Western Health and Social Care Trust

CORPORATE RISK REGISTER & ASSURANCE FRAMEWORK

BRIEFING NOTE PREPARED FOR TRUST BOARD
10 JUNE 2021

There are 18 risks on the Corporate Risk Register as approved at Trust Board on 6th May 2021.

Summary

- Proposed new Corporate Risk re Vacant Paediatric Ophthalmology consultant post (attached)
- Alignment of Corporate Risks to sub-category and risk appetite - Update
- Update on agreed actions from Trust Board workshop (attached)
- Covid-19 risk ID1213 update and indicators

Proposed new Corporate Risk (see attached New Risk form)

Risk Title - Vacant Paediatric Ophthalmology consultant post resulting in no Paediatric Ophthalmology clinics

Risk Description - No consultant to lead Paediatric Ophthalmology services. No routine paediatric cases being seen in Ophthalmology. Long waiting lists with clinical risk of adverse outcomes. No clinical oversight for orthoptic and optometry clinics...

Risk Grading

Current Risk Rating – Consequence MAJOR (4) X Likelihood LIKELY (4) = **HIGH** (16)

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

Lead Director: Geraldine McKay

Alignment of Corporate Risks to sub-category and risk appetite

Update

The Risk Appetite Statement clarifies the Trust Board's expectations in relation to the category of risks they expect the Trust's management to identify and the level of such risk that is acceptable.

The statement is based on the premise that the lower the risk appetite, the less the board is willing to accept in terms of risk and consequently the higher the levels of control that must be put in place to manage the risk.

The higher the appetite for risk, the more the board is willing to accept in terms of risk and consequently the Board will accept business as usual activity for established systems of internal control, and will not necessarily seek to strengthen those controls. Risk appetite will therefore be set at one of the following levels:-

Risk Appetite	What this means:
No Appetite	We are not prepared to accept uncertainty that outcomes can be prevented for this type of risk.
Low appetite	We accept a low level of uncertainty that outcomes can be prevented but expect that risks are managed to a level that may not substantially impede the ability to achieve objectives.
Moderate Appetite	We accept a moderate level of uncertainty but expect that risks are managed to a level that may only delay or disrupt achievement of objectives, but will not stop progress towards objectives.
High Appetite	We accept a high level of uncertainty and expect that risks may only be managed to a level that may significantly impede the ability to achieve objectives.

Risks have been aligned under the following categories:- Finance & Efficiency; Health & Safety; ICT & Physical Infrastructure; People & Resource; Quality of Care; Regulation & Compliance; Public Confidence.

Each category of risk may have various sub-categories, for instance Quality of care risks may be risks related to safety, effectiveness or patient experience. Acceptable risk scores are based on the Regional Risk Matrix and the Board is required to specify the maximum acceptable target scores for each sub-category of risk.

Action

Each Directorate has been tasked at their next Directorate Governance meeting with setting the sub-category and target score for each Corporate Risk under their responsible Director. These will be reviewed and finalized at the following CMT with a proposed final risk appetite to Trust Board for approval.

Update on agreed actions from Trust Board

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

Covid-19 Risk ID 1213 – Indicators

Update

The Covid risk was reviewed at CMT Safety Huddle on 1st June. It was agreed to progress a new Corporate Risk related to Re-build of services to replace the current Covid risk which will be proposed for de-escalation to directorates for management of specific issues at that level. The new risk will be progressed through CMT to Trust Board for final approval.

Table 3

Covid Risk ID1213 - Indicators as at 26/05/21 (April Indicators in Brackets)				
Indicators	**Total**	**Alt.**	**SWAH**	**Comm.**
Covid-19 deaths (Cumulative)	218(217)			
Covid positive inpatients	8(19)	4(9)	4(9)	0(1)
Number in ICU (Covid positive)	1(6)	0(6)	1(0)	
Total number of beds closed	24(59)	20(11)	4(24)	8(24) (Rehab + Waterside)
Hospital Oxygen supply status lt/m		158 (140)	164(54)	
ED waits >12 hours in last 7 days		7.29%(12%)	4.5%(7.2%)	
Staff tested positive (Cumulative)	669(664)			
Staff positives reported under RIDDOR. (Cumulative)	412(406)			
Staff unavailable for work	750(720)	234(226)	90(88)	426(406)
% of Staff unavailable for work	6.65%(6.38%)	5.4%(5.22%)	5.72%(5.59%)	7.93%(7.56%)
incidents reported as being directly related to Covid (last 7 days)	12(11)	2(5)	0(0)	10(6)
No +ve tests (last 7 days) NI	617(788)			
No +ve test (last 7 days) Derry and Strabane Council area	107(160)			
No +ve test (last 7 days) Fermanagh and Omagh	47(27)			
Total vaccinations	162,002 (108,236)			
Early Alerts/Service downturns or Service fragility				
Confirmed outbreak - Cornfield Nursing Home, Limavady				

Western Health and Social Care Trust

Appendix 5 of Risk Management Policy

New Risk Form

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

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

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

9.	**Corporate Objective(s) affected by this risk*** ***(Please tick appropriate box(es) below)***		
	C01	To provide safe, high quality and accessible patient and client focused services	**X**
	C02	To improve and modernise our services in line with evidence-based practice and research	
	C03	To ensure the probity and safety of our processes and systems through active governance arrangements	**X**
	C04	To promote public confidence in our services	
	C05	To create a culture and an environment which will attract and retain high quality staff	
	C06	To build effective relationships with service users, communities and our strategic partners to promote the health and social wellbeing of our population	
	C07	To secure and manage resources effectively and efficiently in order to achieve best outcomes, demonstrate value for money and ensure financial viability	

