Western Health and Social Care Trust

CORPORATE RISK REGISTER & ASSURANCE FRAMEWORK

BRIEFING NOTE PREPARED FOR TRUST BOARD
06 DECEMBER 2018

There are 23 risks on the Corporate Risk Register as approved at Trust Board on 4th October 2018.

Material changes to Corporate Risk Register (CRR) for approval

- **Proposed new Corporate Risk**

  (See enclosed New Risk Form)

  Title: - The risk that the required progress in the delivery of the Transformation Programme of HSC services is not made.

  Description: The risk that the required progress in the delivery of the Transformation Programme of HSC services is not made due to:
  - Inadequate agreed regional process to effect a consistent approach to the development of agreed Transformation initiatives, their approval and implementation
  - Inability to recruit sufficient and appropriate workforce, within required timescales to establish the Transformation initiatives while maintaining stable core service provision, while progressing the transformation programme in parallel (cross reference TIG risk no 012)

- Risk of incurring additional costs to backfill and maintain core service provision above available core budgets, particular use of high cost Agency staffing
- Building future financial commitments beyond lifetime of Transformation Funding
- External influences which either halt or stop reform / transformation e.g. change in political leadership (cross reference TIG risk 002)
- Not having the available resource and capacity to manage and report reform / transformation activity (cross reference "Delivering Together- Transformation Implementation Group" risk register 001)

Not having secured appropriate stakeholder involvement in line with the DOH Co-production guide August 2018 to progress the Transformation programme.

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

- ## Consideration for action re Risk ID 931: Acute shortage of Breast Radiologists in WHSCT

Please consider if the risk grading, controls, gaps in controls and actions require update as a result of the following: -

(Paper enclosed) The purpose of this paper is to update an existing identified risk in Radiology.

Changes to the Risk Status

The service has been informed that the Lead Breast Radiologist for the Trust has indicated his intention to retire, effective March 2019. This will leave the Breast Imaging Service extremely vulnerable. QARC have stated that according to NHSBSP Guidelines Breast Services are not sustainable with a single Radiologist in post. Consequently the senior radiology management team wish to ensure that the Trust has an opportunity to inform, develop and implement an action plan to address the risks.

The identified risks to the Trust are:

1. **The forthcoming retirement of another substantive breast consultant in March 2019**, will leave the trust with a team of only 1 WTE consultant with other interventional radiology commitments e.g. lung biopsy and 1 WTE Consultant Radiographer. This is reduced from 3 WTE Consultant Radiologists in 2016 following a previous retirement
2. **A total of 14 PAs breast work currently provided per week,** Job plans for 3 WTE radiologists provided 12 Sessions (Rad 1 = 5 PAs, Rad 2 = 4 PAs and Rad 3 = 3 PAs. All attended MDT) Friday am and pm clinics were not on any radiology job plan and were covered as WL = 2 PAs.
3. **A maximum of 9 PAs will be available after Mar 2019**. A single Radiologist and Consultant radiographer can provide a maximum of the equivalent of 9 PAs resulting in a maximum of 4 clinics available for symptomatic breast with a maximum of 15 patients per clinic and 1 for Screening Assessment. Other clinical time is Film reading. Volume of Breast screening work remains unchanged and all films must be double read.
4. **A single substantive Consultant Radiologist would not meet the QARC and NHSBSP standards** which require a minimum of 2 Radiologists to be available for Breast Screening and assessment.

5. This will also impact on the Symptomatic breast service with significantly risk of breaching Cancer targets.

Recommendations

1. WHSCT CMT to acknowledge that it is unreasonable and unsustainable to expect a single breast radiologist to cover all of the required duties in both screening and symptomatic and to provide the clinical expertise and management of the Breast Screening service
2. The Trust escalate as a matter of urgency to engage PHA and HSCB senior staff to develop a long term sustainable radiology support for patients in the Western Trust.
3. The trust immediately consider a back stop position and develop a contingency plan to allow for delivery of breast services with
    a. a single breast radiologist in WHSCT or
    b. no breast radiologists in WHSCT, which remains a distinct possibility

Possible new risk being considered, for noting

The Director of Human Resources highlighted that discussions are underway regarding raising a new Corporate Risk regarding the possible strike action due to the prolonged pay discussions. This will be discussed at CMT again following a pay talks meeting on 9 November 2018.

Annual update from De-escalated risks managed at sub-committee level

Risk ID719 "*Risk of failure to meet a standard/protocol/guideline*" (See table of risk below)
Managed by Quality & Standards Sub-Committee

There has been no real progress with implementation of the software solution from Storm to allow better management and monitoring of implementation of NICE guidelines, Standards etc. We have been in regular contact with IT Department who are persistent in their contacts with Storm to try to get issues resolved. There have been fixes applied and testing done by Trust staff but to date issues have not been resolved sufficiently to enable a fully functioning solution at Trust

level. The Trust's IT Department continue to liaise with Storm who have advised that staffing difficulties have delayed progress to date but have undertaken to prioritise this work.

In the interim we continue to manage and monitor implementation of NICE guidelines, Standards etc using an Access database and Excel. Summary dashboards continue to be provided to Directorate Governance meetings and Quality & Standards Sub-Committee on a quarterly basis.

At this point in time we report 'no change' to the current risk rating for ID719.

ID	**719**
Opened	02/12/2013
Rating (initial)	20
Risk level (initial)	EXTREM
Rating (current)	12
Risk level (current)	HIGH
Rating (Target)	8
Risk level (Target)	HIGH
Responsible Director	Mr Kieran Downey
Lead Officer for Risk	Mr Kieran Downey
Corporate Objectives	Governance.
Title	**Risk of failure to meet a standard/protocol/guideline.**
Description	**There is a risk to the Trust if, for whatever reason, it fails to meet a standard/protocol/guideline set that is commensurate to safe and effective care.**

