Western Health and Social Care Trust

CORPORATE RISK REGISTER & ASSURANCE FRAMEWORK

BRIEFING NOTE PREPARED FOR Trust Board
2nd December 2021

There are 20 risks on the Corporate Risk Register as approved at Trust Board on 4th November 2021.

Summary

- New Risk to be added to CRR - ID 1338 Due to staffing shortages within neonatal services in the South West Acute Hospital (particularly those staff qualified in specialty), there are difficulties in covering the rotas potentially requiring unit closure/unsafe levels of care provision.
- Summary report for actions
- Update on outstanding actions from Trust Board workshop

Proposed new Corporate Risk (see attached New Risk Form)

Risk Title - ID 1338 - Due to staffing shortages within neonatal services in the South West Acute Hospital (particularly those staff qualified in specialty), there are difficulties in covering the rotas potentially requiring unit closure/unsafe levels of care provision.

Risk Description - Lack of senior staff, particularly those QIS (qualified in specialty) has resulted in difficulty staffing the NICU safely and effectively and has resulted in cot closures (locally and regionally); inadequately covered shifts; high stress and low morale within nursing; difficulty in planning and may result in unit closure.

NICU closure would subsequently destabilise maternity services as babies cannot be delivered at South West Acute Hospital without access to neonatal services.

Risk Grading

Current Risk Rating – Consequence Major (4) x Likelihood Very Likely/Almost Certain (5) = **Extreme** (20)

Target Risk Rating – Consequence Major (4) x Likelihood RARE (1) = **HIGH** (4)

Lead Director – Deirdre Mahon, Director of Women and Children's Services

This risk is being escalated to a corporate risk as NICU closure would subsequently destabilise maternity services as babies cannot be delivered at South West Acute Hospital without access to neonatal services.

Summary report – for action

Risks not reviewed in last quarter
- All risks have been reviewed within the last quarter.

Action plans not up to date
- There is 1 risk with actions overdue which require updating at date of reporting: - ID1320

Update on outstanding actions from Trust Board

Please see attached list of outstanding 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.

Risk ID	Lead Director	Risk Title	Workshop Action	Progress	Update
1216	Acute	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	10-11-2021 - 13 incidents reported since last update 3 red and 10 amber. **Full Capacity Protocol** The Full Capacity Protocol has been updated for Winter 2021/22. **SWAH & ALTNAGELVIN ED Escalation Plan** Hospital Emergency Department Escalation Plans have also been updated to mirror and reflect the full capacity protocol. 19-10-2021 - 22 incidents reported since last update 12 amber and 10 red. 15-09-21 - Internal Escalation Plan revised; Recruitment active for Registered Nursing staff; ED Tracker JD through Desk top review. 19 incidents reported since last update with 4 amber and 15 red. 20-08-21 14 incidents reported since last update with 4 amber and 8 graded as Extreme risk. 19-07-21 9 incidents reported since last update with 3 amber and 4 graded as Extreme risk.

Risk ID	Lead Director	Risk Title	Workshop Action	Progress	Update
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	October 21: The Quality and Standards meeting in collaboration with all Directors and the Risk Management Team are monitoring adherence to NICE Guidelines. This will allow the Trust to understand better the reasons for non-compliance with these guidelines. 18/8/21: Discussed at Quality & Standards Sub-Committee meeting - members acknowledged it was difficult to reduce the current risk level until a better system is in place in Directorates, issues with the software system are remedied and better ways are identified to monitor progress and improvement. Members agreed that this item would continue to be a standing item on future meetings agendae. 18/8/21: Meeting held with Heads of Service, Healthcare & comments received. Meeting planned with PCOPs Directorate Governance on 2/9/21. Dates to be confirmed with Acute & AMHDS.

Western Health and Social Care Trust

Appendix 5 of Risk Management Policy

New Risk Form

Please complete this form if you have identified a risk which needs to be considered for inclusion on the Trust's Risk Register database (Datix). Appendix 3 of the Trust's Risk Management Policy sets out the process that must be followed. The Policy is available on the intranet,web-link:
http://staffwest.westhealth.ni.nhs.uk/directorates/medical/trustdocs/Risk%20Management%20Policy%20July%2019.pdf#search=Risk%20Management%20Policy

The information requested below is required for completion of fields within Datix. Sections marked with an asterisk (*) are mandatory and must be completed. The completed form should then be considered at the appropriate Sub-Directorate/Divisional/Department Governance meeting.

No	Datix Field Name	Data to be included in this Field	
1.	**Title of Risk *** **(please keep this brief e.g. "Risk of Fire in Trust Premises" –)**	Due to staffing shortages within neonatal services (particularly those staff qualified in specialty), there are difficulties in covering the rotas potentially requiring unit closure/unsafe levels of care provision.	
2.	**Facility** **(only necessary if risk relates to one specific facility)**	SWAH	
3.	**Directorate *** **If risk affects 2 or more Directorates, please list relevant Directorates.**	W&C	
4.	**Sub-Directorate *** **If risk affects two or more Sub-Directorates, please list.**	Healthcare	
5.	**Specialty** **Please list most relevant Specialty this risk relates to.**	Neonatal	
6.	**Ward/Department** **(necessary only if risk relates to one specific Ward/Dept)**	SWAH	
7.	**Risk Type*** **Please indicate which organisational level you are of the opinion this risk should be escalated to (please tick)** **NB: This is subject to approval by relevant Senior Manager/Director/CMT – refer to Appendix 3 of Risk Management Strategy (see web-link above) :-**	Corporate	x
		Directorate	
		Sub- Directorate/Divisional	
		Ward Level	
8.	**Risk Category*** Please tick most appropriate category:	• Finance and Efficiency • Health and Safety X • Quality of Care • ICT and Physical Infrastructure • People and Resource • Public Confidence • Regulation& Compliance (Statutory, Professional, Quality Legislation)	
9.	**Corporate Objective(s) affected by this risk*** ***(Please tick appropriate box(es) below)***		
	C01	Improving the Health of our People	X

	C02	Supporting and Empowering Staff	X
	C03	Ensuring the Stability of our Services	X
	C04	Improving the Quality and Experience of Care	X

