Western Health and Social Care Trust

TRUST BOARD ITEM: BRIEFING NOTE

Meeting Details:	5th September 2024
Director:	Dr Brendan Lavery
Issue Title:	Corporate Risk Register Summary and Corporate Risk Register Assurance Framework
Indicate the connection with the Trust's Mission and Vision *(please tick)*	✓ People who need us feel cared for ✓ People who work with us feel proud ✓ People who live in our communities trust us
Indicate the link to Trust's strategic priorities *(please tick)*	✓ Quality and Safety ☐ Workforce Stabilisation ☐ Performance and Access to Services ☐ Delivering Value ☐ Culture
Summary of issue to be discussed:	For approval: Proposed New Risk relating to Alcohol Related Brain Disease: Non Commissioned service within WHSCT. New Risk form attached. Material changes: ID1375 – proposal to reduce this risk from current Corporate Risk to Directorate Risk Register within Unscheduled Care, Medicine, Cancer and Clinical Services. To note: All Corporate Risks have been updated within this quarter. All action plans have been updated.
Trust Board Response Required *(please tick)*	X For approval ☐ To note

we are west
Caring together.
Committed to better.

	☐ Decision

Western Health and Social Care Trust

CORPORATE RISK REGISTER & ASSURANCE FRAMEWORK

BRIEFING NOTE PREPARED FOR TRUST BOARD 5th SEPTEMBER 2024

There are 20 risks on the Corporate Risk Register as approved at Trust Board Workshop on 15th July 2024.

Summary

- Proposed New Risks;
    - Proposed New Risk relating to Alcohol Related Brain Disease: Non Commissioned service within WHSCT. New Risk form attached.

- Material changes;
    - Risk ID1375 relating to Consultant Cover in Cardiology. Proposal to reduce this risk from current Corporate Risk to a Directorate Risk within Unscheduled Care, Medicine, Cancer and Clinical Services.

- Summary report for action;
    - All action plans currently up to date.

- Proposed New Risks;

    - Proposed New Risk relating to Alcohol Related Brain Disease: Non Commissioned service within WHSCT.

New Risk Form attached for consideration however this risk relates to;
Risk Title: Alcohol Related Brain Disease: Non Commissioned service within WHSCT

Risk Description: The Western Trust do not have the workforce resource to manage this service user group. Typically this service user group require a multi-professional approach, i.e. GP, Psychiatry, psychology, addiction support, nursing, OT, social work, to achieve good outcomes. This service is not commissioned within the WHSCT resulting in early intervention not being achieved and crisis intervention sometimes being required, with on-going delayed discharges within hospital as a result of difficulties in placing service user. . Overall cost to services to support individuals with a formal or suspected diagnosis of ARBD and individuals whose addiction is the significant presenting problem= Total cost pressure is approx. £5.3 million YTD as at 01.07.24. Other patients may be negatively impacted due to staff not having the time to care manage these individuals as per standards due to the additional work created by this service user group.

Current Grading: Moderate (3) x Possible (3) = Moderate (6)

Responsible Director: Director Adult Mental Health and Disability Services

Material changes;

Risk ID1375 relating to Consultant Cover in Cardiology. Proposal to reduce this risk from current Corporate Risk to a Directorate Risk within Unscheduled Care, Medicine, Cancer and Clinical Services. Briefing paper attached for consideration.

Background:

The Interventional Cardiology Consultant Body in March 2022 had been depleted by 50% taking the normative 1:6 rota to an unsustainable rota. The gaps in the rota were covered by Locum Consultants. The Interventional team in the WHSCT are one of two teams that cover the Regional Primary PCI service. The Team have been through a number of recruitment exercises and have successfully appointed 2 Substantive Interventional Consultants. These 2 new consultants are both fully inducted team members. One Consultant vacancy persists however, this is covered by a locum Interventional Consultant who has been a long-term member of staff and has been part of the Cardiology team for 2years.

One further Interventional Consultant has returned from long-term sick leave and has completed a period of supervised practice. This consultant is now back on the interventional rota. Cardiology Service currently moving through recruitment process for 1 Interventional Consultant and 1 non Interventional Consultant

This will facilitate the release of all locum staff and an exit plan for the same following successful recruitment and induction period ensuring a stable substantive team.

Therfore, the risk of instability in the on call PPCI service has now reduced to an acceptable level for the Trust. The Regional service is running at full capacity and the 1:6 commitment has been restored.

This has reduced the risk of burnout to our core staff and patient access to our service is no longer at risk.

Risk to be deescalated from the Corporate Risk Register to the directorate risk register until the final stage of recruitment is complete.

Summary Report for action

- All action plans currently up to date

Update Trust Board actions April 2024

Please see attached list actions as agreed following Trust Board workshop on 04.04.24. These actions are being progressed through the normal CMT-Trust Board approval process and an update on progress is being tabled each month.

Risk ID	Lead Director	Risk Title	Workshop action	Agreed Tolerance	Agreed Risk Appetite	Progress
1133	Director of Nursing, Midwifery and AHP's	Risk to safe patient care relating to inappropriate use of medical air	Trust Board agreed to; 1.De-escalate and close this risk	Risk to close	Risk to close	Closed 15.04.24
1183	Director of Adult Mental Health & disability Services	Where MCA processes are not being followed, patients may be deprived of their liberty, without having safeguards in place	Trust Board agreed to; 1.Keep the tolerance set at LOW due to incomplete actions under Trust control 2.Risk owner to take a fresh look at the controls on CRR to ensure this is consistent with actions discussed and progress.	LOW	Low (target score between 1 -6) Current Target score 6	
1219	Director of Unscheduled Care, Medicine, Cancer and Clinical Services	Lack of endoscopy capacity for endoscopy to meet the demand which impacts on patient outcomes	Trust Board agreed to; 1. Keep tolerance as LOW. 2. Risk owner to reflect the ongoing work in the summary updates or CRR and action section. 3.Risk to be reviewed in 6months	LOW	Low (target score between 1 -6) Current Target score 6	

1334	Director of Surgery, Paediatrics and Women's Health	Stability of surgical services in Southern Sector of Trust due to recruitment & retention difficulties at consultant and middle grades	Trust Board agreed to; 1.Keep tolerance as LOW 2. Risk owner to review controls listed against risk within CRR	LOW	Low (target score between 1 -6) Current Target score 8	
1375	Directorate of unscheduled care, medicine, cancer and clinical services	Consultant cover in cardiology	Trust Board agreed to; 1.Keep risk as is with a view to de-escalating risk within 2-3months to directorate or divisional level	LOW	Low (target score between 1 -6) Current Target score 6	Risk tabaled for de-escalation 30.07.24
1	Director of Performance & Service Improvement	Fire Risks	Trust Board agreed to; 1.Set tolerance as LOW, risk category as H&S and amend target score to between 1-6 2. Risk owner should continue to prioritise actions against controls relating to staff training, fire stopping and storage over next 12 months.	LOW	Low (target score between 1 -6) Current Target score 8	
49	Director of Performance & Service Improvement	The potential impact of a Cyber Security incident on the Western Trust	Trust Board agreed; 1. This risk should be subject to a Deep Dive and presented to Governance committee June 2024. This will review the risk in relation to current tolerance level (specific to	HIGH	Low (target score between 1 -6) Current Target score 6	Risk Presented to Gov Committee June 24

			actions within our control) and propose any amendments as necessary.			
1216	Directorate of Unscheduled Care, Medicine, Cancer and Clinical Services	Risk of patient harm in Trust ED's due to capacity, staffing and patient flow issues	Trust Board agreed to; 1.Risk to remain at current tolerance until full review of the risk has taken place with senior staff in ED, corporate Nursing and community. 2. Risk will be subject to a DEEP DIVE in March 2025	HIGH	Low (target score between 1 -6) Current Target score 6	
1307	Director of Surgery, Paediatrics and women's Health	Clinical Risk regarding delayed transfer of babies, children and adults to other hospitals	Trust board agreed to; 1. Keep tolerance and risk appetite as is. 2.Risk owner to continue to develop and progress actions listed required by Trust	HIGH	Low (target score between 1 -6) Current Target score 6	
1320	Executive Director of Social Work/Director of Family and Children Services	Delayed/inappropriate placement of children assessed as requiring inpatient mental health care	Trust Board agreed to; 1.Current tolerance and risk appetite to remain as is, and risk owner to keep risk under review	HIGH	Moderate (target score between 8-12) Current target score 8	
1487	Director of Human Resources & Organisational Development	Impact on services as a result of industrial action in relation to outstanding agenda	Trust board agreed to; 1.Set tolerance of this risk as High as	HIGH	Moderate (target score between 8-12)	

		for change (AFC) Pay, safe staffing	gaps out side Trust control. 2.Agreement to decrease current risk rating from extreme (20) to high(12) as approved by CMT in March 2024		Current target score 8	
6	Executive Director of social work/Director of Family and Children's services	Children awaiting allocation of Social worker may experience harm or abuse	Trust Board agreed to; 1. Current tolerance and risk appetite to remain as is due to external gaps in control. Keep risk under review	HIGH	Moderate (target score between 8-12) Current target score 8	
284	Director of Performance and Service Improvement	Risk of breach of data protection through loss, mishandling or inaccessibility of personal or sensitive personal information	Trust Board agreed to; 1.Current tolerance to remain due to external gaps in control 2.Proposal to revise the risk grading from 16 to 12 approved	HIGH	Low (target score between 1 -6) Current Target score 6	
955	Director of Finance, contracts and Capital Development	Failure to comply with procurement legislation re social care procurement	Trust board agreed to; 1.de-esclate this risk to the directorate risk register of finance, contracts and capital development	Risk de-escalate to DRR	Risk de-escalate to DRR	De-escalated to DRR 15.04.24
1254	Director of Human Resources and Organisational Development	Inability to deliver safe, high quality and sustainable services due to workforce supply and disruptions	Trust Board agreed to; 1.Current tolerance and risk appetite to remain 2.Risk owner to reflect mitigations	HIGH	Moderate (target score between 8-12) Current	

			discussed within the risk register actions within CRR		target score 8	
1288	Director of Performance & Service Improvement	Risk of failure to meet regulatory standards and compliance associated with Trust infrastructure and estate.	Trust Board agreed to; 1.Current tolerance and risk appetite to remain as is	HIGH	Low (target score between 1 -6) Current Target score 6	
1236	Director of Finance, Contracts and Capital Development	Ability to achieve financial stability, due to both reductions in Income and increased expenditure	Trust Board agreed to; 1. Current tolerance and risk appetite to remain as is. 2.Risk to be kept under review by risk owner	HIGH	Low (target score between 1 -6) Current Target score 6	
1409	Director of unscheduled care, medicine, cancer and clinical services	ED mental Health Patients	Trust Board agreed to; 1.Set risk category as quality of care – patient safety 2.Set tolerance as HIGH and risk appetite as LOW with target score between (1-6) Risk owner to review target score to reflect this. 3.Risk owner to keep this risk under review	HIGH	Low (target score between 1 -6) Current Target score 9	
1469	Medical Director	Health and Safety Risk to staff as a result of Violence and Aggression	Trust Board agreed to; 1.Set tolerance of this risk as LOW, to be reviewed as a DEEP DIVE to be	LOW	Low (target score between 1 -6) Current	

			presented to Governance committee in Dec 24 2. Risk owner to amend description of risk to remove detail relating COVID.		Target score 4	
1472	Director of Performance and Service Improvement	Risk of the Trust not achieving the rebuild targets as set out by SPPG	Trust Board agreed to; 1.De-esclate the risk to Directorate Risk Register of Performance and Service Improvement as proposed at CMT on 25.03.24	Risk de-escalate to DRR	Risk de-escalate to DRR	Risk De-escalated to DRR 15.04.24

