Western Health and Social Care Trust

CORPORATE RISK REGISTER & ASSURANCE FRAMEWORK

BRIEFING NOTE PREPARED FOR TRUST BOARD
1 OCTOBER 2020

There are 29 risks on the Corporate Risk Register as approved at Trust Board on 10th September 2020.

Summary

- Proposed new Corporate Risk relating to Resuscitation of COVID –19 patients in WHSCT settings
- Update on Covid-19 risk ID1213
- Progress re Risk Workshop 2019 actions

Proposed new Corporate Risk by PCOPS directorate

Proposed new risk title: - "Resuscitation of COVID –19 patients in WHSCT settings"

Risk description: - "Resuscitation Council UK (RCUK) advise that chest compressions are an aerosol generating procedure (AGP) and require AGP PPE to be worn for Resuscitation of suspected or confirmed COVID-19 patients.

The guidelines issued by PHE and PHA advise that chest compressions are not an AGP however the RCUK statement on the 4th March 2020 states that chest compressions are an AGP and therefore staff require full AGP PPE before starting chest compressions. PHE statement 21st May 2020 regarding NERVTAG review stated that Healthcare organisations may choose to advise their staff to wear AGP PPE when performing chest compressions but strongly advised that there should be no delay in delivering this life saving intervention.

The guidance from Resuscitation Council UK (RCUK) issued on 11th May 2020 for an adult patient (suspected or confirmed COVID- 19) in an acute hospital setting states that cardiac arrest is confirmed by staff in non- AGP PPE and up to three (defibrillation) shocks can be given in an attempt to restore circulation early and negate the need for chest compressions. Further procedures such as chest compressions and airway manoeuvres including manual ventilation require the donning of AGP PPE and any one in non-AGP PPE must leave the room before chest compressions and manual ventilations are commenced.

The guidance for Primary Care differs slightly from resuscitation in the acute hospital- RCUK still recommend AGP PPE before starting chest compressions but recognise that this may not be achievable in the primary or community care setting depending on the availability or otherwise of PPE.
If no PPE available the individual must decide the course of action- as a bare minimum cover the patient's mouth and nose with a cloth prior to chest compressions being carried out in the home or public space and ideally don at least non – AGP PPE before commencing chest compressions.

Ventilation and further Advanced Life Support measures should only begin when staff are in AGP PPE. All staff expected to perform CPR (to a level of their expected clinical duties) need to be face fitted and trained in the donning and doffing of PPE. All staff must have access to the appropriate level of PPE required to fulfil their clinical duties.
This (guidance) could result in a delay in resuscitation that could result in a hypoxic event for the patient due to lack of oxygen delivered to the brain and result in an increased risk of neurological damage.

A number of the recommendations for adult resuscitation are different to guidelines approved over many years,

- Not to put cheek or ear down to look, listen feel for breathing.
- Delaying compressions until AGP PPE is put on
- Delivering 3 shocks if the patient is in VF/VT instead of 1 shock

The risk is that staff will instinctively do what they have been trained to do over many years and commence CPR without PPE that could result in potential aerosol generating procedure and harm to staff i.e. Increase the risk of contracting COVID-19 and transmission to other staff and wider community.

The updated RCUK statement on PHE PPE guidance from 28th April 2020 states:

"In the absence of high-quality evidence to state that anything less than AGP PPE is sufficient for healthcare professional safety, Resuscitation Council UK maintains its belief that AGP PPE provides the safest level of protection when administering chest compressions, CPR, and advanced airway procedures in known or suspected COVID-19 patients. For this reason, we welcome the fact that PHE's guidance of 24 April now aligns with that of RCUK, inasmuch as it allows Trusts to opt for AGP levels of PPE if they consider this appropriate to best ensure HCP safety."

The Trust Resuscitation Committee has reviewed and decided to continue to follow the Resuscitation Council guidelines"**.**

Current Risk Rating – Consequence MAJOR (4) X Likelihood POSSIBLE (3) = **HIGH** (12)

Target Risk Rating – Consequence MAJOR (4) X Likelihood UNLIKELY (2) = **HIGH** (8)

See attached risk form for details.

Update on Covid-19 Risk ID 1213

Consider the following metrics from Sit-Rep at 22/09/20 when reviewing the current grading of this risk (note the fig. as at 29/04/20 for comparison):-

Table 1 – Metrics comparison as at 22/09/20

Metrics	As at 22/09/20	As at 29/04/20
Covid-19 deaths	**30**	**26**
Total Staff tested positive	**124**	**5 notified in September at 22/09/20. Previous last positive test 15/07/20**
Number of staff positives reported under RIDDOR.	**79**	**Last RIDDOR reported May 2020**

Update on Actions following October Trust Board Risk Register Workshop at 22 September 2020

The following is the latest log on actions from the Trust Board Risk workshop in October 2020. Please provide an updated position against each risk for tabling at October Trust Board.

ID	Lead Dir.	Risk Title	Action from workshop	Update	Action Status
3	Dr Catherine McDonnell	Health and Safety risk - resulting in injury	Acknowledged recent reduction in grading. Review gaps in control as a result and also consider achievable actions over the next year which should help close these gaps further. Health and Safety Committee to consider Incident Trends	Risk reviewed at C&SCG Sub committee on 24/07/20 and agreed risk grading to remain considering ongoing PPE and other covid related Health & Safety issues such as face coverings Gaps in controls revised and accepted at Audit & Risk Assurance Sub Committee as accurate reflection of current situation regarding equipment procurement and maintenance.	Complete
6	Ms Deirdre Mahon	Potential for harm to children whilst awaiting Gateway and Family Intervention Service (unallocated cases)	Remove "Potential for.." from the title. Further gaps in controls to be listed. Consider caseload reviews, funding reviews, escalation process	Gaps in controls updated; Title revised.	Complete
46	Mrs Ann McConnell	Challenges to compliance with Working Time Regulations	Risk to be considered for management at directorate level by each directorate who had specific challenges and the risk tailored to these.	HR has updated risk, this will remain a Corporate Risk until Sleep in cases have been heard (listed for February 2020). Other Directorates to consider for their areas. A new Corporate Risk is proposed for CMT which will include all the workforce issues that feature across all the corporate risks at present	Complete
51	Mr Neil Guckian	The inability of the Trust to achieve break-even or contain expenditure within authorized control limit	This risk should be merged with ID924 and overall risk reviewed. New risk target should be reviewed and may be Medium to adjust for current financial plan.	Finance directorate reviewing risk along with ID924 with a view to merge/replace with one risk. 51 & 924 merged and approved at Trust Board Aug 2020	Complete

