Western Health and Social Care Trust

TRUST BOARD ITEM: BRIEFING NOTE

Meeting Details:	5th December 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 risks; 1. Medium secure placement deficit for patients with highly complex needs. Briefing paper attached. 2. Roster Pro System Failure. Briefing paper attached. 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 ☐ Decision

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Western Health and Social Care Trust

CORPORATE RISK REGISTER & ASSURANCE FRAMEWORK

BRIEFING NOTE PREPARED FOR TRUST BOARD 5th DECEMBER 2024

There are 20 risks on the Corporate Risk Register as approved at Trust Board 7th November 2024.

Summary

- Proposed New Risks;
    1. Medium secure placement deficit for patients with highly complex needs.
    2. Risk of Roster-Pro System failure.
- Material changes;
    - There are no material changes.

- Summary report for action;
    - No action required.

- Proposed New Risks;

1. Proposed New Risk relating to medium secure placement deficit for patients with highly complex needs. A new risk form attached for consideration however this risk relates to;

Risk Title: Medium secure placement deficit for patients with highly complex needs

Risk Description: There is no provision within the Trust for the medium secure placement of individuals with highly complex needs who present as high risk requiring that level of intervention. There is also no provision regionally.

As a result such individuals require to be placed inappropriately; are subject to significant restrictions impacting their human rights; and with limited access to appropriate treatment and care.

Staffing needed to care for such individuals is inadequate in terms of workforce, resource, training or experience. Staff operate without an adequate infrastructure to appropriately meet the individual's needs.

There is no appropriate accommodation or staffing available in a mental health hospital setting to respond appropriately in an emergency

As a result there is an increased risk of harm to the individual and to staff posed by the service user.

There is also a risk that we continue to breach legislation including human rights.

There is a consequent reputational risk to the organisation and ongoing professional risk regarding our ability to deliver safe and effective care within an ethical and legal framework consistent with NHS values.

Proposed Grading: Major (4) x Very Likely (5) = **HIGH** (20)

Responsible Director: Director Adult Mental Health and Disability Services

2. Proposed New Risk relating to Risk of Roster-Pro System failure. A new risk form and briefing note attached for consideration, however this risk relates to;

Risk Title: Risk relating to Risk of Roster-Pro System failure

Risk Description: From 30 Sept 2023 the Roster-Pro system has no software support in place. In the event that the Roster-pro System fails the following risks impact. Loss of electronic rostering function until system function restored if possible.
Loss of ability to use electronic shift data to inform payroll for a large number of staff. Loss of management data on workforce utilisation.
Additional workload for Roster Managers to revert to manual rostering processes as outlined in the contingency arrangements and to process payment for unsocial hours and enhanced rate shifts using ETM02. This may delay staff receiving payment for specialist duty payments.

Note: System failed on 28 May 2024 due to expired License Code. System function re-established on 30 May 2024.

Proposed Grading: Moderate (3) x Possible (3) = MEDIUM (9)

Responsible Director: Director of Nursing, Midwifery and AHP

- Material changes
    - No material changes.

- Summary report for action;
    - No action required.

Update on 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.	LOW	Low (target score between 1 -6) Current Target score 6	Completed deep dive Sept 2024 and risk detail updated to reflect review

			3.Risk to be reviewed in 6months			
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	HIGH	Low (target score between 1 -6) Current Target score 6	Risk Presented to Gov Committee June 24

			current tolerance level (specific to 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 &	Impact on services as a result of industrial action in relation to	Trust board agreed to;	HIGH	Moderate (target score	Completed – risk rating

	Organisational Development	outstanding agenda for change (AFC) Pay, safe staffing	1.Set tolerance of this risk as High as 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		between 8-12) Current target score 8	changed April 2024
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	Completed
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	HIGH	Moderate (target score between 8-12)	

			2.Risk owner to reflect mitigations discussed within the risk register actions within CRR		Current 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	Completed
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	LOW	Low (target score between	

			be reviewed as a DEEP DIVE to be presented to Governance committee in Dec 24 2. Risk owner to amend description of risk to remove detail relating COVID.		1 -6) Current 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

