Western Health and Social Care Trust

CORPORATE RISK REGISTER & ASSURANCE FRAMEWORK

BRIEFING NOTE PREPARED FOR TRUST BOARD
11 JANUARY 2018

There are 23 risks on the Corporate Risk Register as approved at Governance Committee on 13th December 2017.

Material changes to Corporate Risk Register for approval

There are no material changes for consideration for approval.

Two risks have been de-escalated from the Corporate Risk Register following approval at Governance Committee on 13th December 2017. The following risks are now to be managed at Directorate level: -

Risk ID.	Risk Title	Lead Directorate
108	Failure to maintain the quality of services delivered	Medical
948	Delegation of administration of medication and specialised tasks in Short Break Residential Facilities.	Womens and Childrens Services

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	Initial Risk		Current Risk		Target Risk												
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3	16	HIGH	12 (4x3)	HIGH	12	MEDIUM	Medical Director	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Governance.Workforce.	Health and Safety risk - resulting in injury	Risk of injury to patients/clients/staff and visitors arising from failure to fully comply with Health & Safety legislation.	Incident reporting and investigation. Health & Safety Inspections and action plans . Induction and Mandatory Training for Staff. Occupational Health Self and Management Referrals. Use of aids e.g. hi-lo beds, hoists. Patient/client risk assessment. Leadership Walkrounds. KPI for health & safety, e.g. falls. Falls Risk Assessment. Falls Prevention Policy. Labs representative on Health & Safety Working Group Corporate Risk Manager and Risk Management Officer NEBOSH qualified in addition to H&S officer COSHH added as standing item to Health &Safety Working Group agenda. Annual review of completed H&S Risk Assessments Directorate Gov Reports with H&S RA info Health & Safety Policy. Health & Safety Working Group. H&S Risk Assessments. Specific health & safety policies (e.g. COSHH, Latex, Manual Handling, First Aid). Nominated Site (Fire, Health & Safety) Officer training.	Lack of funding to purchase H&S equipment or undertake maintenance of equipment/facilities. Comparatively limited staff resources dedicated to H&S.	RQIA inspections. Internal Audit of H&S Controls Assurance Standard (2012/13). Benchmarking by Regional H&S Practitioners Group. Inspections by HSENI. Inspections by H&S Officer and H&S Working Group members. Review of Incident data by H&S Working Group (inc. Union reps). Inspections by Regional Medical Physics Services Advisers. Sharepoint site for H&S Risk Assessments. Internal Audit of Risk Management Controls Assurance Standard (2013/2014). Manual Handling Audit at Altnagelvin Hospital (July 2013 and re-audit September 2014) Monitoring of implementation of recommendations following inspections/Leadership	No gaps identified.	Labs to be represented on Health & Safety Working Group Priority rationale for H&S Inspection Development of H&S learning themes for Claims, Incidents and Complaints to evidence actions required. Risk Management Officer trained in NEBOSH to complete shadowing of H&S Officer Risk and carry out first H&S Inspection. Corporate Risk Manager to complete NEBOSH qualification. Carry out review of completed H&S Risk Assessments.	31/01/2017 30/09/2017 31/03/2018 28/02/2017 28/02/2017 31/12/2017	09/01/2017 30/09/2017 28/02/2017 28/02/2017
6	25	EXTREM	12 (4x3)	HIGH	8	HIGH	Director of Women & Childrens Services	Women & Children's Services	Safe & Effective Services.	Potential for harm to children whilst awaiting Gateway and Family Intervention Service (unallocated cases)	Potential for harm to children whilst awaiting Gateway and Family Intervention Service and Disability Services (unallocated cases) due to capacity issues in the service limiting the ability to respond in designated timescales.	Ongoing action to secure recurring funding. FGC Service contacts FIS to organise FGCs to reduce risk / attempt early resolution. Looked After Service reviewing capacity to enable transfer of cases. Update meetings between F&CC ADs and Director. Performance Management Review is being undertaken by HSCB with all 5 Trusts focusing on Unallocated cases and timescales Service and SW Managers constantly prioritise workloads.		Quarterly governance reports to Governance Committee. Feedback given to Performance & Service Improvement for accountability meetings with HSCB. Up-dates by Director to CMT and Trust. Delegated Statutory Functions	No gaps identified	redesigning some service areas which will address some of the unallocated cases issue so this will be reviewed again when the new arrangements are in place Staff redeployed temporarily to Enniskillen area until staff recruited	30/09/2017	30/09/2017 30/09/2016

