

**TRUST BOARD ITEM: BRIEFING NOTE**

<b>Meeting Details:</b>	9 <sup>th</sup> January 2025
<b>Director:</b>	Dr Brendan Lavery
<b>Issue Title:</b>	Corporate Risk Register Summary and Corporate Risk Register Assurance Framework
<b>Indicate the connection with the Trust's Mission and Vision (please tick)</b>	<input checked="" type="checkbox"/> People who need us feel cared for <input checked="" type="checkbox"/> People who work with us feel proud <input checked="" type="checkbox"/> People who live in our communities trust us
<b>Indicate the link to Trust's strategic priorities (please tick)</b>	<input checked="" type="checkbox"/> Quality and Safety <input type="checkbox"/> Workforce Stabilisation <input type="checkbox"/> Performance and Access to Services <input type="checkbox"/> Delivering Value <input type="checkbox"/> Culture
<b>Summary of issue to be discussed:</b>	<p>For approval:</p> <p>Proposed new risks;</p> <ol style="list-style-type: none"> <li>1. Non ST Elevation MI (NSTEMI) Patient in emergency department. Briefing note attached.</li> <li>2. Risk ID1647 – Domiciliary Care Retender risk escalated from COP Directorate risk Register for consideration as a new Corporate Risk.</li> <li>3. Human Milk Bank – Legal and Corporate Governance deficits regarding the operational delivery of the Milk Bank Service to ROI. Briefing note attached.</li> </ol> <p>Material Changes;</p> <ul style="list-style-type: none"> <li>• ID49 – Cyber Risk.</li> </ul>

	<p>To note:</p> <p>All Corporate Risks have been updated within this quarter.</p> <p>All action plans have been updated.</p>
<b>Trust Board Response Required (please tick)</b>	<p>X For approval</p> <p><input type="checkbox"/> To note</p> <p><input type="checkbox"/> Decision</p>

# CORPORATE RISK REGISTER & ASSURANCE FRAMEWORK

BRIEFING NOTE PREPARED FOR TRUST BOARD 9<sup>th</sup> JANURARY 2025

There are 22 risks on the Corporate Risk Register as approved at Trust Board 5<sup>th</sup> December 2024.

## Summary

- Proposed New Risks;
  1. Non ST Elevation MI (NSTEMI) Patient in emergency department.
  2. Risk ID1647 - Domiciliary Care Retender risk escalated from COP Directorate Risk register for consideration as a Corporate Risk.
  3. Human Milk Bank - Legal and corporate governance deficits regarding the operational delivery of the Milk Bank Service to RoI.

- Material changes;
  - ID49 – Cyber risk.
- Summary report for action;
  - At time of reporting, all Corporate Risks have been updated and action plans reviewed.

- Proposed New Risks;
  1. Non ST Elevation MI (NSTEMI) Patient in emergency department

**Risk Title:** Non ST Elevation MI (NSTEMI) Patient in emergency department

**Risk Description:** Demand on cardiology beds exceeds the capacity. Patients admitted with NSTEMI presentations should be monitored in a cardiology ward. In the past number of months it is a common occurrence to find on average 4 cardiology patients in ED with no identified bed in the cardiology ward. These patients are at greater risk of arrhythmia/ instability and are not receiving optimised care.

**Proposed Grading:** Major (4) x Likely (4) = **HIGH** (16)

**Responsible Director:** Director of Unscheduled Care, Medicine, Cancer and Clinical Services

2. Risk ID1647 - Domiciliary Care Retender risk escalated from COP Directorate Risk register for consideration as a Corporate Risk.

**Risk Title:** Risk of disruption to the Trust's contracted out domiciliary care services as result of new procurement exercise

**Risk Description:** The Western Trust has advertised its tender for the provision of contracted out domiciliary care services. It is intended that this new tender will be awarded during early 2025 and when the outcomes are known this could potentially lead to a level of disruption and change for both the service providers and service users. Should a current provider not win in the new tender; TUPE will apply and their workforce and clients will transfer to one of the successful providers. Whilst TUPE will help mitigate the change there will still be a level of associated disruption during the transition. Current clients will experience a change in provider should their current provider not be successful in this new tender exercise. The new contract arrangements will not be in place prior to the current contract extension expiring on 30 November 24. The requirement for a further interim extension to allow for the transition to the new contract will also present additional risks to service continuity particularly as the tender outcome will be known and may deter an unsuccessful provider from cooperating with transition arrangements.

**Proposed Grading:** Major (4) x Likely (4) = **HIGH** (16)

**Responsible Director:** Director of Community and Older People's Services

3. Human Milk Bank - Legal and corporate governance deficits regarding the operational delivery of the Milk Bank Service to RoI.

**Risk Title:** Human Milk Bank - Legal and corporate governance deficits regarding the operational delivery of the Milk Bank Service to RoI.

**Risk Description:** A review was undertaken of the current contracts between the WHSCT and the HSE and between WHSCT and Cu Chulainn Blood Bike Group due to a change in the delivery and collection of DEBM. During the review, a number of contractual issues were identified by DLS (see-attached report) which questions the Trusts statutory powers and functions and current corporate governance arrangements regarding provision of service to RoI.

**Proposed Grading:** Major (4) x possible (3) = **HIGH** (12)

**Responsible Director:** Director of Children and Families

- Material changes

Risk ID49 – Cyber Security

- Summary report for action;
  - At time of reporting, all Corporate Risks have been updated and action plans reviewed.

## 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			
<b>1334</b>	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	
<b>1375</b>	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
<b>1</b>	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	
<b>49</b>						
<b>1216</b>	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	HIGH	Low (target score between 1 -6) Current	

			staff in ED, corporate Nursing and community. 2. Risk will be subject to a DEEP DIVE in March 2025		Target score 6	
<b>1307</b>	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	
<b>1320</b>	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	
<b>1487</b>	Director of Human Resources & Organisational Development	Impact on services as a result of industrial action in relation to outstanding agenda for change (AFC) Pay, safe staffing	Trust board agreed to; 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	HIGH	Moderate (target score between 8-12) Current target score 8	Completed – risk rating changed April 2024
<b>6</b>	Executive Director of social work/Director	Children awaiting allocation of Social worker may	Trust Board agreed to; 1. Current tolerance and risk appetite to	HIGH	Moderate (target score between	

	of Family and Children's services	experience harm or abuse	remain as is due to external gaps in control. Keep risk under review		8-12) Current target score 8	
<b>284</b>	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
<b>955</b>	Director of Finance, contracts and Capital Development	Failure to comply with procurement legislation re social care procurement	Trust board agreed to; 1.de-esalate 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
<b>1254</b>	Director of Human Resources and Organisational Development	Inability to deliver safe, high quality and sustainable services due to workforce supply and disruptions	Trust Board agreed to; 1.Current tolerance and risk appetite to remain 2.Risk owner to reflect mitigations discussed within the risk register actions within CRR	HIGH	Moderate (target score between 8-12) Current target score 8	
<b>1288</b>	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 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.	LOW	Low (target score between 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-escalate the risk to Directorate Risk Register of	Risk de-escalate to DRR	Risk de-escalate to DRR	Risk De-escalated to DRR 15.04.24

