

CORPORATE RISK REGISTER & ASSURANCE FRAMEWORK

BRIEFING NOTE PREPARED FOR TRUST BOARD
2ND February 2023

There are 20 risks on the Corporate Risk Register as approved at Trust Board on 5th January 2023.

Summary

- Material Changes to the Risk Register
 - Risk ID1213 (COVID-19) and ID1316 (Re-build post Covid surge). Proposal to amalgamate and revise risks to focus on the risk of inability to achieve rebuild targets as set by SPPG.
 - Risk ID284 Risk of breach of General Data Protection Regulation (GDPR) and Data Protection legislation through loss of personal or sensitive personal information. Proposal to amend risk title and description.
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- Proposed New Risks
 - Risk ID1409 Mental Health Patients in ED. Proposal to escalate to corporate risk register.
 - Risk ID779 Service impacts arising from performance issues within BSO Shared Services. Proposal to escalate to corporate risk register.
- Summary report for actions – No outstanding issues

Material Changes

- **Risk ID1316** Rebuild Risk Post Covid Surge
- **Risk ID1213** COVID-19 risk re assess & response to patient/client need & maintain quality & safety for patients/clients and staff

Proposal to amalgamate and revise risks to focus on the achievement of rebuild targets as set out by SPPG.

Proposed Title – Risk of the Trust not achieving the Rebuild Targets as set out by SPPG.

Risk Description - Following the covid pandemic and the resulting reduction in services we remain in an environment with the potential for resurgence of covid and other pandemic illnesses, adherence to PHA and/or CMO guidance impacting on the ability for all services to achieve pre pandemic levels of activity, workforce challenges and the need to implement a financial recovery plan.

Therefore there is a risk of the Trust not meeting the rebuild targets as set by SPPG (initially to rebuild to 2019/20 pre-pandemic levels).

Current Risk Grading – Outcome Major (4) x Likelihood Possible (3) = **12 HIGH**

Target Risk Grading (appetite) – Outcome Major (4) x Likelihood Unlikely (2) = **8 HIGH**

- **Risk ID284** Risk of breach of General Data Protection Regulation (GDPR) and Data Protection legislation through loss of personal or sensitive personal information.

It is proposed that the title and description of Risk ID284 be amended and the current risk rating and risk target be maintained.

The Trust's Corporate Risk Register contains a specific risk on UK GDPR and the associated data protection risks for the Trust. However, the risk is focused on the low level of IG Awareness training amongst Trust staff, rather than the wider

risk of non-compliance with UKGDPR. As take-up of IG Awareness training has increased to circa 75%, the training aspect is no longer a corporate threat to the Trust and the risk has now been reviewed and revised to accurately reflect the corporate position.

Current Risk Title - Risk of breach of General Data Protection Regulation (GDPR) and Data Protection legislation through loss of personal or sensitive personal information.

Current risk description - 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.

Proposed Risk Title - Risk of breach of Data Protection legislation through loss, mishandling or inaccessibility of personal or sensitive personal information.

Proposed Risk Description - The Trust faces reputation and financial risk from non-compliance across all Directorates with the UK GDPR, Data Protection Act 2018, DoHNI's Good Management, Good Records and the Public Records Act 1923. The risk comprises a number of key factors which increases the level of risk for the Trust:

- Insecurely sharing or accessing the personal data of clients, patients and staff without a legislative basis under UKGDPR or supporting legislation
- The unavailability of records for provision of patient and client care or for legal or public interest purposes
- Concerns on the adherence to records management responsibilities – notably the storage, categorisation and disposal/PRONI transfer of patient, client and staff records.

Current Risk Grading – Outcome Major (4) x Likelihood Likely (4) = **16 HIGH**

Target Risk Grading (appetite) – Outcome Moderate (3) x Likelihood Unlikely (2) = **6 Medium**

Proposed New Risks

- **Title:** Risk ID1409 Mental Health Patients in ED

Risk Description: Due to lack of local and regional mental health beds patients requiring mental health assessment and admission are required to stay in the department for prolonged periods, with minimal mental health input. Voluntary and detained patients are at high risk of harm due to lack of suitable staffing, supervision and infrastructure onsite. The department is overwhelmed with multiple patients awaiting admission some have already absconded and/or attempted self-harm while awaiting transfer or identification of a Mental Health bed due to inadequate supervision.

Current Risk Grading – Outcome Major (4) x Likelihood Likely (5) = **16 HIGH**

Target Risk Grading (appetite) – Outcome Moderate (3) x Likelihood Possible (3) = **9 Medium**

- **Title:** Risk ID779 Service impacts arising from performance issues within BSO Shared Services.

We are escalating the risk due to recruitment performance and this is described within the narrative attached to the update, however the risk is a generic risk which covers all shared services. We would hope that the risk will be able to be deescalated at a point in coming months when the issues have been addressed.

Risk Description: The Recruitment Shared Services Centre (RSSC) is experiencing significant operational and staffing challenges which are adversely impacting the service being provided to the Trust and resulting in major delays in appointing staff. This situation is further impacted by the implementation of Amiqus (new platform for pre-employment checks).

BSO Shared Services Centre are not meeting deadlines in a timely manner for which the Trust as the employing authority has overall responsibility. There is a risk to the delivery of services due to delays filling vacancies and Trust managers not complying with payroll and recruitment processes which may also lead to delays.

Current Risk Grading – Outcome Major (4) x Almost Certain (5) = **20 EXTREME**

Target Risk Grading (appetite) – Outcome Moderate (3) x Likelihood Unlikely (2) = **6 Medium**

Summary report – for action

Risks not reviewed in last quarter

- All risks have been reviewed in the last quarter.

Action plans not up to date

- There are no risks with actions outstanding at the time of reporting.

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
3	Medical Director	Health and Safety Risk - Resulting in Injury	This risk will be revised to focus on more specific issues regarding work related stress and violence and aggression. Currently the risk is too broad including work acquired infection – Higher tolerance – to be reviewed at Trust Board in 1 year.	Completed	05/01/23 – Revised risk approved at Trust Board. Risk has been closed and Risk ID1469 Health & Safety Risk to Staff as a result of Violence and Aggression has been added to the corporate risk register.
1213	Medical Director	COVID-19 risk re assess & response to patient/client need & maintain quality & safety for patients/clients and staff	Risk to be reviewed/reworked in conjunction with Risk ID 1316 service rebuild.		20/12/22– Revised risk approved at PSI SMT in December. Submitted for consideration at CMT 17 th January.

