **16** |  | Dr Mark Macgregor | Apr 2025 | May 2025 | June 2025 | **1 2** |
| S6 | CGC | Healthcare Associated Infections | If we do not maintain adequate precautions we increase our susceptibility to Healthcare Associated Infection events, impacting delivery of corporate objectives. | **8**  **(Med)** | **8**  **(Med)** | **8**  **(Med)** | **8**  **(Med** | **8**  **(Med** | **8**  **(Med** | **8**  **(Med** |  | Nursing Director | Nov  2020 | Apr 2025 | Aug  2025 | **2** |
| B001/22 | CGC | Ability to provide full Laboratory Services on site due to system provider withdrawal | The ability to provide full laboratory services on site is at risk due to the IT system provider withdrawing the right to use their software resulting in organisation not being able to provide laboratory services and a requirement to outsource these to other providers. | **6**  **(Med)** | **6**  **(Med)** | **6**  **(Med)** | **6**  **(Med** | **6**  **(Med** | **6**  **(Med** | **6**  **(Med** |  | Medical Director | Jun  2022 | Apr 2025 | Sept 2025 | **2, 4** |
| DR-207 | CGC | Unavailability of IABP due to inability to deliver mandated safety maintenance | If a patient requires heart function support and there are no available Intra-Aortic Balloon Pump systems, the potential exists that the patients stability / or treatment programme will be adversely affected, which could result in suboptimal treatment and insufficient patient care with an ultimate risk of patient death. | **4**  **(Med)** | **15**  **(High)** | **15**  **(High)** | **15**  **(High** | **15**  **(High)** | **15**  **(High)** | **3**  **(Low)** |  | Medical Director | Dec  2022 | Apr 2025 | July  2025 | **2, 4** |
| B003/22 | SGPCC | Retention and recruitment to senior positions within NHS GJ. | Retention and recruitment to senior positions within NHS GJ due to gap between AfC grades and Executive Director salary scales resulting in NHS GJ being at a competitive disadvantage relative to other boards in Scotland and further afield. | **3**  **(Med)** | **12**  **(High)** | **16**  **(High)** | **16**  **(High)** | **16**  **(High)** | **16**  **(High)** | **16**  **(High)** |  | Director of People & Culture | Jun 2022 | Oct  2024 | Apr  2025 | **1** |
| SR-241 | SGPCC | The cost of organisational change as a result of service re-design | Service re-design means organisational change, with the need to protect (with lifetime protection) the existing terms and conditions of staff members. Although the cost of the existing staff members is already being felt by the organisation (and will need to continue with lifetime protection), there is a financial risk in the need to fund additional resources to ensure each service is resourced in the right way. | **6**  **(Med)** | **12**  **(High)** | **12**  **(High)** | **12**  **(High)** | **12**  **(High)** | **12**  **(High)** | **12**  **(High)** |  | Director of People & Culture | Aug  2024 | Aug 2024 | Feb 2025 | **2, 3** |
| SR-242 | SGPCC | Recruitment and Retention of staff across NHSGJ | Should NHSGJ fail to retain staff in key roles (either through natural attrition or retirement), there’s a risk in the recruitment of their replacements, as a result of National challenges in the employment market. This could negatively impact patient care and the ability to meet activity levels. | **4**  **(Med)** | **9**  **(Med)** | **9**  **(Med)** | **9**  **(Med** | **9**  **(Med** | **9**  **(Med** | **9**  **(Med)** |  | Director of People & Culture | Nov  2020 | Apr 2025 | May 2025 | **1, 2, 3, 6, 7** |
| 230 | SGPCC | Fixed Term Contracts | If NHS GJ fails to ensure robust rigour, from both HR and all managers of Fixed Term contract staff, then there is a risk that Fixed Term contracts can slip further than 24 months (and beyond), which, if not properly thought through and managed, can result in a poor employee experience and/or organisational responsibility/cost. | **4**  **(Med)** | **9**  **(Med)** | **9**  **(Med)** | **9**  **(Med)** | **9**  **(Med)** | **9**  **(Med)** | **9**  **(Med)** |  | Director of People & Culture | Feb  2024 | Apr 2025 | Jun 2025 | **3** |
| SR-243 | SPGCC | Staff wellbeing and Absence | The increased focus on achieving a balanced system may drive service re-design. That service re-design may result in fewer resources delivering the same level of activity (e.g. if any decisions are made to pause the immediate replacement of vacancies). That, in turn, may result in a negative impact on the Health and Wellbeing of staff across NHSGJ, with an increase in absence levels. | **6**  **(Med)** | **16**  **(High)** | **16**  **(High)** | **16**  **(High)** | **16**  **(High)** | **16**  **(High)** | **16**  **(High)** |  | Director of People & Culture | Sept 2024 | Apr 2025 | May 2025 | **7** |
| SR-244 | FPC | Capital Infrastructure | If adequate funding is not available through Scottish Government allocations, we are unable to invest in capital infrastructure | **8**  **(Med)** | **16**  **(High)** | **16**  **(High)** | **16**  **(High)** | **16**  **(High)** | **16**  **(High)** | **16**  **(High)** |  | Director of Finance | Sept 2024 | Apr 2025 | May 2025 | **1** |
| O9 | FPC | Waiting Times Management | If we do not effectively manage waiting times whilst delivering recovery plan targets, we will fail to meet TTG for patients which could result in poorer patient experience and outcomes and reputational impact for the organisation. | **8**  **(Med)** | **12**  **(High)** | **12**  **(High)** | **8**  **(Med)** | **8**  **(Med)** | **8**  **(Med)** | **8**  **(Med)** |  | Director of Operations | Nov  2020 | Apr  2024 | May  2025 | **1** |

