Western Health and Social Care Trust

CORPORATE RISK REGISTER & ASSURANCE FRAMEWORK

BRIEFING NOTE PREPARED FOR TRUST BOARD
03 OCTOBER 2019

There are 26 risks on the Corporate Risk Register as approved at Trust Board on 5th September 2019.

Material changes to Corporate Risk Register (CRR) for approval

There are no material changes.

Update on actions from Risk Register Workshop December 2018

ID	Lead Dir.	Risk Title	Action from workshop	Update at 31st May 2019	Action Status
3	Medical Director	Health and Safety risk - resulting in injury	Proposed revised grading (from 12 to 8 (HIGH)) tabled at Jan Trust Board for consideration. Note issue risk of contractors on site	Risk grading reduced - approved at Feb Trust Board. Contractor construction work onsite discussed at H&S Group April: "WHSCT Occupiers rules & regulations Aug 2017" has now been added to risk controls.	Complete

ID	Lead Dir.	Risk Title	Action from workshop	Update at 31st May 2019	Action Status
46	Director of Human Resources	Challenges to compliance with Working Time Regulations	Risk and grading to be reviewed in light of time since score changed and mitigating actions	Re Sleep in cases, a Tribunal has been postponed in light of the Court of Appeal decision in the Royal Mencap Society case. Risk reviewed and unable to change grading at this stage.	Complete
49	Director of Performance & Service Improvement	Virus attack disables network/services	Risk being reviewed currently as it may need to be higher, based on recent audit reports. Wording of title/description to be considered for possibility of including "cyber".	Risk reviewed. No change to Title and Description includes cyber. Regional discussions taking place, and advice being given by external bodies, about the Corporate risk of Cyber Security. Moved to Finance directorate at July CMT.	Complete
51	Director of Finance	The inability of the Trust to achieve break-even	No change to grading. Director of Finance to review wording of title/description.	Title is changed to "The inability of the Trust to achieve break-even or contain expenditure within authorised control limit". Approved at June Trust Board.	Complete
57	Medical Director	Lack of cross-Directorate learning from adverse incidents, complaints, claims & audit recommendations	Risk wording to be reviewed to ensure risk includes the lack of responsiveness to incidents	Wording added to description - "...or that dissemination is unduly delayed by delays in incident reviews." (Approved at June Trust Board) Additional control gap added - "Significant delays in incidents being reviewed and closed in a timely fashion."	Complete
58	Director of Human Resources	Over dependence on the use of locum and agency staff to sustain services and insufficient induction for locum medical staff	No change (agreed it should remain a separate risk). Risk to be updated with Pathfinder work.	Risk updated as at 2 May 2019. Through the Delivering Value Programme a number of key actions are being progressed. A one day census of agency staff was undertaken on 21 May 2019. A review of the peripatetic teams is also underway. The International Medical Recruitment contract has been extended to including nursing. The Trust and Recruitment & Selection Shared Services are continuing to work through the recruitment backlog.	Complete

ID	Lead Dir.	Risk Title	Action from workshop	Update at 31st May 2019	Action Status
64	Director of Women & Children's Services	Availability of age appropriate inpatient services for children and young people with mental health difficulties	Title and Description require review and risk urgently requires update.	Risk reviewed, no longer risk and closed at August Trust Board.	Complete
73	Director of Performance & Service Improvement	Risk that patient medical records and/or patient information on Trust systems may not be complete, accurate or available at PoC	Dir. Of Acute and Dir. Of P&SI to discuss possibility of de-escalation, also need to agreed which director owns medical record management. M O'N to discuss with Dir of P&SI in first instance.	Director of PSI and Assistant Director to discuss further following update from HoS. Risk could be de-escalated in terms of availability at point of care due to implementation of RFID. Completeness and accuracy of records and information contained within the chart and on systems is not under the control of medical records and this risk sits with the Acute Directorate and areas responsible.	Ongoing actions
81	Director of Performance & Service Improvement	Trust Emergency Plans	Dir. Of P&SI to consider for possible de-escalation. Risk is at target level	De-escalation request (to P&SI Directorate risk) agreed at June Governance Committee and risk de-escalated.	Complete
99	Director of Performance & Service Improvement	Failure to fully comply with Asbestos Regulations	De-escalate to PS&I Directorate	De-escalated March Trust Board	Complete
235	Medical Director	Risks associated Water Borne Pathogens	With resolution of Milk Bank issues after a period of monitoring, risk should be considered for de-escalation. Towerblock work now complete and risk to be updated to reflect this.	Risk updated. June 2019 decision at water safety group is that risk rating is to remain as it is based on the continuing issue of legionella. Also Early Alert in Sept re PSA.	Complete