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46	12	HIGH	12 (4x3)	HIGH	9	MEDIUM	Director of Human Resources	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Challenges to compliance with Working Time Regulations	For Junior Doctors in training the Trust may not be able to fulfil its statutory obligations under the EWTD and/or New Deal due to the intensity of junior doctors rota or lack of doctors participating on the rotas and/or an inability of the Trust to fill vacant posts by recruitment or agency. Doctors on full shift rotas and on call rotas may exceed the maximum 48 hours of actual work thus breaching the maximum hours requirement under EWTD. This may also put the rota into a higher Banding Supplement. In particular the unpredictability of on call rotas means that 11 hours continuous rest (or compensatory rest) in every 24 hour period may not be achieved. "Sleep-in" is a working pattern in residential facilities where a member of staff is required to sleep in the facility as a back up to waking night duty staff. Sleep may be disrupted due to certain situations so compensatory rest is allocated. 	Monitoring of Junior Doctors working hours. Representations made to BLG & NIMDTA regarding ability to sustain rotas. Payroll alerts to HR on excessive working hours. Directorate Support Team working with W&C Directorate to address situation in Residential Children's Homes. Bi-annual monitoring of hours to determine Junior Doctor workload reported to DOH. Ensure compliance with Locum agency contract arrangements. Guidance on EWTD and compensatory rest. AD HR member of Regional Medical and Terms & Conditions Group. Letter sent to Nursing staff in Acute & AMHLD Dirs in July 2013 and PCOP in Oct reminding them of requirements of EWTD. Guidelines to clarify bank arrangements developed (QICR2). Senior HR Managers are assessing the consistency of approach in relation to sleep ins across the Trust. Trust participation on Regional Working Group to review rota for Children's Homes. Agreement to phase out use of Home Care/Home Help high hour contracts.	Despite best efforts the Trust is not always able to meet the requirements of the regulations. Inability of NIMDTA to fill all posts.	Junior Doctors monitoring information submitted to DOH and considered by Board Liaison Group. HSCB, through Board Liaison Group, monitor safe hours of work for Junior Doctors and Dentists.	No gaps identified.	Work continues within relevant Directorates in relation to rotas, sleep ins, etc. Reissue of letter to nursing staff regarding EWTD responsibilities. Review of Guidance on EWTD and compensatory rest.	31/03/2018 31/03/2018 31/03/2018	
49	16	HIGH	16 (4x4)	HIGH	9	MEDIUM	Director of Performance & Service Improvement	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Virus attack disables network/services	Information security across the HSC is of critical importance to delivery of care, protection of information assets and many related business processes. If a Cyber incident should occur, without effective security and controls, HSC information, systems and infrastructure may become unreliable, not accessible when required (temporarily or permanently), or compromised by unauthorised 3rd parties including criminals. This could result in unparalleled HSC-Wide disruption of services due to lack of/unavailability of systems that facilitate HSC services (e.g. appointments, admissions to hospital, ED attendance) or data contained within. This may result in the need to cancel appointments and treatments, or divert emergency/essential clinical or other services. The significant business disruption could also lead to increased waiting lists, delayed urgent clinical interventions, suboptimal clinical outcomes and potentially bring liabilities for the Service. It could also lead to unauthorised	Data & System backups 3rd Secure Remote Access Server / Client patching HSC security software (threat detection, antivirus, email and web filtering) HSC security hardware (e.g. firewalls) 3rd Party Contracts / Data access agreements Contract of employment HR Disciplinary Policy Mandatory training policies Induction policy Regional and local Incident Management & reporting policies & procedures Corporate Risk Management framework, Processes & monitoring Emergency planning & Service business continuity plans Disaster recovery plan Ussr account management processes Change control processes Dat protection Act Regional & Local ICT info security policies	Insufficient User Awareness of impact of personal behaviours in relation to cyber threat Full extent of gaps are not understood at this point - Gap analysis regionally and locally required by HSC to capture a considered extent of vulnerabilities Insufficient corporate recognition and ownership of cyber security threat as a service delivery risk	HSC SIRO Forum for shared learning and collaborative action planning and delivery Internal audit / IT Dept. self-assessment against 10 Steps towards NCSC Technical risks assessments and penetration tests		Plan "faux" cyber security exercises to test user behaviours, service continuity / disaster recovery plans and take appropriate actions in light of consequences and learning Work with colleagues across the region to develop and share learning, techniques, protocols and staff guidance, including User Awareness Campaign and System Managers/Admin training Introduce routine reporting to Trust Board (or other equivalents (local or regional)) on reported incidents/near miss, and other agreed indicators Revisit Business Continuity Planning within context of wide-scale local & regional service disruption during a potential cyber security incident	31/12/2017 31/03/2018 31/08/2017 31/08/2017 31/12/2017 30/11/2017 30/11/2017 30/09/2017	