| **Risk ID** | **Committee** | **Title** | **Risk Description** | **Target** | **Aug**  **24** | **Sept 24** | **Oct**  **24** | **Nov**  **24** | **Mar 25** | **Apr**  **25** | **Trend** | **Exec Lead** | **Opened** | **Last review** | **Next review** | **Corporate Objective** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| S11 | FPC | Expansion programme | If we fail to deliver the expansion programme we would be unable to deliver our commitment to the Scottish Government Treatment Time Guarantee and Annual Delivery Plan which would result in a negative impact on reputation and credibility of clinical models. | **6**  **(Med)** | **9**  **(Med)** | **12**  **(High)** | **12**  **(High)** | **12**  **(High)** | **12**  **(High)** | **12**  **(High)** |  | Director of Operations | Jun 2020 | Mar  2025 | Apr  2025 | **4** |
| S10 | FPC | Cyber Security | A failure to maintain adequate cyber security controls may lead to disruption to digital services resulting in the potential compromise of patient data, damage to equipment and systems, adherence to organisational policies/legislation and reputational damage | **8**  **(Med)** | **8**  **(Med)** | **12**  **(High)** | **12**  **(High)** | **12**  **(High)** | **12**  **(High)** | **8**  **(Med** |  | Director of Finance | Nov  2020 | Apr 2025 | June 2025 | **2** |
| S22 | FPC | Site Masterplan | If we do not ensure a robust approach to planning site capacity then we will fail to effectively utilise the available space. | **4**  **(Med)** | **9**  **(Med)** | **6**  **(Med)** | **6**  **(Med)** | **6**  **(Med)** | **6**  **(Med)** | **6**  **(Med)** |  | Director of Finance | Jun  2021 | Apr 2025 | Sept 2025 | **4** |
| B004/22 | FPC | Centre for Sustainable Delivery | CfSD identity and funding may be unclear due to not having clear boundaries and demarcation and confirmed baselined (annual) funding from the Scottish Government leading to unclear core CfSD workforce costs and limiting CfSD’s autonomy and shift its perception from a national improvement body to a performance organisation. This would impact on engagement with other NHS Boards, delivery of annual objectives and sustainability of service, staff retention and increased staff turnover, with reputational impact on the organisation. | **4**  **(Med)** | **12**  **(High)** | **12**  **(High)** | **12**  **(High)** | **12**  **(High)** | **12**  **(High)** | **12**  **(High)** |  | Director of CfSD | Apr 2022 | Oct  2024 | Apr  2025 | **1, 5, 6** |

| **Risk ID** | **Committee** | **Title** | **Risk Description** | **Target** | **Aug**  **24** | **Sept 24** | **Oct**  **24** | **Nov**  **24** | **Mar 2025** | **Apr 2025** | **Trend** | **Exec Lead** | **Opened** | **Last review** | **Next review** | **Corporate Objective** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SR-245 | FPC | Health & Safety | Failure to provide the agreed standards of protection to employees and others in line with statutory legislation and Health and Safety Executive guidance arising from an ineffective risk assessment framework and suboptimal culture and inappropriate behaviours. This leads to the potential failure to provide employer’s duty of care, resulting in non-compliance with relevant Health & Safety legislation, potential harm to employees/service users, financial claims or fines, prosecution and reputation impact. | **8**  **(Med)** | **-** | **-** | **12**  **(High)** | **12**  **(High)** | **12**  **(High)** | **12**  **(High)** |  | Director of Finance | Oct  2024 | Mar 2025 | Apr  2025 | **3** |
| DR-247 | FPC and CGC for awareness | SNAHFS Funding | The current SNAHFS funding profile is insufficient (as detailed through the Business Case) to meet service requirements. The service delivers activity across a number of pathways – some non-elective (unplanned) and therefore activity is unpredictable. Without sufficient budget, there may be an in year overspend and a requirement to ‘pause’ service resulting in direct harm to patients and a reputational impact to the organisation. | **3**  **(low)** | **-** | **-** | **-** | **5**  **(Med)** | **5**  **(Med)** | **5**  **(Med)** |  | Director of Operations | Nov  2024 | Nov  2024 | Oct  2025 | **1** |
| B002/22 | FPC | Use of unsupported Apps and personal email accounts within the organisation for information sharing purposes | It has been identified that some medical specialties are using WhatsApp and personal email to share treatment information, this type of information sharing is not appropriate, is unsupported and has not been risk assessed. If we continue to use unsupported apps to share information for the purposes of patient care then this could result in an inspection from data protection regulators with the possibility of an enforcement notice and/or monetary penalty. | **3**  **(low)** | **-** | **-** | **-** | **12 (High)** | **12 (High)** | **12 (High)** |  | Director of Finance | June 2022 | Nov 2025 | Apr 2025 | **2** |
| DR-220 | CGC | Cardiac Surgery Waiting List Harm | If the current waiting time for routine elective cardiac surgery is not reduced to under 12 weeks then there is an increased likelihood of patient harm (including death).  If the current waiting time for elective priority cardiac surgery is not reduced to under 4 weeks then there is an increased likelihood of patient harm (including death). | **6 (Med)** | **-** | **-** | **-** | **6 (Med)** | **6 (Med)** | **6 (Med)** |  |  | Sept 2023 | Jan 2025 | June 2025 | **1** |