ID	Lead Dir.	Risk Title	Action from workshop	Update at 31st May 2019	Action Status
284	Director of Performance & Service Improvement	Risk of breach of Data Protection Act through loss of personal or sensitive data	Title to be amended to include GDPR. Risk should remain Corporate. Consider reducing Grading in view of the work undertaken in the past year	Title amended at June Trust Board to "Risk of breach of General Data Protection Regulation (GDPR) and Data Protection legislation through loss of personal or sensitive data" (for approval at June Trust Board). Grading of risk reviewed and not changed. General awareness has increased in light of GDPR, however improvement required in levels of completion of Mandatory IG training.	Complete
535	Director of Nursing, Primary Care & Older People's Services	Risk that patients may experience a reduced quality of nursing care due to workforce deficits	Dir. of PCOPS to consider re-wording to include Beds Protocol. Controls need to be updated/strengthened.	The Directorate is holding a risk register workshop at the end of October and the actions will be discussed at this meeting.	Ongoing actions
547	Director of Nursing, Primary Care & Older People's Services	Inability to access domiciliary care in a timely manner	A separate risk related to Community bed availability should be considered for raising through the PCOPS directorate to CMT	The Directorate has a risk on its risk register regarding patients exhibiting complex behaviour which is directly linked to the shortage of EMI beds in the community.	Complete
694	Director of Acute Services	Risk to patient/client safety because of insufficient Medical cover in PCOPS and Medical Wards in SWAH	Significant re-write required. Should relate to community also and detail specific areas of concern. Revised title wording around "stability and resilience of services due to workforce issues". Altnagelvin related risks to be managed at directorate level.	The PCOPS Directorate has a risk identifying challenges in OPMH services to meet 9-week access targets, which includes the risk related to shortage of medical staff in meeting this target. To be addressed at the PCOPS Directorate risk register workshop at the end of October 2019.	Ongoing actions

ID	Lead Dir.	Risk Title	Action from workshop	Update at 31st May 2019	Action Status
924	Chief Executive	The Trust's ability to achieve Recurrent Balance	No change to grading. Director of Finance to review wording of title/description. Need to reference safra process in the wording.	COMPLETE - No change to title at this stage. It would be incorrect to reference safra as it's out of date. Fully updated in main section including reference to the new WTDV 3 year plan and actions also updated to reflect this.	Complete
931	Director of Acute Hospital Services	Acute shortage of Breast Radiologists in WHSCT	Dir. Of Acute to review in January after appointment of Breast Radiologist with a view to reduce grading.	Request to de-escalate approved at June Trust Board	Complete
955	Chief Executive	Failure to comply with procurement legislation re social care procurement	There is a 5 year implementation plan and therefore risk actions should reflect this.	COMPLETED -We have added to the action section to reflect the 5 year plan.	Complete

WHSCT Corporate Risk Register - Governance Committee 18/09/2019

Risk Summary Report

			Initial		Current		Target		Current Risk Status				
Risk ID	Lead Director	Risk Title	Score	Grade	**Score**	**Grade**	Score	Grade	**Mths since score changed**	**Change in score since last review**	Mths since last updated	Action Plan Status	Latest Update
Compliance with Professional/Clinical/Non-Clinical Standards													
46	Director of Human Resources	Challenges to compliance with Working Time Regulations	12	HIGH	12	HIGH	9	MEDIUM	69	No change	1	Actions listed with future due dates	August 2019: The Trust continues to address Junior Doctor rota non-compliance issues in accordance with EWTD. Currently we have 4 rotas which are non-compliant. In relation to Sleep in cases, the Trust continues to provide ongoing discovery obligations for the 3 test cases. It had been previously agreed that the hearing of the test cases could not proceed pending the outcome of the Royal Mencap Society case. The Mencap case is now listed for hearing at the Supreme Court on 12 and 13 February 2020. As part of Reform of Domiciliary Care Services the phasing out of high hours contracts in relation to split shifts has reduced from 75 to 43.
284	Director of Performance & Service Improvement	Risk of breach of General Data Protection Regulation (GDPR) and Data Protection legislation through loss of personal or sensitive	16	HIGH	16	HIGH	8	HIGH	33	No change	0	Actions listed with future due dates	30 August 2019: Latest figures (09th August 2019) supplied by the Mandatory Training and ELearning team for completion of mandatory Information Governance training show a 3 year compliance figure which equates to 57% of staff in the Trust. The Information Commissioner's Office are currently reviewing training compliance within all Trusts in Northern Ireland as a follow up to survey and site visit to the Trust undertaken in August 2017.
955	Chief Executive	Failure to comply with procurement legislation re social care procurement	12	MEDIUM	12	MEDIUM	4	LOW	37	No change	0	Actions listed with future due dates	Sept 19 - Status of this has not changed. The Permanent Secretary has asked BSO PaLs to review the 5 year plan which is due back to him during this month.
Financial													