Risk ID	Lead Director	Risk Title	Workshop Action	Progress	Update
1216	Director of Acute Hospital Services	Risk of patient harm in Trust EDs due to capacity, staffing and patient flow issues	This risk is to be reviewed and redefined to reflect the wider issue of patient flow in both the acute and community settings.		05/01/23 – A meeting has been arranged for 09/01/23 to finalise draft risk.
1316	Service Re-build post Covid surge	Service Re-build post Covid surge	Risk to be reworked in conjunction with Risk ID1213 to reflect new landscape. Risk to be brought back to Trust Board review once this exercise is complete.		20/12/22 – Revised risk approved at PSI SMT on 20 th December. Submitted for consideration at CMT 17 th January.

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%202019.pdf#search=Risk%20Management%20Policy>

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

No	Datix Field Name	Data to be included in this Field	
1.	Title of Risk * (please keep this brief e.g. "Risk of Fire in Trust Premises" –)	Risk of the Trust not achieving the Rebuild Targets as set out by SPPG.	
2.	Facility (only necessary if risk relates to one specific facility)	Trustwide	
3.	Directorate * If risk affects 2 or more Directorates, please list relevant Directorates.	Performance and Service Improvement	
4.	Sub-Directorate * If risk affects two or more Sub-Directorates, please list.	Trust wide	
5.	Specialty Please list most relevant Specialty this risk relates to.		
6.	Ward/Department (necessary only if risk relates to one specific Ward/Dept)		
7.	Risk Type* Please indicate which organisational level you are of the opinion this risk should be escalated to (please tick) NB: This is subject to approval by relevant Senior Manager/Director/CMT – refer to Appendix 3 of Risk Management Strategy (see web-link above) :-	Corporate	X
		Directorate	
		Sub- Directorate/Divisional	
		Ward Level	
8.	Risk Category* Please tick most appropriate category:	<ul style="list-style-type: none"> • Finance and Efficiency • Health and Safety • Quality of Care • ICT and Physical Infrastructure • People and Resource • Public Confidence • Regulation & Compliance (Statutory, Professional, Quality Legislation) 	
9.	Corporate Objective(s) affected by this risk* (Please tick appropriate box(es) below)		
	C01	Improving the Health of our People	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)	Activity Reporting - Monthly and quarterly reporting internally/SPPG/RMB Workforce absence Respiratory outbreaks	
11.	Lead Officer* with responsibility for managing this risk (Name, Job Title, and Contact Details. (i.e. manager with operational responsibility)	Maura O'Neill, Assistant Director Performance and Service Improvement	
12.	Name of Responsible Director* (NB: Where a risk is Cross-Directorate, the most appropriate Director to manage this risk should be listed. It will be their responsibility to liaise with other Directors re management of this risk).	Teresa Molloy. Director Performance and Service Improvement	
13.	Description of Risk* Please provide a full description of the nature of the risk. Please limit this to 255 characters and structure to include cause, event and effect	Following the covid pandemic and the resulting reduction in services we remain in an environment with the potential for resurgence of covid and other pandemic illnesses, adherence to PHA and/or CMO guidance impacting on the ability for all services to achieve pre pandemic levels of activity, workforce challenges and the need to implement a financial recovery plan. Therefore there is a risk of the Trust not meeting the rebuild targets as set by SPPG (initially to rebuild to 2019/20 pre-pandemic levels).	
14.	Please list all current control measures in place to manage this risk* (e.g. policies, procedures, training)	<ul style="list-style-type: none"> • RAG rated Service Delivery Plans • Monthly monitoring and expected outturn meetings with service areas. • Working Safely alongside COVID-19 & Respiratory Infections guidance • IPC Training • Dynamic Risk Assessments (Annual/Covid/vulnerable staff) • Risk assessment Training • Link to Corporate Workforce Risk IDxx 	
15.	Please list all identified gaps in Controls.*	<ul style="list-style-type: none"> • Continued workforce challenges impacting on service delivery plans. • Validation of data within reporting timeframes. • Impact of financial recovery and/or cost increases. 	

16.	Please list all Assurances currently in place to test adequacy of Controls. (i.e. Audit (Internal/External), inspections by independent organisations, e.g. RQIA, HSENI).	<ul style="list-style-type: none"> • Monthly SPPG reporting templates • Performance Improvement Meetings • Performance management framework • Delivering Strategic Change Board • Working Together Delivering Value • Regional HSC Performance and Transformation Executive Board • Finance and Performance Committee • Trust Board • Benchmarking 	
17.	Please list all identified gaps in Assurances.		
18.	Current level of Risk* (Please tick appropriate box for Impact/Consequence/Severity and Likelihood – refer to Risk Rating Matrix & Impact Assessment Table (Appendix 3 of Risk Management Strategy - see web-link above).		
	Impact/Consequence /Severity	Likelihood	
	Insignificant/none	Rare	
	Minor	Unlikely	
	Moderate	Possible	X
	Major	Likely	X
	Catastrophic	Very Likely/ Almost Certain	
19.	Target/Acceptable level of Risk* (Please tick appropriate box for Impact/Consequence/Severity and Likelihood – refer to Risk Rating Matrix and Impact Assessment Table (Appendix 2 of Risk Management Strategy - see web-link above).		
	Impact/Consequence /Severity	Likelihood	
	Insignificant/none	Rare	
	Minor	Unlikely	X
	Moderate	Possible	
	Major	Likely	X
	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?	Yes

2. Does the proposed action plan take account of any opportunities that could be exploited whilst managing this risk?	Yes
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?	Yes
5. At what point should the decision regarding the management of this risk be escalated to a higher level?	Yes

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
<p>Development of action plan is currently being developed as part of Elective Care Board. This will be monitored in Strategic Change Board. This will include:</p> <ul style="list-style-type: none"> • Service Delivery Plans • Ensure return to pre-covid clinic templates • Regional Elective care Centres (emphasis of SWAH). • Theatre Efficiency and Utilisation • GIRFT – Getting it right first time • Waiting time Management 	01.09.22	31.03.23	Maura O'Neill

