Western Health and Social Care Trust

CORPORATE RISK REGISTER & ASSURANCE FRAMEWORK

BRIEFING NOTE PREPARED FOR TRUST BOARD
05 SEPTEMBER 2019

There are 24 risks on the Corporate Risk Register as approved at Trust Board on 1st August 2019.

Material changes to Corporate Risk Register (CRR) for approval

Proposed new Corporate Risks: (see attached new risk forms)

1.

Risk Title - "**Service Impact of HMRC Regulations in relation to Pensions.**"

Risk Description: - Clinical staff seeking to reduce their additional employment contract commitments due to tax consequences of their HSC pension i.e. Annual Allowance.

Current Risk Rating – Consequence MAJOR (4) X Likelihood ALMOST CERTAIN (5) = EXTREME (20)

Target Risk Rating - Consequence MINOR (2) X Likelihood UNLIKELY (2) = LOW (4)

2.

Risk Title - "**Lack of a robust Governance Structure within AMHDS resulting in risk of not being able to identify emerging risks and missed opportunities to learn from incidents.**"

Risk Description: - RQIA has identified that the AMHDS directorate Governance structure and the systems for recognising and managing adverse incidents and near misses are not sufficiently robust. As a result, opportunities to identify and manage emerging risks, and to identify, implement and share learning to improve quality of care, may be being missed.

Current Risk Rating – Consequence MAJOR (4) X Likelihood ALMOST CERTAIN (5) = EXTREME (20)

Target Risk Rating - Consequence MODERATE (3) X Likelihood POSSIBLE (3) = MEDIUM (9)

Western Health and Social Care Trust

Appendix 5 of Risk Management Policy

New Risk Form

Please complete this form if you have identified a risk which needs to be considered for inclusion on the Trust's Risk Register database (Datix). Appendix 3 of the Trust's Risk Management Policy sets out the process that must be followed. The Policy is available on the intranet, web-link http://whsct/intranetnew/Documents/Risk%20Management%20Strategy.pdf.

The information requested below is required for completion of fields within Datix and is in the order that fields appear on screen. Sections marked with an asterisk (*) are mandatory and must be completed. The completed form should then be considered at the appropriate Sub-Directorate/Divisional/Department Governance meeting. If the risk is approved for inclusion, please then forward the form to the relevant Business Services Officer/Business Services Manager for inputting on Datix. A list of BSOs/BSMs with access to Datix within each Directorate and Sub-Directorate is posted on the intranet – click here.

No	Datix Field Name	Data to be included in this Field	
1.	**Title of Risk *** **(please keep this brief e.g. "Risk of Fire in Trust Premises" –)**	Service Impact of HMRC Regulations in relation to Pensions.	
2.	**Facility** **(only necessary if risk relates to one specific facility)**		
3.	**Directorate *** **If risk affects 2 or more Directorates, please list relevant Directorates.**	Trustwide	
4.	**Sub-Directorate *** **If risk affects two or more Sub-Directorates, please list.**		
5.	**Specialty** **Please list most relevant Specialty this risk relates to.**		
6.	**Ward/Department** **(necessary only if risk relates to one specific Ward/Dept)**		
7.	**Risk Type*** **Please indicate which organisational level you are of the opinion this risk should be escalated to (please tick)** **NB: This is subject to approval by relevant Senior Manager/Director/CMT – refer to Appendix 3 of Risk Management Strategy (see web-link above) :-**	Corporate	✓
		Directorate	
		Sub- Directorate/Divisional	
8.	**Risk Sub-type*** Please tick most appropriate category:	• Clinical Risk • Staff Competence • Compliance with Professional/Clinical/Non-Clinical Standards • Education & Training • Emergency/Contingency Planning Arrangements • Equipment • Financial • Fire Safety • Health & Safety • Independent Sector • Infection Control • Organisational • Professional Issues • Patient/Client Safety • Staffing Issues/Levels ✓	

9.	**Corporate Objective(s) affected by this risk*** ***(Please tick appropriate box(es) below)***		
	C01	To provide safe, high quality and accessible patient and client focused services	✓
	C02	To improve and modernise our services in line with evidence-based practice and research	
	C03	To ensure the probity and safety of our processes and systems through active governance arrangements	
	C04	To promote public confidence in our services	
	C05	To create a culture and an environment which will attract and retain high quality staff	
	C06	To build effective relationships with service users, communities and our strategic partners to promote the health and social wellbeing of our population	
	C07	To secure and manage resources effectively and efficiently in order to achieve best outcomes, demonstrate value for money and ensure financial viability	
10.	**Lead Officer* with responsibility for managing this risk (Name, Job Title, and Contact Details.** **(i.e. manager with operational responsibility)**	Cara McLaughlin, Senior HR Manager	
11.	**Name of Responsible Director*** **(NB: Where a risk is Cross-Directorate, the most appropriate Director to manage this risk should be listed. It will be their responsibility to liaise with other Directors re management of this risk).**	Ann McConnell	
12.	**Description of Risk*** Please provide a full description of the nature of the risk. Please limit this to 255 characters	Clinical staff seeking to reduce their additional employment contract commitments due to tax consequences of their HSC pension i.e. Annual Allowance.	
13.	**Please list all current control measures in place to manage this risk*** (e.g. policies, procedures, training)	• Pension Workshops for high earners in June 2018 and further workshops planned in September and October 2019. • Job Planning Workshop for Assistant Directors and Clinical Directors. • Annual Benefits Statement. • Employer Technical Updates.	
14.	**Please list all identified gaps in Controls.***	• Doctors report insufficient information on this issue being made available to them.	
15.	**Please list all Assurances currently in place to test adequacy of Controls.** (i.e. Audit (Interna/External), inspections by independent organisations, e.g. RQIA, HSENI).	• Discussions ongoing regionally with HSC Pensions, Department of Health, other HSC Trusts and BMA • HSC Pension Board • HSC Scheme Advisory Board • Pension Regulator • National Consultation on 50:50 membership model	

15.	**Please list all identified gaps in Assurances.**	• HSC Pensions Service under resourced. • Impact of McCloud and Sergeant Employment Law cases.