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51	16	HIGH	16 (4x4)	HIGH	8	HIGH	Director of Finance	Finance and Contracting	Financial Management & Performance.	The inability of the Trust to achieve break-even	The inability of the Trust to achieve break-even. The Trust has quantified its opening deficit at £40m and has identified additional in-year cost pressures amounting to £19m. The Trust is awaiting confirmation of the funding to be expected for 2017/18 and discussions are continuing with the DoH.	Monthly review by Director of Finance of ongoing applicability of accounting assumptions and estimates. Corporate Management Team Financial Monitoring Group monitor performance reporting to Trust Board as well as achievement of savings targets. Escalation process for flagging significant issues to the Chief Executive. Directorate Accountability meetings cover performance against financial targets. Development of contingency plans to support delivery of breakeven. Delivering Together Programme Board which monitors delivery of savings. Monitoring of Action plan by HSCB/DOH	Controls are in place. However, it is not always possible to have full financial controls without looking at quality & safety risks to patients/clients.	CMTFMG financial performance reports to Trust Board and CMT members. DHSSPS/HSCB monthly financial monitoring. External Audit (NIAO) . Self-assessment and audit of Financial Management Controls Assurance Standard. Assurance obtained by the Chief Executive from chairing CMTFMG. Assurances from Director of Finance and ADF to CMT & Trust Board. Internal Audit.	No gaps identified.			
57	16	HIGH	8 (4x2)	HIGH	8	HIGH	Medical Director	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Governance.	Lack of cross-Directorate learning from adverse incidents, complaints, claims & audit recommendations	Potential risk that learning from incidents, complaints, litigation and audit is not disseminated across the organisation, or regionally across the HSC.	Reports to Senior Managers re closed incidents. Share to Learn newsletter and Lesson of the Week. Use of Datix to record lessons learned and provision of reports. Quarterly Audit Up-dates to Directorates. Audit Steering Group. Annual Audit Conference. Details of Audits carried out independently by staff are provided to Audit Dept. Role of CMT/Governance Committee/Trust Board. Learning Letters issued by HSCB. Communication of learning arising from incidents, SAIs, complaints and legal claims and associated action plans. Quality Improvement Event SAI Learning Event Automated email to reporters with Learning from incidents through Datix upgrade Mediform pilot SWAH Compliance with Regional Post Falls Review and Learning template - Now on Datix Claims learning themes developed Datix upgraded to maximise potential of system Standard learning reports on Datix for	Learning from Audits that are carried out without knowledge of Audit Department may not be implemented. No regionally agreed process for sharing learning following legal claims (to be developed by Directorate of Legal Services). Learning themes not yet applied which could focus action on broad areas for improvement No system for providing assurance that learning identified has been shared and practice changed.	Monthly reports to HSCB on closed complaints. Inspection by RQIA. BSO Audit of Risk Management and Governance Controls Assurance Standards. BSO Audit of Risk Management Procedures (yearly). External audit (NIAO) . Audit of Junior Doctor Incidents (January 2013). BSO Audit of Claims Management (October 2014). BSO Audit of Health & Safety (June 2014). BSO Audit of Incident Reporting Procedures (February 2012). DHSSPSNI/RQIA Review of SAIs 2009-2013. Learning from Claims, SAIs added to Datix, Automatic feedback on Datix, Ward level learning communication plan SWAH M&M process	No gaps identified.	Identification of learning themes and allocation of these to SAIs and litigation Upgrade Datix to facilitate Automatic Datix feedback Roll out of standard learning reports on Datix Learning Themes developed for Litigation cases Falls learning template system adopted Automated email to reporters with Learning from incidents through Datix upgrade	28/02/2018 31/01/2017 31/12/2016 31/03/2017 31/03/2017 30/09/2017	15/02/2017 30/11/2016 31/03/2017 01/02/2017 18/09/2017

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58	12	MEDIUM	12 (3x4)	MEDIUM	9	MEDIUM	Director of Human Resources	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Over dependence on the use of locum and agency staff to sustain services and insufficient induction for locum medical staff	Risk of inability to maintain services as a result of Trust wide difficulties regarding recruitment to certain specialties across the Trust resulting in an over dependence on the use of agency and locum staff. (Also see Acute Directorate Risk ID344 and PCOPS Risk ID702).□ □ Implementation of Circular HSC (F) 19-2017 - Introduction of new taxation rules applying to off payroll working (IR35).□ □	Trust HR representation at regional AHP Group. Trust HR representation at International Nurse Recruitment Groups. Procedure for IR35 Assessment. Senior HR Manager (Band 8a) Medical Workforce Project and QICR in post. Roll out of Erostering which means better reporting on use of bank and agency staff by area, ward, etc. Medical Workforce Recruitment and Reform Project Board. Directorate summary "yellow pages" information on Agency & Locum costs reported through QICR. Guidelines on use of medical and non-medical agency staff. Use of recognised employment agencies to recruit Locums. Locum placement assessment form. Nursing Peripatetic Nursing Team. Preparation & induction of Locums to undertake their assigned roles. Professional Nurse Interviewers. CVs verified by senior staff. Terms & Conditions of Contract. Representations made to NIMDTA regarding Jnr Dr requirements.	Insufficient applicants for nursing and social work posts. Inability of NIMDTA to provide required number of Junior Doctors for certain specialities. Unpredictability of circumstances i.e. to cover sick leave or an increase in demand for service.	Progress reports to Audit on recommendations. Audit Report on Management of use of agency and medical locum staff.	Lack of a regional cap on agency rates.	Progress Medical Workforce Recruitment & Reform Project Plans Continue to work on a regional level on solutions. Address ad hoc speciality issues as they arise.	31/03/2018 31/03/2018 31/03/2018	
63	15	EXTREM	15 (5x3)	EXTREM	15	EXTREM	Director of Adult Mental Health & Learning Disability	Adult Mental Health & Disability Services	Governance.	High risk forensic/challenging individuals who have potential to cause harm to themselves or others	High risk forensic/challenging individuals who have a potential to cause harm to themselves or others.	Ongoing Training and support to staff. Ongoing Multi-agency monitoring. Individual contingency plans in place. Multidisciplinary & multi-agency discharge review meetings. Management & supervision of register. Live register of those who present most at risk. Keyworkers and Care Co-Ordinators identified for each Enhanced Discharge Plan.	Limited therapeutic environment. Lack of local availability of low secure placements or step-down facilities. Limited ability to ensure therapeutic interventions. Specialist services generally not well resourced.	RQIA inspections/reviews. Low level of incidents reported for this client group.	No gaps identified.	Review Enhanced Care plan list by AMH Governance lead	31/07/2017	