Controls	Lead Officer assigned to each standard and guideline. Approved system in place for disseminating standards and guidelines. The Trust will identify the standards, policies and protocols/guidance not fully met and the rationale for that position through the Quality & Standards Sub-Committee and escalate as appropriate to Trust Governance Committee. A pathway protocol has been designed to reinforce the correct escalation for exceptions to compliance. Standards & Guidelines 'unable to be implemented' are monitored quarterly by Quality & Standards Committee. Standards & Guidelines requiring implementation are shared quarterly with Directorate Governance Groups. Exceptions to Compliance (e.g. Not on Track) report provided for each NICE Guideline Standards & Guidelines recorded on central database.
Gaps in controls	Professional engagement may not be consistent in identifying exceptions and appropriately escalating risks.
Assurance	Provide bi-monthly assurance report to HSCB/PHA BSO Internal Audit of process - Report received in December 2015 - Satisfactory assurance RQIA Audit of selected guidance.
Gaps in assurance	
Updates in last 12 months	22/11/18: IT Dept escalated issues within Storm. Storm to review current arrangements and update IT Dept. 1/11/18: Ongoing communication between IT Dept and Storm. 3/10/18: Testing of fix - problems encountered again. IT Dept aware. 31/7/18: IT forwarded issues to Storm for resolution. 26& 27/7/18 Testing of Fix - problems encountered again. Advised IT. 3/7/18: Storm investigating. 11/5/18: Access problems assigned to engineer in Storm. February 2018 - Respiratory Consultant unable to access new solution - reported to IT and then to Storm. December 2018 - Decision made to only put Guidelines received after 1st January 2018 on new system and to retain old system for existing guidelines. November 17 - Recurring actions moved to 'Controls'; Ongoing monitoring. Following testing a

	new Sharepoint based solution for management of NICE Guidelines was signed off on 8/11/17. It is planned that the new system will go 'live' on 1/1/18. In the interim data from the existing system is being reviewed and will be brought into the new system on a phased basis. User guides in development. IT Department providing support.
Description (Action Plan Summary)	Development of electronic solution to manage standards and guidelines more effectively. Review and follow up of 'unable to be fully implemented' guidelines on annual basis or more frequently if requested by HSCB. Recurring Provide Quarterly summary status position on 'on-going' and 'unable to be fully implemented' standards and guidelines to Quality & Standards Committee. Recurring Reconcile information held on database with 'ongoing' and 'unable to fully implement' Excel spreadsheets. Recurring
Due date (Action Plan Summary)	30/09/2018 30/09/2017 31/05/2017 31/03/2017
Done date (Action Plan Summary)	 27/07/2017 30/06/2017
Corporate Risk Status	De-escalated for annual review
Risk Type	De-escalated CR for Committee management

Corporate Risk Register and Assurance Framework - 01 November 2018

		Initial Risk		Current Risk		Target Risk												
ID	Opened date	Rating (initial)	Risk level (initial)	Rating (current) (Consq x Likli)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Directorate	Corporate Objectives	Title	Description	Controls Assurance	Gaps in controls Assurance	Assurance	Gaps in assurance	Action Plan	Due date for Action Plan	Done date for Action Plan
3	19/11/2008	16	HIGH	12 (4x3)	HIGH	12	MEDIUM	Medical Director	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Governance.Workforce.	Health and Safety risk - resulting in injury	Risk of injury to patients/clients/staff and visitors arising from failure to fully comply with Health & Safety legislation.	Incident reporting and investigation. Criteria based Health & Safety Inspection plan and action plans . Induction and Mandatory Training for Staff. Occupational Health Self and Management Referrals. Use of aids e.g. hi-lo beds, hoists. Patient/client risk assessment. Leadership Walk rounds. KPI for health & safety, e.g. falls. Falls Risk Assessment. Falls Prevention Policy. COSHH added as standing item to Health &Safety Working Group agenda. Labs representative on Health & Safety Working Group Four officers in Risk Management are NEBOSH qualified including H&S officer Falls - Regional Post falls review; Falls Co-ordinator in post 2018; Falls Learning Group; CEC Falls Prevention course 2018 Annual review of completed H&S Risk Assessments Directorate Gov Reports with H&S RA info Health & Safety Policy. Health & Safety Working Group. H&S Risk Assessments. Specific health & safety policies (e.g. COSHH, Latex, Manual Handling, First	Lack of funding to purchase H&S equipment or undertake maintenance of equipment/facilities. Comparatively limited staff resources dedicated to H&S. No overall database of trained nominated H&S officers by facility	RQIA inspections. Internal Audit of H&S Controls Assurance Standard (2017/18). Benchmarking by Regional H&S Practitioners Group. Inspections by HSENI. Inspections by H&S Officer and H&S Working Group members. Review of Incident data by H&S Working Group (inc. Union reps). Inspections by Regional Medical Physics Services Advisers. Sharepoint site for H&S Risk Assessments. Monitoring of implementation of recommendations following inspections/Leadership walkrounds. BSO Internal Audit of H&S (June 2017). Manual Handling Audit at Altnagelvin Hospital (July 2013 and re-audit September 2014) Priority mechanism for Inspections	Learning themes across Incidents and Claims	Labs to be represented on Health & Safety Working Group Priority rationale for H&S Inspection Development of H&S Inspection plan Risk Management Officer trained in NEBOSH to complete shadowing of H&S Officer Risk and carry out first H&S Inspection. Corporate Risk Manager to complete NEBOSH qualification. Carry out review of completed H&S Risk Assessments.	31/01/2017 30/09/2017 31/10/2018 28/02/2017 28/02/2017 31/12/2018	09/01/2017 30/04/2018 30/09/2018 28/02/2017 28/02/2017
6	21/09/2009	25	EXTREM	12 (4x3)	HIGH	8	HIGH	Director of Women & Childrens Services	Women & Children's Services	Safe & Effective Services.	Potential for harm to children whilst awaiting Gateway and Family Intervention Service (unallocated cases)	Potential for harm to children whilst awaiting Gateway and Family Intervention Service and Disability Services (unallocated cases) due to capacity issues in the service limiting the ability to respond in designated timescales.	Ongoing action to secure recurring funding. FGC Service contacts FIS to organise FGCs to reduce risk / attempt early resolution. 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 Looked after services review capacity to enable transfer of cases Staff temporarily redeployed to cover gaps in staffing levels Some areas redesigned to address some of the unallocated cases issue. Service Managers and Social Work Managers monitor and review unallocated cases on a weekly basis. Service and SW Managers constantly prioritise workloads.		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	No gaps identified	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	31/03/2019 31/03/2019	