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:
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For use by BSO/BSM only	Risk ID No: (automatically generated by Datix)
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Corporate Management Team

Meeting Details	17 January 2023
Director:	Teresa Molloy
Topic	Proposal to change Directorate Risk ID 284 –<i>Risk of breach of General Data Protection Regulation (GDPR) and Data Protection legislation through loss of personal or sensitive personal information</i>
Background Information	<p>The Trust's Corporate Risk Register contains a specific risk on UK GDPR and the associated data protection risks for the Trust. However, the risk is focused on the low level of IG Awareness training amongst Trust staff, rather than the wider risk of non-compliance with UKGDPR. As take-up of IG Awareness training has increased to circa 75%, the training aspect is no longer a corporate threat to the Trust and the risk has now been reviewed and revised to accurately reflect the corporate position.</p> <p>Current Risk Title</p> <p><i>Risk of breach of General Data Protection Regulation (GDPR) and Data Protection legislation through loss of personal or sensitive personal information.</i></p> <p>Current risk description:</p> <p><i>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.</i></p>
Review	<p>There has been a data protection risk on the Corporate Risk register since 2011. In 2021 a CMT-approved training plan was implemented which has increased the take up of IG awareness training to 75% of staff, with further targets set for 2023.</p> <p>There is still a corporate risk to the Trust in non-compliance with UKGDPR but the key aspects of the risk have changed:</p> <ul style="list-style-type: none"> • Sharing Personal data without a legislative basis under UKGDPR or related legislation • Mis-sending of personal data by post, email or other electronic means • Inappropriate access of personal data (manual or electronic systems) • Loss of or incomplete historical records

- Poor storage of records which places personal information at risk
- Accidental disposal of records which need to be retained for legislative reasons or beyond retention for public inquiries/reviews

The consequences of these aspects, have also changed and increased:

- Potential reputational damage via negative media coverage
- Potential damage to public confidence in the Trust's handling of their personal data
- Loss of personal data may impact on the delivery of care to patients and or clients
- A loss of sensitive data may directly and negatively impact on the personal life and wellbeing of a patient or client
- Increased potential for litigation against the Trust
- Increased likelihood of Regulatory action and potential of a monetary fine by the Information commissioner.

Risk Description Review

In light of the above, it is recommended that the Risk Description be changed to:

The Trust faces reputation and financial risk from non-compliance across all Directorates with the UK GDPR, Data Protection Act 2018, DoHNI's Good Management, Good Records and the Public Records Act 1923. The risk comprises a number of key factors which increases the level of risk for the Trust:

- Insecurely sharing or accessing the personal data of clients, patients and staff without a legislative basis under UKGDPR or supporting legislation
- The unavailability of records for provision of patient and client care or for legal or public interest purposes
- Concerns on the adherence to records management responsibilities – notably the storage, categorisation and disposal/PRONI transfer of patient, client and staff records

Risk Title Review

It is suggested the risk title be amended to:

Risk of breach of Data Protection legislation through loss, mishandling or inaccessibility of personal or sensitive personal information.

Risk Rating

The risk rating for Risk 284 is currently 16 (high) with a target set for 6 (medium). A review of the rating suggests that the level of risk and target will remain the same.

Proposal	It is proposed that the title and description of Risk ID 284 be amended and the current risk rating and risk target be maintained.
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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%202019.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" –)	Increasing frequency when patients accepted for mental health admission have to wait in Emergency Departments for prolonged periods due to lack of capacity within Adult Mental Health in-patient facilities. This both increases the risk of patients self-harming within the hectic and congested ED, and also a delay in optimum mental health management. Prolonged stays in the ED are not conducive to someone in mental health crisis.	
2.	Facility (only necessary if risk relates to one specific facility)	Altnagelvin and South West Acute Hospitals Emergency Departments	
3.	Directorate * If risk affects 2 or more Directorates, please list relevant Directorates.	Acute Services Mental Health and Adult Physical Disability	
4.	Sub-Directorate * If risk affects two or more Sub-Directorates, please list.	Unscheduled care	
5.	Specialty Please list most relevant Specialty this risk relates to.	Emergency care and medicine	
6.	Ward/Department (necessary only if risk relates to one specific Ward/Dept)	Emergency departments in SWAH and ALT	
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:	<ul style="list-style-type: none"> • Finance and Efficiency • Health and Safety • Quality of Care • ICT and Physical Infrastructure • People and Resource • Public Confidence • Regulation & Compliance (Statutory, Professional, Quality Legislation) 	
9.	Corporate Objective(s) affected by this risk* <i>(Please tick appropriate box(es) below)</i>		
	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)	<ul style="list-style-type: none"> • Number of patients staying longer than 4 hours and 12 hours who are then transferred to in-patient mental health setting. • Datix entries relating to this risk 	
11.	Lead Officer* with responsibility for managing this risk (Name, Job Title, and Contact Details. <i>(i.e. manager with operational responsibility)</i>		
12.	Name of Responsible Director* <i>(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).</i>		Geraldine McKay and Karen O'Brien