51	Director of Finance	The inability of the Trust to achieve break-even or contain expenditure within authorized control limit	16	HIGH	16	HIGH	8	HIGH	16	No change	0	Actions listed with future due dates	Sept19 - The preparation of annual accounts 2018/19 process ended in July 2019 with formal audit clearance received on 3rd July 2019
924	Chief Executive	The Trust's ability to achieve Recurrent Balance	9	MEDIUM	16	HIGH	6	LOW	24	No change	4	Actions listed with future due dates	May 2019 - The Trust has quantified its opening 3 year recovery position as £39m. The delivering value programme structure has been put in place and discussions continue with the DoH on progress during 2019/20.
Health and Safety													
235	Medical Director	Risks associated Water Borne Pathogens	15	EXTREM	15	EXTREM	8	HIGH	57	No change	0	Actions listed with future due dates	September 2019 water testing in the Tower Block has again indicated some positive samples for Legionella. Flushing continues and it is noted that vacant wards are being flushed as part of the contract. The Nucleus continues to have positive water outlets . The plant room has been constructed and work should be completed in 3 - 4 weeks . There has been a reduction in the number of positives and Serogroup 1 in Greenfield RHE following remedial work. There has been a cluster of outlets positive for pseudomonas in 1 particular section of maternity SWAH. Remedial work continues and a review of flushing procedures is in place. All water safety measures are in place. Legionella risk assessment has been carried out and there are 2190 remedial actions to be carried out. these are being carried out on a priority basis from priority group 1 to 3 . This will be a standing item on water safety group agenda regarding progress. Renal Unit Pseudomonas - 23 /41 outlets have tested positive. number of remedial actions have taken place, No clinical concerns regarding patients and no associated clinical specimens linked to this. POU filters are on all outlets , thermal and chemical disinfection , removal of some underused outlets, some taps have been

3	Medical Director	Health and Safety risk - resulting in injury	16	HIGH	8	HIGH	4	HIGH	10	No change	1	Actions listed with future due dates	Aug19 Ligature training complete for Nurse managers. Jul19 - Training on ligature risk assessment arranged for July for Nursing managers.
100	Director of Performance & Service Improvement	Backlog Maintenance	16	HIGH	12	HIGH	12	HIGH	72	No change	1	Actions listed with future due dates	2 Sept 2019: Risk reviewed. 1 July 2019: BLM 19/20 through to procurement stage. Review of 3i Estate Manager database carried out to assess level of positive impact on Trust BLM liability.
Organisational													
49	Director of Finance	Virus attack disables network/services	16	HIGH	16	HIGH	9	MEDIUM	26	No change	1	Actions listed with future due dates	28 August 2019: - Trust wide roll out of Metacompliance courses to 9000+ email users commenced in June 2019.
Patient/Client Safety													
6	Director of Women & Children's Services	Potential for harm to children whilst awaiting Gateway and Family Intervention Service (unallocated cases)	25	EXTREM	12	HIGH	8	HIGH	23	No change	0	Actions listed with future due dates	5.9.19 Unallocated cases are monitored regularly and an Action Plan is in place and has been presented to Trust Board.
63	Director of Adult Mental Health & Learning Disability	High risk forensic/challenging individuals who have potential to cause harm to themselves or others	20	EXTREM	15	EXTREM	12	HIGH	15	No change	0	Actions listed with future due dates	Sept 2019- Risk reviewed at SMT on 11th September and risk to remain on the register. Enhanced care plans were reviewed and updated- for review in Feb 2020.
57	Medical Director	Lack of cross-Directorate learning from adverse incidents, complaints, claims & audit recommendations	16	HIGH	8	HIGH	8	HIGH	23	No change	1	Actions listed with future due dates	Aug19 - Learning from Project responding to RQIA AMHDS Improvement Notice to be applied where appropriate across the Trust. July 19 - Risk description amended as approved at Trust Board to reflect current delays in reviews.
66	Director of Adult Mental Health & Learning Disability	Death or serious injury of patient as a result of a suicide or attempted suicide while in a Trust facility	25	EXTREM	10	HIGH	5	HIGH	70	No change	2	Actions listed with future due dates	July 2019- The risk was reviewed at CSCG and the establishment of a Mental Health and Environmental Health Safety Group chaired by Mr Sean Gibson- Head of Operations and Maintenance has been established and it will work alongside clinical staff to analgized trends and assist in any work that needs progressed in relation to risk potential or actual