10.	**Lead Officer* with responsibility for managing this risk (Name, Job Title, and Contact Details.** **(i.e. manager with operational responsibility)**	Stephanie Johnston, Service Manager Ophthalmology, Ext 215435
11.	**Name of Responsible Director*** **(NB: Where a risk is Cross-Directorate, the most appropriate Director to manage this risk should be listed. It will be their responsibility to liaise with other Directors re management of this risk).**	Geraldine Mc Kay
12.	**Description of Risk*** Please provide a full description of the nature of the risk. Please limit this to 255 characters	No consultant to lead Paediatric Ophthalmology services. No routine paediatric cases being seen in Ophthalmology. Long waiting lists with clinical risk of adverse outcomes. No clinical oversight for orthoptic and optometry clinics.
13.	**Please list all current control measures in place to manage this risk*** (e.g. policies, procedures, training)	Urgent paediatric cases discussed with general ophthalmologists for referral to Belfast as required. ROP screening performed by retinal consultants as a temporary measure
14.	**Please list all identified gaps in Controls.***	Significant clinical risk in ROP screening by consultants without Paediatric fellowship. No consultant oversight for orthoptics and optometry increase clinical risk
15.	**Please list all Assurances currently in place to test adequacy of Controls.** (i.e. Audit (Interna/External), inspections by independent organisations, e.g. RQIA, HSENI).	Ongoing discussions with commissioners as regards filling the post.
15.	**Please list all identified gaps in Assurances.**	

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

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

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

18. Action Plan to reduce Level of Risk

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

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

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

Question	Response
1. Does the proposed action plan actively manage this risk to ensure that the level of risk can be reduced to the target level?	YES
2. Does the proposed action plan take account of any opportunities that could be exploited whilst managing this risk?	YES, cannot recruit to post and no staff with specialist training.
3. Has the target level of risk, and how this will be achieved, been communicated to those staff responsible for the operational management of this risk?	YES
4. How will the proposed actions be monitored to ensure they are completed within identified timescales?	Constantly being monitored and meetings being held to try and resolve risk.
5. At what point should the decision regarding the management of this risk be escalated to a higher level?	Has been escalated to the Chief Executive.

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

Action Required	Start Date	Due Date	Lead Officer
Agree shared contract with Belfast Trust to allow a consultant to work 50% of the time in Western Trust			Stephanie Johnston
Advertise new agreed post			Stephanie Johnston

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

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

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

Actions from Trust Board workshop October 2020 as at 27/05/21

Primary Risk Category	Risk ID	Lead Director	Risk Title	Merge	Lead Director/ Committee	Workshop Action	Progress	Update
Health and Safety	63	AMHDS	High risk forensic/challenging individuals who have potential to cause harm to themselves or others		K O'Brien / AMHDS Governance	ID 63 and ID 66 Merge both risks. To be re-described with Cause, event, effect. Category accepted. To become a Directorate Risk.	completed	Proposal approved at Trust Board February 2021
Health and Safety	66	AMHDS	Death or serious injury of patient as a result of a suicide or attempted suicide while in a Trust facility				completed	
Health and Safety	100	PSI	Backlog Maintenance		T Molloy / Corporate Governance Sub-committee	ID 100 and 235 Agree both risks to be merged. Risk category could be debated. Most likely Statutory requirement. To be reworded to reflect risk.	completed	New proposed risk agreed at Trust Board 01/04/21 09/02/21 New corporate risk infrastructure drafted and measures agreed. Pending approval at PSI Governance Meeting on 8 March 2021 prior to CMT approval. New Water Safety Compliance Directroate Risk drafted following comments from Risk Management and IP&C (W Cross), pending approval at next PSI Governance meeting on 8 March 2021.
Regulation & Compliance (Statutory, Professional & Quality Legislation, standards & guidelines incl. Environmental)	235	MD	Risk of continuing failure to meet statutory requirements for Water Safety				completed	
Health and Safety	3	MD	Health and Safety risk - resulting in injury			ID 3 Risk to remain	No action required	
ICT & Physical Infrastructure	49	DoF	Virus attack disables network/services			ID 49 risk to remain and to be re-described	Completed	People, technology and Legislation (NIS in particular). They are proposing to amend the title and have simplified the language throughout and have attempted to make it as non-technical as possible. This has been approved at their Directorate SMT and at CMT December 2020. Tabled at Trust Board on 07/01/21 and approved.
People & Resource	1075	DoF	No Deal Scenario / Hard Border EU Exit			ID 1075 - to be considered for de-escalation	Completed	May 21 - Meeting held and ongoing registration for Social Workers progressing. Not yet de-escalated. Meeting being planned to look specifically at managing the dual registration for professionals. The meeting will include Acute services and HR Feb 2021 - Risk is currently being reviewed to consider inclusion of emerging post EU Exit risks e.g. possible issues with incomming deliveries and Dual Registration of Trust Staff for Cross
Regulation & Compliance (Statutory, Professional & Quality Legislation, standards & guidelines incl. Environmental)	46	HR	Challenges to compliance with Working Time Regulations		A McConnell / People Committee	ID 46, 1100, 1165, 694 ,58 and 1109 Agreed risks need described more appropriately and merged. Consideration to re-describe and include as 1 overarching risk with blue risks. All linked to availability of staff. Risk ID 547 noted that proposal to de-escalate to directorate and consider re-wording description.	Completed	Category agreed at CMT in April as Quality of Care. CMT 25 March - Proposal for CMT in April New Risk ID1254 approved at Trust Board in January 2021. Trust Board advised February 2021 discussion ongoing with CMT on most appropriate category.
People & Resource	1100	HR	Agenda for Change (AFC) Pay Reform Dispute may impact service provision				Completed	
People & Resource	1165	HR	Service Impact of HMRC Regulations in relation to Pensions.				Completed	
People & Resource	694	AS	Risk to patient/client safety because of insufficient Medical cover in PCOPS and Medical Wards in SWAH				Completed	
People & Resource	58	HR	Over dependence on the use of locum and agency staff to sustain services and insufficient induction for locum medical staff				Completed	