16.	**Current level of Risk*** **(Please tick appropriate box for Impact/Consequence/Severity and Likelihood – refer to Risk Rating Matrix & Impact Assessment Table (Appendix 3 of Risk Management Strategy - see web-link above).**			
	Impact/Consequence /Severity		**Likelihood**	
	Insignificant/none		Rare	
	Minor		Unlikely	
	Moderate		Possible	
	Major	✓	Likely	
	Catastrophic		Very Likely/ Almost Certain	✓
17.	**Target/Acceptable level of Risk*** **(Please tick appropriate box for Impact/Consequence/Severity and Likelihood – refer to Risk Rating Matrix and Impact Assessment Table (Appendix 2 of Risk Management Strategy - see web-link above).**			
	Impact/Consequence /Severity		**Likelihood**	
	Insignificant/none		Rare	
	Minor		Unlikely	✓
	Moderate	✓	Possible	
	Major		Likely	
	Catastrophic		Very Likely/ Almost Certain	

NB: Datix will automatically calculate the level of risk (i.e. Red/Extreme, Amber/High, Yellow/Medium, Low/Green).

18. Action Plan to reduce Level of Risk

When developing an action plan to reduce the level of risk to the target level, Managers should take the Trust's Risk Appetite Statement into consideration, as set out in the Risk Management Policy, as follows:-

"The Trust's appetite for risk is to minimise risk to patient/client/staff safety and the resources of the Trust, whilst acknowledging that it also has to balance this with the need to invest, develop and innovate in order to achieve the best outcomes and value for money for the population that it serves. In this respect, risk controls should not be so rigid that they stifle innovation and imaginative use of limited resources in order to achieve health and social care benefits."

Managers must consider the following questions when developing an action plan to manage the identified risk:-

Question	Response
1. Does the proposed action plan actively manage this risk to ensure that the level of risk can be reduced to the target level?	HMRC and Pension regulations are external to the Trust's control. The proposed actions ensure that the relevant staff are informed to make individual choices and the impact on services can be managed. Service areas identified as having a high impact (i.e. reduced staff due to reduction in contract commitments) will have a plan put in place to mitigate these. Service managers are being trained to handle these requests.

2. Does the proposed action plan take account of any opportunities that could be exploited whilst managing this risk?	In order to identify all possible opportunities to manage the risk a scoping exercise will be undertaken to determine alternative options.
3. Has the target level of risk, and how this will be achieved, been communicated to those staff responsible for the operational management of this risk?	There is awareness that services could be impacted. A formal briefing to the Corporate Management Team is scheduled for 8 August 2019. Staff have been informed through workshops in June 2018 and follow up in September and October 2019 are planned. Employer Technical Updates. Annual Benefits and Pension Savings Statements.
4. How will the proposed actions be monitored to ensure they are completed within identified timescales?	This issue will be monitored through HR Senior Management Team meetings.
5. At what point should the decision regarding the management of this risk be escalated to a higher level?	If the Trust cannot fulfil its SBA commitments or if services are likely to be interrupted.

Please set out below the key actions that will be taken to reduce the level of risk (e.g. develop business case, service redesign, develop policy/procedures, provide training, recruitment of staff, etc):-

Action Required	Start Date	Due Date	Lead Officer
Scope high impact areas and develop an action plan to develop	Asap	End of September 2019	To be nominated by Directorates with support of HR.
Job Planning Workshop with Assistant Directors and Clinical Leads	Asap	End of September 2019	Geraldine McAleer

Once the new risk has been approved, these key actions should be recorded within the "Actions" section of Datix.
Once each action has been completed, the date of completion should be recorded.
Each completed action should then be listed within the "Controls" section of Datix.

If you require advice with regard to completion of this form, or on the use of Datix Risk Register module, please contact the Corporate Risk Manager on extension 214129.

Meeting where risk was approved:	**For use by**	**Risk ID No:**

Date of Meeting:		**BSO/BSM only**	(automatically generated by Datix)

Western Health and Social Care Trust

Appendix 5 of Risk Management Policy

New Risk Form

Please complete this form if you have identified a risk which needs to be considered for inclusion on the Trust's Risk Register database (Datix). Appendix 3 of the Trust's Risk Management Policy sets out the process that must be followed. The Policy is available on the intranet, web-link http://whsct/intranetnew/Documents/Risk%20Management%20Strategy.pdf.

The information requested below is required for completion of fields within Datix and is in the order that fields appear on screen. Sections marked with an asterisk (*) are mandatory and must be completed. The completed form should then be considered at the appropriate Sub-Directorate/Divisional/Department Governance meeting. If the risk is approved for inclusion, please then forward the form to the relevant Business Services Officer/Business Services Manager for inputting on Datix. A list of BSOs/BSMs with access to Datix within each Directorate and Sub-Directorate is posted on the intranet – click here.

