Western Health and Social Care Trust

CORPORATE RISK REGISTER & ASSURANCE FRAMEWORK

BRIEFING NOTE PREPARED FOR TRUST BOARD
6 MAY 2021

There are 19 risks on the Corporate Risk Register as approved at Trust Board on 1st April 2021.

Summary

- Proposed de-escalation of Risk ID1227
- Update on agreed actions from Trust Board workshop (attached)
- Covid-19 risk ID1213 indicators

Proposed de-escalation of ID1227

Risk Title - Action Plan for implementation of new regulations on medical devices by May 2020 as per circular HSE16-19 not completed

Risk Description - 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.

Risk Grading

Risk rating:

	Consequence:	Likelihood:	Rating:	Level:
Initial:	MOD	CERT2	15	HIGH
Current:	MOD	CERT2	15	HIGH
Target:	MOD	POSS2	9	MEDIUM

The Action Plan was discussed and agreed at Clinical & Social Care Governance Sub-committee and proposed for tabling at CMT and Trust Board (see attached) for consideration for de-escalation of risk to directorate level as action plan is now in place.

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 19/04/21

Covid Risk ID1213 - Indicators as at 19/04/21 (March Indicators in Brackets)				
Indicators	**Total**	**Alt.**	**SWAH**	**Comm.**
Covid-19 deaths (Cumulative)	217 (212)			
Covid positive inpatients	19 (43)	9 (27)	9 (12)	1 (4)
Number in ICU (Covid positive)	6 (6)	6 (6)	0 (0)	
Total number of beds closed	59 (62)	11 (40)	24 (8)	24 (14) (Rehab + Waterside)
Hospital Oxygen supply status lt/m		140 (260)	54 (107)	
ED waits >12 hours in last 7 days		12% (12)	7.2% (11)	
Staff tested positive (Cumulative)	664(516)			
Staff positives reported under RIDDOR. (Cumulative)	406 (393)			
Staff unavailable for work	720 (824)	226 (267)	88 (101)	406 (456)
% of Staff unavailable for work	6.38%(7.0%)	5.22%(5.93%)	5.59%(6.16%)	7.56%(8.1%)
incidents reported as being directly related to Covid (last 7 days)	11 (3)	5(0)	0(1)	6(2)
No +ve tests (last 7 days) NI	788(1208)			
No +ve test (last 7 days) Derry and Strabane Council area	160(79)			
No +ve test (last 7 days) Fermanagh and Omagh	27(40)			
No of Trust Staff vaccinations delivered Total vaccinations	44,897*(32,768) 108,236(79,369)	*Total of Trust and Non Trust staff e.g Private Care Homes, Foyle Hospice etc and includes 1st and 2nd doses		
Vaccine Incidents reported	98 (69)			
Early Alerts/Service downturns or Service fragility				

PCOPS

Ward 6 SWAH closed to all admissions, discharges and visiting due to outbreak. **Early Alerts**

Early Alerts

EA11-21 Administration error at Mass Vaccination Centre in Foyle Arena on 27 Mar.

Western Health and Social Care Trust

NEW MEDICAL DEVICE AND IN VITRO DEVICE REGULATIONS

Scoping of impact of new medical device regulations and draft action plan.

December 2020

1.0 Introduction

The new Medical Device Regulation (MD) (2017/745) and In-vitro Diagnostic Medical Device (IVD) Regulation (2017/746) came into force in May 2017. The regulations were to be fully implemented by May 2020 for Medical Devices and May 2022 for In-vitro Diagnostic Medical Devices. The Department of Health issued correspondence to the Western Health and Social Care Trust in July 2019 outlining the obligations on health institutions that will require review by HSC Trusts to ensure that they operate in line with the new regulatory requirements.

The new EU Regulations placed an obligation on health institutions in relation to the in-house manufacture of medical devices, the provision of implant cards to patients, and the recording (preferably electronically) of Unique Device Identifiers for class III medical devices which they have supplied or been supplied with. A toolkit was made available to assist Trusts in reviewing the implications one of these obligations.

This paper presents a summary of the scoping exercise that was undertaken across a range of clinical specialisms to obtain a clearer understanding of the implications of the new regulations and to inform the content of an Action Plan for the Trust.