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64	16	HIGH	9 (3x3)	MEDIUM	6	MEDIUM	Director of Women & Childrens Services	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Availability of age appropriate inpatient services for children and young people with mental health difficulties	The placement of an under 18 in an adult psychiatric ward is not appropriate due to age and need. All risks associated with such a placement require individual attention based on the needs of each situation. Admission to regional Tier 4 services are not always deemed to be therapeutically appropriate as families prefer to stay in localities. Requirement for dedicated, specialist CAMHS service to undertake assessments out of hours.	Risk Assessment and Under-18 Admission Guidelines. Service Improvement Plan under TYC being implemented to assist in development of CAMHS re-design in accordance with Stepped Care Model. Monitoring and reporting to HSCB of Trust position re Under-18 admissions. Pre-employment vetting of new staff who may come into contact with children. Interim arrangements with AMH Directorate with regular interface meetings to review/strengthen practice and transitions. Liaison with the Commissioner re availability of regional beds. New staff starting post in Crisis Home Treatment. This will enhance ability to reduce under 18 admissions. CAMHS Redesign has been fully implemented. WHSCT OOH being reviewed to ensure effective engagement and assessment OOH. The Trust has in place a protocol for "Admission, treatment and discharge of children and young persons under 18 to Adult Wards at Tyrone & Fermanagh, Grangewood and Lakeview Hospitals."	Quarterly reports to RQIA/HSCB re under 18 admissions to adult MH wards. Vetting of all staff on Adult Wards involved in the care of children and young persons not carried out. Full implementation of Child Protection Policy within Acute settings. Lack of Psychiatric Intensive Care Unit for Children and Young People in WH&SCT area.	Directorate reports to Governance Committee. RQIA Reviews. Integrated Intensive Treatment for Teenagers service strengthened to adopt a home treatment approach for young people to maintain them in their own homes thus preventing hospital admission. Audit has taken place on this matter and a repeat audit is planned. Feedback from HSCB confirmed WH&SCT U18 admissions reporting process is good practice and robust.	The Trust have made a bid to the Commissioner (under demographics) for funding to provide a dedicated CAMHS Out of Hours service. Internal Audit of implementation of Under-18 Admissions Protocol. This to take place. New protocol has not been in place long enough to be audited as yet (March 2011)	Protocol to be reviewed Annual Review of Under 18 Admissions to Adults Wards TFH, Grangewood and Lakeview Development Day planned for 5/2/15 to commence implementation of recommendations from Regional Review.	30/09/2017 30/04/2018 30/09/2015	
65	20	EXTREM	20 (4x5)	EXTREM	12	HIGH	Director of Performance & Service Improvement	Trust-wide (Risk Register Use Only)	Financial Management & Performance.	Financial and performance risk	Demand for services exceeds commissioned volumes across a range of planned services. The increased levels of Unscheduled/emergency demand/referrals in 2015/16 have resulted in increased pressure on a range of hospital, Older peoples, MH and Childrens services. There is a financial risk associated with assuring patient safety, and ministerial targets for access to services will not be met as reflected in TDP.	Risk identification and monitoring via incident reporting/staff supervision/HoS meetings/weekly-monthly PFA Monitoring/management accounts reports/Governance, SMT/CMT meetings. Engagement with Commissioner. Regional Access Criteria for Domiciliary Care. Criteria for Access to Nursing/Residential Homes. Directorate and Trust Scrutiny Process	No gaps identified.	RQIA inspections of regulated services. DSF report, clinical audit and reports to Trust Board, Performance report to Trust Board monthly.				
66	25	EXTREM	10 (5x2)	HIGH	5	HIGH	Director of Adult Mental Health & Learning Disability	Adult Mental Health & Disability Services	Safe & Effective Services.	Death or serious injury of patient as a result of a suicide or attempted suicide while in a Trust facility	Death or serious injury of patient as a result of self-harm, attempted or completed suicide, while in a Trust facility.	Close liaison with next-of-kin. Appropriate care plan, nursing and medical management. Ligature assessed environments. Trust Special observation policy is applied Risk Assessment upon admission and regular review. Pre-discharge review and enhanced discharge plan. Collapsible Rails. Induction of new staff ongoing. Review of Risk at AMH&D governance meetings. Serious Adverse Incident investigations and dissemination of learning. Regional AWOL policy is applied. Close liaison with family & PSNI if patients abscond. Policies, procedures and multi-disciplinary working. Staffing levels reviewed to ensure patient safety.	Lack of understanding of policies and procedures of newly qualified staff.	Donaldson Review and review of SAIs reported 2009-2013. RQIA inspections Regular Audit of Risk Assessment by Ward Managers. Review of Serious Adverse Incident Reports by HSCB/RQIA.	No gaps identified.	Maintain regular review.	30/09/2017	