No	Datix Field Name	Data to be included in this Field		
1.	**Title of Risk *** **(please keep this brief e.g. "Risk of Fire in Trust Premises" –)**	Lack of a robust Governance Structure within AMHDS resulting in risk of not being able to identify emerging risks and missed opportunities to learn from incidents.		
2.	**Facility** **(only necessary if risk relates to one specific facility)**	All areas within Adult mental Health and Disability Directorate.		
3.	**Directorate *** **If risk affects 2 or more Directorates, please list relevant Directorates.**	Adult mental Health and Disability Directorate.		
4.	**Sub-Directorate *** **If risk affects two or more Sub-Directorates, please list.**	Adult Mental Health. Learning Disability Physical and Sensory Disability		
5.	**Specialty** **Please list most relevant Specialty this risk relates to.**	All areas within Adult Mental Health and Disability Directorate.		
6.	**Ward/Department** **(necessary only if risk relates to one specific Ward/Dept)**			
7.	**Risk Type*** **Please indicate which organisational level you are of the opinion this risk should be escalated to (please tick)** **NB: This is subject to approval by relevant Senior Manager/Director/CMT – refer to Appendix 3 of Risk Management Strategy (see web-link above) :-**		Corporate	x
			Directorate	
			Sub- Directorate/Divisional	

8.	**Risk Sub-type*** Please tick most appropriate category:	• Clinical Risk • Staff Competence • Compliance with Professional/Clinical/Non-Clinical Standards • Education & Training • Emergency/Contingency Planning Arrangements • Equipment • Financial • Fire Safety • Health & Safety • Independent Sector • Infection Control • Organisational • Professional Issues • Patient/Client Safety -yes • Staffing Issues/Levels	
9.	**Corporate Objective(s) affected by this risk*** ***(Please tick appropriate box(es) below)***		
	C01	To provide safe, high quality and accessible patient and client focused services	x
	C02	To improve and modernise our services in line with evidence-based practice and research	
	C03	To ensure the probity and safety of our processes and systems through active governance arrangements	x
	C04	To promote public confidence in our services	
	C05	To create a culture and an environment which will attract and retain high quality staff	
	C06	To build effective relationships with service users, communities and our strategic partners to promote the health and social wellbeing of our population	
	C07	To secure and manage resources effectively and efficiently in order to achieve best outcomes, demonstrate value for money and ensure financial viability	
10.	**Lead Officer* with responsibility for managing this risk (Name, Job Title, and Contact Details.** **(i.e. manager with operational responsibility)**	Angela O Neill - Governance Lead	
11.	**Name of Responsible Director*** **(NB: Where a risk is Cross-Directorate, the most appropriate Director to manage this risk should be listed. It will be their responsibility to liaise with other Directors re management of this risk).**	Karen O Brien- Director of Adult Mental Health and Disability Service.	
12.	**Description of Risk*** Please provide a full description of the nature of the risk. Please limit this to 255 characters	RQIA has identified that the AMHDS directorate Governance structure and the systems for recognising and managing adverse incidents and near misses are not sufficiently robust. As a result, opportunities to identify and manage emerging risks, and to identify, implement and share learning to improve quality of care, may be being missed.	

13.	**Please list all current control measures in place to manage this risk*** (e.g. policies, procedures, training)	Ongoing training for staff within the Directorate to effectively use the DATIX incident reporting system. SAI/SEA Reviews as per Regional Guidance. Rapid review group meets weekly and reviews all red incidents. Directorate Governance Meetings held monthly and review of the risk register. Monitor complaints within the Directorate. Monitor untoward incidents via the DATIX system.
14.	**Please list all identified gaps in Controls.***	Currently the Directorate has only 1 staff member within the Governance role and the current capacity outweighs demand. Incidents are not being reviewed and closed and this is evidenced by the number of outstanding open incidents. Outstanding SAI/SEA Reports. Ad hoc arrangements for reviewing incidents at local ward level. Risk Management training for all Incident Handlers
15.	**Please list all Assurances currently in place to test adequacy of Controls.** (i.e. Audit (Interna/External), inspections by independent organisations, e.g. RQIA, HSENI).	Quality Improvement audit ongoing with regards incident management within the Acute in-patient psychiatric facilities- Elm and lime –T&F Hospital Omagh and Evish and Carrick-Grangewood Hospital. Unannounced RQIA Inspections. Health and Safety Inspections through the Trust Health and Safety Working Group. Twice yearly ligature risk assessments. Performance reporting on open incidents to Directorate Governance, C&SCG Sub Committee & Governance Committee.
15.	**Please list all identified gaps in Assurances.**	Actions identified within the Service Improvement Notice from RQIA with a review in Oct 2019. Lack of Open incidents escalation process from local level to service managers/ADs prior to Directorate Governance.
16.	**Current level of Risk*** **(Please tick appropriate box for Impact/Consequence/Severity and Likelihood – refer to Risk Rating Matrix & Impact Assessment Table (Appendix 3 of Risk Management Strategy - see web-link above).**	
	Impact/Consequence /Severity	**Likelihood**

	Insignificant/none		Rare	
	Minor		Unlikely	
	Moderate		Possible	
	Major	x	Likely	
	Catastrophic		Very Likely/ Almost Certain	x
17.	**Target/Acceptable level of Risk*** **(Please tick appropriate box for Impact/Consequence/Severity and Likelihood – refer to Risk Rating Matrix and Impact Assessment Table (Appendix 2 of Risk Management Strategy - see web-link above).**			
	Impact/Consequence /Severity		**Likelihood**	
	Insignificant/none		Rare	
	Minor		Unlikely	
	Moderate	x	Possible	x
	Major		Likely	
	Catastrophic		Very Likely/ Almost Certain	

NB: Datix will automatically calculate the level of risk (i.e. Red/Extreme, Amber/High, Yellow/Medium, Low/Green).

18. Action Plan to reduce Level of Risk

When developing an action plan to reduce the level of risk to the target level, Managers should take the Trust's Risk Appetite Statement into consideration, as set out in the Risk Management Policy, as follows:-

"The Trust's appetite for risk is to minimise risk to patient/client/staff safety and the resources of the Trust, whilst acknowledging that it also has to balance this with the need to invest, develop and innovate in order to achieve the best outcomes and value for money for the population that it serves. In this respect, risk controls should not be so rigid that they stifle innovation and imaginative use of limited resources in order to achieve health and social care benefits."