| DR-232 | CGC | NORS Retrieval Service - on call rota | If NHS Golden Jubilee is not able to fully staff the fortnightly on call rota for the National Organ Retrieval Service (NORS), then as an organisation, we will not fulfil our commitments and meet the agreed SLA with NHS BT.  In addition, NHS Golden Jubilee participates in the national DCD Retrieval rota. We are one of only 4 hospitals in the UK offering this specialist type of retrieval. DCD retrieval is of particular benefit to NHS Scotland patient population as use of the Organ Care System (OCS) used in DCD retrieval does not carry the disadvantage of prolonged cross clamp time. For donor organ – if we do not participate in DCD retrieval, we could disadvantage the NHS Scotland patient population with fewer hearts being available for transplanting. | **9**  **(Med)** | **-** | **-** | **-** | **12 (High)** | **12 (High)** | **12 (High)** |  | Director of Operations | March 20024 | Apr 2025 | Sept 2025 | **1** |

## APPENDIX 2 – Strategic Risk Register

Risk is the chance of something happening that will cause harm or detriment to NHS Golden Jubilee, its staff or patients.

**Clinical Governance Committee**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Ref** | **THE RISK – what can happen and how it can impact** | **RISK APPETITE – Controls In Place** | **MITIGATING ACTIONS** | **Risk Level & Rating (Impact x Likelihood)** | **Executive Lead** | **Corporate Objectives** |
| 250 | If surgical outcomes continue to deteriorate, then SACCS patients undergoing surgery will come to harm, and this may be avoidable.    Rising mortality over the last three years, which appears to exceed statistical thresholds (2SD) compared to rUK for both adjusted and unadjusted mortality.  All clinical risk indicators are being reviewed, including morbidity. | Surgical service was paused on 31/3/25. Low risk (< or = 2%) operating re-started 23/4/25.  Percutaneous interventions with higher risk of requiring surgical rescue also paused.  Higher risk patients deferred or referred to NHS England units.  Weekly reports to Executive Triumvirate.  Local Quality Improvement Group commissioned to investigate and report by 9th June 2025.  External review by congenital experts from NHS England to be commissioned by NSD in partnership with GJ. | Patient safety is being protected by reducing operations to lower risk only. However, this is not a sustainable solution, as an increasing number of patients will need to be referred to NHS England (which has limited capacity). The combination of internal and external review is expected to identify opportunities for improvement which is expected to allow safe restart of higher risk operations. | Very High  (5x4) | Dr Mark Macgregor | 1 |
| S6 | If we do not maintain adequate control measures we increase our susceptibility to Healthcare Associated Infection events, resulting in a negative impact on patient care and delivery of clinical and corporate objectives. | HAI has the potential to negatively impact patient clinical outcomes and also affect operational delivery through events such as ward closures threatening SLA delivery.  Increased incidence of HAI may negatively impact staff both morale and productivity through ward closures and additional scrutiny.  If unable to satisfy HEI inspectorate could lead to intervention from HIS and/or SG with supported improvement plans which could have impact on operational delivery, financial resource to support improvements and public reports of non-compliance would damage confidence in GJNH. | The controls in place by the Board and ongoing work mean that this risk is retained.  The Annual work plan approved and progress monitored at PICC meeting.  Appropriate clinical risk assessment and patient screening for MSRA and CPE.  Monitoring and analysis of HEAT target data for SAB and CDI supported by multidisciplinary reduction interventions.  SCNs fully engaged via weekly visits and monthly peer reviews and HEI preparedness committee.  HAI Scribe process in place that ensures Infection Control built in to all building/ estate issues. | 2 x 4 = 8  (Medium) | Nursing Director | 2 |

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| --- | --- | --- | --- | --- | --- | --- |
| **Ref** | **THE RISK – what can happen and how it can impact** | **RISK APPETITE – Controls In Place** | **MITIGATING ACTIONS** | **Risk Level & Rating (Impact x Likelihood)** | **Executive Lead** | **Corporate Objectives** |
| B001/22 | **Ability to provide full Laboratory Services on site due to system provider withdrawal**  The ability to provide full laboratory services on site is at risk due to the IT system provider withdrawing the right to use their software resulting in organisation not being able to provide laboratory services and a requirement to outsource these to other providers.  Golden Jubilee, Borders and Tayside opted to extend their contract with the incumbent supplier to allow upgrades to take place to the existing LIMS system until the national system is available and fit for purpose to allow migration of Jubilee without impacting services. | The Board continues to be an active member of the national LIMS Programme Board monitoring the progress of the development of the national LIMS product.  Process of implementing the upgraded system from the incumbent supplier during this period the current will remain supported by the vendor.  The implementation of the upgraded product is progressing and monitored by a Project Board which reports progress to the Strategic Programmes Board and Finance & Performance Committee. | Go-live of the system is expected in September 2025. | 3 x 2 = 6  (Medium) | Medical Director | 2, 4 |