			Performance and Service Improvement as proposed at CMT on 25.03.24			
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Risk Sub- Category	Risk ID	Lead Director	Risk Title	Initial		Current		Target		Risk Appetite			Current Risk Status		Mths since last updated	Action Plan Status	Latest Update
				Score	Grade	Score	Grade	Score	Grade	Score	Level of Tolerance	Action on Appitite	Mths since score changed	Change in score since last review			
Safe & Effective Services.	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.	6	No change	0	Actions listed with future due dates	[09/12/2024] Estates will prepare a update briefing for CMT in relation to ongoing fire issues. To date (1) the completion of fire risk assessments 78.5% (compliant within 3 months), (2)mandatory fire training is currently 81%. In addition Estates have completed a review of the updated HTM and have a number of actions to take forward.
Quality of Care	6	Executive Director of Social Work/Director of Women & Children Services	Children awaiting allocation of Social Worker may experience harm or abuse	25	EXTREM	12	HIGH	8	HIGH	8	LOW	Trust Board agreed to; 1. Current tolerance and risk appetite to remain as is due to external gaps in control. Keep risk under review	39	No change	0	Actions listed with future due dates	[21/11/2024] - 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.
ICT & Physical Infrastructure	49	Director of Performance, Planning and Corporate Services	The potential impact of a Cyber Security incident on the Western Trust	16	HIGH	20	EXTREM	6	MEDIUM	6	HIGH						
Regulation & Compliance	284	Director of Performance & Service Improvement	Risk of breach of Data Protection legislation through loss, mishandling or inaccessibility of personal or sensitive personal inf	16	HIGH	12	HIGH	6	MEDIUM	6	HIGH	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	9	No change	0	Actions listed with future due dates	[02/12/2024] The majority of Information Asset Owners have returned their the annual SIRO Assurance template and indicated they have updated service entries on the Trust's Information Asset Register. Records Management guidance on the recording of record disposal has been issued as a Trust Communication to all staff.
Regulation & Compliance	1183	Director of Adult Mental Health & Disability Services	Where MCA processes are not being followed, patients may be deprived of their liberty, without having safeguards in place	25	EXTREM	15	HIGH	6	MEDIUM	6	HIGH	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.	12	No change	0	Actions listed with future due dates	[11/12/2024] Risk reviewed. Gap in control - Assurance required that all staff completing MCA forms are suitable qualified to do so - has been closed as process in place to check and take relevant action.
Quality of Care	1216	Director of Diagnostics, Cancer and Medical Specialties	Risk of patient harm in Trust EDs due to capacity, staffing and patient flow issues	15	EXTREM	15	EXTREM	6	MEDIUM	6	LOW	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	28	No change	0	Actions listed with future due dates	[18/11/2024] The risk has been reviewed and remains the same.
Regulation & Compliance	1219	Director of Diagnostics, Cancer and Medical Specialties	Lack of endoscopy capacity for endoscopy to meet the demand which impacts on Patient outcomes	20	EXTREM	20	EXTREM	6	MEDIUM	6	HIGH	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	28	No change	0	Actions listed with future due dates	[05/12/2024] The risk was discussed at CGSC in November and agreement was supported that this should remain corporate until April 2025, the service will then review and advise.

Risk Sub- Category	Risk ID	Lead Director	Risk Title	Initial		Current		Target		Risk Appetite			Current Risk Status		Mths since last updated	Action Plan Status	Latest Update
				Score	Grade	Score	Grade	Score	Grade	Score	Level of Tolerance	Action on Appitite	Mths since score changed	Change in score since last review			
Financial	1236	Executive Director of Finance, Contracts & Capital Development	Stabilisation of Trust Financial position	16	HIGH	16	HIGH	6	MEDIUM	6	LOW	Trust Board agreed to; 1. Current tolerance and risk appetite to remain as is. 2. Risk to be kept under review by risk owner	11	No change	0	Actions listed with future due dates	[22/11/2024] 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.
Quality of Care	1254	Director of Human Resurces & Organisational Devlopement	Inability to deliver safe, high quality and sustainable services due to workforce supply and disruptions	16	HIGH	16	HIGH	8	HIGH	8	HIGH	Trust Board agreed to; 1. Current tolerance and risk appetite to remain 2. Risk owner to reflect mitigations discussed within the risk register actions within CRR	27	No change	0	Actions listed with future due dates	[21/11/2024] Greater demand for link grade posts in areas where the labour market has been repeatedly tested including Estates, Speech & Language Therapy, Pharmacy & Physiotherapy therefore new processes are being scoped and implemented. Bespoke recruitment events ongoing where required i.e. adult learning disability, homecare, supported living. In October 2024 a recruitment campaign for nursing assistants for acute and community settings has resulted in 140 successful applicants for Band 2 NAs and 69 Band 3 Senior NAs.
Regulation & Compliance	1288	Director of Performance & Service Improvement	Risk of failure to meet regulatory standards and compliance associated with Trust infrastructure and estate.	12	HIGH	12	HIGH	6	MEDIUM	6	HIGH	Trust Board agreed to; 1. Current tolerance and risk appetite to remain as is	28	No change	0	Actions listed with future due dates	[09/12/2024] Estates are currently reviewing/ carrying out a deep dive on statutory compliance with fire door. A report shall be issued once complete.
Quality of Care	1307	Director of Surgery, Paediatrics and Women's Health	Clinical Risk regarding Delayed Transfer of Babies, Children and Adults to Other Hospitals	25	EXTREM	25	EXTREM	6	MEDIUM	6	HIGH	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	28	No change	0	Actions listed with future due dates	[25/11/2024] The current availability of NISTAR remains challenging. The predictions for the month of December 24 is very poor. 17 nights and 9 days with no paediatric medical team and 10 days when there is no Neo Natal team. Proposed rota shared amongst staff for awareness of shifts whereby NISTAR is not available.
Quality of Care	1320	Director of Social Work/Director of Women's and Children's Services	Delayed/inappropriate placement of children assessed as requiring inpatient mental health care.	12	HIGH	20	EXTREM	8	HIGH	8	HIGH	Trust Board agreed to; 1. Current tolerance and risk appetite to remain as is, and risk owner to keep risk under review	32	No change	0	Actions listed with future due dates	[26/11/2024] As of 25/11/25 there are 11 inpatients across the unit. 9 of those patients in the unit are detained. 6 for treatment of an eating disorder, 4 patients on NG feeding plans. Acuity levels are measured daily over the past week and we have been able to facilitate admissions by increasing staffing levels. At present we have 2YP on 1:1 observations and 2 on 2:1 observations. Over the reporting period 14th-21st November , there have been 9 incidents which relate to self-harm, and violence and aggression. The service are to review this risk by 31st December 2024 with a view to de-escalation to Directorate Risk Register.
Ensuring Stability of Our Services	1334	Director of surgery, Paediatrics and Women's Health	Sustainability of surgical services in Southern Sector of Trust due to recruitment & retention difficulties at Consultant and Mi	20	EXTREM	15	HIGH	8	HIGH	8	HIGH	Trust Board agreed to; 1. Keep tolerance as LOW 2. Risk owner to review controls listed against risk within CRR	18	No change	0	Actions listed with future due dates	[19/11/2024] General Surgery, since December 2022, have been successful in attracting substantive consultants to the WHSCT with a blend of local and international recruitment initiatives. All newly appointed consultants are employed on a Trust Wide Consultant contract basis with existing consultants now also being job planned to deliver services across all WHSCT clinical facilities both Northern and Southern Sectors.
Quality of Care	1409	Director of Diagnostics, Cancer and Medical Specialties	ED Mental Health Patients	25	EXTREM	16	HIGH	9	MEDIUM	6	LOW	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	23	No change	1	Actions listed with future due dates	[18/10/2024] SWAH Update 17/10/2024] Risk reviewed and considered no change from previous updates.