Risk Register

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26.11.24

			Initial		Current		Target		Risk Appetite			Current Risk Status				
Risk ID	Lead Director	Risk Title	Score	Grade	**Score**	**Grade**	Score	Grade	Score	Level of Tolerance	Action on Appitite	**Mths since score changed**	**Change in score since last review**	Mths since last updated	Action Plan Status	Latest Update
1	Director of Performance & Service Improvement	Fire Risks	20	EXTREM	15	EXTREM	8	HIGH	6	LOW	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.	5	No change	0	Actions listed with future due dates	[05/11/2024] New HTM Fire Guidance has been issued. A briefing paper will be developed on implications and submitted for the next PPCS Governance. Further meetings scheduled for each directorate regarding each directorate fire risk.
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	Trust Board agreed to; 1. Current tolerance and risk appetite to remain as is due to external gaps in control. Keep risk under review	37	No change	0	Actions listed with future due dates	[21/11/2024] November 2024 - Gateway reported an unallocated figure of zero at 31 October 2024. Generic/Family Intervention Service unallocated cases have decreased significantly this month - 15 unallocated families . All unallocated cases are closely monitored as per regional guidance and escalated to Assistant Director level if deemed appropriate.
49	Director of Performance & Service Improvement	The potential impact of a Cyber Security incident on the Western Trust	16	HIGH	20	EXTREM	6	MEDIUM	6	HIGH	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 actions within our control) and propose any amendments as necessary.	14	No change	0	Actions listed with future due dates	[07/11/2024] Governance Update: Work is continuing to review the risk with the proposal to include two additional elements: the 2-way trust for encompass and financial investments. A BCP/DR validation workshop took place on 17th October. A further desktop exercise planned for 13th November and after which the BCP and CR documentation will be updated.
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	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	7	No change	0	Actions listed with future due dates	[11/11/2024] IG awareness has risen to 87% (2% rise on last quarter) and in response to an increase in incidents, Trust comms issued asking clinical staff to take greater care when filing records etc.
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	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 & progress.	11	No change	1	Actions listed with future due dates	[22/10/2024] Updates made against open actions. Actions reviewed and updated. 1 action closed. Risk rating remains unchanged.

			Initial		Current		Target		Risk Appetite			Current Risk Status				
Risk ID	Lead Director	Risk Title	Score	Grade	**Score**	**Grade**	Score	Grade	Score	Level of Tolerance	Action on Appitite	**Mths since score changed**	**Change in score since last review**	Mths since last updated	Action Plan Status	Latest Update
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	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	27	No change	0	Actions listed with future due dates	[18/11/2024] The risk has been reviewed and remains the same. SWAH Update 17/10/24 Risk has been reviewed and considered remains the same.
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	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.Review to be reviewed in 6months	27	No change	0	Actions listed with future due dates	[18/11/2024] There is still gaps on the core endoscopy sessions despite the current recruitment. Two recruited surgeons need trained in endoscopy until 31st march 2025. To facilitate flexible working, one of the 3 newly recruited Gastroenterologist is performing endoscopy at lagan valley, the WHSCT will re-allocate the two endoscopy PA's from within, however, no one has accepted to increase their endoscopy PA at present. One Gastroenterologist will return to independent practice soon but they will need a period of up-skilling, this will take at least 12 months. Two nurse endoscopist are in training, they will start independent sessions from August 2025. The trust continue to utilise the capacity from independent sector providers. The risk will be reviewed again in march 2025 to reconsider if it should be downgraded to the relevant HMT.

		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 Planning, Performance and Corporate Services	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	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.	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 obigation 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.	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 Update Fire Safety Controls assurance Action Plan. No scheduled intrusive surveys programmed. Directorates FIre Safety Risk currently not reviewed at fire safety group and at SMT's. Irregular meetings of Task and Finsh Group and poor representation at walkarounds. Funding for smoke-free warden retracted.	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	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 31/12/2024 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 31/05/2016 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 07/10/2024 02/06/2023 16/02/2024
6	21/09/09	25	Extreme (Red)	12	High (Amber)	8	High (Amber)	Director of Children & Families	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.	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	Reports to SPPG only detail numbers of families. There is no assurance of the mitigations put in place to ensure safeguarding of children awaiting allocation. DSF reporting is bi-annually and taken at a point in time. It does not demonstrate trends over the full reporting periods.	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	29/09/2023 30/09/2020 01/11/2018 31/03/2025 31/03/2025 31/03/2025 31/03/2025 31/03/2025 31/03/2025	29/09/2023 31/12/2019 30/09/2020 06/03/2019

