Western Health and Social Care Trust

TRUST BOARD ITEM: BRIEFING NOTE

Meeting Details:	6th February 2025
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; • No new risks for consideration Material Changes; • No new material changes 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 6th FEBRUARY 2025

There are 25 risks on the Corporate Risk Register as approved at Trust Board 7th January 2025

Summary

- Proposed New Risks;
- No new risks to consider.
- Material changes;
- No material changes to consider.
- Summary report for action;
    - All Corporate Risks have been updated within the previous quarter. Action plans up to date.

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	Closed 23.01.25
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

WHSCT Corporate Risk Register 29/01/2025

Risk Summary Report

				Initial		Current		Target		Risk Appetite			Current Risk Status				
Risk Sub- Category	Risk ID	Lead Director	Risk Title	Score	Grade	**Score**	**Grade**	Score	Grade	Score	Level of Tolerance	Action on Appitite	**Mths since score changed**	**Change in score since last review**	Mths since last updated	Action Plan Status	Latest Update
Regulation & Compliance	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.	7	No change	0	Actions listed with future due dates	[06/01/2025] Fire activation took place in Ward 1 SWAH in which staff and patients were evacuated, as a precautionary measure, due to a faulty electrical component. Smoke was evident but no fire. Fire Safety evacuation procedures implemented successfully.
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	HIGH	Trust Board agreed to; 1. Current tolerance and risk appetite to remain as is due to external gaps in control. Keep risk under review	40	No change	2	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.
ICT & Physical Infrastructure	49	Director of Performance & Service Improvement	The potential impact of a Cyber Security incident on the Western Trust	16	HIGH	20	EXTREM	6	MEDIUM	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.	17	No change	0	Actions listed with future due dates	[14/01/2025 15:40:30] Also: - New Cyber Security Manager took up position at start of January 25 - Notification from Landauer (letter received 06.01.25) that a cyber incident that took place in Oct 2023, which affected some personal data that they process on behalf of the Trust. Information Governance colleagues are currently pursuing the impact of this incident with the services affected
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	10	No change	0	Actions listed with future due dates	[20/01/2025] IG training remains at circa 85% and work is focused on ensuring data protection governance is wrapped around encompass implementation, given staff will have greater access to patient information. January intake of social work students were trained in role-specific data protection training to help reduce low-level IG incidents and replacement IG Manager recruited now in post. Trust communication issued to all staff in December on removing Auto Complete from email functionality due to an incident trend. Two redaction training sessions delivered to 200 staff in December, which will improve staff confidence in releasing records and mitigate against potential incidents.
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	LOW	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.	13	No change	1	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.

WHSCT Corporate Risk Register 29/01/2025

Risk Summary Report

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Risk Sub- Category	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
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	HIGH	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	29	No change	0	Actions listed with future due dates	16/01/2025 15:26:20] [15/01/2025]Alt ED this risk has been reviewed no change noted. [16/01/2025] SWAH ED Update: A review of staffing levels is ongoing. This staffing review will additional staffing given the increased length of time that patients spend in the department with increased DTAs and reduced flow due to the level of delayed discharges. Additional staffing is regularly required however shifts are not always filled. The result of the staffing review will enable recruitment of staffing to ensure additional staff are available. During December 2024 the Department has again experienced DTAs in excess of 40 patients. Full capacity protocol has been stretched to accommodate 3 undesignated beds in appropriate wards.
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	LOW	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	29	No change	0	Actions listed with future due dates	[16/01/2025] Risk reviewed and no change to report. [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.
Financial	1236	Executive Director of Finance, Contracts & Capital Devlopment	Stabilisation of Trust Financial position	16	HIGH	16	HIGH	6	MEDIUM	6	HIGH	Trust Board agreed to; 1. Current tolerance and risk appetite to remain as is. 2.Risk to be kept under review by risk owner	12	No change	2	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 Resiurces & 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	28	No change	2	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	29	No change	0	Actions listed with future due dates	[06/01/2025] Paper developed in relation to Ward 50 ventilation issues. Paper to be discussed with lead directorate with recommendations on how to take forward.
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	29	No change	0	Actions listed with future due dates	[20/01/2025] There was a retrospective review of neonatal transfers undertaken to inform the commissioners of the service. Whilst there is no recurrent funding, there is a commitment to support this service so that they can recruit permanently into posts, and an intention to extend this service from 5pm to midnight.
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	33	No change	2	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.