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73	16	HIGH	12 (3x4)	MEDIUM	6	MEDIUM	Director of Performance & Service Improvement	Trust-wide (Risk Register Use Only)	Governance.	Risk that patient medical records and/or patient information on Trust systems may not be complete, accurate or available at PoC	There is a risk that the Trust will not meet its obligations under GMGR to manage and maintain records and its wider information assets appropriately. There is a risk that the quality and completeness of data on the Trust's systems will not be to the required standard.	Information Governance Steering Group has an assurance role for the Trust. Mandatory training on FOI and DPA. Roll out of Electronic Care Record within the Trust to enable electronic availability of summary medical record. Information Governance / Records Management awareness training programme for IAOs.	Develop Robust awareness training programme. Need to develop formal process to remind staff of responsibilities Level of mandatory training up-take by Trust staff falls well below the required/targeted level. No dedicated Data Quality Team within the Trust to support the improvement of data quality/completeness on Trust systems.	Internal Audit of compliance with GMGR. Briefings to Risk Management Sub-Committee/Governance Committee on significant issues. KPMG review of Information Management CAS self assessment. BSO Audit of Information Management CAS. Internal Audit of Information Management CAS. Chart splitting process developed and responsibilities agreed.	Poor up-take of mandatory training. Record-keeping issues at ward level identified by OPJ project. Mis-filing of records a continued issue as identified through the checking of records required under SAR. Medical records not stored, disposed of or return to libraries in line with required protocols. The Trust received a partially limited assurance in the internal audit of Information Governance, relating to specific areas in the Trust. Actions have been agreed to address these deficiencies.	Director PSI to bring fwd. proposal to establish Data Quality Team within the Trust. RFID project roll out.	30/09/2017 31/10/2017	
81	15	HIGH	15 (3x5)	HIGH	9	MEDIUM	Director of Performance & Service Improvement	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Trust Emergency Plans	Failure to effectively implement the Trust Emergency Plans and Call-out Schedule could lead to a ineffective response to a major incident which could result in serious injury or death to patients/clients or staff and loss of service.	Fire Evacuation Plans for all facilities. Trust participation in live and desk-top exercises. Hospital Lockdown Plan in place for Altnagelvin and SWAH. Mass Prophylaxis Plan. Trust Major Emergency Plan. Major incident plan for Regional Agencies PHA and RSCB. Emergency Planning Officer. Emergency Planning & Business Continuity Strategic Forum. Trust representation on Regional Emergency Planning Forum. Learning from exercises incorporated in the Major Emergency Plan. Training and awareness programme.	Departmental Plans require review / further development Trust Wide. No risk assessments performed.	Emergency Planning Controls Assurance Standard self-assessment. BSO Audit of Emergency Planning Controls Assurance Standard. Annual reports to HSCB/PHA and Emergency Planning & Business Continuity Strategic Forum.	No gaps identified.			
99	16	HIGH	16 (4x4)	HIGH	12	HIGH	Director of Performance & Service Improvement	Performance & Service Improvement	Safe & Effective Services.	Failure to fully comply with Electrical Systems and Asbestos Regulations	Failure to fully comply with Electrical Systems and Asbestos Regulations due to insufficient resources. This may lead to improvement/prohibition notices, restriction/loss of service and injury/death of staff/patient/client or public.	Risk treatment plans in place for majority of high and extreme risks. Trust-wide Estates policies and procedures for all appropriate areas. AE Annual Audits AE & CP Training WHSCT Estate Strategy Estates Compliance Team reviews compliance with standards/regulations. Upgraded Asbestos Management System to comply with proposed new legislation.	Identified risk treatment plans not fully implemented due to resource issues. Software Database of all drawings with up to date electrical systems information. Recurring funding not sufficient to meet all compliance issues.	BSO Audit of relevant controls assurance standards. Authorising engineer audit reports against HTM compliance. Buildings, land, plant & non medical equipment controls assurance standard self-assessment. ISO9001 Trust wide. RQIA audits for registered premises. Third party risk assessments for some standards.	No formal system of estate appraisal in place.	Rewire Nurses Home Source AE & CP Training Competent Persons to be assessed and formally appointed Implement action from Authorising Engineer Report. Removal of asbestos prioritised 14/15. Develop Estate Strategy Secure funding for rewire of Nurses Home Removal of asbestos prioritised 15/16 Rewire of Altnagelvin Tower block Wards 7 Source appropriate software database to house all drawings with up to date electrical systems information. Review implications HTM06/01 Rewire of Ward 6. Asbestos survey to be carried out in Tower Block tunnel Implement AE Audit Recommendations from August 2015 Audit.	31/03/2017 31/05/2015 31/03/2017 31/03/2015 31/03/2015 31/03/2016 30/09/2015 31/03/2016 31/03/2016 31/12/2015 31/12/2017 30/11/2016 31/07/2017 31/03/2016 30/09/2017 31/07/2016 30/09/2017 30/10/2017 31/08/2017 31/03/2015	31/03/2017 31/05/2015 28/02/2017 31/03/2015 31/03/2015 31/01/2016 02/09/2015 31/03/2016 31/12/2015 02/09/2015 03/11/2016 04/07/2017 31/03/2016 04/07/2017 31/07/2016 30/09/2017 30/09/2017 31/08/2017 31/03/2015

