		Initial Risk		Current Risk		Target Risk														
ID	Opened date	Rating (initial)	Risk level (initial)	Rating (current) (Consq x Likli)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Directorate	Corporate Objectives	Title	Description	Controls Assurance	Gaps in controls Assurance	Assurance	Gaps in assurance	Action Plan	Due date for Action Plan	Done date for Action Plan
3	19/11/2008	16	HIGH	20	EXTREM	4	HIGH	Medical Director	Trust-wide (Risk Register Use Only)	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. Crieria 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 Walkrounds. KPI for health & safety, e.g. falls. Falls Risk Assessment. Falls Prevention Policy. Ligature risk assessment tool adopted MAPA training team in place WHSCT Occupiers rules & regulations Aug 2017 Combination training (includes Risk assessment and COSHH risk assessment) Nurse managers trained in Ligatire assessment July 2019 Falls - Regional Post falls review; Falls Co-ordinator in post 2018; Falls Learning Group; CEC Falls Prevention course 2018 COSHH added as standing item to Health &Safety Working Group agenda. Labs representative on Health & Safety Working Group Four officers in Risk Management are	Limitation / constraint on funding to purchase all H&S equipment but the Trust risk assesses each procurement request of H&S equipment funding is allocated accordingly. Similarly a risk based approach is applied to the maintenance of all Trust equipment and facilities in order to mitigate the risk to an appropriate level. Comparatively limited staff resources dedicated to H&S. Limited availability for managers to update risks on Datix. Datixweb module required to allow linking with incidents No overall database of trained nominated H&S officers by facility Limited availability of risk register to managers to allow direct management of risks	RQIA inspections. Internal Audit of H&S Controls Assurance Standard (2017/18). Benchmarking by Regional H&S Practitioners Group. Inspections by HSENI. Inspections by H&S Officer and H&S Working Group members. Review of Incident data by H&S Working Group (inc. Union reps). Inspections by Regional Medical Physics Services Advisers. Sharepoint site for H&S Risk Assessments. Monitoring of implementation of recommendations following inspections/Leadership walkrounds. BSO Internal Audit of H&S (June 2017). Manual Handling Audit at Altnagelvin Hospital (July 2013 and re-audit September 2014)	Learning themes across Incidents and Claims	Include compliance scores on H&S Risk Assessments reports. Train managers on Ligature risk assessment tool Source funding for approved Business case for purchase of Risk Registers on Datixweb Database of nominated H&S officers trained to be developed Review of Fit Testing policy / protocol Complete Inspection plan for 2020 H&S Policy revised COSHH policy revised Agree process for reporting Covid RIDDOR incidents Review monthly Ongoing Advice & Guidance re Covid in Trust docuemnts & comms.	30/06/2019 31/07/2019 31/03/2020 30/09/2020 30/09/2020 31/12/2020 31/03/2020 31/03/2020 15/05/2020 30/06/2020	31/03/2019 31/07/2019 29/02/2020 09/03/2020 09/03/2020 15/05/2020
6	21/09/2009	25	EXTREM	12	HIGH	8	HIGH	Director of Women & Childrens Services	Women & Children's Services	Safe & Effective Services.	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. Update meetings between F&CC ADs and Director. Performance Management Review is being undertaken by HSCB with all 5 Trusts focusing on Unallocated cases and timescales Service Managers and Social Work Managers monitor and review unallocated cases on a weekly basis. Principal Social Work redeployed will monitor Action Plan and progress to stabilise team Early Help staff returned to their substantive posts within gateway to increase the ability to allocate Service and SW Managers constantly prioritise workloads.	Delays in recruitment Inability to get sick leave covered inability to recruit and retain social workers Principal Social Workers review unallocated cases regularly HSCB have drafted a regional paper to secure additional funding for Unallocated Cases.	Quarterly governance reports to Governance Committee. Feedback given to Performance & Service Improvement for accountability meetings with HSCB. Up-dates by Director to CMT and Trust. Action Plan to review and Address Risks within FIS Enniskillen Delegated Statutory Functions		FIS Early Help Team established to help address unallocated cases. Principal SW temporarily redeployed to review all unallocated cases in FIS and then SW caseloads in FIS Action Plan Developed to address and Monitor Risks in FIS Enniskillen	30/09/2020 01/11/2018	31/12/2019 06/03/2019

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46	06/10/2009	12	HIGH	12	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.	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.	Despite best efforts the Trust is not always able to meet the requirements of the regulations. Pressure on services due to intensity of attendances at hospital. A medical administration resource to support doctors rotas.	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.	Inability of NIMDTA to fill all posts.	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. Senior Manager HR to review reasons for current non compliant JD rotas. ADHR to examine checks in place to monitor working time compliance across the Trust.	30/09/2020 30/09/2020 30/09/2020 30/09/2020 30/09/2020	