WHSCT Corporate Risk Register 29/01/2025

Risk Summary Report

				Initial		Current		Target		Risk Appetite			Current Risk Status				
Risk Sub- Category	Risk ID	Lead Director	Risk Title	Score	Grade	Score	Grade	Score	Grade	Score	Level of Tolerance	Action on Appitite	Mths since score changed	Change in score since last review	Mths since last updated	Action Plan Status	Latest Update
Quality of care	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	LOW	Trust Board agreed to; 1.Keep tolerance as LOW 2. Risk owner to review controls listed against risk within CRR	19	No change	0	Actions listed with future due dates	[14/01/2025] w/c 13.01.2025 the WHSCT has 18.00 wte General Surgery consultants who provide OP & IPDC services across three clinical facilities. This staffing level is in excess of the FSL however is within run-rate, the WHSCT are currently scoping further opportunity to recruit to maintain a 1:16 On Call Rota as the Breast Surgeons, in line with other HSC Trusts, do not now form part of the On Call General Surgery provision, one further Consultant does not undertake On Call duties.
Quality of Care	1409	Director of Diagnostics, Cancer and Medical Specialties	ED Mental Health Patients	25	EXTREM	16	HIGH	9	MEDIUM	6	HIGH	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	24	No change	0	Actions listed with future due dates	[16/01/2025] 15/01/2025] Risk reviewed for ALT ED - since opening of Rathview beds risk has improved and generally waiting time for inpatient bed is less than 12 hours. [16/01/2025] SWAH ED Update:In recent times, mental health patients are not waiting a long time in the Emergency Department as they usually attend Rathview prior to their admission. Weekly improvement meetings are now taking place on a regular basis.
Health & Safety	1469	Medical Director	Health & Safety Risk to Staff as a result of Violence and Aggression	12	HIGH	12	HIGH	4	HIGH	4	LOW	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.	25	No change	0	Actions listed with future due dates	[02/01/2025] 13.12.24subject 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	HIGH	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	8	No change	2	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	7	No change	0	Actions listed with future due dates	[14/01/2025] No change, WHSCT plan to engage OMFS Locum consultant w/c 13.01.2005 however this does not provide H&N capacity.
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	7	No change	0	Actions listed with future due dates	[21/01/2025 10:11:08] Since October 2024 the Trust has secured locum GPs to work across all 5 GP Practices. In September 2024 the Trust appointed 5 Salaried GPs, 2 have been appointed to Brookeborough and Tempo and 3 to Fintona GP Practice.

WHSCT Corporate Risk Register 29/01/2025

Risk Summary Report

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Risk Sub- Category	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
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	5	No change	0	Actions listed with future due dates	[20/01/2025] WHSCT continues to implement it's programme as per Epic / encompass guidelines and agreed governance. The area of MDI continues to be raised as a concern and has been brought onto the GRLA to ensure that this it continues to monitored closely. Concerns regarding resource capacity in terms of staffing and planning programme are mitigated through recruitment / secondments to support programme implementation; review of corporate services and contingency measures to create capacity for encompass implementation; and standing-down and change to frequency of meetings, as appropriate. Dedicated weekly encompass Corporate Management Team meetings have been established, fortnightly encompass Senior Management Team meetings continue to review the most critical elements of the programme with SHSCT, encompass & Epic. WHSCT Go-Live Planning Committee takes place 24/1/2025 in addition to the GLRAs taking place every 30 days until Go-Live on 8th May.
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	4	No change	0	Actions listed with future due dates	[13/01/2025 18] Joint task and finish group and oversight group meeting took place on Friday 10th January 2025. Updated business case shared with peers for comment. Draft demand/capacity shared with peers also for comment. Professional meetings to be set up week commencing 13th January 2025 to finalise same- with final figures to be shared by midday 15.01.25, Further meeting planned for Friday 17th January 2025 to finalise business case and demand capacity. adding capital costs to business case to complete same. Please see documents for detail
Financial	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	1	No change	0	Actions listed with future due dates	[23/01/2025] 21/01/2025 - Allocate Health Roster Optima implemented with 2681 nursing and midwifery users (51%). Implementation to Cohort 4 users scheduled for March 2025 and additional 1068 users will equate to 71% of nursing and midwifery users. All the other controls remain the same.
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	1	No change	0	Actions listed with future due dates	[03/01/2025] New Corporate Risk approved at CMT and Trust Board in Nov 2024.
Quality of care	1647	Director for Primary Care and Older People	Risk of disruption to the Trust's contracted out domiciliary care services as result of new procurement exercise	20	Extreme	20	Extreme	9	high	5	Low	To be reviewed at next Trust Board Workshop	0	No change	0	Actions listed with future due dates	[15/01/2025] Actions re implementation plan and transition team updated from end of January 2025 to mid-February 2025 following extension of the tender closing date.
Regulation & Compliance	1423	Executive Director of Social Work/Director of Women & Children Services	Human Milk Bank - Does not meet Governance and Information requirements	12	MEDIUM	12	MEDIUM	1	Green	5	Low	To be reviewed at next Trust Board Workshop	0	N0 change	0	Actions listed with future due dates	[20/01/2025] This risk was amended from a Directorate Risk to a Corporate Risk as per CMT and Trust Board approval o 07.01.25 [04/11/2024] New tracking system was ordered from Savant on 15.10.24. Framework time for delivery and installation is approx. 12 weeks. Future meetings to be arranged with Lead Nurse, Public Health, Trust ICT and Savant regarding roll out.
Quality of care	1653	Director of Diagnostics, Cancer and Medical Specialties	NSTEMI IN ED	20	Extreme	20	Extreme	10	MEDIUM	5	Low	To be reviewed at next Trust Board Workshop	0	No change	0	Actions listed with future due dates	[22/01/2025] Non ST Elevation MI (NSTEMI) Patient in emergency department was approved as a Corporate Risk at Trust Board on 7th January 2025