73	Director of Performance & Service Improvement	Risk that patient medical records and/or patient information on Trust systems may not be complete, accurate or available at PoC	16	HIGH	12	MEDIUM	6	MEDIUM	66	No change	1	Actions listed with future due dates	30 August 2019: RFID Hardware installed into North Wing and system ready to be configured.
1133	Primary care and Older People services	Risk to safe patient care relating to inappropriate use of medical air	15	EXTREM	15	EXTREM	5	HIGH	5	No change	1	Actions listed without due dates	Aug 19 - Agreed at Trust Board as Corporate Risk. Risk agreed and approved at Governance Meeting on 30th April 2019.
1166	Director of Adult Mental Health & Learning Disability	Lack of a robust Governance Structure within AMHDS resulting in risk of not being able to identify emerging risks and Learn	20	EXTREM	20	EXTREM	9	MEDIUM	2	No change	0	Actions listed with future due dates	Sept 19 - Approved at Trust Board as Corporate risk. Aug 19 - Improvement plan in place.
Service Delivery													
547	Director of Nursing, Primary Care & Older People's Services	Inability to access domiciliary care in a timely manner	15	HIGH	16	HIGH	8	MEDIUM	52	No change	0	Actions listed with future due dates	Sep 19: The Trust did not proceed with appointing a transformational lead for this area to progress the regionally identified test of change area of utilising technology as the overall transformation funding position for 2019/20 was uncertain. Consideration is now been given to deploying the post for the remainder of 2019/20 should transformation slippage become available. The Trust has deployed a project resource to review and improve the utilisation of block funded rotas which will increase the overall level of domiciliary care capacity available to meet need. The delivered benefits will be reported through the DVMB. At this time access remains a challenge in some specific localities across the Trust and the assessed risk remains the same.
1091	Director of Performance & Service Improvement	Service Disruption/Loss of Service	12	HIGH	12	HIGH	6	MEDIUM	10	No change	1	Actions listed with future due dates	22 August 19: NIHG inform JPB that risk ranking unchanged.

1092	Director of Performance & Service Improvement	Delivery of Transformation	12	HIGH	12	HIGH	9	MEDIUM	10	No change	1	Actions listed with future due dates	30 August 2019: IPTs/Addendums including for supplementary allocations completed and returned to relevant commissioner by required deadline. Monitoring of receipt of allocations ongoing, internal project monitoring commenced during August 2019 with agreed escalation process to highlight projects that will not achieve or deliver transformation outcomes as per IPT objectives. Work has commenced to explore and agree mainstreaming priorities for projects across August/September/October with workshop planned for Trust directors in December 2019 to finalise plans prior to financial year end
Workforce Issues														
535	Director of Nursing, Primary Care & Older People's Services	Risk that patients may experience a reduced quality of nursing care due to workforce deficits	16	HIGH	20	EXTREM	8	HIGH	71	No change	0	Actions listed with future due dates	September 2019: Currently this is further compounded in OPMH by experienced staff (including SW, Nursing and AHPs) accepting posts in GP MDTs.
694	Director of Acute Services	Risk to patient/client safety because of insufficient Medical cover in PCOPS and Medical Wards in SWAH	9	MEDIUM	12	HIGH	9	MEDIUM	35	No change	8	Actions listed with future due dates	January 2019: Currently 2 locum staff grades employed to cover the 3 care of elderly wards in SWAH Wards 5,6 &7. These posts have significantly improved safety but do not have a recurrent funding stream and are filled by locums. The consultants in care of the elderly remain in discussion through the Job planning process to seek funding for a 4th consultant post to meet workload and demand. If the 4th consultant and the staff grades were recurrently funded i.e. agreed with the commissioner then the issue would no longer require to be on the risk register
58	Director of Human Resources	Over dependence on the use of locum and agency staff to sustain services and insufficient induction for locum medical staff	12	MEDIUM	15	HIGH	9	MEDIUM	19	No change	1	Actions listed with future due dates	August 2019: Under Medical Reform and Recruitment Project 333 posts have been offered, of which 99 doctors have taken up post (47 currently still in post). 207 offers have been declined or withdrawn and 27 doctors are progressing in the recruitment process. 9 doctors started in 2019/20.