Risk Sub- Category	Risk ID	Lead Director	Risk Title	Initial		Current		Target		Risk Appetite			Current Risk Status		Mths since last updated	Action Plan Status	Latest Update
				Score	Grade	Score	Grade	Score	Grade	Score	Level of Tolerance	Action on Appitite	Mths since score changed	Change in score since last review			
Health & Safety	1469	Medical Director	Health & Safety Risk to Staff as a result of Violence and Aggression	12	HIGH	12	HIGH	4	HIGH	4	HIGH	Trust Board agreed to; 1. Set tolerance of this risk as LOW, to 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.	● 24	No change	0	Actions listed with future due dates	13.12.24 subject of a deep dive at Governance Committee and it was noted that the risk will be considered by the MOVA group for review of current grading in light of increase in number, severity and widening nature of incidents being reported. A change in description will also be considered prior to the Trust Board workshop. Ongoing actions were acknowledged as appropriate to mitigating the risk going forward.
Quality of Care	1487	Director of Human Resources & Organisational Development	Impact on services as a result of Industrial Action in relation pay, safe staffing and travel rates.	20	EXTREM	20	EXTREM	8	HIGH	8	LOW	Trust board agreed to; 1. Set tolerance of this risk as High as gaps outwith Trust control. 2. Agreement to decrease current risk rating from extreme (20) to high(12) as approved by CMT in March 2024	● 7	No change	0	Actions listed with future due dates	[21/11/2024] Discussions are ongoing between the Minister of Health, Trade Unions and HSC Employers regarding the Agenda for Change Pay Award for 2024/25. There is a proposal to implement the pay award for part of the year and a commitment given to use their best efforts to firm up funding to pay the remaining from 1 April 2024. Discussions are also ongoing to seek to conclude 2024/25 pay for Resident, Specialty and Associate Specialist Doctors.
Quality of Care	1601	Director of surgery, Paediatrics and Women's Health	Inability to retain ENT Head & Neck Service Provision	16	High	16	high	8	high	8	HIGH	To be reviewed at next Trust Board Workshop	● 6	No change	0	Actions listed with future due dates	[15/11/2024] No change in risk currently recruiting via IMR with a candidate with interest in Head and Neck. Recent visit from PHA discussion around exploring regional consideration provision of head and neck services to the inability to recruit consultants.
Quality of Care	1602	Director for Primary Care and Older People	Risk no GP cover Trust managed GP Practices	16	High	16	high	12	high	5	LOW	To be reviewed at next Trust Board Workshop	● 6	No change	2	Actions listed with future due dates	[24/10/2024 14:08:33] GP cover has been secured for all uncovered rotas up until 31st December 2024. There are currently no uncovered GP session slots
Resource & People	1612	Director of Performance, Planning and Corporate Services	Risk to WHSCT achieving the proposed encompass Go Live date due to safety concerns	10	High	10	High	8	High	5	LOW	To be reviewed at next Trust Board Workshop	● 4	No change	0	Actions listed with future due dates	[06/12/2024] Work continues to find an alternative training venue to facilitate Safety Intervention Training and storage within the Southern Sector. Colleagues within Risk Management are exploring alternative venues within community/Voluntary and Council. A proposal has been developed and presented to the Medical Directorate SMT. Assurance has been provided by the Central Team and Epic regarding 2 Trusts going live (Western and Southern). The Trust has been advised that staff levels to support go live have been increased to support both Trusts and is equal to the support provided to Belfast Trust. There is continued focus on a small number of specialists areas. Currently the only area of concern is MDI, however this has been brought onto the GRLA to ensure that this is monitored closely. Additional controls have also been put in place with the establishment of a fortnightly joint meeting with the Western and Southern Trust.
Quality of Care	1629	Director of Adult Mental Health & Disability Services	Alcohol Related Brain Disease: Non Commissioned service within WHSCT	9	High	9	High	6	High	8	Low	To be reviewed at next Trust Board Workshop	● 3	No change	2	Actions listed with future due dates	[25/09/2024] Internal task and Finish group and oversight group continue to meet. Regional meeting also arranged for 8.10.24 to develop an agreed interim pathway. WHSCT continue to research with Scottish colleagues re best practice and gold standard models in order to inform business case.
Finance & Efficiency	1656	Director of Nursing	Risk of Roster- Pro System Failure	9	High	9	High	6	High	5	Low	To be reviewed at next Trust Board Workshop	● 0	No change	0	Actions to be added - new corporate risk	New Corporate risk approved at Trust Board 05.12.24
Quality of care	1657	Director of Adult Mental Health & Disability Services	Medium secure placement deficit for patients with highly complex needs	20	Extreme	20	Extreme	8	high	5	Low	To be reviewed at next Trust Board Workshop	● 0	No change	0	Actions to be added - new corporate risk	New Corporate risk approved at Trust Board 05.12.25