2.0 Part 1 Scoping of Services/Departments

The Western Health and Social Care Trust is a provider of health and social care services. The lead clinicians from the range of clinical specialties listed above were consulted on the new medical devices regulations, including Trauma and Orthopaedics, Maxillofacial, Dental, Cardiology, Radiotherapy, Colorectal surgery, Urology, Breast Surgery and Gynaecology. These clinical specialisms were select as they would regularly utilise medical devices in their treatments and may also use invitro medical devices. The criteria for medical devices listed within the regulations included;

- Manufacturing of medical devices
- Modification of medical devices
- Non-medical products
- Research or investigational use product
- Off label use of devices
- Custom made devices
- Other (please state)

2.1 Manufacturing of medical devices

Whilst it is recognised that the new Medical Device Regulations are geared primarily at the manufacturers of medical devices, the scoping exercise explored if any of the Trust clinical specialisms manufactured or modified medical devices. The clinical specialisms that did manufacture medical devices included;

Dental: The dental service design and manufacture removable devices to the specification for each patient. The devices are manufactured to a specification developed by the General Dental Council who serve as the regulator in this instance.

Radiotherapy: The Radiotherapy Centre has a contract in place with a local manufacturer of groin protection devices. The Radiotherapy staff design and specify the devices used to protect a patients reproductive organs during radiotherapy treatments. Neither of these devices are considered to be invitro devices.

2.2 Modification of medical devices.

All of the clinical specialisms stated that they do not use any medical devices beyond the product licence. Changes may be made to some medical devices before being used in the treatment plans but these changes are permitted within the product licence such as altering the length of a product to ensure that it appropriate fits with a patient's anatomy. No exemptions on using medical devices have been approved by the Trust Clinical and Social Care Governance committee.

Table 1: Clinical Specialism that manufacture or modify medical devices.

Criteria	T & O	Max-Facs	Dental	Cardio	Radio	Colorectal	Urology	Breast	Gynae
Manufacture	No	No	Yes	No	Yes	No	No	No	No
Modify	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes

2.3 Gap analysis:

From the initial scoping of clinical services listed above no immediate gaps have been identified. The Trust has robust governance arrangements in place that requires clinical teams who plan to introduce a new medical devices to complete and submit and risk assessment paper to the Clinical and Social Care Governance Committee.

The Medical Devices Procurement Committee requests clinicians to secure approval for the introduction of new treatments including how the governance and financial risks may be managed.

2.4 Assess appropriateness of QMS:

There was no specific Quality Management Systems (QMS) identified during the scoping exercise. It was acknowledge that the QMS that would normally apply would be ISO related standards. As the Trust has limited manufacturing activity there was no specific ISO awards applied for.

I should be noted that in the two examples of manufacturing devices reported that the dental service manufactures devices to a specification developed by the General Dental Council who are also the regulator in this instance. The Radiotherapy Team do not have a quality management system in place.

Action: To explore the need for a QMS or other appropriate standards for the product designed and commissioned by the Radiotherapy Team.

2.5 Assess adequacy of technical documentation:
All procured medical devices are compliant with the manufacturing criteria.
The Dental Devices that are manufactured by the Trust conform to General Dental Council standards. Records of all custom made devices are recorded on a local departmental database.

Where technical documentation is available, such as product labels with bar codes, they are filed in the patient care records in paper format. In some specialties the technical documentation is scanned and uploaded to the patients' Electronic Care Record (ECR).

Within Orthopaedics and Cardiology, clinicians submit data on medical devices used in treatments to National Databases. For example, within Trauma and Orthopaedics details of all joint implants onto the National Joint Registry. Patient consent is obtained and the patients H&C number is the unique identifier. Within Cardiology, implantable devices are recorded on a national database.

Some medical devices have literature for use by the person or service users but many do not. The clinical leads highlighted the presence of literature for use by the patients.

Action: To highlight the need for patient information data at procurement stage and to communicate this requirement to the Regional Procurement Team to be incorporated into the product specification for future procurements.

2.6 Assess adequacy of clinical evidence and risk management for all affected products:

The clinical evidence base for medical devices may vary but prior to a clinician introducing a procedure that may require a particular medical device, a proposal is presented to the Trust Clinical and Social Care Governance Committee detailing the evidence base for the particular device, the preparation and training of the clinician or clinical team to perform the clinical treatment or procedure to promote safe outcomes for the patients, the plan to review the quality and outcomes of the procedure or treatment and the arrangements for quality improvement.

2.7 Identify all non-compliances to General Safety and Performance Requirements (GSPR):

The GSPR relate primarily to the manufacturers of medical devices. Within the requirements of manufacturers, Users, defined as clinicians, patients and care givers, need to be alert to any non-compliances to GSPR of the manufacturers.

