Western Health and Social Care Trust

CORPORATE RISK REGISTER & ASSURANCE FRAMEWORK

BRIEFING NOTE PREPARED FOR TRUST BOARD
1 APRIL 2021

There are 21 risks on the Corporate Risk Register as approved at Trust Board on 4th March 2021.

Summary

- Proposal to update Corporate Risk ID57 to include ID1166 – Agreed at CMT 25/03/21
- Proposal for new Corporate Risk replacing Corporate Risks ID100 and ID235 – Agreed at CMT 25/03/21
- Proposal to amend title and description of Risk ID6 and revise category. – Agreed at CMT 25/03/21
- Proposed revised current risk grading for Risk ID1207 from High (12) to High (8). – Agreed at CMT 25/03/21
- Update on agreed actions from Trust Board workshop (attached)
- Covid-19 risk ID1213 indicators

Update Corporate Risk 57 to include 1166

At October 20 Trust Board Workshop on Corporate risks, it was agreed that risks 57 and 1166 were similar and one Corporate risk to capture learning deficits relating to safety and quality should be progressed. The following is a proposal to update Risk ID57 to include ID1166 and revise as follows:-

Current risks

Risk level (current)	Title	Description
HIGH 12 ID57	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 reviews.
EXTREM 20 ID1166	Lack of a robust Governance Structure within AMHDS resulting in risk of not being able to identify emerging risks and Learn	Oct 2019 Risk reviewed at SMT/CSCG/ Directorate Governance and the Directorate is working as per the service improvement plan. Within AMH the CSCG Meeting has been amalgamated with SMT to ensure the focus of governance is everyone's business and that this will allow a framework for good governance at all senior management meetings. 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.

Proposed new risk title and description

New risk is titled: "*Failure to learn from quality and safety risk indicators may result in harm*."

New Risk Description:- "*Due to resourcing; cultural and organisational deficiencies in ensuring robust Governance structures and arrangements, the learning from Incidents, Complaints, M&M reviews and other quality and safety risk indicators may not be shared appropriately or in a timely way. This may result in potential avoidable harm to service users, staff and others".*

The existing Controls and Assurances and the action plan will be updated and merged.

Proposed new Current Risk Grading:- Consequence CATESTROPHIC (5) X Likelihood POSSIBLE (3) = **EXTREME** (15)

Proposed Category: - Quality of Care

Proposed Indicators: - Monthly Overdue SAIs/Complaints; Incidents open > 3 months; Timelines of M&M reviews and any Never Events.

Proposal for new Corporate Risk (attached) replacing Corporate Risks ID100 and ID235

Attached is the new PSI Corporate risk for Infrastructure. It was approved at the PSI SMT Governance meeting on 8/03/21 and is tabled here for consideration. This risk replaces ID100 “Backlog Maintenance” and ID235 “Risk of continuing failure to meet statutory requirements for Water Safety” as proposed at the Risk Workshop in October 2020. The Water safety risk is being revised to be managed at directorate level.

Current risks

ID	Risk level (current)	Title	Description
100	HIGH 12	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.
235	EXTREM 15	Risk of continuing failure to meet statutory requirements for Water Safety	As a result of partial compliance to Water Systems Safety Regulations the Trust is continuing to fail to meet statutory requirements for Water Safety and associated risk of Legionella in the water system and a patient/client developing Legionnaire's pneumonia.

Proposed new risk

New risk is titled: "*Risk of failure to meet regulatory standards and compliance associated with Trust infrastructure and estate*."

New Risk Description:- "*There is a risk of deterioration in the Trust Estate due to ageing and lack of capital 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 (e.g. water, electrical, asbestos and physical infrastructure)".*

Proposed new Current Risk Grading: - Consequence MAJOR (4) X Likelihood POSSIBLE (3) = **HIGH** (12)

Proposed Category: - Regulation & Compliance (Statutory, Professional, Quality Legislation)

Proposed Indicators: - KPI'S PAM Plan (Annually); Facilities Oakleaf (Condition) (Annually); Datix's (Monthly); SAI's (6 Monthly); Investment Plan monitoring.

Proposed amendment to title and description of risk ID6

A further action from the Risk workshop in October 2020 was to revise the wording of risk ID6 to reflect more clearly the actual risk in terms of cause, event and outcomes.

Previous title and description:-

Title - *Harm to children whilst awaiting Gateway and Family Intervention Service (unallocated cases)*

Description: - *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*.

Proposed revised wording:-

New title: - *Children awaiting allocation of social worker may experience harm or abuse*.

New Description: - *Due to capacity and demand issues within Family & Childcare children may not be allocated a social worker in a timely manner to provide appropriate support. Children may experience harm as a result and the Trust may not meet its associated professional and organisational requirements*.

One of the following categories should be selected against this new risk:-

Risk Category: This risk is currently aligned to the "People & Resource" category though consideration should be given to realigning to either "Quality of Care" or "Regulation and Compliance" to capture appetite against the revised risk outcomes.

Proposed revised current risk grading of Risk ID1207 – "Care, safety and quality standards delivered in Independent Sector Nursing and Residential Care Facilities"

The current risk level has been reviewed and based on current RQIA enforcement activity (currently 1 residential home in Omagh is subject to RQIA enforcement activity), it is considered that the current risk level can be reduced from HIGH(12) to HIGH(8).

Current Risk Grading:- Consequence MAJOR (4) X Likelihood POSSIBLE (3) = **HIGH** (12)

Proposed new Current Risk Grading:- Consequence MAJOR (4) X Likelihood UNLIKELY (2) = **HIGH** (8)

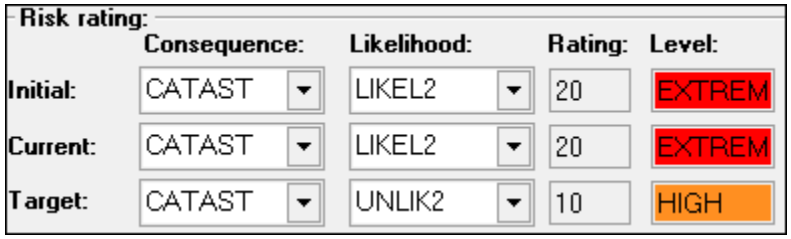
Please consider for approval.

Update on agreed actions from Trust Board

Please see attached list of actions as agreed following Trust Board workshop. These actions are being progressed through the normal CMT-Trust Board approval process and an update on progress is being tabled each month.

Covid-19 Risk ID 1213 – Indicators at 18/03/21

This risk grading has remained at the same since being opened on 04/04/20.



The grading is currently being reviewed and is to be discussed at CMT Safety Huddle in early April for a decision. Please see the following list of indicators from the Silver Sit-Rep reports at 18/03/21:-

Table 1 – Covid-19 Indicators

Covid Risk ID1213 - Indicators as at 18/03/21 (February Indicators in Brackets)				
Indicators	**Total**	**Alt.**	**SWAH**	**Comm.**
Covid-19 deaths (Cumulative)	213 (206)			
Covid positive inpatients	43 (45)	27 (26)	12 (19)	4 (10)
Number in ICU (Covid positive)	6 (6)	6 (6)	0 (0)	
Total number of beds closed	62 (54)	40 (22)	8 (6)	14 (26) (Includes 10 Rehab + Waterside)
Hospital Oxygen supply status lt/m		195 (376)	82 (85)	
ED waits >12 hours in last 7 days		12% (12)	10.9% (11)	
Staff tested positive (Cumulative)	516			
Staff positives reported under RIDDOR. (Cumulative)	393 (332)			
Staff unavailable for work	824 (916)	267 (272)	101 (130)	456 (514)
% of Staff unavailable for work	7.0% (7.8%)	5.93%(5.98%)	6.16%(8.01%)	8.1%(9.21%)
incidents reported as being directly related to Covid (last 7 days)	3 (46)	0(6)	1(2)	2(38)
No +ve tests (last 7 days) NI	1208 (2140)			
No +ve test (last 7 days) Derry and Strabane Council area	79 (120)			
No +ve test (last 7 days) Fermanagh and Omagh	40 (64)			

No of Trust Staff vaccinations delivered Total vaccinations	32,768* 79,369(48,101)	*Total of Trust and Non Trust staff e.g Private Care Homes, Foyle Hospice etc
Vaccine Incidents reported	69 (55)	

Early Alerts/Service downturns or Service fragility

Benbradagh Day Centre

The centre closed on 03.03.21 following a covid outbreak.

Early Alerts

EA09-21 Vaccine administration on 25.02.21.