WHSCT Corporate Risk Register 29/08/2024

Risk Summary Report

				Initial		**Current**		Target		Risk Appetite			**Current Risk Status**				
Risk Sub- Category	Risk ID	Lead Director	Risk Title	Score	Grade	**Score**	**Grade**	Score	Grade	score	Level of Tolerance	Action on Appetite	**Mths since score changed**	**Change in score since last review**	Mths since last updated	Action Plan Status	Latest Update
Safe & Effective Services.	1	Director of Performance & Service Improvement	Fire Risks	20	EXTREM	15	EXTREM	8	HIGH	8	LOW	1. Set tolerance as a LOW, risk category as H&S and amend target score to between 1-6 2.Risk owner shuld continue to prioritise actions against controls relating to staff training, fire stopping and storage over next 12 months	4	No change	0	Actions listed with future due dates	[01/08/2024] 1/8/24: Fire evacuation exercise has taken place as part of the business continuity / fire evacuation procedures. number of schemes have been identified to improve fire stopping throughout the WHSCT. Estates current schemes are being funded from BLM.
Quality of Care	6	Executive Director of Social Work/Director of Women & Children Services	Children awaiting allocation of Social Worker may experience harm or abuse	25	EXTREM	12	HIGH	8	HIGH	8	LOW	1. Set tolerance as a LOW, risk category as H&S and amend target score to between 1-6 2.Risk owner shuld continue to prioritise actions against controls relating to staff training, fire stopping and storage over next 12 months	34	No change	1	Actions listed with future due dates	[15/07/2024 June 2024 - Unallocated figures for Gateway and Generic teams have significantly decreased this month. A number of newly qualified students have taken up post in both services. All unallocated cases are closely monitored as per regional guidance and escalated to Assistant Director level if deemed appropriate.
ICT & Physical Infrastructure	49	Director of Performance & Service Improvement	The potential impact of a Cyber Security incident on the Western Trust	16	HIGH	20	EXTREM	6	MEDIUM	8	HIGH	1. Current tolerance and risk appetite to remain as is due to external gaps in control. Keep risk under review.	11	No change	0	Actions listed with future due dates	[12/08/2024] Governance Update Liaison continued with competent authority to ensure actions are completed and sufficient evidence is gathered for NIS Confidence Report to indicate where progress and compliance on the CAF profile is being achieved.
Regulation & Compliance	284	Director of Performance & Service Improvement	Risk of breach of Data Protection legislation through loss, mishandling or inaccessibility of personal or sensitive personal inf	16	HIGH	12	HIGH	6	MEDIUM	6	HIGH	1. This risk should be subject to a Deep Dive and presented to Governance Committee June 2024. This will review the risk in relation to current tolerance level (specific to actions within our control) and propose any ammendments as necessary.	4	No change	0	Actions listed with future due dates	[20/08/2024] IG training now at 85% and new staff guidance on use of ID badges/physical access privileges and controls when allowing contractors on site, has been issued last month [22/07/2024] New DPIA template developed regionally for HSC staff (Trust Comm Issued to promote to WHSCT staff). A Data Quality poster, data input guidance, DQ video and Trust Comm issued to all staff. IG training at 83% and encompass Orb chairs asked to consider need for DQ training to be mandatory for certain job roles.
Regulation & Compliance	1183	Director of Adult Mental Health & Disability Services	Where MCA processes are not being followed, patients may be deprived of their liberty, without having safeguards in place	25	EXTREM	15	HIGH	6	MEDIUM	6	HIGH	1. Current tolerance to remain due to external gaps in controls. 2. Proposal to revise the risk grading from 16 to 12 approved.	8	No change	2	Actions listed with future due dates	[28/06/2024] Update from Surgery,Paed and Women's Health Gov committee on 27.10.24 service will identify a number of doctors who Trust can train in this specific area (MCA)
Quality of Care	1216	Director of Diagnostics, Cancer and Medical Specialties	Risk of patient harm in Trust EDs due to capacity, staffing and patient flow issues	15	EXTREM	15	EXTREM	6	MEDIUM	6	LOW	1. Keep the tolerance set as LOW due to incomplete actions under Trust control. 2. Risk owner to take a fresh look at the controls on CRR to ensure this is consistent with actions discussed and progress.	24	No change	0	Actions listed with future due dates	[20/08/2024] Risk reviewed and considered no change from previous updates.
Regulation & Compliance	1219	Director of Diagnostics, Cancer and Medical Specialties	Lack of endoscopy capacity for endoscopy to meet the demand which impacts on Patient outcomes	20	EXTREM	20	EXTREM	6	MEDIUM	6	HIGH	1. Risk to remain at current tolerance until full review of the risk has taken place with senior staff in ED, corporate Nursing and community. 2. Risk will be subject to a Deep Dive in March 2025	24	No change	0	Actions listed with future due dates	[16/08/2024] Risk reviewed and remains the same at this point. A deep dive is required for this risk to consider if it's appropriate to deescalate it to directorate level. This is due to be carried out Aug/Sept 2024, same being arranged by Risk Department with the service.
Financial	1236	Executive Director of Finance, Contracts & Capital Devlopment	Stabilisation of Trust Financial position	16	HIGH	16	HIGH	6	MEDIUM	6	LOW	1. Keep tolerance as LOW. 2. Risk owner to reflect the ongoing work in the summary updates or CRR and action section. 3. Risk to be reviewed in 6months	6	No change	0	Actions listed with future due dates	[23/08/2024 11:02:26 Oonagh ODoherty] In 2024/25 the Trust has opened with a forecast deficit of £59m as a consequence of a poor budget settlement for HSC in 2024/25, unfunded demographic growth in 2023/24 and 2024/25 and a recurrent reduction to Trust baseline budget in 2023/24 of £24.1m without effective time to enable planning and implementation of recovery actions. The Trust has complied with its obligations to provide a Financial Plan and Contingency Savings Plan for 2024/25. The Trust has effectively communicated it's ambition to deliver £24m of low and medium impact savings in 2024/25 which results in a deficit of £35m. SPPG have provided £31.5m of deficit funding to the Trust leaving a deficit of £3.5m and an expectation that this balance can be found from savings. The Trust have not accepted this position. There are a number of risks: i. Unfunded demographic growth resulting in increased financial pressures above forecast; ii. Achievement against savings targets. iii. There are no opportunities to resolve the £3.5m gap from low/medium savings options [26/03/2024] Risk actions updated to include; ID3304 - SP monitoring will be completed by end of March, and review of this will take place over a 6 week period and a new target date has been set. ID3302 - new target date set for end of June to consider a number of mop up sessions needed relating to this training