Managers must consider the following questions when developing an action plan to manage the identified risk:-

Question	Response
1. Does the proposed action plan actively manage this risk to ensure that the level of risk can be reduced to the target level?	Yes
2. Does the proposed action plan take account of any opportunities that could be exploited whilst managing this risk?	Yes
3. Has the target level of risk, and how this will be achieved, been communicated to those staff responsible for the operational management of this risk?	Yes. This was discussed and agreed at Directorate Governance on 19th July 2019 and agreed that it should be escalated to Corporate Risk.
4. How will the proposed actions be monitored to ensure they are completed within identified timescales?	The Directorate Governance Lead will update and review the risk with appropriate staff through the monthly Directorate Governance meetings.
5. At what point should the decision regarding	If the Directorate is unable

the management of this risk be escalated to a higher level?	to meet the recommendations from RQIA Service Improvement Notice. If the Directorate is unable to recruit a Governance Team. If the controls and assurances are not addressing the risk.

Please set out below the key actions that will be taken to reduce the level of risk (e.g. develop business case, service redesign, develop policy/procedures, provide training, recruitment of staff, etc):-

Action Required	**Start Date**	**Due Date**	**Lead Officer**
Karen O' Brien to secure financial funding for governance Team	July 2019	ASAP	Karen O' Brien
IR Improvement Plan to include: • Review of past incidents including risk assessment and identification, actions, learning, responsibility, closure, safeguarding requirements and trends. • Review of incident handlers and develop new comprehensive list aligned to every ward/facility. • Training Needs Analysis and training delivered on Risk, Incidents and Safeguarding. • Roll out of Organisation chart, flowchart and trigger list (from QI work) across the Directorate to assist staff in following the Incident Reporting process correctly • Review of Divisional/Directorate Risk Registers • An Incident Review Group will be established and Directorate Governance Meetings will increase to fortnightly, both linking in with Directorate	July 2019	Oct 2019	Louise Hunter / Angela O Neill / Brian McGarvey / Christine McLaughlin

Governance			

Once the new risk has been approved, these key actions should be recorded within the "Actions" section of Datix.
Once each action has been completed, the date of completion should be recorded.
Each completed action should then be listed within the "Controls" section of Datix.

If you require advice with regard to completion of this form, or on the use of Datix Risk Register module, please contact the Corporate Risk Manager on extension 214129.

Meeting where risk was approved: **Date of Meeting:**	**For use by BSO/BSM only**	**Risk ID No:** (automatically generated by Datix)

		Initial Risk		Current Risk		Target Risk													
ID	Opened date	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
3	19/11/2008	16	HIGH	8	HIGH	4	HIGH	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. Criteria based Health & Safety Inspection plan 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 Walk rounds. KPI for health & safety, e.g. falls. Falls Risk Assessment. Falls Prevention Policy. Ligature risk assessment tool adopted MAPA training team in place WHSCT Occupiers rules & regulations Aug 2017 Falls - Regional Post falls review; Falls Co-ordinator in post 2018; Falls Learning Group; CEC Falls Prevention course 2018 Labs representative on Health & Safety Working Group COSHH added as standing item to Health &Safety Working Group agenda. Four officers in Risk Management are NEBOSH qualified including H&S officer Annual review of completed H&S Risk Assessments Directorate Gov Reports with H&S RA	Lack of funding to purchase H&S equipment or undertake maintenance of equipment/facilities. Comparatively limited staff resources dedicated to H&S. Limited availability for managers to update risks on Datix. Datixweb module required to allow linking with incidents No overall database of trained nominated H&S officers by facility Limited availability of risk register to managers to allow direct management of risks	RQIA inspections. Internal Audit of H&S Controls Assurance Standard (2017/18). 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. Monitoring of implementation of recommendations following inspections/Leadership walkrounds. BSO Internal Audit of H&S (June 2017). Manual Handling Audit at Altnagelvin Hospital (July 2013 and re-audit September 2014)	Learning themes across Incidents and Claims	Include compliance scores on H&S Risk Assessments reports. Train managers on Ligature risk assessment tool Business case for purchase of Risk Registers on Datixweb Database of nominated H&S officers trained to be developed	30/06/2019 31/07/2019 30/09/2019 30/09/2019	31/03/2019
6	21/09/2009	25	EXTREM	12	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. 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 Staff temporarily redeployed to cover gaps in staffing levels Some areas redesigned to address some of the unallocated cases issue. Service Managers and Social Work Managers monitor and review unallocated cases on a weekly basis. Looked after services review capacity to enable transfer of cases Principal Social Work redeployed will monitor Action Plan and progress to stabilise team Service and SW Managers constantly prioritise workloads.	Delays in recruitment	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. Action Plan to review and Address Risks within FIS Enniskillen Delegated Statutory Functions	No gaps identified	FIS Early Help Team established to help address unallocated cases. Principal SW temporarily redeployed to review all unallocated cases in FIS and then SW caseloads in FIS Action Plan Developed to address and Monitor Risks in FIS Enniskillen	31/03/2019 01/11/2018	01/11/2018 06/03/2019