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46	06/10/2009	12	HIGH	12 (4x3)	HIGH	9	MEDIUM	Director of Human Resources	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Challenges to compliance with Working Time Regulations	For Junior Doctors in training the Trust may not be able to fulfil its statutory obligations under the EWTD and/or New Deal due to the intensity of junior doctors rota or lack of doctors participating on the rotas and/or an inability of the Trust to fill vacant posts by recruitment or agency. Doctors on full shift rotas and on call rotas may exceed the maximum 48 hours of actual work thus breaching the maximum hours requirement under EWTD. This may also put the rota into a higher Banding Supplement. In particular the unpredictability of on call rotas means that 11 hours continuous rest (or compensatory rest) in every 24 hour period may not be achieved. "Sleep-in" is a working pattern in residential facilities where a member of staff is required to sleep in the facility as a back up to waking night duty staff. Sleep may be disrupted due to certain situations so compensatory rest is allocated. Home Care staff who have	Monitoring of Junior Doctors working hours. Representations made to BLG & NIMDTA regarding ability to sustain rotas. Payroll alerts to HR on excessive working hours. Directorate Support Team working with W&C Directorate to address situation in Residential Children's Homes. Bi-annual monitoring of hours to determine Junior Doctor workload reported to DOH. Ensure compliance with Locum agency contract arrangements. Guidance on EWTD and compensatory rest. AD HR member of Regional Medical and Terms & Conditions Group. Letter sent to Directors and Assistant Director for sharing with staff regarding EWTD requirements in July 2018. Guidelines to clarify bank arrangements developed (QICR2). Senior HR Managers are assessing the consistency of approach in relation to sleep ins across the Trust. Director of Nursing reminding nurses of the need for compliance at Trust Nursing and Midwifery Group. Agreement to phase out use of Home Care/Home Help high hour contracts. Trust participation on Regional Working Group to review rota for	Despite best efforts the Trust is not always able to meet the requirements of the regulations. Inability of NIMDTA to fill all posts. Pressure on services due to intensity of attendances at hospital.	Junior Doctors monitoring information submitted to DOH and considered by Board Liaison Group. HSCB, through Board Liaison Group, monitor safe hours of work for Junior Doctors and Dentists. Regional review of Guidance on EWTD and compensatory rest.	No gaps identified.	Work continues within relevant Directorates in relation to rotas, sleep ins, etc. Participate in Sleep in statutory cases as required. Continue to populate gaps in rotas with International Recruitment and ongoing engagement with NIMDTA.	31/03/2019 31/03/2019 31/03/2019	
49	06/10/2009	16	HIGH	16 (4x4)	HIGH	9	MEDIUM	Director of Performance & Service Improvement	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Virus attack disables network/services	Information security across the HSC is of critical importance to delivery of care, protection of information assets and many related business processes. If a Cyber incident should occur, without effective security and controls, HSC information, systems and infrastructure may become unreliable, not accessible when required (temporarily or permanently), or compromised by unauthorised 3rd parties including criminals. This could result in unparalleled HSC-Wide disruption of services due to lack of/unavailability of systems that facilitate HSC services (e.g. appointments, admissions to hospital, ED attendance) or data contained within. This may result in the need to cancel appointments and treatments, or divert emergency/essential clinical or other services. The significant business disruption could also lead to increased waiting lists, delayed urgent clinical interventions, suboptimal clinical outcomes and potentially bring liabilities for the Service. It could also lead to unauthorised access to any of our systems or	Data & System backups 3rd Secure Remote Access Server / Client patching HSC security software (threat detection, antivirus, email and webfiltering) HSC security hardware (e.g. firewalls) 3rd Party Contracts / Data access agreements Contract of employment HR Disciplinary Policy Mandatory training policies Induction policy Regional and local Incident Management & reporting policies & procedures Corporate Risk Management framework, Processes & monitoring Emergency planning & Service business continuity plans Disaster recovery plan Ussr account management processes Change control processes Data protection Act Regional & Local ICT info security policies	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	There is a resource issue regarding Cyber Staff in the Trust. The Business Case that was approved should address this pressure however experience from other Government Organisations would sugges that is difficult to attract and retain specialist skills in this area. Unable to have consistent patching of critical/core serves due to service disruption. Limited testing of Data and Systems restores.	Recruitment of Band 7 Cyber Security Manager Recruitment of Band 6 to support implementation of Cyber Security Action Plan Full implementation for Metacompliance across the Trust with regular course updates being issued thereafter Introduce routine reporting to Trust Board (or other equivalents (local or regional)) on reported incidents/near miss, and other agreed indicators	31/12/2018 31/03/2019 30/09/2018 31/08/2018	