| DR-207 | **Unavailability of Intra-Aortic Balloon Pumps**  If a patient requires heart function support and there are no available Intra-Aortic Balloon Pump systems, the potential exists that the patients stability / or treatment programme will be adversely affected. | IABP status web page used to track and co-ordinate use. Process is in place for MDT agreement before use (other than emergent insertion).  Medical Equipment Off Label Risk Assessment in place to cover potential return to use of additional systems.  Discussions ongoing with supplier to prioritise delivery of parts to GJNH.  Stakeholder Response Group not pursuing possibly of changing to an alternative supplier (quality issues with the product in NHS Lothian and the timing of implementation when compared to projected resolution of the supply issue) | Capital planning funding allocated to replace Intra-Aortic Balloon Pumps in GJNH, evaluation of replacement product underway. | 3 x 1 =3  (Low) | Medical Director | 2, 4 |

**Staff Governance and Person Centred Care Committee**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Ref** | **THE RISK – what can happen and how it can impact** | **RISK APPETITE – Controls In Place** | **MITIGATING ACTIONS** | **Risk Level & Rating (Impact x Likelihood)** | **Executive Lead** | **Corporate Objectives** |
| SR-241 | **The cost of organisational change as a result of service re-design**  Service re-design means organisational change, with the need to protect (with lifetime protection) the existing terms and conditions of staff members. Although the cost of the existing staff members is already being felt by the organisation (and will need to continue with lifetime protection), there is a financial risk in the need to fund additional resources to ensure each service is resourced in the right way.  Organisational change as a result of service re-design is likely, with the risk of resourcing costs (with the need to protect the pay of existing staff).  If staff members are displaced they could remain on redeployment and given a work assignment. Costs still lie with the organisation as there is no compulsory redundancy. | The NHSGJ Organisational Change Policy and Oversight Group is in place to assess and document the impacts of all Organisational Change.  This process ensures that all potential changes that result in the need for additional resources will be presented to ELT for review and decision.  This process also considers the redeployment implications of all change, with the desire to redeploy staff based on their skill set. | The NHSGJ Organisational Change Policy and Oversight Group is in place to assess and document the impacts of all Organisational Change.  This process ensures that all potential changes that result in the need for additional resources will be presented to ELT for review and decision.  This process also considers the redeployment implications of all change, with the desire to redeploy staff based on their skill set. | 3 x 4 = 12  (High) | Director of People & Culture | 2, 3 |
| SR-242 | **Recruitment and Retention of staff across NHS GJ**  Should NHSGJ fail to retain staff in key roles (either through natural attrition or retirement), there’s a risk in the recruitment of their replacements, as a result of National challenges in the employment market. This could negatively impact patient care and the ability to meet activity levels.  Consistency of AFC JE panels may provide challenge, as roles across NHSS can be matched to higher bands than NHSGJ. This can impact on hard to fill roles. | Succession planning and PDP’s to support the organisation’s skill retention and ensure staff see NHSGJ as an attractive option.  SLT sessions to support development of staff.  Job descriptions for ESM staff go through NEC which ensures there is consistency in terms of pay for these roles.  Escalation to SG on consistency and organisational risk at period of significant change and growth.  Workforce risks developed at Divisional level where key roles are identified as hard to fill with contingency plans in place to ensure services are delivered. E.g. Anaesthetists, Radiology, Key Nursing roles, Perfusionists.  Contingency plans in place in form of WLI, Agency and Locum where staffing would impact on services delivery  Details of workforce challenges contained within the service/ department workforce heatmap.  Monitoring staff turnover, iMatter scores which detail ERR scores and recruitment across the entire organisation via Vacancy Management Group which highlights ongoing recruitment. |  | 3 x 3 = 9  (Medium) | Director of People & Culture | 1, 2, 3, 6, 7 |
| **Ref** | **THE RISK – what can happen and how it can impact** | **RISK APPETITE – Controls In Place** | **MITIGATING ACTIONS** | **Risk Level & Rating (Impact x Likelihood)** | **Executive Lead** | **Corporate Objectives** |