WHSCT Corporate Risk Register 21/03/2021

Risk Summary Report

				Initial		Current		Target		Current Risk Status				
Risk Category **(to be revised)**	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
Health & Safety	3	Medical Director	Health and Safety risk - resulting in injury	16	HIGH	20	EXTREM	4	HIGH	10	No change	0	Actions listed with future due dates	Mar21 - Consideration of indicators at February Health & Safety Group and agree risk should remain at existing level. RIDDOR incidents excl Covid related - Oct-Dec20(Oct-Dec19) 13(11). Covid RIDDOR incidents Oct20=73,Nov20=68,Dec20=44. Annual Risk Assessment compliance levels for Oct-Dec 20 (same period previous year in brackets):- Acute 51%(33); AMHLD 99%(83); PSI 100%(83); PCOP 57%(33); W&C 30%(21); Overall this represents an increased compliance on previous year from 44% to 62%.
"Quality of Care" or "Regulation and Compliance"?	6	Director of Women & Children's Services	Children awaiting allocation of Social Worker may experience harm or abuse	25	EXTREM	12	HIGH	8	HIGH	40	No change	0	One action overdue	Mar21 - Revised title and description proposal to CMT in March and Trust Board in April. Feb 21. Enniskillen pilot ongoing with consultation process completed. Pilot will be monitored through Childcare Strengthening Pathways Big Programme of work. Evaluation of this pilot will inform way forward.
ICT & Physical Infrastructure	49	Director of Finance	The potential impact of a Cyber Security incident on the Western Trust	16	HIGH	16	HIGH	9	MEDIUM	44	No change	1	Actions listed with future due dates	9 Feb 2021: Following discussions within the ICT department, and a workshop organised by Corporate Risk Management team, this risk was reviewed and revamped, with changes made to its description, controls and assurances entries. Changes were necessitated due to legislation, technical and regional developments which had a bearing on this risk. The changes are a better reflection of the Cyber environment locally and regionally. To improve readability, categories such as Staffing, Governance, Technical etc were introduced into the Controls, Assurance etc entities.
Quality of Care	57	Medical Director	Lack of cross-Directorate learning from adverse incidents, complaints, claims & audit recommendations	16	HIGH	12	HIGH	8	HIGH	34	No change	0	Actions listed with future due dates	Mar21 - Proposal to update risk with ID1166 going to CMT March and April Trust Board. Indicators pending approval but note that at 18/03/21 SAIs overdue = 56 (65 previous month). February 2021 Medical Directorate Team meeting planned for March 2021 where merging of risks 1166, 1133 and 57 will be reframed into a Safety risk.
Health & Safety	100	Director of Performance & Service Improvement	Backlog Maintenance	16	HIGH	12	HIGH	12	HIGH	90	No change	0	Actions listed with future due dates	01/03/21 Risk has been developed and will be taken through the appropriate approval process. Metrics have been agreed. 09/02/21 New Corporate risk re Infrastructure and Directorate risk re Water awaiting approval at PSI Governance meeting on the 8 March 2021. Delivery of BLM plan underway.

WHSCT Corporate Risk Register 21/03/2021

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Regulation & Compliance	235	Medical Director	Risk of continuing failure to meet statutory requirements for Water Safety	15	EXTREM	15	EXTREM	8	HIGH	75	No change	0	Actions listed with future due dates	March 2021 44% increase in the number of Legionella positive water samples. The main areas contributing to the increase are on the Altnagelvin site, including Nucleus, South Wing, North Wing and Spruce House. The increased levels of legionella within the Trust Water Systems corresponds with the standing down of services or reduced services throughout the Covid pandemic. It is believed that the Lack of usage of water outlets during this time, has led to the possible stagnation of the system, causing bacterial growth and increasing the risks of Legionnaires' disease. February 2021 - As per risk ID 100 New Corporate risk re Infrastructure and Directorate risk re Water awaiting approval at PSI Governance meeting on the 8 March 2021. 14/01/21 Work progressing to agree the measures for the new corporate infrastructure risk for approval at next PSI Governance Meeting in March. New PSI directorate risk being set up for water safety and comments received from W Cross.
Regulation & Compliance	284	Director of Performance & Service Improvement	Risk of breach of General Data Protection Regulation (GDPR) and Data Protection legislation through loss of personal or sensitiv	16	HIGH	16	HIGH	8	HIGH	51	No change	1	Actions listed with future due dates	26/02/21 - IG training has dropped by 2% to 60% so IG training sessions for Managers will be organised via Zoom , to increase take-up and encourage managers to ensure their teams complete the IG e-learning. Staff compliance - Mandatory Training (Monthly) IG training is at 60% which is a drop of 2%. Incidents (Bi monthly) 14 incidents reported. No incidents reported to ICO in last 2 months Incident trend analysis - Of the 14 incidents , 9 were Acute, 3 Social work and 2 HR related. Key trend remains the same - Information sent to wrong recipient via post (3 incidents and one SAI notification). Three of the reported acute incidents were not IG related - patient A called by name but Patient B responded and presented for treatment (all were caught in time). The remaining incidents were individual issues of missing notes, low level ICT/social media incidents and accidental sharing of patient info. Complaints - 1 GDPR related Complaint - parent received wrong child's information in post. SAI's - One SAI, related to an incident where in responding to a subject access request, notes relating to several patients on the same ward, were included. Remedial Action:The drop in IG training and the identified trend, suggest human error/lack of checks is the key IG concern to the Trust. In response the IG team will develop a training session(s) targeting managers, to cascade the key IG messages and encourage managers to increase IG training within their teams.
People & Resource	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	69	No change	5	Actions listed with future due dates	Oct20 - The Trust's Delivering Value programme has identified project resources to progress a specific initiative progressed to increase the utilisation of block contracts which in turn has facilitated increasing demand for homecare and has also optimised the available carer resource across the Trust. This work will continue for the remainder of 2020 and into 2021. The Trust is waiting on the region to issue the proposed framework but this has been delayed due to Covid. The Trust continues to develop its own commissioning framework for these services in the future that will be closely linked to the regional framework

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Regulation & Compliance	719	Director of Women & Children's Services	Risk of failure to meet a standard/protocol/guideline.	20	EXTREM	12	HIGH	8	HIGH	76	No change	0	Actions listed with future due dates	15/03/21: No feedback from Directorates on progress updates. It has been agreed to hold a workshop towards end of April. Directorates will provide updates at this workshop and highlight challenges and way forward. Tom Cassidy will lead on this workshop. 03 Feb 21: Assistant Governance Manager sent out ongoing Standards and Guidelines to all Directorates for review, update and return by 26 Feb 2021 in preparation for Workshop.. Short briefing planning for CMT Huddle on 2 Mar 2021.
Regulation & Compliance	955	Director of Finance	Failure to comply with procurement legislation re social care procurement	12	MEDIUM	12	MEDIUM	4	LOW	54	No change	4	Actions listed with future due dates	Nov20 - Reviewed at Trust Board workshop, DoF to be responsible director and to remain on CRR. August 20 The Trust is participating in the Light Touch Regime with regional prioritisation of social care procurements. The decision has been made to begin preparations for the retendering of contracts for Domiciliary Care although the decision to complete will require further consideration.
People & Resource	1075	Director of Finance	No Deal Scenario / Hard Border EU Exit	12	HIGH	16	HIGH	4	LOW	29	No change	0	No open actions	Mar21 - Meeting being planned to look specifically at managing the dual registration for professionals. The meeting will include Acute services and HR.