WHSCT Corporate Risk Register 29/08/2024

Risk Summary Report

				Initial		**Current**		Target		Risk Appetite			**Current Risk Status**				
Risk Sub- Category	Risk ID	Lead Director	Risk Title	Score	Grade	**Score**	**Grade**	Score	Grade	score	Level of Tolerance	Action on Appetite	**Mths since score changed**	**Change in score since last review**	Mths since last updated	Action Plan Status	Latest Update
Quality of Care	1254	Director of Human Resiurces & Organisational Devlopement	Inability to deliver safe, high quality and sustainable services due to workforce supply and disruptions	16	HIGH	16	HIGH	8	HIGH	6	HIGH	1. Current tolerance and risk appetite to remain as is. 2. Risk to be kept under review by risk owner.	22	No change	2	Actions listed with future due dates	[11/06/2024] The Trust continues to address workforce and recruitment challenges in a multifaceted approach through workforce stabilisation programmes, targeted and bespoke recruitment, campaigns, development of new roles, etc. As a result of a workforce stabilisation project within Support Services this has led to a significant reduction on reliance on agency usage and stabilisation of the workforce through dedicated recruitment activities. An update of the analysis carried out in early 2023 of medical workforce staffing levels will be finalised shortly and ensures there is accurate information recorded, retained and shared appropriately to monitor staffing capacity and capability and the ability to deliver safe services. A number of previous early alerts have had updates submitted to DoH in May 2024 in relation to continuing challenges in securing consultant staffing within psychiatry and ENT. Despite a number of recruitment campaigns there have been no applicants. In relation to psychiatry an application to DoH for recruitment and retention premium is being appealed.
Regulation & Compliance	1288	Director of Performance & Service Improvement	Risk of failure to meet regulatory standards and compliance associated with Trust infrastructure and estate.	12	HIGH	12	HIGH	6	MEDIUM	8	HIGH	1. Current tolerance and risk appeite to remain. 2. Risk owner to reflect mitigations discussed within the risk register actions with CRR	24	No change	0	Actions listed with future due dates	[01/08/2024] 01/08/2024: State of the estate information provided to DoH for year end 2023/24. The Trust continue to target BLM at highest risk areas and are currently proceeding with a number of schemes within the nucleus. Across 2023/24 and 2024/25, estates will have invested approximately £4.2m to target high risk areas within this block. Despite this investment the nucleus still has a substantial BLM liability of approximately £15m.
Quality of Care	1307	Director of Surgery, Paediatrics and Women's Health	Clinical Risk regarding Delayed Transfer of Babies, Children and Adults to Other Hospitals	25	EXTREM	25	EXTREM	6	MEDIUM	6	HIGH	1. Current tolerance and risk appetite to remain as is.	24	No change	3	Actions listed with future due dates	[23/05/2024] There was a good attendance at the update NEOSIM training on the 30th April 24. There has been on site training carried out for those unable to attend on the 30th April by Angela Hughes (PNP). The weekly rota from NISTAR still shows vulnerability in peads and neo natal only The Trust continues to risk assess which transfers to move in the absence of the retrieval Team.
Quality of Care	1320	Director of Social Work/Director of Women's and Children's Services	Delayed/inappropriate placement of children assessed as requiring inpatient mental health care.	12	HIGH	20	EXTREM	8	HIGH	6	HIGH	1. Keep tolerance and risk appetite as is. 2. Risk owner to continue to develop and progress actions listed required by Trust.	27	No change	1	Actions listed with future due dates	[31/07/2024] Risk remains live and is currently monitored regularly. Significant pressures remain within Regional Inpatient unit which has a significant secondary impact for Community CAMHS and wider networks. Cohort of young people presenting with and experiencing severe and enduring Anorexia Nervosa is unprecedented following coronavirus pandemic. Owing to ongoing severity/ acuity with medical stabilisation for this cohort of YP a recent Regional position paper has been put forward for consultation with respect to an eating disorder pathway and treatment approach by Beechcroft. Community CAMHS considering response to this currently owing to service implication/ wider network namely paediatrics/acute medical if new pathway implemented . WT Community CAMHS will be stressing need for consultation/communication with our wider stakeholders prior to any pathway change.
Ensuring Stability of Our Services	1334	Director of surgery, Paediatrics and Women's Health	Sustainability of surgical services in Southern Sector of Trust due to recruitment & retention difficulties at Consultant and Mi	20	EXTREM	15	HIGH	8	HIGH	8	HIGH	1. Current tolerance and risk appetite to remain as is, and risk owner to keep risk under review.	3	No change	2	Actions listed with future due dates	[20/08/2024] The temporary suspension of emergency general surgery at SWAH remains in place, and the Trust is considering option for the long term future of this service, alongside ongoing monitoring of the impact of the temporary arrangement. A number of consultant surgeons have joined the permanent Trust workforce, and the Trust has submitted draft job descriptions to the Royal College of surgeons for approval. When approved and in place the new skill mix will facilitate more flexible service delivery in the Southern Sector.
Ensuring Stability of Our Services	1375	Director of Diagnostics, Cancer and Medical Specialties	Consultants Cover in Cardiology	16	HIGH	16	HIGH	6	LOW	8	LOW	1. Keep tolerance as LOW. 2. Risk owner to review controls listed against risk with CRR	29	No change	0	Actions listed with future due dates	[20/08/2024] A briefing paper was tabled at the Directorate governance meeting to de-escalate this risk from Corporate to Directorate Risk. This was approved and will be tabled at the upcoming CMT for consideration.
Quality of Care	1409	Director of Diagnostics, Cancer and Medical Specialties	ED Mental Health Patients	25	EXTREM	16	HIGH	9	MEDIUM	6	LOW	1. Keep risk as is with a view to de-escalating risk within 2-3months to directorate or divisional level	18	No change	0	Actions listed with future due dates	[20/08/2024] Risk reviewed and considered no change from previous updates.

WHSCT Corporate Risk Register 29/08/2024

Risk Summary Report

				Initial		**Current**		Target		Risk Appetite			**Current Risk Status**				
Risk Sub- Category	Risk ID	Lead Director	Risk Title	Score	Grade	**Score**	**Grade**	Score	Grade	score	Level of Tolerance	Action on Appetite	**Mths since score changed**	**Change in score since last review**	Mths since last updated	Action Plan Status	Latest Update
Health & Safety	1469	Medical Director	Health & Safety Risk to Staff as a result of Violence and Aggression	12	HIGH	12	HIGH	4	HIGH	9	HIGH	1. Set tolerance as HIGH and risk appetite as LOW with target score between (1-6) Risk owner to review target score to reflect this. Risk owner to keep this under review	19	No change	1	Actions listed with future due dates	[25/07/2024] At a recent MOVA meeting, the DOH framework was reviewed and an action plan created. This is tabled for further discussion at the upcoming MOVA meeting in August. A full report of MOVA related incidents will also be provided to the group for detailed review.
Quality of Care	1487	Director of Human Resources & Organisational Development	Impact on services as a result of Industrial Action in relation pay, safe staffing and travel rates.	20	EXTREM	20	EXTREM	8	HIGH	4	LOW	1. Set tolerance of this risk as LOW, to be reviewed as a DEEP DIVE to be presnted to Governance committee in Dec 2024 2. Risk owner to amend description of risk to remove detail relating to COVID	2	No change	2	Actions listed with future due dates	[11/06/2024] Risk amended to reflect recent material changes at Trust Board on 06.06.24. Amendment to risk title, description and score
Quality of Care	1601	Director of surgery, Paediatrics and Women's Health	Inability to retain ENT Head & Neck Service Provision	16	High	16	high	8	high	8	HIGH	1. Set tolerance of this risk as HIGH as gaps outside of Trust control. 2. Agreement to decrease current risk rating from extreme (20) to high (12) as approved by CMT in March 2024	2	No change	0	Actions listed with future due dates	[20/08/2024] Southern Eastern Trust have agreed to take 20 patients within agreed post codes for review. Western Trust specialist doctors continue to see patients post 2years treatment. At present we still have a cohort of patients post oncology treatment and those in the first 2 years that we don't have a current pathway for. Outreach clinic with Belfast Trust took place in May 24. The red flag referral pathway is currently in place for new patients to be seen in Belfast prior to commencing treatment if required. Service currently looking at potential options in house for this cohort to be reviewed by a general ENT consultant although this would be outside of recommended guidelines, and this would potentially require support of the other Head and Neck consultants across the region. The recent recruitment exercise and successful candidate has turned down the post and accepted a post overseas.
Quality of Care	1602	Director for Primary Care and Older People	Risk no GP cover Trust managed GP Practices	16	High	16	high	12	high	5	LOW	To be reviewed at next Trust Board Workshop	2	No change	1	Actions listed with future due dates	[15/07/2024] As at 11 July 2024 for the remainder of July and August 2024 and across the 4 GP practices there are a total of 70 sessions (35 days) with no GP cover, 54 of these sessions relate to Dromore/Trillick and Fintona Practices. In addition to this there is only 1 GP on site on most other days in the Dromore/Trillick and Fintona Practices.
Resource & People	1612	Director of Performance, Planning and Corporate Services	Risk to WHSCT achieving the proposed encompass Go Live date due to safety concerns	10	High	10	High	8	High	5	LOW	To be reviewed at next Trust Board Workshop	0	No change	0	Actions listed with future due dates	20/08/2024] Risk remains unchanged 1. Programme plan detailing all readiness activities with target dates completed, this is reviewed and updated by programme manager on monthly & adhoc basis as required 2. ORB's established across all operational directorates working on readiness checklists and achieving key programme milestones 3. People change readiness group working to support workforce transition and preparedness 4. Digital services Group established and working to deliver technical infrastructure and device deployment work in line with target dates 5. Trust Readiness group meeting monthly basis chaired By SRO reviewing all directorate readiness preparedness escalating and providing mitigations as required. 6. Programme Board (CMT) meeting monthly providing oversight strategic review and decision making as well as providing overall accountability for readiness 7. Discussion ongoing in terms of recruitment of Clinical safety officer 8. Professional Lead team in place as well as Programme leadership team and PMO to monitor progress of programme readiness 9. Continuous assessment of workflows and safety of implementation via regional encompass decision groups