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51	06/10/2009	16	HIGH	16 (4x4)	HIGH	8	HIGH	Director of Finance	Finance and Contracting	Financial Management & Performance.	The inability of the Trust to achieve break-even	The inability of the Trust to achieve break-even.	Monthly review by Director of Finance of ongoing applicability of accounting assumptions and estimates. Corporate Management Team Financial Monitoring Group monitor performance reporting to Trust Board as well as achievement of savings targets. Escalation process for flagging significant issues to the Chief Executive. Directorate Accountability meetings cover performance against financial targets. Development of contingency plans to support delivery of breakeven. Delivering Together Programme Board which monitors delivery of savings. Monitoring of Action plan by HSCB/DOH	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. DHSSPS/HSCB monthly financial monitoring. External Audit (NIAO) . Self-assessment and audit of Financial Management Controls Assurance Standard. Assurance obtained by the Chief Executive from chairing CMTFMG. Assurances from Director of Finance and ADF to CMT & Trust Board. Internal Audit.	No gaps identified.	Ongoing financial management and monitoring		
57	06/10/2009	16	HIGH	8 (4x2)	HIGH	8	HIGH	Medical Director	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Governance.	Lack of cross-Directorate learning from adverse incidents, complaints, claims & audit recommendations	Potential risk that learning from incidents, complaints, litigation and audit is not disseminated across the organisation, or regionally across the HSC.	Reports to Senior Managers re closed incidents. Share to Learn newsletter and Lesson of the Week. Use of Datix to record lessons learned and provision of reports. Quarterly Audit Up-dates to Directorates. Audit Steering Group. Annual Audit Conference. Details of Audits carried out independently by staff are provided to Audit Dept. Role of CMT/Governance Committee/Trust Board. Learning Letters issued by HSCB. Communication of learning arising from incidents, SAIs, complaints and legal claims and associated action plans. Quality Improvement Event SAI Learning Event Compliance with Regional Post Falls Review and Learning template - Now on Datix Claims learning themes developed Datix upgraded to maximise potential of system Mediform pilot SWAH Automated email to reporters with Learning from incidents through Datix upgrade Standard learning reports on Datix for Datixweb users to produce their own	Learning from Audits that are carried out without knowledge of Audit Department may not be implemented. Learning themes not yet applied which could focus action on broad areas for improvement No system for providing assurance that learning identified has been shared and practice changed.	Monthly reports to HSCB on closed complaints. Inspection by RQIA. BSO Audit of Risk Management and Governance Controls Assurance Standards. BSO Audit of Risk Management Procedures (yearly). External audit (NIAO) . Audit of Junior Doctor Incidents (January 2013). BSO Audit of Claims Management (October 2014). BSO Audit of Health & Safety (June 2014). BSO Audit of Incident Reporting Procedures (February 2012). DHSSPSNI/RQIA Review of SAIs 2009-2013. Learning from Claims, SAIs added to Datix, Automatic feedback on Datix, Ward level learning communication plan SWAH M&M process BSO Audit of	No gaps identified.	Develop SAI training incl family engagement Upgrade Datix to facilitate Automatic Datix feedback Roll out of standard learning reports on Datix Learning Themes developed for Litigation cases Falls learning template system adopted Automated email to reporters with Learning from incidents through Datix upgrade Learning themes being developed regionally for Litigation Review of Governance arrangements and ensure clear mechanism for sharing learning and implementation of resulting improvements.	30/09/2018 31/01/2017 31/12/2016 31/03/2017 31/03/2017 30/09/2017 31/12/2018 31/12/2018	10/09/2018 15/02/2017 30/11/2016 31/03/2017 01/02/2017 18/09/2017

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58	06/10/2009	12	MEDIUM	15 (3x5)	HIGH	9	MEDIUM	Director of Human Resources	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Over dependence on the use of locum and agency staff to sustain services and insufficient induction for locum medical staff	Risk of inability to maintain services as a result of Trustwide difficulties regarding recruitment to certain specialties across the Trust resulting in an over dependence on the use of agency and locum staff. (Also see Acute Directorate Risk ID344 and PCOPS Risk ID702). Implementation of Circular HSC (F) 19-2017 - Introduction of new taxation rules applying to off payroll working (IR35). 	Addressing speciality issues as they arise. Trust HR representation at regional AHP Group. Trust HR representation at International Nurse Recruitment Groups. Procedure for IR35 Assessment. Senior HR Manager (Band 8a) Medical Workforce Project and QICR in post. Roll out of Erostering which means better reporting on use of bank and agency staff by area, ward, etc. Directorate summary "yellow pages" information on Agency & Locum costs reported through QICR. Guidelines on use of medical and non-medical agency staff. Medical Workforce Recruitment and Reform Project Board. Use of recognised employment agencies to recruit Locums. Locum placement assessment form. Nursing Peripatetic Nursing Team. Preparation & induction of Locums to undertake their assigned roles. Professional Nurse Interviewers. CVs verified by senior staff. Terms & Conditions of Contract. Representations made to NIMDTA regarding Jnr Dr requirements.	Insufficient applicants for nursing and social work posts. Inability of NIMDTA to provide required number of Junior Doctors for certain specialities. Unpredictability of circumstances i.e. to cover sick leave or an increase in demand for service.	Progress reports to Audit on recommendations. Audit Report on Management of use of agency and medical locum staff.	Lack of a regional cap on agency rates.	Support the development of a local post graduate medical school. Introduce and evaluate Physician's Associate role. Progress Medical Workforce Recruitment & Reform Project Plans. Continue to work on a regional level on solutions. Support transformation programmes.	31/03/2019 31/03/2019 31/03/2019 31/03/2019 31/03/2019	
63	07/10/2009	20	EXTREM	15 (5x3)	EXTREM	12	HIGH	Director of Adult Mental Health & Learning Disability	Adult Mental Health & Disability Services	Governance.	High risk forensic/challenging individuals who have potential to cause harm to themselves or others	High risk forensic/challenging individuals who have a potential to cause harm to themselves or others.	Ongoing Training and support to staff. Ongoing Multi-agency monitoring. Individual contingency plans in place. Multidisciplinary & multi-agency discharge review meetings. Management & supervision of register. Live register of those who present most at risk. Keyworkers and Care Co-Ordinators identified for each Enhanced Discharge Plan.	Limited therapeutic environment. Lack of local availability of low secure placements or step-down facilities. Limited ability to ensure therapeutic interventions. Specialist services generally not well resourced.	RQIA inspections/reviews. Low level of incidents reported for this client group.	No gaps identified.	Review Enhanced Care plan list by AMH Governance lead Continue to review enhanced care plan list by AMH	31/07/2017 31/01/2019	20/07/2018
64	07/10/2009	16	HIGH	9 (3x3)	MEDIUM	6	MEDIUM	Director of Women & Childrens Services	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Availability of age appropriate inpatient services for children and young people with mental health difficulties	The placement of an under 18 in an adult psychiatric ward is not appropriate due to age and need. All risks associated with such a placement require individual attention based on the needs of each situation. Admission to regional Tier 4 services are not always deemed to be therapeutically appropriate as families prefer to stay in localities. Requirement for dedicated, specialist CAMHS service to undertake assessments out of hours.	Risk Assessment and Under-18 Admission Guidelines. Service Improvement Plan under TYC being implemented to assist in development of CAMHS re-design in accordance with Stepped Care Model. Monitoring and reporting to HSCB of Trust position re Under-18 admissions. Pre-employment vetting of new staff who may come into contact with children. Interim arrangements with AMH Directorate with regular interface meetings to review/strengthen practice and transitions. Liaison with the Commissioner re availability of regional beds. WHSCT OOH being reviewed to ensure effective engagement and assessment OOH. New staff starting post in Crisis Home Treatment. This will enhance ability to reduce under 18 admissions. CAMHS Redesign has been fully implemented. The Trust has in place a protocol for "Admission, treatment and discharge of children and young persons under 18 to Adult Wards at Tyrone & Fermanagh, Grangewood and Lakeview Hospitals."	Quarterly reports to RQIA/HSCB re under 18 admissions to adult MH wards. Vetting of all staff on Adult Wards involved in the care of children and young persons not carried out. Full implementation of Child Protection Policy within Acute settings. Lack of Psychiatric Intensive Care Unit for Children and Young People in WH&SCT area.	Directorate reports to Governance Committee. RQIA Reviews. Integrated Intensive Treatment for Teenagers service strengthened to adopt a home treatment approach for young people to maintain them in their own homes thus preventing hospital admission. Audit has taken place on this matter and a repeat audit is planned. Feedback from HSCB confirmed WH&SCT U18 admissions reporting process is good practice and robust.	The Trust have made a bid to the Commissioner (under demographics) for funding to provide a dedicated CAMHS Out of Hours service. Internal Audit of implementation of Under-18 Admissions Protocol. This to take place. New protocol has not been in place long enough to be audited as yet (March 2011)	Internal Audit re compliance Protocol to be reviewed Annual Review of Under 18 Admissions to Adults Wards TFH, Grangewood and Lakeview Protocol in the process of being reviewed and once finalised will be forwarded to SMT for approval. Development Day planned for 5/2/15 to commence implementation of recommendations from Regional Review.	31/08/2018 30/09/2017 30/04/2018 30/09/2015	