ID	Lead Dir.	Risk Title	Action from workshop	Update	Action Status
57	Dr Catherine McDonnell	Lack of cross-Directorate learning from adverse incidents, complaints, claims & audit recommendations	All directorates to prioritise this risk for significant progress over next 12 months.	Sept20 - Briefing to September Trust Board on SAI performance and focus on legacy SAIs. Monthly briefings to Trust Board on progress of Safety Quality Management System Improvement Plan.	In progress
58	Mrs Ann McConnell	Over dependence on the use of locum and agency staff to sustain services and insufficient induction for locum medical staff	To remain a Corporate risk but each directorate should be asked to evaluate their contribution to managing this risk and update the risk with ongoing input from directorates. Need to identify the scale of the risk a monitor % increase or decrease	HR has updated risk. There is an overlap across a number of risks for consideration by Directorates for merging. However, Risk ID535 should remain as this relates to nursing workforce issues which is the responsibility of the Executive Director of Nursing. A new Corporate Risk is proposed for CMT which will include all the workforce issues that feature across all the corporate risks at present	Complete
63	Ms Karen OBrien	High risk forensic/challenging individuals who have potential to cause harm to themselves or others	Review gaps in control and re-word "specialist services generally not well resourced". Actions should correspond to the gaps identified.	Re-worded - "AMH Forensic Specialist services require existing staffing and resources to be maintained to meet quality standards." Action Plan corresponds to gaps identified.	Complete
73	Mrs Teresa Molloy	Risk that patient medical records and/or patient information on Trust systems may not be complete, accurate or available at PoC	Current grading to be reviewed based on a review of incidents to be completed by IGSG. Incident review to include 1) Availability of records and 2) completeness and accuracy of the records.	Request to de-escalate to directorate at July CMT. Discussed at August Trust Board but decision making deferred to October workshop	Complete
235	Dr Catherine McDonnell	Risks associated Water Borne Pathogens	Consider changing target score to 10 (c5xl2) as ongoing actions will only reduce likelihood. Confirmed current grading not changed since 2014. Review in light of all work complete in Tower block.	Meeting 15/01/20 Risk to be de-escalated and PSA risk raised to Dir register, Legionella risk will be included in a re-worded risk regarding continuing failure to meet statutory requirements of Water safety, for raising as Corporate Risk. W Cross to raise proposal to CMT. Risk title and description amended at Sept Trust Board	Complete
535	Dr Bob Brown	Risk that patients may experience a reduced quality of nursing care due to workforce deficits	Risk requires fundamental review and rewording and considered in context of workforce risks generally. Need to consider Unscheduled Care issues.	Dr Brown to present update report to Trust Board in August 2020. Proposal to de-escalate risk to directorate level being tabled at July CMT. Discussed at August Trust Board but decision making deferred to October workshop	Complete

ID	Lead Dir.	Risk Title	Action from workshop	Update	Action Status
547	Dr Bob Brown	Inability to access domiciliary care in a timely manner	This should reflect the increased risk to patients in community and the controls in place to manage this. Should be described as a quality & safety risk rather than simply access issues.	Risk is being re-assessed in terms of overall patient ham against the volume of care that is commissioned each week. Aim to bring proposal to September CMT	In progress
694	Geraldine McKay	Risk to patient/client safety because of insufficient Medical cover in PCOPS and Medical Wards in SWAH	Current grading requires to be updated in light of actions completed against this risk in last 12 months. Controls must be updated to reflect all controls in place now. Need to quantify impact. Can this be downgraded?	A paper is currently being prepared for CMT consideration which aims to stabilise the medical workforce across South West & Omagh Hospitals	In progress
924	Dr Anne Kilgallen	The Trust's ability to achieve Recurrent Balance	This risk should be merged with ID51 and overall risk reviewed. New risk target may be Medium to adjust for current financial plan.	Finance directorate reviewing risk along with ID51 with a view to merge/replace with one risk. 51 & 924 merged and approved at Trust Board Aug 2020	Complete
955	Dr Anne Kilgallen	Failure to comply with procurement legislation re social care procurement	Should be retained as Corporate risk but each directorate to review and update controls as current list not reflective of all controls in place	The Trust is participating in the Light Touch Regime with regional prioritisation of social care procurements. The decision has been made to begin preparations for the retendering of contracts for Domiciliary Care although the decision to complete will require further consideration.	In progress
1109	Ms Deirdre Mahon	Difficulty Recruiting to Family Intervention and Gateway Enniskillen	Review risk to consider should this be a Directorate risk or combined with ID6? Review incidents over last 2 years of harm / suspected harm to inform review.	Title amended to "Difficulty Recruiting to all frontline social work areas across the Trust" to reflect Trust wide risk. Separate to ID 6.	Complete
1133	Dr Bob Brown	Risk to safe patient care relating to inappropriate use of medical air	The controls need to be evidenced and current grading reviewed.	3 SAI reviews ongoing with risk to be updated as learning /actions identified.	In progress
1165	Mrs Ann McConnell	Service Impact of HMRC Regulations in relation to Pensions.	New risk	This needs to remain a Corporate Risk until the outcome of the consultation by the Department of Health and Social Care in England is known. The Trust is continuing to address issues raised by clinicians who may be impacted by tax consequences of their HSC Pension i.e. Life Time and or Annual Allowances.	Complete

New Risk Form

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

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

No	Datix Field Name	Data to be included in this Field		
1.	**Title of Risk *** **(please keep this brief e.g. "Risk of Fire in Trust Premises" –)**	Resuscitation of COVID –19 patients in WHSCT settings		
2.	**Facility** **(only necessary if risk relates to one specific facility)**			
3.	**Directorate *** **If risk affects 2 or more Directorates, please list relevant Directorates.**			
4.	**Sub-Directorate *** **If risk affects two or more Sub-Directorates, please list.**	Any area where a patient suffers a cardiopulmonary arrest and requires staff to start cardiopulmonary resuscitation.		
5.	**Specialty** **Please list most relevant Specialty this risk relates to.**			
6.	**Ward/Department** **(necessary only if risk relates to one specific Ward/Dept)**			
7.	**Risk Type*** **Please indicate which organisational level you are of the opinion this risk should be escalated to (please tick)** **NB: This is subject to approval by relevant Senior Manager/Director/CMT – refer to Appendix 3 of Risk Management Strategy (see web-link above) :-**		Corporate	✓
			Directorate	
			Sub- Directorate/Divisional	

8.	**Risk Sub-type*** Please tick most appropriate category:	• Clinical Risk ✓ • Staff Competence • Compliance with Professional/Clinical/Non-Clinical Standards ✓ • Education & Training ✓ • Emergency/Contingency Planning Arrangements • Equipment • Financial • Fire Safety • Health & Safety ✓ • Independent Sector ✓ • Infection Control • Organisational • Professional Issues ✓ • Patient/Client Safety✓ • Staffing Issues/Levels

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

10.	**Lead Officer* with responsibility for managing this risk (Name, Job Title, and Contact Details.** **(i.e. manager with operational responsibility)**	Dr Adesh Ramsewak, Chair Resuscitation Committee
11.	**Name of Responsible Director*** **(NB: Where a risk is Cross-Directorate, the most appropriate Director to manage this risk should be listed. It will be their responsibility to liaise with other Directors re management of this risk).**	Dr Bob Brown Director PCOP Dr Catherine McDonnell, Medical Director

12.	**Description of Risk*** Please provide a full description of the nature of the risk. Please limit this to 255 characters	Resuscitation Council UK (RCUK) advise that chest compressions are an aerosol generating procedure (AGP) and require AGP PPE to be worn for Resuscitation of suspected or confirmed COVID-19 patients. The guidelines issued by PHE and PHA advise that chest compressions are not an AGP however the RCUK statement on the 4th March 2020 states that chest compressions are an AGP and therefore staff require full AGP PPE before starting chest compressions. PHE statement 21st May 2020 regarding NERVTAG review stated that Healthcare organisations may choose to advise their staff to wear AGP PPE when performing chest compressions but strongly advised that there should be no delay in delivering this life saving intervention. The guidance from Resuscitation Council UK (RCUK) issued on 11th May 2020 for an adult patient (suspected or confirmed COVID- 19) in an acute hospital setting states that cardiac arrest is confirmed by staff in non- AGP PPE and up to three (defibrillation) shocks can be given in an attempt to restore circulation early and negate the need for chest compressions. Further procedures such as chest compressions and airway manoeuvres including manual ventilation require the donning of AGP PPE and any one in non-AGP PPE must leave the room before chest compressions and manual ventilations are commenced. The guidance for Primary Care differs slightly from resuscitation in the acute hospital- RCUK still recommend AGP PPE before starting chest compressions but recognise that this may not be achievable in the primary or community care setting depending on the availability or otherwise of PPE. If no PPE available the individual must decide the course of action- as a bare minimum cover the patient's mouth and nose with a cloth prior to chest compressions being carried out in the home or public space and ideally don at least non –AGP PPE before commencing chest compressions.