		Initial Risk		Current Risk		Target Risk												
ID	Opened date	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
46	06/10/2009	12	HIGH	12	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 Directors and Assistant Director for sharing with staff regarding EWTD requirements in July 2018. Senior HR Managers are assessing the consistency of approach in relation to sleep ins across the Trust. Guidelines to clarify bank arrangements developed (QICR2). Director of Nursing reminding nurses of the need for compliance at Trust Nursing and Midwifery Group. Trust participation on Regional Working Group to review rota for	Despite best efforts the Trust is not always able to meet the requirements of the regulations. Pressure on services due to intensity of attendances at hospital.	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. Regional review of Guidance on EWTD and compensatory rest.	Inability of NIMDTA to fill all posts.	Work continues within relevant Directorates in relation to rotas, sleep ins, etc. Participate in Sleep in statutory cases as required. Continue to populate gaps in rotas with International Recruitment and ongoing engagement with NIMDTA. ADHR to examine checks in place to monitor working time compliance across the Trust.	30/09/2019 30/09/2019 30/09/2019 30/09/2019	
49	06/10/2009	16	HIGH	16	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.	Data & System backups 3rd Secure Remote Access Server / Client patching HSC security software (threat detection, antivirus, email and webfiltering) HSC security hardware (eg 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 Data protection Act Regional & Local ICT info security policies Band 7 & band 6 recruited to support Cyber security	Current inability to obtain 100% coverage on patch updates due to a combination of user behaviours and service needs 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	Internal audit / IT Dept. self-assessment against 10 Steps towards NCSC Technical risks assessments and penetration tests HSC SIRO Forum for shared learning and collaborative action planning and delivery	There is a resource issue regarding Cyber Staff in the Trust. The Business Case that was approved should address this pressure however experience from other Government Organisations would suggest that is difficult to attract and retain specialist skills in this area. Unable to have consistent patching of critical/core serves due to service disruption. Limited testing of Data and Systems restores.	Recruitment of Band 7 Cyber Security Manager Recruitment of Band 6 to support implementation of Cyber Security Action Plan Full implementation for Metacompliance across the Trust with regular course updates being issued thereafter Introduce routine reporting to Trust Board (or other equivalents (local or regional)) on reported incidents/near miss, and other agreed indicators	31/03/2019 31/03/2019 30/06/2019 31/08/2018	28/02/2019 31/03/2019 31/08/2018
51	06/10/2009	16	HIGH	16	HIGH	8	HIGH	Director of Finance	Finance and Contracting	Financial Management & Performance.	The inability of the Trust to achieve break-even or contain expenditure within authorized control limit	The inability of the Trust to achieve break-even or contain expenditure within authorized control limit.	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.	Ongoing financial management and monitoring Preparation of Annual Accounts	31/03/2019 13/06/2019	31/03/2019

		Initial Risk		Current Risk		Target Risk													
ID	Opened date	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
57	06/10/2009	16	HIGH	8	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, or that dissemination is unduly delayed by delays in incident reviews.	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 SAI training for staff including family engagement Rapid Review group Regionally learning following legal claims shared via DLS Regional Litigation meeting. Compliance with Regional Post Falls Review and Learning template - Now on Datix Claims learning themes developed	Learning from Audits that are carried out without knowledge of Audit Department may not be implemented. 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. Lack of Datixweb Dashboards, risk and Complaints module which limits triangulation of data for learning Significant delays in incidents being reviewed and closed in a timely fashion.	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	No gaps identified.	Learning Themes developed for Litigation cases Falls learning template system adopted Automated email to reporters with Learning from incidents through Datix upgrade Develop SAI training incl family engagement Upgrade Datix to facilitate Automatic Datix feedback Roll out of standard learning reports on Datix Trust SAI learning event Establish Learning site on Sharepoint Business case for Datixweb Risk, Dashboards and Complaints module Learning themes being developed regionally for Litigation Review of Governance arrangements and ensure clear mechanism for sharing learning and implementation of	31/03/2017 31/03/2017 30/09/2017 30/09/2018 31/01/2017 31/12/2016 31/10/2019 30/09/2019 30/09/2019 31/12/2018 30/09/2019	31/03/2017 01/02/2017 18/09/2017 10/09/2018 15/02/2017 30/11/2016 31/12/2018
58	06/10/2009	12	MEDIUM	15	HIGH	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 Trustwide 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).	Trust HR representation at regional AHP Group. Trust HR representation at International Nurse Recruitment Groups. 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. Addressing speciality issues as they arise. Procedure in place for IR35 Assessment. Implementation of Circular HSC (F) 19 2017 - Introduction of New Taxations Rules applying to off payroll working. AHP Peripatetic Teams in place. Directorate summary "yellow pages" information on Agency & Locum costs reported through QICR. Guidelines on use of medical and non-medical agency staff. Medical Workforce Recruitment and Reform Project Board. 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.	Lack of co-ordinated information on agency staffing. Insufficient applicants for nursing and social work posts. Unpredictability of circumstances i.e. to cover sick leave or an increase in demand for service. Inability of NIMDTA to provide required number of Junior Doctors for certain specialities.	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.	Support the development of a local post graduate medical school. Introduce and evaluate Physician's Associate role. Progress Medical Workforce Recruitment & Reform Project Plans. Continue to work on a regional level on solutions. Support Working Together Delivering Value Programme to reduce reliance on bank and agency staff. Support transformation programmes.	30/09/2019 30/09/2019 30/09/2019 30/09/2019 31/12/2019 30/09/2019	
63	07/10/2009	20	EXTREM	15	EXTREM	12	HIGH	Director of Adult Mental Health & Learning Disability	Adult Mental Health & Disability Services	Governance.	High risk forensic/challenging individuals who have a 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 Continue to review enhanced care plan list by AMH	31/07/2017 31/01/2020	20/07/2018