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66	07/10/2009	25	EXTREM	10 (5x2)	HIGH	5	HIGH	Director of Adult Mental Health & Learning Disability	Adult Mental Health & Disability Services	Safe & Effective Services.	Death or serious injury of patient as a result of a suicide or attempted suicide while in a Trust facility	Death or serious injury of patient as a result of self-harm, attempted or completed suicide, while in a Trust facility.	Close liaison with next-of-kin. Appropriate care plan, nursing and medical management. Ligature assessed environments. Trust Special observation policy is applied Risk Assessment upon admission and regular review. Pre-discharge review and enhanced discharge plan. Collapsible Rails. Induction of new staff ongoing. Review of Risk at AMH&D governance meetings. Serious Adverse Incident investigations and dissemination of learning. Regional AWOL policy is applied. Close liaison with family & PSNI if patients abscond. Policies, procedures and multi-disciplinary working. Staffing levels reviewed to ensure patient safety.	Lack of understanding of policies and procedures of newly qualified staff.	Donaldson Review and review of SAIs reported 2009-2013. Review of Serious Adverse Incident Reports by HSCB/RQIA. RQIA inspections Regular Audit of Risk Assessment by Ward Managers.	No gaps identified.	Maintain regular review.	30/09/2018	
73	07/10/2009	16	HIGH	12 (3x4)	MEDIUM	6	MEDIUM	Director of Performance & Service Improvement	Trust-wide (Risk Register Use Only)	Governance.	Risk that patient medical records and/or patient information on Trust systems may not be complete, accurate or available at PoC	There is a risk that the Trust will not meet its obligations under GMGR to manage and maintain records and its wider information assets appropriately. There is a risk that the quality and completeness of data on the Trust's systems will not be to the required standard.	Information Governance Steering Group has an assurance role for the Trust. Mandatory training on FOI and DPA. Roll out of Electronic Care Record within the Trust to enable electronic availability of summary medical record. Information Governance / Records Management awareness training programme for IAOs.	Develop Robust awareness training programme. Need to develop formal process to remind staff of responsibilities Level of mandatory training up-take by Trust staff falls well below the required/targeted level. No dedicated Data Quality Team within the Trust to support the improvement of data quality/completeness on Trust systems.	Internal Audit of compliance with GMGR. Briefings to Risk Management Sub-Committee/Governance Committee on significant issues. BSO Audit of Information Management Chart splitting process developed and responsibilities agreed.	Poor up-take of mandatory training. Record-keeping issues at ward level identified by OPJ project. Mis-filing of records a continued issue as identified through the checking of records required under SAR. Medical records not stored, disposed of or return to libraries in line with required protocols.	Development of performance report on the implementation of RFID within Medical Records Library	31/03/2019	
81	08/10/2009	15	HIGH	9 (3x3)	MEDIUM	9	MEDIUM	Director of Performance & Service Improvement	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Trust Emergency Plans	Failure to effectively implement the Trust Emergency Plans and Call-out Schedule could lead to a ineffective response to a major incident which could result in serious injury or death to patients/clients or staff and loss of service.	Fire Evacuation Plans for all facilities. Trust participation in live and desk-top exercises. Hospital Lockdown Plan in place for Altnagelvin and SWAH. Mass Prophylaxis Plan. Trust Major Emergency Plan. Major incident plan for Regional Agencies PHA and RSCB. Emergency Planning Officer. Emergency Planning & Business Continuity Strategic Forum. Trust representation on Regional Emergency Planning Forum. Learning from exercises incorporated in the Major Emergency Plan. Training and awareness programme.	Departmental Plans require review / further development Trust Wide. No risk assessments performed.	Emergency Planning Annual self-assessment shared with Emergency Planning Branch BSO Audit of Emergency Planning periodically Annual reports to HSCB/PHA and Emergency Planning & Business Continuity Strategic Forum.	No gaps identified.	Training needs analysis completed and training scheduled developed for Trust. Training to be rolled including Mass Casualty Awareness Session within ED and Desktop Exercises Monthly testing of ATHOC Major Incident Alterting system	31/03/2019 01/05/2019	