		Initial Risk		Current Risk		Target Risk													
ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Sub-Directorate	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date	Done date
1	19/11/08	20	Extreme (Red)	15	Extreme (Red)	8	High (Amber)	Director of Performance & Service Improvement	Planning & Performance - Facilities Management	Safe & Effective Services.	Fire Risks	As a result of the nature, use and condition of Trust owned, leased, occupied or unoccupied premises there is a risk of fire which could result in injury or death to staff, clients or public, damage to property, financial loss or loss of service.	Fire Safety Policy, procedures and manual. Including: Site specific fire emergency plans for SWAH and ALT. Departmental fire procedures in place for all areas. Staff Training and awareness. Mandatory Fire Safety awareness training. Recording and reporting of Fire Safety Mandatory Training Nominated Officers appointed and trained. Reporting of all fire incidents, unwanted fire alarms. Regional Fire Managers Group Nominated Officer Fire Safety Log Books Trust Fire risk assessments Recommendations from Resulting fromInspections of Regulatory bodies e.g. NIFRS and RQIA. Fire Safety Controls Assurance Standard action plan. Regular fire drills and emergency exercises Fire improvement works	Not all staff are trained in mandatory fire safety awareness training. Potential exists for Premises to be operational without a Nominated Fire Officer in the Department Regional Group meetings are infrequent Not all Fire Risk Assessment are completed within designated Timeframe. Target is 100% Infrequent Drills due to competing Pressures. Financial Constraints Competing priorities Ageing Estate and deteriation of physical infrastructure Working with service to ensure service delivery/care is not impacted. Not all Directorates have included fire on their directorate risk register. Current risks not aligned to the corporate risk ID01. Systems are currently not in place for annual attendance at Directorate SMT's. Space limitations within Trust	Fire Safety Policy, procedures and manual. Including: Site specific fire emergency plans for SWAH and ALT. Departmental fire procedures in place for all areas. These policies are corporate documents that apply to all staff within the Trust. Contractual obligation under the employment contract. Monthly reports provided to Business managers for distribution to HOS/AD's to identify staff compliance. Fire risk assessment audits. Fire Safety Working Group. Monthly drilldown of nominated fire officers throughout the Trust. Incidents are investigated by the Trust incident management process. Learning is cascaded both locally and regionally. Oversight over regional learning and good practice To ensure that nominated fire officer are aware of their fire safety responsibilities in each department/premises. Monitored through Fire risk	Accuracy of Learn HSCNI reporting of mandatory training compliance Potential Exists for Premises to be operational without a Nominated Fire Officer in the Department None adherence to Learning Incomplete Documentation within fire safety log books Failure to sustain recommendations on a long term basis Failure to	Emergency Lighting replacement Implement fire safety improvements Implement Fire Safety Improvements -18/19 NIFRS to speak with clients implement fire safety improvement works 17/18 Fire safety objectives review for 16/17 Fire Safety Report 15/16 Priority list of firecode works to be prepared Fire Improvement Works 14/15. Implementation of Directorate Action Plans. Fire Improvement Works 15/16 Hospital Fire Storage Working Group to be set up Working Group to be established to Review Inappropriate draining of Medical Gas Cylinders leading to a Fire/Explosion risk Review storage under Ward 31/ 32 stairwell Implement elearning fire safety training Head of FS and Fire Manager to	31/03/2021 31/03/2021 31/03/2019 30/09/2018 31/03/2018 30/06/2016 30/06/2016 31/07/2016 31/03/2015 31/12/2015 31/03/2016 31/03/2024 30/04/2024 30/06/2024 30/09/2017 31/03/2025 31/03/2024 31/03/2017 03/01/2024 31/12/2023 31/03/2021 31/03/2023 30/06/2022 25/04/2022 30/09/2024 30/09/2024 21/12/2022 30/06/2023	31/03/2021 31/03/2021 31/03/2019 30/09/2018 31/03/2018 31/05/2016 30/06/2016 30/06/2016 31/03/2015 31/12/2015 31/03/2016 22/02/2024 16/04/2024 30/04/2024 30/09/2017 22/02/2024 31/03/2017 03/01/2024 31/12/2023 31/03/2021 02/06/2023 06/09/2022 06/09/2022 02/06/2023 16/02/2024
6	21/09/09	25	Extreme (Red)	12	High (Amber)	8	High (Amber)	Excutitive Director of Finance, Contracts and Capital Development	Safeguarding Children	Safe & Effective Services.	Children awaiting allocation of Social Worker may experience harm or abuse	Due to capacity and demand issues within Family & Childcare, children may not be allocated a Social Worker in a timely manner to provide appropriate support. Children may experience harm as a result and the Trust may not meets its associated professional and organisational requirements.	Ongoing action to secure recurring funding. Update meetings between F&CC ADs and Director. Performance Management Review is being undertaken by HSCB with all 5 Trusts focusing on Unallocated cases and timescales Early Help staff returned to their substantive posts within gateway to increase the ability to allocate Principal Social Work redeployed will monitor Action Plan and progress to stabilise team Service Managers and Social Work Managers monitor and review unallocated cases on a weekly basis. Service and SW Managers constantly prioritise workloads.	Inability to get sick leave covered inability to recruit and retain social workers Principal Social Workers review unallocated cases regularly HSCB have drafted a regional paper to secure additional funding for Unallocated Cases. Delays in recruitment	Feedback given to Performance & Service Improvement for accountability meetings with HSCB. Quarterly governance reports to Governance Committee. Up-dates by Director to CMT and Trust. Action Plan to review and Address Risks within FIS Enniskillen Delegated Statutory Functions		Piloting a generic model of practice FIS Early Help Team established to help address unallocated cases. Principal SW temporarily redeployed to review all unallocated cases in FIS and then SW caseloads in FIS Action Plan Developed to address and Monitor Risks in FIS Enniskillen increased student placements to work on Family support casess and provide positive practise experience to encourage students to take up posts Retirees working alongside family support workers and social workers assistants providing assessments, support and interventions to those cases on the waiting list (unallocated) Overtime offered in Enniskillen to allocate cases for interventions to work towards closure Principle practitioner allocated	29/09/2023 30/09/2020 01/11/2018 30/09/2024 30/09/2024 30/09/2024 30/09/2024 30/09/2024 30/09/2024	29/09/2023 31/12/2019 30/09/2020 06/03/2019

		Initial Risk		Current Risk		Target Risk												
ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Sub-Directorate	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date	Done date
49	06/10/09	16	High (Amber)	20	Extreme (Red)	6	Medium (Yellow)	Director of Performance & Service Improvement	ICT Services	Safe & Effective Services.	The potential impact of a Cyber Security incident on the Western Trust	Information security across the HSC is of critical importance to the delivery of care, protection of information assets and many related business processes. Without effective security and controls; compromises can arise from technology and people which can lead to breaches of Data Protection Act and Network and Information Systems (NIS) regulations. A Cyber incident will directly impact on the delivery of patient/client care. Compromises can arise from; (1). NON Managed Trust ICT Equipment (e.g. Radiology modalities, cameras, door access, medical devices etc) in areas such as Radiology, Labs, PFI, HSDU, Estates, GP's etc are operating un-supported operating systems, e.g. Windows XP, and/or do not have the most up to date software updates (patching) and/or have end-point software applications	(1).PEOPLE CONTROLS - (1). Cyber Security Training , (2).Information Governance,(IG) Mandatory Training, (3). Staff Contract of Employment (2).GOVERNANCE CONTROLS - (1). Network Information Systems (NIS) Cyber Assessment Framework (CAF) (2). User account management processes (Standard Operating Procedure - SOP) (3). HSC Information Security, Policy, Standards, Guidelines and Standard Operating Procedures (SOPs) (4). Trust Cyber Governance Oversight Group (COG), Risk Management Group (RMG),Vulnerability Management Group (VMG), Corporate Governance Sub-committee (CGSG) (5). Change Advisory Board (CAB) (Local and Regional) 6). Regional Oversight Governance Groups - Cyber Programmes Board, Regional	GAPS IN PEOPLE CONTROLS : (1). Insufficient User Uptake of ICT Security and cyber awareness training and instructions, in particular user behaviour (e.g Not rebooting ICT Equipment when prompted) . (2). Insufficient buy-in from Services to agree maintenance window with ICT with regard to their departmental systems (3). Cyber Training is not mandatory GAPS IN GOVERNANCE CONTROLS: Local Assurance (1). Leavers and movers processes (2). Technical Disaster Recovery Plan 3). Resource for contracting function to cover governance elements and that GDPR is correct (4). Supplier Framework - Resource required by WHSCT (5). SOP for Information Asset Handling Corporate Assurance (1). WHSCT have not adopted the HSC ICT Security Policy	PEOPLE ASSURANCE: (1). As part of a Regional Cyber Programme, a Regional Cyber Phishing Exercise has been carried out (2). Mandatory IG Training Reporting Available (3). Contract of Employment Provides assurance that staff can be held to account (4). Regional E-Learning programme (Metacompliance) (5). Business Continuity (Desktop Exerecises undertaken by Staff) GOVERNANCE ASSURANCE: (1). Internal audit / IT Dept self-assessment against National Cyber Security Centre (NCSC) 10 Steps towards Cyber Security (2). ICT Vulnerabilty Management Group (VMG) regularly reviews and assesses Cyber threats and vulnerabilities (3). ICT Security Review meetings regularly reviews and assesses service submitted ICT Security Questionnaire (4). The regional Network Infrastructure Group (N.I.G) has	(4). Staff using unapproved and unsupported communication tools on personal devices i.e Instant messaging solutions for patient care containing trust data GAPS IN GOVERNANCE ASSURANCE: Local Assurance (1). Newly Established Groups e.g. COG will take time to get established in terms of process (2). Work to be carried out	Implementation of cyber security work plan which has been agreed with the Region. Recruitment of Band 7 Cyber Security Manager. Recruitment of Band 6 to support implementation of Cyber Security Action Plan. Full implementation for Metacompliance across the Trust with regular course updates being issued thereafter. Introduce routine reporting to Trust Board (or other equivalents (local or regional)) on reported incidents/near miss, and other agreed indicators. People Governance Supply Chain Technical	30/09/2024 31/03/2019 31/03/2019 31/03/2020 31/08/2018 31/03/2025 31/03/2025 31/03/2025 31/03/2025	 28/02/2019 31/03/2019 31/08/2019 31/08/2018
284	13/12/10	16	High (Amber)	12	High (Amber)	6	Medium (Yellow)	Director of Performance & Service Improvement	Planning & Performance - Performance Mgmt	Governance.	Risk of breach of Data Protection legislation through loss, mishandling or inaccessibility of personal or sensitive personal inf	The Trust faces reputation and financial risk from non-compliance across all Directorates with the UK GDPR, Data Protection Act 2018, DoHNI's Good Management, Good Records and the Public Records Act 1923. The risk comprises a number of key factors which increases the level of risk for the Trust: • Insecurely sharing or accessing the personal data of clients, patients and staff without a legislative basis under UKGDPR or supporting legislation • The unavailability of records for provision of patient and client care or for legal or public interest purposes • Concerns on the adherence to records management responsibilities – notably the storage, categorisation and disposal/PRONI transfer of patient, client and staff records	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. Data Guardians role. Regional DHSSPS Information Governance Advisory Group. Electronic transmission protocol. Investigation of incidents. 2 secondary storafe facilities available across NS & SS Trust Protocol for Vacating & Decommissioning of HSC Facilities. Scoping exercise to identify volume and location of secondary place records	Potential that information may be stored/transferred in breach of Trust policies. Limited uptake of Information Governance and Records Management training. No capacity within the team to take on provision of IG training	Reports to Risk Management Sub-Committee/Governance Committee BSO Audit of ICT and Information Management Standards. BSO Internal Audit of Information Governance. Revised composition and terms of reference of the Information Governance Steering Group as a result of the new SIRO/IAO framework.		Band 3 0.5 post inceased to full time Recruitment of Band 4 Information Governance Development of information leaflet for Support Services Staff to increase awareness of information governance Review of regional e-learning IG training Establishment of Regional Records Man Group Development of IG action plan to be finalised through IGSG Recruitment of band 5 IG post to support DPA Development of IG information leaflet for support staff Review of Primary (acute) records storage in AAH Restructure of IAO process Review of Secondary storage in Maple Villa Production of Records Storage guidance for home working staff working from home New secondary storage facility in the southern sector Recruitment of IG Team leader	31/03/2019 31/03/2019 31/03/2019 31/12/2020 30/09/2020 30/09/2020 31/12/2020 30/09/2020 31/03/2025 30/09/2024 31/03/2025 31/12/2021 30/09/2024 01/06/2022 31/03/2023	31/03/2019 28/02/2019 01/03/2019 25/11/2020 30/09/2020 30/09/2020 31/12/2020 30/09/2020 09/09/2021 01/06/2022 08/03/2023