49	06/10/2009	16	HIGH	16	HIGH	9	MEDIUM	Director of Finance	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.	Data & System backups 3rd Secure Remote Access Server / Client patching HSC security software (threat detection, antivirus, email and webfiltering) HSC security hardware (eg firewalls) 3rd Party Contracts / Data access agreements Contract of employment HR Disciplinary Policy Mandatory traiing policies Induction policy Regional and local Incident Management & reporting policies & procedures Corporate Risk Management framkwork, Processes & monitoring Emergency planning & Service business continuity plans Disaster recovery plan Ussr account management processes Change control processes Data protection Act Regional & Local ICT info security policies Band 7 & band 6 recruited to support Cyber security Trust and Regional Cyber Project Boards	Current inability to obtain 100% coverage on patch updates due to a combination of user behaviours and service needs Insufficient User Awareness of impact of personal behaviours in relation to cyber threat Full extent of gaps are not understood at this point - Gap analysis regionally and locally required by HSC to capture a considered extent of vulnerabilities Insufficient corporate recognition and ownership of cyber security threat as a service delivery risk	Internal audit / IT Dept self-assessment against 10 Steps towards NCSC Technicial 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 crtical/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. Implementation of cyber security work plan which has been agreed with the Region. Introduce routine reporting to Trust Board (or other equivalents (local or regional)) on reported incidents/near miss, and other agreed indicators.	31/03/2019 31/03/2019 31/03/2020 31/03/2022 31/08/2018	28/02/2019 31/03/2019 31/08/2019 31/08/2018

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51	06/10/2009	16	HIGH	16	HIGH	8	HIGH	Director of Finance	Finance and Contracting	Financial Management & Performance.	The inability of the Trust to achieve break-even or contain expenditure within authorized control limit	The inability of the Trust to achieve break-even or contain expenditure within authorized control limit.	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 Preparation of Annual Accounts	31/03/2021 13/06/2019	03/07/2019
57	06/10/2009	16	HIGH	12	HIGH	8	HIGH	Medical Director	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Go vernance.	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, or that dissemination is unduly delayed by delays in reviews.	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 SAI training for staff including family engagement Rapid Review group Regionally learning following legal claims shared via DLS Regional Litigation meeting. Claims learning themes developed Datix upgraded to maximise potential of system Compliance with Regional Post Falls	Learning from Audits that are carried out without knowledge of Audit Department may not be implemented. No system for providing assurance that learning ientified has been shared and practice changed. Learning themes not yet applied which could focus action on broad areas for improvement Lack of Datixweb Dashboards, risk and Complaints module which limits triangulation of data for learning Significant delays in incidents being reviewed and closed in a timely fashion.	Monthly reports to HSCB on closed complaints. Inspection by RQIA. BSO Audit of Risk Management and Governance Controls Assurance Standards. BSO Audit of Risk Management Procedures (yearly). External audit (NIAO) . Audit of Junior Doctor Incidents (January 2013). BSO Audit of Claims Management (October 2014). BSO Audit of Health & Safety (June 2014). BSO Audit of Incident Reporting Procedures (February 2012). DHSSPSNI/RQIA Review of SAIs 2009-2013. Learning from Claims, SAIs added to Datix, Automatic feedback on Datix, Ward level learning communication plan SWAH	No gaps identified.	Learning Themes developed for Litigation cases Falls learning template system adopted Automated email to reporters with Learning from incidents through Datix upgrade Develop SAI training incl family engagement Upgrade Datix to facilitate Automatic Datix feedback Roll out of standard learning reports on Datix Trust SAI learning event Establish Learning site on Sharepoint Business case for Datixweb Risk, Dashboards and Complaints module Learning themese being deveoped regionally for Litigation Revision of Governance arrangements under Covid-19 Acute review of SAI management	31/03/2017 31/03/2017 30/09/2017 30/09/2018 31/01/2017 31/12/2016 31/10/2019 30/06/2020 31/01/2020 31/12/2018 31/05/2020 30/06/2020 31/08/2020 31/05/2021	31/03/2017 01/02/2017 18/09/2017 10/09/2018 15/02/2017 30/11/2016 03/10/2019 31/01/2020 31/12/2018 30/04/2020

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58	06/10/2009	12	MEDIUM	15	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).	Trust HR representation at regional AHP Group. Trust HR representation at International Nurse Recruitment Groups. 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. Addressing speciaility issues as they arise. Procedure in place for IR35 Asessment. Implementation of Circular HSC (F) 19 2017 - Introduction of New Taxations Rules applying to off payroll working. AHP Peripatetic Teams in place. Medical Workforce Recruitment and Reform Project Board. Directorate summary "yellow pages" information on Agency & Locum costs reported through QICR. Guidelines on use of medical and non-medical agency staff. 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.	Lack of co-ordinated information on agency staffing. Insufficient applicants for nursing and social work posts. Unpredictability of circumstances i.e. to cover sick leave or an increase in demand for service. Inability of NIMDTA to provide required number of Junior Doctors for certain specialities.	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 Working Together Delivering Value Programme to reduce reliance on bank and agency staff. Support transformation programmes.	30/09/2020 30/09/2020 30/09/2020 30/09/2020 30/09/2020 30/09/2020	