		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
1	19/11/08	20	Extreme (Red)	15	Extreme (Red)	8	High (Amber)	Director of Performance & Service Improvement	Planning & Performance - Facilities Management	Safe & Effective Services.	Fire Risks	As a result of the nature, use and condition of Trust owned, leased, occupied or unoccupied premises there is a risk of fire which could result in injury or death to staff, clients or public, damage to property, financial loss or loss of service.	Fire Safety Policy, procedures and manual. Including: Site specific fire emergency plans for SWAH and ALT. Departmental fire procedures in place for all areas. Staff Training and awareness. Mandatory Fire Safety awareness training. Recording and reporting of Fire Safety Mandatory Training Nominated Officers appointed and trained. Reporting of all fire incidents, unwanted fire alarms. Regional Fire Managers Group Nominated Officer Fire Safety Log Books Trust Fire risk assessments Recommendations from Resulting fromInspections of Regulatory bodies e.g. NIFRS and RQIA. Fire Safety Controls Assurance Standard action plan. Regular fire drills and emergency exercises Fire improvement works All Trust fire safety advisors to	Not all staff are trained in mandatory fire safety awareness training. Potential exists for Premises to be operational without a Nominated Fire Officer in the Department Regional Group meetings are infrequent Not all Fire Risk Assessment are completed within designated Timeframe. Target is 100% Infrequent Drills due to competing Pressures. Financial Constraints Competing priorities Ageing Estate and deteriation of physical infrastructure Working with service to ensure service delivery/care is not impacted. Not all Directorates have included fire on their directorate risk register. Current risks not aligned to the corporate risk ID01. Systems are currently not in place for annual attendance at Directorate SMT's.	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. Learning is cascaded both locally and regionally. Oversight over regional learning and good practice To ensure that nominated fire officer are aware of their fire safety responsibilities in each department/premises.	Accuracy of Learn HSCNI reporting of mandatory training compliance Potential Exists for Premises to be operational without a Nominated Fire Officer in the Department None adherence to Learning Incomplete Documentation within fire safety log books Failure to sustain recommendations on a long term basis Failure to	Emergency Lighting replacement Implement fire safety improvements Implement Fire Safety Improvements -18/19 NIFRS to speak with clients implement fire safety improvement works 17/18 Fire safety objectives review for 16/17 Fire Safety Report 15/16 Priority list of firecode works to be prepared Fire Improvement Works 14/15. Implementation of Directorate Action Plans. Fire Improvement Works 15/16 Hospital Fire Storage Working Group to be set up Working Group to be established to Review Inappropriate draining of Medical Gas Cylinders leading to a Fire/Explosion risk Review storage under Ward 31/ 32 stairwell Implement elearning fire safety training Head of SS and Fire Manager to	31/03/2021 31/03/2021 31/03/2019 30/09/2018 31/03/2018 30/06/2016 30/06/2016 31/07/2016 31/03/2015 31/12/2015 31/03/2016 31/03/2024 30/04/2024 30/06/2024 30/09/2017 31/03/2025 31/03/2024 31/03/2017 03/01/2024 31/12/2023 31/03/2021 31/03/2023 30/06/2022 25/04/2022 31/03/2025 30/09/2024 21/12/2022 30/06/2023
6	21/09/09	25	Extreme (Red)	12	High (Amber)	8	High (Amber)	Executive Dirctor of Ocial Work/Director of Women & Children's Services	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&CCADs and Director. Performance Management Review is being undertaken by HSCB with all 5 Trusts focusing on Unallocated cases and timescales Early Help staff returned to their substantive posts within gateway to increase the ability to allocate Principal Social Work redeployed will monitor Action Plan and progress to stabilise team Service Managers and Social Work Managers monitor and review unallocated cases on a weekly basis. Service and SW Managers constantly prioritise workloads.	Inability to get sick leave covered inability to recruit and retain social workers Principal Social Workers review unallocated cases regularly HSCB have drafted a regional paper to secure additional funding for Unallocated Cases. Delays in recruitment	Feedback given to Performance & Service Improvement for accountability meetings with HSCB. Quarterly governance reports to Governance Committee. Up-dates by Director to CMT and Trust. Action Plan to review and Address Risks within FIS Enniskillen Delegated Statutory Functions	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 towards closure Principle practitioner allocated cases to complete work and	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