10.	**Key Performance Indicators to show how the risk is being managed (Please list 3-4) * (e.g. number of incidents, compliance with H&S – number of Risk assessments returned etc)**	1. No. of Incidents 2. Staffing Levels – QIS levels 3. Cot Closures (to be monitored regionally)
11.	**Lead Officer* with responsibility for managing this risk (Name, Job Title, and Contact Details.** **(i.e. manager with operational responsibility)**	Nuala Colton HOS Paediatric and Neonatal Services Ext 214815
12.	**Name of Responsible Director*** **(NB: Where a risk is Cross-Directorate, the most appropriate Director to manage this risk should be listed. It will be their responsibility to liaise with other Directors re management of this risk).**	Deirdre Mahon
13.	**Description of Risk*** Please provide a full description of the nature of the risk. Please limit this to 255 characters and structure to include cause, event and effect	Lack of senior staff, particularly those QIS (qualified in specialty) has resulted in difficulty staffing the NICU safely and effectively and has resulted in cot closures (locally and regionally); inadequately covered shifts; high stress and low morale within nursing; difficulty in planning and may result in unit closure. NICU closure would subsequently destabilise maternity services as babies cannot be delivered at SWAH without access to neonatal services.
14.	**Please list all current control measures in place to manage this risk*** (e.g. policies, procedures, training)	1. Currently we are utilising staff who are willing to do bank/ additional/ overtime hours. Staff have joined a WhatsApp's group and urgent messages sent when staffing is depleted at short notice. 2. Acting Manager and HOS cover clinical shifts when no/ inadequate neonatal QIS nurse/s are available 3. Cot closures may occur in consultation with medical staff and NNNI. 4. SWAH contingency plan drawn up

15.	**Please list all identified gaps in Controls.***	Due to the reduced number of QIS nurses who cover additional shifts, there are occasions when no additional staff can be sourced. This is particularly relevant when there is unpredicted staff absences at short notice. This may result in cot closures/ transfers and in SWAH the local contingency plans will be implemented. Inability to transfer antenatal patients or neonates further adds to this safety issue as these babies will have to either be stabilised for transfer or remain locally. Unpredicted emergencies in both units, with babies requiring high dependency or intensive care- some of which can take a prolonged period of stabilisation.
16.	**Please list all Assurances currently in place to test adequacy of Controls.** (i.e. Audit (Interna/External), inspections by independent organisations, e.g. RQIA, HSENI).	Datix incidents will be reported and escalated to the senior management team. Cot closures monitored regionally.
17.	**Please list all identified gaps in Assurances.**	The unpredictability of women delivering and babies requiring emergency and ongoing care is difficult to plan for. Staffing could potentially be inadequate for stabilising and transfer. There may be a lack of regional cots and neonatal transfer services which results in babies having to stay in the neonatal unit for longer than expected, thus putting more pressure on an already depleted team and increasing the safety risk.

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

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

20. Action Plan to reduce Level of Risk

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

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

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

Question	Response
1. Does the proposed action plan actively manage this risk to ensure that the level of risk can be reduced to the target level?	No, the level of risk remains highly likely as the staffing for QIS/ experienced neonatal nurses remains inadequate, and a high absence level persists.
2. Does the proposed action plan take account of any opportunities that could be exploited whilst managing this risk?	Neonatal nursing is a highly specialised field of nursing and unless staffing is increased and a robust training/ development programme is undertaken this risk will remain. This can only occur with additional staffing/ reduced absence. In SWAH, many of the senior experienced staff have left/ planning to leave in the next year and this leaves a huge void of experienced staff who can safely care for babies requiring a higher level of care. In both units, a rotation programme for newly qualified nurses is introduced but this is in its infancy and needs further development and 'buy-in' from paediatric dept.
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?	The proposed actions are short-term actions only to minimise the current safety risks. Longer terms actions can only be implemented if staffing is increased to ensure BAPM guidance on safe staffing levels are met. A neonatal workforce review had previously been undertaken in 2015 but this work was stalled and has now been restarted in combination with paediatric nursing review. It is not anticipated that this will completed or implemented in the near future. Therefore, monitoring will continue with a review of the number of datix reported and the number of times that cots are closed (this is reported regionally).
5. At what point should the decision regarding the management of this risk be escalated to a higher level?	This is currently escalated to Director level and Director of nursing level.

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

Action Required	**Start Date**	**Due Date**	**Lead Officer**
Regular review of neonatal nursing staffing	13 Oct 21	13 Oct 21	Nuala Colton
SWAH contingency plan shared with MDT and implemented when appropriate to do so.	13 Oct 21	13 Oct 21	Nuala Colton
Nursing cross-cover from paediatric wards. Rotational programme commenced	13 Oct 21	13 Oct 21	Nuala Colton
Bid for additional nursing staff to cover shifts and allow time for training and development	13 Oct 21	13 Oct 21	Nuala Colton/Mary McKenna
Continue cot closures as appropriate	13 Oct 21	13 Oct 21	Nuala Colton
Obstetric and Neonatal meetings when	13 Oct 21	13 Oct 21	Nuala Colton

appropriate			
Liaise with NNNI when staffing depleted/ transfers required	13 Oct 21	13 Oct 21	Nuala Colton
Continue to monitor clinical incidents/ staffing shortages	13 Oct 21	13 Oct 21	Nuala Colton

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)

WHSCT Corporate Risk Register 25/11/2021

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	17	No change	0	Actions listed with future due dates	11th November 21 - Trend report on work acquired staff Covid infections from 01/10/20 – 11/11/21 monthly figures as follows:- Oct101;Nov72;Dec74;Jan59;Feb14;Mar7;Apr3;May1;Jun1;Jul7;Aug12;Sep7; Oct8. There were 52 incidents reported to Health & Safety Executive (RIDDOR reportable) from 01/08/2021 - 11/11/2021 of which 34 were Covid-19 related infections. Cumulatively 458 incidents were reported as RIDDOR relating to covid at 11 Nov 21. Current compliance rates for submission of annual risk assessments is as follows: Acute - 95%(88) compliance; AMHLD - 99%(82) compliance; PSI - 79%(23) compliance; PCOP - 63%(71) compliance; W&C - 62%(42) compliance.
Quality of Care	6	Director of Women & Children's Services	Children awaiting allocation of Social Worker may experience harm or abuse	25	EXTREM	12	HIGH	8	HIGH	47	No change	0	Actions listed with future due dates	November 21. Social Work capacity remains an issue for all Trusts. The Women & Children's Senior Management Team continue to closely monitor all unallocated cases.
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	51	No change	1	Actions listed with future due dates	Oct 21 • The Trust continue to work with the Regional Cybersecurity Programme on the existing Cyber programme. • A Regional Information Security Policy has being developed by the Regional Cybersecurity Programme Board and has been issued to Trust for adoption. This is currently been taken through approval stages within the Trust. • DHCNI have just launched the Regional Cybersecurity Strategy. The Regional Cybersecurity Programme Board are currently developing a Cybersecurity Work Programme based on the new Strategy. Trust will be required to develop local work plans using this programme template. • Trust Governance arrangement for Cybersecurity, including cyber awareness and training are being reviewed in conjunction with our Emergency Planning and Business Continuity Strategic Forum. Contemplating the establishment of a Cybersecurity Oversight Sub-Committee with membership nominated from EP&BCSF.
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	No change	0	Actions listed with future due dates	Oct 21 - SAIs overdue 47(50 previous month). 37 (22) formal complaints open greater than 20 working days. 1909 (2006) incidents open greater than 3 months.