63	07/10/2009	20	EXTREM	15	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 , support and clinical supervision to staff within AMH Forensic Services. Ongoing Multi-agency managenmnet and review. Individual contingency plans in place. Multidisciplinary & multi-agency discharge /review meetings. AMH Forensic Service have regular clinical meetings to discuss patients allocated/referred to the Team. Keyworkers and Care Co-Ordinators identified for each Enhanced Care Plan.	Ongonig limited safe therapeutic environment to access and review AMH Forensic patients (Dawson House and Roe Valley Limavady) . Lack of local/Regional availability of low secure placements or step-down facilities. Limited ability to ensure therapeutic interventions. AMH Forensic Specialist services require excisting staffing and resourses to be maintained to meet quality standards.	RQIA inspections/reviews. Low level of incidents reported for this client group.	No gaps identified.	Review Enhanced Careplan list by AMH Governance lead Continue to review enhanced careplan list by AMH. Within AMH Forensic services Enhanced Care Plans are reviewed formally at PQC Meetings.	31/07/2017 31/03/2021	09/03/2020

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66	07/10/2009	25	EXTREM	10	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. Additional Independent Expert Reviewers appoited to asssit with the backlog of SAI's. 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. staff are reviewing Datix incidents in line with WHSCT Incident Reporting policy standards Operational managers are collating monthly stats in relation to incidents	Lack of understanding of policies and procedures of newly qualified /recruited staff. Delay in completing SAI/SEA Reviews; resulting in a delay in dissemination of learning from review	RQIA inspections Regular Audit of Risk Assessment by Ward Managers. Review of Serious Adverse Incident Reports by HSCB/RQIA. Donaldson Review and review of SAIs reported 2009-2013.	No gaps identified.	Maintain regular review. Ligature assessment tool to be developed Learning from SAI Nov 18 to be shared	31/03/2021 30/09/2019 31/07/2019	 29/02/2020 31/01/2020
73	07/10/2009	16	HIGH	12	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 informaton 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. performance report on the implementation of RFID within Medical Records Library	Develop Robust awareness training programme. Need to develop formal process to remind staff of responsibilites 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 Extension of rfid to North Wing AAH Review of secondary storage and development of business case.	31/03/2019 30/06/2020 30/09/2020	31/03/2019
100	26/10/2009	16	HIGH	12	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.	Estates Strategy 2015/16-2020/21 Annual review of building condition (3i) and creation of prioritised BLM list 2019/20 Backlog maintenance programme developed Targetting of priority areas as funding becomes available. Continual bidding for funding to address backlog maintenance. Should a critical issue materialise further funding can be sought from DOH or existing funding reprioritised to address the new critical issue 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 Create prioritised BLM 19/20 list Create priortsied list BLM 20/21 Include backlog maintenance in capital plan presented to CMT Procure 19/20 BLM 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 31/03/2020 30/06/2020 30/06/2016 31/03/2020 31/03/2017 30/10/2015 31/03/2019	30/04/2015 31/05/2016 30/04/2017 31/05/2018 05/06/2019 16/06/2016 31/03/2020 31/03/2017 03/09/2015 31/03/2019

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235	08/12/2010	15	EXTREM	15	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 Toiwer Block levels 1-5 and Dermatology upgrade of water system, water system and associated processes Milk Bank SWAH Replace RO water system Renal Unit upgrade water system Nucleus, reenfield, Carnhill, Avoca lodge updated wtaer safety plans pseudomonas risk assessment for augmented care	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. liimited assurance regarding flushing underused outlets	Independent Authorised Engineers appointed for Water Safety. Independent Audit of Water Safety (November 2014). RQIA Inspections of augmented care. Updated Risk assessments included in water safety plans CMT/Trust Board Water Hygiene Policy May 2017 Updated Water Safety Plans. Independent audit of Water Safety October 2016 . Water Safety Group review implementation of Water Safety Plans.	Independant 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. update Water Safety Plan upgrade ward wing toilets (40) Upgrade water system Nucleus Installation of hot water supply to Milk Bank SWAH action Independant audit recommendations pseudomonas risk assessment augmented care areas	30/09/2020 01/07/2017 01/11/2016 01/07/2017 31/07/2014 30/09/2014 30/09/2020 31/03/2019 30/09/2020 31/08/2018 30/09/2020 31/03/2020	 31/03/2018 31/05/2017 31/03/2017 30/09/2014 06/10/2014 31/03/2019 31/08/2018 31/12/2019
284	13/12/2010	16	HIGH	16	HIGH	8	HIGH	Director of Performance & Service Improvement	Performance & Service Improvement	Governance.	Risk of breach of General Data Protection Regulation (GDPR) and Data Protection legislation through loss of personal or sensitiv	As a result of gaps in staff awareness and training in data protection requirements and non-adherence to retention and disposal guidance, there is a risk that personal or sensitive data could be lost, inappropriately stored or accessed; records could be retained beyond their lifecycle and lead to a breach of confidentiality and the Data Protection Act, DoH Good Management Good Records Guidelines and result in potential enforcement action from the Information Commissioners' Office alongside damage to the Trust' reputation.	Subject Access and Data Access agreement procedures. Information Governance/Records Management induction/awareness training. 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 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 Data Protection & Confidentiality Policy. Information Governance SIRO and IAO Framework.	