13.	<p>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</p>	<p>Due to demand on local and regional mental health bed capacity, patients requiring mental health assessment and admission are required to stay in our Emergency Departments for prolonged periods, with minimal specialist mental health input. Voluntary and detained patients at high risk of harm due to lack of suitable staffing, supervision and infrastructure onsite within our Emergency Departments. Our EDs are overwhelmed with multiple patients awaiting admission. These patients with specific mental health needs are among these large number of patients waiting for admission. There have been multiple occasions when these patients have absconded and/or attempted self-harm while awaiting transfer or identification of a Mental Health bed due to inadequate supervision. Some of these patients have been waiting 2-3 days within the Emergency Department for access to a mental health in-patient bed. While there is input from the Nursing team of the Mental Health Home Treatment and Liaison services, the patients are not under direct Mental Health Consultant in-patient care.</p> <p>The frequent exposure of the Emergency Team staff to patients self-harming within the ED is stressful and detrimental to their wellbeing. The Nursing staff in ED are significantly challenged in attempting to monitor these patients while they wait for transfer to an in-patient Mental Health facility while managing the wide range of patients in need.</p>
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14.	<p>Please list all current control measures in place to manage this risk* (e.g. policies, procedures, training)</p>	<ul style="list-style-type: none"> • Mental Health Liaison service accessible 24/7 • Contingency plan to support ED when more than 3 patients waiting for mental health bed. This will assist in ensuring supervision and basic care needs • Social Worker access • ED staff strive to ensure that patients feel safe and supported within a busy environment • ED staff strive to ensure that patients remain in the ED to minimise risk of patients absconding. However, if patients are not detained, it is not possible • ED will attempt to identify a staff member these specific patients, however, given the significant staffing challenges and large number of attendances and DTAs, this will not always be possible • Early referral to Mental Health team
15.	<p>Please list all identified gaps in Controls.*</p>	<ul style="list-style-type: none"> - No direct Mental Health Consultant on site - Delays in prescribing medications due to lack of speciality input - The hectic ED environment is not conducive to a patient experiencing a Mental Health Crisis - When 1- 2 patients awaiting transfer to mental Health setting, no additional resource to focus on their needs. - Staff from mental health Team not always available when contingency plan activated
16.	<p>Please list all Assurances currently in place to test adequacy of Controls. (i.e. Audit (Internal/External), inspections by independent organisations, e.g. RQIA, HSENI).</p>	<ul style="list-style-type: none"> - Challenges and incidents being discussed and reviewed at ED and Mental Health Interface meetings - Related incidents being recorded on Datix and reviewed at RRG and Corporate Safety Huddle - Issue escalated to the regional Adult Mental Health Group and Directors Forum - RQIA monthly monitoring of inpatient capacity
17.	<p>Please list all identified gaps in Assurances.</p>	

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	
	Moderate	x	Possible	x
	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).

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?	While the action plan contains steps to manage the risk within the Emergency Department, it remains that patients will stay in the busy ED while awaiting an appropriate bed. While this capacity issue within Mental Health in-patient settings continues across the region, further input will be required to support ED while awaiting further capacity in Mental Health.
2. Does the proposed action plan take account of any opportunities that could be exploited whilst managing this risk?	Further exploration of mental Health Consultant review and ownership of individuals awaiting transfer to mental Health in-patient facility
3. Has the target level of risk, and how this will be achieved, been communicated to those	Yes. Both ED and Mental Health aware, as well as Director of

staff responsible for the operational management of this risk?	Acute Services, Director of Adult Mental Health and Disability Services, Medical Director
4. How will the proposed actions be monitored to ensure they are completed within identified timescales?	Through Acute and Mental Health Directorate Governance structures
5. At what point should the decision regarding the management of this risk be escalated to a higher level?	Currently escalated through to Corporate levels with Early Alert shared with Department of Health

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

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: <small>(automatically generated by Datix)</small>
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Risk Sub- Category	Risk ID	Lead Director	Risk Title	Initial		Current		Risk Appetite			Current Risk Status		Mths since last updated	Action Plan Status	Latest Update
				Score	Grade	Score	Grade	Score	Level of Toleranc e	Action on appetite	Mths since score changed	Change in score since last review			
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	Review risk in terms of demand capacity. Tolerance will be Reviewed at Trust Board workshop in April 2023	● 62	No change	0	Actions listed with future due dates	09/01/2023 January 2023 - Looked After Children services unallocated case figures have started to increase again which is directly linked to staffing levels. FIS and Gateway unallocated figures have stabilised. High levels of staff vacancies persist in all frontline teams which directly impacts on unallocated case figures. Workforce review is ongoing to address recruitment and retention as part of the Ray Jones and Children's Services review and associated workstreams. W&C Senior Management Team continue to closely monitor unallocated case numbers. Monthly returns submitted to SPPG.
ICT & Physical Infrastructure	49	Director of Finance	The potential impact of a Cyber Security incident on the Western Trust	16	HIGH	16	HIGH	6	HIGH	Tolerance will be reviewed at Trust Board Workshop in April 2023	● 66	No change	0	Actions listed with future due dates	12/01/2023 - As an operator of essential services under the NIS regulations 2018 regulation 10, the Trust must complete a self-assessment called a Cyber Assessment Framework (CAF). This is to provide assurance to the Network and Infrastructure Services (NIS) on how we maintain our essential services as a Trust (not ICT), and controls we have in place in the event of an outage. A working group has been established and Directorate leads have been asked for input. The Phase 1 CAF return will be tabled at the Cyber Oversight Group (COG) on the 19th January for approval, before approval at CMT, for return to NIS on 27th January. The full return is due in May 2023. The ICT Audit this year will be on the topic of Cyber Security. A draft audit plan has been developed and it is likely to focus on the areas of training and engagement and technical vulnerability management. The audit is due to commence February 2023. Due to the increase in targeted attacks on HSCNI, there has been a regional decision to advance the use of Multi-Factor Authentication (MFA) alongside the move to MS Office 365 and MS Teams (both cloud based). A Trust Communication has been issued to staff and uptake is slowly progressing. A planned campaign will be launched to improve MFA uptake in the clinical areas through the use of Trust Communication, Staff West app, staff Intranet and site visits. The next Cyber Oversight Group meeting is scheduled for 19 January 2023 and the next Cyber Training and Awareness Group meeting is scheduled for 02 February 2023.
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	6	HIGH	Tolerance will be reviewed at Trust Board Workshop in April 2023	● 73	No change	0	Actions listed with future due dates	09/01/2023 - Risk title and description reviewed at PSI Governance meeting on 12 December 2022. Proposed changes approved and paper submitted to CMT for approval.
Regulation & Compliance	955	Director of Finance	Failure to comply with procurement legislation re social care procurement	12	MEDIUM	12	MEDIUM	9	HIGH	Tolerance will be reviewed at Trust Board Workshop in April 2023.	● 76	No change	2	Actions listed with future due dates	Reviewed 17/11/22 - No further 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	LOW	All actions to be completed within 12 months with a view to reducing the risk to appetite level within 12 months and de-escalating risk	● 32	No change	0	Actions listed with future due dates	13.01.2023 - It is expected that all areas involved will be using electronic nebulisers by the end of January.
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	15	HIGH	6	LOW	Actions should be completed within 12 months with a view to de-escalation for management at directorate level.	● 6	No change	1	Actions listed with future due dates	07/12/2022. Outstanding actions reviewed and updated. 2 additional actions added.
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	6	LOW	Risk to be transferred within a service rebuild risk	● 33	No change	0	Actions listed with future due dates	13/01/23 - Will be taken forward as part of rebuild risk. Rebuild risk has been revised and submitted to CMT for approval.