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99	26/10/2009	16	HIGH	12 (4x3)	HIGH	12	HIGH	Director of Performance & Service Improvement	Performance & Service Improvement	Safe & Effective Services.	Failure to fully comply with Asbestos Regulations	Failure to fully comply with Asbestos Regulations due to insufficient resources. This may lead to improvement/prohibition notices, restriction/loss of service and injury/death of staff/patient/client or public.	Risk treatment plans in place for majority of high and extreme risks. Trust-wide Estates policies and procedures for all appropriate areas. AE Annual Audits AE & CP Training WHSCT Estate Strategy Estates Compliance Team reviews compliance with standards/regulations. Upgraded Asbestos Management System to comply with proposed new legislation.	Identified risk treatment plans not fully implemented due to resource issues. Software Database of all drawings with up to date electrical systems information. Recurring funding not sufficient to meet all compliance issues.	ISO9001 Trustwide. RQIA audits for registered premises. Third party risk assessments for some standards.		Rewire Nurses Home Source AE & CP Training Competent Persons to be assessed and formally appointed Implement action from Authorising Engineer Report. Removal of asbestos prioritised 14/15. Develop Estate Strategy Source appropriate software database to house all drawings with up to date electrical systems information. Secure funding for rewire of Nurses Home Removal of asbestos prioritised 15/16 Rewire of Altnagelvin Tower block Wards 7 Establish Electrical Safety Group Review implications HTM06/01 Rewire of Ward 6. Asbestos survey to be carried out in Tower Block tunnel Implement AE Audit Recommendations from August 2015 Audit	31/03/2017 31/05/2015 31/03/2017 31/03/2015 31/03/2015 31/03/2016 31/12/2015 30/09/2015 31/03/2016 31/03/2016 30/06/2018 31/12/2017 30/11/2016 31/07/2017 31/03/2016 30/09/2017 31/12/2018 31/07/2016 30/09/2017 30/10/2017 31/08/2017 31/03/2015	31/03/2017 31/05/2015 28/02/2017 31/03/2015 31/03/2015 31/01/2016 02/09/2015 02/09/2015 31/03/2016 31/12/2015 01/05/2018 31/12/2017 03/11/2016 04/07/2017 31/03/2016 04/07/2017 31/07/2016 30/09/2017 30/09/2017 31/08/2017 31/03/2015
100	26/10/2009	16	HIGH	12 (4x3)	HIGH	12	HIGH	Director of Performance & Service Improvement	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Backlog Maintenance	There is a risk of deterioration in the Trust Estate due to lack of investment in the maintenance of building services infrastructure and physical environment which could lead to loss of service and non-compliance with regulatory and statutory standards.	Annual review of building condition (3i) and creation of prioritised BLM list Estates Strategy 2015/16-2020/21 2018/19 Backlog maintenance programme developed Targeting of priority areas as funding becomes available. Continual bidding for funding to address backlog maintenance. Backlog maintenance list annually reviewed.	Lack of Funding for backlog maintenance.	Authorising Engineer audits. RQIA inspections/audits. Environmental Cleanliness audits. Health & Safety audits. Back-log Maintenance list.	No gaps identified.	Create prioritised list of BLM Create prioritised list of BLM Create prioritised list BLM 17/18 Create prioritised list BLM 18/19 Include backlog maintenance in capital plan presented to CMT Procure and carry out schemes Present BLM paper to CMT Procure 18/19 backlog list	30/04/2015 31/05/2016 31/05/2017 31/05/2018 30/06/2016 31/03/2017 30/10/2015 31/03/2019	30/04/2015 31/05/2016 30/04/2017 31/05/2018 16/06/2016 31/03/2017 03/09/2015
235	08/12/2010	15	EXTREM	15 (5x3)	EXTREM	8	HIGH	Medical Director	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Risks associated Water Borne Pathogens	As a result of partial compliance Water Systems Safety Regulation HTM-04-01,HSC L8, HTM 0401 PARTA,B,C 2016 there is a risk of exposure to water borne pathogens which may result in injury/death to patients/staff.□	Planned programme of testing and remedial maintenance as required. Risk assessment. WH&SCTand Interserve Water Safety Plans. Flushing regime for little-used outlets. Water Safety Working Group. Implementation of Zetasafe water compliance tool. Responsible Persons appointed for Water Safety. Water borne pathogen testing by Public Health Laboratory. Upgrade water supply in Tower Block levels 1-5 and Dermatology	Insufficient recurring resources to provide full compliance in Augmented Care areas. Limited maintenance regimes in low risk facilities as risk assessed within water safety plan . Limited legionella testing in low risk facilities risk assessed as such in the water safety plan.	Independent Authorised Engineers appointed for Water Safety. Independent Audit of Water Safety (November 2014). RQIA Inspections of augmented care. Independent audit of Water Safety October 2016 . Water Safety Group review implementation of Water Safety Plans. Updated Risk assessments included in water safety plans CMT/Trust Board Water Hygiene Policy May 2017 Updated Water Safety Plans.	Independent Water Safety Audit 2017	Upgrade work for Greenfields RH. Upgrade treatment wing Tower Block . Up-date WH&SCT Water Safety Plan. Business case to support upgrade for Nucleus. Continue to follow-up appointment of Interserve Authorised Engineer. Continue to follow-up Interserve Water Safety Plan. upgrade ward wing toilets (40) Upgrade water system Nucleus Installation of hot water supply to Milk Bank SWAH action Independent audit recommendations	01/07/2017 01/11/2016 01/07/2017 31/07/2014 30/09/2014 31/03/2019 31/03/2019 31/08/2018 31/03/2019	31/03/2018 31/05/2017 31/03/2017 30/09/2014 06/10/2014