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 Planning, Performance and Corporate Services	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	(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	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 -	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	(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 in co-ordinating Regional and Trust Governance arrangements (3). Sucession Planning (4). Lack of consistent contribution from Trust Services in completion of NIS Assessments thereby resulting in reduced compliance. GAPS IN TECHNICAL ASSURANCE: Local Assurance (1). External factors impacting on diversion of ICT	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	31/12/2024 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 Planning, Performance and Corporate Services	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	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	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	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 31/03/2025 31/03/2025 31/12/2021 31/03/2025 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

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 and Disability Services	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.	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	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	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,	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 Gap between MCA and MHO Conveyance issues between Health Trusts, PSNI & NIAS	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	31/12/2020 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 28/06/2024 30/06/2023 31/03/2023 28/03/2025 30/04/2024 30/11/2022 30/11/2022 31/03/2024 31/12/2024 30/06/2024 30/06/2024 31/03/2025 31/03/2025 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 27/09/2024 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 Unscheduled Care	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	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 31/12/2024 28/02/2022	06/05/2022 15/03/2022

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1219	30/04/20	20	Extreme (Red)	20	Extreme (Red)	6	Medium (Yellow)	Director of Unscheduled Care	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, has resulted in breaching of the two 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 SAI's.	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	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 gastroenterology training and service provision. The need to address the impact of a job plan which includes the medical on-call rota The need to urgently increase the consultant workforce and make the Trust an attractive opportunity for the next round of doctors in training due for recruitment April 2021	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 31/12/2024	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 Development	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	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 31/12/2024 31/12/2024 31/03/2025	30/09/2024 29/03/2024

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1254	18/01/21	16	High (Amber)	16	High (Amber)	8	High (Amber)	Director of Human Resources and 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 -	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	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 -	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 demands of medical and nursing workforce. HMRC Regulations and impact for staff HSC Pension particularly high earners. Impact of McCloud and Sergeant Employment Law cases. Safe staffing model for social work. Lack of regional cap on medical agency rates Legal challenges to Terms	Looking After our People Growing for the Future Belonging to the HSC New Ways of Working	31/03/2025 31/03/2025 31/03/2025 31/03/2025	
1288	08/04/21	12	High (Amber)	12	High (Amber)	6	Medium (Yellow)	Director of Planning, Performance and Corporate Services	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	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	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 31/01/2025 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 07/10/2024 09/04/2024

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1307	16/06/21	25	Extreme (Red)	25	Extreme (Red)	6	Medium (Yellow)	Director of Surgery, Peadiatrics 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 avaiilable. 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 the fragility of medical staff within Paediatrics,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 31/12/2024 31/12/2024	03/02/2022 03/02/2022 03/02/2022
1320	15/09/21	12	High (Amber)	20	Extreme (Red)	8	High (Amber)	Director of Children & Families	Childrens Health & Disability	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	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	01/12/2024 01/12/2024 01/12/2024 01/12/2024 01/12/2024 01/12/2024 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

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1334	26/10/21	20	Extreme (Red)	15	High (Amber)	8	High (Amber)	Director of Surgery, Peadiatrics 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	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	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 31/12/2024 31/12/2024 31/12/2024	13/06/2023
1409	01/07/22	25	Extreme (Red)	16	High (Amber)	9	Medium (Yellow)	Director of Unscheduled Care	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	-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	-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 31/12/2024 31/12/2024	18/09/2023

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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	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	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	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	31/12/2024 31/12/2024	
1487	06/04/23	20	Extreme (Red)	20	Extreme (Red)	8	High (Amber)	Director of Human Resources and 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	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 Panels. Court	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. Staff are not required to let their manager know in advance if they intend to participate in strike action.	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	31/03/2025 31/03/2025 31/03/2025 31/03/2025	

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
1601	11/06/24	16	High (Amber)	16	High (Amber)	8	High (Amber)	Director of Surgery, Peadiatrics 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					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	31/03/2025 30/03/2025 31/03/2025 31/01/2025	
1602	11/06/24	16	High (Amber)	16	High (Amber)	12	High (Amber)	Director of Community and Older Peoples 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 31/03/2025 30/11/2024	29/08/2024 22/11/2024