WHSCT Corporate Risk Register 25/11/2021

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	58	No change	0	Actions listed with future due dates	10 November 2021: An Information Governance Audit received a limited assurance rating in July and the following actions are in place to address the recommendations: • All directorates have been assigned IG training targets • Training has been provided for Information Asset Owners and Assistant IAOs • All IAOs asked to update Information Asset Register • All IAOS to provide a formal Assurance to the Senior Information Risk Owner (Mrs Teresa Molloy) • All actions will be reviewed by the Information Governance Steering Group • A new IG Hub on StaffWest has been updated with Records Management guidance for categorising and storing of records • Work is commenced to review the medical records function in SWAH/Omagh.
Regulation & Compliance	719	Director of Women & Children's Services	Risk of failure to meet a standard/protocol/guideline.	20	EXTREM	12	HIGH	8	HIGH	82	No change	1	Actions listed with future due dates	Update October 21. The Quality and Standards meeting in collaboration with all Directors and the Risk Management Team are monitoring adherence to NICE Guidelines. This will allow the Trust to understand better the reasons for non-compliance with these guidelines.
Regulation & Compliance	955	Director of Finance	Failure to comply with procurement legislation re social care procurement	12	MEDIUM	12	MEDIUM	4	LOW	61	No change	3	Actions listed with future due dates	Aug 21 - Dom Care Tender progressing. Trust aligned with Regional Approach to Social Care procurement Light Touch Regime 8 year plan.
People & Resource	1075	Director of Finance	No Deal Scenario / Hard Border EU Exit	12	HIGH	16	HIGH	4	LOW	36	No change	1	Actions listed with future due dates	Oct 21 -On 13th October 2021 the EU came forward with their legislative proposals on the NI Protocol in response to difficulties in existing arrangements as expressed by the UK government. Negotiations between the UK and EU are ongoing as of 26th October 2021. The DOH regional Arms Length Bodies meeting re-convenes on 9th November 2021 so we hope to obtain a formal update. General Supply Chain: In terms of the Trusts holding contingency non-stock, the advice from DOH and BSO (as of 28th September 2021) is still to retain the buffer non-stock supplies and rotate those items (in line with shelf life) into usage. Until the grace periods, including parcel handling, have been surpassed or removed, there is still a risk of logistical barriers. Dual Registration of Trust Staff As regards social work personnel this has been a cumbersome process. As of 13th September there were approximately 60 SW staff needing to be registered with CORU. A process for payment has been agreed through Trust Finance and staff are to be given protected time to go through the application process. As well as a €450 recognition fee, there may be an annual fee of €100 which requires a solution.

WHSCT Corporate Risk Register 25/11/2021

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	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	16	No change	2	Actions listed with future due dates	September 21 - Actions from the SAIs are being taken forward with the oversight of the project group, and a trial of nebulised air is due to commence in October, with a view to rolling out this approach, which if successful would ultimately replace the need for medical air wall outlets.
Regulation & Compliance	1183	Director of Adult Mental Health & Learning Disability	Where MCA processes are not being followed, patients may be deprived of their liberty, without having safeguards in place	25	EXTREM	20	EXTREM	12	HIGH	5	No change	2	Actions listed with future due dates	September 21 - review of risk and actions.
Quality of Care	1213	Trust-wide (Risk Register Use Only)	COVID-19 risk re assess & response to patient/client need & maintain quality & safety for patients/clients and staff	20	EXTREM	20	EXTREM	10	HIGH	18	No change	0	Actions listed with future due dates	Nov21- There has been 13 red and amber incidents regarding ED capacity in the last month. The ED action plan was discussed at RRG and 7 themes were highlighted around which actions are being taken forward- (1)10 New Band 5 Staff Nurse posts (2)Funding for additional band 6 Nurse(3)Ongoing work to improve flow between ED and Ward space(4)Full Capacity Protocol: Awaiting final approval (5)Triage Nurse Staff Shortage: 38 Nurses trained in triage (6)Ambulance Turnaround: New build offload area (7)Funded Band 5 Nurse posts to manage Ambulance offload area. Agreement at CMT that Access control to the main hospitals is to be removed for a 4 week period initially with appropriate signage to be erected along with Trust communication to remind staff that it is everyone responsibility to maintain Covid safe envronment
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	19	No change	0	Actions listed with future due dates	10/11/2021 - 13 incidents reported since last update, 3 red and 10 amber. **Full Capacity Protocol** The Full Capacity Protocol has been updated for Winter 2021/22. **SWAH & ALTNAGELVIN ED Escalation Plan** Hospital Emergency Department Escalation Plans have also been updated to mirror and reflect the full capacity protocol.
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	8	No change	0	Actions listed with future due dates	10/11/2021 - There is no change 24/09/ 2021- Further reduction of endoscopy capacity due to redeployment of Nursing staff. Endoscopy services was partialy stood down on the 6th of september 2021. Endoscopy activities at OHPCC was stood down for 2 week. Altnagelvin capacity was reduced from 3 operating rooms to 2 rooms. 334 appointments were cancelled, 153 has been rescheduled. On 21/09/2021 activities in OHPCC was restored. However, Altangelvin's situation remains the same with weekly lost capacity 63 appointments per week.
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	14	No change	3	Actions listed with future due dates	Aug 21 - The Director of Finance and Chief Executive continue to make progress on its Recovery Plan and are engaging with HSCB/DoH on their contribution to same. Trust Director of Finance and Chief Executive are engaging with DoH & HSCB as part of a HSC system-wide approach to finance sustainability.