Actions from Trust Board workshop October 2020 as at 27/05/21

Primary Risk Category	Risk ID	Lead Director	Risk Title	Merge	Lead Director/ Committee	Workshop Action	Progress	Update
People & Resource	547	PCOPS	Inability to access domiciliary care in a timely manner				Completed	
People & Resource	1109	W&C	Difficulty Recruiting to all frontline social work areas across the Trust				Completed	
People & Resource	6	W&C	Harm to children whilst awaiting Gateway and Family Intervention Service (unallocated cases)			ID 6 To come to CMT re-worded to better describe.	Completed	Rewording approved at Trust Board 01/04/21
Quality of Care	1216	AS	Risk of patient harm in Trust EDs due to capacity, staffing and patient flow issues			1216 to remain on CRR expected actions will able risk to be reduced in December	In Progress	Action Plan in place, action plan to be updated as a result of recent moves and considered after this for deescalation to Directorate risk
Quality of Care	1166	AMHDS	Lack of a robust Governance Structure within AMHDS resulting in risk of not being able to identify emerging risks and Learn		Dr McDonnell / C&SCG Sub-committee	1166 and 57 . Needs to be reworded and merged. Risk 1133 to be separate and to be re-worded and de-escalated when actions complete	Completed	Update briefing paper on ID1133 went to Governance Committee in April 21. Agreed proposed merged risk at Trust Board 01/04/21 . Update required on ID1133 22-2-2021 AMHDS Progressing additional Governance posts including 2 x Band 8c posts. Controls and gaps in AMHDS risk to be incorporated into Risk 57 in January 2021. Medical Directorate Team meeting planned for March 2021 where merging of risks will be reframed into a Safety risk. Risk 1133 SAI reports completed
Quality of Care	1133	PCOPS	Risk to safe patient care relating to inappropriate use of medical air				Completed	
Quality of Care	57	MD	Lack of cross-Directorate learning from adverse incidents, complaints, claims & audit recommendations				Completed	
Quality of Care	1207	PCOPS	Care, safety and quality standards delivered in Independent Sector Nursing and Residential Care Facilities			ID 1207 - Actions and controls to be updated	Completed	Risk grading revised and agreed at Trust Board 01/04/21 .
Quality of Care	1213	MD	COVID-19 risk re assess & response to patient/client need & maintain quality & safety for patients/clients and staff			1213 - Risk to remain at present	No action required	
Regulation & Compliance (Statutory, Professional & Quality Legislation, standards & guidelines incl. Environmental)	955	DOF	Failure to comply with procurement legislation re social care procurement			ID 955 to remain as a corporate risk. DOF to be the lead.	Completed	
Regulation & Compliance (Statutory, Professional & Quality Legislation, standards & guidelines incl. Environmental)	1183	AMHDS	Mental Capacity Assessment Training			id 1183 Proposal that risk can be de-escalated to Directorates. Karen will come to CMT with this proposal.	Completed	04/05/21. Risk updated to highlight criminal liability, Current risk rating and target risk rating updated.
Regulation & Compliance (Statutory, Professional & Quality Legislation, standards & guidelines incl. Environmental)	1227	PCOPS	Action Plan for implementation of new regulations on medical devices by May 2020 as per circular HSE16-19 not completed			ID 1227 There has been a lot of progress on actions and these need to be updated to reflect current position	Completed	Action Plan approved at CSCG Sub Committee and agreed to table for discussion at CMT in April re de-escalation to Directorate registers. Update February 2021 Scoping across a broad range of clinical specialities completed action plan drafted December 2020 and cicrulcated for review to Corporate Risk Team and Lead Director for Review. Plan to present for approval at C&SC Governance meeting March with the aim to de-escalate risk. Actions have
Regulation & Compliance (Statutory, Professional & Quality Legislation, standards & guidelines incl. Environmental)	284	PSI	Risk of breach of General Data Protection Regulation (GDPR) and Data Protection legislation through loss of personal or sensitive			ID 284 Risk noted Risk to remain	No action required	