		Initial Risk		Current Risk		Target Risk												
ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Sub-Directorate	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date	Done date
1183	27/11/19	25	Extreme (Red)	15	High (Amber)	6	Medium (Yellow)	Director of Adult Mental Health & Disability	Directorate-wide (Risk Register Use only)	Governance., Safe & Effective Services.	Where MCA processes are not being followed, patients may be deprived of their liberty, without having safeguards in place	Where MCA processes are not being followed, there is the risk that patients may be deprived of their liberty, without having the relevant safeguards in place, with the result that individual staff may be held criminally liable with appropriate sanctions, including financial penalties and imprisonment. For patients that lack capacity and for whom safeguards are not in place, there is the risk that statutory services may not be delivered. Emergency provisions should be considered where deemed appropriate, to support continuing service delivery until the safeguards are approved. Where emergency provisions apply, fully authorisations are required to be urgently followed up. The Department of Health, requires H&SC Trusts to proceed with a partial implementation of the Mental Capacity Act (NI)	Staff training is available online & classroom, provided by Trust Trainers. Progressing interactive online training via VC. Training videos developed MCA resources are available via MCA HUB on StaffWest DOLs office supports administration processes, including advice to support completion of forms Staff training is available via eLearning as well as from CEC. Training available online & classroom, provided by Trust Trainers. Progressing interactive online training via VC. Emergency provisions to be used, where deemed appropriate, to support continuing service delivery until the safeguards are approved. Directorate resource to support Directorate related MCA activity	Medic capacity to ensure timely completion of relevant forms and availability to sit on Panels Funding not adequate to deliver the projected activity. Funding not provided recurrently, compounding recruitment issues Assurance that there are timely completion of MCA processes following use of Emergency Provisions community teams staffing issues resulting in anallocated caseloads Timing of progression to the introduction of the second phase of MCA legislation is yet to be confirmed. Review of requirement for DoLS in Special Schools Structures to be developed to ensure relevant identification and completion of STDA processes within Acute settings Review of administration systems and Processes re interaction with NIRT	First Line of Assurance STDA Operational Group MCA Team, including Supervision MCA Information T&F group (systems, processes & reporting) Training T&F group Second Line of Assurance Updates to Trust Board Corporate Risk Internal Audit Third Line of Assurance MCA Legislation / Code of Practivce Mental Health Order Role of General Attorneys Office Role of Northern Ireland Review Tribunal SPPG Regional monthly activity reporting Role of RQIA MCA Regional Leads Group MCA Miltiagency Group (NIRT, AG, RQIA, DLS, SPPG, MCA Leads MCA Project Board	Systems, Processes & Reporting to be strengthened & formalised - Encompass is the Regional Direction, Western Trust go live is April 25 Assurance required that all staff completing MCA forms are suitable qualified to do so Escalation processes to be bedded in across Acute and Community Issues in relation to	Engage with programme board and team Scope potential Mental Capacity/DoLs assessments A Programme Implementation Officer to continue engaging on leading implementation. Trust Lead Directors and Responsible leads in each Sub-Directorate to be identified Quantification of Costs and completion of the IPT bid to ensure fully funded MCA arrangements and minimise financial risk HR & remunerations for staff identified to undertake duties on panels Seek Interest from relevant staff to sit on panels. Ensure sufficient staff attend training to allow them to undertake statutory functions commencing 2nd December 2019 Seek Interest from Nurses at Band 7 and above to sit on panels.	31/12/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2020 29/10/2021 31/03/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2021 30/07/2021 31/10/2024 31/10/2024 31/03/2023 28/03/2025 30/04/2024 30/11/2022 30/11/2022 31/03/2024 31/10/2024 31/10/2024 31/10/2024 31/10/2024 30/09/2024 30/11/2022 30/11/2022	31/08/2019 02/12/2019 31/08/2019 31/08/2019 01/11/2019 01/12/2019 25/10/2021 31/03/2020 31/03/2020 02/12/2019 31/01/2020 21/04/2021 21/07/2021 20/06/2024 30/06/2023 26/04/2023 16/04/2024 07/12/2022 07/12/2022 28/03/2024 11/06/2024 11/06/2024 07/12/2022 07/12/2022
1216	15/04/20	15	Extreme (Red)	15	Extreme (Red)	6	Medium (Yellow)	Director of Diagnostics, Cancer and Medical Specialities	Acute - Emergency Care & Medicine	Public Confidence., Safe & Effective Services.	Risk of patient harm in Trust EDs due to capacity, staffing and patient flow issues	If Emergency Department (ED) Physical capacity and staffing levels are not sufficient to meet the demands of patient numbers and acuity, there will be increased likelihood of significant patient harm, risk to staff wellbeing and damage to Trust reputation as a direct result.	Business case approved dedicated HALO (Hospital Ambulance Liaison Officer NIAS crews waiting to offload in our hospital early warning score Ongoing Trust recruitment focus on Critical posts IE Medical and Nursing Use of Medical locums/ Bank and agency Nurses. Social Media Campaign Escalation protocol within full capacity protocol Nursing KPI and audit (ALAMAC) Ongoing in house Quality improvement work (implementation of SAFER principles) Daily regional huddle meeting with escalation as required IT systems - Symphony Flow board On call managers/medics rota Ongoing MDT patient flow huddles in department/wards Medical team ED reviews Hub flow meetings with lead nurse attendance. Patient flow teams/ night service	Implementation of SAFER principles challenged due to Medical Job plans and current Medical team models in operation ageing population living with challenging health needs Community infrastructure to meet needs of patients i.e. Gp appointments, social care packages Recruitment to perm medical posts Challenging across NI	Datix - Incident, Complaints, Litigation, Risk register Patient flow teams, Night service manager, SPOC, Hub Regional huddle Established patient pathways	Gaps in patient pathway	PACE implementation to commence March 2020. Improvement QI work commencing with aim to address communication within department. Full capacity protocol	31/03/2022 30/09/2024 28/02/2022	06/05/2022 15/03/2022

		Initial Risk		Current Risk		Target Risk												
ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Sub-Directorate	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date	Done date
1219	30/04/20	20	Extreme (Red)	20	Extreme (Red)	6	Medium (Yellow)	Director of Diagnostics, Cancer and Medical Specialities	Acute - Diagnostics & Cancer Services	Safe & Effective Services.	Lack of endoscopy capacity for endoscopy to meet the demand which impacts on Patient outcomes	Lack of endoscopy capacity in the Trust has resulted in breaching of the 2 week red flag wait/9 week urgent and routine wait and surveillance targets for endoscopy. The lack of timeliness for endoscopy will lead to delayed diagnosis of cancer and poor outcome for these patients as evidenced in SAIs. The service has been further impacted by Covid -19 where the service has been reduced to emergency and red flag endoscopy only and reduced turnaround times between patients due to IPC requirements.	Telephone pre assessment of colonoscopy on-going to improve list utilisation and reduce DNA rates Independent sector was utilised to deliver 250 surveillance colonoscopies from January to March 2020. Further use of Independent Sector to be explored post Covid -19 Surveillance waiting lists are being validated in line with new guidelines. Discussions have commenced with the commissioner to recurrently fund one of the posts in 20/21 to address the demand/capacity gap. The second post will be funded from a current vacancy. Training of 2 nurse endoscopists under transformation commenced in September 2018 - trainees were to be signed off by the end of 2020 the delay was due to Covid-19. Short-term provision by SE Trust to provide WT in IS tender	Band 4 team lead recruited to manage waiting lists and oversee the scheduling team and processes. Encourage consultants to triage referrals in line with NICAN suspect cancer guidelines (Oct 2019) and utilise the urgent and routine categories. Additional funding for a second pre assessment nurse has been discussed with the commissioner- await confirmation in 2021 allocation	Waiting lists discussed monthly at the Endoscopy Users Group Clinical audits are completed annually to benchmark the service against National Standards. Monthly monitoring of waiting lists is carried out to identify longest waits and prioritise for scheduling.	The need for the Trust to invest further in the development of GI Trainees in line with the evidence base for modernisation , thereby proactively growing the team to meet future demand. The need to develop the service to include the inclusion of a hepatologist as part of the team in line with Royal College modernisation of	Explore the possibility of utilising the Independent Sector to address waiting lists. Need to review GI consultants job plan to reduce General Medicine commitment to increase availability for endoscopy lists. Secure funding for an additional pre assessment nurse to support list utilisation and reduce DNA rates. Recruit 2 trainee nurse endoscopist Recruitment of a further GI consultant to fill present vacancy and increase the medical team to 6 wte.	05/10/2021 30/10/2022 30/04/2023 30/06/2023 30/09/2024	05/10/2021 14/11/2022 04/04/2023 19/06/2023
1236	21/08/20	16	High (Amber)	16	High (Amber)	6	Medium (Yellow)	Director of Finance, Contracts and Capital Developme nt	Finance	Ensuring Stability of Our Services	Stabilisation of Trust Financial position	In 2024/25 the Trust has opened with a forecast deficit of £59m as a consequence of a poor budget settlement for HSC in 2024/25, unfunded demographic growth in 2023/24 and 2024/25 and a recurrent reduction to Trust baseline budget in 2023/24 of £24.1m without effective time to enable planning and implementation of recovery actions. The Trust has complied with its obligations to provide a Financial Plan and Contingency Savings Plan for 2024/25. The Trust has effectively communicated it's ambition to deliver £24m of low and medium impact savings in 2024/25 which results in a deficit of £35m. SPPG have provided £31.5m of deficit funding to the Trust leaving a deficit of £3.5m and an expectation that this balance can be found from savings. The Trust have not accepted this	Chief Executive Assurance meetings to review performance Annual Financial Plan to review risks to financial position and opportunities for savings Trust Board (and Finance & Performance Committee), DVMB and CMT oversight of the financial position monthly Monthly budget reports for all levels in the organisation, with follow-up on movements in variances Monthly Finance focus meetings between Finance and Directors / Senior Directorate Officers		Internal Audit. Assurance obtained by the Chief Executive from his assurance meetings with Directors and regular updates External Audit (NIAO) . DHSSPS/HSCB monthly financial monitoring. Monthly financial performance reporting to CMT and Trust Board Assurances from Director of Finance and ADF to CMT & Trust Board.	Gaps in assurance that budget holders are applying effective budgetary control in the management of their service Gaps in assurance that budget holders are trained to manage their budgets accordingly Gaps in assurance that managers are reviewing their staff in post reports	Ongoing financial management and monitoring Operation of DVMB (Delivering Value Management Board) Monitoring and reporting of management attendances at Budgetary Control training Support to managers in accessing and using CP to support budgetary management Performance of Managers against SIP reviews	31/03/2025 31/03/2025 31/10/2024 31/10/2024 31/10/2024	