Potential that information may be stored/transferred in breach of Trust policies. Limited uptake of Information Governance and Records Management training. No capacity within the team to take on provision of IG training	Reports to Risk Management Sub-Committee/Governance Committee BSO Audit of ICT and Information Management Standards. BSO Internal Audit of Information Governance. Revised composition and terms of reference of the Information Governance Steering Group as a result of the new SIRO/IAO framework.		Band 3 0.5 post inceased to full time Recruitment of Band 4 Information Governance Development of information leaflet for Support Services Staff to increase awareness of information governance Recruitment of band 5 IG post to support DPA Development of IG information leaflet for support staff Development of IG action plan to be finalised through IGSG	31/03/2019 31/03/2019 31/03/2019 30/09/2020 30/09/2020 30/09/2020	31/03/2019 28/02/2019 01/03/2019

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ID	Opened date	Rating (initial)	Risk level (initial)	Rating (current) (Consq x Likli)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Directorate	Corporate Objectives	Title	Description	Controls Assurance	Gaps in controls Assurance	Assurance	Gaps in assurance	Action Plan	Due date for Action Plan	Done date for Action Plan
535	15/11/2011	16	HIGH	20	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 pateint 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. Nursing KPI Report tabled at CMT monthly The bed compliment of wards is adjusted to reflect their respective normative staffing levels.	No gaps identified.	Monthly review of patient falls through Falls Action Group. Quartelry 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	31/08/2017 30/11/2017 31/12/2016 31/03/2021	31/12/2017 30/09/2017 02/08/2017 31/07/2017 31/07/2017 31/12/2017 30/11/2017 31/12/2016
547	21/09/2012	15	HIGH	16	HIGH	8	MEDIUM	Director of Nursing, Primary Care & Older People's Services	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Public Confidence. Partnerships. Financial Management & Performance. Modernisation.	Inability to access domiciliary care in a timely manner	There is a risk that both hospital patients and community service users will not receive their assessed domiciliary care package in a timely manner. Patients delayed in hospital may be at greater risk of infection and/or falls. Patients in the community may be a greater risk of falls or other injuries. Community service users may have to wait longer for their assessed care package as hospital patients may be prioritised for care packages to maintain hospital flows. Adult Community Care Divisions are experiencing difficulties with accessing responsive domiciliary care service provision due to the following factors; Rurality and the ability to source and secure a sustained domiciliary care service provision in some remote areas across the Trust This risk is impacting service users and carers across both community and hospital care settings resulting in delayed discharges, temporary placements being made in	Interim additional rotas have been established in 12 locations across the Trust through a co-ordinated exercise to address issues where accessing service provision has been identified across all POC's. The Trust continues to implement its reablement service model which is operationally linked to the reform of its in-house homecare service. The combination of these measures is will assist in addressing the risks being experienced and reported.	There is unmet need mainly due to difficulties in recruiting carers, particularly in rural areas	PCOP Domiciliary Care Waiting List There are a range of monitoring and reporting processes in place to ensure this risk is actively monitored A service response to assessed need is progressed on each individual cases through keyworkers and brokerage Actions are taken with regards to the position as reported through these assurance and monitoring mechanisms PFA Discharge Targets Daily Delayed Discharge Report	The focus remains to ensure optimum utilisation of available resource and progress actions in areas where there are clusters of unmet need Total assurance cannot be given as the demand and location of cases cannot be projected or planned for.	Negotiate new contracts with Independent Sector providers. Discussing individual priority clients with providers to re-organise care Providing a range of alternatives, e.g. direct payments Procurement for dom care is almost complete Member of Reablement steering group In-house reform to establish core and reablement teams across the Trust In-house service completing a productivity and efficiency improvement programme to ensure there is optimum utilisation of the rotas. regional development of a new Framework For Delivery of Care and Support in Own Home Project resource to review and improve the utilisation of block	21/04/2016 21/04/2016 21/04/2016 21/04/2016 21/04/2016 31/08/2018 30/09/2018 30/09/2020 30/09/2020	13/09/2016 28/02/2017 13/09/2016 13/09/2016 13/09/2016 31/08/2018 30/09/2018
694	02/08/2013	9	MEDIUM	12	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.		Update 2016 plan Monitoring and review	31/12/2020 31/03/2021	

		Initial Risk		Current Risk		Target Risk													
ID	Opened date	Rating (initial)	Risk level (initial)	Rating (current) (Consq x Likli)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Directorate	Corporate Objectives	Title	Description	Controls Assurance	Gaps in controls Assurance	Assurance	Gaps in assurance	Action Plan	Due date for Action Plan	Done date for Action Plan