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
1612	22/07/24	10	High (Amber)	10	High (Amber)	8	High (Amber)	Director of Planning, Performance and Corporate Services	Directorate-wide (Risk Register Use only)	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.	Data quality validations issued to heads of service to address Open registrations 2.GLRA assessment documents issued to ORBS for completion and assessment of overall readiness position 150 day GLRA scheduled for 19th December to complete organisational readiness assessment Role Analysis Turbo room being completed to ensure as required training is assigned to staff 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.	31/01/2025 20/12/2024 19/12/2024 20/12/2024 30/09/2024 30/11/2024 30/07/2024	18/10/2024 19/11/2024 20/08/2024
1629	19/09/24	9	Medium (Yellow)	9	Medium (Yellow)	6	Medium (Yellow)	Director of Adult Mental Health and Disability Services	AMHDS - Adult Mental Health	Ensuring Stability of Our Services, Improving the Health of Our People, Improving the Quality and Experience of Care, Supporting and Empowering Staff	Alcohol Related Brain Disease: Non Commissioned service within WHSCT	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	•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 •Review of delayed discharges •On-going review if incidents/SEAs/ SAIs •MDT discussion in regards to individual cases with escalation if case remains unallocated to Head of Service, Assistant Director and Director	•Commissioned Pathway for this Service User group	Review of Incidents Oversight of Delayed Discharges Case Conferencing Review of Complaints	•Commissioned pathway for this client goup	SCOPING EXERCISE TO BE COMPLETED COMPLETE ARBD RESEARCH CREATE REFERRAL CRITERIA REGIONAL WORK- LEAD TASK AND FINISH/OVERSIGHT GROUP BUSINESS CASE	29/08/2024 31/12/2024 23/10/2024 31/12/2024 03/12/2024 31/12/2024	01/08/2024 22/10/2024 27/09/2024

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" –)**	Medium secure placement deficit for patients with highly complex needs.
2.	**Facility** **(only necessary if risk relates to one specific facility)**	Heather House and potentially AMH PICU
3.	**Directorate *** **If risk affects 2 or more Directorates, please list relevant Directorates.**	AMHD
4.	**Sub-Directorate *** **If risk affects two or more Sub-Directorates, please list.**	Learning Disabilities Adult Mental Health
5.	**Specialty** **Please list most relevant Specialty this risk relates to.**	Learning Disabilities
6.	**Ward/Department** **(necessary only if risk relates to one specific Ward/Dept)**	

7.	**Risk Type*** **Please indicate which organisational level you are of the opinion this risk should be escalated to (please tick)** **NB: This is subject to approval by relevant Senior Manager/Director/CMT – refer to Appendix 3 of Risk Management Strategy (see web-link above) :-**	Corporate	x
		Directorate	
		Sub- Directorate/Divisional	
		Ward Level	

8.	**Risk Category*** Please tick most appropriate category:	• Finance and Efficiency • Health and Safety • Quality of Care x • ICT and Physical Infrastructure • People and Resource • Public Confidence • Regulation& Compliance (Statutory, Professional, Quality Legislation)

9.	**Corporate Objective(s) affected by this risk*** ***(Please tick appropriate box(es) below)***		
	C01	Improving the Health of our People	x
	C02	Supporting and Empowering Staff	x

	C03	Ensuring the Stability of our Services	x
	C04	Improving the Quality and Experience of Car	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)**	• The risk is currently a new risk on the ALD risk register and monitored through the action plan. • MDT support and planning across childrens and adult services has been in place to manage the transition and plan of care. This has highlighted variation in professional approaches to care and risk management in the transition. • Incidents regarding the client are now managed , reviewed and recorded on DATIX • PQC risk assessment is in place and available to all staff to support safe care for the individual and support staff safety. • Daily update to MDT by HH staff for ongoing organisational , information sharing, safety and planning purposes and for professional assessment and review update • Governance oversight in daily and weekly meetings • Weekly update to CMT? • Regular meetings with SPPG • Ongoing regular discussions with RQIA • Regular discussion with family • ECR has been applied for and discussions ongoing with SPPG • Early Alerts to DOH • Information shared with Trust Comms.	
11.	**Lead Officer* with responsibility for managing this risk (Name, Job Title, and Contact Details.** **(i.e. manager with operational responsibility)**	Christine McLaughlin Assistant Director Adult Learning Disability	
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	There is no provision within the Trust for the medium secure placement of individuals with highly complex needs who present as high risk requiring that level of intervention. There is also no provision regionally. As a result such individuals require to be placed inappropriately; are subject to significant restrictions impacting their human rights; and with limited access to appropriate treatment and care. Staffing needed to care for such individuals is inadequate in terms of workforce, resource, training or experience. Staff operate without an adequate infrastructure to appropriately meet the individual's needs. There is no appropriate accommodation or staffing available in a mental health hospital setting to respond appropriately in an emergency As a result there is an increased risk of harm to the individual and to staff posed by the service user. There is also a risk that we continue to breach legislation including human rights. There is a consequent reputational risk to the organisation and ongoing professional risk regarding our ability to deliver safe and effective care within an ethical and legal framework consistent with NHS values.