Within the Western Trust the systems in place to identify non-compliance to GSPR include.

1 Procurement:
Where products may be demonstrated to a Contract Adjudication Group (CAG), non-compliance to GSPR may be detected.

2. Acceptance Testing: Primarily for electrical devices.
On receipt of a new medical device, the product will be subjected to the Trust Acceptance and Testing procedures. If not electrically powered, the User will determine the functionality against that expected performance. Where the User finds that the medical device does not function as expected a datix incident will be submitted.

3. Trust Incident Reporting System – Datix.
In the event that a Clinical User discovers safety concerns with the medical device they are required to report this through theTrust Datix System. Following investigation of an incident, if there are further safety concerns with the medical device this is escalated to the Northern Ireland Adverse Incident Centre (NIAIC).

4. Northern Ireland Adverse Incident Centre (NIAIC).
Where medical devices are involved in clinical risks the Trust will report these to NIAIC. NIAIC will determine the level of risk or potential risk from the medical device will conduct an independent investigation on the medical device. If the safety concerns are upheld a Medical Device Alert (MDA) is circulated to all HSC Trusts with recommendations for action.

3.0 Review arrangements for gathering in-use clinical experience and AI reporting:

The scoping exercise did not identify robust arrangements for gathering in-use clinical experience and AI reporting. New medical devices may be trialled in agreement with a supplier or manufacturer. These products are often new to the market but have completed all stages of the manufacturing and validation process and are therefore commercially available.

At present there is a limited number of medical devices with AI capacity. It is acknowledged however that the technology in this field is developing rapidly and it is anticipated that this will be a challenge in the near future.

The profile of networked medical devices is also currently limited but again a rapidly developing area and one that is a risk of system security breaches. The Trust ICT Department has a nominated senior officer assigned to lead on this work stream. This member of staff has recently been co-opted to the membership of the Medical Devices Working Group and the Trust Policy on the Management of Medical Devices has had a new section added to highlight this need to clinicians.

4.0 Consider how to make information publicly available:

The scoping exercise highlighted that there is a reliance on paper based recording systems. The retrieval of client information in the event of a public enquiry would he significantly challenging.

Action: To review the current reliance on manual recording processes and explore potential solutions across the HSC to address this need.

4.1 Consider impact of independent inspections

Informed by the reliance on manual recording systems, the Trust would be at a disadvantage should specific data on medical devices involved in the care and treatment of service users was urgently required.

Action: To explore potential ICT solutions to address this need.

5.0 QMS: Upgrade or implement QMS to include regulatory requirements:

As the Trust does not manufacture many medical devices the applicability of this criteria may be limited. The Dental Services Laboratory does develop custom made removable devices that are manufactured in accordance with the General Dental Council standards and the Technical staff are GDC registered.

The Trust has limited capacity for electronic QMS.
Clinical care is recorded on paper based patient/client notes. A summary of the patients care and treatment whilst in hospital is completed using **Patient Centre** and on the **Electronic Care Record** (ECR) System. Community based services are using **PARIS**.

Very few of the clinical specialisms included in the scoping exercise use electronic systems that could enable the extraction of outcomes data.

The **Datix System** used to record incidents relating to the clinical care and where medical devices were used in the patients' treatment. This system is able to be interrogated but there is limited outcomes data entered.

The Trust is engaged in the regional project to implement the **Encompass system** as part of a regional implementation across Health and Social Care Services. The time line for full implementation is not finalised as yet.

Action: To explore the capacity and functionality of the Encompass System to be the solution to the reliance on paper-based records.

Note: Members of the Task Group have engaged with the Encompass Implementation Team and have secured membership of the Medical Devices Subgroup.

6.0 Identify responsibilities for regulatory requirements and any training needs:

The Datix System allows for the recording of incidents that are required to be investigated. The outcome of the investigation may identify competence concerns that prompt a need for initial support with training and skills development. Where the outcome of the investigation is found to be poor practice – this would prompt a need for a formal capability procedure or a referral to the appropriate professional regulator.

7.0 Implementation roadmap
Conduct a risk/benefit analysis for affected products bearing in mind the outputs from your gap analysis:

The Gap Analysis has highlighted deficits in the Trust's capacity to capture data on medical devices used in the provision of care and treatment and particularly in the ability to retrieve data on outcomes. To address this deficits will require significant investment in clinical information systems. Reference has been made to the Encompass System which may provide some of that capacity when implemented. The capacity of the Encompass system to capture this level of data will need to be explored with the Project Lead. The timeline for the implementation of the Encompass System will determine when the Trust would be in a position to report that this concern is addressed.