719	02/12/2013	20	EXTREM	12	HIGH	8	HIGH	Director of Women & Childrens Services	Trust-wide (Risk Register Use Only)	Governance.	Risk of failure to meet a standard/protocol/guideline.	There is a risk to the Trust if, for whatever reason, it fails to meet a standard/protocol/guideline set that is commensurate to safe and effective care.	Lead Officer assigned to each standard and guideline. Approved system in place for disseminating standards and guidelines. The Trust will identify the standards, policies and protocols/guidance not fully met and the rationale for that position through the Quality & Standards Sub-Committee and escalate as appropriate to Trust Governance Committee. A pathway protocol has been designed to reinforce the correct escalation for exceptions to compliance. Standards & Guidelines requiring implementation are shared quarterly with Directorate Governance Groups. Standards & Guidelines unable to be fully implemented are shared quarterly with Directorate Governance Groups. Standards & Guidelines 'unable to be implemented' are monitored quarterly by Quality & Standards Committee. Exceptions to Compliance (e.g. Not on Track) report provided for each NICE Guideline Standards & Guidelines recorded on central database.	Engagement from Clinical/Professional is not consistent in identifying exceptions and appropriately escalating risks. Pathway protocol may not always be strictly adhered to	Provide bi-monthly assurance report to HSCB/PHA BSO Internal Audit of process - Report received in December 2015 - Satisfactory assurance RQIA Audit of selected guidance.	Capacity to follow up on outstanding guidelines in particular those 'unable to be fully implemented' - growing list	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 Annual reconciliation information held on database against dashboards	31/03/2021 31/03/2021 31/05/2017 31/03/2017 31/03/2021	 27/07/2017 30/06/2017
924	04/04/2016	9	MEDIUM	16	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		Financial Recovery plan to be agreed and approved Operation of DVMB (Delivering Value Management Baord) to ensure delivery of the 3 year financial recovery process Implementation of the Recurrent Balance Solutions Project Initiation Document (PID) Establishment of Working Together Delivering Value Programme Structure	31/12/2018 31/03/2022 31/03/2016 28/02/2019	06/12/2018 31/03/2016 28/02/2019
955	11/08/2016	12	MEDIUM	12	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.			The 5 year implentation plan will continue to be monitored - via Regional Procurement Board, Trust Procurement Board and Social Care Procurement Group.	31/03/2021	

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1075	23/08/2018	12	HIGH	16	HIGH	4	LOW	Director of Finance	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Public Confidence. Workforce.Partnerships.	No Deal Scenario / Hard Border EU Exit	With the imminent EU exit, there is potential for a No Deal Scenario or Hard Border between Northn and South of Ireland. The full impact of the UKs exit from the EU is not yet known and given uncertainty around the UK EU ongoing discussions and potential agreements, there may be impacts such as - workforce, including recruitment and retention, changes to regulations, movement of people and goods, border controls and access to healthcare in EU member states. Day one delivery planning is required to ensure services continue to operate effectively on day one following EU Exit and in the longer term, and that there is no, or minimal disruption to services. Although this is categorised as an organisational risk it also has implications for clinical risk, financail risk, patient and client safety and staffing issues/levels. Lead Officer is Paul Quigley and Reponsible Director is Lesley Mitchell, Director of Fiannce and Contracting.	Detailed review of mitigating actions to be completed by 30 December 2018. Increased frequency of meetings of both regional and local Task and Finishing Groups. Labour, including Cross Border analysis , to be made available to service colleagues. Service focused workshop event arranged for 17 December 2018. Lead Officer is member of EU Finance Subgroup. Communicating financial risks for 2018-19 and 2019-20 predominately. Trust Pharmacy Dept reviewing national pharmacy plans to determine any additional local migration actions eg radioisotopes; non stock and off contract items eg medical gases. Lead Officer to brief CMT of evolving plans on 22 November 2018 BSO Pals providing analysis of high usage nonstock items for consideration bof risk assessment by Trust. BSO Pals assuring lead for stock items including stock building. EU Exit Task & Fnish Group in place incldluing service directorate membership. No Deal Continuity Plans for Services Participation on DoH Regional EU Exit	A number of national and regional risk mitigation issues are being managed at DOH / Government level. The Lead Officer participates in the Regional DoH EU Exit Group.	Continuity Plans developed for Pathology, Pharmacy, FM and Paying Patients department with all other areas in progress and due to be submitted by 24 January 2019. Details of staffing implications by Directorate sourced and being pullled together by HR. the Trust continues to attend various regional forums on EU Exit, incldluing the Doh EU Exit Regional Meeting and other Regional Meetings such as Medicines Preparedness, Information Governance, HR and Emergency Planning. Final Version of Yellow Hammer Document received by Trust EU Exit Task and Finish Group meet monthly. Day one delivery plan	The DOH reported that further discussion at the EU Exit ALBs meeting has clarified that disruption to healt and social care services is not anticipated as a result of any impediment to movement of people at the border and that existing business continuity plans and mitigating actions for potential staff shortages should apply and suffice. Anne Kilgallen, Trust CE has fortnightly meetings with Richard Pengelly and CE of HSC - of which EU Exit and associated continuity planning progress are discussed.	Detailed Review of Mitigating Actions to be completed - Continuity plan Lead Officer to brief CMT of evolving plans on 22 November 2018 Service Focused Workshop to be held on 17 December 2018 Trust Communication to be issued referring to the pilot EU Settlement Scheme being launched on 29 November 2018 Continued regular update internal EU Exit Meetings and updates to CMT. Application of any regional or strategic directives on EU exit. Trust representatives continue to be involved in regional working groups led by DoH in order to inform and assist the Trust in EU Exit Planning. Next meeting due to take place on 21 Januar Assurance Statement to	24/01/2019 22/11/2018 17/12/2018 28/12/2018 31/12/2020 21/01/2019 28/01/2019 21/01/2019 12/02/2019 05/02/2019 04/03/2019 11/02/2019 31/10/2020 31/08/2020 31/12/2020 30/09/2019 30/06/2020	24/01/2019 22/11/2018 17/12/2018 03/12/2018 21/01/2019 29/06/2018 28/01/2019 21/01/2019 12/02/2019 05/02/2019 04/03/2019 11/02/2019 31/10/2019