14.	**Please list all current control measures in place to manage this risk*** (e.g. policies, procedures, training)and under review by SPPG	• MDT working is in place and decisions are subject to MDT input. • Recruitment of Community Service Manager to manage the service • Agreement that Children's service staff will remain in place to facilitate transition. • Recruitment of LD staff to replace current children staff. • Application made to register Heather House facility as Adult Learning Disability facility • Scoping of potential facilities throughout the region due to the urgent need to secure appropriate placement for assessment and treatment • Identification of all revenue and capital funding requirements and preparation of business cases to secure funding – ECR application made and under review by SPPG – further information requested and provided frequently. • ALD has sought legal advice from DLS • Identify additional staffing that can support during transition phase and longer term • Updating of all Risk Assessments, Forensic Assessment and Capacity Assessments • Regular communication with RQIA, SPPG and DoH– support from RQIA to manage in the short term only pending further decisions

15.	**Please list all identified gaps in Controls.***	• Decision required re ECR placement – most recent has been rejection of request to fund Cygnet. • Children's service staff leave Heather House 8th December 2024 and arrangements not yet in place to replace these staff. • Insufficient planning in place should an ECR not be granted • High volume of vacant posts within the service • Dependency on Bank/Agency staff • Challenges associated covering annual/sick leave • Staff who have been seconded to the service returning to their permanent posts on 8th December 2024 • Psychological risk to staff i.e. working within the environment/burnout • Seclusion in place 24/7 however no seclusion policy and no formal regulation of the service • Community Service Manager post ends in December 2024 • Recruitment of LD staff taking longer than expected • IPT funding not released for 2024/25 complex cases • No medium – secure facility available in Northern Ireland. AMH in patient facilities not suitable to accommodate emergency or other placement if detention is required and insufficient staffing to manage

16.	**Please list all Assurances currently in place to test adequacy of Controls.** (i.e. Audit (Interna/External), inspections by independent organisations, e.g. RQIA, HSENI).	First Line of Assurance • Daily MDT board meeting • Daily MH/LD planning meeting • Governance Oversight • SOP Heather House • RQIA Variation Document • Incident reporting/review • Legal Advice – DLS • ASG Policy &Procedure • MCA • Restrictive Practice Policy • PQC Risk Assessment • Incident Escalation protocol • Risk Management Policy • Ambulance/A&E Protocol • Generic H&S Risk Assessment Second Line of Assurance • CMT update • Updates to SPPG/DoH Third Line of Assurance • SPPG/DoH • RQIA • DLS • Early Alerts • H&SE involvement (pre transition – 2 staff absences in 2022 – one case ongoing)
17.	**Please list all identified gaps in Assurances.**	• RQIA intend to de-register the facility as a residential home and will not register facility as an Adult facility

18.	**Current level of Risk*** **(Please tick appropriate box for Impact/Consequence/Severity and Likelihood – refer to Risk Rating Matrix & Impact Assessment Table (Appendix 3 of Risk Management Strategy - see web-link above).**			
	Impact/Consequence /Severity		**Likelihood**	
	Insignificant/none		Rare	
	Minor		Unlikely	
	Moderate		Possible	
	Major	x	Likely	
	Catastrophic		Very Likely/ Almost Certain	x
19.	**Target/Acceptable level of Risk*** **(Please tick appropriate box for Impact/Consequence/Severity and Likelihood – refer to Risk Rating Matrix and Impact Assessment Table (Appendix 2 of Risk Management Strategy - see web-link above).**			
	Impact/Consequence /Severity		**Likelihood**	
	Insignificant/none		Rare	
	Minor		Unlikely	x
	Moderate	x	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?	Action plan reduces the risk however number of variable outside the control of the service, i.e.: deregistration
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?	Ongoing review with CSM/HOS/AD through MDT, Directors/ SMT, Governance
5. At what point should the decision regarding the management of this risk be escalated to a higher level?	Immediately