		Ventilation and further Advanced Life Support measures should only begin when staff are in AGP PPE. All staff expected to perform CPR (to a level of their expected clinical duties) need to be face fitted and trained in the donning and doffing of PPE. All staff must have access to the appropriate level of PPE required to fulfil their clinical duties. This (guidance) could result in a delay in resuscitation that could result in a hypoxic event for the patient due to lack of oxygen delivered to the brain and result in an increased risk of neurological damage. A number of the recommendations for adult resuscitation are different to guidelines approved over many years, • Not to put cheek or ear down to look, listen feel for breathing. • Delaying compressions until AGP PPE is put on • Delivering 3 shocks if the patient is in VF/VT instead of 1 shock The risk is that staff will instinctively do what they have been trained to do over many years and commence CPR without PPE that could result in potential aerosol generating procedure and harm to staff i.e. Increase the risk of contracting COVID-19 and transmission to other staff and wider community. The updated RCUK statement on PHE PPE guidance from 28th April 2020 states: "In the absence of high-quality evidence to state that anything less than AGP PPE is sufficient for healthcare professional safety, Resuscitation Council UK maintains its belief that AGP PPE provides the safest level of protection when administering chest compressions, CPR, and advanced airway procedures in known or suspected COVID-19 patients. For this reason, we welcome the fact that PHE's guidance of 24 April now aligns with that of RCUK, inasmuch as it allows Trusts to opt for AGP levels of PPE if they consider this appropriate to best ensure HCP safety." The Trust Resuscitation Committee has reviewed and decided to continue to follow the Resuscitation Council guidelines.

13.	**Please list all current control measures in place to manage this risk*** (e.g. policies, procedures, training)	Trust communication regarding update from RCUK guidance on the resuscitation of adult COVID-19 patients in Primary Care settings issued on 11/04/2020 with links to the information/infographics and the Resuscitation Share Point site. Cascade trainers taught using the COVID-19 guidance from RCUK.
14.	**Please list all identified gaps in Controls.***	Guidance from Resuscitation Council UK varies from that issued by PHE and PHA. NERVTAGE consensus 21st May 2020.
15.	**Please list all Assurances currently in place to test adequacy of Controls.** (i.e. Audit (Interna/External), inspections by independent organisations, e.g. RQIA, HSENI).	The Resuscitation team will continue to monitor and audit all 6666 calls across Trust facilities. RQIA will continue to monitor the independent sector. Datix incident reporting system will alert the Trust of potential risks to both patients and staff.
15.	**Please list all identified gaps in Assurances.**	

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

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

18. Action Plan to reduce Level of Risk

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

"The Trust's appetite for risk is to minimise risk to patient/client/staff safety and the resources of the Trust, whilst acknowledging that it also has to balance this with the need to invest, develop and innovate in order to achieve the best outcomes and value

for money for the population that it serves. In this respect, risk controls should not be so rigid that they stifle innovation and imaginative use of limited resources in order to achieve health and social care benefits."

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

Question	Response
1. Does the proposed action plan actively manage this risk to ensure that the level of risk can be reduced to the target level?	
2. Does the proposed action plan take account of any opportunities that could be exploited whilst managing this risk?	
3. Has the target level of risk, and how this will be achieved, been communicated to those staff responsible for the operational management of this risk?	
4. How will the proposed actions be monitored to ensure they are completed within identified timescales?	
5. At what point should the decision regarding the management of this risk be escalated to a higher level?	

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

Action Required	Start Date	Due Date	Lead Officer
Trust communication detailing latest guidance from the Resuscitation Council sent 27/05/20 and this is has been shared with care providers by Head of Contracting.	11th April 2020		Kathy Mackey
Staff face fit tested and level 3 PPE available in facilities.	April 2020		Directorate leads
Ongoing monitoring of 666 calls across all Trust facilities by the resuscitation team.	Ongoing		Kathy Mackey

Once the new risk has been approved, these key actions should be recorded within the "Actions" section of Datix.

Once each action has been completed, the date of completion should be recorded. Each completed action should then be listed within the “Controls” section of Datix.

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

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

WHSCT Corporate Risk Register 23/09/2020

Risk Summary Report

				Initial		Current		Target		Current Risk Status				
Risk Category	Risk ID	Lead Director	Risk Title	Score	Grade	**Score**	**Grade**	Score	Grade	**Mths since score changed**	**Change in score since last review**	Mths since last updated	Action Plan Status	Latest Update
Health and Safety	3	Medical Director	Health and Safety risk - resulting in injury	16	HIGH	20	EXTREM	4	HIGH	4	No change	1	Actions listed with future due dates	August 2020 - No Covid RIDDOR incidents since May 2020 as at 21/08/20. A meeting took place of the H&S working group in July which included update on reset guide for safety at work. It was also agreed that the need for a Trust employed qualified Occupational Hygienist was to be escalated for consideration by CMT. July 2020 - Reviewed at C&SCG Sub Committee and agreed grading remains same due to PPE and other covid issues. RIDDOR reported incidents in relation to Covid-19 remain at 79. The risk was also discussed at the July Health and Safety Working group. Members advised that it is their view that the risk should remain as currently graded on the basis that:- the transmission level of covid remains the same with some evidence of new clusters; Shielding staff may be returning to work and may be at an increased risk; Re-set of services will mean that increase in people attending services and coming to premises.
Patient/Client Safety	6	Director of Women & Children's Services	Harm to children whilst awaiting Gateway and Family Intervention Service (unallocated cases)	25	EXTREM	12	HIGH	8	HIGH	34	No change	4	Actions listed with future due dates	29.5.20 Due toCOVID19 and social distancing the ability to allocate referrals for assessment has been impacted Feb 20 - Title amendment updated as approved Trust Board 6-2-20. 5.2.20 Unallocated cases continue to rise due to sickness. Managers continue to monitor current action plans and review those where there also issues re: recruitment and retention which affects ability to allocated.
Compliance with Professional/Clinical/Non-Clinical Standards	46	Director of Human Resources	Challenges to compliance with Working Time Regulations	12	HIGH	12	HIGH	9	MEDIUM	81	No change	1	Actions listed with future due dates	August 2020: At Trust Board Workshop it was agreed to develop a new Corporate Risk which covers all workforce related issues. Draft risk being submitted to August CMT.
Organisational	49	Director of Finance	Virus attack disables network/services	16	HIGH	16	HIGH	9	MEDIUM	38	No change	1	Actions listed with future due dates	20th August 2020 - The Western Trust, BSO and other Trusts continue to experience huge increase in Spamming and Phishing emails specifically relating to Covid19. Western Trust ICT continues to provide short monthly Metacompliance courses and regular Trust Communications covering issues and topics relating to Cyber Security and awareness e.g. phishing, strong passwords, suspicious wording in emails etc. The Trust continues to work with the Regionals Cyber Programme Board on the development of Regional Cyber Policies and alignment of existing ICT Security Polices. A network security review have been carried out by ANSEC as part of the Regional Cyber Security Programme and we will develop a workplan based on the recommendations that comes from this audit. This programme is being managed by the Regional Cyber Programme Board who will identify the required funding.