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284	13/12/2010	16	HIGH	16 (4x4)	HIGH	8	HIGH	Director of Performance & Service Improvement	Performance & Service Improvement	Governance.	Risk of breach of Data Protection Act through loss of personal or sensitive data	As a result of gaps in staff awareness and training in data protection requirements and non-adherence to retention and disposal guidance, there is a risk that personal or sensitive data could be lost, inappropriately stored or accessed; records could be retained beyond their lifecycle and lead to a breach of confidentiality and the Data Protection Act, DoH Good Management Good Records Guidelines and result in potential enforcement action from the Information Commissioners' Office alongside damage to the Trust' reputation.	Subject Access and Data Access agreement procedures. Information Governance/Records Management induction/awareness training. Regional code of practice. Information Governance Steering Group. Records held securely/restricted access. ICT security policies. Raised staff awareness via Trust Communications/Share to Learn. Fair processing leaflets/posters. Investigation of incidents. Investigation of incidents. Data Guardians role. Regional DHSSPS Information Governance Advisory Group. Electronic transmission protocol. 2 secondary storage facilities available across NS & SS Trust Protocol for Vacating & Decommissioning of HSC Facilities. Scoping exercise to identify volume and location of secondary close records completed in December 2010. Data Protection & Confidentiality Policy. Information Governance SIRO and IAO Framework. Laptops encrypted & use of Trust-issued Safe Sticks.	Potential that information may be stored/transferred in breach of Trust policies. Limited uptake of Information Governance and Records Management 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.		Recruitment of Band 4 Information Governance Development of information leaflet for Support Services Staff to increase awareness of information governance Band 3 0.5 post increased to full time	31/03/2019 31/03/2019 31/03/2019	
535	15/11/2011	16	HIGH	20 (4x5)	EXTREM	8	HIGH	Director of Nursing, Primary Care & Older People's Services	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Risk that patients may experience a reduced quality of nursing care due to workforce deficits	Risk that patients in acute and primary care and older people's secondary care services may experience a reduced quality of nursing care due to unplanned staff absence and workforce deficits, which results in a reliance on bank and agency nursing staff and the associated financial risks.	Review of nursing resources, influence Commissioner, use of temporary contracts. Monitoring of performance through KPIs. Daily monitoring of staffing levels and bank/agency usage. Daily senior management patient flow walkabouts. Monitoring of escalation beds. Twice daily bed management meetings. Absenteeism policy; E-rostering system. No bank only contracts in place. Clinical supervision. Normative staffing has been completed in COE wards. ITR's have been processed Nurse Staffing Reviews completed in a range of Acute and PCOP wards in Altnagelvin and SWAH using the Safer Nursing Care Toolkit. Reviews completed in 2016. Altnagelvin - Ward 1, Ward 3. SWAH Wards 5,6,7. Ward 1. Where the need for additional nursing staff required - proposal submitted to responsible Directorate Management Teams. Nursing Staffing Reviews completed in 2017 - Altnagelvin Ward 44, Ward 20. The bed compliment of wards is adjusted to reflect their respective normative staffing levels. Nursing KPI Report tabled at CMT monthly	No gaps identified.	Monthly review of patient falls through Falls Action Group. Quarterly review of nursing medical errors. Monthly review of nursing complaints. Ongoing staff reviews. Monthly accountability reviews on quality of patient care. Nursing Validation. Beyond the Grapevine RQIA inspections Nursing KPI Report tabled at Trust Board monthly	No gaps identified.	Absences are being managed through the Trust's Managing Absenteeism Policy on an on-going basis Analysis of Nursing Staff reviews in Altnagelvin Ward 44, Ward 20. CMT decision to initiate Business Continuity initiative. Stood down 2/8/17 CMT made decision to submit Early Alert to DOH on need to close beds due to staffing shortages and IP&C issues. Directorates taken to close 25 beds in Altnagelvin Hospital due to nurse staffing shortages. Regular vacancy monitoring through Band 5 stabilisation monitoring 103 Adult Nurse Graduates employed. Working towards registration a total of 84 RN employed through regular recruitment	31/08/2017 30/11/2017 31/12/2016	02/08/2017 31/07/2017 31/07/2017 31/12/2016

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547	21/09/2012	15	HIGH	16 (4x4)	HIGH	8	MEDIUM	Director of Nursing, Primary Care & Older People's Services	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Public Confidence.□ Partnerships. Financial Management & Performance. Modernisation.	Inability to access domiciliary care in a timely manner	There is a risk that both hospital patients and community service users will not receive their assessed domiciliary care package in a timely manner. Patients delayed in hospital may be at greater risk of infection and/or falls. Patients in the community may be a greater risk of falls or other injuries. Community service users may have to wait longer for their assessed care package as hospital patients may be prioritised for care packages to maintain hospital flows. Adult Community Care Divisions are experiencing difficulties with accessing responsive domiciliary care service provision due to the following factors;□ Rurality and the ability to source and secure a sustained domiciliary care service provision in some remote areas across the Trust□ This risk is impacting service users and carers across both community and hospital care settings resulting in delayed discharges, temporary placements being made in nursing and residential homes and unmet need being reported	Interim additional rotas have been established in 12 locations across the Trust through a co-ordinated exercise to address issues where accessing service provision has been identified across all POC's. The Trust continues to implement its reablement service model which is operationally linked to the reform of its in-house homecare service. The combination of these measures is will assist in addressing the risks being experienced and reported.	There is unmet need mainly due to difficulties in recruiting carers, particularly in rural areas	PCOP Domiciliary Care Waiting List There are a range of monitoring and reporting processes in place to ensure this risk is actively monitored A service response to assessed need is progressed on each individual cases through keyworkers and brokerage Actions are taken with regards to the position as reported through these assurance and monitoring mechanisms PFA Discharge Targets Daily Delayed Discharge Report	Total assurance cannot be given as the demand and location of cases cannot be projected or planned for. The focus remains to ensure optimum utilisation of available resource and progress actions in areas where there are clusters of unmet need	Negotiate new contracts with Independent Sector providers. Discussing individual priority clients with providers to re-organise care Providing a range of alternatives, e.g. direct payments Procurement for dom care is almost complete Member of Reablement steering group In-house reform to establish core and reablement teams across the Trust In-house service completing a productivity and efficiency improvement programme to ensure there is optimum utilisation of the rotas.	21/04/2016 21/04/2016 21/04/2016 21/04/2016 21/04/2016 31/08/2018 30/09/2018	13/09/2016 28/02/2017 13/09/2016 13/09/2016 13/09/2016
694	02/08/2013	9	MEDIUM	12 (4x3)	HIGH	9	MEDIUM	Director of Acute Hospital Services	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Modernisation.□ Workforce.	Risk to patient/client safety because of insufficient Medical cover in PCOPS and Medical Wards in SWAH	Insufficient medical staff at weekends in SWAH to effectively cover the number of Medical & Care of Elderly wards - Older persons wards defaulted to F1 grade.	Referred to NIMDTA and School Board of Medicine. Raised with Commissioner. Medical prioritisation. Consultant on-call rota in place two junior doctors OOH No F2's are working unsupervised	No overnight or weekend Hospital @ Night support for medical team. Insufficient medical cover OOH	Additional post secured in OPAL Service in SWAH which may relieve pressure in COE wards. Awaiting funding from Commissioner to progress recruitment.		Completion of Business case for Medical cover	31/07/2017	
924	04/04/2016	9	MEDIUM	16 (4x4)	HIGH	6	LOW	Chief Executive	Trust-wide (Risk Register Use Only)	Financial Management & Performance.	The Trust's ability to achieve Recurrent Balance	Risk that the Trust will fail to breakeven in the current and future years given the reliance on non-recurring measures and the challenge in maintaining these in the medium to long term within the context of continuing cash releasing savings and increasing demand.	Annual Review of Recurrent Balance position. Monthly monitoring of the delivery of the financial plan by CMT FMG and the Trust Board. The development of an annual financial plan.		Internal Audit. Corporate Management Team - Financial Monitoring Group		Planned Financial sustainability event for Autumn. Implementation of the Recurrent Balance Solutions Project Initiation Document (PID)	31/10/2018 31/03/2016	31/03/2016