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100	16	HIGH	12 (4x3)	HIGH	12	HIGH	Director of Performance & Service Improvement	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Backlog Maintenance	There is a risk of deterioration in the Trust Estate due to lack of investment in the maintenance of building services infrastructure and physical environment which could lead to loss of service and non-compliance with regulatory and statutory standards.	Annual review of building condition (3i) and creation of prioritised BLM list Estates Strategy 2015/16-2020/21 2016/17 Backlog maintenance programme developed Targeting of priority areas as funding becomes available. Continual bidding for funding to address backlog maintenance. Backlog maintenance list annually reviewed.	Lack of Funding for backlog maintenance.	Authorising Engineer audits. BSO Audit of relevant Controls Assurance Standards. Environmental Cleanliness Controls Assurance Standard self-assessment. Building, Land, Plant and Non-Medical Equipment Controls Assurance Standard self-assessment. RQIA inspections/audits. Environmental Cleanliness audits. Health & Safety audits. Back-log Maintenance list.	No gaps identified.	Create prioritised list of BLM Create prioritised list of BLM Create prioritised list BLM 17/18 Include backlog maintenance in capital plan presented to CMT Procure and carry out schemes Present BLM paper to CMT	30/04/2015 31/05/2016 31/05/2017 30/06/2016 31/03/2017 30/10/2015	30/04/2015 31/05/2016 30/04/2017 16/06/2016 31/03/2017 03/09/2015
235	15	EXTREM	15 (5x3)	EXTREM	8	HIGH	Medical Director	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Risks associated Water Borne Pathogens	As a result of partial compliance Water Systems Safety Regulation HTM-04-01,HSC L8, HTM 0401 PARTA,B,C 2016 there is a risk of exposure to water borne pathogens which may result in injury/death to patients/staff.□	Planned programme of testing and remedial maintenance as required. Risk assessment. WH&SCTand Interserve Water Safety Plans. Flushing regime for little-used outlets. Water Safety Working Group. Implementation of Zetasafe water compliance tool. Responsible Persons appointed for Water Safety. Water borne pathogen testing by Public Health Laboratory.	Insufficient recurring resources to provide full compliance in Augmented Care areas. Limited maintenance regimes in low risk facilities as risk assessed within water safety plan . Limited legionella testing in low risk facilities risk assessed as such in the water safety plan.	Independent Authorised Engineers appointed for Water Safety. Independent Audit of Water Safety (November 2014). RQIA Inspections of augmented care. Updated Risk assessments included in water safety plans CMT/Trust Board Water Hygiene Policy May 2017 Updated Water Safety Plans. Independent audit of Water Safety October 2016 . Water Safety Group review implementation of Water Safety Plans.		Upgrade work for Greenfiels RH. Upgrade treatment wing Tower Block . Up-date WH&SCT Water Safety Plan. Business case to support upgrade for Nucleus. Continue to follow-up appointment of Interserve Authorised Engineer. Continue to follow-up Interserve Water Safety Plan.	01/07/2017 01/11/2016 01/07/2017 31/07/2014 30/09/2014	31/05/2017 30/09/2014 06/10/2014