Actions from Trust Board workshop October 2020 as at 27/05/21

Primary Risk Category	Risk ID	Lead Director	Risk Title	Merge	Lead Director/ Committee	Workshop Action	Progress	Update
Regulation & Compliance (Statutory, Professional & Quality Legislation, standards & guidelines incl. Environmental)	719	W&C	Risk of failure to meet a standard/protocol/guideline.			ID 719 - agreed risk needs to be more clearly defined. Workshop to get clarity on benchmarking the position and what the risk is to the Trust so that assurance can be given	In Progress	18/04/21 - Workshop will be held in May. 15/03/21: No feedback from Directorates on progress updates. It has been agreed to hold a workshop towards end of April. Directorates will provide updates at this workshop and highlight challenges and way forward. Tom Cassidy will lead on this workshop. 3 Feb 21: Assistant Governance Manager sent out ongoing Standards and Guidelines to all Directorates for review, update and return by 26 Feb 2021 in preparation for Workshop

WHSCT Corporate Risk Register 27/05/2021

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	12	No change	1	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). Cuurent 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	42	No change	0	Actions listed with future due dates	May 2021. Enniskillen pilot ongoing, Evaluation due late Autumn 21. All unallocated cases are reviewed by Senior Managers on a weekly basis. Snr Practitioners maintain regular contact with families whose case awaits allocation and where possible services are provided pending allocation to a SW.
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	46	No change	0	Actions listed with future due dates	18 May 2021: General - The Health Service Executive (HSE) in the Republic of Ireland has experienced a Cyber incident which has resulted in HSC disabling all communications (email and collaborative applications) to the ROI. This is an ongoing incident which has Governance issues for the Trust and wider HSC. Impact to the Trust ICT is Low but for wider WHSCT is deemed as Medium, with Radiology, Radiotherapy, Maxi facial, Paediatric and some other services impacted. This is the third Cyber incident since February, due to Ransomware, that has had an impact on Trust services. The previous QUB and NWIH attacks are on-going incidents with email and direct connections still being disconnected. - Following the NWIH incident a Cyber Response Group was established, which ICT is a part of. Business Continuity Planning - The Trust Emergency Preparedness and Business Continuity Strategic Forum at their meeting on 28 April has asked departments to review their BC Plans specifically with reference to an assessment of Data flows and the level of risk they present should services be disrupted. This should then be reviewed against their current BCPs and any gaps identified and addressed. Governance - The QUB, NWIH and HSE cyber incidents are recognised as Supply Chain attacks. These attacks have not been directly on the WHSCT or wider HSC but have impacted on services provided by the Trusts. Associated risks with these incidents are around Governance, handling of the data and contracts. As part of the HSE incident; Trust ICT have investigated emails sent from/to
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	2	No change	0	Actions listed with future due dates	May21 - SAIs overdue 49 (46 previous month). 31 (32) formal complaints open great than 20 working days. SAI workshop held on 20/05/21with Trust Board. Actions include Directorates to provide one page summary of their processes for identifying and sharing leanrning via SAIs and Complaints.

WHSCT Corporate Risk Register 27/05/2021

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
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	53	No change	0	Actions listed with future due dates	12/05/21- In response to the Infected Blood Inquiry, circa 80,000 records (deceased patients, Altnagelvin site) are being transferred into off-site storage to ensure the completeness and availability of the records, should they be requested by the Inquiry. Records Management and Data Protection Polices have been updated
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	71	No change	7	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	78	No change	1	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	56	No change	6	Actions listed with future due dates	Nov20 - Reviewed at Trust Board workshop, DoF to be responsible director and to remain on CRR. August 20 The Trust is participating in the Light Touch Regime with regional prioritisation of social care procurements. The decision has been made to begin preparations for the retendering of contracts for Domiciliary Care although the decision to complete will require further consideration.
People & Resource	1075	Director of Finance	No Deal Scenario / Hard Border EU Exit	12	HIGH	16	HIGH	4	LOW	31	No change	1	Actions listed with future due dates	April 21 - Process is underway for Social Workers who are required to be dual registered. Required visits in ROI are being done remotely. No additional doctors or nurses are required to be registered in ROI as those who provide services there are already dual registered. ADHR joined CEX in meeting with Womens and Childrens and Acute Directors meeting, where dual registration was discussed.
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	11	No change	1	Actions listed with future due dates	April 21 - Update briefing paper to Governance Committee. February 2021. SAI reports completed and submitted to the Board. Actions are being taken forward.
Regulation & Compliance	1183	Director of Adult Mental Health & Learning Disability	Insufficient relevant staff available to undertake DOLS processes may result in patients being deprived of their liberty, withou	25	EXTREM	20	EXTREM	12	HIGH	0	-5	0	Actions listed with future due dates	04/05/21. Risk updated to highlight criminal liability, Current risk rating and target risk rating updated.