WHSCT Corporate Risk Register 25/11/2021

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	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	9	No change	1	Actions listed with future due dates	October 2021: Work is progressing as per the action plans for the four workstreams outlined in the HR Directorate Plan. These were reviewed through HR Governance on 12/10/21 with progress noted against all. A number of amber and red incidents have been reported in recent weeks relating to workforce shortages and supply issues which are impacting on the delivery of the range of Neonatal services at SWAH. The Neonatal Unit (NNU) has been closed to external admissions and the threshold has been increased to 36 weeks to reduce the risk of babies that may need to transfer to NNU. Maternity services across both hospitals is also declaring red incidents in relation to staffing over the last number of weeks.
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	7	No change	0	Actions listed with future due dates	Nov 21 - Trust received a letter from CMO requiring development and implementation of an Aspergillus policy for all Trusts within the region. WHSCT is setting up a task and finish group to action this. Estates Dept continue to complete and submit business cases to complete addition BLM funding works
Quality of Care	1306	Acute Hospital Services	Vacant Paediatric Ophthalmology consultant post resulting in no Paediatric Ophthalmology clinics	16	HIGH	16	HIGH	4	LOW	4	No change	0	Actions listed with future due dates	10/11/2021 - There has been no change Sep 21 - At present we do not have a paediatric ophthalmologist in the Western Health and Social care Trust and we are liaising with the Belfast Trust also in regard to this. The Clinical Leads for WHSCT and BHSCT along with the Health and Social Care Board are working together to deal with the waiting times for paediatric ophthalmology across the province. Patients are being triaged by our consultants depending on clinical need and being referred to the Belfast Trust as appropriate. We have recruited a locum Doctor who is helping with the ROP screening service along with Mr Mulholland and Dr Nour. Every Tuesday there is a ROP screening meeting with the Belfast Trust to discuss the cases. Squint surgery has still not recommenced in the Belfast Trust and we are looking at out sourcing this surgery due to the backlog and the clinically indicated timeframe for treatment of these patients.
Quality of Care	1307	Director of Women & Children's Services	Clinical Risk regarding Delayed Transfer of Babies, Children and Adults to Other Hospitals	25	EXTREM	25	EXTREM	10	HIGH	1	No change	1	Actions listed with future due dates	Update Oct 21: There are still issues re the availability of the regional transfer team which is resulting in delayed transfers or Trust staff having to facilitate the transfer which leaves the core staff depleted. Situation being closely monitored by senior Managers.
Quality of Care	1316	Director of Performance & Service Improvement	Service Re-build post Covid surge	12	HIGH	12	HIGH	6	MEDIUM	3	No change	0	Actions listed with future due dates	November 21 - A suite of Flexible/Agile working policies and procedures are in final draft, anticipated that these will be signed off in the New Year. The Corprorate Comms Team continue to work directly with services to ensure communications are tailored to each area.
Quality of Care	1320	Director of Women & Children's Services	Delayed/inappropriate placement of children assessed as requiring inpatient mental health care.	12	HIGH	12	HIGH	8	HIGH	1	No change	1	Actions Overdue	Oct 21 -This risk remains the same. It is a regional risk which is beyond the ability of the WHSCT to address. The appropriate staff are in regular discussions with the Region in relation to this situation.

Corporate Risk Register and Assurance Framework - 25/11/2021

		Initial Risk		Current Risk		Target Risk												
ID	Opened date	Rating (initial)	Risk level (initial)	Rating (current) (Consq x Likli)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Directorate	Corporate Objectives	Title	Description	Controls Assurance	Gaps in controls Assurance	Assurance	Gaps in assurance	Action Plan	Due date for Action Plan	Done date for Action Plan
3	19/11/2008	16	HIGH	20	EXTREM	4	HIGH	Medical Director	Trust-wide (Risk Register Use Only)	Governance. Safe & Effective Services.W orkforce.	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-low beds, hoists. Patient/client risk assessment. Leadership Walkrounds. KPI for health & safety, e.g. falls. Falls Risk Assessment. Falls Prevention Policy. Ligature risk assessment tool adopted Falls - Regional Post falls review; Falls Co-ordinator in post 2018; Falls Learning Group; CEC Falls Prevention course 2018 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 Labs representative on Health & Safety Working Group Four officers in Risk Management are NEBOSH qualified including H&S officer COSHH added as standing item to	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 Limited availability of risk register to managers to allow direct management of risks No overall database of trained nominated H&S officers by facility	RQIA inspections. Internal Audit of H&S Controls Assurance Standard (2017/18). Benchmarking by Regional H&S Practitioners Group. Inspections by HSENI. Inspections by H&S Officer and H&S Working Group members. Review of Incident data by H&S Working Group (inc. Union reps). Inspections by Regional Medical Physics Services Advisers. Sharepoint site for H&S Risk Assessments. Monitoring of implementation of recommendations following inspections/Leadership walkrounds. BSO Internal Audit of H&S (June 2017). Manual Handling Audit at Altnagelvin Hospital (July 2013 and re-audit September 2014)	Learning themes across Incidents and Claims	Include compliance scores on H&S Risk Assessments reports. Develop and roll out virtual training Agree process for reporting Covid RIDDOR incidents Review monthly Ongoing Advice & Guidance re Covid in Trust docuemnts & 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 Review of Fit Testing policy / protocol	30/06/2019 31/12/2020 15/05/2020 31/03/2022 31/03/2022 31/03/2020 31/03/2020 31/07/2019 31/03/2020 31/12/2021 31/05/2021	31/03/2019 31/12/2020 15/05/2020 09/03/2020 09/03/2020 31/07/2019 29/02/2020 31/05/2021
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 Principal Social Work redeployed will monitor Action Plan and progress to stabilise team Service Managers and Social Work Managers monitor and review unallocated cases on a weekly basis. 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. Delegated Statutory Functions Action Plan to review and Address Risks within FIS Enniskillen		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