Risk Sub- Category	Risk ID	Lead Director	Risk Title	Initial		Current		Risk Appetite			Current Risk Status		Mths since last updated	Action Plan Status	Latest Update
				Score	Grade	Score	Grade	Score	Level of Tolerance	Action on appetite	Mths since score changed	Change in score since last review			
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	6	HIGH	This risk is to be reviewed and redefined to reflect the wider issue of patient flow in both the acute and community settings.	● 34	No change	0	Actions listed with future due dates	09/01/2023 -The risk associated with congestion and high levels of patients awaiting admission to wards remains, and has deteriorated. Full capacity protocol used when required. Work ongoing to formalise use of escalation beds/spaces, non designated beds. Discharge lounge pilot continue to use in effort to create capacity early in the day.
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	6	LOW	This risk should be reduced to the appetite level set by April 2023.	● 24	No change	0	Actions listed with future due dates	09/01/2023 - As per previous updates, the service has ongoing contracts for insourcing and outsourcing by independent providers. IPT allocation letter for Nurse Endoscopist and associated infrastructure was received on 25th November 2022. The Nurse Endoscopist post has been advertised and awaiting interview. Two GI consultant posts are going to be advertised before end of the year, 2023. Job description is to be configured by GI consultants. They will meet with Dr Shivashankar to review job plans and free up PAs. SPPG have issued a further IPT on 03.01.2023 for an additional GI consultant to provide capacity for local and regional endoscopy services.
Financial	1236	Director of Finance	Ability to achieve financial stability, due to both reductions in Income and increased expenditure.	16	HIGH	16	HIGH	6	HIGH	Risk tolerance will be reviewed at Trust Board Workshop in April 2023	● 29	No change	1	Actions listed with future due dates	07/12/2022 - No further 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	8	HIGH	Risk tolerance will be reviewed at Trust Board Workshop in April 2023	● 25	No change	0	Actions listed with future due dates	09/01/2023- Industrial Action (IA) by a number of Trades Unions continues and the Trust is awaiting confirmation of IA dates for January 2023. The Trust's Corporate Management Team and senior staff in all Directorates continue to work to manage risks and ensure patient safety. A number of services were postponed in December as a result of IA and it is anticipated further services may be disrupted in January.
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	6	HIGH	Tolerance will be reviewed at Trust Board Workshop in April 2023	● 23	No change	0	Actions listed with future due dates	04/01/2023 - Approval for Derg Valley hospital to be demolished. Planned works to be completed by March 2023. Harvey Halls in-depth condition survey actions identified have all been completed December 2022. Long term strategy for redevelopment of staff accommodation has been developed. Business Case has been developed and funding secured for further improvement works.
Quality of Care	1306	Acute Hospital Services	Vacant Paediatric Ophthalmology consultant post resulting in no Paediatric Ophthalmology clinics	16	HIGH	16	HIGH	8	LOW	This risk tolerance will be reviewed In 6 – 12 months with the expectation that the level of risk is reduced and de-escalated for management at directorate level.	● 19	No change	0	Actions listed with future due dates	09/01/2023 - We have still ongoing meetings with BSHCT to discuss paediatric ophthalmology and any concerns/risks regarding the patients. New paediatric ophthalmology patients continue to be sent to the Belfast Trust to be triaged and are seen in the Ballymena Eye Clinic supported by WHSCT optometry and orthoptics staff but review patients still remain a risk as BHSCT do not have capacity. ROP patients are being screened in Altnagelvin on a Tuesday and discussed at a regional meeting at 4.30pm. There are discussions ongoing regarding a paediatric clinic being in the RASC which will incorporate WHSCT patients and it is on the agenda for the paediatric meeting on 27/1/23 with BHSCT.
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	6	HIGH	Risk to be kept under review and re-examined within 3 months with deep dive.	● 16	No change	2	Actions listed with future due dates	30/11/2022 A deep dive exercise has been completed. Actions regarding time critical transfers are being taken forwards.
Quality of Care	1316	Director of Performance & Service Improvement	Service Re-build post Covid surge	12	HIGH	12	HIGH	8	HIGH	Risk to be reworked in conjunction with Risk ID1213 to reflect new landscape. Risk to be brought back to Trust Board review once this exercise is complete.	● 19	No change	0	Actions listed with future due dates	09/01/2023 - Rebuild risk approved at PSI Governance meeting on the 12 December 2022. Awaiting CMT and Trust Board approval.