Initial Risk										Current Risk		Target Risk		Risk Register and Assurance Framework												
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)			
1	19/11/2008	20	Extreme (Red)	15	Extreme (Red)	8	High (Amber)	Director of Performance & Service Improvement	Planning & Performance Facilities Management	Safe & Effective Services.	Fire Risks	<p>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.</p>			<p>Fire Safety Policy, procedures and manual. Including: Site specific fire emergency plans for SWAH and ALT. Departmental fire procedures in place for all areas.</p> <p>Staff Training and awareness.</p> <p>Mandatory Fire Safety awareness training. Recording and reporting of Fire Safety Mandatory Training Nominated Officers appointed and trained.</p> <p>Reporting of all fire incidents, unwanted fire alarms.</p> <p>Regional Fire Managers Group Nominated Officer Fire Safety Log Books</p> <p>Trust Fire risk assessments Recommendations from Resulting from Inspections of Regulatory bodies e.g. NIFRS and RQIA.</p> <p>Fire Safety Controls Assurance Standard action plan.</p> <p>Regular fire drills and emergency exercises</p> <p>Fire improvement works</p> <p>All Trust fire safety advisors to hold appropriate external accreditation.</p> <p>Every Directorate to develop a Fire Risk within their Directorate Risk Register to ensure that all fire risks are managed appropriately.</p> <p>Engagement with Directors and AD's re fire safety.</p> <p>Housekeeping and space utilisation</p> <p>Fire Stopping of SWAH PFI Facilities. Program of fire stopping working underway.</p>		<p>Not all staff are trained in mandatory fire safety awareness training.</p> <p>Potential exists for Premises to be operational without a Nominated Fire Officer in the Department</p> <p>Regional Group meetings are infrequent</p> <p>Not all Fire Risk Assessment are completed within designated Timeframe. Target is 100%</p> <p>Infrequent Drills due to competing Pressures.</p> <p>Financial Constraints Competing priorities Ageing Estate and deterioration of physical infrastructure</p> <p>Working with service to ensure service delivery/care is not impacted.</p> <p>Not all Directorates have included fire on their directorate risk register.</p> <p>Current risks not aligned to the corporate risk ID01.</p> <p>Systems are currently not in place for annual attendance at Directorate SMT's.</p> <p>Space limitations within Trust footprint. Stock control management at a service level.</p> <p>Limited opportunities for management walkarounds</p> <p>Firestopping defects still present on SWAH site.</p> <p>Difficulties in recruitment of trained fire officers. Currently 25% vacancy (1/4)</p> <p>Evidence of staff, visitors and patients not adhering to smokefree</p>		<p>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.</p> <p>Contractual obligation under the employment contract. Monthly reports provided to Business managers for distribution to HOS/AD's to identify staff compliance.</p> <p>Fire risk assessment audits. Fire Safety Working Group. Monthly rolldown of nominated fire officers throughout the Trust.</p> <p>Incidents are investigated by the Trust incident management process.</p> <p>Learning is cascaded both locally and regionally.</p> <p>Oversight over regional learning and good practice</p>		<p>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.</p> <p>Contractual obligation under the employment contract. Monthly reports provided to Business managers for distribution to HOS/AD's to identify staff compliance.</p> <p>Fire risk assessment audits. Fire Safety Working Group. Monthly rolldown of nominated fire officers throughout the Trust.</p> <p>Incidents are investigated by the Trust incident management process.</p> <p>Learning is cascaded both locally and regionally.</p> <p>Oversight over regional learning and good practice</p>		<p>Accuracy of Learn HSCNI reporting of mandatory training</p> <p>Potential Exists for Premises to be operational without a Nominated Fire Officer in the Department</p> <p>Non adherence to Learning Incomplete Documentation within fire safety log books</p> <p>Failure to sustain recommendation s on a long term basis</p> <p>To ensure that nominated fire officer are aware of their fire safety responsibilities in each department/premises. Monitored through Fire risk assessment audits.</p> <p>Space limitations within Trust footprint. Stock control management at a service level.</p> <p>Limited opportunities for management walkarounds</p> <p>Fire risk assessments are completed by Trust Fire safety advisors</p> <p>Frequency is dependent on criticality of premises.</p> <p>Inspections by external bodies (both planned and ahoc basis).</p> <p>Partnership working with multi-disciplinary agencies included RQIA and NIFRS. Assurance Provided to</p>		<p>Emergency Lighting replacement</p> <p>Implement fire safety improvements</p> <p>Implement Fire Safety Improvements -18/19</p> <p>NIFRS to speak with clients implement fire safety improvement works 17/18</p> <p>Fire safety objectives review for 16/17</p> <p>Fire Safety Report 15/16</p> <p>Priority list of firecode works to be prepared</p> <p>Fire Improvement Works 14/15.</p> <p>Implementation of Directorate Action Plans.</p> <p>Fire Improvement Works 15/16</p> <p>Hospital Fire Storage Working Group to be set up</p> <p>Working Group to be established to Review inappropriate draining of Medical Gas Cylinders leading to a Fire/Explosion risk</p> <p>Review storage under Ward 31/ 32 stairwell</p> <p>Implement elearning fire safety training</p> <p>Head of SS and Fire Manager to attend all Directorate SMTs bi-annually</p> <p>Head of Specialist Services and Fire Manager to attend Directorate SMTs Emergency Lighting Testing and Repair - Tower Block Altnagelvin</p> <p>Fire due to Covid 19 (ID1263) to be closed</p> <p>Strategy for monitoring and reporting of fire training on LMS to be</p>	
6	21/09/2009	25	Extreme (Red)	12	High (Amber)	8	High (Amber)	Executive Director of Social Work/Director of Women & Children's Services	Safeguarding Children	Safe & Effective Services.	Children awaiting allocation of Social Worker may experience harm or abuse	<p>Due to capacity and demand issues within Family &amp; Childcare, children may not be allocated a Social Worker in a timely manner to provide appropriate support.</p> <p>Children may experience harm as a result and the Trust may not meet its associated professional and organisational requirements.</p>			<p>Ongoing action to secure recurring funding.</p> <p>Update meetings between F&amp;CC ADs and Director.</p> <p>Performance Management Review is being undertaken by HSCB with all 5 Trusts focusing on Unallocated cases and timescales</p> <p>Early Help staff returned to their substantive posts within gateway to increase the ability to allocate</p> <p>Principal Social Work redeployed will monitor Action Plan and progress to stabilise team</p> <p>Service Managers and Social Work Managers monitor and review unallocated cases on a weekly basis.</p> <p>Service and SW Managers constantly prioritise workloads.</p>		<p>Inability to get sick leave covered</p> <p>inability to recruit and retain social workers</p> <p>Principal Social Workers review unallocated cases regularly</p> <p>HSCB have drafted a regional paper to secure additional funding for Unallocated Cases.</p> <p>Delays in recruitment</p>		<p>Feedback given to Performance &amp; Service Improvement for</p> <p>accountability meetings with HSCB.</p> <p>Quarterly governance reports to Governance Committee.</p> <p>Up-dates by Director to CMT and Trust.</p> <p>Action Plan to review and Address Risks within FIS Enniskillen</p> <p>Delegated Statutory Functions</p>		<p>Reports to SPPG only</p> <p>detail numbers of families.</p> <p>There is no assurance of the mitigations put in place to ensure safeguarding of children awaiting allocation.</p> <p>DSF reporting is bi-annually and taken at a point in time. It does not demonstrate trends over the full reporting periods.</p>		<p>Piloting a generic model of practice FIS Early Help Team established to help address unallocated cases.</p> <p>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 cases and provide positive practise experience to encourage students to take up posts</p> <p>Retirees working alongside family support workers and social workers assistants providing assessments, support and interventions to those cases on the waiting list (unallocated)</p> <p>Overtime offered in Enniskillen to allocate cases for interventions to work towards closure</p> <p>Principle practitioner allocated cases to complete work and close interventions were ongoing support is no longer required and no assessed risk</p> <p>Principal practitioner posts in hard to fill areas has been successful in retaining staff</p> <p>In areas we have full staffing levels there are no unallocated cases</p>			
49	06/10/2009	16	High (Amber)	20	Extreme (Red)	6	Medium (Yellow)				The potential impact of a Cyber Security incident on the Western Trust															