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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
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 webfiltering) HSC security hardware (eg firewalls) 3rd Party Contracts / Data access agreements Contract of employment HR Disciplinary Policy Mandatory traiing policies Induction policy Regional and local Incident Management & reporting policies & procedures Corporate Risk Management framkwork, Processes & monitoring Emergency planning & Service business continuity plans Disaster recovery plan Ussr account management processes Change control processes Data protection Act Regional & Local ICT info security policies Band 7 & band 6 recruited to support Cyber security Trust and Regional Cyber Project Boards ICT Security Assessment Questionnaire	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 Current inability to obtain 100% coverage on patch updates due to a combination of user behaviours and service needs	Internal audit / IT Dept self-assessment against 10 Steps towards NCSC Technicial risks assessments and penetration tests HSC SIRO Forum for shared learning and collaborative action planning and delivery ICT Security Review meetings regularly reviews and assesses service submitted ICT Security Questionnaire	There is a resource issue regarding Cyber Staff in the Trust. The Business Case that was approved should address this pressure however experience from other Government Organisations would sugges that is difficult to attract and retain specialist skills in this area. Unable to have consistent patching of crtical/core serves due to service disruption. Limited testing of Data and Systems restores.	Implementation of cyber security work plan which has been agreed with the Region. Recruitment of Band 7 Cyber Security Manager. Recruitment of Band 6 to support implementation of Cyber Security Action Plan. Full implementation for Metacompliance across the Trust with regular course updates being issued thereafter. Introduce routine reporting to Trust Board (or other equivalents (local or regional)) on reported incidents/near miss, and other agreed indicators.	31/03/2022 31/03/2019 31/03/2019 31/03/2020 31/08/2018	 28/02/2019 31/03/2019 31/08/2019 31/08/2018
57	06/10/2009	16	HIGH	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 Automated email to reporters with	Learning from Audits that are carried out without knowledge of Audit Department may not be implemented. Significant delays in incidents being reviewed and closed in a timely fashion. Datixweb Complaints modules not yet implemented which limits triangulation of data for learning Learning themes not yet applied which could focus action on broad areas for improvement No system for providing assurance that learning ientified has been shared and practice changed.	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.	Revision of Governance arrangements under Covid-19 Learning Themes developed for Litigation cases Falls learning template system adopted Automated email to reporters with Learning from incidents through Datix upgrade Develop SAI training incl family engagement Upgrade Datix to facilitate Automatic Datix feedback Roll out of standard learning reports on Datix Trust SAI learning event Establish Learning site on Sharepoint Business case for Datixweb Risk, Dashboards and Complaints module Learning themese being deveoped regionally for Litigation Learning from Project responding to RQIA AMHDS Improvement	31/05/2020 31/03/2017 31/03/2017 30/09/2017 30/09/2018 31/01/2017 31/12/2016 31/10/2019 31/12/2021 31/01/2020 31/12/2018 31/12/2020 31/03/2021 31/12/2021 30/11/2020 31/12/2021 30/09/2021 31/03/2021	30/04/2020 31/03/2017 01/02/2017 18/09/2017 10/09/2018 15/02/2017 30/11/2016 03/10/2019 31/01/2020 31/12/2018 01/12/2020 31/03/2021 30/11/2020 31/07/2021 31/03/2021

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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 sensitiv	As a result of gaps in staff awareness and training in data protection requirements and non-adherence to retention and disposal guidance, there is a risk that personal or sensitive data could be lost, inappropriately stored or accessed; records could be retained beyond their lifecycle and lead to a breach of confidentiality and the Data Protection Act, DoH Good Management Good Records Guidelines and result in potential enforcement action from the Information Commissioners' Office alongside damage to the Trust' reputation.	Subject Access and Data Access agreement procedures. Information Governance/Records Management induction/awareness training. 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. Data Guardians role. Regional DHSSPS Information Governance Advisory Group. Electronic transmission protocol. Investigation of incidents. 2 secondary storafe facilities available across NS & SS Trust Protocol for Vacating & Decommissioning of HSC Facilities. Scoping exercise to identify volume and location of secondary close records completed in December 2010. band 3 post in place Review of regional IG training available on HSC Learning completed and updated to provide more robust training fro staff.	Potential that information may be stored/transferred in breach of Trust policies. Limited uptake of Information Governance and Records Management training. No capacity within the team to take on provision of IG training	Reports to Risk Management Sub-Committee/Governance Committee BSO Audit of ICT and Information Management Standards. BSO Internal Audit of Information Governance. Revised composition and terms of reference of the Information Governance Steering Group as a result of the new SIRO/IAO framework.		Band 3 0.5 post inceased to full time Recruitment of Band 4 Information Governance Development of information leaflet for Support Services Staff to increase awareness of information governance Review of regional e-learning IG training Establishment of Regional Records Man Group 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 Review of Primary (acute) records storage in AAH Review of Secondary storage in Maple Villa Production of Records Storage guidance for home working staff working from home	31/03/2019 31/03/2019 31/03/2019 31/12/2020 30/09/2020 30/09/2020 31/12/2020 30/09/2020 28/02/2022 31/03/2022 31/12/2021	31/03/2019 28/02/2019 01/03/2019 25/11/2020 30/09/2020 30/09/2020 31/12/2020 30/09/2020 09/09/2021
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.	Standards & Guidelines recorded on central database. Approved system in place for disseminating standards and guidelines. Lead Officer assigned to each standard and guideline. Updates requested from Clinical/Professional Leads on quarterly basis for standards on 'Ongoing' Dashboard 'Not on Track' template completed for each NICE Guideline that is unable to be fully implemented The Trust identifies the standards, policies and protocols/guidance not fully met and the rationale for that position, report to Quality & Standards Sub-Committee and escalate as appropriate to Trust Governance Committee. Standards & Guidelines related reports are provided quarterly to Directorate Governance Committees and Quality & Standards Committee. Annual reconciliation of information held on database against dashboards	Engagement and Ownership within Directorates is not consistent in highlighting non-compliance/patient safety issues and appropriately escalating risks. Existing timelines for responses/updates are not always adhered to Need for regional coherence/approach to enable implementation of some NICE Guidelines Lack of engagement with 3rd Party Provider re Standards & Guidelines system Capacity within Governance team to manage standards & guidelines	Trust provides bi-monthly assurance report relating to NICE Guidelines to HSCB/PHA BSO Internal Audit audit of processes - reports received December 2015 & January 2021 - Satisfactory Assurance RQIA Audit of selected guidance.	Capacity to follow up on all outstanding guidelines - growing list Difficulty getting feedback from clinical/professional leads	Enhancement 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 Organise Workshop re Arrangements in Directorates for managing NICE Guidelines Reconcile information held on database with 'ongoing' and 'unable to fully implement' Excel spreadsheets. Recurring Secure engagement with 3rd Party Provider Review and follow up of 'unable to be fully implemented' guidelines Directorates to review	31/03/2022 31/05/2017 31/05/2021 31/03/2017 30/06/2021 31/03/2022 31/12/2021 31/03/2022 31/03/2022	27/07/2017 14/05/2021 30/06/2017 30/06/2021
955	11/08/2016	12	MEDIUM	12	MEDIUM	4	LOW	Director of Finance	Trust-wide (Risk Register Use Only)	Financial Management & Performance. Modernisation.Public Confidence.	Failure to comply with procurement legislation re social care procurement	The risk that the Trust will breach UK procurement legislation rules in awarding contracts for the provision of social care services. The legislation outlines that a formal tender process must be followed when awarding contracts that are expected to be above a specified threshold. This is to be managed by BSO PaLS on behalf of all Trusts but the current proposed work programme means that Trusts will not be fully compliant with the legislation for a period of 5 years ending on 31 March 2022.	The issue has been discussed at the Trust's Procurement Board and Social Care Procurement Group. The Trust's Director of Finance & Contracting has highlighted this issue to the Regional Procurement Board.	The Trust does not have the resource or infrastructure required to manage this risk internally. DOH has determined that the issue should be managed regionally.			The 5 year implentation plan will continue to be monitored - via Regional Procurement Board, Trust Procurement Board and Social Care Procurement Group.	31/03/2022	