Risk Sub- Category	Risk ID	Lead Director	Risk Title	Initial		Current		Risk Appetite			Current Risk Status		Mths since last updated	Action Plan Status	Latest Update
				Score	Grade	Score	Grade	Score	Level of Tolerance	Action on appetite	Mths since score changed	Change in score since last review			
Quality of Care	1320	Director of Women & Children's Services	Delayed/inappropriate placement of children assessed as requiring inpatient mental health care.	12	HIGH	20	EXTREM	8	HIGH	It was agreed that this risk should remain on the corporate risk register to provide corporate oversight. The tolerance will be reviewed at Trust Board Workshop in April 2023	7	No change	0	Actions listed with future due dates	16/01/2023- Risk Reviewed. Situation remains unchanged. Regional updates have been requested.
Ensuring Stability of Our Services	1334	Acute Hospital Services	Sustainability of surgical services in Southern Sector of Trust due to recruitment & retention difficulties at Consultant and Mi	20	EXTREM	20	EXTREM	8	LOW	Low tolerance for risk remaining at this level and aim to be deescalated by April 2023.	16	No change	0	Actions listed with future due dates	09/01/2023 -A temporary change in the provision of Emergency Surgical Services has been implemented from 5th December 2022, which involves new pathways for emergency surgical admissions from the Southern Sector of the Trust, a new Emergency Surgical Ambulatory Assessment Unit on the SWAH site, and centralisation of colorectal surgery on the Altnagelvin site. A public consultation on the new arrangements for surgical services will open by the end of January, which will inform further planning on the future of these services.
Ensuring Stability of Our Services	1338	Director of Women & Children's Services	Risk to Provision of Neonatal Care in SWAH due to staffing shortages particularly staff qualified in specialty.	20	EXTREM	20	EXTREM	6	HIGH	Tolerance will be reviewed quarterly at Trust Board	13	No change	0	Actions listed with future due dates	16/01/2023 - One Band 6 and Band 5 post still vacant, rota being filled by additional hours and bank staff. There are difficulties associated with BSO recruitment shared services staff which are being highlighted to our HR staff.
Ensuring Stability of Our Services	1375	Acute Hospital Services	Consultants Cover in Cardiology	16	HIGH	16	HIGH	6	LOW	This risk will be reviewed within 6 months with view to de-escalating in 12 months.	11	No change	0	Actions listed with future due dates	09/01/2023 - Clinical lead appointed, interviews taking place for speciality doctors, clinical fellow x 2 before end of January 2023. Trust Locum appointed Friday 06/01/2023. Until all recruitment completed successfully, risk remains.
Health & Safety	1469	Acute Hospital Services	Health & Safety Risk to Staff as a result of Violence and Aggression	12	HIGH	12	HIGH	4	TBC	Tolerance level will be considered at Trust Board Workshop in April 2023.	0	No change	0	Actions listed with future due dates	Risk ID3 closed to create new Risk - approved 02/01/23. From 1st April 22 - 30th September 22 926 incidents of Violence and Aggression reported.

ID	Opened date	Initial Risk		Current Risk		Target Risk		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
		Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)												
6	21/09/2009	25	EXTREM	12	HIGH	8	HIGH	Director of Women & Children's Services	Women & Children's Services	Safe & Effective Services.	Children awaiting allocation of Social Worker may experience harm or abuse	Due to capacity and demand issues within Family & Childcare, children may not be allocated a Social Worker in a timely manner to provide appropriate support. Children may experience harm as a result and the Trust may not meets its associated professional and organisational requirements.	Ongoing action to secure recurring funding. Update meetings between F&CC ADs and Director. Performance Management Review is being undertaken by HSCB with all 5 Trusts focusing on Unallocated cases and timescales Service Managers and Social Work Managers monitor and review unallocated cases on a weekly basis. Principal Social Work redeployed will monitor Action Plan and progress to stabilise team Early Help staff returned to their substantive posts within gateway to increase the ability to allocate Service and SW Managers constantly prioritise workloads.	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. 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	29/09/2023 30/09/2020 01/11/2018	31/12/2019 30/09/2020 06/03/2019
49	06/10/2009	16	HIGH	16	HIGH	6	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 □ □ The outcomes of a compromise, due to a cyber attack/equipment or network failure/damage/theft or erroneous mistake(s), could result in;□ • unparalleled HSC-Wide disruption of services due to lack of/unavailability of systems that facilitate HSC services	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 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 Usr 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	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 Technical 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 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.	Implementa tion 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 implementa tion of Cyber Security Action Plan. Full implemen tation for Metacompl iance across the Trust with regular course updates being	31/03/2023 31/03/2019 31/03/2019 31/03/2020 31/08/2018	28/02/2019 31/03/2019 31/08/2019 31/08/2018

ID	Opened date	Initial Risk		Current Risk		Target Risk		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
		Rating (initial)	Risk level (initial)	Rating (current) (Conseq x Likli)	Risk level (current)	Rating (Target)	Risk level (Target)												
284	13/12/2010	16	HIGH	16	HIGH	6	MEDIUM	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 increased to full time Recruitment of Band 4 Information Governanc e Developme nt 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 Developme nt of IG action plan	31/03/2019 31/03/2019 31/03/2019 31/12/2020 30/09/2020 31/12/2020 30/09/2020 29/03/2024 31/01/2023 31/03/2023 31/12/2021 28/02/2023 01/06/2022 31/12/2022	31/03/2019 28/02/2019 01/03/2019 25/11/2020 30/09/2020 30/09/2020 31/12/2020 30/09/2020 30/09/2020 09/09/2021 01/06/2022
955	11/08/2016	12	MEDIUM	12	MEDIUM	9	MEDIUM	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 implementation plan will continue to be monitored - via Regional Procurement Board, Trust Procurement Board and Social Care Procurement Group.	30/06/2023		

ID	Opened date	Initial Risk		Current Risk		Target Risk		Responsible Director	Directorate (Risk Register Use Only)	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
		Rating (initial)	Risk level (initial)	Rating (current) (Conseq x Likli)	Risk level (current)	Rating (Target)	Risk level (Target)												
1133	23/05/2019	15	EXTREM	25	EXTREM	5	HIGH	Director of 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 flowmeters that are not fully compliant with colour coding (not mandatory) Not all medical air flowmeters had airguards but they do now Incidents are continuing to happen during 2020, lack of confidence that the actions taken last year are being adhered to in all areas - further review of processes and controls undertaken 29 May 2020. Lack of knowledge of colour coding and appreciation of risks with medical gases	Walk around to be carried out in SWAH/OHPCC although they have new flowmeters with air-guards. Walk around on Altnagelvin site occurred in November 2018. To be repeated February 2019. To be picked up on annual medical gases walkaround. No external inspections Update 05 June 2020 - Lead nurses and service managers have been asked to provide assurances on the actions taken in response to the revised controls for each of their designated areas of responsibility. May 2020 update - regular Walk rounds 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 flowmeters removed to ensure colour coding approach is	30/12/2022 31/12/2022 31/12/2019	31/12/2019 31/12/2019 31/12/2019 31/12/2019
1183	27/11/2019	25	EXTREM	15	HIGH	6	MEDIUM	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 imprisonment. □ For patients that lack capacity and for whom safeguards are not in place, there is the risk that statutory services 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. □ □ 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	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 strengthened Extended scope of Legacy to Day Care and Dom Care requires additional Resourcing Funding not adequate to deliver the projected activity. Funding not provided recurrently, compounding recruitment issues	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 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	31/12/2020 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 31/03/2023 30/11/2022 30/11/2022 30/11/2022	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 07/12/2022 07/12/2022 07/12/2022 07/12/2022