| 230 | **Fixed Term Contracts**  If NHS GJ fails to ensure robust rigor from both HR and all managers of Fixed Term contract staff, then there is a risk that Fixed Term contracts can slip further than 24 months (and beyond), which, if not properly thought through and managed, can result in a poor employee experience and/or organisational responsibility/cost.  Failure to effectively manage contracts for employees who are fixed term may result in an impact on adequate staffing levels to support operational delivery of services.  There is a risk to the wellbeing of colleagues on long term fixed term contracts, loss of talent and increased retention.  Missing information within the eESS system could lead to missed opportunity to manage individuals on fixed term contracts resulting in NHS GJ failing to comply with Fixed Term Contract legislation.  Failure to effectively manage fixed term contract could lead to staff being entitled to permanent contracts resulting in financial impact to the organisation and additional risk of Employment Tribunals. | Consistent decision making with the instances in which Fixed Term contracts are used, with scrutiny over the approvals process.  Accurate and timely data, so that we’re clear on the tenure of all Fixed Term contract employees.  Close collaboration between HR and the managers of Fixed Term contract employees to anticipate the end of Fixed Term contracts in good time for rich employee conversations to take place and for appropriate notice to be provided in accordance with Fixed Term Contract policy and Contracts of Employment.  Quality assurance is undertaken on monthly basis on reports from eESS to ensure data is accurate and complete. All fixed term contracts logged in eESS.  Staff support mechanisms are widely available to staff to support psychological safety and wellbeing.  Workforce data is monitored at each Staff Governance Person Centred Committee meeting.  Staff on fixed term contracts have to be given time on redeployment and this is linked to the pay grade of the staff member.  There is a formal query currently logged with National Team to identify if any additional actions could be implemented to further reduce the risk including implementation of more streamlined reporting. |  | 3 x 3 = 9  (Medium) | Director of People & Culture | 2, 3 |

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| **Ref** | | **THE RISK – what can happen and how it can impact** | **RISK APPETITE – Controls In Place** | **MITIGATING ACTIONS** | **Risk Level & Rating (Impact x Likelihood)** | **Executive Lead** | **Corporate Objectives** | |
| SR-243 | | **Staff wellbeing and Absence**  The increased focus on achieving a balanced system may drive service re-design. That service re-design may result in fewer resources delivering the same level of activity (e.g. if any decisions are made to pause the immediate replacement of vacancies). That, in turn, may result in a negative impact on the Health and Wellbeing of staff across NHSGJ, with an increase in absence levels. | 5 pillars of Wellbeing linked to the Wellbeing plan are in place to support all staff and volunteers across NHSGJ.  EAP in place for all staff.  OH team and Spiritual Care team to support staff and volunteers with counselling, mindfulness and a listening ear.  OD team to support team interventions across NHSGJ.  Vaccination programme for Flu and Covid.  Physiotherapy team to support MSK issues for staff in place.  Staff rostering monitors working hours and this is reported to ELT (over 48hrs working).  Hybrid working in place for staff  Resilience training framework in place to support staff.  SG Culture and wellbeing DL linked to improving staff wellbeing and organisational culture to support staff wellbeing and culture.  Vacancy approval process in place.  Vacancies can still be raised by managers albeit there are financial saving and targets on all divisions and departments across NHS GJ. | Absence Management training in place to support staff with Absence Management process linked to HR support and OH support.  Stress risk assessment linked to Stress risk management policy in place to support staff members prior to OH becoming involved.  Wellbeing Zone being developed for staff use.  Board wide Culture and Leadership programme being developed to support staff health and wellbeing and ensure that NHSGJ has a healthy working culture. | 4 x 4 = 16  (High) | Director of People & Culture | 7 | |
| B003/22 | **Retention and recruitment to senior positions within NHS GJ.**  This is due to differential position across NHS Scotland which may place NHSGJ at a competitive disadvantage relative to other boards in Scotland and further afield.  The recent outcome of job descriptions progressed through the NEC process have resulted in 3 remaining at their current Executive banding level. The recent AfC pay award removes any gap between AfC Grades and Executive salary scales.  The absence of appeal mechanisms for affected staff and the lack of consistency in approach to evaluation and equivalent positions in other NHS Boards may provide a disadvantage to the recruitment and retention of senior/executive posts to NHS GJ. | The recent outcome of job descriptions progressed through the NEC process have resulted in 3 remaining at their current Executive banding level. This recent AfC proposed pay award also reduces the gap between AfC Grades and Executive salary scales. | Succession planning of Aspiring Directors and Aspiring Chief Executives  The consistency in approach to evaluation and equivalent positions in other NHS Boards may provide a disadvantage to the recruitment and retention of senior/executive posts to NHS GJ.  Mitigations will include maintenance of risk, review of succession planning, further review of banding where applicable and escalation to Scottish Government on consistency and organisational risk at a period of significant growth and input to NHS Scotland recovery plans. | 4 x 4 = 16  (High) | Director of People & Culture | | 1 |