1100	07/11/2019	12	HIGH	8	HIGH	8	HIGH	Director of Human Resources	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Agenda for Change (AFC) Pay Reform Dispute may impact service provision	Agenda for Change Pay Dispute is resolved for all unions except NIPSA who represent mainly Social Work and Administration staff in the WHSCT. Further action may arise from this.	Local TU engagement. Trust compliance with Agenda for Change Terms and Conditions of Service. Regional Joint Consultation and Negotiation Forum. Emergency Planning Business Continuity protocols. Contingency Plan submitted to HSCB. Briefing to Corporate Management Team and Trust Board. Local Strike Committee meeting. Industrial Action Guides for Staff and Managers. Briefing for Medical Staff on planned Industrial Action of AfC Colleagues.	Pay discussions are led by Department of Health and the Trust is a member of the discussion group.	Information sought for collective bargaining purposes has been verified. Regional TU Side relations - consultation arrangements in place. The Western Trust with other HSC employers is participating in NI AFC Pay Reform discussions. Analysis of impact of pay reform underway. Options Appraisal considering year 2 pay options has been completed by DOH and Employers. The Public Sector Pay Policy has been published.	England, Scotland and Wales have increased pay for AFC staff and reformed payscales for 3 years 2018 - 2021. Department of Health Budget. Safe staffing model for social work. Pay parity with England means unsocial hours rates are part of the deal.	Engagement with social services staff on caseload management and Quality Improvement work. Continued discussions regionally with DOH and Trade Union Side. Within the Trust consider service impact. Continue discussions locally engaging with TU Side. Ensure Business Continuity Arrangements are developed.	30/09/2020 30/09/2020 30/09/2020 30/09/2020 30/09/2020	
1109	30/01/2019	16	HIGH	16	HIGH	4	LOW	Director of Women & Childrens Services	Women & Children's Services	Safe & Effective Services.	Difficulty Recruiting to all frontline social work areas across the Trust	There has been longstanding issues recruiting and retaining staff to Family Intervention Service and Gateway Service in Enniskillen. This has resulted in a high number of unallocated cases and reprioritising of active caseloads to ensure the highest priority/risk are allocated resulting in some cases being placed back on the unallocated list. Current staff are working long hours due to pressure of responding to duty work.	Links being established with schools and colleges Meeting scheduled with community/volunatry organisations and family support services in Enniskillen to ascertain what support can be provided to families waiting on a service.	Insufficient number of social work student applications to the University Degree Course from the Fermanagh area. Need to liaise with the University	Quarterly Governance Meetings Action Plan developed to review and monitor Recruitment Issues and explore possible solutions		Family Intervention staff are establishing links with schools and colleges to encourage social work as a career choice. Close liaison with HR in relation to recruit drives Advertise and Recruit on a rolling basis Recruitment Panel to recruit to Southern Sector	30/09/2020 31/03/2021 31/03/2021 30/01/2019	 07/03/2019

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ID	Opened date	Rating (initial)	Risk level (initial)	Rating (current) (Consq x Likli)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Directorate	Corporate Objectives	Title	Description	Controls Assurance	Gaps in controls Assurance	Assurance	Gaps in assurance	Action Plan	Due date for Action Plan	Done date for Action Plan
1133	23/05/2019	15	EXTREM	15	EXTREM	5	HIGH	Director of Nursing, Primary Care & Older People's Services	Primary Care and Older People Services	Safe & Effective Services.	Risk to safe patient care relating to inappropriate use of medical air	Risk of patient receiving medical air in error when oxygen is required resulting in hypoxia.	Regional procurement process - will no longer be able to buy a medical air flowmeter without a flowguard In the Trust's clinical procedures for medical gases Included on the medical gas training for wards Medical air blanking caps have been circulated to wards to insert into outlets that wont be used Colour coding of medical air flowmeters and air outlet on most wards Flowmeters with air-guards attached on all wards now.	Lack of knowledge of colour coding and appreciation of risks with medical gases Potentially have old flometers that are not fully compliant with colour coding (not mandatory) Not all medical air flowmeters had airguards but they do now	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	Lack of training on medical gases. This has increased now since included in Trust Combination training days.	SAI reviews to identify learning and progress actions to completion Review the mitigating actions and any gaps in controls Possible further learning from SAI investigation Continue to include in Trust combination training days Old flow-meters removed to ensure colour coding approach is used Air outlet blocking caps to be inserted to air outlets that are not needed Ensure full compliance with use of air guards on medical air flowmeters across all three sites	30/09/2020 07/06/2020 31/12/2019	 31/12/2019 31/12/2019 31/12/2019 31/12/2019 31/12/2019