ID	Opened date	Initial Risk		Current Risk		Target Risk		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
		Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)												
1213	04/04/2020	20	EXTREM	20	EXTREM	6	MEDIUM	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	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 specialities (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) IPC audits and dashboards/reporting system for escalation Trust Silver monitoring of	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 30/09/2022	20/11/2020 31/05/2020 31/05/2020 22/09/2022
1216	15/04/2020	15	EXTREM	15	EXTREM	6	MEDIUM	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.	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 Business case approved dedicated HALO (Hospital Ambulance Liaison Officer NIAS crews waiting to offload in our hospital early warning score	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. Improve ntl QI work commencing with aim to address communication within department. Full capacity protocol	31/03/2022 31/01/2023 28/02/2022	06/05/2022 15/03/2022

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1219	30/04/2020	20	EXTREM	20	EXTREM	6	MEDIUM	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 SAls.□ 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 NIKAN 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 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	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.	05/10/2021 30/10/2022 14/02/2023 31/03/2023	05/10/2021 14/11/2022
1236	21/08/2020	16	HIGH	16	HIGH	6	MEDIUM	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 Monthly Finance focus meetings between Finance and Directors / Senior Directorate Officers	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	31/01/2023 31/01/2023	

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1254	18/01/2021	16	HIGH	16	HIGH	8	HIGH	Director of Human Resources	Trust-wide (Risk Register Use Only)	Ensuring Stability of Our Servicesimproving the Quality and Experience of CareSupporting and Empowering Staff	Inability to deliver safe, high quality and sustainable services due to workforce supply and disruptions	Due to an inability to attract, recruit and retain staff throughout the Trust, services may not be able to maintain sufficient staffing levels to sustain high quality safe services which may result in a reduction in service provision.	Trust Business Continuity Plans with full HR support on hospital / community workforce groups. Delivering Care: Nurse Staffing in Northern Ireland Organisation Development Steering Group Health and Wellbeing Strategy Engagement & Involvement Strategy DOH Workforce Strategy & Trust Workforce Strategy and key actions Trust EU Exit Group - Contingency Planning processes i.e. workforce, data sharing, etc. (Risk 1075) Policies - Rec & Selection Framework, Attendance at Work, Flexible Working, Redundancy and Redeployment, etc. HR Strategic Business Partner identified for each Directorate - targeted interventions in relation to absence, agency usage, temporary staffing and other identified Directorate priorities. (Risk 6, 1075) Pension information sessions Joint Forum, Joint LNC and Consultation Group Workforce Information reports provided to key stakeholders 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.	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 Planning, Temporary Staffing, Agency Staffing, Turnover and	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	Looking After our People Growing for the Future Belonging to the HSC New Ways of Working	31/03/2023 31/03/2023 31/03/2023			
1288	08/04/2021	12	HIGH	12	HIGH	6	MEDIUM	Director of Performance & Service Improvement	Trust-wide (Risk Register Use Only)	Ensuring Stability of Our Servicesimproving 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 re-prioritised to address the new critical issue Estates Strategy 2015/16-2020/21 Annual review of building condition (3i) and creation of prioritised BLM list. 2022/23 Backlog maintenance programme developed and implemented 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	30/06/2022 30/09/2021 07/09/2021 30/04/2021 03/08/2021 30/04/2021 03/08/2021 30/09/2021 07/09/2021 31/03/2022 12/04/2022 31/08/2021 31/08/2021 31/03/2022 12/04/2022 30/06/2022 06/06/2022 30/09/2022 30/09/2022	06/06/2022 07/09/2021 03/08/2021 03/08/2021 07/09/2021 07/09/2021 12/04/2022 31/08/2021 31/08/2021 12/04/2022 12/04/2022 06/06/2022 06/06/2022 30/09/2022		

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1306	16/06/2021	16	HIGH	16	HIGH	8	HIGH	Director of Acute Hospital Services	Acute Hospital Services	Ensuring Stability of Our Services	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 for a General Ophthalmology Consultant Agree solution for review patients	30/03/2023 30/03/2023	
1307	16/06/2021	25	EXTREM	25	EXTREM	6	MEDIUM	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. □	Consider stabilising and holding patient until NISTAR available. Ensure staff are trained in use of transport equipment in case required to transfer patient in absence of NISTAR In absence of NISTAR, Pro-paramedics (independent company) may be used. NISTAR will make ambulance and driver available if local team can do transfer			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.	30/06/2022 31/03/2022 31/03/2022	03/02/2022 03/02/2022 03/02/2022	
1316	16/07/2021	12	HIGH	12	HIGH	8	HIGH	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 domiciliary 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 advisory group Business continuity activated with 3 Bronze Control rooms: - Altnagelvin Acute; SWAH Acute; Community 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 communication 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	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 31/12/2022 31/03/2022 30/12/2022 30/09/2021 31/03/2023 31/05/2022	10/11/2021 06/01/2023 09/03/2022 20/07/2021 12/04/2022