8.0 Define the projects needed to fill gaps on those products that you plan to make or modify and use after the transition date:

The Trust manufactures a very limited range of medical devices, none of which are in-vitro devices. This requirement has limited applicability to the Trust.

9.0 Put in place alternative arrangements for products that will no longer be made or modified after the transition date for which there is a continued need (e.g. alternative suppliers):

Where the Trust receives notification from manufacturers or suppliers of medical devices that they will no longer be made, or that components will no longer be available to maintain and/or repair existing medical devices a replacement programme is initiated.
This requires a business case to be completed to secure the necessary capital and recurring costs.
The Trust will then engage in a procurement procedure in partnership with the BSO PALs Teams, to secure an alternative medical device.

10. Ensure arrangements are in place for gathering clinical evidence and mitigating identified risks now and for the lifetime of affected products:

The Trust currently maintains the Backtraq database for medical devices that includes data on warranty, planned preventative maintenance and repair history. This database does not have the capacity to capture clinical evidence.

The current clinical information systems such as Patient Centre and NI Electronic Care Record are not routinely used to capture information on medical devices or any associated mitigating identified risks. These systems have limited interrogation functionality.

The Task Group will pursue this option through the proposed Encompass System.

11. Set up a project steering group (e.g. linked with medical device management committee or equivalent) and establish responsibilities for all aspects of implementation:

The Trust's Management of Medical Devices Working Group already exists to address the responsibilities of procurement, safety testing, competence training, incident reviews, disposal and replacement of medical devices.

The Working Group has a multi-professional membership which includes representatives from Nursing, Allied Health Professionals, Medical Engineering, Decontamination, Procurement and Risk Management. The membership does not include Medical Clinicians.

The Medical Devices Working Group has led in the scoping work and development of this Action Plan.

12.Set up a cross functional project management team to cover all aspects of implementation:

Members of the Management of Medical Devices Working Group have engaged the Lead Clinicians in core specialisms to review the new standards and consider the implications for clinical practice, particularly for the invitro medical devices.

13. Review progress of implementation against the roadmap and establish lines of reporting progress for review by senior management:

A Project Team has been established to lead on the scoping of the impact of the new medical device regulations. The membership of the Project Team has been drawn from the Trust Management of Medical Devices Working Group.

14. Continue to review the implementation roadmap to identify any new or ongoing areas of risk:

The Management of Medical Devices Working Group will continue to review the implementation roadmap. The Working Group reports directly to the Trust Clinical and Social Care Governance Committee through which issues and concerns can be escalated.

15. Action Plan

The outcome of the scoping exercise across a broad range of clinical specialties has identified areas that require action to support the implementation of the new Medical Devices Regulations. Summary of actions to be taken forward into the Action Plan.

1. To set up a project steering group (e.g. linked with medical device management committee or equivalent) and establish responsibilities for all aspects of implementation.

2. To set up a cross functional project management team to cover all aspects of implementation.

3. To explore the need for a QMS or other appropriate standards for the product designed and commissioned by the Radiotherapy Team.

4. To highlight the need for patient information data at procurement stage and to communicate this requirement to the Regional Procurement Team to be incorporated into the product specification for future procurements.

5. To review the current reliance on manual recording processes and explore potential solutions across the HSC to address this need.

6. To explore the capacity and functionality of the Encompass System to be the solution to the reliance on paper-based records.

Draft Action Plan

The scoping exercise identified the following areas where the Trust has limited evidence to support the implementation of the new medical device regulations.

No.	Action Required	Timeline	Action Taken
1.	To set up a project steering group (e.g. linked with medical device management committee or equivalent) and establish responsibilities for all aspects of implementation.	January 2021	The Trust Medical Devices Working Group will serve as the project steering group and already has multi-professional membership and includes colleagues from BSO PALs Procurement. Progress on the implementation of the Action Plan will be reported to the Trust Clinical and Social Care Governance Committee.
2.	To set up a cross functional project management team to cover all aspects of implementation.		
3.	To explore the need for a QMS or other appropriate standards for the product designed and commissioned by the Radiotherapy Team.	June 2021	
4.	To highlight the need for patient information data at procurement stage and to communicate this requirement to the Regional Procurement Team to be incorporated into the product specification for future procurements.	September 2021	The Task Group has highlighted this need to BSO PALs Procurement colleagues and requested that the need for patient information literature be incorporated into procurement specifications going forward.
5.	To review the current reliance on manual recording processes and explore potential solutions across the HSC to address this need.	WHSCT scheduled for implementation of Encompass in 2023. This may be subject to change.	