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1075	23/08/2018	12	HIGH	16	HIGH	4	LOW	Director of Finance	Trust-wide (Risk Register Use Only)	Partnerships. Public Confidence. Safe & Effective Services.Workforce.	No Deal Scenario / Hard Border EU Exit	With the imminent EU exit, there is potential for a No Deal Scenario or Hard Border between Northn and South of Ireland. The full impact of the UKs exit from the EU is not yet known and given uncertainty around the UK EU ongoing discussions and potential agreements, there may be impacts such as - workforce, including recruitment and retention, changes to regulations, movement of people and goods, border controls and access to healthcare in EU member states. Day one delivery planning is required to ensure services continue to operate effectively on day one following EU Exit and in the longer term, and that there is no, or minimal disruption to services. Although this is categorised as an organisational risk it also has implications for clinical risk, financail risk, patient and client safety and staffing issues/levels. Lead Officer is Paul Quigley and Reponsible Director is Lesley Mitchell, Director of Fiannce and Contracting.	EU Exit Task & Fnish Group in place incldiung 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 eg 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, incldiung 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	The DOH reported that further discussion at the EU Exit ALBs meeting has clarified that disruption to healt and social care services is not anticipated as a result of any impediment to movement of people at the border and that existing business continuity plans and mitigating actions for potential staff shortages should apply and suffice. Anne Kilgallen, Trust CE has fortnightly meetings with Richard Pengelly and CE of HSC - of which EU Exit and associated continuity planning progress are discussed.	Continued regular update internal EU Exit Meetings and updates to CMT. Application of any regional or strategic directives on EU exit. Trust representatives continue to be involved in regional working groups led by DoH in order to inform and assist the Trust in EU Exit Planning. Next meeting due to take place on 21 Januar Assurance Statement to be forwarded from the CE to the Permanent Secretary, DoH confirming that the Trust is actively scoping the potential impact of a no deal outcome from the UK EU negotiations on the services provided by the Trust etc Detailed Review of Mitigating Actions to be completed - Continuity plan Lead Officer to brief	31/12/2020 21/01/2019 24/01/2019 22/11/2018 17/12/2018 28/12/2018 28/01/2019 21/01/2019 12/02/2019 05/02/2019 04/03/2019 11/02/2019 30/11/2020 31/12/2020 31/12/2020 31/12/2021 31/12/2021 31/12/2021 31/12/2019	31/12/2020 21/01/2019 29/06/2018 24/01/2019 22/11/2018 17/12/2018 03/12/2018 28/01/2019 21/01/2019 12/02/2019 05/02/2019 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	EXTREM	5	HIGH	Executive Director of Nursing, Primary Care and Older Peoples Services	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Risk to safe patient care relating to inappropriate use of medical air	Risk of patient receiving medical air in error when oxygen is required resulting in hypoxia.	Regional procurement process - will no longer be able to buy a medical air flowmeter without a flowguard In the Trust's clinical procedures for medical gases Included on the medical gas training for wards Medical air blanking caps have been circulated to wards to insert into outlets that wont be used Colour coding of medical air flowmeters and air outlet on most wards Flowmeters with air-guards attached on all wards now.	Lack of knowledge of colour coding and appreciation of risks with medical gases Potentially have old flometers that are not fully compliant with colour coding (not mandatory) Not all medical air flowmeters had airguards but they do now Incidents are continuing to happen during 2020, lack of confidence that the actions taken last year are being adherred to in all areas - further review of processes and controls undertaken 29 May 2020. Lack of knowledge of colour coding and appreciation of risks with medical gases	Walk around to be carried out in SWAH/OHPCC although they have new flowmeters with air-guards. Walk around on Altnagelvin site occurred in November 2018. To be repeated February 2019. To be picked up on annual medical gases walkaround. No external inspections Update 05 June 2020 - Lead nurses and service managers have been asked to provide assurances on the actions taken in response to the revised controls for each of their designated areas of responsibility. May 2020 update - regular Walk arounds to be undertaken on all hospital sites until assurance in place.	Lack of training on medical gases. This has increased now since included in Trust Combination training days.	SAI reviews 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	31/12/2021 31/12/2021 31/12/2019	 31/12/2019 31/12/2019 31/12/2019 31/12/2019 31/12/2019