				Initial		Current		Target		Current Risk Status				
Risk Category	Risk ID	Lead Director	Risk Title	Score	Grade	**Score**	**Grade**	Score	Grade	**Mths since score changed**	**Change in score since last review**	Mths since last updated	Action Plan Status	Latest Update
Patient/Client Safety	57	Medical Director	Lack of cross-Directorate learning from adverse incidents, complaints, claims & audit recommendations	16	HIGH	12	HIGH	8	HIGH	28	No change	1	Actions listed with future due dates	Sept20 - Briefing to September Trust Board on SAI performance and focus on legacy SAIs. Monthly briefings to Trust Board on progress of Safety Quality Management System Improvement Plan.
Workforce Issues	58	Director of Human Resources	Over dependence on the use of locum and agency staff to sustain services and insufficient induction for locum medical staff	12	MEDIUM	15	HIGH	9	MEDIUM	31	No change	1	Actions listed with future due dates	August 2020: At Trust Board Workshop it was agreed to develop a new Corporate Risk which covers all workforce related issues. Draft risk being submitted to August CMT.
Patient/Client Safety	63	Director of Adult Mental Health & Learning Disability	High risk forensic/challenging individuals who have potential to cause harm to themselves or others	20	EXTREM	15	EXTREM	12	HIGH	26	No change	2	Actions listed with future due dates	15th July 2020 Discussed at SMGM and controls and assurances remain appropriate to this risk.9th June 2020Risk reviewed and controls and assurances remain appropriate for risk.
Patient/Client Safety	66	Director of Adult Mental Health & Learning Disability	Death or serious injury of patient as a result of a suicide or attempted suicide while in a Trust facility	25	EXTREM	10	HIGH	5	HIGH	81	No change	0	Actions listed with future due dates	11th September 2020 Following review of Datix Incidents and risk associated with the bedroom doors. Following a site visit to SEHSCT to view Instastop door sensors a proposal to secure these for the inpatients wards was commenced. Agreement at Directorate Governance on 9th Sept followed by AMH Environmental Safety Group on the same day it was agreed to progress with same. 130,000 funding secured and an action plan for installation commenced. Briefing paper preperared for the Corporate Governance Sub-committee on 14/09/2020
Patient/Client Safety	73	Director of Adult Mental Health & Learning Disability	Risk that patient medical records and/or patient information on Trust systems may not be complete, accurate or available at PoC	16	HIGH	12	MEDIUM	6	MEDIUM	77	No change	0	Actions listed with future due dates	Sept 2020 - Records Management week planned for late October to heighten awareness of data quality and records management issues, for staff . A revised Regional IG e-learning will be available to staff by Dec 2020. Ifit system continues to be rolled out across AAH and will reduce the potential for loss of records. Transportation of medical records between WHSCT/NHSCT has been reviewed . A susbtantial weeding exercise is underway by Medical Records, which will identify records for disposal and some misfiled records. August 2020 Chairman had asked that this risk remain on the risk register until the Trust Board Workshop where there is a chance to consider this.
Health and Safety	100	Director of Performance & Service Improvement	Backlog Maintenance	16	HIGH	12	HIGH	12	HIGH	83	No change	0	Actions listed with future due dates	4 Sept 2020: BLM Plan has been approved and under procurement,.
Health and Safety	235	Medical Director	Risk of continuing failure to meet statutory requirements for Water Safety	15	EXTREM	15	EXTREM	8	HIGH	69	No change	0	Actions listed with future due dates	Sept20 - Risk title and description amended following approval at Trust Board. August 20 - Risk revision proposal to August CMT to change the description to "The risk associated with Legionella in the water system and a patient/client developing Legionnaire's pneumonia as a result as a result of non-compliance with statutory requirements ".

				Initial		Current		Target		Current Risk Status				
Risk Category	Risk ID	Lead Director	Risk Title	Score	Grade	**Score**	**Grade**	Score	Grade	**Mths since score changed**	**Change in score since last review**	Mths since last updated	Action Plan Status	Latest Update
Compliance with Professional/Clinical/Non-Clinical Standards	284	Director of Performance & Service Improvement	Risk of breach of General Data Protection Regulation (GDPR) and Data Protection legislation through loss of personal or sensitiv	16	HIGH	16	HIGH	8	HIGH	44	No change	0	Actions listed with future due dates	Sept 20: An IG leaflet has been produced for staff who do not have access to a computer. The leaflet will be distributed to these staff by nominated managers, who will record on a specialised field within HRPTS. 2,500 staff who can work from home/remotely received an email from SIRO, stating IG training had to be completed as a condition of homeworking. Training update will be reported at next IGSG meeting. Home working and Data Breach Reporting guidance was issued to all staff in August to heighten awareness of IG/RM issues. A records Management week is planned for October to increase records management/data quality awareness. Appointment of permanent B5 Secondary Records Officer willl improve advice provision to managers on records management retention and assist with a review of secondary records storage across the Trust. A new post will be be created to support IG Manager role and improve delivery of IG training.
Workforce Issues	535	Director of Nursing, Primary Care & Older People's Services	Risk that patients may experience a reduced quality of nursing care due to workforce deficits	16	HIGH	20	EXTREM	8	HIGH	83	No change	1	Actions listed with future due dates	August 2020 Chairman had asked that this risk remain on the risk register until the Trust Board Workshop where there is a chance to consider this. June 20: Just appointed a new Information Governance HOS. Open Actions to be completed by 30/09/20. 3 March 2020. Latest figures for IG compliance show a further 5% increase to 66%. New Band 5 IG manager post has been created to support DPO role which includes IG training. ITR submitted and closing date is 04th March 2020.
Service Delivery	547	Director of Nursing, Primary Care & Older People's Services	Inability to access domiciliary care in a timely manner	15	HIGH	16	HIGH	8	MEDIUM	63	No change	1	Actions listed with future due dates	Aug20 - Risk is being re-assessed in terms of overall patient ham against the volume of care that is commissioned each week. Aim to bring proposal to September CMT.
Workforce Issues	694	Director of Acute Services	Risk to patient/client safety because of insufficient Medical cover in PCOPS and Medical Wards in SWAH	9	MEDIUM	12	HIGH	9	MEDIUM	47	No change	1	Actions listed with future due dates	August 2020: Work is continuing on the Medical Staffing Paper as per July update. It is hoped this Paper will be submitted to September SMT for consideration. July 2020: A paper is currently being prepared for CMT consideration which aims to stabilise the medical workforce across South West & Omagh Hospitals. This medical staffing paper is being completed on a site-wide basis and will update the paper presented in October 2016 to take account of practice changes, governance requirements and a sustainable staffing model. It is intended that this paper will be presented to CMT before September 2020. The site remain reliant on locum provision and it is hoped that this model will deliver a more attractive proposition to medical staff to work within the South West & Omagh model.