WHSCT Corporate Risk Register 27/05/2021

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
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	2	No change	1	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	14	No change	1	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	14	No change	0	Actions overdue	05-05-21 11 incidents (graded 10 red, one amber) reported relating to capacity/demand pressures since 18-03-21. 01 - 05 May - seen within 4 hours Alt 42%, SWAH 67%. Fortnightly meeting set up co-chaired by GMcK and DrBB to look at flow systems and processes.
Regulation & Compliance	1219	Acute Hospital Services	Lack of endoscopy capacity for endoscopy to meet the demand which impacts on Patient outcomes	20	EXTREM	20	EXTREM	1	LOW	0	No change	2	Actions overdue	Mar21 - Risk approved at Trust Board for adding to Corporate Risk Register. Performance Position 31 December 2020 Overall position: Total number of patients waiting for endoscopy: 4,908. Further breakdown: Red Flag patients: 844 patients waiting (NS waits- 281, SS waits-563), with the longest patients waiting 25 weeks. Red flag referrals should be seen within 2 weeks. Urgent patients: 3,669 patients waiting, with the longest patients waiting up to 106 weeks. Urgent patients should be seen within 9 weeks. Routine patients:1,645 patients waiting over 52 weeks, with the longest patients waiting up to 154 weeks. Urgent patients should be seen within 9 weeks. Surveillance patients: 2,703 patients are waiting with the waiting list dating back to 2016. These patients are on a watch and wait list and may be developing a cancer while waiting to be assessed
Financial	1236	Director of Finance	Ability to achieve financial stability, due to both reductions in Income and increased expenditure.	16	HIGH	16	HIGH	8	HIGH	5	No change	6	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	3	No change	2	Actions listed with future due dates	March 2021: As a result of further discussions and refinement of the HR Action Plan required to address People & Resources Corporate Risk, five workstreams have now being agreed to take forward these key actions (i) Looking after our People (ii) Growing for the future (iii) New ways of working (iv) Belonging in the HSC and (iv) Improving Statutory Performance. A HR workshop is planned for April 2021 to identify the Key Performance Indicators for each of the five workstreams and these will be linked to the HR Directorate Plan.

WHSCT Corporate Risk Register 27/05/2021

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
Regulation & Compliance	1288	Director of Performance & Service Improvement	Risk of failure to meet regulatory standards and compliance associated with Trust infrastructure and estate.	12	HIGH	12	HIGH	12	HIGH	0	No change	0	Actions overdue	12 May 21 - BLM plan has been submitted to BCRG for approval. Oakleaf survey is 90% complete. Early indications show BLM liabilities costs have increased to approximately to £200m, this will be confirmed within the next month and briefing paper prepared for CMT consideration which will outline any significant findings.

		Initial Risk		Current Risk		Target Risk													
ID	Opened date	Rating (initial)	Risk level (initial)	Rating (current) (Consq x Likli)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Directorate	Corporate Objectives	Title	Description	Controls Assurance	Gaps in controls Assurance	Assurance	Gaps in assurance	Action Plan	Due date for Action Plan	Done date for Action Plan
3	19/11/2008	16	HIGH	20 (4x5)	EXTREM	4	HIGH	Medical Director	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Governance. Workforce.	Health and Safety risk - resulting in injury	Risk of injury to patients/clients/staff and visitors arising from failure to fully comply with Health & Safety legislation.	Incident reporting and investigation. 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. KPI for health & safety, e.g. falls. Falls Risk Assessment. Falls Prevention Policy. Leadership Walk rounds. Ligature risk assessment tool adopted MAPA training team in place WHSCT Occupiers rules & regulations Aug 2017 Combination training (includes Risk assessment and COSHH risk assessment) Nurse managers trained in 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 of risk register to managers to allow direct management of risks No overall database of trained nominated H&S officers by facility Limited availability for managers to update risks on Datix. Datixweb module required to allow linking with incidents	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 walk rounds. 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 (4x3)	HIGH	8	HIGH	Director of Women & Children's Services	Women & Children's Services	Safe & Effective Services.	Children awaiting allocation of Social Worker may experience harm or abuse	Due to capacity and demand issues within Family & 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.	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. Delays in recruitment	Quarterly governance reports to Governance Committee. Feedback given to Performance & Service Improvement for accountability meetings with HSCB. Up-dates by Director to CMT and Trust. Action Plan to review and Address Risks within FIS Enniskillen Delegated Statutory Functions		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	30/11/2021 30/09/2020 01/11/2018	 31/12/2019 30/09/2020 06/03/2019

		Initial Risk		Current Risk		Target Risk												
ID	Opened date	Rating (initial)	Risk level (initial)	Rating (current) (Consq x Likli)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Directorate	Corporate Objectives	Title	Description	Controls Assurance	Gaps in controls Assurance	Assurance	Gaps in assurance	Action Plan	Due date for Action Plan	Done date for Action Plan
49	06/10/2009	16	HIGH	16 (4x4)	HIGH	9	MEDIUM	Director of Finance	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	The potential impact of a Cyber Security incident on the Western Trust	Information security across the HSC is of critical importance to the delivery of care, protection of information assets and many related business processes. Without effective security and controls; compromises can arise from technology and people which can lead to breaches of Data Protection Act and Network and Information Systems (NIS) regulations Compromises can arise from; • NON Managed Trust ICT Equipment (e.g. Radiology modalities, cameras, door access, medical devices etc.) in areas such as Radiology, Labs, PFI, HSDU, Estates, GP's etc. are operating un-supported operating systems, e.g. Windows XP, and/or do not have the most up to date software updates (patching) which can lead to Ransomware attacks, introduction of malware or hacking incidents • Lack of Cyber Security awareness or training among Trust staff	Data & System backups 3rd Secure Remote Access Server / Client patching HSC security software (threat detection, antivirus, email and 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 (5x3)	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 31/12/2021 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