		Initial Risk		Current Risk		Target Risk												
ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Sub-Directorate	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date	Done date
1254	18/01/21	16	High (Amber)	16	High (Amber)	8	High (Amber)	Director of Human Resouces & Organisational Development	Trust-wide (Risk Register use only)	Ensuring Stability of Our Services, Improving the Quality and Experience of Care, Supporting and Empowering Staff	Inability to deliver safe, high quality and sustainable services due to workforce supply and disruptions	Due to an inability to attract, recruit and retain staff throughout the Trust, services may not be able to maintain sufficient staffing levels to sustain high quality safe services which may result in a reduction in service provision.	Trust Business Continuity Plans with full HR support on hospital / community workforce groups. Delivering Care: Nurse Staffing in Northern Ireland Organisation Development Steering Group Health and Wellbeing Strategy Engagement & Involvement Strategy DOH Workforce Strategy & Trust Workforce Strategy and key actions Policies - Rec & Selection Framework, Attendance at Work, Flexible Working, Redundancy and Redeployment, etc. HR Strategic Business Partner identified for each Directorate - targeted interventions in relation to absence, agency usage, temporary staffing and other identified Directorate priorities. (Risk 6, 1075) Pension information sessions Joint Forum, Joint LNC and Consultation Group Workforce Information reports across and recognise overwhelm	Occupational Health - absence of locums and increasing demands on team without additional resources. Low uptake of mandatory training and completed annual appraisal. Inability to follow normal policies and procedures during periods of Industrial Action and also during emergency situations such as Pandemic. Lack of co-ordinated information on agency staffing Due to demand in services compliance with Working Time Regulations and New Deal. BSO Recruitment Shared Service provides recruitment services for the Trust and there has been an increased delay in recruitment and dependence on them for related information. Inability of NIMDTA to provide required number of Junior Doctors for certain specialities and localities. (Risk 694) Difficulty in recruiting in rural	Working Together Delivering Value Health check measurements on absence hours lost, mandatory training, appraisal, time to fill posts, job planning completion rate. Involvement Committee - Quarterly monitoring of staff engagement on initiatives that contribute to achievement of Trust Great Place ambitions (start life, live well and grow old). Pension Regulator Compliance Junior Doctors Hours monitored twice yearly and returns submitted to DOH. People Committee - Workforce Strategy, Recruitment and NIMDTA Allocation Updates twice per year. People Committee - Quarterly monitoring of Absence, Appraisal, Mandatory Training, Consultant Job Planning, Temporary Staffing, Agency Staffing, Turnover and Grievance/Disciplinary/Statutory Cases	BSO Shared Service not meeting statutory or procedural deadlines resulting in, for example, delays in recruitment Inability of NIMTDA to fill all posts. Insufficient number of social work student applications to the University Degree Course in rural areas. (Risk 1109) Insufficient training places being procured by Department of Health to meet the	Looking After our People Growing for the Future Belonging to the HSC New Ways of Working	30/09/2024 30/09/2024 30/09/2024 30/09/2024	
1288	08/04/21	12	High (Amber)	12	High (Amber)	6	Medium (Yellow)	Director of Performance & Service Improvement	Trust-wide (Risk Register use only)	Ensuring Stability of Our Services, Improving the Quality and Experience of Care	Risk of failure to meet regulatory standards and compliance associated with Trust infrastructure and estate.	There is a risk of deterioration in the Trust Estate due to ageing and lack of capital investment in the maintenance of building services infrastructure and physical environment which could lead to loss of service and non-compliance with regulatory and statutory standards (e.g. water, electrical, asbestos and physical infrastructure).	Monitoring and review by PSI SMT of directorate risks including water, electrical, fire safety, vacant estate asbestos and physical infrastructure. Should a critical issue materialise further funding can be sought from DOH or existing funding reprioritised to address the new critical issue Estates Strategy 2015/16-2020/21 Annual review of building condition (3i) and creation of prioritised BLM list. 2022/23 Backlog maintenance programme developed and implemented Continual bidding for funding to address backlog maintenance Targeting of priority areas as funding becomes available. Monthly review of Backlog Maintenance capital investment plan Priority Backlog Maintenance capital investment plan 2024/25 Backlog maintenance programme developed and	Ageing infrastructure resulting in deterioration of buildings Insufficient funding to carry out full remedial works identified.	Back-log Maintenance list Health & Safety audits Environmental Cleanliness audits Authorising Engineer audits Annual inspections carried out Membership at Health and Safety/ Water Safety Groups Reports to Corporate Governance Sub Committee/Governance Committee Assurance standards Buildings, Land, Plant & Non-Medical Equipment Oakleaf - 6 facet independent survey	Lack of Funding for backlog maintenance.	Review of emerging issues and response required Development of business cases for 2021/22 backlog maintenance agreed action plan. CMT approval of BLM 2021/22 for submission. Development of 2021/22 BLM bid Completion of six facet condition survey Review of emerging issues and response required Monthly review of Backlog Maintenance capital investment plan Review Ward 50 ventilation system performance BLM and Capital Plan Project Delivery for 21/22 BLM and Capital Plan Delivery 23/24 Develop BLM bid 22/23 DoH approval of BLM 2022/23. Develop BLM plan for 24/25 Review and Update Condition Surveys of WHSCT Estates Portfolio Review and Prioritise Ventilation	30/06/2022 30/09/2021 30/04/2021 30/04/2021 30/09/2021 30/09/2021 31/03/2022 31/08/2021 31/03/2022 31/03/2025 30/06/2022 30/09/2022 30/06/2024 31/10/2024 31/10/2024 30/04/2024	06/06/2022 07/09/2021 03/08/2021 03/08/2021 07/09/2021 07/09/2021 12/04/2022 31/08/2021 12/04/2022 06/06/2022 30/09/2022 31/05/2024 09/04/2024

		Initial Risk		Current Risk		Target Risk												
ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Sub-Directorate	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date	Done date
1307	16/06/21	25	Extreme (Red)	25	Extreme (Red)	6	Medium (Yellow)	Director of Surgery, Paediatrics and Women's Health	Women & Childrens - Health Division	Supporting and Empowering Staff	Clinical Risk regarding Delayed Transfer of Babies, Children and Adults to Other Hospitals	Due to limitations on the NISTAR resource and ability of Trust to facilitate transfers that don't meet NISTAR protocols and lack of clarity around same, time critical transfers are being either delayed or are completed using sub-optimal alternatives. This may result in harm to patients being transferred, the patients in the services covering the transfer as well as additional financial cost to the Trust.	Consider stabilisitng and holding patient until NISTAR availlable. Ensure staff are trained in use of transport equipment in case required to transfer patient in absence of NISTAR In absence of NISTAR, Pro-paramedics (independent company) may be used. NISTAR will make ambulance and driver available if local team can do transfer	Impact on Services when Trust Staff are called away to facilitate transfer Working with neonatal shortage - no adequately trained staff to backfill and training delivered during core time No funding for dedicated rota Difficulty ensuring ongoing professional development to maintain skills. Requirement to provide/source Trust Time Critical Transfer Training tailored to all disciplines i.e. Paediatricians require different training to anaesthetists, and nurses also require different training as they all have separate roles. proparamedics are no longer able ot supply NISTAR with back up			Escalate to Director of Acute services for discussion with counterpart in Belfast as he/she is responsible for NISTAR. Raise at corporate safety huddle and RRG Escalate through child health partnership. Review of stabilization of medical staff Trust Wide Review of staff training needs in line with possible training opportunities within the region	30/06/2022 31/03/2022 31/03/2022 01/10/2024 01/10/2024	03/02/2022 03/02/2022 03/02/2022
1320	15/09/21	12	High (Amber)	20	Extreme (Red)	8	High (Amber)	Director of Social Work/Director of Women & Children's Services		Improving the Quality and Experience of Care	Delayed/inappropriate placement of children assessed as requiring inpatient mental health care.	Increasing demand for the need for inpatient beds has resulting in capacity issues within the regional adolescent mental health inpatient unit. There is significant challenges for CAMHS resulting in increasing delays in accessing and securing emergency, urgent or planned admission for treatment to a regional bed for vulnerable adolescents requiring immediate and planned inpatient mental health care. As a consequence of this children are being placed inappropriately in inpatient AMHS beds when available and/or acute medical and paediatric wards or are being managed by Community CAMHS intensively with heightened complex risk. As a consequence CAMHS staff from other steps within the Service are being redeployed to support this intensive working. Community CAMHS remains under [illegible]	Staff training in Paediatrics Staff training in Emergency Department Regular meetings with AMH services Regular meetings with Beechcroft (weekly) and daily updates Policy on age appropriate care to acute setting Policy on U18 admission to AMH wards Protocol CAMHS/AMHS pathway OOH (2011) - under review at present	Environmental risks of temporary placement wards/facilities in particular YP presenting self-harm, suicidal risk, risk of absconding. Supervision deficit in ED/AMH/Paeds wards Psychiatric cover limited in CAMHS and AMHS Delayed & limited availability of AMH beds in Trust. Training/knowledge deficit re pathways related to high staff turnover in acute medical/AMHS setting CAMHS/AMHS OOH Pathway review overdue Unfunded demand for CAMHS OOH Limited regional capacity for inpatient beds	Monitoring of waiting lists Regional AD Forum - standing item Regional Care Network - weekly data collation Daily updates with Beechcroft In-house monitoring of inappropriate admissions Early Alerts of inappropriate placements both in AMHS wards and Acute medical /Paediatric wards. Weekly review and monitoring by HSCB Escalation to HSCB/DOH		CAMHS Business case to be developed to progress development of CAMHS OOH service provision Family & Child Care Social work input in over 16 MH assessment with AMHS to be reviewed to ensure cover and consistency to mitigate risk WTCAMHS/AMHS OOH 2011 pathway to be considered and reviewed When a young person presents in a mental health crisis OOH the WTCAMHS/AMHS OOH protocol adhered and followed. No MH Adolescent, No AMHS, No Medical paediatric wards CAMHS will attempt to work intensively with YP and family notwithstanding capacity and resource issues Task and finish group to support unmet needs re training /risks identified and policy regarding YP requiring MH admission inappropriately placed on medical wards. [illegible]	30/09/2024 30/09/2024 30/09/2024 30/09/2024 30/09/2024 30/09/2024 31/05/2023 31/05/2023 31/05/2023 31/05/2023 31/05/2023	 24/01/2024 24/01/2024 24/01/2024 24/01/2024 24/01/2024