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

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1183	27/11/19	25	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, patients may be deprived of their liberty, without having safeguards in place	Where MCA processes are not being followed, there is the risk that patients may be deprived of their liberty, without having the relevant safeguards in place, with the result that individual staff may be held criminally liable with appropriate sanctions, including financial penalties and imprisonment. For patients that lack capacity and for whom safeguards are not in place, there is the risk that statutory services may not be delivered. Emergency provisions should be considered where deemed appropriate, to support continuing service delivery until the safeguards are approved. Where emergency provisions apply, fully authorisations are required to be urgently followed up. The Department of Health, requires H&SC Trusts to proceed with a partial implementation of	Staff training is available online & classroom, provided by Trust Trainers. Progressing interactive online training via VC. Training videos developed MCA resources are available via MCA HUB on StaffWest DOLs office supports administration processes, including advice to support completion of forms Staff training is available via eLearning as well as from CEC. Training available online & classroom, provided by Trust Trainers. Progressing interactive online training via VC. Emergency provisions to be used, where deemed appropriate, to support continuing service delivery until the safeguards are approved. Directorate resource to support Directorate related MCA activity	Medic capacity to ensure timely completion of relevant forms and availability to sit on Panels Funding not adequate to deliver the projected activity. Funding not provided recurrently, compounding recruitment issues Assurance that there are timely completion of MCA processes following use of Emergency Provisions community teams staffing issues resulting in anallocated caseloads Timing of progression to the introduction of the second phase of MCA legislation is yet to be confirmed. Review of requirement for DolS in Special Schools Structures to be developed to ensure relevant identification and completion of STDA processes within Acute settings Review of administration systems and Processes re interaction with NIRT	First Line of Assurance STDA Operational Group MCA Team, including Supervision MCA Information T&F group (systems, processes & reporting) Training T&F group Second Line of Assurance Updates to Trust Board Corporate Risk Internal Audit Third Line of Assurance MCA Legislation / Code of Practivce Mental Health Order Role of General Attorneys Office Role of Northern Ireland Review Tribunal SPPG Regional monthly activity reporting Role of RQIA MCA Regional Leads Group MCA Miltiagency Group (NIRT, AG, RQIA, DLS, SPPG, MCA Leads MCA Project Board	Systems, Processes & Reporting to be strengthened & formalised - Encompass is the Regional Direction, Western Trust go live is April 25 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 Seek Interest from Nurses at Band 7 and above to sit on panels.	31/12/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2020 29/10/2021 31/03/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2021 30/07/2021 28/06/2024 30/06/2023 31/03/2023 28/03/2025 30/04/2024 30/11/2022 30/11/2022 31/03/2024 31/03/2025 30/06/2024 30/06/2024 31/03/2025 31/03/2025 30/11/2022 30/11/2022
1216	15/04/20	15	Extreme (Red)	15	Extreme (Red)	6	Medium (Yellow)	Director of Diagnostics, Cancer and Medical Specialities	Acute - Emergency Care & Medicine	Public Confidence., Safe & Effective Services.	Risk of patient harm in Trust EDs due to capacity, staffing and patient flow issues	If Emergency Department (ED) Physical capacity and staffing levels are not sufficient to meet the demands of patient numbers and acuity, there will be increased likelihood of significant patient harm, risk to staff wellbeing and damage to Trust reputation as a direct result.	Business case approved dedicated HALO (Hospital Ambulance Liaison Officer NIAS crews waiting to offload in our hospital early warning score Ongoing Trust recruitment focus on Critical posts IE Medical and Nursing Use of Medical locums/ Bank and agency Nurses. Social Media Campaign Escalation protocol within full capacity protocol Nursing KPI and audit (ALAMAC) Ongoing in house Quality improvement work (implementation of SAFER principles) Daily regional huddle meeting with escalation as required IT systems - Symphony Flow board On call managers/medics rota Ongoing MDT patient flow huddles in department/wards Medical team ED reviews Hub flow meetings with lead nurse attendance.	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 31/01/2025 28/02/2022