		Initial Risk		Current Risk		Target Risk													
ID	Opened date	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
64	07/10/2009	16	HIGH	9	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. WHSCT OOH being reviewed to ensure effective engagement and assessment OOH. New staff starting post in Crisis Home Treatment. This will enhance ability to reduce under 18 admissions. CAMHS Redesign has been fully implemented. 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)	Annual Review of Under 18 Admissions to Adults Wards TFH, Grangewood and Lakeview	31/03/2020	
66	07/10/2009	25	EXTREM	10	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.	RQIA inspections Regular Audit of Risk Assessment by Ward Managers. Review of Serious Adverse Incident Reports by HSCB/RQIA. Donaldson Review and review of SAIs reported 2009-2013.	No gaps identified.	Maintain regular review. Ligature assessment tool to be developed Learning from SAI Nov 18 to be shared	31/03/2020 30/09/2019 31/07/2019	
73	07/10/2009	16	HIGH	12	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. performance report on the implementation of RFID within Medical Records Library	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. BSO Audit of Information Management 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.	Development of performance report on the implementation of RFID within Medical Records Library Extension of rfid to North Wing AAH Review of secondary storage and development of business case.	31/03/2019 30/06/2019 30/09/2019	31/03/2019

		Initial Risk		Current Risk		Target Risk													
ID	Opened date	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
100	26/10/2009	16	HIGH	12	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.	Estates Strategy 2015/16-2020/21 Annual review of building condition (3i) and creation of prioritised BLM list 2019/20 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. 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 Create prioritised list BLM 18/19 Create prioritised BLM 19/20 list Include backlog maintenance in capital plan presented to CMT Procure 19/20 BLM Procure and carry out schemes Present BLM paper to CMT Procure 18/19 backlog list	30/04/2015 31/05/2016 31/05/2017 31/05/2018 31/03/2020 30/06/2016 31/03/2020 31/03/2017 30/10/2015 31/03/2019	30/04/2015 31/05/2016 30/04/2017 31/05/2018 05/06/2019 16/06/2016 31/03/2017 03/09/2015 31/03/2019
235	08/12/2010	15	EXTREM	15	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. Upgrade water supply in Tower Block levels 1-5 and Dermatology upgrade of water system, water system and associated processes Milk Bank SWAH	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. limited assurance regarding flushing underused outlets	Independent Authorised Engineers appointed for Water Safety. Independent Audit of Water Safety (November 2014). RQIA Inspections of augmented care. Independent audit of Water Safety October 2016 . Water Safety Group review implementation of Water Safety Plans. Updated Risk assessments included in water safety plans CMT/Trust Board Water Hygiene Policy May 2017 Updated Water Safety Plans.	Independent Water Safety Audit 2017	Upgrade work for Greenfields 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. update Water Safety Plan upgrade ward wing toilets (40) Upgrade water system Nucleus Installation of hot water supply to Milk Bank SWAH action Independent audit recommendations	31/12/2019 01/07/2017 01/11/2016 01/07/2017 31/07/2014 30/09/2014 31/07/2019 31/03/2019 30/09/2019 31/08/2018 31/12/2019	 31/03/2018 31/05/2017 31/03/2017 30/09/2014 06/10/2014 31/03/2019 31/08/2018
284	13/12/2010	16	HIGH	16	HIGH	8	HIGH	Director of Performance & Service Improvement	Performance & Service Improvement	Governance.	Risk of breach of General Data Protection Regulation (GDPR) and Data Protection legislation through loss of personal or sensitive	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. band 3 post in place Data Protection & Confidentiality Policy. Information Governance SIRO and IAO Framework.	Potential that information may be stored/transferred in breach of Trust policies. Limited uptake of Information Governance and Records Management training.	Reports to Risk Management Sub-Committee/Governance Committee BSO Audit of ICT and Information Management Standards. 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.		Scoping capacity within wider IG Team to deliver face to face training sessions and development of IG Band 3 0.5 post increased to full time Recruitment of Band 4 Information Governance Development of information leaflet for Support Services Staff to increase awareness of information governance	06/06/2019 31/03/2019 31/03/2019 31/03/2019	 31/03/2019 28/02/2019 01/03/2019

		Initial Risk		Current Risk		Target Risk													
ID	Opened date	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
535	15/11/2011	16	HIGH	20	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 workforce deficits, 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. Nursing KPI Report tabled at CMT monthly The bed compliment of wards is adjusted to reflect their respective normative staffing levels.	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 Nursing KPI Report tabled at Trust Board monthly	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 31/03/2020	31/12/2017 30/09/2017 02/08/2017 31/07/2017 31/07/2017 31/12/2017 30/11/2017 31/12/2016
547	21/09/2012	15	HIGH	16	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;□ Rurality and the ability to source and secure a sustained domiciliary care service provision in some remote areas across the Trust□ This risk is impacting service users and carers across both community and hospital care settings resulting in delayed discharges, temporary placements being made in	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 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 mainly due to difficulties in recruiting carers, particularly in rural areas	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	Total assurance cannot be given as the demand and location of cases cannot be projected or planned for. The focus remains to ensure optimum utilisation of available resource and progress actions in areas where there are clusters of unmet need	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 In-house reform to establish core and reablement teams across the Trust In-house service completing a productivity and efficiency improvement programme to ensure there is optimum utilisation of the rotas. Recruit post re regional development of a new Framework For Delivery of Care and Support in Own Home regional development of a new Framework For	21/04/2016 21/04/2016 21/04/2016 21/04/2016 21/04/2016 31/08/2018 30/09/2018 30/06/2019 30/09/2019	13/09/2016 28/02/2017 13/09/2016 13/09/2016 13/09/2016 31/08/2018 30/09/2018
694	02/08/2013	9	MEDIUM	12	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 two junior doctors OOH No F2's are working unsupervised	No overnight or weekend Hospital @ Night support for medical team. Insufficient medical cover OOH	Additional post secured in OPAL Service in SWAH which may relieve pressure in COE wards. Awaiting funding from Commissioner to progress recruitment.		Monitoring and review	31/03/2020	