1165	06/09/2019	20	EXTREM	12	HIGH	4	LOW	Director of Human Resources	Trust-wide (Risk Register Use Only)	Workforce.	Service Impact of HMRC Regulations in relation to Pensions.	Clinical staff seeking to reduce their additional employment contract commitments due to tax consequences of their HSC pension i.e. Annual Allowance.	Employer Technical Updates Annual Benefits Statement Job Planning Workshop for Assistant Directors and Clinical Directors held on 18 November 2019, 22 January 2020 and 4 February 2020. Pension Workshops for high earners in June 2018, September 2019 and October 2019. Directorate SMTs briefed on issue.	Doctors report insufficient information on this issue being made available to them	National Consultation on 50:50 membership model Pension Regulator HSC Scheme Advisory Board HSC Pension Board Discussions ongoing regionally with HSC Pensions, Department of Health, other HSC Trusts and BMA Finance Bill 2020	Impact of McCloud and Sergeant Employment Law cases HSC Pensions Service under resourced.	Consider the impact of job plans as agreed on service areas.	30/09/2020	
1166	06/09/2019	20	EXTREM	20	EXTREM	9	MEDIUM	Director of Adult Mental Health & Learning Disability	Adult Mental Health & Disability Services	Safe & Effective Services.Go vernance.	Lack of a robust Governance Structure within AMHDS resulting in risk of not being able to identify emerging risks and Learn	Oct 2019 Risk reviewed at SMT/CSCG/ Directorate Governance and the Directorate is working as per the service improvement plan. Within AMH the CSCG Meeting has been amalgamated with SMT to ensure the focus of governance is everyone's business and that this will allow a framework for good governance at all senior management meetings. RQIA has identified that the AMHDS directorate Governance structure and the systems for recognising and managing adverse incidents and near misses are not sufficiently robust. As a result, opportunities to identify and manage emerging risks, and to identify, implement and share learning to improve quality of care, may be being missed.	Formal monthly update of the Action Plan to be submitted to RQIA. If unable to make the dealine RQIA to be informed prior to the formal monthly update. RQIA contacted and requested that as a Trust we pause monthly updates until the end of Covid-19. Monitor untoward incidents via the DATIX system Monitor complaints within the Directorate. Additional Governance posts will address complaints. Directorate Governance Meetings increased to fortnightly and review of the risk register Rapid review group meets weekly and reviews all red incidents SAI/SEA Reviews as per Regional Guidance. Additional staff from Beeches Centre employed to asssit with outstanding SAI/SEA. Ongoing training for staff within the Directorate to effectively use the DATIX incident reporting system.	Lack of robust Governance structure for directorate. Two additional staff have been secured for the governance Team Band 8C and 1 8B. 2 8A Governace posts outstanding. Risk Management training for all Incident Handlers Ad hoc arrangements for reviewing incidents at local ward level Outstanding SAI/SEA Reports. Incidents are not being reviewed and closed 1 staff member within the Governance role and the current capacity outweighs demand	Performance reporting on open incidents to Directorate Governance, C&SCG Sub Committee & Governance Committee. Twice yearly ligature risk assessments Health and Safety Inspections through the Trust Health and Safety Working Group Unannounced RQIA Inspections Quality Improvement audit ongoing	Lack of Open incidents escalation process from local level to service managers/ADs prior to Directorate Governance. Actions identified within the Service Improvement Notice from RQIA with a review in Oct 2019. Recieved extension of timescale in relation to improvement notice to 22/06/2020	Improvement plan to meet improvement notice requirements, action plan to be updated and submitted to RQIA monthly. From March 2020 RQIA have agreed that due to additional pressures from Covid that the monthly updates will be temporary suspended. Share learning from improvement plan Trust wide. 5/2/2020 WHSCT recieved an extension of timescale improvemnet notic to 22/06/2020 Secure financial funding for governance Team. Additional 2 staff members have been redeployed to the governance Team-Band 8C and 1 8B. 2 Additional Band 8A being developed.	30/06/2020 22/06/2020 30/06/2020	

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1183	27/11/2019	25	EXTREM	25	EXTREM	15	EXTREM	Director of Adult Mental Health & Learning Disability	Adult Mental Health & Disability Services	Governance. Safe & Effective Services.	Mental Capacity Assessment Training	The Department of Health, requires H&SC Trusts to proceed with a partial implementation of the Mental Capacity Act (NI) 2016 (MCA) for providing a statutory framework for the Deprivation of Liberty from the 2nd December 2019 with full implementation by December 2020. By the 2nd December 2019, the Trust must have sufficient numbers of staff identified and trained & structures and administrative process put in place to ensure legal compliance in situations where the care of a patient requires a deprivation of liberty to take place. If these arrangements are not ready and working efficiently then there is a significant risk to the effective delivery of care including our ability to treat patients in the hospital using short-term detention orders and our ability to discharge patients from hospital where a Trust Panel decision is required. Failure in these arrangements would affect adversely on performance and consequently patient safety and	short term detention training ASW freed up to work in the