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Quality of Care	1133	Director of Nursing, Primary Care & Older People's Services	Risk to safe patient care relating to inappropriate use of medical air	15	EXTREM	25	EXTREM	5	HIGH	9	No change	1	Actions listed with future due dates	February 2021. SAI reports completed and submitted to the Board. Actions are being taken forward.Jan 2021 - 3 SAIs had been tabled at RRG and now with Assistant director for final amendments. Aug 2020 - SAI meeting 24/08/20, SAI draft report progressing, aim for submission mid September. July 2020 - Grading revised following consideration at CMT in June from 15 to 25 EXTREME following 3 SAIs / Never Events. SAIs being progressed and ToR and Team membership sent to HSCB on 10-07-20. Update 29 May and 05 June 2020 - A Trust comms message was sent out regarding bedside checks and other actions as follows, reinforced at ward/department level and requesting that every shift turnover has a medical gases briefing and safety checks. 1) The medical air flow meters when not required for prescribed purpose, are not to be attached to the air outlet, they are to be removed and stored in a designated area within the ward. 2) Bedside checks will be undertaken after each patient discharge and if medical air is not required for the incoming patient, the air flow meter will be removed. 3) All wards advised to remove all medical air flow meters from all bedheads across SWAH and Altnagelvin sites other than those in use for prescribed reason. Medical air flow meters have black safety guards in place and for those outlets not required, a black cap seal is inserted into the air out port (a checks process has been in place for this and the effectiveness of this is being reviewed with a view to enhancing). 4) A walk around checking process will be scheduled for all Trust hospitals.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 outl. Colour coding of medical air flowmeters and air outlet on most wards Flowmeters with air-guards attached on all wards now.
Quality of Care	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	19	No change	0	Action overdue	Mar21 - Proposal to merge with ID57 going to CMT on March 25th.
Regulation & Compliance	1183	Director of Adult Mental Health & Learning Disability	Insufficient relevant staff trained in DoLS processes may result in the Trust depriving patients of their liberty with the resu	25	EXTREM	25	EXTREM	15	EXTREM	16	No change	1	Actions listed with future due dates	24/02/21 - Controls, Assurances, Gaps and action plan review and updated. 15/01/21 MCA team supporting Directorates to develop their Directorate MCA risk - currently working with and progressing PCOP risk.
Quality of Care	1207	Director of Nursing, Primary Care & Older People's Services	Care, safety and quality standards delivered in Independent Sector Nursing and Residential Care Facilities	9	MEDIUM	12	HIGH	6	MEDIUM	12	No change	0	Actions listed with future due dates	March 2021 - the current risk level has been reviewed and based on current RQIA enforcement activity (currently 1 residential home in Omagh is subject to RQIA enforcement activity), it is considered that the current risk level can be changed to MEDIUM).

WHSCT Corporate Risk Register 21/03/2021

Risk Summary Report

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Risk Category **(to be revised)**	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
Quality of Care	1213	Medical Director	COVID-19 risk re assess & response to patient/client need & maintain quality & safety for patients/clients and staff	20	EXTREM	20	EXTREM	10	HIGH	12	No change	0	Actions listed with future due dates	18/03/2021 - 213 Covid related deaths (cumulatively); 43 Covid positive inpatients 6 positive patients in ICU 62 beds closed. 516 staff tested positive. 393 RIDDOR reports. 824 staff unavailable for work (7%). 3 COVID incidents in week.. Positives cases in last 7 days NI 2108 Derry and Strabane 79 Omagh and Fermanagh 40. Vaccinations administered 79,369. Total vaccine incidents 69.
Quality of Care	1216	Acute Hospital Services	Risk of patient harm in Trust EDs due to capacity, staffing and patient flow issues	15	EXTREM	15	EXTREM	5	HIGH	12	No change	0	Actions listed with future due dates	18-03-21 4 incidents related to capacity/demand pressures reported since 14/01/21.
Regulation & Compliance	1219	Acute Hospital Services	Lack of endoscopy capacity for endoscopy to meet the demand which impacts on Patient outcomes	20	EXTREM	20	EXTREM	1	LOW	0	New Corp. Risk	0	Actions listed with future due dates	Mar21 - Risk approved at Trust Board for adding to Corporate Risk Register. Performance Position 31 December 2020 Overall position: Total number of patients waiting for endoscopy: 4,908. Further breakdown: Red Flag patients: 844 patients waiting (NS waits- 281, SS waits-563), with the longest patients waiting 25 weeks. Red flag referrals should be seen within 2 weeks. Urgent patients: 3,669 patients waiting, with the longest patients waiting up to 106 weeks. Urgent patients should be seen within 9 weeks. Routine patients:1,645 patients waiting over 52 weeks, with the longest patients waiting up to 154 weeks. Urgent patients should be seen within 9 weeks. Surveillance patients: 2,703 patients are waiting with the waiting list dating back to 2016. These patients are on a watch and wait list and may be developing a cancer while waiting to be assessed
Financial	1227	Director of Nursing, Primary Care & Older People's Services	Action Plan for implementation of new regulations on medical devices by May 2020 as per circular HSE16-19 not completed	15	HIGH	15	HIGH	9	MEDIUM	0	-1	1	Actions listed with future due dates	Update February 2021 Scoping across a broad range of clinical specialities completed action plan drafted December 2020 and cicrulcated for review to Corporate Risk Team and Lead Director for Review. Plan to present for approval at C&SC Governance meeting March with the aim to de-escalate risk.December 2020: The report/action plan is scheduled for completion by the end of December 2020.
People & Resource or Quality of Care?	1236	Director of Finance	Ability to achieve financial stability, due to both reductions in Income and increased expenditure.	16	HIGH	16	HIGH	8	HIGH	3	0	4	Actions listed with future due dates	Nov20 - Reviewed at Trust Board workshop, actions to be reviewed and risk to remain. August 2020 - Added as a new Corporate Risk with merging of risks ID51 & ID924.
People & Resource or Quality of Care?	1254	Director of Human Resources	Inability to deliver safe, high quality and sustainable services due to workforce supply and disruptions	16	HIGH	16	HIGH	9	MEDIUM	0	No change	0	Actions listed with future due dates	March 2021: As a result of further discussions and refinement of the HR Action Plan required to address People & Resources Corporate Risk, five workstreams have now being agreed to take forward these key actions (i) Looking after our People (ii) Growing for the future (iii) New ways of working (iv) Belonging in the HSC and (iv) Improving Statutory Performance. A HR workshop is planned for April 2021 to identify the Key Performance Indicators for each of the five workstreams and these will be linked to the HR

Corporate Risk Register and Assurance Framework - 18/03/2021

		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	20 (4x5)	EXTREM	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 WHSCT Occupiers rules & regulations Aug 2017 MAPA training team in place 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 COSHH added as standing item to Health &Safety Working Group agenda. Labs representative on Health & Safety Working Group Four officers in Risk Management are	Limitation / constraint on funding to purchase all H&S equipment but the Trust risk assesses each procurement request of H&S equipment funding is allocated accordingly. Similarly a risk based approach is applied to the maintenance of all Trust equipment and facilities in order to mitigate the risk to an appropriate level. 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. Develop and roll out virtual training Review of Fit Testing policy / protocol Agree process for reporting Covid RIDDOR incidents Review monthly Ongoing Advice & Guidance re Covid in Trust docuemnts & comms. Complete Inspection plan for 2020 H&S Policy revised COSHH policy revised 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	30/06/2019 31/12/2020 31/03/2021 15/05/2020 31/03/2021 31/03/2021 31/03/2020 31/03/2020 31/07/2019 31/03/2020 31/03/2021	31/03/2019 31/12/2020 15/05/2020 09/03/2020 09/03/2020 31/07/2019 29/02/2020
6	21/09/2009	25	EXTREM	12 (4x3)	HIGH	8	HIGH	Director of Women & Children's Services	Women & Children's Services	Safe & Effective Services.	Children awaiting allocation of Social Worker may experience harm or abuse	Due to capacity and demand issues within Family & Childcrae children may not be allocated a Social Worker in a timely manner to provide appropriate support. Children may experience harm as a result and the Trust may not meets its associated professional and organisational requirements.	Ongoing action to secure recurring funding. Update meetings between F&CC ADs and Director. Performance Management Review is being undertaken by HSCB with all 5 Trusts focusing on Unallocated cases and timescales Service Managers and Social Work Managers monitor and review unallocated cases on a weekly basis. Principal Social Work redeployed will monitor Action Plan and progress to stabilise team Early Help staff returned to their substantive posts within gateway to increase the ability to allocate Service and SW Managers constantly prioritise workloads.	Delays in recruitment Inability to get sick leave covered inability to recruit and retain social workers Principal Social Workers review unallocated cases regularly HSCB have drafted a regional paper to secure additional funding for Unallocated Cases.	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		Piloting a generic model of practice 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	30/11/2020 30/09/2020 01/11/2018	 31/12/2019 30/09/2020 06/03/2019