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
Confirmation of Independent advocate	09/09/2024	09/09/2024	Claire Farry
Daily/Weekly ALD meetings stood up	09/09/2024	09/09/2024	Claire Farry

Weekly updates to be provided to Trust Board regarding case	09/09/2024	09/09/2024	Christine McLaughlin
Appoint new CSM to manage Client case.	31/08/2024	09/09/2024	Margaret Mulligan
Maintain current staffing provision and placement for transition period	09/09/2024	09/09/2024	Claire Farry
Service redesign to include staffing skill mix	09/09/2024	09/02/2025	Claire Farry
Recruitment of all staffing required for service	09/09/2024	02/12/2024	Claire Farry
Risk Assessment re RS, care, treatment and support	03/10/2024	03/10/2024	Claire Farry
Updated Forensic Assessment	09/09/2024	17/09/2024	Dr Anderson
Capacity Assessments: - Care & Treatment - Living arrangements	30/08/2024	09/09/2024	Dr Arun
Identify all revenue and capital funding requirement and prepare business cases to secure funding	09/09/2024	09/09/2024	Johnathan McCartney
Scope suitable placement for care according to service users assessed needs	30/08/2024	09/09/2024	Claire Farry
Submit Annual General H&S risk assessment	09/09/2024	1/11/2024	Eoghan Nelis

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:	**For use by BSO/BSM only**	**Risk ID No:**

Date of Meeting: 25/11/2024		(automatically generated by Datix)

Supporting information

This case has been managed through a transition process to adult services for a service user previously known to childrens disability services. His current living environment was previously registered as Childrens Home – RQIA intend to deregister and are indicating intention to publish an inspection report highlighting their findings including significant use of restriction.

This young man experiences emotional dysregulation resulting in acts of verbal and actual aggression/violence, harm and threat of violence to self and others including his parents and staff members. As an example a total of 372 incidents have been recorded in notes or on Datix in a three month period between June and August 2024

At times this has resulted in catastrophic physical and psychological assaults, threats to kill/maim, property damage and resisting arrest which has resulted in liberty being restricted.
He experiences suicidal ideation and self-harms regularly.

This young man has been assessed as requiring a medium secure placement and there is no suitable placement/ living environment to meet his needs for a medium secure placement in Northern Ireland or across Ireland. He engages in a range of behaviours including defecation and urination in inappropriate places leading to serious health and safety issues requiring input from infection control.
He has been known to gorge on food and head bang with and without helmet.
In his case there is a high risk of delay in emergency response due to rurality of facility.

There are significant restrictive practices in place that amount to seclusion/withdrawal in a community setting. The service user is assessed as high risk and recognises he cannot share space and represents a risk to others.
He spends extended periods of time living behind a locked door (at his own request) in a non regulated facility.
Should he request it the door cannot be opened in any case due to threats of harm to self and others including threats to kill, resulting in deprivation of his liberty and impacting his human rights

The ECR process has been protracted and has resulted in delays in decision making by SPPG/DOH to fund a placement at a non NHS facility in England. There is no available, suitable NHS facility with the right level of restriction. The service user requires specialist support in a safe environment where he can be properly assessed, and managed safely with therapeutic input and planning to enable testing out of his potential to live safely in the community.

There is an insufficient pool of appropriately trained staff in adult services to manage him in his community setting even if regulation could be agreed.

Trust cannot maintain current arrangements without regulation or appropriate staffing including a trained social care team and high levels of MDT input. This would take time to source and needs to occur against a back drop of appropriate assessment.

**There is also a prohibitive lack of suitably trained and available staff or accomodation to enable safe and legal care for this person should he require detention under the MHO leading to short term emergency or medium/ longer term care in a mental health in patient unit in WHSCT(including PICU)
Lack of a seclusion space in WHSCT and no availability regionally.
WHSCT does not offer seclusion.

There is potential need for chemical restraint to enable any move for this patient.

Trust will continue to breach clients human rights and face challenges in seeking lawful solutions to managing deprivation of liberty/restrictive practices (i.e. seclusion/withdrawal)

There has been a recent Subject Access Request for records dating back to 2006 and potential legal challenge from the family. This has been updated to request notes from 2018.