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1183	27/11/2019	25	EXTREM	20	EXTREM	12	HIGH	Director of Adult Mental Health & Disability Services	Adult Mental Health & Disability Services	Governance. Safe & Effective Services.	Where MCA processes are not being followed, patients may be deprived of their liberty, without having safeguards in place	Where MCA processes are not being followed, there is the risk that patients may be deprived of their liberty, without having the relevant safeguards in place, with the result that individual staff may be held criminally liable with appropriate sanctions, including financial penalties and imprisionment. For patients that lack capacity and for whom safeguards are not in place, there is the risk that statutory servies may not be delivered. Emergency provisions should be considered where deemed appropriate, to support continuing service delivery until the safeguards are approved. 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. 	Staff training is available online & classroom, provided by Trust Trainers. Progressing interactive online training via VC. Training videos developed MCA resources are available via MCA HUB on StaffWest DOLs office supports administration processes, including advice to support completion of forms 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. Emergency provisions to be used, where deemed appropriate, to support continuing service delivery until the safeguards are approved. Directorate resource to support Directorate related MCA activity	Medic capacity to ensure timely completion of relevant forms and sit on Panels Queries from NIRT / requirement for submission of evidence to hearings is an additional task on top of current job plans. Role of Community Teams in making DOLS applications to be strengthened Role of Managers in quality Assuring DOLS applications to be strenghtened	RQIA monitoring role MCA Information T&F group (systems, processes & reporting) Trust is engaging with regional arrangements to share practice and develop solutions MCA Project Board held monthly. Training T&F group Mental Health Order MCA Project Team	Systems, Processes & Reporting to be strengthened & formalised - Regional Direction required but none identified	Engage with programme board and team Scope potential Mental Capacity/DoLs assessments A Programme Implementation Officer to continue engaging on leading implementation. Trust Lead Directors and Responsible leads in each Sub-Directorate to be identified 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 Seek Interest from relevant staff to sit on panels. Ensure sufficient staff attend training to allow them to undertake statutory functions commencing 2nd	31/12/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2020 29/10/2021 31/03/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2021 30/07/2021 31/12/2021 31/12/2021	31/08/2019 02/12/2019 31/08/2019 31/08/2019 01/11/2019 01/12/2019 25/10/2021 31/03/2020 31/03/2020 02/12/2019 31/01/2020 21/04/2021 21/07/2021
1213	04/04/2020	20	EXTREM	20	EXTREM	10	HIGH	Medical Director	Trust-wide (Risk Register Use Only)	Governance. Safe & Effective Services.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 rebuild of services following/during surge, 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 saftey huddles for noting and actions)	No Regional process/guidance for approving donated PPE Covid-19 Independent sector reporting	Update risk to second surge environment Develop Covid risk & control document Facilitate daily monitoring and reporting on Risks Monitor, manage and update Risk & Control document	31/10/2020 31/05/2020 31/05/2020 31/12/2021	20/11/2020 31/05/2020 31/05/2020

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1216	15/04/2020	15	EXTREM	15	EXTREM	5	HIGH	Director of Acute Hospital Services	Acute Hospital Services	Public Confidence. Safe & Effective Services.	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. Full capacity protocol	31/03/2022 31/12/2021 31/12/2021	
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 200 patients identified and moved to the independent sector.	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 31/03/2022 30/11/2021 30/11/2021 31/03/2022	05/10/2021

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1236	21/08/2020	16	HIGH	16	HIGH	8	HIGH	Director of Finance	Finance and Contracting	Ensuring Stability of Our Services	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	
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 CareSuppo rting and Empowering Staff	Inability to deliver safe, high quality and sustainable services due to workforce supply and disruptions	Due to an inability to attract, recruit and retain staff throughout the Trust, services may not be able to maintain sufficient staffing levels to sustain high quality safe services which may result in a reduction in service provision.	Trust Business Continuity Plans with full HR support on hospital / community workforce groups. Delivering Care: Nurse Staffing in Northern Ireland Organisation Development Steering Group Health and Wellbeing Strategy Engagement & Involvement Strategy DOH Workforce Strategy & Trust Workforce Strategy and key actions Trust EU Exit Group - Contingency Planning processes i.e. workforce, data sharing, etc. (Risk 1075) Professional Guidance - Telford, Royal Colleges, NI Delivering Care (N&M) Policies - Rec & Selection Framework, Attendance at Work, Flexible Working, Redundancy and Redeployment, etc. Safety Standards HR Strategic Business Partner identified for each Directorate Pension information sessions Joint Forum, Joint LNC and Consultation Group Workforce Information reports provided to key stakeholders Trust Healthcheck information - absence, appraisal, mandatory training, agency usage, etc. Trust Governance Arrangements - People Committee	Occupational Health - absence of locums and increasing demands on team without additional resources. Low uptake of mandatory training and completed annual appraisal. Inability to follow normal policies and procedures during periods of Industrial Action and also during emergency situations such as Pandemic. Lack of co-ordinated information on agency staffing Due to demand in services compliance with Working Time Regulations and New Deal. BSO Recruitment Shared Service provides recruitment services for the Trust and there has been an increased delay in recruitment and dependence on them for related information. Inability of NIMDTA to provide required number of Junior Doctors for certain specialities and localities. (Risk 694) Difficulty in recruiting in rural areas and accessing cover when needed in those areas i.e. Domiciliary Care Workers. (Risk 547) Insufficient applicants for medical, nursing and social work posts. (Risks 6,1109)	Working Together Delivering Value Health check measurements on absence hours lost, mandatory training, appraisal, time to fill posts, job planning completion rate. Involvement Committee - Quarterly monitoring of staff engagement on initiatives that contribute to achievement of Trust Great Place ambitions (start life, live well and grow old). Pension Regulator Compliance Junior Doctors Hours monitored twice yearly and returns submitted to DOH. People Committee - Workforce Strategy, Recruitment and NIMDTA Allocation Updates twice per year. People Committee - Quarterly monitoring of Absence, Appraisal, Mandatory Training, Consultant Job	BSO Shared Service not meeting statutory or procedural deadlines resulting in, for example, delays in recruitment Government/Department of Health managing a number of risk mitigation issues associated with EU Exit including cross border matters. (Risk 1075) Inability of NIMTDA to fill all posts. Insufficient number of social work student applications to the University Degree Course in rural areas. (Risk 1109) Insufficient training places being procured by Department of Health to meet the demands of medical and nursing workforce. HMRC Regulations and impact for staff HSC Pension particularly high earners. Impact of McCloud and Sergeant Employment Law cases. Safe staffing model for	Looking After our People Growing for the Future Belonging to the HSC New Ways of Working	31/03/2022 31/03/2022 31/03/2022 31/03/2022	
1288	08/04/2021	12	HIGH	12	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 BLM and Capital Plan Project Delivery for 21/22	31/03/2022 30/09/2021 30/04/2021 30/04/2021 30/09/2021 30/09/2021 31/03/2022 31/03/2022	07/09/2021 03/08/2021 03/08/2021 07/09/2021 07/09/2021