		Initial Risk		Current Risk		Target Risk													
ID	Opened date	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
924	04/04/2016	9	MEDIUM	16	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		Financial Recovery plan to be agreed and approved Operation of DVMB (Delivering Value Management Board) to ensure delivery of the 3 year financial recovery process Implementation of the Recurrent Balance Solutions Project Initiation Document (PID) Establishment of Working Together Delivering Value Programme Structure	31/12/2018 31/03/2022 31/03/2016 28/02/2019	06/12/2018 31/03/2016 28/02/2019
955	11/08/2016	12	MEDIUM	12	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.			The 5 year implantation plan will continue to be monitored - via Regional Procurement Board, Trust Procurement Board and Social Care Procurement Group.	31/03/2020	
1075	23/08/2018	12	HIGH	16	HIGH	4	LOW	Director of Finance	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Public Confidence.□ Workforce.Partnerships.	No Deal Scenario / Hard Border EU Exit	With the imminent EU exit, there is potential for a No Deal Scenario or Hard Border between Northn and South of Ireland. The full impact of the UKs exit from the EU is not yet known and given uncertainty around the UK EU ongoing discussions and potential agreements, there may be impacts such as - workforce, including recruitment and retention, changes to regulations, movement of people and goods, border controls and access to healthcare in EU member states. Day one delivery planning is required to ensure services continue to operate effectively on day one following EU Exit and in the longer term, and that there is no, or minimal disruption to services. Although this is categorised as an organisational risk it also has implications for clinical risk, financial risk, patient and client safety and staffing issues/levels. Lead Officer is Paul Quigley and Responsible Director is Lesley Mitchell, Director of Finance and Contracting.	Detailed review of mitigating actions to be completed by 30 December 2018. Increased frequency of meetings of both regional and local Task and Finishing Groups. Labour, including Cross Border analysis , to be made available to service colleagues. Service focused workshop event arranged for 17 December 2018. Lead Officer is member of EU Finance Subgroup. Communicating financial risks for 2018-19 and 2019-20 predominately. Trust Pharmacy Dept reviewing national pharmacy plans to determine any additional local migration actions eg radioisotopes; non stock and off contract items eg medical gases. Lead Officer to brief CMT of evolving plans on 22 November 2018 BSO Pals providing analysis of high usage nonstock items for consideration bof risk assessment by Trust. BSO Pals assuring lead for stock items including stock building. EU Exit Task & Finish Group in place including service directorate membership. No Deal Continuity Plans for Services Participation on DoH Regional EU Exit Group	A number of national and regional risk mitigation issues are being managed at DOH / Government level. The Lead Officer participates in the Regional DoH EU Exit Group.	EU Exit Task and Finish Group meet monthly. Day one delivery plan developed and reviewed. Continuity Plans developed for Pathology, Pharmacy, FM and Paying Patients department with all other areas in progress and due to be submitted by 24 January 2019. Details of staffing implications by Directorate sourced and being pulled together by HR. the Trust continues to attend various regional forums on EU Exit, including the Doh EU Exit Regional Meeting and other Regional Meetings such as Medicines Preparedness, Information Governance, HR and Emergency Planning. Final Version of Yellow	The DOH reported that further discussion at the EU Exit ALBs meeting has clarified that disruption to health and social care services is not anticipated as a result of any impediment to movement of people at the border and that existing business continuity plans and mitigating actions for potential staff shortages should apply and suffice. Anne Kilgallen, Trust CE has fortnightly meetings with Richard Pengelly and CE of HSC - of which EU Exit and associated continuity planning progress are discussed.	Continued regular update internal EU Exit Meetings and updates to CMT. Application of any regional or strategic directives on EU exit. Trust representatives continue to be involved in regional working groups led by DoH in order to inform and assist the Trust in EU Exit Planning. Next meeting due to take place on 21 January Assurance Statement to be forwarded from the CE to the Permanent Secretary, DoH confirming that the Trust is actively scoping the potential impact of a no deal outcome from the UK EU negotiations on the services provided by the Trust etc. Detailed Review of Mitigating Actions to be completed - Continuity plan Lead Officer to brief	17/01/2019 21/01/2019 24/01/2019 22/11/2018 17/12/2018 28/12/2018 21/01/2019 12/02/2019 05/02/2019 28/01/2019 04/03/2019 11/02/2019 30/09/2019 15/02/2019	17/01/2019 21/01/2019 29/06/2018 24/01/2019 22/11/2018 17/12/2018 03/12/2018 21/01/2019 12/02/2019 05/02/2019 28/01/2019 04/03/2019 11/02/2019 07/02/2019