		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)				
284	13/12/2010	16	High (Amber)	12	High (Amber)	6	Medium (Yellow)	Director of Performance & Service Improvement	Planning & 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:		<ul style="list-style-type: none"> <li>Insecurely sharing or accessing the personal data of clients, patients and staff without a legislative basis under UKGDPR or supporting legislation</li> <li>The unavailability of records for provision of patient and client care or for legal or public interest purposes</li> <li>Concerns on the adherence to records management responsibilities – notably the storage, categorisation and disposal/PRONI transfer of patient, client and staff records</li> </ul>		<ul style="list-style-type: none"> <li>Subject Access and Data Access agreement procedures.</li> <li>Information Governance/Records Management induction/awareness training.</li> <li>Regional code of practice.</li> <li>Information Governance Steering Group.</li> <li>Records held securely/restricted access.</li> <li>ICT security policies.</li> <li>Raised staff awareness via Trust Communications/Share to Learn.</li> <li>Fair processing leaflets/posters.</li> <li>Investigation of incidents.</li> <li>Data Guardians role.</li> <li>Regional DHSSPS Information Governance Advisory Group.</li> <li>Electronic transmission protocol.</li> <li>Investigation of incidents.</li> <li>2 secondary storage facilities available across NS &amp; SS</li> <li>Trust Protocol for Vacating &amp; Decommissioning of HSC Facilities.</li> <li>Scoping exercise to identify volume and location of secondary close records completed in December 2010.</li> <li>band 3 post in place</li> <li>Review of regional IG training available on HSC Learning completed and updated to provide more robust training for staff.</li> <li>Data Protection &amp; Confidentiality Policy.</li> <li>Information Governance SIRO and IAO Framework.</li> </ul>		<ul style="list-style-type: none"> <li>Potential that information may be stored/transferred in breach of Trust policies.</li> <li>Limited uptake of Information Governance and Records Management training.</li> <li>No capacity within the team to take on provision of IG training</li> </ul>		<ul style="list-style-type: none"> <li>Reports to Risk Management Sub-Committee/Governance Committee</li> <li>BSO Audit of ICT and Information Management Standards.</li> <li>BSO Internal Audit of Information Governance.</li> <li>Revised composition and terms of reference of the Information Governance Steering Group as a result of the new SIRO/IAO framework.</li> </ul>		<ul style="list-style-type: none"> <li>Band 3 0.5 post increased to full time</li> <li>Recruitment of Band 4 Information Governance</li> <li>Development of information leaflet for Support Services Staff to increase awareness of information governance</li> <li>Review of regional e-learning IG training</li> <li>Establishment of Regional Records Man Group</li> <li>Development of IG action plan to be finalised through IGSG</li> <li>Recruitment of band 5 IG post to support DPA</li> <li>Development of IG information leaflet for support staff</li> <li>Review of Primary (acute) records storage in AAH</li> <li>Restructure of IAO process</li> <li>Review of Secondary storage in Maple Villa</li> <li>Production of Records Storage guidance for home working staff working from home</li> <li>New secondary storage facility in the southern sector</li> <li>Recruitment of IG Team leader post</li> <li>Introduction of Infreemation for IG requests</li> </ul>			
1183	27/11/2019	28	Extreme (Red)	15	High (Amber)	6	Medium (Yellow)	Director of Adult Mental Health & Disability Services	Directorate-wide (Risk Register Use only)	Governance .. Safe & Effective Services.	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.	<ul style="list-style-type: none"> <li>Staff training is available online &amp; classroom, provided by Trust Trainers. Progressing interactive online training via VC. Training videos developed</li> <li>MCA resources are available via MCA HUB on StaffWest</li> <li>DOLs office supports administration processes, including advice to support completion of forms</li> <li>Staff training is available via eLearning as well as from CEC.</li> <li>Training available online &amp; classroom, provided by Trust Trainers. Progressing interactive online training via VC.</li> <li>Emergency provisions to be used, where deemed appropriate, to support continuing service delivery until the safeguards are approved. Where emergency provisions apply, fully authorisations are required to be urgently followed up.</li> </ul>		<ul style="list-style-type: none"> <li>Medic capacity to ensure timely completion of relevant forms and availability to sit on Panels</li> <li>Funding not adequate to deliver the projected activity.</li> <li>Funding not provided recurrently, compounding recruitment issues</li> <li>Assurance that there are timely completion of MCA processes following use of Emergency Provisions</li> <li>community teams staffing issues resulting in unallocated caseloads</li> <li>Timing of progression to the introduction of the second phase of MCA legislation is yet to be confirmed.</li> <li>Review of requirement for DoIs in Special Schools</li> </ul>		<ul style="list-style-type: none"> <li>First Line of Assurance</li> <li>STDA Operational Group</li> <li>MCA Team, including Supervision</li> <li>MCA Information T&amp;F group (systems, processes &amp; reporting)</li> <li>Training T&amp;F group</li> <li>Second Line of Assurance</li> <li>Updated to Trust Board</li> <li>Corporate Risk Internal Audit</li> <li>Third Line of Assurance</li> <li>MCA Legislation / Code of Practice</li> <li>Mental Health Order</li> <li>Role of General Attorneys Office</li> <li>Role of Northern Ireland Review Tribunal</li> <li>SPPG</li> <li>Regional monthly activity reporting</li> <li>Role of RQIA</li> <li>MCA Regional Leads Group</li> <li>MCA Miltiagency Group (NIRT, AG, RQIA, DLS, SPPG, MCA Leads</li> <li>MCA Project Board</li> </ul>		<ul style="list-style-type: none"> <li>Systems, Processes &amp; Reporting to be strengthened &amp; formalised - Encompass is the Regional Direction, Western Trust go live is April 25</li> <li>Escalation processes to be bedded in across Acute and Community</li> <li>Issues in relation to Gap between MCA and MHO</li> <li>Conveyance issues between Health Trusts, PSNI &amp; NIAS</li> </ul>		<ul style="list-style-type: none"> <li>Engage with programme board and team</li> <li>Scope potential Mental Capacity/DoLs assessments</li> <li>A Programme Implementation Officer to continue engaging on leading implementation.</li> <li>Trust Lead Directors and Responsible leads in each Sub-Directorate to be identified</li> <li>Quantification of Costs and completion of the IPT bid to ensure fully funded MCA arrangements and minimise financial risk</li> <li>HR &amp; remunerations for staff identified to undertake duties on panels</li> <li>Seek Interest from relevant staff to sit on panels.</li> <li>Ensure sufficient staff attend training to allow them to undertake statutory functions commencing 2nd December 2019</li> <li>Seek Interest from Nurses at Band 7 and above to sit on panels.</li> <li>Rotas for panel activity and short-term authorisation to be developed.</li> <li>Ongoing communication with the Unions.</li> <li>Communication Plan to be developed - draft to be presented at Mar21 Project Board</li> <li>Resource appointed from within directorate to support identification, completion of forms and processing of all required Safeguards.nance.</li> <li>Currently engaged with Acute and</li> </ul>					