6.	To explore the capacity and functionality of the Encompass System to record and report on medical devices used in procedures and treatments. It is expected that this action will be taken forward through the work of the Medical Device Interoperability Group.		Members of the Trust Task Group have engaged with the Encompass Implementation Team and have secured membership of the Medical Device Interoperability Group. First meeting of Medical Device Interoperability Group was planned for 26 January 2021 but deferred due to the covid-19 pandemic.

WHSCT Corporate Risk Register 20/04/2021

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	11	No change	0	Actions listed with future due dates	Apr 21 - 187 incidents were reported as RIDDOR from Jan'21 to Mar'21 in which 168 were covid (19 non covid). Current compliance rates for submission of annual risk assessments is as follows:- Acute - 42% compliance (44 out of 99) - 24 received in Jan'21 to Mar'21; AMHLD - 99% compliance (78 out of 79) - 10 received in Jan'21 to Mar'21; PSI - 100% compliance (27 out of 27) - 2 received in Jan'21 to Mar'21; PCOP - 59% compliance (61 out of 104) - 21 received in Jan'21 to Mar'21; W&C - 33% compliance (23 out of 69) - 9 received in Jan'21 to Mar'21
"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	41	No change	0	One action overdue	Apr21 - Risk title and description amended following approval at Trust Board.
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	45	No change	0	Actions listed with future due dates	16 Apr 2021: General - QUB has experienced an Cyber incident which has resulted in HSC disabling all communications (email and collaborative applications) to the University. This is an ongoing incident which may have Governance issues for the Trust and wider HSC. Impact to the WHSCT is deemed as Low, however Clinical Education Centre (CEC) services, and to some extent Library services, have been impacted. There have been a number of Ransomware attacks on Universities (4) and schools in the past number of weeks. - NWIC are currently experiencing technical difficulties as part of a response to a cyber-attack reported on 13 April. The detailed nature of the incident is still unknown and given that situation, this means that HSC systems and services are potentially at risk through existing ICT connections and information transfer. To manage that risk, HSC have disconnected a number of services and email (from NWIC) in order to minimise the risk to HSC services and the information we hold. Governance - ICT have been asked to assist and advise a number of Trust services regarding connections to, or use of, 3rd party systems or services as well as the incorporation of collaborative tools onto Trust devices. These requests have raised a number of Governance issues/concerns for the services, 3rd parties and the Trust. - As part of the QUB incident Trust ICT have investigated emails sent to the University, from Trust email accounts, for potential Confidentiality and Governance breaches. Staffing - ICT conducted a Business Continuity desktop exercise in March. The objectives of the exercise were to a) due to Covid, to test the use of video conferencing application instead of staff in a room b) to cascade the experience and decision making downwards to Band 5 staff and c) as part of a review and update to the existing ICT Business Continuity Plan Technical - Microsoft published an immediate, and Critical, world-wide alert regarding a vulnerability to its Exchange (email) product. The Regional Cyber security lead directed all Trusts to mitigate the vulnerability with the published remediation ASAP. This was completed within 2 days. - Review and updating of ICT Business and Cyber Continuity Plan following BC Desktop exercise on 23 March 2021.
Quality of Care	57	Medical Director	Failure to learn from quality and safety risk indicators may result in harm.	16	HIGH	15	EXTREM	8	HIGH	0	↑ 3	0	Actions listed with future due dates	Apr21 - Risk updated to include ID1166. SAIs overdue = 46 (56 previous month); 32 (48) formal complaints open great than 20 working days.