**Finance & Performance Committee**

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| SR-244 | **Capital Infrastructure**  If adequate funding is not available through Scottish Government allocations, we are unable to invest in capital infrastructure.  If we fail to invest adequate funding into our capital programme, we will risk the failure of critical infrastructure resulting in an impact on patient care, waiting time, staff morale and organisational reputation. | Capital programme initiated following agreement on funding allocations and robust prioritisation in place, including forward look at equipment needs across the organisation.  Robust governance in place through Strategic Capital Group and Capital Delivery Group which ensure a robust objective and risk based prioritisation process.  Capital programme is reviewed and scrutinized through the Finance and Performance Committee. | Robust review and completion of the Whole System Infrastructure Planning Directors DL through a risk based approach to understand priorities and the financial impact | 3 x 4 = 12  (High) | Director of Finance | 1 |
| O9 | **Waiting Times Management**  If we do not effectively manage waiting times whilst delivering recovery plan targets, we will fail to meet TTG for patients which could result in poorer patient experience and outcomes and reputational impact for the organisation.  Patients may deteriorate clinically whilst awaiting treatment; need to ensure review and prioritisation of clinically urgent patients.  Patient experience of waiting in excess of TTG; increase in complaints relating to waiting times.  We will be seen as unable to deliver operational targets and impact on the reputation of the organisation.  Inability to meet waiting list may result in loss of income within NES. | Key initiatives agreed with SG; ongoing liaison with NHS Boards to support implementation. Specific work implemented to minimise cancellations.  Monthly SG meeting with access support team on activity and challenges and SLA leads meetings for NES.  Weekly performance review meetings to consider performance against recovery plan. Monthly IPR report with waiting times.  Robust governance mechanisms for waiting time report through confirm & challenge, finance and performance committee with the implementation of recovery plans to support where required.  Opening of Phase 2 to support increase capacity  Working with CfSD and NECU to improve pathways to help reduce waiting times  Adherence to the new national waiting times guidance | Improved communication with patients around waiting times. | 4 x 2 = 8  (Medium) | Director of Operations | 1 |

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| S11 | **Expansion Programme**  If we fail to deliver the expansion programme we would be unable to deliver our commitment to the Scottish Government Treatment Time Guarantee and Annual Delivery Plan which would result in a negative impact on reputation and credibility of clinical models.  Failure to achieve key strategic objective, ability to deliver wider commitments of programme and added value at national level.  Impacts on national government strategy of failure to deliver.  Potential for financial impact should a breach occur.  Being unable to have the staffing compliment to deliver services linked to Expansion programme and deliver key services due to lack of staff. | Robust governance structure in place with Senior User Group reporting to the Expansion Programme Board.  High level milestones agreed and an agreed programme in place for remaining works for CSPD and EDU.  Project team, principal supply chain partner, designer and contractors in place.  Agreed finance model in place with Scottish Government.  Reporting mechanisms which outlines posts that have and have not been filled in place. | Risk appetite to be developed for the work task order programme | 4 x 3 = 12  (High) | Director of Operations | 4 |
| S22 | **Site Masterplan**  If we do not ensure a robust approach to planning site capacity, then we will fail to effectively utilise the available space  Increasing demands on the available space via Expansion and natural growth in service mean conflicting pressures for space.  Short term moves to accommodate risk multiple relocation of services, moves that are not fit for purpose, impact on staff morale, financial and service costs of multiple moves and risk that we do not maximise available opportunities. | Site utilisation and management group in place and initial plans defined  Workplace for the future programme  Phase 2 Expansion programme design  Direct communications with departments to confirm in advance requirements prior to move  All moves require validation and authorisation from Executive Leadership Team.  Direct communication with all groups effected to confirm on requirements and timelines.  Co-ordinated approach with eHealth |  | 3 x 2 = 6  (Medium) | Director of Finance | 4 |