Corporate Risk Register and Assurance Framework - 18/03/2021

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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
49	06/10/2009	16	HIGH	16 (4x4)	HIGH	9	MEDIUM	Director of Finance	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	The potential impact of a Cyber Security incident on the Western Trust	Information security across the HSC is of critical importance to the delivery of care, protection of information assets and many related business processes. Without effective security and controls; compromises can arise from technology and people which can lead to breaches of Data Protection Act and Network and Information Systems (NIS) regulations Compromises can arise from; • NON Managed Trust ICT Equipment (e.g. Radiology modalities, cameras, door access, medical devices etc) in areas such as Radiology, Labs, PFI, HSDU, Estates, GP's etc are operating un-supported operating systems, e.g. Windows XP, and/or do not have the most up to date software updates (patching) which can lead to Ransomware attacks, introduction of malware or hacking incidents • Lack of Cyber Security awareness or training among Trust staff	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 Trust and Regional Cyber Project Boards	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.	Implementation of cyber security work plan which has been agreed with the Region. 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.	31/03/2022 31/03/2019 31/03/2019 31/03/2020 31/08/2018	 28/02/2019 31/03/2019 31/08/2019 31/08/2018
57	06/10/2009	16	HIGH	12 (4x3)	HIGH	8	HIGH	Medical Director	Trust-wide (Risk Register Use Only)	Governance. Safe & Effective Services.	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 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/RRG. 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 Regional learning following legal claims shared via DLS Regional Litigation meeting. Claims learning themes developed Datix upgraded to maximise potential of system Compliance with Regional Post Falls	Learning from Audits that are carried out without knowledge of Audit Department may not be implemented. No system for providing assurance that learning ientified has been shared and practice changed. Learning themes not yet applied which could focus action on broad areas for improvement Datixweb Dashboards, risk and Complaints modules not yet implemented 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 Business case for Datixweb Risk, Dashboards and Complaints module Trust SAI learning event Establish Learning site on Sharepoint Revision of Governance arrangements under Covid-19 Learning themese being deveoped regionally for Litigation Learning from Project responding to RQIA AMHDS Improvement	31/03/2017 31/03/2017 30/09/2017 30/09/2018 31/01/2017 31/12/2016 31/01/2020 31/10/2019 30/06/2021 31/05/2020 31/12/2018 31/12/2020 31/03/2021 31/05/2021 30/11/2020 31/12/2021 30/09/2021 31/03/2021	31/03/2017 01/02/2017 18/09/2017 10/09/2018 15/02/2017 30/11/2016 31/01/2020 03/10/2019 30/04/2020 31/12/2018 01/12/2020 30/11/2020

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100	26/10/2009	16	HIGH	12 (4x3)	HIGH	12	HIGH	Director of Performance & Service Improvement	Performance & Service Improvement	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.	Should a critical issue materialise further funding can be sought from DOH or existing funding reprioritised to address the new critical issue 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 Create prioritsied list BLM 20/21 Include backlog maintenance in capital plan presented to CMT Procure 19/20 BLM Deliver BLM projects 20/21 Procure and carry out schemes Present BLM paper to CMT Procure 18/19 backlog list BCs developed and approved	30/04/2015 31/05/2016 31/05/2017 31/05/2018 31/03/2020 30/08/2020 30/06/2016 31/03/2020 31/03/2021 31/03/2017 30/10/2015 31/03/2019 30/09/2020	
235	08/12/2010	15	EXTREM	15 (5x3)	EXTREM	8	HIGH	Medical Director	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Risk of continuing failure to meet statutory requirements for Water Safety	As a result of partial compliance to Water Systems Safety Regulations the Trust is continuing to fail to meet statutory requirements for Water Safety and associated risk of Legionella in the water system and a patient/client developing Legionnaire's pneumonia.	Planned programme of testing and remedial maintenance as required. Risk assessment.Legionella 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 Additional Flushing program Estates Water Safety Audits complance Replace RO water system Renal Unit upgrade water system Nucleus, Greenfield, Carnhill, Avoca lodge updated wtaer safety plans pseudomonas risk assessment for augmented care	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. Iiimited assurance regarding flushing underused outlets Unexpected COVID pandemic and impact of stand down of servcies	Independent Authorised Engineers appointed for Water Safety. Independent Audits of Water Safety RQIA Inspections of augmented care. Updated Risk assessments included in water safety plans CMT/Trust Board/ Corporate governance Committee Laboratory Surveillance Updated Water Safety Plans. Water Safety Group review implementation of Water Safety Plans. Water Sampling Trends	Independant Water Safety Audit Compliance Compliance with flushing underused outlets Engagement regarding changig use of facilities	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. pseudomonas risk assessment augmented care areas upgrade ward wing toilets (40) Upgrade water system Nucleus Installation of hot water supply to Milk Bank SWAH action Independant audit recommendations update Water Safety Plan	30/09/2020 01/07/2017 01/11/2016 01/07/2017 31/07/2014 30/09/2014 31/03/2020 31/03/2019 30/09/2020 31/08/2018 31/03/2021 30/09/2020	30/09/2020 31/03/2018 31/05/2017 31/03/2017 30/09/2014 06/10/2014 31/12/2019 31/03/2019 30/09/2020 31/08/2018 30/09/2020

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284	13/12/2010	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 Review of regional IG training available on HSC Learning completed and updated to provide more robust training fro staff.	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 Review of regional e-learning IG training Establishment of Regional Records Man Group Review of Secondary storage in Maple Villa Review of Primary (acute) records storage in AAH Production of Records Storage guidance for home working staff working from home Development of IG action plan to be finalised through IGSG Recruitment of band 5 IG post to support DPA Development of IG information leaflet for support staff	31/03/2019 31/03/2019 31/03/2019 31/12/2020 30/09/2020 31/03/2021 31/03/2021 31/03/2021 30/09/2020 31/12/2020 30/09/2020	31/03/2019 28/02/2019 01/03/2019 25/11/2020 30/09/2020 30/09/2020 31/12/2020 30/09/2020
547	21/09/2012	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	The focus remains to ensure optimum utilisation of available resource and progress actions in areas where there are clusters of unmet need Total assurance cannot be given as the demand and location of cases cannot be projected or planned for.	Negotiate new contracts with Independent Sector providers. Discussing individual priority clients with providers to re-organise care Providing a range of alternatives, e.g. direct payments Procurement for dom care is almost complete Member of Reablement steering group 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. regional development of a new Framework For Delivery of Care and Support in Own Home Project resource to review and improve the utilisation of block	21/04/2016 21/04/2016 21/04/2016 21/04/2016 21/04/2016 31/08/2018 30/09/2018 31/03/2021 31/03/2021	13/09/2016 28/02/2017 13/09/2016 13/09/2016 13/09/2016 31/08/2018 30/09/2018

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719	02/12/2013	20	EXTREM	12 (4x3)	HIGH	8	HIGH	Director of Women & Childrens Services	Trust-wide (Risk Register Use Only)	Governance.	Risk of failure to meet a standard/protocol/guideline.	There is a risk to the Trust if, for whatever reason, it fails to meet a standard/protocol/guideline set that is commensurate to safe and effective care.	Lead Officer assigned to each standard and guideline. Approved system in place for disseminating standards and guidelines. The Trust will identify the standards, policies and protocols/guidance not fully met and the rationale for that position through the Quality & Standards Sub-Committee and escalate as appropriate to Trust Governance Committee. A pathway protocol has been designed to reinforce the correct escalation for exceptions to compliance. Standards & Guidelines requiring implementation are shared quarterly with Directorate Governance Groups. Standards & Guidelines unable to be fully implemented are shared quarterly with Directorate Governance Groups. Standards & Guidelines 'unable to be implemented' are monitored quarterly by Quality & Standards Committee. Exceptions to Compliance (e.g. Not on Track) report provided for each NICE Guideline Standards & Guidelines recorded on central database.	Engagement from Clinical/Professional is not consistent in identifying exceptions and appropriately escalating risks. Pathway protocol may not always be strictly adhered to	Provide bi-monthly assurance report to HSCB/PHA BSO Internal Audit of process - Report received in December 2015 - Satisfactory assurance RQIA Audit of selected guidance.	Capacity to follow up on all outstanding guidelines - growing list Difficulty getting feedback from clinical/professional leads	Development of electronic solution to manage standards and guidelines more effectively. Provide Quarterly summary status position on 'on-going' and 'unable to be fully implemented' standards and guidelines to Quality & Standards Committee and Directorate Governance Meetings. Recurring Workshop planned for Feb 2021 to review ongoing Standards& NICE Guidelines, for update and decision on risk, responsibility and actions to be completed. Reconcile information held on database with 'ongoing' and 'unable to fully implement' Excel spreadsheets. Recurring Review and follow up of 'unable to be fully implemented' guidelines on annual basis or more	31/03/2021 31/05/2017 31/03/2017 31/03/2021 31/03/2021 30/04/2021 31/03/2021 31/03/2021	27/07/2017 30/06/2017
955	11/08/2016	12	MEDIUM	12 (3x4)	MEDIUM	4	LOW	Director of Finance	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.	31/03/2021	
1075	23/08/2018	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.	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 received by Trust EU Exit Task and Finish Group meet monthly. Day one delivery plan	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.	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 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	31/12/2020 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 30/11/2020 31/12/2020 31/12/2020 31/12/2019	31/12/2020 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 31/12/2020 31/12/2020 31/12/2020 31/10/2019