1075	Director of Finance	No Deal Scenario / Hard Border EU Exit	12	HIGH	16	HIGH	4	LOW	11	No change	0	Actions listed with future due dates	12 Sept 2019 - Updated action plan included. Major actions completed in period include Assurances obtained on EU Exit preparedness from Independent Sector Providers contracted to the Trust; Update to Trust CMT on EU Exit Status in Sept; Review of Non Stock Supplies for shelf life concerns held in Trust in July.
1109	Director of Women & Children's Services	Difficulty Recruiting to Family Intervention and Gateway Enniskillen	16	HIGH	16	HIGH	4	LOW	9	No change	0	Actions listed with future due dates	5.9.19 Interviews were held in Southern Sector and posts have been offered out and An Action Plan is developed and has been presented to Trust Board.
1151	Acute Hospital Services	Neurology Outpatient Deficit	15	HIGH	15	HIGH	9	MEDIUM	0	0	1	Actions overdue	Aug19 - the locum neurologist was not appointed as planned in early July.
1165	Trust-wide (Risk Register Use Only)	Service Impact of HMRC Regulations in relation to Pensions.	20	EXTREM	20	EXTREM	4	LOW	2	No change	0	Actions listed with future due dates	Sep19 - Approved at Trust Board as Corporate Risk.

Corporate Risk Register and Assurance Framework - 18 September 2019

	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
3	16	HIGH	8 (4x2)	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. Crieria 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 Walkrounds. 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 Combination training (includes Risk assessment and COSHH risk assessment) Nurse managers trained in Ligatire assessment July 2019 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	Lack of funding to purchase H&S equipment or undertake maintenance of equipment/facilities. Comparatively limited staff resources dedicated to H&S. Limited availability of risk register to managers to allow direct management of risks 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	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 Source funding for approved Business case for purchase of Risk Registers on Datixweb Database of nominated H&S officers trained to be developed H&S Policy and COSHH policy revised	30/06/2019 31/07/2019 31/12/2019 30/09/2019 30/09/2019	31/03/2019 31/07/2019 31/08/2019
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. 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	31/10/2019 01/11/2018	06/03/2019

	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
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 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.	31/12/2019 31/03/2020 31/12/2019 31/12/2019	
49	16	HIGH	16 (4x4)	HIGH	9	MEDIUM	Director of Finance	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 traiing policies Induction policy Regional and local Incident Management & reporting policies & procedures Corporate Risk Management framkwork, 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 Technicial 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 sugges that is difficult to attract and retain specialist skills in this area. Unable to have consistent patching of crtical/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 Implementation of cyber security work plan which has been agreed with the Region 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 31/03/2020 31/03/2022 31/08/2018	28/02/2019 31/03/2019 31/08/2019 31/08/2018

	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
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 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
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, 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 Datix upgraded to maximise potential	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 ientified has been shared and practice changed. Significant delays in incidents being reviewed and closed in a timely fashion. Lack of Datixweb Dashboards, risk and Complaints module which limits triangulation of data for learning	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 themese being deveoped regionally for Litigation Review of Governance arrangements and ensure clear mechanism for sharing learning and implementation of resulting improvements	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 31/03/2020	31/03/2017 01/02/2017 18/09/2017 10/09/2018 15/02/2017 30/11/2016 31/12/2018