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931	20/04/2016	20	EXTREM	20 (4x5)	EXTREM	9	MEDIUM	Director of Acute Hospital Services	Acute Hospital Services	Safe & Effective Services.Modernisation.Public Confidence.Workforce.Partnerships.Financial Management & Performance.	Acute shortage of Breast Radiologists in WHSCT	There is chronic shortage of radiologists in WHSCT. 1. Potential suspension of Breast Screening service provided by the Western Breast Unit resulting in loss of service to ladies in the screening group 2. Reduction in provision of breast radiologist for triple assessment clinics resulting in risk of delayed diagnosis of breast cancer 3. Highly visible and sensitive are of work. There is likely to be a high level of public and media interest should either service be unavailable. Potentially very damaging to the trust's reputation as a provider of screening and symptomatic services.	The issue has been highlighted as part of the Imaging Review There are 4 screening units in NI 2 of which have a full complement of breast radiologists and 1 in a similar positon to WHSCT This includes escalation via the Managed Radiology Clinical Network (MRCN), QARC and PHA WHSC Trust has approached the other trusts in NI for occasional support with very limited success The Trust is actively recruiting 2 breast radiologists but is unlikely to be successful in this round as there are no training radiologists in this specialty who have expressed an interest in WHSCT There are plans to further role extend the breast radiographers to include Ultrasound of the breast although there is a significant lead in time Radiographers in Nuclear Medicine perform sentinel node injections. 1 Role extended radiographer undertakes film reading and breast biopsies with another in training. WHSCT has 2 breast radiologists and a third who undertakes symptomatic work on an ad hoc basis since his retirement QARC and MRCN informed and support agreed Surgical Teams informed of potential	Breast Screening targets re reporting time and assessment times are at risk. Sudden surges in demand e.g. following TV campaigns can be accommodated within the specified ministerial target. With a two breast radiologists 52 week cover cannot be guaranteed.	Both services have been maintained largely by huge efforts by the two remaining Full time breast radiologists but there is a risk that either may not be available permanently and one is due to retire within the next 2-3 years. External oversight by QARC and inspection by RQIA has indicated that the services provided are safe and fit for purpose. QARC, PHA, HSCB and clinical colleagues are aware of the position and it has been escalated through all known channels		Immediate regional discussion with HSCB or other trusts to enquire if radiology breast resources can be readily available to WHSCT QARC and MRCN informed and request made for support Surgical Teams informed of potential issues Table at CMT for decision re increased risk	31/08/2018	08/03/2016 08/03/2016
955	11/08/2016	12	MEDIUM	12 (3x4)	MEDIUM	4	LOW	Chief Executive	Trust-wide (Risk Register Use Only)	Modernisation. Public Confidence.Financial Management & Performance.	Failure to comply with procurement legislation re social care procurement	The risk that the Trust will breach UK procurement legislation rules in awarding contracts for the provision of social care services. The legislation outlines that a formal tender process must be followed when awarding contracts that are expected to be above a specified threshold. This is to be managed by BSO PaLS on behalf of all Trusts but the current proposed work programme means that Trusts will not be fully compliant with the legislation for a period of 5 years ending on 31 March 2022.	The issue has been discussed at the Trust's Procurement Board and Social Care Procurement Group. The Trust's Director of Finance & Contracting has highlighted this issue to the Regional Procurement Board.	The Trust does not have the resource or infrastructure required to manage this risk internally. DOH has determined that the issue should be managed regionally.			Continue to monitor progress at Regional Procurement Board, Trust Procurement Board and Social Care Procurement Group.		

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1075	23/08/2018	12	HIGH	12 (4x3)	HIGH	4	LOW	Director of Finance	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Public Confidence.□ Workforce.Partnerships.	No Deal Scenario / Hard Border EU Exit	With the imminent EU exit, there is potential for a No Deal Scenario or Hard Border between Northn and South of Ireland. The full impact of the UKs exit from the EU is not yet known and given uncertainty around the UK EU ongoing discussions and potential agreements, there may be impacts such as - workforce, including recruitment and retention, changes to regulations, movement of people and goods, border controls and access to healthcare in EU member states. Day one delivery planning is required to ensure services continue to operate effectively on day one following EU Exit and in the longer term, and that there is no, or minimal disruption to services. Although this is categorised as an organisational risk it also has implications for clinical risk, financial risk, patient and client safety and staffing issues/levels. Lead Officer is Paul Quigley and Responsible Director is Lesley Mitchell, Director of Finance and Contracting.	EU Exit Task & Finish Group in place including service directorate membership. No Deal Continuity Plans for Services Liaison with Regional EU Exit Group Engagement with CAWT Partnership to support the Trust with continuity plans. Review of SLAs /Contracts to ensure EU Exit considered. Regional issues escalated to appropriate Group e.g. HR Directors / Finance Directors Local issues identified and day one plan developed. Emerging issues log established and being maintained. The Lead Officer, Paul Quigley has met with all Directorate SMTs to raise awareness and discuss issues. HR have noted on their Directorate Risk Register. Trust Reps continue to be involved in regional working groups led by DoH in order to inform and assist the Trust in EU Exit Planning .	A number of national and regional risk mitigation issues are being managed at DOH / Government level. The Lead Officer participates in the Regional DoH EU Exit Group.	EU Exit Task and Finish Group meet monthly. Day one delivery plan developed and reviewed.		Continued regular update internal EU Exit Meetings Application of any regional or strategic directives on EU exit. Trust representatives continue to be involved in regional working groups led by DoH in order to inform and assist the Trust in EU Exit Planning. Assurance Statement to be forwarded drom the CE to the Permanent Secretary, DoH confirming that the Trust is actively scoping the potential impact of a no deal outcome from the UK EU negotiations on the services provided by the Trust etc Assurance Statement above to also assure DoH that the Trust will alert if departmental policy leads to any additional issues identified that have not already been highlighted by the Dept.	30/09/2018	