hospital to undertake short detention orders. Meetings are held on a weekly basis Staff training is available via eLearning as well as from CEC Project Implementation Officer Programme Management arrangements	Cost of implementation of MCA. Capacity of medics to sit on panels Not having enough staff trained to undertake the duties of MCA Current strike action advising work to rule Ongoing challenges and negotiations with the Unions regarding staff engagement in the process	Medical directors are meeting with the CMO RQIA monitoring role HR T&F group Business Case T&F group Information T&F group Overall regional group comprising the director leads identified in each Trust Trust is engaging with regional arrangements to share practice and develop solutions		Quantification of Costs and completion of the IPT bid to ensure fully funded MCA arrangements and minimise financial risk To agreed HR & remunerations for staff identified to undertake duties on panels Identifying medical staff to undertake patient examination and capacity reports to go to panel for new patients ensure sufficient staff attend training to allow them to undertake statutory functions commencing 2nd December 2019 Identification and agreement of the medical and other appropriate healthcare professionals necessary to undertake short term detention authorisations in hospital E-Learning (Level 2) - All staff who provide patient care in an	31/03/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2020 31/12/2020	
1207	04/03/2020	9	MEDIUM	12	HIGH	8	HIGH	Director of Nursing, Primary Care & Older People's Services	Primary Care and Older People Services	Safe & Effective Services.Public Confidence. Partnerships. Governance.	Care, safety and quality standards delivered in Independent Sector Nursing and Residential Care Facilities	RQIA had issued a number of Failure to Comply notices to care facilities across the Trust in relation to their leadership, quality, safety and standards of care. The Trust will work with these Care Facilities to ensure safe and effective care is delivered to all residents whilst they have Failure to comply notices and continue to monitor thereafter to ensure standards are sustained.	Trust Monitoring Visits Contract review meetings Trust meetings with providers are scheduled on a regular basis ISP Governance Group CISGG	The Independent Homes are under the management of private owners and the Trust has to work with these owners and staff to ensure standards are reached and sustained.	COPNI Oversight All providers are required to be registered with RQIA and are subject to regular monitoring visits RQIA involvement Meeting with Care Managers and families and residents. monitoring visits, enhanced monitoring visits, meetings with families, owners, other Trust, RQIA	Reliance on owners to meet and sustain the required standards.	Community Independent Sector Governance Group (CISGG) to be set up to develop a robust governance framework in relation to community independent sector services contracted by the Trust Task and Finish Group to be set up to develop recommendations and action list for monitoring framework for independent nursing and residential homes.	31/12/2019 30/06/2020	31/12/2019

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1213	04/04/2020	20	EXTREM	20	EXTREM	10	HIGH	Medical Director	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Governance.Workforce.	COVID-19 risk re assess & response to patient/client need & maintain quality & safety for patients/clients and staff	If current capacity limitations and activity levels across all Trust services remain or increase, the Trust may not be able to meet the increased demand placed on it following an outbreak of Coronavirus (Covid-19), 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 Daily links to Regional HSC Silver Control Group 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;	A lack of additional resource to manage community screening and subsequent management. Environmental challenges in ED to facilitate appropriate isolation facilities Gaps in regional /national supply issues on commodities/medicine etc A lack of guidance on pathways for specialties (regional/national) Availability and quality challenges re PPE Awaiting additional equipment (regional) Single database for reporting monitoring on staff positive figures	Corporate Safety Team / RRG reporting Sit-rep reports (Trust & Indep sector) Health checks Governance framework for Covid-19 management Covid-19 Risk Register Covid-19 Corporate Risk Datix incidents, complaints Daily briefings - Bronze and Silver control, planning groups RIDDOR reporting	No Regional process/guidance for approving donated PPE Covid-19 Independent sector reporting	Develop Covid risk & control document Facilitate daily monitoring and reporting on Risks Revise Covid risk & control document to reflect re-set	31/05/2020 31/05/2020 30/06/2020	31/05/2020 31/05/2020
1216	15/04/2020	15	EXTREM	15	EXTREM	5	HIGH	Director of Acute Hospital Services	Acute Hospital Services	Safe & Effective Services.Public Confidence.	Risk of patient harm in Trust EDs due to capacity, staffing and patient flow issues	If 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	Implementation of SAFER principles challenged due to Medical Job plans and current Medical team models in operation ageing population living with challenging health needs Community infrastructure to meet needs of patients i.e. Gp appointments, social care packages Recruitment to perm medical posts Challenging across NI	Datix - Incident, Complaints, Litigation, Risk register Patient flow teams, Night service manager, SPOC, Hub Regional huddle Established patient pathways	Gaps in patient pathway	PACE implementation to commence March 2020. Improvement QI work commencing with aim to address communication within department.	31/03/2021 31/03/2021	

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923
86
46
284
213
855
694
924
58
285
948