| S10 | **Cybersecurity**  A failure to maintain adequate cyber security controls may lead to disruption to digital services resulting in the potential compromise of patient data, damage to equipment and systems, adherence to organisational policies/legislation and reputational damage  Failure to keep up to date with the latest techniques, approaches, technology  Cyber hygiene completion and compliance with the module may not meet the organisational standard  Content sent via email or accessed over the internet can still be visible on the network  Security patching not fully embedded and any patches not being completed remains a threat to the network  Our 3rd party suppliers/vendors could be compromised and in turn could result in local network being compromised and infected  In the event of a cyber-incident occurring out of hours, there is insufficient cover to respond to reporting requirement in a legislative timely manner  A misconfigured component resulting in a significant outage of services | Client and server anti-virus that provides protection against from malicious software.  Perimeter firewalls that prevents access to the network from unauthorised sources.  Security monitoring capabilities which provide visibility over active or potential security threats.  Email and internet filtering prevents the download of unwanted / inappropriate content.  Policies and processes that ensure we adhere to our legislative requirements, which are reviewed within time periods and where incidents still occur.  Education programme that covers good cyber hygiene across the entire user population.  Multiple external agency support provides expanded capability cyber incident monitoring and response.  System security patching to ensure software in use is adequately protected from cyber threats. | Improved contract management processes, internally and with external vendors  Potential for cyber hygiene training to become mandatory  Cyber security response process developed to ensure clear roles & responsibilities  Maintaining skill sets and introducing robust change control within the team | 3 x 2 = 6  (Medium) | Director of Finance | 2 |
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| B004/22 | **Centre for Sustainable Delivery**  CfSD identity and funding may be unclear due to not having clear boundaries and demarcation and confirmed baselined (annual) funding from the Scottish Government leading to unclear core CfSD workforce costs and limiting CfSD’s autonomy and shift its perception from a national improvement body to a performance organisation. This would impact on engagement with other NHS Boards, delivery of annual objectives and sustainability of service, staff retention and increased staff turnover, with reputational impact on the organisation  Boards not seeing CfSD as neutral and therefore disengaging with reluctance to share data  Blurred boundaries leading to competing priorities with the Golden Jubilee and Scottish Government, hindering CfSD's ability to deliver on its own objectives with a shift in perception from a national improvement body to a performance management organisation could dilute CfSD's focus on service redesign, innovation and transformation  CfSD's reputation as a change driver and innovator in health and social care could be weakened, reducing its influence and effectiveness at a national level, through loss of confidence from key stakeholders  **I**nability to retain core staff levels, leading to potential disruptions in CfSD programme delivery and programme sustainability  Increased costs due to recruitment and training of staff due to staff turnover  Lack of recurring funding hinders long-term strategic planning and decision-making for workforce development. | Board Engagement Meetings to reinforce the distinction between both organisations in terms of service provision and areas of responsibility.  Regular engagement with SG around budget and funding when meeting with SG sponsorship team.  Continuing Engagement with SG for multi-year funding arrangements to reduce reliance on annual financial cycles  Ongoing monitoring of CfSD workforce costs and funding gaps, allowing early detection of risks and timely mitigation actions.  Evidence-based annual reporting demonstrating the impact and value of CfSD's work  Quarterly reporting on milestones and outcomes to the Scottish Government. | Defined CfSD Roles & Purpose through detailed MoU  Review & Align CfSD Strategic Objectives with service improvement rather than performance monitoring with formal definitions to differentiate activities  Create a comprehensive funding strategy that explores confirmed funding sources from SG to ensure financial sustainability for core CfSD workforce costs. | 4 x 3 = 12  (High) | Director of CfSD | 1, 5, 6 |

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| SR-245 | **Health & Safety**  Failure to provide the agreed standards of protection to employees and others in line with statutory legislation and Health and Safety Executive guidance arising from an ineffective risk assessment framework and suboptimal culture and inappropriate behaviours. This leads to the potential failure to provide employer’s duty of care, resulting in non-compliance with relevant Health & Safety legislation, potential harm to employees/service users, financial claims or fines, prosecution and reputation impact. | Health and safety policies, procedures and guidance with clearly documented roles and responsibilities outlined are available to all staff and members via share point to ensure we adhere to our legislative requirements.  Robust governance in place through the H&S Clinical Divisions Meetings, H&S Corporate Divisional Forum and H&S Committee to enable sharing, approval and distribution of policies and procedures.  Education resources available covering Risk assessment for Line Managers, DSE Awareness, DSE Assessor, RIDDOR  A-Z guide for managers in place  Online Health and Safety monthly inspection tool for managers to monitor their departments relating to Health and Safety performance and compliance in key areas.  Program of H&S audits of all departments with feedback mechanisms for service leads by Health and Safety Team.  Adverse incidents are recorded and investigated via Datix, with trends and themes highlighted and areas requiring further investigation or action. | To ensure we have an appropriate system to support management of risk relating to Health & Safety at an appropriate level  Review existing tools and training to support managers (competencies). Develop and deliver new resource materials where identified.  Consideration of Health and Safety training module as statutory/mandatory.  Digitisation of risk assessments, i.e. hosted on datix or similar  Review of induction process for new staff to ensure they received the agreed information at the agreed times. | 4 x 3 = 12  (High) | Director of Finance | 1, 7 |