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1133	23/05/2019	15	EXTREM	25 (5x5)	EXTREM	5	HIGH	Director of Nursing, Primary Care & Older People's Services	Trust-wide (Risk Register Use Only)	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 Incidents are continuing to happen during 2020, lack of confidence that the actions taken last year are being adherred to in all areas - further review of processes and controls undertaken 29 May 2020. Lack of knowledge of colour coding and appreciation of risks with medical gases	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 Update 05 June 2020 - Lead nurses and service managers have been asked to provide assurances on the actions taken in response to the revised controls for each of their designated areas of responsibility. May 2020 update - regular Walk arounds to be undertaken on all hospital sites until assurance in place.	Lack of training on medical gases. This has increased now since included in Trust Combination training days.	SAI reviews to identify learning and progress actions to completion Review the mitigating actions and any gaps in controls Possible further learning from SAI investigation Continue to include in Trust combination training days (potential for this to become a mandatory area) 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	31/03/2021 08/09/2020 31/12/2019	15/09/2020 31/12/2019 31/12/2019 31/12/2019 31/12/2019 31/12/2019
1166	06/09/2019	20	EXTREM	20 (4x5)	EXTREM	9	MEDIUM	Director of Adult Mental Health & Learning Disability	Adult Mental Health & Disability Services	Governance.□ Safe & Effective Services.	Lack of a robust Governance Structure within AMHDS resulting in risk of not being able to identify emerging risks and Learn	Oct 2019 Risk reviewed at SMT/CSCG/ Directorate Governance and the Directorate is working as per the service improvement plan. Within AMH the CSCG Meeting has been amalgamated with SMT to ensure the focus of governance is everyone's business and that this will allow a framework for good governance at all senior management meetings. 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.	Formal monthly update of the Action Plan to be submitted to RQIA. If unable to make the dealine RQIA to be informed prior to the formal monthly update. RQIA contacted and requested that as a Trust we pause monthly updates until the end of Covid-19. Improvement plan implemented and notice lifted IPT (Mental Health Demography) completed & submitted for funding Rolling programme for staff within Acute In- Patient wards for Datix Training- monthly initially then as and when required. Safety huddle established on the in--patient wards to review all Datix Incidents Incidents are being mointored and closed within a timely fashion with Wards. 2 Monthly audits ongoing Monitor untoward incidents via the DATIX system Monitor complaints within the Directorate. Additional Governance posts will address complaints. Directorate Governance Meetings increased to fortnightly and review of the risk register Rapid review group meets weekly and reviews all red incidents	Lack of robust Governance structure for directorate. Two additional staff have been secured for the governance Team Band 8C and 1 8B. 2 8A Governace posts outstanding. Outstanding SAI/SEA Reports. 1 staff member within the Governance role and the current capacity outweighs demand	RQIA Service Improvemnet Notice lifted Aug 2020 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. Recieved extension of timescale in relation to improvement notice to 22/06/2020	Improvement plan to meet improvement notice requirements, action plan to be updated and submitted to RQIA monthly. From March 2020 RQIA have agreed that due to additional pressures from Covid that the monthly updates will be temporary suspended. Share learning from improvement plan Trust wide. Secure financial funding for governance Team. Additional 2 staff members have been redeployed as an interum measure to the governance Team- Band 8C and 1 8B. 1 Additional Band 8A has also been redeployed in the interim period as Governance lead Patient/ Consider for move to Directorate risk register	31/07/2020 30/09/2020 31/07/2020 28/02/2021	19/08/2020 09/09/2020 17/07/2020

		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
1183	27/11/2019	25	EXTREM	25 (5x5)	EXTREM	15	EXTREM	Director of Adult Mental Health & Learning Disability	Adult Mental Health & Disability Services	Governance.□ Safe & Effective Services.	Insufficient relevant staff trained in DoLS processes may result in the Trust depriving patients of their liberty with the resu	The Department of Health, requires H&SC Trusts to proceed with a partial implementation of the Mental Capacity Act (NI) 2016 (MCA) for providing a statutory framework for the Deprivation of Liberty from the 2nd December 2019 with full implementation by December 2020. □ □ By the 2nd December 2019, the Trust must have sufficient numbers of staff identified and trained & structures and administrative process put in place to ensure legal compliance in situations where the care of a patient requires a deprivation of liberty to take place. If these arrangements are not ready and working efficiently then there is a significant risk to the effective delivery of care including our ability to treat patients in the hospital using short-term detention orders and our ability to discharge patients from hospital where a Trust Panel decision is required. □ □ There is a further porential	short term detention training - 6 NS, 5 SS. Cover required for MH wards ASW freed up to work in the hospital to undertake short detention orders. ASW from Hospital Discharge teams to undertake STDAs Meetings are held on a weekly basis Staff training is available via eLearning as well as from CEC. Training available online & classroom, provided by Trust Trainers. Progressing interactive online training via VC. Project Implementation Officer - To be readvertised Oct20 Programme Management arrangements Detailes modelling of MCA resource requirements being progressed with finance Maternity cover for MCA Lead role commenced 22/02/21	Cost of implementation of MCA. BC completed for 19/20. Approach to funding for 21/22 being progressed with HSCB. Non Recurrent IPT received July20. Capacity of medics to sit on panels. Sufficuent at present but progressing further recruitment to support Legacy Cases. Not having enough staff trained to undertake the duties of MCA. Sufficient staff trained to meet current demand, however training ongoing to ensure that all staff with patient contact receive the appropriate training. Current strike action advising work to rule. NIPSA Strike action paused. Other union issues resolved. Ongoing challenges and negotiations with the Unions regarding staff engagement in the process. Communication plan promoting engagement in development. Medics in SWAH have advised that they not have capacity to support MCA activity. Only 4 GP practices have engaged, via LES, with providing Medical input to PA in the community (new and legacy)	Medical directors are meeting with the CMO - Plan for GP & Medic engagement to be progressed RQIA monitoring role HR T&F group Business Case T&F group Information T&F group (Systems, processes, reporting) Overall regional group comprising the director leads identified in each Trust Trust is engaging with regional arrangements to share practice and develop solutions	MCA risk to move to Directorate Risk Registers	Quantification of Costs and completion of the IPT bid to ensure fully funded MCA arrangements and minimise financial risk HR & remunerations for staff identified to undertake duties on panels Identifying medical staff to undertake patient examination and capacity reports to go to panel for new patients. Partially complete - Not being completed SWAH & in majority of GP practices. ITR MCA team Medic to undertake role. Ensure sufficient staff attend training to allow them to undertake statutory functions commencing 2nd December 2019 Identification and agreement of the medical and other appropriate healthcare professionals necessary	31/03/2020 31/03/2020 31/03/2021 31/03/2020 31/03/2021 31/03/2020 31/03/2020 31/03/2021 31/03/2021 31/03/2020 31/03/2020 31/03/2020 31/12/2020 31/03/2021	01/11/2019 01/12/2019 31/03/2020 31/03/2020 02/12/2019 31/01/2020 02/12/2019 31/08/2019 31/08/2019 31/08/2019
1207	04/03/2020	9	MEDIUM	12 (4x3)	HIGH	6	MEDIUM	Director of Nursing, Primary Care & Older People's Services	Primary Care and Older People Services	Governance.□ Partnerships. Public Confidence.□ Safe & Effective Services.	Care, safety and quality standards delivered in Independent Sector Nursing and Residential Care Facilities	RQIA had issued a number of Failure to Comply notices to care facilities across the Trust in relation to their leadership, quality, safety and standards of care.□ The Trust will work with these Care Facilities to ensure safe and effective care is delivered to all residents whilst they have Failure to comply notices and continue to monitor thereafter to ensure standards are sustained.	Trust Monitoring Visits Contract review meetings Trust meetings with providers are scheduled on a regular basis Action Plan set up by Task & Finish Group ISP Governance Group CISGG monitoring and oversight group	The Independent Homes are under the management of private owners and the Trust has to work with these owners and staff to ensure standards are reached and sustained.	COPNI Oversight All providers are required to be registered with RQIA and are subject to regular monitoring visits RQIA involvement Meeting with Care Managers and families and residents. monitoring visits, enhanced monitoring visits, meetings with families, owners, other Trust, RQIA quality assurance framework	Reliance on owners to meet and sustain the required standards.	Monthly monitoring of Improvement plan	31/03/2021	