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1219	30/04/20	20	Extreme (Red)	20	Extreme (Red)	6	Medium (Yellow)	Director of Diagnostics, Cancer and Medical Specialities	Acute - Diagnostics & Cancer Services	Safe & Effective Services.	Lack of endoscopy capacity for endoscopy to meet the demand which impacts on Patient outcomes	Lack of endoscopy capacity, 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	Band 4 team lead recruited to manage waiting lists and oversee the scheduling team and processes. Encourage consultants to triage referrals in line with NICAN suspect cancer guidelines (Oct 2019) and utilise the urgent and routine categories. Additional funding for a second pre assessment nurse has been discussed with the commissioner- await confirmation in 2021 allocation	Waiting lists discussed monthly at the Endoscopy Users Group Clinical audits are completed annually to benchmark the service against National Standards. Monthly monitoring of waiting lists is carried out to identify longest waits and prioritise for scheduling.	The need for the Trust to invest further in the development of GI Trainees in line with the evidence base for modernisation, thereby proactively growing the team to meet future demand. The need to develop the service to include the inclusion of a hepatologist as part of the team in line with Royal College modernisation of	Explore the possibility of utilising the Independent Sector to address waiting lists. Need to review GI consultants job plan to reduce General Medicine commitment to increase availability for endoscopy lists. Secure funding for an additional pre assessment nurse to support list utilisation and reduce DNA rates. Recruit 2 trainee nurse endoscopist Recruitment of a further GI consultant to fill present vacancy and increase the medical team to 6 wte.	05/10/2021 30/10/2022 30/04/2023 30/06/2023 31/12/2024
1236	21/08/20	16	High (Amber)	16	High (Amber)	6	Medium (Yellow)	Excutive Director of Finance, Contracts & Capital Developme nt	Finance	Ensuring Stability of Our Services	Stabilisation of Trust Financial position	In 2024/25 the Trust has opened with a forecast deficit of £59m as a consequence of a poor budget settlement for HSC in 2024/25, unfunded demographic growth in 2023/24 and 2024/25 and a recurrent reduction to Trust baseline budget in 2023/24 of £24.1m without effective time to enable planning and implementation of recovery actions. The Trust has complied with its obligations to provide a Financial Plan and Contingency Savings Plan for 2024/25. The Trust has effectively communicated it's ambition to deliver £24m of low and medium impact savings in 2024/25 which results in a deficit of £35m. SPPG have provided £31.5m of deficit funding to the Trust leaving a deficit of £3.5m and an expectation that this balance can be found from savings. The Trust have not accepted this position. There are	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

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1254	18/01/21	16	High (Amber)	16	High (Amber)	8	High (Amber)	Director of Human Resources & Organisational Development	Trust-wide (Risk Register use only)	Ensuring Stability of Our Services, Improving the Quality and Experience of Care, Supporting and Empowering Staff	Inability to deliver safe, high quality and sustainable services due to workforce supply and disruptions	Due to an inability to attract, recruit and retain staff throughout the Trust, services may not be able to maintain sufficient staffing levels to sustain high quality safe services which may result in a reduction in service provision.	Trust Business Continuity Plans with full HR support on hospital / community workforce groups. Delivering Care: Nurse Staffing in Northern Ireland Organisation Development Steering Group Health and Wellbeing Strategy Engagement & Involvement Strategy DOH Workforce Strategy & Trust Workforce Strategy and key actions Policies - Rec & Selection Framework, Attendance at Work, Flexible Working, Redundancy and Redeployment, etc. HR Strategic Business Partner identified for each Directorate - targeted interventions in relation to absence, agency usage, temporary staffing and other identified Directorate priorities. (Risk 6, 1075) Pension information sessions Joint Forum, Joint LNC and Consultation Group Workforce Information reports	Occupational Health - absence of locums and increasing demands on team without additional resources. Low uptake of mandatory training and completed annual appraisal. Inability to follow normal policies and procedures during periods of Industrial Action and also during emergency situations such as Pandemic. Lack of co-ordinated information on agency staffing Due to demand in services compliance with Working Time Regulations and New Deal. BSO Recruitment Shared Service provides recruitment services for the Trust and there has been an increased delay in recruitment and dependence on them for related information. Inability of NIMDTA to provide required number of Junior Doctors for certain specialities and localities. (Risk 694) Difficulty in recruiting in rural	Working Together Delivering Value Health check measurements on absence hours lost, mandatory training, appraisal, time to fill posts, job planning completion rate. Involvement Committee - Quarterly monitoring of staff engagement on initiatives that contribute to achievement of Trust Great Place ambitions (start life, live well and grow old). Pension Regulator Compliance Junior Doctors Hours monitored twice yearly and returns submitted to DOH. People Committee - Workforce Strategy, Recruitment and NIMDTA Allocation Updates twice per year. People Committee - Quarterly monitoring of Absence, Appraisal, Mandatory Training, Consultant Job Planning, Temporary Staffing, Agency Staffing, Turnover and Grievance/Disciplinary/Statutory Cases.	BSO Shared Service not meeting statutory or procedural deadlines resulting in, for example, delays in recruitment Inability of NIMTDA to fill all posts. Insufficient number of social work student applications to the University Degree Course in rural areas. (Risk 1109) Insufficient training places being procured by Department of Health to meet the	Looking After our People Growing for the Future Belonging to the HSC New Ways of Working	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 Performance & Service Improvement	Trust-wide (Risk Register use only)	Ensuring Stability of Our Services, Improving the Quality and Experience of Care	Risk of failure to meet regulatory standards and compliance associated with Trust infrastructure and estate.	There is a risk of deterioration in the Trust Estate due to ageing and lack of capital investment in the maintenance of building services infrastructure and physical environment which could lead to loss of service and non-compliance with regulatory and statutory standards (e.g. water, electrical, asbestos and physical infrastructure).	Monitoring and review by PSI SMT of directorate risks including water, electrical, fire safety, vacant estate asbestos and physical infrastructure. Should a critical issue materialise further funding can be sought from DOH or existing funding reprioritised to address the new critical issue Estates Strategy 2015/16-2020/21 Annual review of building condition (3i) and creation of prioritised BLM list. 2022/23 Backlog maintenance programme developed and implemented Continual bidding for funding to address backlog maintenance Targeting of priority areas as funding becomes available. Monthly review of Backlog Maintenance capital investment plan Priority Backlog Maintenance capital investment plan 2024/25 Backlog maintenance	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	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 31/03/2025 30/04/2024