WHSCT Corporate Risk Register 20/04/2021

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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	52	No change	0	Actions listed with future due dates	19/04/21 - A pilot project has been completed to enable Pin print in the Woman and Children's Directorate. Information Governance lead and ICT are in discussions regarding the roll out of the pilot across the Trust (dependent on resources). Information Assets Owners Training organised for the 25 May and is fully booked (40 placed). Works completed on the shelving in Great Hall Tyrone and Fermanagh Hospital. Discussions will take place on the allocation of shelving for services. The transfer of corporate records to PRONI has been agreed and the first transfer is due to take place in late summer 2021.
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	70	No change	6	Actions overdue	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
Regulation & Compliance	719	Director of Women & Children's Services	Risk of failure to meet a standard/protocol/guideline.	20	EXTREM	12	HIGH	8	HIGH	77	No change	0	Actions listed with future due dates	19/4/21: The Directorate has confirmed this workshop will now be held in May 21. Directorates will provide updates at this workshop and highlight challenges and way forward. Tom Cassidy will lead on this workshop.
Regulation & Compliance	955	Director of Finance	Failure to comply with procurement legislation re social care procurement	12	MEDIUM	12	MEDIUM	4	LOW	55	No change	5	One action overdue	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	30	No change	1	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.

WHSCT Corporate Risk Register 20/04/2021

Risk Summary Report

Risk Category **(to be revised)**	Risk ID	Lead Director	Risk Title	Initial Score	Initial Grade	**Current Score**	**Current Grade**	Target Score	Target Grade	**Current Risk Status: Mths since score changed**	**Current Risk Status: Change in score since last review**	Mths since last updated	Action Plan Status	Latest Update
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	10	No change	2	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.
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	17	No change	2	Actions overdue	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	8	HIGH	6	MEDIUM	0	-4	0	Actions listed with future due dates	Apr21 - Revision of risk grading approved at Trust Board from High (12) to High (8).
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	13	No change	0	Actions listed with future due dates	19-04-21 (previous months figures in brackets) 217(212) COVID related deaths (cumulatively); 19(43) Covid positive inpatients, 3(6) positive patients in ICU; 59(62) adult beds closed. 664(516) staff tested positive. 406(393) RIDDOR reports. 720(824) staff unavailable for work 6.38%(7%). 11(3) COVID incidents in week. Total ED waits over 12 hours 194 (367). Positives cases in last 7 days NI 788(2108) Derry and Strabane 160(79) Omagh and Fermanagh 27(40). Vaccinations administered 108,236(79,369) with number of HSE staff given first dose at 25,820. Total vaccine incidents 98(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	13	No change	1	Actions overdue	18-03-21 4 incidents related to capacity/demand pressures reported since 14/01/21.

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				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
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	9	No change	1	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
Regulation & Compliance	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	8	No change	0	Actions listed with future due dates	April 21 - Action Plan in place and discussed at C&SCG Subcommittee and proposal agreed to table at CMT for de-escalation of risk to Directorate level now that an Action Plan is in place.
Financial	1236	Director of Finance	Ability to achieve financial stability, due to both reductions in Income and increased expenditure.	16	HIGH	16	HIGH	8	HIGH	4	No change	5	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.
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	1	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 work streams 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 work streams and these will be linked to the HR Directorate Plan.
Regulation & Compliance	1288	Director of Human Resources	Risk of failure to meet regulatory standards and compliance associated with Trust infrastructure and estate.	12	HIGH	12	HIGH	12	HIGH	0	New risk	New Risk	Actions listed with future due dates	Apr21 - Risk approved at Trust Board (replacing previous risks ID100 and ID235).

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3	19/11/2008	16	HIGH	20	EXTREM	4	HIGH	Medical Director	Trust-wide (Risk Register Use Only)	Safe & Effective Services.G overnance.□ Workforce.	Health and Safety risk - resulting in injury	Risk of injury to patients/clients/staff and visitors arising from failure to fully comply with Health & Safety legislation.	Incident reporting and investigation. Criteria based Health & Safety Inspection plan and action plans . Induction and Mandatory Training for Staff. Occupational Health Self and Management Referrals. Use of aids e.g. hi-lo beds, hoists. Patient/client risk assessment. Leadership Walk rounds. KPI for health & safety, e.g. falls. Falls Risk Assessment. Falls Prevention Policy. Ligature risk assessment tool adopted WHSCT Occupiers rules & regulations Aug 2017 MAPA training team in place Combination training (includes Risk assessment and COSHH risk assessment) Nurse managers trained in Ligature 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 documents & comms. Complete Inspection plan for 2021 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 31/05/2021 15/05/2020 31/03/2022 31/03/2022 31/03/2020 31/03/2020 31/07/2019 31/03/2020 31/08/2021	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	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 & 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 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