Corporate Risk Register and Assurance Framework - 18/03/2021

		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
1213	04/04/2020	20	EXTREM	20 (5x4)	EXTREM	10	HIGH	Medical Director	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Governance.Workforce.	COVID-19 risk re assess & response to patient/client need & maintain quality & safety for patients/clients and staff	If current capacity limitations and activity levels across all Trust services remain or increase, the Trust may not be able to meet the increased demand placed on it during an outbreak of Coronavirus (Covid-19) or in the reset of services following an outbreak, resulting in possible harm to patients and staff.	Residential Accommodation Surge Plan Additional screening POD in place for screening pathways Chief Executive video Fit testing / PPE Podcast and video training' face to face training, Posters Fit-testing use of private company to assist OH Intranet Covid19 site to ensure information shared across the Trust Sub groups Workforce planning - regional PPE Group; Regional Discussion Group Screening & assessment pathways and designated areas Health & Safety Policy Guidelines on Management of COVID-19 as PHE IPC policy Revised Governance arrangements - Corporate Safety team 3 Planning groups; Acute; Community & Support Services Business continuity activated with 3 Bronze Control rooms: - Altnagelvin Acute; SWAH Acute; Community Internal document suite to support surge plan Hospital Surge plan (review completed Sept 2020) Revised Governance Arrangements -	A lack of additional resource to manage community screening and subsequent management. Environmental challenges in ED to facilitate appropriate isolation facilities Gaps in regional /national supply issues on commodities/medicine etc A lack of guidance on pathways for specialties (regional/national) Availability and quality challenges re PPE Awaiting additional equipment (regional) Single database for reporting monitoring on staff positive figures Suspended Regional HSC Silver Control Group	Corporate Safety Huddle / RRG reporting Sit-rep reports (Trust & Indep sector) Health checks Governance framework for Covid-19 management Covid-19 Risk Register Covid-19 Corporate Risk Datix incidents, complaints Daily briefings - Bronze and Silver control, planning groups RIDDOR reporting Covid App Staffing indicators Covid pathways compliance - incidents Hand hygiene compliance audits Stats on 12 hour delays / overcrowding in ED Minutes / action notes of meetings and safety huddles Documentation of risk assessments Local PPE audits (on daily saftey huddles for	No Regional process/guidance for approving donated PPE Covid-19 Independent sector reporting	Monitor, manage and update Risk & Control document Develop Covid risk & control document Facilitate daily monitoring and reporting on Risks Update risk to second surge environment	31/03/2021 31/05/2020 31/05/2020 31/10/2020	31/05/2020 31/05/2020 20/11/2020
1216	15/04/2020	15	EXTREM	15 (5x3)	EXTREM	5	HIGH	Director of Acute Hospital Services	Acute Hospital Services	Safe & Effective Services.Public Confidence.	Risk of patient harm in Trust EDs due to capacity, staffing and patient flow issues	If Emergency Department (ED) Physical capacity and staffing levels are not sufficient to meet the demands of patient numbers and acuity, there will be increased likelihood of significant patient harm, risk to staff wellbeing and damage to Trust reputation as a direct result.	Business case approved dedicated HALO (Hospital Ambulance Liaison Officer NIAS crews waiting to offload in our hospital early warning score Ongoing Trust recruitment focus on Critical posts IE Medical and Nursing Use of Medical locums/ Bank and agency Nurses. Social Media Campaign Escalation protocol within full capacity protocol Nursing KPI and audit (ALAMAC) Ongoing in house Quality improvement work (implementation of SAFER principles) Daily regional huddle meeting with escalation as required IT systems - Symphony Flow board On call managers/medics rota Ongoing MDT patient flow huddles in department/wards Medical team ED reviews Hub flow meetings with lead nurse attendance. Patient flow teams/night service manager Major incident policy Full capacity protocol	Implementation of SAFER principles challenged due to Medical Job plans and current Medical team models in operation ageing population living with challenging health needs Community infrastructure to meet needs of patients i.e. Gp appointments, social care packages Recruitment to perm medical posts Challenging across NI	Datix - Incident, Complaints, Litigation, Risk register Patient flow teams, Night service manager, SPOC, Hub Regional huddle Established patient pathways	Gaps in patient pathway	PACE implementation to commence March 2020. Improvement QI work commencing with aim to address communication within department.	31/03/2021 31/03/2021	

		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
1219	30/04/2020	20	EXTREM	20 (4x5)	EXTREM	1	LOW	Director of Acute Hospital Services	Acute Hospital Services	Safe & Effective Services.	Lack of endoscopy capacity for endoscopy to meet the demand which impacts on Patient outcomes	Lack of endoscopy capacity in the Trust has resulted in breaching of the 2 week red flag wait/9 week urgent and routine wait and surveillance targets for endoscopy. The lack of timeliness for endoscopy will lead to delayed diagnosis of cancer and poor outcome for these patients as evidenced in SAIs. The service has been further impacted by Covid -19 where the service has been reduced to emergency and red flag endoscopy only and reduced turnaround times between patients due to IPC requirements.	Telephone pre assessment of colonoscopy on-going to improve list utilisation and reduce DNA rates Independent sector was utilised to deliver 250 surveillance colonoscopies from January to March 2020. Further use of Independent Sector to be explored post Covid -19 Surveillance waiting lists are being validated in line with new guidelines. Discussions have commenced with the commissioner to recurrently fund one of the posts in 20/21 to address the demand/capacity gap. The second post will be funded from a current vacancy. Training of 2 nurse endoscopists under transformation commenced in September 2018 - trainees were to be signed off by the end of 2020 the delay was due to Covid-19. Short-term provision by SE Trust to provide WT in IS tender	Band 4 team lead recruited to manage waiting lists and oversee the scheduling team and processes. Encourage consultants to triage referrals in line with NICAN suspect cancer guidelines (Oct 2019) and utilise the urgent and routine categories. Additional funding for a second pre assessment nurse has been discussed with the commissioner- await confirmation in 2021 allocation	Waiting lists discussed monthly at the Endoscopy Users Group Clinical audits are completed annually to benchmark the service against National Standards. Monthly monitoring of waiting lists is carried out to identify longest waits and prioritise for scheduling.	The need for the Trust to invest further in the development of GI Trainees in line with the evidence base for modernisation, thereby proactively growing the team to meet future demand. The need to develop the service to include the inclusion of a hepatologist as part of the team in line with Royal College modernisation of gastroenterology training and service provision. The need to address the impact of a job plan which includes the medical on-call rota The need to urgently increase the consultant workforce and make the Trust an attractive opportunity for the next round of doctors in training due for recruitment April 2021	Explore the possibility of utilising the Independent Sector to address waiting lists. Need to review GI consultants job plan to reduce General Medicine commitment to increase availability for endoscopy lists. Secure funding for an additional pre assessment nurse to support list utilisation and reduce DNA rates. Secure additional recurrent funding to support 2nd post for trainee nurse endoscopist completing training. Recruitment of a further GI consultant to fill present vacancy and increase the medical team to 6 wte.	30/06/2021 30/04/2021 30/04/2021 30/04/2021 30/04/2021	
1227	09/07/2020	15	HIGH	15 (3x5)	HIGH	9	MEDIUM	Director of Nursing, Primary Care & Older People's Services	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Modernisation. Governance. Public Confidence. Financial Management & Performance.	Action Plan for implementation of new regulations on medical devices by May 2020 as per circular HSE16-19 not completed	The recommendations contained within Circular HSC (SQSD) 16/19 required that organisations would fully implement the requirements by May 2020. The Action Plan has not been completed due to the impact of Industrial Action during November 2019- January 2020 and Covid-19 from end of February to end of May 2020.	Draft Action Plan circulated for completion by Clinical Leads Circular HSC (SQSD) 16/19 has been circulated to a wide range of clinical specialisms.	Clarifying level of data recorded on Trust clinical info systems to identify medical devices implanted as part of clinical interventions and treatment. further clarity will be required on definitions of modified devices. Control measures not fully identified	Medical Device alerts & FSNs Incident reporting Medical Devices woriing group The development of the Action Plan	Action Plan not fully developed	Scoping Impact to Obstetrics and Gynae and General Surgery Complete actions in action plan re Circular HSC (SQSD) 16/19 Develop an Action Plan to support implementing the requirements of Circular HSC (SQSD) 16/19 Action plan to be approved by C&SC Governance Medical devices members to become members of Encompass Group to address overreliance on paper based evidence Need to produce patient information leaflet	31/12/2020 31/12/2020 30/09/2020 30/04/2021 28/02/2021 30/06/2021	31/12/2020 31/12/2020 30/09/2020 22/02/2021
1236	21/08/2020	16	HIGH	16 (4x4)	HIGH	8	HIGH	Chief Executive	Finance and Contracting	Financial Management & Performance.	Ability to achieve financial stability, due to both reductions in Income and increased expenditure.	With continued reductions in income from savings requirements coupled with increased expenditure due to demand and risk, there will be a reduction in the Trust's ability to achieve financial stability in the current and future years, resulting in significant challenges in meeting the Trust strategic priorities	Chief Executive Assurance meetings to review performance Recovery Plan Oversight - Directorate, CMT, Trust Board (and Finance & Performance Committee) and DoH Annual Financial Plan to review risks to financial position and opportunities for savings Trust Board (and Finance & Performance Committee) and CMT oversight of the financial position monthly Monthly budget reports for all levels in the organisation, with follow-up variances				Ongoing financial management and monitoring Operation of DVMB (Delivering Value Management Board) to ensure delivery of the 3 year financial recovery process	31/03/2021 31/03/2022	