		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
284	13/12/2010	16	HIGH	16 (4x4)	HIGH	8	HIGH	Director of Performance & Service Improvement	Performance & Service Improvement	Governance.	Risk of breach of General Data Protection Regulation (GDPR) and Data Protection legislation through loss of personal or 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. ICT security policies. Raised staff awareness via Trust Communications/Share to Learn. Regional code of practice. Information Governance Steering Group. Records held securely/restricted access. 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 (4x4)	HIGH	8	MEDIUM	Director of Nursing, Primary Care & Older People's Services	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Public Confidence.□ Partnerships. Financial Management & Performance. Modernisation.	Inability to access domiciliary care in a timely manner	There is a risk that both hospital patients and community service users will not receive their assessed domiciliary care package in a timely manner. Patients delayed in hospital may be at greater risk of infection and/or falls. Patients in the community may be a greater risk of falls or other injuries. Community service users may have to wait longer for their assessed care package as hospital patients may be prioritised for care packages to maintain hospital flows. Adult Community Care Divisions are experiencing difficulties with accessing responsive domiciliary care service provision due to the following factors;□ Rurality and the ability to source and secure a sustained domiciliary care service provision in some remote areas across the Trust□ This risk is impacting service users and carers across both community and hospital care settings resulting in delayed discharges, temporary placements being made in	Interim additional rotas have been established in 12 locations across the Trust through a co-ordinated exercise to address issues where accessing service provision has been identified across all POC's. The Trust continues to implement its reablement service model which is operationally linked to the reform of its in-house homecare service. The combination of these measures is will assist in addressing the risks being experienced and reported.	There is unmet need mainly due to difficulties in recruiting carers, particularly in rural areas	PCOP Domiciliary Care Waiting List There are a range of monitoring and reporting processes in place to ensure this risk is actively monitored A service response to assessed need is progressed on each individual cases through keyworkers and brokerage Actions are taken with regards to the position as reported through these assurance and monitoring mechanisms PFA Discharge Targets Daily Delayed Discharge Report	The focus remains to ensure optimum utilisation of available resource and progress actions in areas where there are clusters of unmet need Total assurance cannot be given as the demand and location of cases cannot be projected or planned for.	Negotiate new contracts with Independent Sector providers. Discussing individual priority clients with providers to re-organise care Providing a range of alternatives, e.g. direct payments Procurement for dom care is almost complete Member of Reablement steering group In-house reform to establish core and reablement teams across the Trust In-house service completing a productivity and efficiency improvement programme to ensure there is optimum utilisation of the rotas. regional development of a new Framework For Delivery of Care and Support in Own Home Project resource to review and improve the utilisation of block	21/04/2016 21/04/2016 21/04/2016 21/04/2016 21/04/2016 31/08/2018 30/09/2018 31/03/2021 31/03/2021	13/09/2016 28/02/2017 13/09/2016 13/09/2016 13/09/2016 31/08/2018 30/09/2018

		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
719	02/12/2013	20	EXTREM	12 (4x3)	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 May 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 31/05/2021 31/03/2017 31/03/2022 31/03/2022 31/05/2021 31/03/2022	27/07/2017 30/06/2017
955	11/08/2016	12	MEDIUM	12 (3x4)	MEDIUM	4	LOW	Director of Finance	Trust-wide (Risk Register Use Only)	Modernisation.Public Confidence.□ Financial Management & Performance.	Failure to comply with procurement legislation re social care procurement	The risk that the Trust will breach UK procurement legislation rules in awarding contracts for the provision of social care services. The legislation outlines that a formal tender process must be followed when awarding contracts that are expected to be above a specified threshold. This is to be managed by BSO Pals on behalf of all Trusts but the current proposed work programme means that Trusts will not be fully compliant with the legislation for a period of 5 years ending on 31 March 2022.	The issue has been discussed at the Trust's Procurement Board and Social Care Procurement Group. The Trust's Director of Finance & Contracting has highlighted this issue to the Regional Procurement Board.	The Trust does not have the resource or infrastructure required to manage this risk internally. DOH has determined that the issue should be managed regionally.			The 5 year implementation plan will continue to be monitored - via Regional Procurement Board, Trust Procurement Board and Social Care Procurement Group.	31/03/2022	

		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
1075	23/08/2018	12	HIGH	16 (4x4)	HIGH	4	LOW	Director of Finance	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Public Confidence. Workforce. Partnerships.	No Deal Scenario / Hard Border EU Exit	With the imminent EU exit, there is potential for a No Deal Scenario or Hard Border between Northn and South of Ireland. The full impact of the UKs exit from the EU is not yet known and given uncertainty around the UK EU ongoing discussions and potential agreements, there may be impacts such as - workforce, including recruitment and retention, changes to regulations, movement of people and goods, border controls and access to healthcare in EU member states. Day one delivery planning is required to ensure services continue to operate effectively on day one following EU Exit and in the longer term, and that there is no, or minimal disruption to services. Although this is categorised as an organisational risk it also has implications for clinical risk, 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.	EU Exit Task & Finish Group in place including service directorate membership. No Deal Continuity Plans for Services Participation on DoH Regional EU Exit Group Engagement with CAWT Partnership to support the Trust with continuity plans. Review of SLAs /Contracts to ensure EU Exit considered. Regional issues escalated to appropriate Group e.g. HR Directors / Finance Directors Local issues identified and day one plan developed. Emerging issues log established and being maintained. The Lead Officer, Paul Quigley has met with all Directorate SMTs to raise awareness and discuss issues. HR have noted on their Directorate Risk Register. Trust Reps continue to be involved in regional working groups led by DoH in order to inform and assist the Trust in EU Exit Planning . 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	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.	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 reviewed. Continuity Plans developed for Pathology, Pharmacy, FM and Paying Patients department with all other areas in progress and due to be submitted by 24 January 2019. Details of staffing implications by Directorate sourced and being pulled together by	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 30/06/2021 31/05/2021 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
1133	23/05/2019	15	EXTREM	25 (5x5)	EXTREM	5	HIGH	Director of Nursing, Primary Care & Older People's Services	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Risk to safe patient care relating to inappropriate use of medical air	Risk of patient receiving medical air in error when oxygen is required resulting in hypoxia.	Regional procurement process - will no longer be able to buy a medical air flowmeter without a 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 air guards 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 walk around. 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	30/06/2021 08/09/2020 31/12/2019	15/09/2020 31/12/2019 31/12/2019 31/12/2019 31/12/2019 31/12/2019