				Initial		Current		Target		Current Risk Status				
Risk Category	Risk ID	Lead Director	Risk Title	Score	Grade	**Score**	**Grade**	Score	Grade	**Mths since score changed**	**Change in score since last review**	Mths since last updated	Action Plan Status	Latest Update
Compliance with Professional/Clinical/Non-Clinical Standards	719	Director of Women & Children's Services	Risk of failure to meet a standard/protocol/guideline.	20	EXTREM	12	HIGH	8	HIGH	69	No change	0	Actions listed with future due dates	Sept 20 - Raised as an agenda item at Quality & Standards Sub Committee on 26 August 2020. Therese Brown Chaired and advised Risk ID719 is a Corporate Risk, Deirdre Mahon is the responsible person for assurance that this Risk is regularly reviewed and appropriately graded. Therese asked that it remains as a standing agenda item and is raised as the 1st point on the agenda going forward. She asked members to encourage Leads to review the NICE Guidelines and Standards on the 'Ongoing and Unable' dashboard and update were applicable reflecting where recommendations can't be meet if this poses a risk and if so it should be reflected on the appropriate risk register. The 'unable to implement NICE Guidelines' Dashboards stands at 124 presently and is increasing monthly. Many have not been reviewed in several years. This is a concern. Therese agreed to write out to Directors and ask for both the ongoing and unable NICE Guidelines to be reviewed and asked Lorraine Adams to reflect any improvement in her reports at the next meeting.
Compliance with Professional/Clinical/Non-Clinical Standards	955	Chief Executive	Failure to comply with procurement legislation re social care procurement	12	MEDIUM	12	MEDIUM	4	LOW	48	No change	1	Actions listed with future due dates	August 20 The Trust is participating in the Light Touch Regime with regional prioritisation of social care procurements. The decision has been made to begin preparations for the retendering of contracts for Domiciliary Care although the decision to complete will require further consideration.
Workforce Issues	1075	Director of Finance	No Deal Scenario / Hard Border EU Exit	12	HIGH	16	HIGH	4	LOW	22	No change	0	Actions listed with future due dates	Sept 20 - The Risk of No Deal Exit has been accentuated by the current UK Government debate and voting of a potentially contentious Internal Market Bill. Given the implications upon the UK/EU discussions, the Trust continues to: Retain buffer levels of Non-Stock supplies; Communicate with the Department of Health on any appropriate EU Exit matters; Address any outstanding data sharing agreement issues; Have the ability to seek a review of previously compiled contingency plans.
Workforce Issues	1100	Director of Human Resources	Agenda for Change (AFC) Pay Reform Dispute may impact service provision	12	HIGH	8	HIGH	8	HIGH	4	No change	1	Actions listed with future due dates	August 2020: At Trust Board Workshop it was agreed to develop a new Corporate Risk which covers all workforce related issues. Draft risk being submitted to August CMT.
Workforce Issues	1109	Director of Women & Children's Services	Difficulty Recruiting to all frontline social work areas across the Trust	16	HIGH	16	HIGH	4	LOW	20	No change	4	Actions listed with future due dates	29.5.20 There has been some staff recruited and recently student social workers who were due to qualify have been placed in Enniskillen. Rolling advertisements will recommence to recruit to Southern Sector of the Trust

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Patient/Client Safety	1133	Director of Nursing, Primary Care & Older People's Services	Risk to safe patient care relating to inappropriate use of medical air	15	EXTREM	25	EXTREM	5	HIGH	3	No change	1	Actions listed with future due dates	Aug 2020 - SAI meeting 24/08/20, SAI draft report progressing, aim for submission mid September. July 2020 - Grading revised following consideration at CMT in June from 15 to 25 EXTREME following 3 SAIs / Never Events. SAIs being progressed and ToR and Team membership sent to HSCB on 10-07-20.
Workforce Issues	1165	Director of Human Resources	Service Impact of HMRC Regulations in relation to Pensions.	20	EXTREM	12	HIGH	4	LOW	4	No change	1	Actions listed with future due dates	August 2020: At Trust Board Workshop it was agreed to develop a new Corporate Risk which covers all workforce related issues. Draft risk being submitted to August CMT.
Patient/Client Safety	1166	Director of Adult Mental Health & Learning Disability	Lack of a robust Governance Structure within AMHDS resulting in risk of not being able to identify emerging risks and Learn	20	EXTREM	20	EXTREM	9	MEDIUM	13	No change	0	Actions listed with future due dates	23/09/2020 awaiting funding to secure governance posts in the interim governance structure outlined and agreed with RQIA and Trust. 27/08/20 - Improvement notice lifted 19 August. IPT (Mental Health Demography) completed & submitted 17 July to secure funding for Governance structure.
Compliance with Professional/Clinical/Non-Clinical Standards	1183	Director of Adult Mental Health & Learning Disability	Mental Capacity Assessment Training	25	EXTREM	25	EXTREM	15	EXTREM	10	No change	2	Actions listed with future due dates	9/07/20. Controls and Assurances reviewed and updated. Target completion dates reviewed and updated. 9/06/20. Risk lead changed to Christine McLaughlin. Controls and Assurances updated. 10 Actions closed through review, 5 remain open - target completion dates reviewed and updated.
Patient/Client Safety	1207	Director of Nursing, Primary Care & Older People's Services	Care, safety and quality standards delivered in Independent Sector Nursing and Residential Care Facilities	9	MEDIUM	12	HIGH	8	HIGH	5	No change	1	Actions listed with future due dates	28.08.20 - The Community Independent Sector Services Oversight Group has not met in its formal capacity since March 2020. The next scheduled meeting in September 2020 will go ahead and will continue to meet monthly until all task and finish groups have completed their work. The key members of the Community Independent Sector Services Governance Group (CISSGG) have met twice/three times per week in the various Covid forums including the Community Governance Group, Community Oversight Group and Community
Patient/Client Safety	1213	Medical Director	COVID-19 risk re assess & response to patient/client need & maintain quality & safety for patients/clients and staff	20	EXTREM	20	EXTREM	10	HIGH	5	No change	1	Actions listed with future due dates	22/09/20 - Covid-19 deaths total = 30; Total Staff tested positive =124. Command and Control Review 2020 Paper for discussion at Trust Silver on 23/09/20 for agreement on Trust implementation.
Patient/Client Safety	1216	Acute Hospital Services	Risk of patient harm in Trust EDs due to capacity, staffing and patient flow issues	15	EXTREM	15	EXTREM	5	HIGH	5	No change	0	Actions listed with future due dates	Sept 2020 - In period 07/08/20 - 20/09/20 34 incidents reported re Capacity / Demand / Staffing in EDs with SWAH ED reporting 19 Red incidents and 12 Amber incidents and Altnagelvin ED reporting 2 Red and 1 Amber in period. Details attached to risk. Email from Sr in ED SWAH to Dr Brown and D Keenan outlining current Nursing risks in that depart (attached to risk on Datix). Also includes suggested solutions for consideration.