Corporate Risk Register and Assurance Framework - 18/03/2021

		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
1254	18/01/2021	16	HIGH	16 (4x4)	HIGH	9	MEDIUM	Director of Human Resources	Trust-wide (Risk Register Use Only)	Ensuring Stability of Our ServicesImproving the Quality and Experience of CareSupporting and Empowering Staff	Inability to deliver safe, high quality and sustainable services due to workforce supply and disruptions	Due to an inability to attract, recruit and retain staff throughout the Trust, services may not be able to maintain sufficient staffing levels to sustain high quality safe services which may result in a reduction in service provision.	Trust Business Continuity Plans with full HR support on hospital / community workforce groups. Delivering Care: Nurse Staffing in Northern Ireland Organisation Development Steering Group Health and Wellbeing Strategy Engagement & Involvement Strategy DOH Workforce Strategy & Trust Workforce Strategy and key actions Trust EU Exit Group - Contingency Planning processes i.e. workforce, data sharing, etc. (Risk 1075) Professional Guidance - Telford, Royal Colleges, NI Delivering Care (N&M) Policies - Rec & Selection Framework, Attendance at Work, Flexible Working, Redundancy and Redeployment, etc. Safety Standards HR Strategic Business Partner identified for each Directorate Pension information sessions Joint Forum, Joint LNC and Consultation Group Workforce Information reports provided to key stakeholders Trust Healthcheck information - absence, appraisal, mandatory training, agency usage, etc. Trust Governance Arrangements - People Committee	Occupational Health - absence of locums and increasing demands on team without additional resources. Low uptake of mandatory training and completed annual appraisal. Inability to follow normal policies and procedures during periods of Industrial Action and also during emergency situations such as Pandemic. Lack of co-ordinated information on agency staffing Due to demand in services compliance with Working Time Regulations and New Deal. BSO Recruitment Shared Service provides recruitment services for the Trust and there has been an increased delay in recruitment and dependence on them for related information. Inability of NIMDTA to provide required number of Junior Doctors for certain specialities and localities. (Risk 694) Difficulty in recruiting in rural areas and accessing cover when needed in those areas i.e. Domiciliary Care Workers. (Risk 547) Insufficient applicants for medical, nursing and social work posts. (Risks 6,1109)	Working Together Delivering Value Health check measurements on absence hours lost, mandatory training, appraisal, time to fill posts, job planning completion rate. Involvement Committee - Quarterly monitoring of staff engagement on initiatives that contribute to achievement of Trust Great Place ambitions (start life, live well and grow old). Pension Regulator Compliance Junior Doctors Hours monitored twice yearly and returns submitted to DOH. People Committee - Workforce Strategy, Recruitment and NIMDTA Allocation Updates twice per year. People Committee - Quarterly monitoring of Absence, Appraisal, Mandatory Training, Consultant Job	BSO Shared Service not meeting statutory or procedural deadlines resulting in, for example, delays in recruitment Government/Department of Health managing a number of risk mitigation issues associated with EU Exit including cross border matters. (Risk 1075) Inability of NIMTDA to fill all posts. Insufficient number of social work student applications to the University Degree Course in rural areas. (Risk 1109) Insufficient training places being procured by Department of Health to meet the demands of medical and nursing workforce. HMRC Regulations and impact for staff HSC Pension particularly high earners. Impact of McCloud and Sergeant Employment Law cases. Safe staffing model for	Staff retention initiatives Workforce efficiency improvement Medical workforce review Attraction & recruitment - workforce plans and supply solutions	30/06/2021 30/06/2021 30/06/2021 30/06/2021	

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://staffwest.westhealth.ni.nhs.uk/directorates/medical/trustdocs/Risk%20Management%20Policy%20July%2019.pdf#search=Risk%20Management%20Policy

The information requested below is required for completion of fields within Datix. 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.

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" –)**	Risk of failure to meet regulatory standards and compliance associated with Trust infrastructure and estate.	
2.	**Facility** **(only necessary if risk relates to one specific facility)**	Trust Wide	
3.	**Directorate *** **If risk affects 2 or more Directorates, please list relevant Directorates.**	Performance and Service Improvement	
4.	**Sub-Directorate *** **If risk affects two or more Sub-Directorates, please list.**	Estates Services	
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	X
		Directorate	
		Sub- Directorate/Divisional	
		Ward Level	
8.	**Risk Category*** Please tick most appropriate category:	• Finance and Efficiency • Health and Safety • Quality of Care • ICT and Physical Infrastructure • People and Resource • Public Confidence • Regulation& Compliance (Statutory, Professional, Quality Legislation)	
9.	**Corporate Objective(s) affected by this risk*** ***(Please tick appropriate box(es) below)***		
	C01	Improving the Health of our People	
	C02	Supporting and Empowering Staff	

	C03	Ensuring the Stability of our Services	X
	C04	Improving the Quality and Experience of Care	X

10.	**Key Performance Indicators to show how the risk is being managed (Please list 3-4) * (e.g. number of incidents, compliance with H&S – number of Risk assessments returned etc)**	**KPI'S PAM Plan (Annually)** • % of buildings graded A/B for physical condition • % of buildings graded A/B for engineering **Facilities Oakleaf (Condition) (Annually)** • Number of buildings rated high risk • Number of building rated medium risk • Number of buildings rate low risk **Datix's (Monthly)** • Number of datix for slips, trips and falls • Number of incidents were loss of heating is reported • Trend analysis of reported datix's • No. of incidents reported relating to water, asbestos, Infrastructure and fire **SAI's (6 Monthly)** • Number of SAI reported **Investment Plan monitoring** • % completion of in year investment plan. • % overall capital spent in Trust on improving infrastructure • Improvements in energy as result of new technologies – heating/ventilation/lighting etc
11.	**Lead Officer* with responsibility for managing this risk (Name, Job Title, and Contact Details.** **(i.e. manager with operational responsibility)**	Sean Gibson, Head of estates services
12.	**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).**	Teresa Molloy, Performance and Service Improvement
13.	**Description of Risk*** Please provide a full description of the nature of the risk. Please limit this to 255 characters and structure to include cause, event and effect	There is a risk of deterioration in the Trust Estate due ageing and lack of capital 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 (e.g water, electrical, asbestos and physical infrastructure)

14.	**Please list all current control measures in place to manage this risk*** (e.g. policies, procedures, training)	• Priority Backlog Maintenance capital investment plan. • Monthly review of Backlog Maintenance capital investment plan. • Targeting of priority areas as funding becomes available. • Continual bidding for funding to address backlog maintenance. • 2019/20 Backlog maintenance programme developed. • Annual review of building condition (3i) and creation of prioritised BLM list. • Estates Strategy 2015/16-2020/21. • Should a critical issue materialise further funding can be sought from DOH or existing funding reprioritised to address the new critical issue. • Monitoring and review by PSI SMT of directorate risks including water, electrical, asbestos and physical infrastructure.
15.	**Please list all identified gaps in Controls.***	• Insufficient funding to carry out full remedial works identified. • Ageing infrastructure resulting in deterioration of buildings
16.	**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).	• Assurance standards Buildings, Land, Plant & Non-Medical Equipment • Reports to Corporate Governance Sub Committee/Governance Committee • Membership at Health and Safety/ Water Safety Groups • Annual inspections carried out. • Authorising Engineer audits. • Environmental Cleanliness audits. • Health & Safety audits. • Back-log Maintenance list.
17.	**Please list all identified gaps in Assurances.**	• Lack of Funding for backlog maintenance.
18.	**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	X
	Major	X	Likely	
	Catastrophic		Very Likely/ Almost Certain	

19.	**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	x
	Major	x	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).

20. 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?	
2. Does the proposed action plan take account of any opportunities that could be exploited whilst managing this risk?	
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?	
4. How will the proposed actions be monitored to ensure they are completed within identified timescales?	
5. At what point should the decision regarding the management of this risk be escalated to a higher level?	