| SR-246 | **SNAHFS Funding**  The current SNAHFS funding profile is insufficient (as detailed through recent Business Case) to meet service requirements. The service delivers activity across a number of pathways – some non-elective (unplanned) and therefore activity is unpredictable. Without sufficient budget, there may be an in year overspend and a requirement to ‘pause’ service resulting in direct harm to patients and a reputational impact to the organisation.  The SNAHFS is a national service working alongside 5 other UK transplant services. If the service were to pause – there would not be capacity across the other centers to support Scottish patients, nor would this be safe, patient centered or financially sensible.  If the service were to ‘pause’ there would be direct harm to patients. | Robust governance and escalation in place through the performance governance framework to ensure robust monitoring.  Monthly financial monitoring in place within service to review spend against budget. | Working with executive and Finance colleagues to seek additional funding for this service from NSD and SG | 5 x 1 = 5  (Medium) | Director of Operations | 1 |
| B002/22 | **Use of unsupported Apps and personal email accounts within the organisation for information sharing purposes**  It has been identified that some medical specialties are using WhatsApp and personal email to share treatment information, this type of information sharing is not appropriate, is unsupported and has not been risk assessed. If we continue to use unsupported apps to share information for the purposes of patient care then this could result in an inspection from data protection regulators with the possibility of an enforcement notice and/or monetary penalty. | Guidance being drafted to be disseminated to staff regarding the use of these platforms and safer supported methods that are available.  Providing end users with the appropriate tools to allow them to communicate via the approved methods. |  | **High** |  |  |
| DR-220 | **Cardiac Surgery Waiting List Harm**  If the current waiting time for routine elective cardiac surgery is not reduced to under 12 weeks then there is an increased likelihood of patient harm (including death).  If the current waiting time for elective priority cardiac surgery is not reduced to under 4 weeks then there is an increased likelihood of patient harm (including death). | •Clinical Prioritisation of referrals  •Clinical (SOD) prioritisation of the theatre list for next day  •Waiting List Management - weekly review of patient waiting times and treatment plans for long waiting patients.  •Activity and Demand reports are reviewed monthly and shared as part of the Confirm and Challenge meeting with Exec Team to ensure awareness of the waiting times.  •Patient Information - Worsening advice guidance (for patients, relatives and referrers). Follow up phone call from nurse scheduler for patients making contact with deteriorating symptoms  •Training and Education for secretarial and booking staff– awareness of the patient pathway and how deteriorating patients can be escalated  •Mortality and morbidity reviews.  •Extended theatre day -work underway to increase number of theatres staffed to run past 1800 (to allow more 2 case lists to proceed)  •Theatre efficiency – reduce cancellations, early start/K2S, reduce turnaround time |  | **Med** | Director of Operations |  |
| DR-232 | **NORS Retrieval Service - on call rota**  If NHS Golden Jubilee is not able to fully staff the fortnightly on call rota for the National Organ Retrieval Service (NORS), then as an organisation, we will not fulfil our commitments and meet the agreed SLA with NHS BT  In addition, NHS Golden Jubilee participates in the national DCD Retrieval rota. We are one of only 4 hospitals in the UK offering this specialist type of retrieval. DCD retrieval is of particular benefit to NHS Scotland patient population as use of the Organ Care System (OCS) used in DCD retrieval does not carry the disadvantage of prolonged cross clamp time. For donor organ – if we do not participate in DCD retrieval, we could disadvantage the NHS Scotland patient population with fewer hearts being available for transplanting. | 1.Fortnightly NORS debrief meeting – which includes:  I)Review of retrievals from previous week  ii) Review of the on call rota for the forthcoming week (consultant, SAS and theatre) groups of staff.  iii)Review of any adverse incidents relating to retrievals  2.Formal and informal discussions with NHS BT regarding issues with rota cover in an effort to try to cover from other sites  3. Using individual contacts from other centres to assist with locum cover. These individuals have been encouraged to join our Staff Bank to ensure payment can be made.  4. Working to appoint a 2nd retrieval surgeon to help reduce impact on 5 NORS surgeons – awaiting formal sign off still  5. All SAS doctors now trained in DCD retrieval and there is a training programme in place for theatre nursing staff. |  | 4 x 3 = 12  (High) |  |  |