		Initial Risk		Current Risk		Target Risk													
ID	Opened date	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
1091	19/12/2018	12	HIGH	12	HIGH	6	MEDIUM	Director of Performance & Service Improvement	Performance & Service Improvement	Safe & Effective Services.Governance.Public Confidence.	Service Disruption/Loss of Service	Interserve FM (IFM) would be unable to sustain the PFI contract at SWAH, leading to service disruption/potential loss of service and resulting in the need for NIHG to appoint a new Hard FM Service Provider. This risk has been escalated due to IFM corporate position and collapse of their share price (10/12/18).	PFI contract management focus on continuous performance improvement, addressing areas of under-performance and contract stability. The Trust shall retain Trust's Remedial Rights under clause 29.6 to 29.12 of the Project Agreement including step-in. Stakeholders to maintain dialogue at a Senior Level with IFM Board, Trust Board and NIHG Shareholders to assess on regular and on-going basis the sustainability of SWAH contract. Agenda item for Joint Liaison Committee meetings NIHG contingency plan for the loss of Hard FM Service Provider, including procurement procedures and handover arrangements; to be updated by 14.12.18. Plan to comply with obligations in clause 50.5 (Sub-Contractors) of the Project Agreement.	Early Warning system of alert to change in likelihood of risk; supported by Government Partners in Strategic Investment Board and informed by Specialist PFI Advisers. Assurance/testing of NIHG and Trust-Step in Contingency Plans to complete State of Readiness check.	Specialist PFI Advisers in place and alert to risk. Robust PFI Governance Arrangements.		PFI Continuous Improvement Plan/Address areas of underperformance completion of Savings and Efficiency and impact from QI project. Early warning alert system Trust step in:Online Contingency plan Senior Stakeholder dialogue (Board Level) Assurances on NIHG's State of Readiness Contingency Plan	31/12/2019 31/03/2020 17/12/2018 19/12/2018 13/12/2018	 14/12/2018 14/12/2018 11/12/2018
1092	31/12/2018	12	HIGH	12	HIGH	9	MEDIUM	Director of Performance & Service Improvement	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Delivery of Transformation	The risk that the required progress in the delivery of the Transformation Programme of HSC services is not made due to: Inadequate agreed regional process to effect a consistent approach to the development of agreed Transformation initiatives, their approval and implementation Inability to recruit sufficient and appropriate workforce, within required timescales to establish the Transformation initiatives while maintaining stable core service provision, while progressing the transformation programme in parallel (cross reference TIG risk no 012) Risk of incurring additional costs to backfill and maintain core service provision above available core budgets, particular use of high cost Agency staffing Building future financial commitments beyond lifetime of Transformation Funding External influences which either halt or stop reform / transformation e.g. change in political leadership (cross	Quarterly review of Reform priorities at Strategic EMT Ad-Hoc working groups Specialist services meeting with Commissioners. Internal Audit, Performance management. Escalation briefings to EMT Trust Delivery Plan/ Trust Management Plan - monitoring. HSCB Performance/Monitoring Reports. Monthly Trust board reporting. Accountability Reviews (DOH and Chief Executive).	External and political influences on ability to reform. Regional reform impact on local reform. Co-ordinated prioritisation of local need and allocation of resource. Continuous need to review potential outcomes from investment to realise reform. Continue to engage with regional reform groups and HSCB/ LCG as plans develop to gain necessary support.	Development of measures that are SMART for each reform investment opportunity Internal Audit, Augmented Trust Board reporting against Outcomes Trust Management Plan Trust Delivery Plan HSCB Performance/Monitoring Reports Monthly performance review meetings Strategic EMT Accountability Reviews	Indications from HSCB in respect of further investment and potential savings plans required in 2019/20 and recurring in 2020/21. Ability to deliver on Transformation agenda in absence of political systems and full budget.	Fortnightly transformation meetings with ADs, project managers and business support; monthly updates to CMT; Finance & Performance Committee and Delivering Together Programme Board and LCG. Regular updates to staff side via Joint Forum on all transformation initiatives. Ongoing financial review to ensure that agency/locum spend incurred through transformation projects is aligned appropriately and not reported as core service delivery agency/locum spend reporting Weekly HR recruitment activity report shared internally with directors and assistant directors.	30/09/2019 31/03/2020 31/03/2020 30/09/2019	
1109	30/01/2019	16	HIGH	16	HIGH	4	LOW	Director of Women & Childrens Services	Women & Children's Services	Safe & Effective Services.	Difficulty Recruiting to Family Intervention and Gateway Enniskillen	There has been longstanding issues recruiting and retaining staff to Family Intervention Service and Gateway Service in Enniskillen. The situation has been extremely difficult over the past 9 months. This has resulted in a high number of unallocated cases and reprioritising of active caseloads to ensure the highest priority/risk are allocated resulting in some cases being placed back on the unallocated list. Current staff are working long hours due to pressure of responding to duty work.	Currently advertised for social work staff which is also open to students due to qualify in May/June 2019 Meeting scheduled with community/voluntary organisations and family support services in Enniskillen to ascertain what support can be provided to families waiting on a service. Meeting occurred on 18.01.18 with all Senior Managers and it was agreed staff from Fostering, Early Years, LAC and Adoption will help respond to duty to allow Social Workers to prioritise work in their own caseloads Additional Service Manager and Social Work Manager deployed to Enniskillen to support Managers and review current caseloads, review unallocated cases and prioritise most high risk cases to be allocated	Visiting local schools and career events to promote a career in Social Work Insufficient number of social work student applications to the University Degree Course from the Fermanagh area. Need to liaise with the University	Quarterly Governance Meetings Action Plan developed to review and monitor Recruitment Issues and explore possible solutions		Recruitment Panel to recruit to Southern Sector	30/01/2019	07/03/2019

		Initial Risk		Current Risk		Target Risk													
ID	Opened date	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
1151	05/07/2019	15	HIGH	15	HIGH	9	MEDIUM	Director of Acute Hospital Services	Acute Hospital Services	Safe & Effective Services.Wo rkforce.	Neurology Outpatient Deficit	Visiting consultant neurologist from BHSCT to SWAH will not engage with Trust e-referral triage as standard procedure within this Trust. Visiting consultant neurologist from BHSCT to Altnagelvin has been on sick leave for 2 months. We are unable to comply with HSCB request to provide a Multiple Sclerosis Specific Outpatient Clinic as this consultant provided that expertise and that developing this service will reduce general neurology capacity and increase waiting list times. Current outpatient demand as above and as a consequence of Risk ID 977 requires at least 1 further WTE consultant and 2 specialty doctors. Patients are awaiting an appointment for up to 4 years who are facing a life-changing diagnosis that could be managed sooner if seen and prescribed disease modifying drugs.	A job description for a new consultant neurologist has been submitted to the Royal College.	Funding for new consultant and specialty doctor posts has not been secured.		Unable to cleanse the waiting list where potential serious neurology conditions will remain diagnosed as the waiting list has not reduced in 4 years.	Prepare evidence for presentation to Trust Board highlighting significant areas of concern Work with the Commissioners and Trust staff to propose increase in infrastructure	31/03/2019 31/03/2019	