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Compliance with Professional/Clinical/Non-Clinical Standards	1227	Director of Nursing, Primary Care & Older People's Services	Action Plan for implementation of new regulations on medical devices by May 2020 as per circular HSE16-19 not completed	15	HIGH	15	HIGH	9	MEDIUM	2	No change	1	Actions listed with future due dates	Aug 2020 - Draft Version 1 of the scoping exercise and Action Plan for the Trust against the new Medical Device Regulations 2017 tabled at C&SCG Subcommittee 26/08/20. June 2020 - Approved for Corporate Risk Register at June Trust Board. Circular HSC (SQSD) 16/19 has been circulated to Clinical Leads. The Circular set out the expectations of HSC organisations in respect of managing risk. Proposed monitoring will incorporate data recorded on Trust information systems in the first instance. Gaps in the information could be managed by agreed periodic audits. When the Action Plan is fully developed there will be clarity on what elements of the requires are achievable and which may not. At this stage it would be appropriate to escalate to DOH what elements the Trust is unable to meet.
Financial	1236	Director of Finance	Ability to achieve financial stability, due to both reductions in Income and increased expenditure.	16	HIGH	16	HIGH	8	HIGH	1	No change	1	Actions listed with future due dates	August 2020 - Added as a new Corporate Risk with merging of risks ID51 & ID924.

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3	19/11/2008	16	HIGH	20 (4x5)	EXTREM	4	HIGH	Medical Director	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Governance.Workforce.	Health and Safety risk - resulting in injury	Risk of injury to patients/clients/staff and visitors arising from failure to fully comply with Health & Safety legislation.	Incident reporting and investigation. Criteria based Health & Safety Inspection plan and action plans . Induction and Mandatory Training for Staff. Occupational Health Self and Management Referrals. Use of aids e.g. hi-lo beds, hoists. Patient/client risk assessment. 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 Ligature assessment July 2019 Falls - Regional Post falls review; Falls Co-ordinator in post 2018; Falls Learning Group; CEC Falls Prevention course 2018 COSHH added as standing item to Health &Safety Working Group agenda. Labs representative on Health & Safety Working Group Four officers in Risk Management are	Limitation / constraint on funding to purchase all H&S equipment but the Trust risk assesses each procurement request of H&S equipment funding is allocated accordingly. Similarly a risk based approach is applied to the maintenance of all Trust equipment and facilities in order to mitigate the risk to an appropriate level. Comparatively limited staff resources dedicated to H&S. Limited availability 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 documents & 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 30/09/2020	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 (4x3)	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 (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.	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.	31/12/2020 31/12/2020 31/12/2020 31/12/2020 31/12/2020	
49	06/10/2009	16	HIGH	16 (4x4)	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 training policies Induction policy Regional and local Incident Management & reporting policies & procedures Corporate Risk Management framework, Processes & monitoring Emergency planning & Service business continuity plans Disaster recovery plan Ussr account management processes Change control processes Data protection Act Regional & Local ICT info security policies Band 7 & band 6 recruited to support Cyber security Trust and Regional Cyber Project Boards	Current inability to obtain 100% coverage on patch updates due to a combination of user behaviours and service needs Insufficient User Awareness of impact of personal behaviours in relation to cyber threat Full extent of gaps are not understood at this point - Gap analysis regionally and locally required by HSC to capture a considered extent of vulnerabilities Insufficient corporate recognition and ownership of cyber security threat as a service delivery risk	Internal audit / IT Dept self-assessment against 10 Steps towards NCSC Technical risks assessments and penetration tests HSC SIRO Forum for shared learning and collaborative action planning and delivery	There is a resource issue regarding Cyber Staff in the Trust. The Business Case that was approved should address this pressure however experience from other Government Organisations would suggest that is difficult to attract and retain specialist skills in this area. Unable to have consistent patching of critical/core serves due to service disruption. Limited testing of Data and Systems restores.	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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57	06/10/2009	16	HIGH	12 (4x3)	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 recommendati ons	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 identified 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 Revision of Governance arrangements under Covid-19 Learning themes being developed regionally for Litigation Learning from Project responding to RQIA AMHDS Improvement	31/03/2017 31/03/2017 30/09/2017 30/09/2018 31/01/2017 31/12/2016 31/10/2019 30/09/2020 31/01/2020 31/05/2020 31/12/2018 31/12/2020 30/09/2020 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 30/04/2020 31/12/2018
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 Trust wide 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 speciality issues as they arise. Procedure in place for IR35 Assessment. 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.	31/12/2020 31/12/2020 31/12/2020 31/12/2020 31/12/2020 31/12/2020	

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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 , support and clinical supervision to staff within AMH Forensic Services. Ongoing Multi-agency management and review. Well managed recruitment and vacancy controls. Well managed staff recruitment and vacancy controls 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.	Ongoing limited safe therapeutic environment to access and review AMH Forensic patients (Dawson House and Roe Valley Limavady) . Lack of local/Regional availability of low/medium secure placements or step-down facilities. Limited ability to ensure therapeutic interventions. AMH Forensic Specialist services require existing staffing and recourses 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
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. Additional Independent Expert Reviewers appointed to assist 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. Mental Health environmental safety Group has been established and meets every 2 months. This is a sub-committee of the Trust Governance . staff are reviewing Datix incidents in line with WHSCT Incident Reporting	Lack of understanding of policies and procedures of newly qualified /recruited staff. Finance to enable capital works identified through risk assessment. 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.	Continuous risk trend analysis from SAI, near misses and Directorate Quality and Safety Reports 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 (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. 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 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 Extension of rfid to North Wing AAH Development of new regional IG training for trust staff Promotion of Records Management Week Review of secondary storage and development of business case.	31/03/2019 30/09/2020 31/12/2020 31/10/2020 31/03/2021	31/03/2019

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		Initial Risk		Current Risk		Target Risk													
ID	Opened date	Rating (initial)	Risk level (initial)	Rating (current) (Consq x Likli)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Directorate	Corporate Objectives	Title	Description	Controls Assurance	Gaps in controls Assurance	Assurance	Gaps in assurance	Action Plan	Due date for Action Plan	Done date for Action Plan
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.	Estates Strategy 2015/16-2020/21 Annual review of building condition (3i) and creation of prioritised BLM list 2019/20 Backlog maintenance programme developed Targeting 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 prioritised list BLM 20/21 Include backlog maintenance in capital plan presented to CMT Procure 19/20 BLM Deliver BLM projects 20/21 Procure and carry out schemes Present BLM paper to CMT Procure 18/19 backlog list BCs developed and approved	30/04/2015 31/05/2016 31/05/2017 31/05/2018 31/03/2020 30/08/2020 30/06/2016 31/03/2020 31/03/2021 31/03/2017 30/10/2015 31/03/2019 30/09/2020	30/04/2015 31/05/2016 30/04/2017 31/05/2018 05/06/2019 30/08/2020 16/06/2016 31/03/2020 31/03/2017 03/09/2015 31/03/2019
235	08/12/2010	15	EXTREM	15 (5x3)	EXTREM	8	HIGH	Medical Director	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Risk of continuing failure to meet statutory requirements for Water Safety	As a result of partial compliance to Water Systems Safety Regulations the Trust is continuing to fail to meet statutory requirements for Water Safety and associated risk of Legionella in the water system and a patient/client developing Legionnaire's pneumonia.	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 upgrade of water system, water system and associated processes Milk Bank SWAH Replace RO water system Renal Unit upgrade water system Nucleus, greenfield, Cornhill, Avoca lodge updated water 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. limited 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.	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. pseudomonas risk assessment augmented care areas update 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	30/09/2020 01/07/2017 01/11/2016 01/07/2017 31/07/2014 30/09/2014 31/03/2020 30/09/2020 31/03/2019 30/09/2020 31/08/2018 30/09/2020	 31/03/2018 31/05/2017 31/03/2017 30/09/2014 06/10/2014 31/12/2019 31/03/2019 31/08/2018