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49	06/10/2009	16	HIGH	16	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 web filtering) HSC security hardware (e.g. firewalls) 3rd Party Contracts / Data access agreements Contract of employment HR Disciplinary Policy Mandatory training policies Induction policy Regional and local Incident Management & reporting policies & procedures Corporate Risk Management framework, Processes & monitoring Emergency planning & Service business continuity plans Disaster recovery plan Ussr account management processes Change control processes 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 Technical risks assessments and penetration tests HSC SIRO Forum for shared learning and collaborative action planning and delivery	There is a resource issue regarding Cyber Staff in the Trust. The Business Case that was approved should address this pressure however experience from other Government Organisations would suggest that is difficult to attract and retain specialist skills in this area. Unable to have consistent patching of critical/core serves due to service disruption. Limited testing of Data and Systems restores.	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	15	EXTREM	8	HIGH	Medical Director	Trust-wide (Risk Register Use Only)	Governance. Safe & Effective Services.	Failure to learn from quality and safety risk indicators may result in harm.	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 potentially avoidable harm to service users, staff and others.	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 identified has been shared and practice changed. Learning themes not yet applied which could focus action on broad areas for improvement Datixweb 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 themes being developed regionally for Litigation Learning from Project responding to RQIA	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 31/03/2021 30/11/2020 31/03/2021

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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
284	13/12/2010	16	HIGH	16	HIGH	8	HIGH	Director of Performance & Service Improvement	Performance & Service Improvement	Governance.	Risk of breach of General Data Protection Regulation (GDPR) and Data Protection legislation through loss of personal or sensitive	As a result of gaps in staff awareness and training in data protection requirements and non-adherence to retention and disposal guidance, there is a risk that personal or sensitive data could be lost, inappropriately stored or accessed; records could be retained beyond their lifecycle and lead to a breach of confidentiality and the Data Protection Act, DoH Good Management Good Records Guidelines and result in potential enforcement action from the Information Commissioners' Office alongside damage to the Trust' reputation.	Subject Access and Data Access agreement procedures. Information Governance/Records Management induction/awareness training. Regional code of practice. Information Governance Steering Group. Records held securely/restricted access. ICT security policies. Raised staff awareness via Trust Communications/Share to Learn. Fair processing leaflets/posters. Investigation of incidents. Investigation of incidents. Data Guardians role. Regional DHSSPS Information Governance Advisory Group. Electronic transmission protocol. 2 secondary storage facilities available across NS & SS Trust Protocol for Vacating & Decommissioning of HSC Facilities. Scoping exercise to identify volume and location of secondary close records completed in December 2010. band 3 post in place 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 increased 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 30/06/2021 30/06/2021 30/06/2021 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	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	HIGH	8	HIGH	Director of Women & Children's 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 frequently if requested	31/05/2021 31/05/2017 31/03/2017 31/03/2022 31/03/2022 31/05/2021 31/03/2022 31/03/2022	 27/07/2017 30/06/2017
955	11/08/2016	12	MEDIUM	12	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 implantation 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	HIGH	4	LOW	Director of Finance	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Public Confidence. Workforce. Partnerships.	No Deal Scenario / Hard Border EU Exit	With the imminent EU exit, there is potential for a No Deal Scenario or Hard Border between Northn and South of Ireland. The full impact of the UKs exit from the EU is not yet known and given uncertainty around the UK EU ongoing discussions and potential agreements, there may be impacts such as - workforce, including recruitment and retention, changes to regulations, movement of people and goods, border controls and access to healthcare in EU member states. Day one delivery planning is required to ensure services continue to operate effectively on day one following EU Exit and in the longer term, and that there is no, or minimal disruption to services. Although this is categorised as an organisational risk it also has implications for clinical risk, financial risk, patient and client safety and staffing issues/levels. Lead Officer is Paul Quigley and Responsible Director is Lesley Mitchell, Director of Finance and Contracting.	Detailed review of mitigating actions to be completed by 30 December 2018. Increased frequency of meetings of both regional and local Task and Finishing Groups. Labour, including Cross Border analysis , to be made available to service colleagues. Service focused workshop event arranged for 17 December 2018. Lead Officer is member of EU Finance Subgroup. Communicating financial risks for 2018-19 and 2019-20 predominately. Trust Pharmacy Dept reviewing national pharmacy plans to determine any additional local migration actions e.g. radioisotopes; non stock and off contract items e.g. medical gases. Lead Officer to brief CMT of evolving plans on 22 November 2018 BSO Pals providing analysis of high usage nonstock items for consideration bof risk assessment by Trust. BSO Pals assuring lead for stock items including stock building. EU Exit Task & Finish Group in place including service directorate membership. No Deal Continuity Plans for Services Participation on DoH Regional EU Exit Group	A number of national and regional risk mitigation issues are being managed at DOH / Government level. The Lead Officer participates in the Regional DoH EU Exit Group.	Continuity Plans developed for Pathology, Pharmacy, FM and Paying Patients department with all other areas in progress and due to be submitted by 24 January 2019. Details of staffing implications by Directorate sourced and being pulled together by HR. the Trust continues to attend various regional forums on EU Exit, including the DoH EU Exit Regional Meeting and other Regional Meetings such as Medicines Preparedness, Information Governance, HR and Emergency Planning. Final Version of Yellow Hammer Document received by Trust EU Exit Task and Finish Group meet monthly. Day one delivery plan developed and	The DOH reported that further discussion at the EU Exit ALBs meeting has clarified that disruption to health and social care services is not anticipated as a result of any impediment to movement of people at the border and that existing business continuity plans and mitigating actions for potential staff shortages should apply and suffice. Anne Kilgallen, Trust CE has fortnightly meetings with Richard Pengelly and CE of HSC - of which EU Exit and associated continuity planning progress are discussed.	Continued regular update internal EU Exit Meetings and updates to CMT. Application of any regional or strategic directives on EU exit. Trust representatives continue to be involved in regional working groups led by DoH in order to inform and assist the Trust in EU Exit Planning. Next meeting due to take place on 21 January Assurance Statement to be forwarded from the CE to the Permanent Secretary, DoH confirming that the Trust is actively scoping the potential impact of a no deal outcome from the UK EU negotiations on the services provided by the Trust etc. Detailed Review of Mitigating Actions to be completed - Continuity plan Lead Officer to brief	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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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
1133	23/05/2019	15	EXTREM	25	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 flow guard 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 flowmeters 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 adhered 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
1183	27/11/2019	25	EXTREM	25	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 potential	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 Details 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. Sufficient 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 31/03/2020 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