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
Monthly review of Backlog Maintenance capital investment plan		March 2021	

Review of emerging issues and response required		March 2021	
Completion of six facet condition survey		March 2021	
Development of 2021/22 BLM bid.		March 2021	
CMT approval of BLM 2021/22 for submission.		April 2021	
Development of business cases for 2021/22 backlog maintenance agreed action plan.		September 2021	
Review of emerging issues and response required		March 2022	

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)

Actions from Trust Board workshop October 2020 as at 25/03/21

Primary Risk Category	Risk ID	Lead Director	Risk Title	Merge	Lead Director/ Committee	Workshop Action	Progress	Update
Health and Safety	63	AMHDS	High risk forensic/challenging individuals who have potential to cause harm to themselves or others		K O'Brien / AMHDS Governance	ID 63 and ID 66 Merge both risks. To be re-described with Cause, event, effect. Category accepted. To become a Directorate Risk.	completed	Proposal approved at Trust Board February 2021
Health and Safety	66	AMHDS	Death or serious injury of patient as a result of a suicide or attempted suicide while in a Trust facility				completed	
Health and Safety	100	PSI	Backlog Maintenance		T Molloy / Corporate Governance Sub-committee	ID 100 and 235 Agree both risks to be merged. Risk category could be debated. Most likely Statutory requirement. To be reworded to reflect risk.	In Progress	25-03-21 New proposed risk agreed at CMT on 25th March. 09/02/21 New corporate risk infrastructure drafted and measures agreed. Pending approval at PSI Governance Meeting on 8 March 2021 prior to CMT approval. New Water Safety Compliance Directroate Risk drafted following comments from Risk Management and IP&C (W Cross), pending approval at next PSI Governance meeting on 8 March 2021.
Regulation & Compliance (Statutory, Professional & Quality Legislation, standards & guidelines incl. Environmental)	235	MD	Risk of continuing failure to meet statutory requirements for Water Safety				In Progress	
Health and Safety	3	MD	Health and Safety risk - resulting in injury			ID 3 Risk to remain	No action required	
ICT & Physical Infrastructure	49	DoF	Virus attack disables network/services			ID 49 risk to remain and to be re-described	Completed	ICT work progressed to merge 3 risks into one re People, technology and Legislation (NIS in particular). They are proposing to amend the title and have simplified the language throughout and have attempted to make it as non-technical as possible. This has been approved at their Directorate SMT and at CMT December 2020. Tabled at Trust Board on 07/01/21 and approved.
People & Resource	1075	DoF	No Deal Scenario / Hard Border EU Exit			ID 1075 - to be considered for de-escalation	In Progress	Meeting being planned to look specifically at managing the dual registration for professionals. The meeting will include Acute services and HR Feb 2021 - Risk is currently being reviewed to consider inclusion of emerging post EU Exit risks e.g. possible issues with incomming deliveries and Dual Registration of Trust Staff for Cross
Regulation & Compliance (Statutory, Professional & Quality Legislation, standards & guidelines incl. Environmental)	46	HR	Challenges to compliance with Working Time Regulations		A McConnell / People Committee	ID 46, 1100, 1165, 694 ,58 and 1109 Agreed risks need described more appropriately and merged. Consideration to re-describe and include as 1 overarching risk with blue risks. All linked to availability of staff. Risk ID 547 noted that proposal to de-escalate to directorate and	In Progress	CMT 25 March - Proposal for CMT in April New Risk ID1254 approved at Trust Board in January 2021. Trust Board advised February 2021 discussion ongoing with CMT on most appropriate category.
People & Resource	1100	HR	Agenda for Change (AFC) Pay Reform Dispute may impact service provision				In Progress	
People & Resource	1165	HR	Service Impact of HMRC Regulations in relation to Pensions.				In Progress	
People & Resource	694	AS	Risk to patient/client safety because of insufficient Medical cover in PCOPS and Medical Wards in SWAH				In Progress	

Actions from Trust Board workshop October 2020 as at 25/03/21

Primary Risk Category	Risk ID	Lead Director	Risk Title	Merge	Lead Director/ Committee	Workshop Action	Progress	Update
People & Resource	58	HR	Over dependence on the use of locum and agency staff to sustain services and insufficient induction for locum medical staff			consider re-wording description.	In Progress	
People & Resource	547	PCOPS	Inability to access domiciliary care in a timely manner				In Progress	
People & Resource	1109	W&C	Difficulty Recruiting to all frontline social work areas across the Trust				In Progress	
People & Resource	6	W&C	Harm to children whilst awaiting Gateway and Family Intervention Service (unallocated cases)			ID 6 To come to CMT re-worded to better describe.	In Progress	25-03-21 Revised wording agreed at CMT
Quality of Care	1216	AS	Risk of patient harm in Trust EDs due to capacity, staffing and patient flow issues			1216 to remain on CRR expected actions will able risk to be reduced in December	In Progress	Action Plan in place, action plan to be updated as a result of recent moves and considered after this for deescalation to Directorate risk
Quality of Care	1166	AMHDS	Lack of a robust Governance Structure within AMHDS resulting in risk of not being able to identify emerging risks and Learn		Dr McDonnell / C&SCG Sub-committee	1166 and 57 . Needs to be reworded and merged. Risk 1133 to be separate and to be re-worded and de-escalated when actions complete	In Progress	25-03-21 Agreed proposed merged risk at CMT. Update required on ID1133 22-2-2021 AMHDS Progressing additional Governance posts including 2 x Band 8c posts. Controls and gaps in AMHDS risk to be incorporated into Risk 57 in January 2021. Medical Directorate Team meeting planned for March 2021 where merging of risks will be reframed into a Safety risk. Risk 1133 SAI reports completed submitted to the Board. Actions are being taken forward.
Quality of Care	1133	PCOPS	Risk to safe patient care relating to inappropriate use of medical air				In Progress	
Quality of Care	57	MD	Lack of cross-Directorate learning from adverse incidents, complaints, claims & audit recommendations				In Progress	
Quality of Care	1207	PCOPS	Care, safety and quality standards delivered in Independent Sector Nursing and Residential Care Facilities			ID 1207 - Actions and controls to be updated	In Progress	Risk grading revisedand agreed at CMT March 25th
Quality of Care	1213	MD	COVID-19 risk re assess & response to patient/client need & maintain quality & safety for patients/clients and staff			1213 - Risk to remain at present	No action required	
Regulation & Compliance (Statutory, Professional & Quality Legislation, standards & guidelines incl. Environmental)	955	DOF	Failure to comply with procurement legislation re social care procurement			ID 955 to remain as a corporate risk. DOF to be the lead.	Action Completed	
Regulation & Compliance (Statutory, Professional & Quality Legislation, standards & guidelines incl. Environmental)	1183	AMHDS	Mental Capacity Assessment Training			id 1183 Proposal that risk can be de-escalated to Directorates. Karen will come to CMT with this proposal.	In Progress	24/02/21 - Controls, Assurances, Gaps and action plan reviewed and updated
Regulation & Compliance (Statutory, Professional & Quality Legislation, standards & guidelines incl. Environmental)	1227	PCOPS	Action Plan for implementation of new regulations on medical devices by May 2020 as per circular HSE16-19 not completed			ID 1227 There has been a lot of progress on actions and these need to be updated to reflect current position	In Progress	Update February 2021 Scoping across a broad range of clinical specialities completed action plan drafted December 2020 and cicrulcated for review to Corporate Risk Team and Lead Director for Review. Plan to present for approval at C&SC Governance meeting March with the aim to de-escalate risk. Actions have been updated.

Actions from Trust Board workshop October 2020 as at 25/03/21

Primary Risk Category	Risk ID	Lead Director	Risk Title	Merge	Lead Director/ Committee	Workshop Action	Progress	Update
Regulation & Compliance (Statutory, Professional & Quality Legislation, standards & guidelines incl. Environmental)	284	PSI	Risk of breach of General Data Protection Regulation (GDPR) and Data Protection legislation through loss of personal or sensitive			ID 284 Risk noted Risk to remain	No action required	
Regulation & Compliance (Statutory, Professional & Quality Legislation, standards & guidelines incl. Environmental)	719	W&C	Risk of failure to meet a standard/protocol/guideline.			ID 719 - agreed risk needs to be more clearly defined. Workshop to get clarity on benchmarking the position and what the risk is to the Trust so that assurance can be given	In Progress	15/03/21: No feedback from Directorates on progress updates. It has been agreed to hold a workshop towards end of April. Directorates will provide updates at this workshop and highlight challenges and way forward. Tom Cassidy will lead on this workshop. 3 Feb 21: Assistant Governance Manager sent out ongoing Standards and Guidelines to all Directorates for review, update and return by 26 Feb 2021 in preparation for Workshop