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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
58	12	MEDIUM	15 (3x5)	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 speciaility issues as they arise. Procedure in place for IR35 Asessment. 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.	31/12/2019 31/12/2019 31/12/2019 31/12/2019 31/12/2019 31/12/2019	
63	20	EXTREM	15 (5x3)	EXTREM	12	HIGH	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 Careplan list by AMH Governance lead Continue to review enhanced careplan list by AMH	31/07/2017 31/01/2020	20/07/2018
66	25	EXTREM	10 (5x2)	HIGH	5	HIGH	Director of Women & Childrens Services	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	

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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 informaton 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 responsibilites 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 30/09/2019 30/09/2019	31/03/2019
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.	Estates Strategy 2015/16-2020/21 Annual review of building condition (3i) and creation of prioritised BLM list 2019/20 Backlog maintenance programme developed Targetting 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	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. Upgrade water supply in Toiwer 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. liimited 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.	Independant 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 Independant audit recommendations pseudomonas risk assessment augmented care areas	31/12/2019 01/07/2017 01/11/2016 01/07/2017 31/07/2014 30/09/2014 31/10/2019 31/03/2019 30/09/2019 31/08/2018 31/12/2019 31/03/2020	31/03/2018 31/05/2017 31/03/2017 30/09/2014 06/10/2014 31/03/2019 31/08/2018

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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 General Data Protection Regulation (GDPR) and Data Protection legislation through loss of personal or sensitiv	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 storafe 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. No capacity within the team to take on provision of IG 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.		Band 3 0.5 post inceased to full time Recruitment of Band 4 Information Governance Development of information leaflet for Support Services Staff to increase awareness of information governance Development of IG action plan to be finalised through IGSG	31/03/2019 31/03/2019 31/03/2019 15/12/2019	31/03/2019 28/02/2019 01/03/2019
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 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 pateint 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. The bed compliment of wards is adjusted to reflect their respective normative staffing levels. Nursing KPI Report tabled at CMT monthly	No gaps identified.	Monthly review of patient falls through Falls Action Group. Quartelry 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	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

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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;□ 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	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 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	
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		Financial Recovery plan to be agreed and approved Operation of DVMB (Delivering Value Management Baord) 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

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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.			The 5 year implentation plan will continue to be monitored - via Regional Procurement Board, Trust Procurement Board and Social Care Procurement Group.	31/03/2020	
1075	12	HIGH	16 (4x4)	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, financail risk, patient and client safety and staffing issues/levels. Lead Officer is Paul Quigley and Reponsible Director is Lesley Mitchell, Director of Fiannce 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 & Fnish Group in place incldluing 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 pullled together by HR. the Trust continues to attend various regional forums on EU Exit, incldluing the Doh EU Exit Regional Meeting and other Regional Meetings such as Medicines Preparedness, Information Governance, HR and Emergency Planning. Final Version of Yellow Hammer Document	The DOH reported that further discussion at the EU Exit ALBs meeting has clarified that disruption to healt 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.	Detailed Review of Mitigating Actions to be completed - Continuity plan Lead Officer to brief CMT of evolving plans on 22 November 2018 Service Focused Workshop to be held on 17 December 2018 Trust Communication to be issued referring to the pilot EU Settlement Scheme being launched on 29 November 2018 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 Januar Assurance Statement to	24/01/2019 22/11/2018 17/12/2018 28/12/2018 17/01/2019 21/01/2019 21/01/2019 12/02/2019 05/02/2019 28/01/2019 04/03/2019 11/02/2019 30/10/2019 31/10/2019 30/09/2019 15/02/2019	24/01/2019 22/11/2018 17/12/2018 03/12/2018 17/01/2019 21/01/2019 29/06/2018 21/01/2019 12/02/2019 05/02/2019 28/01/2019 04/03/2019 11/02/2019 07/02/2019
1091	12	HIGH	12 (4x3)	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