		Initial Risk		Current Risk		Target Risk												
ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Sub-Directorate	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date	Done date
1334	26/10/21	20	Extreme (Red)	15	High (Amber)	8	High (Amber)	Director of Surgery, Paediatrics and Women's Health	Surgical Services	Ensuring Stability of Our Services, Improving the Health of Our People, Improving the Quality and Experience of Care	Sustainability of surgical services in Southern Sector of Trust due to recruitment & retention difficulties at Consultant and Mi	Inability to recruit and retain permanent general surgical staff particularly at Consultant and middle tier level in South West Acute. This is threatening the ability to deliver 24/7 emergency service and the range of commissioned elective activity. There has been a high turn-over of locum consultant surgeons who have been appointed to cover gaps, leading to gaps and concerns about continuity of care. It has been highlighted that emergency surgical services are at risk within the next 4 months due to inability to sustain a Surgeon of the Week and On-call emergency rota at consultant level	Trust have authorised a Sustainable Surgical Services project to examine surgical services pan-Trust wef 18/10/21 Recruitment campaign is continuous at Speciality Dr and trainee level. Funded establishment should be 6.5 wte consultant Surgeons - current baseline is 3.0 wte with 3.5 wte gap Specialty Drs funded for 8.0 wte; 5.0 in place 2 of whom are locums and one acting up. Ongoing use of locums from within the Trust to sustain the rota at South West Acute. Newly appointed Consultant taking up post 25/10/21 Ongoing efforts to recruit - Interviews planned for 2.0 wte Consultants late October 2021 (now currently deferred pending Royal College approval)	Reluctance from other surgeons across NI to participate in providing locum cover due to the generality of surgical cover required. Difficulties recruiting and retaining at locum and permanent level as above. Difficulty securing Royal College approval for general surgical posts.	Continuing support from Altnagelvin Surgical body to provide locum cover for rota gaps. Programme Board will have fortnightly oversight of all of the actions within the Review Programme. Senior clinical support to project identified and in place. Project lead has been seconded full time to Project team. Project Lead currently briefs CMT twice weekly This will be taken over by Programme Board with fortnightly oversight from 01/11/2021 CMT will continue to support service and project		A Proposal for Sustainable Surgical Services will be developed by end January 2022 to address the most emergent issue eg emergency surgical services in the Southern Sector of the Trust. Continue with ongoing recruitment to fill vacant consultant posts Develop plan for the release of locum surgeons to align with on boarding of recent consultant surgeon appointees, when start dates confirmed Ongoing monitoring of the temporary suspension of emergency surgery and contingency arrangements in place, through the Project Team	01/09/2023 01/10/2024 01/10/2024 01/10/2024	13/06/2023
1375	15/03/22	16	High (Amber)	16	High (Amber)	6	Low (Green)	Director of Diagnostics, Cancer and Medical Specialities	Acute - Emergency Care & Medicine	Ensuring Stability of Our Services, Improving the Health of Our People, Improving the Quality and Experience of Care	Consultants Cover in Cardiology	Due to challenges regionally in relation to securing substantive positions and the limited availability of locum resources, a 6 person on call rota has been depleted by 50% leading to potential gaps in the rota.	Working with International Recruitment team to expedite a new appointment. Working through current job plans to identify monies to increase the Consultant complement. -Secured short term locum Middle Grade Doctor to support Ward based work on a short to medium term basis. Worked with Medical HR to secure short to medium term locums (starting 27th February). Link with regional pPCI network to seek support for any gaps in rota. Linkage with RCM to ensure sign off of job plans and job descriptions. -A review of current workload and a short term reduction in outpatient work to facilitate redistribution.	Locum resources has limited availability. Challenges regionally in relation to securing substantive positions.	Medical HR working collaboratively on recruitment. Clinical Lead has oversight of the rota Business continuity arrangements are in place should there be an unplanned rota gap.	Locum resources has limited availability. Challenges regionally in relation to securing substantive positions.	Recruitment to fill vacant posts. Ongoing review and monitoring of recruitment gaps to include the use of locums	31/07/2023 01/09/2024	15/08/2023

		Initial Risk		Current Risk		Target Risk												
ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Sub-Directorate	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date	Done date
1409	01/07/22	25	Extreme (Red)	16	High (Amber)	9	Medium (Yellow)	Director of diagnostics, Cancer and Medical Specialities	Acute - Unscheduled Care	Ensuring Stability of Our Services, Improving the Health of Our People, Improving the Quality and Experience of Care, Supporting and Empowering Staff	ED Mental Health Patients	Due to lack of local and regional mental health beds patients requiring mental health assessment and admission are required to stay in the department for prolonged periods, with minimal mental health input. Voluntary and detained patients at high risk of harm due to lack of suitable staffing, supervision and infrastructure onsite. The department is overwhelmed with multiple patients awaiting admission some have already absconded and/or attempted self-harm while awaiting transfer or identification of a Mental Health bed due to inadequate supervision.	-Crisis/MHL will review all patients every 24 hours and liaise with psychiatry as required -ED will complete Kardex's – Psych Consultants will be available for advice if needed -Additional staffing support when available from Mental Health Grangewood to ED when a threshold of three or more has been reached. -Weekly meetings planned for ED and Mental Health to work collaboratively to improve the safety and experience for patients (commenced 16th June 2022). -Continue to report and review all associated incidents via datix to further understand risk and mitigations -MAPA training	-Timely access to Mental Health beds continue -Overall congestion and capacity issues within ED compounds the challenge in managing this group of patients	Daily engagement with MH and ED to manage risk Newly established weekly meetings between ED and mental health teams		Meetings Workforce Improvement Meetings	03/07/2023 01/10/2024 01/10/2024	18/09/2023
1469	06/01/23	12	High (Amber)	12	High (Amber)	4	High (Amber)	Medical director	Trust-wide (Risk Register use only)	Supporting and Empowering Staff	Health & Safety Risk to Staff as a result of Violence and Aggression	Increases in the number and complexity of patients being treated and awaiting treatment in all our settings; along with social; economic; and environmental factors; restrictive guidelines / practices resulting from Covid etc; increased social media challenges; and the absence of a Corporate legal remedy; have all contributed to an already high level of abuse, violence and aggression against Trust staff. The result is that staff are increasingly subjected to both sporadic and longer consistent patterns of patients/client/visitors displaying abusive, challenging, aggressive and violent behaviours in our facilities, communities and home environments leading to significant risk of emotional and physical harm.	Management of Violence and Aggression (MOVA) group in place. Zero Tolerance & Security policy Trust adherence to The Management of Health and Safety at Work Regulations NI (2000). Health and Safety at Work NI Order 1978 Lone Working Guidance Staff support through Occupational Health Safety Intervention training - available to relevant staff. V&A risk assessment. Usage of Trust General Risk Assessment form for document of specific risks. Incident reporting on DATIX – identification of trends. Risk Register process in place RIDDOR reporting of staff absence and further scrutiny Policy for the Use of Restrictive Interventions with Adult Service Users – May 2017 Trust Security Working Group Ad hoc Risk Strategy Meetings	MOVA Policy - Await implementation of regional guidance Limited Legal support available for staff from the Trust when seeking prosecutions/non-molestation orders against violent individuals. No Acute Liaison Psychiatry service in ED No programme of regular education regarding mental health presentations in ED and other acute settings of risk. CAMHS referral pathways not clarified for patients aged 0-18. CAMHS not co-located in hospital. No dedicated area for intoxicated or consistently violent patients to be treated in ED. Lack of resource to provide safety intervention training following CEC cessation of training provision. Paris alert system not utilised in all areas to warn staff regarding	Audit Trust controls assurance standards reporting Risk assessment compliance reporting on corporate risk register, directorate governance Incident reporting to MOVA Steering Group Audit Regional Benchmarking and DOH return on violence against staff Health and Safety Inspections		Adopt and imbed regional MOVA policy in Trust Policy and Procedures Draft business case to expand resources for Safety Intervention Training	30/09/2024 30/09/2024	

		Initial Risk		Current Risk		Target Risk												
ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Sub-Directorate	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date	Done date
1487	06/04/23	20	Extreme (Red)	20	Extreme (Red)	8	High (Amber)	Director of Human Resouces & Organisational Development	Human Resources	Ensuring Stability of Our Services, Supporting and Empowering Staff	Impact on services as a result of Industrial Action in relation pay, safe staffing and travel rates.	Impact on services as a result of ongoing Industrial Action, including both strike action and action short of strike, taken in relation to Agenda for Change (AFC) pay, safe staffing and travel rates (AFC staff make up 94% of overall workforce) and also Junior Doctor Pay.	Trust compliance with Agenda for Change Terms and Conditions of Services. TU Side engagement with local and regional representatives regarding derogations and service level planning for service delivery on the basis of agreed derogations. Command and Control Silver and Bronze arrangements in place including arrangements for escalation of risks and issues to Health Silver through SPPG and DOH. HR Industrial Action Group established to work closely with Services on IA plans, development of derogations and negotiation with Trade Unions. Business Continuity Plans have been updated and impact assessments completed to identify specific risks as each notice of action is received. Business continuity plans implemented to adapt service delivery in light of ASOS and	Service impacts over a prolonged period of time of Industrial action. Postponement and rescheduling of appointments increasing delays for patients on waiting lists. Increasing unallocated cases across a number of areas i.e. nursing, social work. Vacant/uncovered cases not worked unless immediate risk to life and limb harm accepted by Trade Union representatives. Not able to make the necessary improvements in statutory requirements for review Compromising ability to meet statutory social work responsibilities for children i.e. delays in permanency planning, presentation to Trust Adoption Panel, Court timescales, etc. Impacting on consistency of social work input to inform planning processes for children e.g. child protection, looked after children and family support	Trust is in line with NHS Terms and Conditions of Service. Partnership Working with TU Side. Regular engagement with DoH to influence e.g. mileage rate.	Pay discussions in NI are led by Department of Health however the dispute in relation to the 2022/23 pay award is being managed by Government at Westminster and there is no capacity for the WHSCT to influence resolution of dispute. Absence of Health Minister to engage with this. Outstanding Pay Awards for all staff.	Resolution of local issues Plans to address continued service impacts Continued engagement with local and regional TU Side representatives on derogations. Implementation of Business Continuity arrangements	30/09/2024 30/09/2024 30/09/2024 30/09/2024	
1601	11/06/24	16	High (Amber)	16	High (Amber)	8	High (Amber)	Director of Surgery, Paediatrics and Women's Health	Surgical Services		Inability to retain ENT Head and Neck service provision	The ENT service in the Western Health and Social Care Trust is funded 6 WTE consultants. 4 consultants in post. 2 vacant post currently filled with Locum. One head and neck consultant who has retired on the 6th September 2023. This consultant managed both complex cancer and benign head & neck conditions, including thyroids. This Consultant returned following retirement for a short period (September to December) on a bank contract. Moving forward this surgeon is no longer available. The Trust has previously tried to recruit a 2nd Head and Neck cancer consultant 4 times nationally and 3 times internationally with no success since 2019. Currently 2 benign Head and Neck with interest in thyroid surgery consultant and general ENT consultant posts re advertised via IMR and global recruitment					Recruitment of head and neck consultant x 2 Potential Service delivery redesigns Formal Pathway to be agreed with Belfast Trust and Western trust regarding transfer of patients Formal lookback to be undertaken in relation to patients underwent thyroid surgery in trust and via IS provider in relation to patient care and management for the last 2 years	31/10/2024 31/10/2024 31/10/2024 31/10/2024	