		Initial Risk		Current Risk		Target Risk												
ID	Opened date	Rating (initial)	Risk level (initial)	Rating (current) (Consq x Likli)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Directorate	Corporate Objectives	Title	Description	Controls Assurance	Gaps in controls Assurance	Assurance	Gaps in assurance	Action Plan	Due date for Action Plan	Done date for Action Plan
1183	27/11/2019	25	EXTREM	20 (4x5)	EXTREM	12	HIGH	Director of Adult Mental Health & Learning Disability	Adult Mental Health & Disability Services	Governance. Safe & Effective Services.	Insufficient relevant staff available to undertake DOLS processes may result in patients being deprived of their liberty, without	Full Title: Insufficient relevant staff available to undertake DOLS processes may result in patients being deprived of their liberty, without having the relevant safeguards in place, in breach of MCA legislation, with the result that the Trust, and or individual staff, may be held criminally liable with appropriate sanctions, including financial penalties and imprisonment. 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	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 Communications Plan in place	Cost of implementation of MCA. BC completed for 19/20. Approach to funding for 21/22 being progressed with HSCB. IPT drafted April21. 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. Covid - impacting on ability to undertake Legacy cases. Likely extension of full implementation to June 2021. Medics in SWAH have advised that they not have capacity to support MCA activity. Only 4 GP practices have engaged	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 31/05/2021 31/03/2020 31/05/2021 31/03/2020 31/03/2020 31/03/2020 31/03/2021 31/05/2021 31/03/2020 31/03/2020 31/03/2020 31/12/2020 31/05/2021	01/11/2019 01/12/2019 31/03/2020 31/03/2020 02/12/2019 31/01/2020 21/04/2021 02/12/2019 31/08/2019 31/08/2019 31/08/2019
1207	04/03/2020	9	MEDIUM	8 (4x2)	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 monitoring and oversight group Action Plan set up by Task & Finish Group ISP Governance Group CISGG	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	31/03/2022	

		Initial Risk		Current Risk		Target Risk												
ID	Opened date	Rating (initial)	Risk level (initial)	Rating (current) (Consq x Likli)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Directorate	Corporate Objectives	Title	Description	Controls Assurance	Gaps in controls Assurance	Assurance	Gaps in assurance	Action Plan	Due date for Action Plan	Done date for Action Plan
1213	04/04/2020	20	EXTREM	20 (5x4)	EXTREM	10	HIGH	Medical Director	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Governance.□ Workforce.	COVID-19 risk re assess & response to patient/client need & maintain quality & safety for patients/clients and staff	If current capacity limitations and activity levels across all Trust services remain or increase, the Trust may not be able to meet the increased demand placed on it during an outbreak of Coronavirus (Covid-19) or in the reset of services following an outbreak, resulting in possible harm to patients and staff.	Residential Accommodation Surge Plan Additional screening POD in place for screening pathways Chief Executive video Fit testing / PPE Podcast and video training' face to face training, Posters Fit-testing use of private company to assist OH Intranet Covid19 site to ensure information shared across the Trust Sub groups Workforce planning - regional PPE Group; Regional Discussion Group Screening & assessment pathways and designated areas Health & Safety Policy Guidelines on Management of COVID-19 as PHE IPC policy Revised Governance arrangements - Corporate Safety team 3 Planning groups; Acute; Community & Support Services Business continuity activated with 3 Bronze Control rooms: - Altnagelvin Acute; SWAH Acute; Community Community planning group - follow up of clusters in Indep sector Paediatric Service - pathway review; Hospital Planning Group to review pathways	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 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 noting and actions)	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	31/05/2021 31/05/2020 31/05/2020 31/10/2020	31/05/2020 31/05/2020 20/11/2020
1216	15/04/2020	15	EXTREM	15 (5x3)	EXTREM	5	HIGH	Director of Acute Hospital Services	Acute Hospital Services	Safe & Effective Services.Public Confidence.	Risk of patient harm in Trust EDs due to capacity, staffing and patient flow issues	If Emergency Department (ED) Physical capacity and staffing levels are not sufficient to meet the demands of patient numbers and acuity, there will be increased likelihood of significant patient harm, risk to staff wellbeing and damage to Trust reputation as a direct result.	Business case approved dedicated HALO (Hospital Ambulance Liaison Officer NIAS crews waiting to offload in our hospital early warning score Ongoing Trust recruitment focus on Critical posts IE Medical and Nursing Use of Medical locums/ Bank and agency Nurses. Social Media Campaign Escalation protocol within full capacity protocol Nursing KPI and audit (ALAMAC) Ongoing in house Quality improvement work (implementation of SAFER principles) Daily regional huddle meeting with escalation as required IT systems - Symphony Flow board On call managers/medics rota Ongoing MDT patient flow huddles in department/wards Medical team ED reviews Hub flow meetings with lead nurse attendance. Patient flow teams/night service manager Major incident policy Full capacity protocol	Implementation of SAFER principles challenged due to Medical Job plans and current Medical team models in operation ageing population living with challenging health needs Community infrastructure to meet needs of patients i.e. Gp appointments, social care packages Recruitment to perm medical posts Challenging across NI	Datix - Incident, Complaints, Litigation, Risk register Patient flow teams, Night service manager, SPOC, Hub Regional huddle Established patient pathways	Gaps in patient pathway	PACE implementation to commence March 2020. Improvement QI work commencing with aim to address communication within department.	31/03/2021 31/03/2021	