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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 General Data Protection Regulation (GDPR) and Data Protection legislation through loss of personal or sensitive	As a result of gaps in staff awareness and training in data protection requirements and non-adherence to retention and disposal guidance, there is a risk that personal or sensitive data could be lost, inappropriately stored or accessed; records could be retained beyond their lifecycle and lead to a breach of confidentiality and the Data Protection Act, DoH Good Management Good Records Guidelines and result in potential enforcement action from the Information Commissioners' Office alongside damage to the Trust' reputation.	Subject Access and Data Access agreement procedures. Information Governance/Records Management induction/awareness training. 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. 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 increased to full time Recruitment of Band 4 Information Governance Development of information leaflet for Support Services Staff to increase awareness of information governance Review of regional e-learning IG training Establishment of Regional Records Man Group Review of Secondary storage in Mable Villa Review of Primary (acute) records storage in AAH Development of IG action plan to be finalised through IGSG Recruitment of band 5 IG post to support DPA Development of IG information leaflet for support staff	31/03/2019 31/03/2019 31/03/2019 31/12/2020 30/09/2020 30/09/2020 30/09/2020 30/09/2020 31/12/2020 30/09/2020	31/03/2019 28/02/2019 01/03/2019
535	15/11/2011	16	HIGH	20 (4x5)	EXTREM	8	HIGH	Director of Nursing, Primary Care & Older People's Services	Primary Care and Older People Services	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. 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. 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	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

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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	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 (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.		Revised paper to CMT Monitoring and review	30/09/2020 31/03/2021	
719	02/12/2013	20	EXTREM	12 (4x3)	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

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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.			The 5 year implantation plan will continue to be monitored - via Regional Procurement Board, Trust Procurement Board and Social Care Procurement Group.	31/03/2021	
1075	23/08/2018	12	HIGH	16 (4x4)	HIGH	4	LOW	Director of Finance	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Public Confidence. Workforce.Partnerships.	No Deal Scenario / Hard Border EU Exit	With the imminent EU exit, there is potential for a No Deal Scenario or Hard Border between Northern 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.	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 & Finish Group in place including service directorate membership. No Deal Continuity Plans for Services Participation on DoH Regional EU Exit Group	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 pulled together by HR. the Trust continues to attend various regional forums on EU Exit, including the Doh EU Exit Regional Meeting and other Regional Meetings such as Medicines Preparedness, Information Governance, HR and Emergency Planning. Final Version of Yellow Hammer Document received by Trust EU Exit Task and Finish Group meet monthly. Day one delivery plan	The DOH reported that further discussion at the EU Exit ALBs meeting has clarified that disruption to health and social care services is not anticipated as a result of any impediment to movement of people at the border and that existing business continuity plans and mitigating actions for potential staff shortages should apply and suffice. Anne Kilgallen, Trust CE has fortnightly meetings with Richard Pengelly and CE of HSC - of which EU Exit and associated continuity planning progress are discussed.	Continued regular update internal EU Exit Meetings and updates to CMT. Application of any regional or strategic directives on EU exit. Trust representatives continue to be involved in regional working groups led by DoH in order to inform and assist the Trust in EU Exit Planning. Next meeting due to take place on 21 January Assurance Statement to be forwarded from the CE to the Permanent Secretary, DoH confirming that the Trust is actively scoping the potential impact of a no deal outcome from the UK EU negotiations on the services provided by the Trust etc. Detailed Review of Mitigating Actions to be completed - Continuity plan Lead Officer to brief	31/12/2020 21/01/2019 24/01/2019 22/11/2018 17/12/2018 28/12/2018 21/01/2019 12/02/2019 05/02/2019 28/01/2019 04/03/2019 11/02/2019 31/10/2020 31/08/2020 31/12/2020 30/09/2019	21/01/2019 29/06/2018 24/01/2019 22/11/2018 17/12/2018 03/12/2018 21/01/2019 12/02/2019 05/02/2019 28/01/2019 04/03/2019 11/02/2019 31/10/2019
1100	07/11/2019	12	HIGH	8 (4x2)	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.	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.	31/12/2020 31/12/2020 31/12/2020 31/12/2020 31/12/2020	

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1109	30/01/2019	16	HIGH	16 (4x4)	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/voluntary 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
1133	23/05/2019	15	EXTREM	25 (5x5)	EXTREM	5	HIGH	Director of Nursing, Primary Care & Older People's Services	Trust-wide (Risk Register Use Only)	Safe & Effective Services.	Risk to safe patient care relating to inappropriate use of medical air	Risk of patient receiving medical air in error when oxygen is required resulting in hypoxia.	Regional procurement process - will no longer be able to buy a medical air flowmeter without a flow guard In the Trust's clinical procedures for medical gases Included on the medical gas training for wards Medical air blanking caps have been circulated to wards to insert into outlets that wont be used Colour coding of medical air flowmeters and air outlet on most wards Flowmeters with air-guards attached on all wards now.	Lack of knowledge of colour coding and appreciation of risks with medical gases Potentially have old flowmeters that are not fully compliant with colour coding (not mandatory) Not all medical air flowmeters had air guards but they do now Incidents are continuing to happen during 2020, lack of confidence that the actions taken last year are being adhered to in all areas - further review of processes and controls undertaken 29 May 2020. Lack of knowledge of colour coding and appreciation of risks with medical gases	Walk around to be carried out in SWAH/OHPCC although they have new flowmeters with air-guards. Walk around on Altnagelvin site occurred in November 2018. To be repeated February 2019. To be picked up on annual medical gases walk around. No external inspections Update 05 June 2020 - Lead nurses and service managers have been asked to provide assurances on the actions taken in response to the revised controls for each of their designated areas of responsibility. May 2020 update - regular Walk arounds to be undertaken on all hospital sites until assurance in place.	Lack of training on medical gases. This has increased now since included in Trust Combination training days.	SAI reviews to identify learning and progress actions to completion Review the mitigating actions and any gaps in controls Possible further learning from SAI investigation Continue to include in Trust combination training days (potential for this to become a mandatory area) Old flow-meters removed to ensure colour coding approach is used Air outlet blocking caps to be inserted to air outlets that are not needed Ensure full compliance with use of air guards on medical air flowmeters across all three sites	30/09/2020 08/09/2020 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 (4x3)	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.	30/11/2020	