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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 2nd On-call Rota Dec 24 & Jan 25	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 Not always someone available in SWAH for a 2nd On-call Rota due to the small number of Trust Drs living in this area.			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 31/03/2025 31/03/2025
1320	15/09/21	12	High (Amber)	20	Extreme (Red)	8	High (Amber)	Executive Dirctor 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.	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.	31/03/2025 31/03/2025 31/03/2025 31/03/2025 31/03/2025 31/03/2025 31/05/2023 31/05/2023 31/05/2023 31/05/2023 31/05/2023

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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)	Due date
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 highlighted that emergency surgical services are at risk within the next 4 months due to inability to sustain a Surgeon of the Week and On-call emergency rota at consultant level	Trust have authorised a Sustainable Surgical Services project to examine surgical services pan-Trust wef 18/10/21 Recruitment campaign is continuous at Speciality Dr and trainee level. Funded establishment should be 6.5 wte consultant Surgeons - current baseline is 3.0 wte with 3.5 wte gap Specialty Drs funded for 8.0 wte; 5.0 in place 2 of whom are locums and one acting up. Ongoing use of locums from within the Trust to sustain the rota at South West Acute. Newly appointed Consultant taking up post 25/10/21 Ongoing efforts to recruit - Interviews planned for 2.0 wte Consultants late October 2021 (now currently deferred pending Royal College approval)	Reluctance from other surgeons across NI to participate in providing locum cover due to the generality of surgical cover required. Difficulties recruiting and retaining at locum and permanent level as above. Difficulty securing Royal College approval for general surgical posts.	Continuing support from Altnagelvin Surgical body to provide locum cover for rota gaps. Programme Board will have fortnightly oversight of all of the actions within the Review Programme. Senior clinical support to project identified and in place. Project lead has been seconded full time to Project team. Project Lead currently briefs CMT twice weekly This will be taken over by Programme Board with fortnightly oversight from 01/11/2021 CMT will continue to support service and project		A Proposal for Sustainable Surgical Services will be developed by end January 2022 to address the most emergent issue eg emergency surgical services in the Southern Sector of the Trust. Continue with ongoing recruitment to fill vacant consultant posts Develop plan for the release of locum surgeons to align with on boarding of recent consultant surgeon appointees, when start dates confirmed Ongoing monitoring of the temporary suspension of emergency surgery and contingency arrangements in place, through the Project Team	01/09/2023 31/03/2025 31/03/2025 31/03/2025
1409	01/07/22	25	Extreme (Red)	16	High (Amber)	9	Medium (Yellow)	Director of Diagnostics, Cancer and Medical Specialities	Acute - Unscheduled Care	Ensuring Stability of Our Services, Improving the Health of Our People, Improving the Quality and Experience of Care, Supporting and Empowering Staff	ED Mental Health Patients	Due to lack of local and regional mental health beds patients requiring mental health assessment and admission are required to stay in the department for prolonged periods, with minimal mental health input. Voluntary and detained patients at high risk of harm due to lack of suitable staffing, supervision and infrastructure onsite. The department is overwhelmed with multiple patients awaiting admission some have already absconded and/or attempted self harm while awaiting transfer or identification of a Mental Health bed due to inadequate supervision.	-Crisis/MHL will review all patients every 24 hours and liaise with psychiatry as required -ED will complete Kardex's – Psych Consultants will be available for advice if needed -Additional staffing support when available from Mental Health Grangewood to ED when a threshold of three or more has been reached. -Weekly meetings planned for ED and Mental Health to work collaboratively to improve the safety and experience for patients (commenced 16th June 2022). -Continue to report and review all associated incidents via datix to further understand risk and mitigations -MAPA training	-Timely access to Mental Health beds continue -Overall congestion and capacity issues within ED compounds the challenge in managing this group of patients	Daily engagement with MH and ED to manage risk Newly established weekly meetings between ED and mental health teams		Meetings Workforce Improvement Meetings	03/07/2023 31/12/2024 31/12/2024