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ID	Rating (initial)	Risk level (initial)	Rating (current) (Consq x Likli)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Directorate	Corporate Objectives	Title	Description	Controls Assurance	Gaps in controls Assurance	Assurance	Gaps in assurance	Action Plan	Due date for Action Plan	Done date for Action Plan
284	16	HIGH	16 (4x4)	HIGH	8	HIGH	Director of Performance & Service Improvement	Performance & Service Improvement	Governance.	Risk of breach of Data Protection Act through loss of personal or sensitive data	As a result of gaps in staff awareness and training in data protection requirements and non-adherence to retention and disposal guidance, there is a risk that personal or sensitive data could be lost, inappropriately stored or accessed; records could be retained beyond their lifecycle and lead to a breach of confidentiality and the Data Protection Act, DoH Good Management Good Records Guidelines and result in potential enforcement action from the Information Commissioners' Office alongside damage to the Trust' reputation.	Subject Access and Data Access agreement procedures. Information Governance/Records Management induction/awareness training. Regional code of practice. Information Governance Steering Group. Records held securely/restricted access. ICT security policies. Raised staff awareness via Trust Communications/Share to Learn. Fair processing leaflets/posters. Investigation of incidents. Investigation of incidents. Data Guardians role. Regional DHSSPS Information Governance Advisory Group. Electronic transmission protocol. 2 secondary storage facilities available across NS & SS Trust Protocol for Vacating & Decommissioning of HSC Facilities. Scoping exercise to identify volume and location of secondary close records completed in December 2010. Data Protection & Confidentiality Policy. Information Governance SIRO and IAO Framework. Laptops encrypted & use of Trust-issued Safe Sticks.	Potential that information may be stored/transferred in breach of Trust policies. Limited uptake of Information Governance and Records Management training.	ICT controls assurance standard. BSO Audit of ICT and Information Management Standards. Information Management Controls Assurance Standard. Reports to Risk Management Sub-Committee/Governance Committee BSO Internal Audit of Information Governance. Revised composition and terms of reference of the Information Governance Steering Group as a result of the new SIRO/IAO framework.		Begin roll out of single e-learning module Complete further scoping exercise to identify volume and location of secondary closed records across Trust Review Strategic Direction in relation to secondary storage facilities and electronic records storage plans (e-Health strategy) IG Assurance Inspection Week	31/03/2018 30/11/2017 31/12/2017 31/03/2017	31/03/2017
535	16	HIGH	20 (4x5)	EXTREM	8	HIGH	Director of Nursing, Primary Care & Older People's Services	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Risk that patients may experience a reduced quality of nursing care due to workforce deficits	Risk that patients in acute and primary care and older people's secondary care services may experience a reduced quality of nursing care due to unplanned staff absence and vacant posts that cannot be filled, which results in a reliance on bank and agency nursing staff and the associated financial risks.	Review of nursing resources, influence Commissioner, use of temporary contracts. Monitoring of performance through KPIs. Daily monitoring of staffing levels and bank/agency usage. Daily senior management patient flow walkabouts. Monitoring of escalation beds. Twice daily bed management meetings. Absenteeism policy; E-rostering system. No bank only contracts in place. Clinical supervision. Normative staffing has been completed in COE wards. ITR's have been processed Nurse Staffing Reviews completed in a range of Acute and PCOP wards in Altnagelvin and SWAH using the Safer Nursing Care Toolkit. Reviews completed in 2016. Altnagelvin - Ward 1, Ward 3. SWAH Wards 5,6,7. Ward 1. Where the need for additional nursing staff required - proposal submitted to responsible Directorate Management Teams. Nursing Staffing Reviews completed in 2017 - Altnagelvin Ward 44, Ward 20.	No gaps identified.	Monthly review of patient falls through Falls Action Group. Quarterly review of nursing medical errors. Monthly review of nursing complaints. Ongoing staff reviews. Monthly accountability reviews on quality of patient care. Nursing Validation. Beyond the Grapevine RQIA inspections	No gaps identified.	Absences are being managed through the Trust's Managing Absenteeism Policy on an on-going basis Analysis of Nursing Staff reviews in Altnagelvin Ward 44, Ward 20. CMT decision to initiate Business Continuity initiative. Stood down 2/8/17 CMT made decision to submit Early Alert to DOH on need to close beds due to staffing shortages and IP&C issues. Directorates taken to close 25 beds in Altnagelvin Hospital due to nurse staffing shortages. Regular vacancy monitoring through Band 5 stabilisation monitoring 103 Adult Nurse Graduates employed. Working towards registration a total of 84 RN	31/08/2017 30/11/2017 31/12/2016	02/08/2017 31/07/2017 31/07/2017 31/12/2016

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	Initial Risk		Current Risk		Target Risk													
ID	Rating (initial)	Risk level (initial)	Rating (current) (Consq x Likli)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Directorate	Corporate Objectives	Title	Description	Controls Assurance	Gaps in controls Assurance	Assurance	Gaps in assurance	Action Plan	Due date for Action Plan	Done date for Action Plan
547	15	HIGH	16 (4x4)	HIGH	8	MEDIUM	Director of Nursing, Primary Care & Older People's Services	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Public Confidence.□ Partnerships. Financial Management & Performance. Modernisation.	Inability to access domiciliary care in a timely manner	There is a risk that both hospital patients and community service users will not receive their assessed domiciliary care package in a timely manner. Patients delayed in hospital may be at greater risk of infection and/or falls. Patients in the community may be a greater risk of falls or other injuries. Community service users may have to wait longer for their assessed care package as hospital patients may be prioritised for care packages to maintain hospital flows. Adult Community Care Divisions are experiencing difficulties with accessing responsive domiciliary care service provision due to the following factors;□ • Uncertainty and transitional processes within the independent sector linked to the re-tender of independent sector domiciliary care contracts.□ • Rurality and the ability to source and secure a sustained domiciliary care service provision in some remote areas across the Trust□ • The current reform of the Trust's in-house Homecare	Interim additional rotas have been established in 12 locations across the Trust through a co-ordinated exercise to address issues where accessing service provision has been identified across all POC's. The Trust will now award new contracts for its independent sector service provision. The process of implementation will be managed through a structured project managed approach with a risk register to ensure transitional arrangements are managed and risks minimised. The Trust continues to implement its reablement service model which is operationally linked to the reform of its in-house homecare service. The combination of these measures is will assist in addressing the risks being experienced and reported.	There is unmet need due to financial constraints and difficulties associated with rurality.	PCOP Domiciliary Care Waiting List There are a range of monitoring and reporting processes in place to ensure this risk is actively monitored A service response to assessed need is progressed on each individual cases through keyworkers and brokerage Actions are taken with regards to the position as reported through these assurance and monitoring mechanisms PFA Discharge Targets Daily Delayed Discharge Report	The focus remains to ensure optimum utilisation of available resource and progress actions in areas where there are clusters of unmet need Total assurance cannot be given as the demand and location of cases cannot be projected or planned for.	Negotiate new contracts with Independent Sector providers. Discussing individual priority clients with providers to re-organise care Providing a range of alternatives, e.g. direct payments Procurement for dom care is almost complete Member of Reablement steering group	21/04/2016 21/04/2016 21/04/2016 21/04/2016 21/04/2016	13/09/2016 28/02/2017 13/09/2016 13/09/2016 13/09/2016
694	9	MEDIUM	12 (4x3)	HIGH	9	MEDIUM	Director of Acute Hospital Services	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Modernisation.□ Workforce.	Risk to patient/client safety because of insufficient Medical cover in PCOPS and Medical Wards in SWAH	Insufficient medical staff at weekends in SWAH to effectively cover the number of Medical & Care of Elderly wards - Older persons wards defaulted to F1 grade.	Referred to NIMDTA and School Board of Medicine. Raised with Commissioner. Medical prioritisation. Consultant on-call rota in place	No overnight or weekend Hospital @ Night support for medical team. Insufficient medical cover at weekends and night	Additional post secured in OPAL Service in SWAH which may relieve pressure in COE wards. Awaiting funding from Commissioner to progress recruitment.		Completion of Business case for Medical cover	31/07/2017	
924	9	MEDIUM	16 (4x4)	HIGH	6	LOW	Chief Executive	Trust-wide (Risk Register Use Only)	Financial Management & Performance.	The Trust's ability to achieve Recurrent Balance	Risk that the Trust will fail to breakeven in the current and future years given the reliance on non-recurring measures and the challenge in maintaining these in the medium to long term within the context of continuing cash releasing savings and increasing demand.	Annual Review of Recurrent Balance position. Monthly monitoring of the delivery of the financial plan by CMT FMG and the Trust Board. The development of an annual financial plan.		Internal Audit. Corporate Management Team - Financial Monitoring Group		Implementation of the Recurrent Balance Solutions Project Initiation Document (PID)	31/03/2016	