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1306	16/06/2021	16	HIGH	16	HIGH	4	LOW	Director of Acute Hospital Services	Acute Hospital Services	Ensuring Stability of Our Serviceslm proving the Quality and Experience of Care	Vacant Paediatric Ophthalmology consultant post resulting in no Paediatric Ophthalmology clinics	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.	ROP screening performed by retinal consultants as a temporary measure Urgent paediatric cases discussed with general ophthalmologists for referral to Belfast as required.	No consultant oversight for orthoptics and optometry increase clinical risk Significant clinical risk in ROP screening by consultants without Paediatric fellowship.	Ongoing discussions with commissioners as regards filling the post.		Advertise new agreed post Agree shared contract with Belfast (50% in WHSCT)	31/03/2022 31/03/2022	
1307	16/06/2021	25	EXTREM	25	EXTREM	10	HIGH	Director of Women & Children's Services	Women & Children's Services	Supporting and Empowering Staff	Clinical Risk regarding Delayed Transfer of Babies, Children and Adults to Other Hospitals	Due to limitations on the NISTAR resource and ability of Trust to facilitate transfers that don't meet NISTAR protocols and lack of clarity around same, time critical transfers are being either delayed or are completed using sub-optimal alternatives. This may result in harm to patients being transferred, the patients in the services covering the transfer as well as additional financial cost to the Trust.□ □					Escalate to Director of Acute services for discussion with counterpart in Belfast as he/she is responsible for NISTAR. Raise at corporate safety huddle and RRG Escalate through child health partnership.	31/03/2022 31/03/2022 31/03/2022	
1316	16/07/2021	12	HIGH	12	HIGH	6	MEDIUM	Director of Performance & Service Improvement	Trust-wide (Risk Register Use Only)	Ensuring Stability of Our Services	Service Re-build post Covid surge	If re-build of services is not effectively risk assessed, planned and coordinated Trust wide, re-opening of services could be delayed or create risks in other areas which are unprepared, or result in services being opened in a sub-optimal Covid-safe environment. This may result in delays for service users awaiting appropriate treatment and care, potential for harm to staff/ service users where Covid safe environment compromised and damage to the reputation of the Trust.	Ongoing Fit testing / PPE management, training and Posters Intranet Covid19 site to ensure information shared across the Trust Regional PPE Group; Regional Discussion Group Regional IPC cell and Product Review Group Health & Safety Policy Guidelines on Management of COVID-19 as PHE COVID zoom training for acute and community, PPE videos completed for acute care and domicillary care IPC policy and procedures, mandatory IPC training, IPC audit process Revised Governance arrangements - Corporate Safety team 3 Planning groups; Acute; Community & Support Services, Trust PPE advsiory group Business continuity activated with 3 Bronze Control rooms: - Altnagelvin Acute; SWAH Acute; Communit Community planning group - follow up of clusters in Indep sector Community Oversight Governance group Clinical Advisory Group Ethics Committee Continued testing services for staff	Storage issues in Altnagelvin with PPE Storage requirements and service rebuild Inappropriate storage for records due to displacement for PPE/ Tea rooms under Covid environment Lack of Corporate comunication clarifying Home working requirements in context of re-build and safe working Re-build risk assessments not completed W&C - need for additional staff to undertake the screening questionnaires Poor Vaccine uptake in Band 5 nursing We don't routinely screen staff for Covid Work force appeal staff remain key to service delivery in some areas but not funded. There will be a risk to elective service in the event that we experience a further early surge	Covid dashboard Silver various reports e.g. bed occupancy, ED monitoring, Covid app Sit rep report Governance assurance framework		Agile Working Guidance Re-build Risk Assessment Guidance Record Storage Communication Action Plan Safe Working Job Profiling Promotion of Covid 19 Vaccine for Staff Trust Working Flexibly and From Home Policy	31/01/2022 31/12/2021 31/12/2021 31/12/2021 30/09/2021 31/12/2021 31/01/2022	10/11/2021 20/07/2021

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1320	15/09/2021	12	HIGH	12	HIGH	8	HIGH	Director of Women & Children's Services	Women & Children's Services	Improving the Quality and Experience of Care	Delayed/inappropriate placement of children assessed as requiring inpatient mental health care.	Increasing demand for the need for inpatient beds has resulting in capacity issues within the regional adolescent mental health inpatient unit. There is significant challenges for CCAMHS resulting in increasing delays in accessing and securing emergency, urgent or planned admission for treatment to a regional bed for vulnerable adolescents requiring immediate and planned inpatient mental health care. As a consequence of this children are being placed inappropriately in inpatient AMHS beds when available and/or acute medical and paediatric wards or are being managed by Community CAMHS intensively with heightened complex risk. As a consequence CAMHS staff from other steps within the Service are being redeployed to support this intensive working. Community CAMHS remains under significant capacity and resource issues. CAMHS is not currently commissioned for an OOH Service as such an OOH	Staff training in Paediatrics Staff training in Emergency Department Regular meetings with AMH services Regular meetings with Beechcroft (weekly) and daily updates Policy on age appropriate care to acute setting Policy on U18 admission to AMH wards Protocol CAMHS/AMHS pathway OOH (2011) - under review at present	Environmental risks of temporary placement wards/facilities in particular YP presenting self-harm, suicidal risk, risk of absconding. Supervision deficit in ED/AMH/Paeds wards Psychiatric cover limited in CAMHS and AMHS Delayed & limited availability of AMH beds in Trust. Training/knowledge deficit re pathways related to high staff turnover in acute medical/AMHS setting CAMHS/AMHS OOH Pathway review overdue Unfunded demand for CAMHS OOH Limited regional capacity for inpatient beds	Monitoring of waiting lists Regional AD Forum - standing item Regional Care Network - weekly data collation Daily updates with Beechcroft In-house monitoring of inappropriate admissions Early Alerts of inappropriate placements both in AMHS wards and Acute medical /Paediatric wards. Weekly review and monitoring by HSCB Escalation to HSCB/DOH		CAMHS Business case to be developed to progress development of CAMHS OOH service provision Family & Child Care Social work input in over 16 MH assessment with AMHS to be reviewed to ensure cover and consistency to mitigate risk WTCAMHS/AMHS OOH 2011 pathway to be considered and reviewed When a young person presents in a mental health crisis OOH the WTCAMHS/AMHS OOH protocol adhered and followed. No MH Adolescent, No AMHS, No Medical paediatric wards CAMHS will attempt to work intensively with YP and family notwithstanding capacity and resource issues Task and finish group to support unmet needs re	31/12/2021 30/09/2021 31/12/2021 30/09/2021 30/09/2021 09/09/2021 30/09/2021 30/09/2021 30/09/2021 30/09/2021 30/09/2021	