Western Health and Social Care Trust

CMT Briefing – November2024

Meeting Details:	CMT Meeting; 26 November 2024
Issue Title:	**Roster-pro Electronic Roster System proposed Corporate Risk**
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:	**Context** The Roster-pro electronic rostering system in use by the Trust from 2010 is outside any software maintenance arrangements from September 2023. The Trust has procured a replacement rostering system, Allocate Health Roster Optima and is currently implementing this system to transition the former 6000 users from the Roster-pro system. Implementation commenced in March 2024 with an 18 month implementation plan to conclude in September 2025. The implementation plan has completed with Cohort 1 and 2 (SWAH and OHPCC) with Cohort 3 due to go live on the Allocate System from end of November 2024.

Total Users to Transition		6310
Cohort	**Live from**	**Users**
Cohort 1 (	May 2024	680
Cohort 2	Aug 2024	606
Cohort 3	Nov 2024	1395
	Total	**(42%) 2681**
Total User on Roster-Pro		**(58%) 3629**

The Risk.
The Roster-pro system is outside all software maintenance support arrangements from the Supplier.

The system did have a period of outage at the end of May 2024 which result in 4 days disruption and implementation of the contingency plan.

The impact of the outage was managed through good collaboration between the Trust Roster Team, Finance, Human Resources and BSO Payroll. The payment of staff special duty enhancements were processed using the ETM02 processes. This generated significant additional work for Heads of Department and their Teams.

The Roster-pro system has continued to function as expected since the Supplier applied the 'fix'.

Controls in place.
From the Risk Template the following controls remain in place.

- Roster-pro system functionality tested daily by E-Roster Team.
- System back-up processed by Digital Services Team.
- Nurse Bank Office produce weekly report on shifts bookings as back-up
- Roster preparation will revert to paper based option.
- ETM02 available for staff to record special duty enhancements to inform payroll.

Directorate or Corporate Risk
A risk template for the Roster-pro system was previously submitted for consideration as a Corporate Risk by CMT. The paper was deferred at that time to allow time for discussion and review by AD Digital Services.

The risk was considered at that time to be a Directorate level risk prior to the actual experience of the outage period.

	The contingency implementation and the need for significant support from Support Directorates prompted the E-Roster Steering Committee to ask for the risk to be revisited and considered as a corporate risk given the organisational response required to manage the period of outage of Roster-pro. As the implementation of Allocate Health Roster Optima progresses – the risk will be reducing. The risk however will remain until all users are transitioned from Roster-Pro to Allocate Health Roster Optima – targeted for September 2025. At November 2024 2681 Users have been transitioned to Allocation (42%) with 3629 (58%) continuing on Roster-Pro. As implementation progresses the remaining user decrease. **Request to CMT** Is the remaining risk associated with the Roster-Pro System categorised as a Corporate Risk or a Directorate Risk?

Western Health and Social Care Trust

Appendix 5 of Risk Management Policy

New Risk Form (Updated)

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" –)**	Risk of Roster-Pro System failure.
2.	**Facility** **(only necessary if risk relates to one specific facility)**	Roster-pro system users Trust –wide.
3.	**Directorate *** **If risk affects 2 or more Directorates, please list relevant Directorates.**	Unscheduled Care, Medicine, Cancer Services; Planned Care, Women's Health and Surgical Services Community and Older People's Services AMHD, PSI
4.	**Sub-Directorate *** **If risk affects two or more Sub-Directorates, please list.**	All service area currently using the RosterPro E-Roster System.
5.	**Specialty** **Please list most relevant Specialty this risk relates to.**	N/A
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	✓
		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	
	C02	Supporting and Empowering Staff	✓

	C03	Ensuring the Stability of our Services	
	C04	Improving the Quality and Experience of Care	
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)**	1. Roster-Pro System performance monitoring daily by E-Roster Team 2. Roster Managers will access the system throughout the working day.	
11.	**Lead Officer* with responsibility for managing this risk (Name, Job Title, and Contact Details.** **(i.e. manager with operational responsibility)**	Brendan McGrath AD Nursing (Workforce Planning and Modernisation) brendan.mcgrath@westerntrust.hscni.net Tel: 07912046380	
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).**	Donna Keenan. Interim EDON, Director of PCOP	
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	From 30 Sept 2023 the Roster-Pro system has no software support in place. In the event that the Roster-pro System fails the following risks impact. • Loss of electronic rostering function until system function restored if possible. • Loss of ability to use electronic shift data to inform payroll for a large number of staff • Loss of management data on workforce utilisation. • Additional workload for Roster Managers to revert to manual rostering processes as outlined in the contingency arrangements and to process payment for unsocial hours and enhanced rate shifts using ETM02. This may delay staff receiving payment for specialist duty payments. Note: System failed on 28 May 2024 due to expired Licence Code. System function re-established on 30 May 2024.	