Initial Risk												Current Risk		Target Risk		Risk Register and Assurance Framework													
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)		
1216	15/04/2020	15	Extreme (Red)	15	Extreme (Red)	6	Medium (Yellow)	Director of Diagnostics, Cancer and Medical Specialities	Acute - Emergency Care & Medicine	Public Confidence, Safe & Effective Services.	Risk of patient harm in Trust EDs due to capacity, staffing and patient flow issues	If Emergency Department (ED) Physical capacity and staffing levels are not sufficient to meet the demands of patient numbers and acuity, there will be increased likelihood of significant patient harm, risk to staff wellbeing and damage to Trust reputation as a direct result.	Business case approved dedicated HALO (Hospital Ambulance Liaison Officer) NIAS crews waiting to offload in our hospital early warning score Ongoing Trust recruitment focus on Critical posts IE Medical and Nursing Use of Medical locums/ Bank and agency Nurses. Social Media Campaign Escalation protocol within full capacity protocol Nursing KPI and audit ( ALAMAC) Ongoing in house Quality improvement work ( implementation of SAFER principles) Daily regional huddle meeting with escalation as required IT systems - Symphony Flow board On call managers/medics rota Ongoing MDT patient flow huddles in department/wards Medical team ED reviews Hub flow meetings with lead nurse attendance. Patient flow teams/night service manager Major incident policy Full capacity protocol			implementation of SAFER principles challenged due to Medical Job plans and current Medical team models in operation ageing population living with challenging health needs Community infrastructure to meet needs of patients i.e. Gp appointments, social care packages Recruitment to perm medical posts Challenging across NI			Datix - Incident, Complaints, Litigation, Risk register Patient flow teams, Night service manager, SPOC, Hub Regional huddle Established patient pathways			Gaps in patient pathway			PACE implementation to commence March 2020. Improvement QI work commencing with aim to address communication within department. Full capacity protocol				
1219	30/04/2020	20	Extreme (Red)	20	Extreme (Red)	6	Medium (Yellow)	Director of Diagnostics, Cancer and Medical Specialities	Acute - Diagnostics & Cancer Services	Safe & Effective Services.	Lack of endoscopy capacity for endoscopy to meet the demand which impacts on Patient outcomes	Lack of endoscopy capacity, 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 vacancy. Training of 2 nurse endoscopists under transformation commenced in September 2018 - trainees were to be signed off by the end of 2020 the delay was due to Covid-19. Short-term provision by SE Trust to provide WT in IS tender 200 patients identified and moved to the independent sector.			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			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.				

Corporate Risk Register and Assurance Framework 31.12.2024																	
		Initial Risk		Current Risk		Target Risk		Risk Register and Assurance Details									
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)
1236	21/08/2020	16	High (Amber)	16	High (Amber)	6	Medium (Yellow)	Executive Director of Finance, Contracts & 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 Savings Plan for 2024/25. The Trust has effectively communicated its ambition to deliver £24m of low and medium impact savings in 2024/25 which results in a deficit of £35m. SPPG have provided £21.5m of deficit funding to the Trust leaving a deficit of £3.5m and an expectation that this balance can be found from savings. The Trust have not accepted this position. There are a number of risks: i. Unfunded demographic growth resulting in increased financial pressures above forecast; ii. Achievement against savings targets. iii. There are no opportunities to resolve the £3.5m gap from low/medium savings options	Chief Executive Assurance meetings to review performance Annual Financial Plan to review risks 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
1254	18/01/2021	16	High (Amber)	16	High (Amber)	8	High (Amber)	Director of Human Resources & Organisational Development	Trust-wide Risk Register use	Ensuring Stability of Our Services, Improving the Quality and Experience of Care, Supporting and Empowering Staff	Inability to deliver safe, high quality and sustainable services due to workforce supply and disruptions	Due to an inability to attract, recruit and retain staff throughout the Trust, services may not be able to maintain sufficient staffing levels to sustain high quality safe services which may result in a reduction in service provision.  Trust Business Continuity Plans with full HR support on hospital / community workforce groups. Delivering Care: Nurse Staffing in Northern Ireland Organisation Development Steering Group Health and Wellbeing Strategy Engagement & Involvement Strategy DOH Workforce Strategy & Trust Workforce Strategy and key actions Policies - Rec & Selection Framework, Attendance at Work, Flexible Working, Redundancy and Redeployment, etc. HR Strategic Business Partner identified for each Directorate - targeted interventions in relation to absence, agency usage, temporary staffing and other identified Directorate priorities. (Risk 6, 1075) Pension information sessions Joint Forum, Joint LNC and Consultation Group Workforce Information reports provided to key stakeholders Trust Governance Arrangements - People Committee Use of Bank/Agency/Locum Staff through Locum's Nest. Single Employer Project Group Review of existing Locum Framework Regional Strategic and Implementation Groups established to consider WFP implications for reform initiatives	Occupational Health - absence of locums and increasing demands on team without additional resources. Low uptake of mandatory training and completed annual appraisal. Inability to follow normal policies and procedures during periods of Industrial Action and also during emergency situations such as Pandemic. Lack of co-ordinated information on agency staffing Due to demand in services compliance with Working Time Regulations and New Deal. BSO Recruitment Shared Service provides recruitment services for the Trust and there has been an increased delay in recruitment and dependence on them for related information. Inability of NIMDTA to provide required number of Junior Doctors for certain specialities and localities. (Risk 694) Difficulty in recruiting in rural areas and accessing cover when needed in those areas i.e. Domiciliary Care Workers. (Risk 547) Insufficient applicants for medical, nursing and social work posts. (Risks 6,1109) Process improvement required for consultant recruitment in order to ensure process works effectively.	Working Together Delivering Value Health check measurements on absence hours lost, mandatory training, appraisal, time to fill posts, job planning completion rate. Involvement Committee - Quarterly monitoring of staff engagement on initiatives that contribute to achievement of Trust Great Place ambitions (start life, live well and grow old) Pension Regulator Compliance Junior Doctors Hours monitored twice yearly and returns submitted to DOH. People Committee - Workforce Strategy, Recruitment and NIMDTA Allocation Updates twice per year. People Committee - Quarterly monitoring of Absence, Appraisal, Mandatory Training, Consultant Job Planning, Temporary Staffing, Agency Staffing, Turnover and Grievance/Disciplinary/Statutory Cases. RQIA Inspections of services which link to employment matters UK Border Agency Inspections on ad hoc basis. Audit assurance and progress reports in relation to Audit recommendations provided at least twice per year to internal audit. Professional Guidance - Telford, Royal Colleges, NI Delivering Care (N&M)	BSO Shared Service not meeting statutory or procedural deadlines resulting in, for example, delays in recruitment inability of NIMDTA 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	Looking After our People Growing for the Future Belonging to the HSC New Ways of Working	