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		Initial Risk		Current Risk		Target Risk													
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1166	06/09/2019	20	EXTREM	20 (4x5)	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 deadline 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. Improvement plan implemented and notice lifted IPT (Mental Health Demography) completed & submitted for funding 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 assist 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 Governance 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. Received 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. Secure financial funding for governance Team. Additional 2 staff members have been redeployed as an interim measure to the governance Team-Band 8C and 1 8B. 1 Additional Band 8A has also been redeployed in the interim period as Governance lead Patient/	31/07/2020 30/09/2020 31/07/2020	19/08/2020 17/07/2020
1183	27/11/2019	25	EXTREM	25 (5x5)	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 care. There is a further financial	short term detention training - 6 NS, 5 SS. Cover required for MH wards ASW freed up to work in the hospital to undertake short detention orders. ASW from Hospital Discharge teams to undertake STDAs Meetings are held on a weekly basis Staff training is available via eLearning as well as from CEC. Training available online & classroom, provided by Trust Trainers. Progressing interactive online training via VC. Project Implementation Officer Programme Management arrangements	Cost of implementation of MCA. BC completed for 19/20. Approach to funding for 20/21 being progressed with HSCB. Recurrent IPT received July20. Capacity of medics to sit on panels. Sufficient at present but progressing further recruitment to support Legacy Cases. Not having enough staff trained to undertake the duties of MCA. Sufficient staff trained to meet current demand, however training ongoing to ensure that all staff with patient contact receive the appropriate training. Current strike action advising work to rule. NIPSA Strike action paused. Other union issues resolved. Ongoing challenges and negotiations with the Unions regarding staff engagement in the process. Communication plan promoting engagement in development. Medics in SWAH have advised that they not have capacity to support MCA activity. Only 4 GP practices have engaged, via LES, with providing Medical input to PA in the community (new and legacy)	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		Engage with programme board and team 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	31/12/2020 31/03/2020 31/03/2020 30/09/2020 31/03/2020 30/09/2020 30/09/2020 31/03/2020 31/03/2020 31/03/2020 30/09/2020 30/09/2020 31/03/2020 31/03/2020 31/03/2020	31/08/2019 01/11/2019 01/12/2019 31/03/2020 31/03/2020 02/12/2019 31/01/2020 02/12/2019 31/08/2019 31/08/2019
1207	04/03/2020	9	MEDIUM	12 (4x3)	HIGH	8	HIGH	Director of Nursing, Primary Care & Older People's Services	Primary Care and Older People Services	Safe & Effective Services.Pu blic 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 30/09/2020	31/12/2019

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1213	04/04/2020	20	EXTREM	20 (5x4)	EXTREM	10	HIGH	Medical Director	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Governance.Workforce.	COVID-19 risk re assess & response to patient/client need & maintain quality & safety for patients/clients and staff	If current capacity limitations and activity levels across all Trust services remain or increase, the Trust may not be able to meet the increased demand placed on it during an outbreak of Coronavirus (Covid-19) or in the reset of services following an outbreak, resulting in possible harm to patients and staff.	Residential Accommodation Surge Plan Additional screening POD in place for screening pathways Chief Executive video Fit testing / PPE Podcast and video training' face to face training, Posters Fit-testing use of private company to assist OH Intranet Covid19 site to ensure information shared across the Trust Sub groups Workforce planning - regional PPE Group; Regional Discussion Group Screening & assessment pathways and designated areas Health & Safety Policy Guidelines on Management of COVID-19 as PHE IPC policy Revised Governance arrangements - Corporate Safety team 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 Covid Governance audit 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 Realign risk to reset environment	31/05/2020 31/05/2020 30/09/2020	31/05/2020 31/05/2020
1216	15/04/2020	15	EXTREM	15 (5x3)	EXTREM	5	HIGH	Director of Acute Hospital Services	Acute Hospital Services	Safe & Effective Services.Public Confidence.	Risk of patient harm in Trust EDs due to capacity, staffing and patient flow issues	If Emergency Department (ED) Physical capacity and staffing levels are not sufficient to meet the demands of patient numbers and acuity, there will be increased likelihood of significant patient harm, risk to staff wellbeing and damage to Trust reputation as a direct result.	Business case approved dedicated HALO (Hospital Ambulance Liaison Officer NIAS crews waiting to offload in our hospital early warning score Ongoing Trust recruitment focus on Critical posts IE Medical and Nursing Use of Medical locums/ Bank and agency Nurses. Social Media Campaign Escalation protocol within full capacity protocol Nursing KPI and audit (ALAMAC) Ongoing in house Quality improvement work (implementation of SAFER principles) Daily regional huddle meeting with escalation as required IT systems - Symphony Flow board On call managers/medics rota Ongoing MDT patient flow huddles in department/wards Medical team ED reviews Hub flow meetings with lead nurse attendance. Patient flow teams/night service manager Major incident policy Full capacity protocol	Implementation of SAFER principles challenged due to Medical Job plans and current Medical team models in operation ageing population living with challenging health needs Community infrastructure to meet needs of patients i.e. Gp appointments, social care packages Recruitment to perm medical posts Challenging across NI	Datix - Incident, Complaints, Litigation, Risk register Patient flow teams, Night service manager, SPOC, Hub Regional huddle Established patient pathways	Gaps in patient pathway	PACE implementation to commence March 2020. Improvement QI work commencing with aim to address communication within department.	31/03/2021 31/03/2021	
1227	09/07/2020	15	HIGH	15 (3x5)	HIGH	9	MEDIUM	Director of Nursing, Primary Care & Older People's Services	Trust-wide (Risk Register Use Only)	Safe & Effective Services.Modernisation. Governance. Public Confidence. Financial Management & Performance.	Action Plan for implementation of new regulations on medical devices by May 2020 as per circular HSE16-19 not completed	The recommendations contained within Circular HSC (SQSD) 16/19 required that organisations would fully implement the requirements by May 2020. The Action Plan has not been completed due to the impact of Industrial Action during November 2019- January 2020 and Covid-19 from end of February to end of May 2020.	Draft Action Plan circulated for completion by Clinical Leads Circular HSC (SQSD) 16/19 has been circulated to a wide range of clinical specialisms.	Clarifying level of data recorded on Trust clinical info systems to identify medical devices implanted as part of clinical interventions and treatment. further clarity will be required on definitions of modified devices. Control measures not fully identified	Medical Device alerts & FSNs Incident reporting Medical Devices working group The development of the Action Plan	Action Plan not fully developed	Develop an Action Plan to support implementing the requirements of Circular HSC (SQSD) 16/19	31/08/2020	

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1236	21/08/2020	16	HIGH	16 (4x4)	HIGH	8	HIGH	Chief Executive	Finance and Contracting	Financial Management & Performance.	Ability to achieve financial stability, due to both reductions in Income and increased expenditure.	With continued reductions in income from savings requirements coupled with increased expenditure due to demand and risk, there will be a reduction in the Trust's ability to achieve financial stability in the current and future years, resulting in significant challenges in meeting the Trust strategic priorities	Chief Executive Assurance meetings to review performance Recovery Plan Oversight - Directorate, CMT, Trust Board (and Finance & Performance Committee) and DoH Annual Financial Plan to review risks to financial position and opportunities for savings Trust Board (and Finance & Performance Committee) and CMT oversight of the financial position monthly Monthly budget reports for all levels in the organisation, with follow-up variances				Ongoing financial management and monitoring Operation of DVMB (Delivering Value Management Board) to ensure delivery of the 3 year financial recovery process	31/03/2021 31/03/2022	