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931	20	EXTREM	20 (4x5)	EXTREM	9	MEDIUM	Director of Acute Hospital Services	Acute Hospital Services	Safe & Effective Services.Modernisation.□ Public Confidence.□ Workforce.Partnerships.□ Financial Management & Performance.	Acute shortage of Breast Radiologists in WHSCT	There is chronic shortage of radiologists in WHSCT.□ 1. Potential suspension of Breast Screening service provided by the Western Breast Unit resulting in loss of service to ladies in the screening group □ 2. Reduction in provision of breast radiologist for triple assessment clinics resulting in risk of delayed diagnosis of breast cancer□ 3. Highly visible and sensitive are of work. There is likely to be a high level of public and media interest should either service be unavailable. Potentially very damaging to the trust's reputation as a provider of screening and symptomatic services.	The issue has been highlighted as part of the Imaging Review There are 4 screening units in NI 2 of which have a full complement of breast radiologists and 1 in a similar positon to WHSCT This includes escalation via the Managed Radiology Clinical Network (MRCN), QARC and PHA WHSC Trust has approached the other trusts in NI for occasional support with very limited success The Trust is actively recruiting 2 breast radiologists but is unlikely to be successful in this round as there are no training radiologists in this specialty who have expressed an interest in WHSCT There are plans to further role extend the breast radiographers to include Ultrasound of the breast although there is a significant lead in time Radiographers in Nuclear Medicine perform sentinel node injections. 1 Role extended radiographer undertakes film reading and breast biopsies with another in training. WHSCT has 2 breast radiologists and a third who undertakes symptomatic work on an ad hoc basis since his retirement QARC and MRCN informed and support agreed	Breast Screening targets re reporting time and assessment times are at risk. Sudden surges in demand e.g. following TV campaigns can be accommodated within the specified ministerial target. With a two breast radiologists 52 week cover cannot be guaranteed.	Both services have been maintained largely by huge efforts by the two remaining Full time breast radiologists but there is a risk that either may not be available permanently and one is due to retire within the next 2-3 years. External oversight by QARC and inspection by RQIA has indicated that the services provided are safe and fit for purpose. QARC, PHA, HSCB and clinical colleagues are aware of the position and it has been escalated through all known channels		Immediate regional discussion with HSCB or other trusts to enquire if radiology breast resources can be readily available to WHSCT QARC and MRCN informed and request made for support Surgical Teams informed of potential issues		08/03/2016 08/03/2016
955	12	MEDIUM	12 (3x4)	MEDIUM	4	LOW	Chief Executive	Trust-wide (Risk Register Use Only)	Modernisation .Public Confidence.□ Financial Management & Performance.	Failure to comply with procurement legislation re social care procurement	The risk that the Trust will breach UK procurement legislation rules in awarding contracts for the provision of social care services. The legislation outlines that a formal tender process must be followed when awarding contracts that are expected to be above a specified threshold. This is to be managed by BSO PaLS on behalf of all Trusts but the current proposed work programme means that Trusts will not be fully compliant with the legislation for a period of 5 years ending on 31 March 2022.	The issue has been discussed at the Trust's Procurement Board and Social Care Procurement Group. The Trust's Director of Finance & Contracting has highlighted this issue to the Regional Procurement Board.	The Trust does not have the resource or infrastructure required to manage this risk internally. DOH has determined that the issue should be managed regionally.			Continue to monitor progress at Regional Procurement Board, Trust Procurement Board and Social Care Procurement Group.		