		Initial Risk		Current Risk		Target Risk													
ID	Opened date	Rating (initial)	Risk level (initial)	Rating (current) (Consq x Likli)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Directorate	Corporate Objectives	Title	Description	Controls Assurance	Gaps in controls Assurance	Assurance	Gaps in assurance	Action Plan	Due date for Action Plan	Done date for Action Plan
1219	30/04/2020	20	EXTREM	20 (4x5)	EXTREM	1	LOW	Director of Acute Hospital Services	Acute Hospital Services	Safe & Effective Services.	Lack of endoscopy capacity for endoscopy to meet the demand which impacts on Patient outcomes	Lack of endoscopy capacity in the Trust has resulted in breaching of the 2 week red flag wait/9 week urgent and routine wait and surveillance targets for endoscopy. The lack of timeliness for endoscopy will lead to delayed diagnosis of cancer and poor outcome for these patients as evidenced in SAIs. The service has been further impacted by Covid -19 where the service has been reduced to emergency and red flag endoscopy only and reduced turnaround times between patients due to IPC requirements.	Telephone pre assessment of colonoscopy on-going to improve list utilisation and reduce DNA rates Independent sector was utilised to deliver 250 surveillance colonoscopies from January to March 2020. Further use of Independent Sector to be explored post Covid -19 Surveillance waiting lists are being validated in line with new guidelines. Discussions have commenced with the commissioner to recurrently fund one of the posts in 20/21 to address the demand/capacity gap. The second post will be funded from a current vacancy. Training of 2 nurse endoscopists under transformation commenced in September 2018 - trainees were to be signed off by the end of 2020 the delay was due to Covid-19. Short-term provision by SE Trust to provide WT in IS tender	Band 4 team lead recruited to manage waiting lists and oversee the scheduling team and processes. Encourage consultants to triage referrals in line with NICAN suspect cancer guidelines (Oct 2019) and utilise the urgent and routine categories. Additional funding for a second pre assessment nurse has been discussed with the commissioner- await confirmation in 2021 allocation	Waiting lists discussed monthly at the Endoscopy Users Group Clinical audits are completed annually to benchmark the service against National Standards. Monthly monitoring of waiting lists is carried out to identify longest waits and prioritise for scheduling.	The need for the Trust to invest further in the development of GI Trainees in line with the evidence base for modernisation, thereby proactively growing the team to meet future demand. The need to develop the service to include the inclusion of a hepatologist as part of the team in line with Royal College modernisation of gastroenterology training and service provision. The need to address the impact of a job plan which includes the medical on-call rota The need to urgently increase the consultant workforce and make the Trust an attractive opportunity for the next round of doctors in training due for recruitment April 2021	Explore the possibility of utilising the Independent Sector to address waiting lists. Need to review GI consultants job plan to reduce General Medicine commitment to increase availability for endoscopy lists. Secure funding for an additional pre assessment nurse to support list utilisation and reduce DNA rates. Secure additional recurrent funding to support 2nd post for trainee nurse endoscopist completing training. Recruitment of a further GI consultant to fill present vacancy and increase the medical team to 6 wte.	30/06/2021 30/04/2021 30/04/2021 30/04/2021 30/04/2021	
1236	21/08/2020	16	HIGH	16 (4x4)	HIGH	8	HIGH	Chief Executive	Finance and Contracting	Financial Management & Performance.	Ability to achieve financial stability, due to both reductions in Income and increased expenditure.	With continued reductions in income from savings requirements coupled with increased expenditure due to demand and risk, there will be a reduction in the Trust's ability to achieve financial stability in the current and future years, resulting in significant challenges in meeting the Trust strategic priorities	Chief Executive Assurance meetings to review performance Recovery Plan Oversight - Directorate, CMT, Trust Board (and Finance & Performance Committee) and DoH Annual Financial Plan to review risks to financial position and opportunities for savings Trust Board (and Finance & Performance Committee) and CMT oversight of the financial position monthly Monthly budget reports for all levels in the organisation, with follow-up variances	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	31/03/2022 31/03/2022	

		Initial Risk		Current Risk		Target Risk													
ID	Opened date	Rating (initial)	Risk level (initial)	Rating (current) (Consq x Likli)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Directorate	Corporate Objectives	Title	Description	Controls Assurance	Gaps in controls Assurance	Assurance	Gaps in assurance	Action Plan	Due date for Action Plan	Done date for Action Plan
1254	18/01/2021	16	HIGH	16 (4x4)	HIGH	9	MEDIUM	Director of Human Resources	Trust-wide (Risk Register Use Only)	Ensuring Stability of Our 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 (4x3)	HIGH	12	HIGH	Director of Performanc e & Service Improvemen t	Trust-wide (Risk Register Use Only)	Ensuring Stability of Our ServicesIm proving the Quality and Experience of Care	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 Oakleaf - 6 facet independent survey	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	