Initial Risk				Current Risk			Target Risk		Corporate Risk Register and Assurance Framework 31.12.2024														
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)		
1288	08/04/2021	12	High (Amber)	12	High (Amber)	6	Medium (Yellow)	Director of Performance & Service Improvement	Trust-wide (Risk Register use only)	Ensuring Stability of Our Services, Improving the Quality and Experience of Care	Risk of failure to meet regulatory standards and compliance associated with Trust infrastructure and estate.	There is a risk of deterioration in the Trust Estate due to ageing and lack of capital investment in the maintenance of building services infrastructure and physical environment which could lead to loss of service and non-compliance with regulatory and statutory standards (e.g. water, electrical, asbestos and physical infrastructure).		Monitoring and review by PSI SMT of directorate risks including water, electrical, fire safety, vacant estate asbestos and physical infrastructure. Should a critical issue materialise further funding can be sought from DoH or existing funding reprioritised to address the new critical issue Estates Strategy 2015/16-2020/21 Annual review of building condition (31) and creation of prioritised BLM list. 2022/23 Backlog maintenance programme developed and implemented Continual bidding for funding to address backlog maintenance Targeting of priority areas as funding becomes available. Monthly review of Backlog Maintenance capital investment plan Priority Backlog Maintenance capital investment plan 2024/25 Backlog maintenance programme developed and implemented		Ageing infrastructure resulting in deterioration of buildings Insufficient funding to carry out full remedial works identified.		Back-log Maintenance list Health & Safety audits Environmental Cleanliness audits Authorising Engineer audits Annual inspections carried out Membership at Health and Safety/ Water Safety Groups Reports to Corporate Governance Sub Committee/Governance Committee Assurance standards Buildings, Land, Plant & Non-Medical Equipment Oakleaf - 6 facet independent survey		Lack of Funding for backlog maintenance.	Review of emerging issues and response required Development of business cases for 2021/22 backlog maintenance agreed action plan. CMT approval of BLM 2021/22 for submission. Development of 2021/22 BLM bid Completion of six facet condition survey Review of emerging issues and response required Monthly review of Backlog Maintenance capital investment plan Review Ward 50 ventilation system performance BLM and Capital Plan Project Delivery for 21/22 BLM and Capital Plan Delivery 23/24 Develop BLM bid 22/23 DoH approval of BLM 2022/23. Develop BLM plan for 24/25 Review and Update Condition Surveys of WHSCT Estates Portfolio Review and Prioritise Ventilation Safety Works in conjunction with clinical directorates Paper to be developed and submitted to Governance Committee on the current risk associated with BLM, including current controls measures which have been implemented to mitigate against this risk.		
1307	16/06/2021	25	Extreme (Red)	25	Extreme (Red)	6	Medium (Yellow)	Director of Surgery, Paediatrics and Women's Health	Women & Childrens - Health Division	Supporting and Empowering Staff	Clinical Risk regarding Delayed Transfer of Babies, Children and Adults to Other Hospitals	Due to limitations on the NISTAR resource and ability of Trust to facilitate transfers that don't meet NISTAR protocols and lack of clarity around same, time critical transfers are being either delayed or are completed using sub-optimal alternatives. This may result in harm to patients being transferred, the patients in the services covering the transfer as well as additional financial cost to the Trust.		Consider stabilising and holding patient until NISTAR available. 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 to 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	

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)	
1320	15/09/2021	12	High (Amber)	20	Extreme (Red)	8	High (Amber)	Executive Director of Social Work/Director of Women & Children's Services	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 being placed inappropriately in inpatient AMHS beds when available and/or acute medical and paediatric wards or are being managed by Community CAMHS intensively with heightened complex risk. As a consequence CAMHS staff from other steps within the Service are being redeployed to support this intensive working. Community CAMHS remains under significant capacity and resource issues. CAMHS is not currently commissioned for an OOH Service as such an OOH pathway is in place to mitigate risk in conjunction with CAMHS/AMHS/ED Colleagues. This increases potential for: - sub-optimal care whilst inappropriately placed in hospital; risks to other patients and staff in those areas. Heightened risks of both physical and mental health deterioration and associated harm relating to safety	Staff training in Paediatrics Staff training in Emergency Department Regular meetings with AMH services Regular meetings with Beechcroft (weekly) and daily updates Policy on age appropriate care to acute setting Policy on U18 admission to AMH wards Protocol CAMHS/AMHS pathway OOH (2011) - under review at present	Environmental risks of temporary placement wards/facilities in particular YP presenting self-harm, suicidal risk, risk of absconding. Supervision deficit in ED/AMH/Paeds wards Psychiatric cover limited in CAMHS and AMHS Delayed & limited availability of AMH beds in Trust. Training/knowledge deficit re pathways related to high staff turnover in acute medical/AMHS setting CAMHS/AMHS OOH Pathway review overdue Unfunded demand for CAMHS OOH Limited regional capacity for inpatient beds	Monitoring of waiting lists Regional AD Forum - standing item Regional Care Network - weekly data collation Daily updates with Beechcroft In-house monitoring of inappropriate admissions Early Alerts of inappropriate placements both in AMHS wards and Acute medical /Paediatric wards. Weekly review and monitoring by HSCB Escalation to HSCB/DOH			CAMHS Business case to be developed to progress development of CAMHS OOH service provision Family & Child Care Social work input in over 16 MH assessment with AMHS to be reviewed to ensure cover and consistency to mitigate risk WTCAMHS/AMHS OOH 2011 pathway to be considered and reviewed When a young person presents in a mental health crisis OOH the WTCAMHS/AMHS OOH protocol adhered and followed. No MH Adolescent, No AMHS, No Medical paediatric wards CAMHS will attempt to work intensively with YP and family notwithstanding capacity and resource issues Task and finish group to support unmet needs re training /risks identified and policy regarding YP requiring MH admission inappropriately placed on medical wards. Daily contact with Beechcroft re bed availability and hospital to hospital tx asap 1:1 Nursing on ward to support YP and support system provided through agency cover when possible to secure CAMHS continue to hold clinical responsibility for these young people In situation of no available bed CAMHS seek AMHS inpatient bed
1334	26/10/2021	20	Extreme (Red)	15	High (Amber)	8	High (Amber)	Director of Surgery, Paediatrics and Women's Health	Surgical Services	Ensuring Stability 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.	Trust have authorised a Sustainable Surgical Services project to examine surgical services pan-Trust wef 18/10/21 Recruitment campaign is continuous at Speciality Dr and trainee level. Funded establishment should be 6.5 wte consultant Surgeons - current baseline is 3.0 wte with 3.5 wte gap Specialty Drs funded for 8.0 wte: 5.0 in place 2 of whom are locums and one acting up. Ongoing use of locums from within the Trust to sustain the rota at South West Acute. Newly appointed Consultant taking up post 25/10/21 Ongoing efforts to recruit - Interviews planned for 2.0 wte Consultants late October 2021 (now currently deferred pending Royal College approval)	Reluctance from other surgeons across NI to participate in providing locum cover due to the generality of surgical cover required. Difficulties recruiting and retaining at locum and permanent level as above. Difficulty securing Royal College approval for general surgical posts.	Continuing support from Altnagelvin Surgical body to provide locum cover for rota gaps. Programme Board will have fortnightly oversight of all of the actions within the Review Programme. Senior clinical support to project identified and in place. Project lead has been seconded full time to Project team. Project Lead currently briefs CMT twice weekly This will be taken over by Programme Board with fortnightly oversight from 01/11/2021 CMT will continue to support service and project			A Proposal for Sustainable Surgical Services will be developed by end January 2022 to address the most emergent issue eg emergency surgical services in the Southern Sector of the Trust. Continue with ongoing recruitment to fill vacant consultant posts Develop plan for the release of locum surgeons to align with on boarding of recent consultant surgeon appointees, when start dates confirmed Ongoing monitoring of the temporary suspension of emergency surgery and contingency arrangements in place, through the Project Team	