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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)	Due date
1423	17/08/22	12	Medium (Yellow)	12	Medium (Yellow)	1	Low (Green)	Medical Director	Childrens Health & Disability	Ensuring Stability of Our Services, Improving the Quality and Experience of Care	Human Milk Bank - Does not meet Governance and Information requirements	The Trust is required to keep a tracking system of all Donor Expressed Breast Milk (DEBM) from donor right through to recipient for a period of 30 years. This is currently managed using a manual paper system. Paper label (track back labels) with a 'Batch Number' are attached to each batch of milk distributed to individual hospital units. The recipient unit then records what infant received which batch of milk on the track back label and posts back to the Human Milk Bank. Milk Bank staff then record the infants' details against each batch number on a manual spreadsheet. Track Back labels are then stored in the T&F Hospital secondary storage facility. Individual units do not always return this information which results in gaps in information we hold on file. In addition, over time the track back labels become illegible eg ink fades, paper clips rusting and	remind units of requirements to return all back track labels on a regular basis Continue to use manual system to record Store back track labels in sealed envelopes to preserve store in dry and secure secondary storage	Capacity within secondary storage remains an issue no alert system in place for outstanding return of track back labels from receiving units	Recent audit completed of all returned track back labels for quality	Last audit of paper records in secondary storage carried out in 2017	Develop Business Case Secure Funding ROI Units Training of staff	31/12/2022 30/06/2023 31/12/2022 30/06/2023
1469	06/01/23	12	High (Amber)	12	High (Amber)	4	High (Amber)	Director of Human Resources & Organisational Development	Trust-wide (Risk Register use only)	Supporting and Empowering Staff	Health & Safety Risk to Staff as a result of Violence and Aggression	Increases in the number and complexity of patients being treated and awaiting treatment in all our settings; along with social; economic; and environmental factors; restrictive guidelines / practices resulting from Covid etc; increased social media challenges; and the absence of a Corporate legal remedy; have all contributed to an already high level of abuse, violence and aggression against Trust staff. The result is that staff are increasingly subjected to both sporadic and longer consistent patterns of patients/client/visitors displaying abusive, challenging, aggressive and violent behaviours in our facilities, communities and home environments leading to significant risk of emotional and physical harm.	Management of Violence and Aggression (MOVA) group in place. Zero Tolerance & Security policy Trust adherence to The Management of Health and Safety at Work Regulations NI (2000). Health and Safety at Work NI Order 1978 Lone Working Guidance Staff support through Occupational Health Safety Intervention training - available to relevant staff. V&A risk assessment. Usage of Trust General Risk Assessment form for document of specific risks. Incident reporting on DATIX – identification of trends. Risk Register process in place RIDDOR reporting of staff absence and further scrutiny Policy for the Use of Restrictive Interventions with Adult Service Users – May 2017 Trust Security Working Group Ad hoc Risk Strategy Meetings	MOVA Policy - Await implementation of regional guidance Limited Legal support available for staff from the Trust when seeking prosecutions/non-molestation orders against violent individuals. No Acute Liaison Psychiatry service in ED No programme of regular education regarding mental health presentations in ED and other acute settings of risk. CAMHS referral pathways not clarified for patients aged 0-18. CAMHS not co-located in hospital. No dedicated area for intoxicated or consistently violent patients to be treated in ED. Lack of resource to provide safety intervention training following CEC cessation of training provision. Paris alert system not utilised in all areas to warn staff regarding patients with a history 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	31/03/2025 31/03/2025