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1320	15/09/2021	12	HIGH	20	EXTREM	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 CAMHS 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 pathway is in place to mitigate risk in conjunction with CAMHS/AMHS/ED Colleagues.□ This increases potential for: - sub-optimal care whilst inappropriately placed in hospital; risks to other	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	31/03/2023 31/03/2023 31/03/2023 31/03/2023 31/03/2023 31/03/2023 31/03/2023	
1334	26/10/2021	20	EXTREM	20	EXTREM	8	HIGH	Director of Acute Hospital Services	Acute Hospital Services	Ensuring Stability of Our Services Improving the Health of Our People Improving the Quality and Experience of Care	Sustainability of surgical services in Southern Sector of Trust due to recruitment & retention difficulties at Consultant and Mi	Inability to recruit and retain permanent general surgical staff particularly at Consultant and middle tier level in South West Acute. □ This is threatening the ability to deliver 24/7 emergency service and the range of commissioned elective activity. □ There has been a high turn-over of locum consultant surgeons who have been appointed to cover gaps, leading to gaps and concerns about continuity of care.□ It has been highlighted that emergency surgical services are at risk within the next 4 months due to inability to sustain a Surgeon of the Week and On-call emergency rota at consultant level □	Trust have authorised a Sustainable Surgical Services project to examine surgical services pan-Trust wef 18/10/21 Recruitment campaign is continuous at Speciality Dr and trainee level. Funded establishment should be 6.5 wte consultant Surgeons - current baseline is 3.0 wte with 3.5 wte gap Specialty Drs funded for 8.0 wte; 5.0 in place 2 of whom are locums and one acting up. Ongoing use of locums from within the Trust to sustain the rota at South West Acute. Newly appointed Consultant taking up post 25/10/21 Ongoing efforts to recruit - Interviews planned for 2.0 wte Consultants late October 2021 (now currently deferred pending Royal College approval)	Reluctance from other surgeons across NI to participate in providing locum cover due to the generality of surgical cover required. Difficulties recruiting and retaining at locum and permanent level as above. Difficulty securing Royal College approval for general surgical posts.	Continuing support from Altnagelvin Surgical body to provide locum cover for rota gaps. Programme Board will have fortnightly oversight of all of the actions within the Review Programme. Senior clinical support to project identified and in place. Project lead has been seconded full time to Project team. Project Lead currently briefs CMT twice weekly This will be taken over by Programme Board with fortnightly oversight from 01/11/2021 CMT will continue to support service and project		A Proposal for Sustainable Surgical Services will be developed by end January 2022 to address the most emergent issue eg emergency services in the Southern Sector of the Trust.	31/01/2023	

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1338	08/11/2021	20	EXTREM	20	EXTREM	6	MEDIUM	Director of Women & Children's Services	Women & Children's Services	Ensuring Stability of Our Services	Risk to Provision of Neonatal Care in SWAH due to staffing shortages particularly staff qualified in specialty.	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 subseuntly destabilise maternity services as babies cannot be delivered at SWAH without access to neonatal services.	Staff working additional hours/bank/overtime. Acting Manager and Head of Service covering clinical shifts when the number is inadequate or when there isn't enough QIS available. WhatsApp group set up and urgent messages sent when staffing is depleted at short notice. Cot closures after consultation with medical staff and Neonatal Network of NI Contingency plan drawn up	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 unpredictable 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	Cot closures monitored regionally	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.	Review of Staffing Contingency Plan Rotation between Paeds and NICU Bid for staff to backfill training Close cots as necessary Inform Commissioners and NNNI Monitor clinical incidents	30/09/2022 31/03/2022 13/10/2021 13/03/2022 30/10/2021 30/09/2022	29/07/2022 01/04/2022 13/10/2021 01/04/2022 13/10/2021 29/10/2021 29/07/2022
1375	15/03/2022	16	HIGH	16	HIGH	6	LOW	Director of Acute Hospital Services	Acute Hospital Services	Ensuring Stability of Our Services	Consultants Cover in Cardiology	Due to challenges regionally in relation to securing substantive positions and the limited availability of locum resources, a 6 person on call rota has been depleted by 50% leading to potential gaps in the rota.	Working with International Recruitment team to expedite a new appointment. Working through current job plans to identify monies to increase the Consultant complement. -Secured short term locum Middle Grade Doctor to support Ward based work on a short to medium term basis. Worked with Medical HR to secure short to medium term locums (starting 27th February). Link with regional pPCI network to seek support for any gaps in rota. Linkage with RCM to ensure sign off of job plans and job descriptions. -A review of current workload and a short term reduction in outpatient work to facilitate redistribution.	Locum resources has limited availability. Challenges regionally in relation to securing substantive positions.	Medical HR working collaboratively on recruitment. Clinical Lead has oversight of the rota Business continuity arrangements are in place should there be an unplanned rota gap.	Locum resources has limited availability. Challenges regionally in relation to securing substantive positions.	Recruitment has commenced to fill vacant posts.	31/01/2023	

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1469	06/01/2023	12	HIGH	12	HIGH	4	HIGH	Medical Director	Trust-wide (Risk Register Use Only)	Supporting and Empowering Staff	Health & Safety Risk to Staff as a result of Violence and Aggression	Increases in the number and complexity of patients being treated and awaiting treatment in all our settings; along with social, economic; and environmental factors; restrictive guidelines / practices resulting from Covid etc; increased social media challenges; and the absence of a Corporate legal remedy; have all contributed to an already high level of abuse, violence and aggression against Trust staff. <input type="checkbox"/> The result is that staff are increasingly subjected to both sporadic and longer consistent patterns of patients/client/visitors displaying abusive, challenging, aggressive and violent behaviours in our facilities, communities and home environments leading to significant risk of emotional and physical harm. <input type="checkbox"/>	Management of Violence and Aggression (MOVA) group in place. Zero Tolerance & Security policy Trust adherence to The Management of Health and Safety at Work Regulations NI (2000). Health and Safety at Work NI Order 1978 Lone Working Guidance Staff support through Occupational Health Safety Intervention training - available to relevant staff. V&A risk assessment. Usage of Trust General Risk Assessment form for document of specific risks. Incident reporting on DATIX – identification of trends. Risk Register process in place RIDDOR reporting of staff absence and further scrutiny Policy for the Use of Restrictive Interventions with Adult Service Users – May 2017 Trust Security Working Group Ad hoc Risk Strategy Meetings Trust Health and Safety Policy	MOVA Policy - Await implementation of regional guidance Limited Legal support available for staff from the Trust when seeking prosecutions/non-molestation orders against violent individuals. No Acute Liaison Psychiatry service in ED No programme of regular education regarding mental health presentations in ED and other acute settings of risk. CAMHS referral pathways not clarified for patients aged 0-18. CAMHS not co-located in hospital. No dedicated area for intoxicated or consistently violent patients to be treated in ED. Lack of resource to provide safety intervention training following CEC	Audit Trust controls assurance standards reporting Risk assessment compliance reporting on corporate risk register, directorate governance Incident reporting to MOVA Steering Group Audit Regional Benchmarking and DOH return on violence against staff Health and Safety Inspections		Adopt and imbed regional MOVA policy in Trust Policy and Procedures Draft business case to expand resources for Safety Intervention Training	03/04/2023 03/04/2023	