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

		Initial Risk		Current Risk		Target Risk		Risk Register and Assurance Framework										
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)	
1487	06/04/2023	20	Extreme (Red)	20	Extreme (Red)	8	High (Amber)	Director of Human Resources & Organisational Development	Human Resources	Ensuring Stability of Our Services, Supporting and Empowering Staff	Impact on services as a result of 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.	Impact on services as a result of ongoing Industrial Action, including both strike action and action short of strike, taken in relation to Agenda for Change (AFC) pay, safe staffing and travel rates (AFC staff make up 94% of overall workforce) and also Junior Doctor Pay.	Trust compliance with Agenda for Change Terms and Conditions of Services. TU Side engagement with local and regional representatives regarding derogations and service level planning for service delivery on the basis of agreed derogations. Command and Control Silver and Bronze arrangements in place including arrangements for escalation of risks and issues to Health Silver through SPPG and DOH. HR Industrial Action Group established to work closely with Services on IA plans, development of derogations and negotiation with Trade Unions. Business Continuity Plans have been updated and impact assessments completed to identify specific risks as each notice of action is received. Business continuity plans implemented to adapt service delivery in light of ASOS and strike action including standing down of services which cannot be safely maintained. Risk based contingency plans applied in other services which cannot be stood down to ensure that the most vulnerable patients continue to receive a service. Communications with staff, patients and the public.	Service impacts over a prolonged period of time of Industrial action. Postponement and rescheduling of appointments increasing delays for patients on waiting lists. Increasing unallocated cases across a number of areas i.e. nursing, social work. Vacant/uncovered cases not worked unless immediate risk to life and limb harm accepted by Trade Union representatives. Not able to make the necessary improvements in statutory requirements for review. Compromising ability to meet statutory social work responsibilities for children i.e. delays in permanency planning, presentation to Trust Adoption Panel, Court timescales, etc. Impacting on consistency of social work input to inform planning processes for children e.g. child protection, looked after children and family support processes. Business as usual and service improvement programmes impacted due to diversion of resources to IA. Impact on the health and wellbeing of staff involved in IA coordination due to additional working hours and stress. No requirement for staff to work to derogated staffing levels and risks to patient/client safety. Legal entitlement of TU members to	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.	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
1601	11/06/2024	16	High (Amber)	16	High (Amber)	8	High (Amber)	Director of Surgery, Paediatrics and Women's Health	Surgical Services	Inability to retain ENT Head and Neck service provision	The ENT service in the Western Health and Social Care Trust is funded 6 WTE consultants. 4 consultants in post. 2 vacant post currently filled with Locum. One head and neck consultant who has retired on the 6th September 2023. This consultant managed both complex cancer and benign head & neck conditions, including thyroids. This Consultant returned following retirement for a short period (September to December) on a bank contract. Moving forward this surgeon is no longer available. The Trust has previously tried to recruit a 2nd Head and Neck cancer consultant 4 times nationally and 3 times internationally with no success since 2019. Currently 2 benign Head and Neck with interest in thyroid surgery consultant and general ENT consultant posts re advertised via IMR and global recruitment. Closing date 30th April 24. 3 applicants awaiting shortlisting. There are immediate concerns about the sustainability of the ENT Head and Neck service.	Cause Inability to recruit H&N consultants x 2 posts. Replacement will be challenging given the current position of service and recruitment generally to this speciality is expected to be difficult regionally.						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

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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)	
1602	11/06/2024	16	High (Amber)	16	High (Amber)	12	High (Amber)	Director of Older People's Services	COP - Primary & Community Care		Risk of no GP cover in Trust managed GP Practices	110 vacant sessions across 4 GP practices between 1 May 24 and 31 August 24, equivalent to 55 days without GP cover. 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.					Develop a salaried GP job description and T&C's Recruitment Process ANP post	
1612	22/07/2024	10	High (Amber)	10	High (Amber)	8	High (Amber)	Director of Performance & Service Improvement	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 Go Live date due to safety concerns associated with service delivery, because of key readiness activities not being completed within the required timescales.	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.	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 Joint Western Trust and Southern Trust Fortnightly Meeting	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.	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.	3.Go-Live readiness assessments scheduled at 30 day intervals from now until go-live 4.Role Analysis Turbo room completed with training tracks assigned with ongoing review taking place End user devices deployment across all service areas has commenced which will be closely followed by Technical dress rehearsal 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 Directors for implementation 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.

		Initial Risk		Current Risk		Target Risk		Responsible Director	Sub-Directorate	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)
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1629	19/09/2024	9	Medium (Yellow)	9	Medium (Yellow)	6	Medium (Yellow)	Director of Adult Mental Health & 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 difficulties in placing service user. Overall cost to services to support individuals with a formal or suspected diagnosis of ARBD and individuals whose addiction is the significant presenting problem= Total cost pressure is approx. £5.3 million YTD as at 01.07.24. Other patients may be negatively impacted due to staff not having the time to care manage these individuals as per standards due to the additional work created by this service user group.	<ul style="list-style-type: none"> <li>Task and Finish and oversight group set up to scope current pressures and map potential solutions.</li> <li>Business case as a result of work above to be submitted to commissioners</li> <li>Review of delayed discharges</li> <li>On-going review if incidents/SEAs/SALs</li> <li>MDT discussion in regards to individual cases with escalation if case remains unallocated to Head of Service, Assistant Director and Director</li> </ul>	Commissioned Pathway for this Service User group	Review of Incidents Oversight of Delayed Discharges Case Conferencing Review of Complaints	Commissioned pathway for this client group	SCOPING EXERCISE TO BE COMPLETED COMPLETE ARBD RESEARCH CREATE REFERRAL CRITERIA REGIONAL WORK- LEAD TASK AND FINISH/OVERSIGHT GROUP BUSINESS CASE
1656	12/12/2024	9	Medium (Yellow)	9	Medium (Yellow)	6	Low (Green)	Director of Nursing, Midwifery and AHP's		Risk of Roster - Pro System Failure	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. <ul style="list-style-type: none"> <li>Loss of electronic rostering function until system function restored if possible.</li> <li>Loss of ability to use electronic shift data to inform payroll for a large number of staff</li> <li>Loss of management data on workforce utilisation.</li> <li>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.</li> </ul> Note: System failed on 28 May 2024 due to expired Licence Code. System function re-established on 30 May 2024.						

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1657	12/12/2024	20	Extreme (Red)	20	Extreme (Red)	8	High (Amber)	Director of Adult Mental Health & Disability Services	AMHDS - Adult Learning Disability		Medium secure placement deficit for patients with highly complex needs.	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						