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		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
1207	04/03/2020	9	MEDIUM	8	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	
1213	04/04/2020	20	EXTREM	20	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 safety 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	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	

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1219	30/04/2020	20	EXTREM	20	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	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 working 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	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	Controls are in place. However, it is not always possible to have full financial controls without looking at quality & safety risks to patients/clients.	CMTFMG financial performance reports to Trust Board and CMT members. Internal Audit. Assurances from Director of Finance and ADF to CMT & Trust Board. Assurance obtained by the Chief Executive from chairing CMTFMG Self-assessment and audit of Financial Management Controls Assurance Standard. External Audit (NIAO) . DHSSPS/HSCB monthly financial monitoring.	No gaps identified.	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	

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1254	18/01/2021	16	HIGH	16	HIGH	9	MEDIUM	Director of Human Resources	Trust-wide (Risk Register Use Only)	Ensuring Stability of Our ServicesIm proving the Quality and Experience of CareSuppor ting 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	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	
1288	08/04/2021	12	HIGH	12	HIGH	12	HIGH	Director of Performanc e & Service Improvemen t	Trust-wide (Risk Register Use Only)	Improving the Quality and Experience of CareEnsuri ng Stability of Our Services	Risk of failure to meet regulatory standards and compliance associated with Trust infrastructure and estate.	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).	Monitoring and review by PSI SMT of directorate risks including water, electrical, asbestos and physical infrastructure. 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. Continual bidding for funding to address backlog maintenance Targeting of priority areas as funding becomes available. Monthly review of Backlog Maintenance capital investment plan Priority Backlog Maintenance capital investment plan	Ageing infrastructure resulting in deterioration of buildings Insufficient funding to carry out full remedial works identified.	Back-log Maintenance list Health & Safety audits Environmental Cleanliness audits Authorising Engineer audits Annual inspections carried out Membership at Health and Safety/ Water Safety Groups Reports to Corporate Governance Sub Committee/Governance Committee Assurance standards Buildings, Land, Plant & Non-Medical Equipment	Lack of Funding for backlog maintenance.	Review of emerging issues and response required Development of business cases for 2021/22 backlog maintenance agreed action plan. CMT approval of BLM 2021/22 for submission. Development of 2021/22 BLM bid Completion of six facet condition survey Review of emerging issues and response required Monthly review of Backlog Maintenance capital investment plan	31/03/2022 30/09/2021 30/04/2021 30/04/2021 30/06/2021 30/04/2021 31/03/2022	