		Initial Risk		Current Risk		Target Risk													
ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Sub-Directorate	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date	Done date
1602	11/06/24	16	High (Amber)	16	High (Amber)	12	High (Amber)	Director of Community and Older People's Services	COP - Primary & Community Care		Risk of no GP cover in Trust managed GP Practices	110 vacant sessions across 4 GP practices between 1 May 24 and 31 August 24, equivalent to 55 days without GP cover. In addition there are 162 sessions with only 1 GP, this is equivalent to 81 days. The Trust has lost 5 locum GPs from their pool as a result of 2 on maternity leave and 3 taking up posts elsewhere. The Trust is trying to manage 1 additional GP practice in Omagh locality with a reduced number of locums.					Develope salaried GP job description and T&C's Recruitment Process ANP post	30/08/2024 30/11/2024 30/11/2024	29/08/2024
1612	22/07/24	10	High (Amber)	10	High (Amber)	8	High (Amber)	Director of Performance & Service Improvement		Ensuring Stability of Our Services, Improving the Quality and Experience of Care, Supporting and Empowering Staff	Risk to WHSCT achieving the proposed encompass Go Live date due to safety concerns	There is a risk to WHSCT achieving the proposed Go Live date due to safety concerns associated with service delivery, because of key readiness activities not being completed within the required timescales. A funding shortfall is anticipated to cover enabling works, staffing, preparatory activities and ICT devices and infrastructure.	Encompass Programme Plan Programme Board Readiness Assurance Group Operational Readiness Boards Change Impact Board People Change Readiness Workgroup Benefits Realisation Workgroup PMO Structure Epic Team Regional encompass Team Learning from other Trusts	Inadequate funding for following items required for encompass Go-Live •Network hardware •IT staffing •Estates enabling works •Training venue preparation •Estates staffing •PMO staffing Business continuity planning per Directorate will be required to replace the existing processes when moving from legacy systems to the new electronic health and care record.	Programme Board Readiness Assurance Group Operational Readiness Boards PMO controls: •Risk Register •Project Plan •Communication Plan •Diaries	Go-Live Risk Assessments to be held 120 days from Go-Live at 30 day intervals. Risk Summit to be held on 30th July with regional team, WHSCT & SHSCT.	Distribute an updated readiness checklist and timescales to Directorates for implemenation Recruitment of superusers to support Northern Trust go live Risk Summit to take place on 30 July 2024 with Southern Trust and go live date to be agreed.	30/09/2024 31/10/2024 30/07/2024	20/08/2024

Western Health and Social Care Trust

Appendix 5 of Risk Management Policy

New Risk Form

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

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

No	Datix Field Name	Data to be included in this Field	
1.	**Title of Risk *** **(please keep this brief e.g. "Risk of Fire in Trust Premises" –)**	Alcohol Related Brain Disease: Non Commissioned service within WHSCT	
2.	**Facility** **(only necessary if risk relates to one specific facility)**	N/A	
3.	**Directorate *** **If risk affects 2 or more Directorates, please list relevant Directorates.**	AMHLD	
4.	**Sub-Directorate *** **If risk affects two or more Sub-Directorates, please list.**	AMH	
5.	**Specialty** **Please list most relevant Specialty this risk relates to.**	Recovery, Addictions, Physical Disability, PCOP, Acute	
6.	**Ward/Department** **(necessary only if risk relates to one specific Ward/Dept)**	n/a	
7.	**Risk Type*** **Please indicate which organisational level you are of the opinion this risk should be escalated to (please tick)** **NB: This is subject to approval by relevant Senior Manager/Director/CMT – refer to Appendix 3 of Risk Management Strategy (see web-link above) :-**	Corporate	x
		Directorate	
		Sub- Directorate/Divisional	
		Ward Level	
8.	**Risk Category*** Please tick most appropriate category:	• Finance and Efficiency • Health and Safety • Quality of Care • ICT and Physical Infrastructure • People and Resource • Public Confidence • Regulation& Compliance (Statutory, Professional, Quality Legislation)	

9.	**Corporate Objective(s) affected by this risk*** ***(Please tick appropriate box(es) below)***		
	C01	Improving the Health of our People	x
	C02	Supporting and Empowering Staff	
	C03	Ensuring the Stability of our Services	x
	C04	Improving the Quality and Experience of Care	x

10.	**Key Performance Indicators to show how the risk is being managed (Please list 3-4) * (e.g. number of incidents, compliance with H&S – number of Risk assessments returned etc)**	• Review of delayed discharges • Review incidents/SEA/SAI • Case Reviews
11.	**Lead Officer* with responsibility for managing this risk (Name, Job Title, and Contact Details.** **(i.e. manager with operational responsibility)**	Jamie Wallace (Interim HoS Primary Care and Specialist Services) Assistant Director: Colleen Harkin
12.	**Name of Responsible Director*** **(NB: Where a risk is Cross-Directorate, the most appropriate Director to manage this risk should be listed. It will be their responsibility to liaise with other Directors re management of this risk).**	Karen O'Brien
13.	**Description of Risk*** Please provide a full description of the nature of the risk. Please limit this to 255 characters and structure to include cause, event and effect	The Western Trust do not have the workforce resource to manage this service user group. Typically this service user group require a multi-professional approach, i.e. GP, Psychiatry, psychology, addiction support, nursing, OT, social work, to achieve good outcomes. This service is not commissioned within the WHSCT resulting in early intervention not being achieved and crisis intervention sometimes being required, with on-going delayed discharges within hospital as a result of difficulties in placing service user. . Overall cost to services to support individuals with a formal or suspected diagnosis of ARBD and individuals whose addiction is the significant presenting problem= Total cost pressure is approx. £5.3 million YTD as at 01.07.24. Other patients may be negatively impacted due to staff not having the time to care manage these individuals as per standards due to the additional work created by this service user group.

14.	**Please list all current control measures in place to manage this risk*** (e.g. policies, procedures, training)	• Task and Finish and oversight group set up to scope current pressures and map potential solutions. • Business case as a result of work above to be submitted to commissioners • On-going review if incidents/SEAs/ SAIs • Review of delayed discharges • MDT discussion in regards to individual cases with escalation if case remains unallocated to Head of Service, Assistant Director and Director
15.	**Please list all identified gaps in Controls.***	• Commissioned Pathway for this Service User group
16.	**Please list all Assurances currently in place to test adequacy of Controls.** (i.e. Audit (Internal/External), inspections by independent organisations, e.g. RQIA, HSENI).	• Review of incidents • Review of complaints • Oversight of delayed discharges • Case Conferencing
17.	**Please list all identified gaps in Assurances.**	• Commissioned pathway for this client goup

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

20. Action Plan to reduce Level of Risk

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

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

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

Question	Response
1. Does the proposed action plan actively manage this risk to ensure that the level of risk can be reduced to the target level?	Yes
2. Does the proposed action plan take account of any opportunities that could be exploited whilst managing this risk?	Yes
3. Has the target level of risk, and how this will be achieved, been communicated to those staff responsible for the operational management of this risk?	Yes
4. How will the proposed actions be monitored to ensure they are completed within identified timescales?	• On-going local review and MDT management approach • Monitoring through T&F and Oversight Group
5. At what point should the decision regarding the management of this risk be escalated to a higher level?	• If cases increase thus escalating risk of harm to patients

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
Scoping and new service design to conclude within T&F and Oversight Group	On-going	31.08.24	Colleen Harkin Jamie Wallace, Darren Strawbridge, Orla McConkey, Mairead Quinn
Business case to be submitted to commissioners	On-going	01.07.24	Colleen Harkin, Aaron McShane, Jamie Wallace
On-going case reviews in relation to patient cases	On-going	01.09.24	Assistant Directors and HoS

Engagement with external providers regarding referral criteria	On-going	30.09.24	HoS
Escalation to Head of Service, Assistant Director and Director where required	On-going	On-going	HoS

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)

Western Health and Social Care Trust

Acute Directorate

Briefing Note Re: corporate risk 1375
Date: 4th June 2024

TOPIC	BRIEFING
Consultant Cover in Cardiology	**Purpose of this Brief** To reduce the Consultant Cover in Cardiology from a Corporate risk to a Directorate risk **Background** The Interventional Cardiology Consultant Body in March 2022 had been depleted by 50% taking the normative 1:6 rota to an unsustainable rota. The gaps in the rota were covered by Locum Consultants. The Interventional team in the WHSCT are one of two teams that cover the Regional Primary PCI service. The Team have been through a number of recruitment exercises and have successfully appointed 2 Substantive Interventional Consultants. These 2 new consultants are both fully inducted team members. One Consultant vacancy persists however, this is covered by a locum Interventional Consultant who has been a long-term member of staff and has been part of the Cardiology team for 2years. 1 further Interventional Consultant has returned from long-term sick leave and has completed a period of supervised practice. This consultant is now back on the interventional rota. Cardiology Service currently moving through recruitment process for 1 Interventional Consultant and 1 non Interventional Consultant This will facilitate the release of all locum staff and an exit plan for the same following successful recruitment and induction period ensuring a stable substantive team.

	<u>Outcome</u> The risk of instability in the on call PPCI service has now reduced to an acceptable level for the Trust. The Regional service is running at full capacity and the 1:6 commitment has been restored. This has reduced the risk of burnout to our core staff and patient access to our service is no longer at risk. Risk to be deescalated from the Corporate Risk Register to the directorate risk register until the final stage of recruitment is complete.