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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)	Due date
1487	06/04/23	20	Extreme (Red)	20	Extreme (Red)	8	High (Amber)	Director of Surgery, Peadiatrics and Women's Health	Human Resources	Ensuring Stability of Our Services, Supporting and Empowering Staff	Impact on services as a result of Industrial Action in relation pay, safe staffing and travel rates.	Impact on services as a result of ongoing Industrial Action, including both strike action and action short of strike, taken in relation to Agenda for Change (AFC) pay, safe staffing and travel rates (AFC staff make up 94% of overall workforce) and also Junior Doctor Pay.	Trust compliance with Agenda for Change Terms and Conditions of Services. TU Side engagement with local and regional representatives regarding derogations and service level planning for service delivery on the basis of agreed derogations. Command and Control Silver and Bronze arrangements in place including arrangements for escalation of risks and issues to Health Silver through SPPG and DOH. HR Industrial Action Group established to work closely with Services on IA plans, development of derogations and negotiation with Trade Unions. Business Continuity Plans have been updated and impact assessments completed to identify specific risks as each notice of action is received. Business continuity plans implemented to adapt service delivery in light of ASOS and	Service impacts over a prolonged period of time of Industrial action. Postponement and rescheduling of appointments increasing delays for patients on waiting lists. Increasing unallocated cases across a number of areas i.e. nursing, social work. Vacant/uncovered cases not worked unless immediate risk to life and limb harm accepted by Trade Union representatives. Not able to make the necessary improvements in statutory requirements for review Compromising ability to meet statutory social work responsibilities for children i.e. delays in permanency planning, presentation to Trust Adoption Panel, Court timescales, etc. Impacting on consistency of social work input to inform planning processes for children e.g. child protection, looked after children and family support	Trust is in line with NHS Terms and Conditions of Service. Partnership Working with TU Side. Regular engagement with DoH to influence e.g. mileage rate.	Pay discussions in NI are led by Department of Health however the dispute in relation to the 2022/23 pay award is being managed by Government at Westminster and there is no capacity for the WHSCT to influence resolution of dispute. Absence of Health Minister to engage with this. Outstanding Pay Awards for all staff.	Resolution of local issues Plans to address continued service impacts Continued engagement with local and regional TU Side representatives on derogations. Implementation of Business Continuity arrangements	31/03/2025 31/03/2025 31/03/2025 31/03/2025
1601	11/06/24	16	High (Amber)	16	High (Amber)	8	High (Amber)	Director of community & Older People's Services	Surgical Services		Inability to retain ENT Head and Neck service provision	The ENT service in the Western Health and Social Care Trust is funded 6 WTE consultants. 4 consultants in post. 2 vacant post currently filled with Locum. One head and neck consultant who has retired on the 6th September 2023. This consultant managed both complex cancer and benign head & neck conditions, including thyroids. This Consultant returned following retirement for a short period (September to December) on a bank contract. Moving forward this surgeon is no longer available. The Trust has previously tried to recruit a 2nd Head and Neck cancer consultant 4 times nationally and 3 times internationally with no success since 2019. Currently 2 benign Head and Neck with interest in thyroid surgery consultant and general ENT consultant posts re advertised via IMR and global recruitment					Recruitment of head and neck consultant x 2 Potential Service delivery redesigns Formal Pathway to be agreed with Belfast Trust and Western trust regarding transfer of patients Formal lookback to be undertaken in relation to patients underwent thyroid surgery in trust and via IS provider in relation to patient care and management for the last 2 years	31/03/2025 30/03/2025 31/03/2025 31/01/2025

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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)	Due date
1602	11/06/24	16	High (Amber)	16	High (Amber)	12	High (Amber)	Director of Performance & Service Improvement	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
1612	22/07/24	10	High (Amber)	10	High (Amber)	8	High (Amber)	Director of Adult Mental Health & Disability 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 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.	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	30/04/2025 30/04/2025 30/04/2025 31/03/2025 30/04/2025 19/12/2024 31/03/2025 30/09/2024 30/11/2024 30/07/2024

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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)	Due date
1629	19/09/24	9	Medium (Yellow)	9	Medium (Yellow)	6	Medium (Yellow)	Director of Nursing, Midwifery and AHP's	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	•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 31/01/2025 31/01/2025 31/01/2025
1647	21/11/24	20	Extreme (Red)	20	Extreme (Red)	9	Medium (Yellow)	Director of Adult Mental Health & Disability Services	COP - Intermediate Care & Rehabilitation	Ensuring Stability of Our Services, Improving the Quality and Experience of Care	Risk of disruption to the Trust's contracted out domiciliary care services as result of new procurement exercise	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	Project Management & Implementation Plan DLS & BSO PaLS support Contract monitoring & management Meetings with providers Close links with social work staff who are the key workers for our clients	No gaps identified.	Regulated service with RQIA and subject to regular inspection. Internal audit inspections. Contract management	No gaps identified.	Implementation plan to be developed once tender outcomes are known Dedicated tender transition team to be identified	14/02/2025 14/02/2025

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1653	09/12/24	20	Extreme (Red)	20	Extreme (Red)	10	Medium (Yellow)	Director of unscheduled care, cancer and diagnostics	Acute - Emergency Care & Medicine		NSTEMI IN ED	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. Beds in ward 22 are not available due to site pressure demands. We have 10 beds which should be for Cardiology patients in ward 22 and on average we have only 2-3 patients there at any one time.						
1656	12/12/24	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. •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						

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1657	12/12/24	20	Extreme (Red)	20	Extreme (Red)	8	High (Amber)	Director of Adult Mental Health & Disability Services	AMHDS - Adult Learning Disability	Ensuring Stability of Our Services, Improving the Health of Our People, Improving the Quality and Experience of Care, Supporting and Empowering Staff	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						