14.	**Please list all current control measures in place to manage this risk*** (e.g. policies, procedures, training)	WHSCT has procured a replacement E-Roster System. Implementation commencing March 2024 expected to be completed by September 2025 (18months). The Digital Services Team process a system back-up on a bi-monthly basis. This would maintain the data integrity up to the last update. Section 11 of the WHSCT Nursing and Midwifery Rostering Policy outlines the contingency arrangements in the event of roster system failure. Contingency measures tested during the Roster-Pro system outage 28 – 30 May 2024. Updated to reflect learning and need for more process directed instruction to Roster Managers. Updated Contingency measure communicated to all Roster Managers June 2024.
15.	**Please list all identified gaps in Controls.***	• No software maintenance support available from 30 Sept 2023. • No alternative electronic option to manage processing data on special duties enhancements to payroll.
16.	**Please list all Assurances currently in place to test adequacy of Controls.** (i.e. Audit (Interna/External), inspections by independent organisations, e.g. RQIA, HSENI).	• Roster-pro system functionality tested daily be E-Roster Team. • System back-up processed by Digital Services Team. • Nurse Bank Office produce weekly report on shifts bookings as back-up • Roster preparation will revert to paper based option. • ETM02 available for staff to record special duty enhancements to inform payroll.
17.	**Please list all identified gaps in Assurances.**	• Additional workload for line managers to approve numerous ETM02 claims for special duty enhancements.
18.	**Current level of Risk*** **(Please tick appropriate box for Impact/Consequence/Severity and Likelihood – refer to Risk Rating Matrix & Impact Assessment Table (Appendix 3 of Risk Management Strategy - see web-link above).**	

	Impact/Consequence /Severity		**Likelihood**	
	Insignificant/none		Rare	
	Minor		Unlikely	
	Moderate	✓	Possible	✓
	Major		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	✓	Unlikely	
	Moderate		Possible	✓
	Major		Likely	
	Catastrophic		Very Likely/ Almost Certain	

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

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?	Procurement of replacement E-Roster System completed. Implementation commencing March 2024 with 18month implementation plan for all 6000 users. As users from the 6000 population are transitioned from Roster-Pro to Allocate Health Roster Optima the risk will reduce.
2. Does the proposed action plan take account of any opportunities that could be exploited whilst managing this risk?	WHSCT purchased Accelerated Implementation support from RLDatix supplier of the Allocation Health Roster Optima System. Implementation expected to be completed in 18months (March 2024 – September 2025) Contingency arrangements tested in May 2024. Updated and re-circulated to Roster Managers.
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?	The Roster System Manager is aware of the risk. As Staff Teams transition from Roster-Pro to Allocation Health Roster Optima the risk is eliminated for those staff. In the event of roster system failure the contingency arrangements will be implemented.

4. How will the proposed actions be monitored to ensure they are completed within identified timescales?	The implementation of the replacement roster system – Allocate Health Roster Optima is being project managed with progress reported to the Project Steering Group on a monthly basis. Communication outlining the Updated contingency arrangements have been circulated to all Roster Managers in June 2024.
5. At what point should the decision regarding the management of this risk be escalated to a higher level?	The risk is considered to be a Directorate level risk that will impact on the Directorates listed at No 3. CMT is aware of this risk.

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
Business Case to procure a replacement roster system completed and presented to CMT and DHCNI.	Jan 2023	30 April 2023 (completed)	Brendan McGrath
Taking forward the process to purchase the replacement roster system following receipt of correspondence from DHCNI Lead Dan West September 2023	September 2023	November 2023 (completed)	Brendan McGrath, PALs colleagues and colleagues from Digital Services Team.
Implementation of the new e-rostering system as per the approved Implementation Plan.	March 2024	October 2025 (in progress)	Brendan McGrath and E-Roster Project Manager
Develop Contingency Processes to guide Roster Managers in the event of Roster-pro system failure.	September 2023	Amended June 2024. (completed)	Brendan McGrath and Christine McGuckin

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:** **Content updated**		**For use by BSO/BSM only**	**Risk ID No:** (automatically generated by Datix)