	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
1092	12	HIGH	12 (4x3)	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.	Monthly transformation meetings with ADs, project managers and business support; monthly updates to CMT; Finance & Performance Committee and Delivering Together Proramme 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. Directors Workshop in December 2019 Mainstreaming/exit clinics in August	30/09/2019 31/03/2020 31/03/2020 30/09/2019 31/12/2019 30/11/2019 31/03/2020	
1109	16	HIGH	16 (4x4)	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/volunatry organisations and family support services in Enniskillen to ascertain what support can be provided to families waiting on a service. Meeting occured 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	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		Close liaison with HR in relation to recruit drives Advertise and Recruit on a rolling basis Recruitment Panel to recruit to Southern Sector	19/09/2019 30/01/2019	07/03/2019
1133	15	EXTREM	15 (5x3)	EXTREM	5	HIGH	Director of Nursing, Primary Care & Older People's Services	Primary Care and Older People Services	Safe & Effective Services.	Risk to safe patient care relating to inappropriate use of medical air	Risk of patient receiving medical air in error when oxygen is required resulting in hypoxia.	Regional procurement process - will no longer be able to buy a medical air flowmeter without a flowguard In the Trust's clinical procedures for medical gases Included on the medical gas training for wards Medical air blanking caps have been circulated to wards to insert into outlets that wont be used Colour coding of medical air flowmeters and air outlet on most wards Flowmeters with air-guards attached on all wards now.	Lack of knowledge of colour coding and appreciation of risks with medical gases Potentially have old flometers that are not fully compliant with colour coding (not mandatory) Not all medical air flowmeters had airguards but they do now	Walk around to be carried out in SWAH/OHPCC although they have new flowmeters with air-guards. Walk around on Altnagelvin site occurred in November 2018. To be repeated February 2019. To be picked up on annual medical gases walkaround. No external inspections	Lack of training on medical gases. This has increased now since included in Trust Combination training days.	Possible further learning from SAI investigation Daily bed space checks to be carried out Continue to include in Trust combination training days Old flow-meters removed to ensure colour coding approach is used Air outlet blocking caps to be inserted to air outlets that are not needed Ensure full compliance with use of air guards on medical air flowmeters across all three sites		

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1151	15	HIGH	15 (3x5)	HIGH	9	MEDIUM	Director of Acute Hospital Services	Acute Hospital Services	Safe & Effective Services.Workforce.	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	
1165	20	EXTREM	20 (4x5)	EXTREM	4	LOW	Director of Human Resources	Trust-wide (Risk Register Use Only)	Workforce.	Service Impact of HMRC Regulations in relation to Pensions.	Clinical staff seeking to reduce their additional employment contract commitments due to tax consequences of their HSC pension i.e. Annual Allowance.	Employer Technical Updates Annual Benefits Statement Job Planning Workshop for Assistant Directors and Clinical Directors Pension Workshops for high earners in June 2018 and further workshops planned in September and October 2019.	Doctors report insufficient information on this issue being made available to them	National Consultation on 50:50 membership model Pension Regulator HSC Scheme Advisory Board HSC Pension Board Discussions ongoing regionally with HSC Pensions, Department of Health, other HSC Trusts and BMA	Impact of McCloud and Sergeant Employment Law cases HSC Pensions Service under resourced.	Job Planning Workshop with Assistant Directors and Clinical Leads Scope high impact areas and develop an action plan to develop	30/09/2019 30/09/2019	
1166	20	EXTREM	20 (4x5)	EXTREM	9	MEDIUM	Director of Adult Mental Health & Learning Disability	Adult Mental Health & Disability Services	Safe & Effective Services.Governance.	Lack of a robust Governance Structure within AMHDS resulting in risk of not being able to identify emerging risks and Learn	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.	Monitor untoward incidents via the DATIX system Monitor complaints within the Directorate Directorate Governance Meetings held monthly and review of the risk register Rapid review group meets weekly and reviews all red incidents SAI/SEA Reviews as per Regional Guidance. Ongoing training for staff within the Directorate to effectively use the DATIX incident reporting system.	Lack of robust Governance structure for directorate Risk Management training for all Incident Handlers Ad hoc arrangements for reviewing incidents at local ward level Outstanding SAI/SEA Reports Incidents are not being reviewed and closed 1 staff member within the Governance role and the current capacity outweighs demand	Performance reporting on open incidents to Directorate Governance, C&SCG Sub Committee & Governance Committee. Twice yearly ligature risk assessments Health and Safety Inspections through the Trust Health and Safety Working Group Unannounced RQIA Inspections Quality Improvement audit ongoing	Lack of Open incidents escalation process from local level to service managers/ADs prior to Directorate Governance. Actions identified within the Service Improvement Notice from RQIA with a review in Oct 2019	Improvement plan to meet improvement notice requirements Share leanring from improvement plan Trust wide Secure financial funding for governance Team	22/10/2019 31/03/2020 30/09/2019	