TRUST BOARD ITEM: BRIEFING NOTE

Meeting Details:	1st May 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 to consider Material changes; • ID 1602 – Proposal to close risk – briefing note attached. • ID1320 – Proposal to de-escalate to Directorate Risk Register of Children and Families – briefing note attached. Action summary; • All actions have been reviewed within previous quarter.

Trust Board Response Required *(please tick)*	X For approval ☐ To note ☐ Decision

Western Health and Social Care Trust

CORPORATE RISK REGISTER & ASSURANCE FRAMEWORK

BRIEFING NOTE PREPARED FOR TRUST BOARD 1ST MAY 2025

There are 24 risks on the Corporate Risk Register as approved at Trust Board 3rd April 2025.

Summary

- Proposed New Risks;
  - No new risks to consider
- Material changes;
  1. ID1602 – Risk of no GP cover in Trust managed GP practices – proposal to close risk. Briefing note attached.
  2. ID1320 – Delayed/Inappropriate placement of children assessed as requiring inpatient mental health care. Proposal to de-escalate to Directorate Risk register of Children and Families Directorate. Briefing note attached.
- Summary report for action;
  - No items to consider

Proposed New Risk

- No new risks to consider

Material Changes;

1. ID1602 – Risk of no GP cover in Trust managed GP Practices - proposal to close this risk based on following update;

- Risk 1602 was originally added to the Corporate Risk Register as a result of no GP locum cover in the 4 Trust managed GP Practices in the period May to August 2024.The Assistant Director, Primary and Community Care, advised the Directorate's Governance Meeting on 13th March 2025 that all GP rotas for Trust-operated GP Practices were fully populated until the end of September 2025, with full cover in place over the summer period and subsequently, this risk could be removed from the directorate and corporate risk registers.

Responsible Director: Director of Community & Older People's Service

2. ID1320 – Delayed/Inappropriate placement of children assessed as requiring in patient mental health care.
   Risk ID1320

- Serious challenges with respect to WTCAMHS timely access to the Regional Adolescent Mental Health Inpatient unit with secondary impact on the network were discussed with respect to rational for initial escalation of risk.
- Discussion with respect to measures that have been employed by Regional MH adolescent unit to mitigate risk and provide a revised pathway to support and ensure timely access to YP presenting with a mental health emergency requiring admission for assessment and inpatient treatment.
- WTCAMHS remains cognisant of pressures pertaining to workforce stabilisation and clinical acuity within the regional unit that said timely access through admission to the regional unit has been facilitated when required preventing secondary inappropriate admission to medical wards over the past 6 months. Assurances in place to mitigate risk by Beechcroft in tandem with collaborative community CAMHS assurances and positive working relationships is supporting timely access.
- Consideration for risk to be de-escalated is requested.

Responsible Director: Executive Director of Social work/Director of Children and Families

Summary Report for Action;

- All action plans have been reviewed within previous quarter.

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				
1216	Directorate of Unscheduled Care, Medicine,	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	HIGH	Low (target score between	

	Cancer and Clinical Services		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 * Update Deep Dive will now take place in June 2025		1 -6) Current Target score 6	
1307	Director of Surgery, Paediatrics and women's Health	Clinical Risk regarding delayed transfer of babies, children and adults to other hospitals	Trust board agreed to; 1. Keep tolerance and risk appetite as is. 2.Risk owner to continue to develop and progress actions listed required by Trust	HIGH	Low (target score between 1 -6) Current Target score 6	
1320	Executive Director of Social Work/Director of Family and Children Services	Delayed/inappropriate placement of children assessed as requiring inpatient mental health care	Trust Board agreed to; 1.Current tolerance and risk appetite to remain as is, and risk owner to keep risk under review	HIGH	Moderate (target score between 8-12) Current target score 8	
1487	Director of Human Resources & Organisational Development	Impact on services as a result of industrial action in relation to outstanding agenda 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	HIGH	Moderate (target score between 8-12) Current target score 8	Completed – risk rating changed April 2024

			approved by CMT in March 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 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	
1288	Director of Performance	Risk of failure to meet regulatory standards and compliance	Trust Board agreed to;	HIGH	Low (target score	Completed

	& Service Improvement	associated with Trust infrastructure and estate.	1.Current tolerance and risk appetite to remain as is		between 1 -6) Current Target score 6	
1236	Director of Finance, Contracts and Capital Development	Ability to achieve financial stability, due to both reductions in Income and increased expenditure	Trust Board agreed to; 1. Current tolerance and risk appetite to remain as is. 2.Risk to be kept under review by risk owner	HIGH	Low (target score between 1 -6) Current Target score 6	
1409	Director of unscheduled care, medicine, cancer and clinical services	ED mental Health Patients	Trust Board agreed to; 1.Set risk category as quality of care – patient safety 2.Set tolerance as HIGH and risk appetite as LOW with target score between (1-6) Risk owner to review target score to reflect this. 3.Risk owner to keep this risk under review	HIGH	Low (target score between 1 -6) Current Target score 9	
1469	Medical Director	Health and Safety Risk to staff as a result of Violence and Aggression	Trust Board agreed to; 1.Set tolerance of this risk as LOW, to be reviewed as a DEEP DIVE to be 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-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 24/04/2025

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, Planning and Corporate Services	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.	10	No change	0	Actions listed with future due dates	[04/04/2025] SWAH - A meeting to be arranged with NIFRS and NIHG/ Mitie in order to reassure NIFRS of the appropriateness of existing mitigations.
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	43	No change	0	Actions listed with future due dates	[10/04/2025] Due to capacity and demand issues within Family & Childcare, children may not always be allocated a Social Worker in a timely manner and it is likely that children may experience harm as a result of Trust staff not being able to provide appropriate support and implement safe plans.
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, Planning and Corporate Services	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	13	No change	0	Actions listed with future due dates	[09/04/2025] Internal Audit has given the Trust a Satisfactory rating for the Security of Acute Records (across Northern and Southern sectors). Senior IG staff have been trained in the use of Privacy Tools, ahead of encompass Go Live. ICO has been formally notified of potential delays to FOI/SAR responses during the Go-Live period.
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.	16	No change	0	Actions listed with future due dates	[10/04/2025] Actions updates - timeframe to complete scoping to DoLS in special schools extended to Mar26; recruitment plan for 25/26 updated. 2PA funding provided to support MCA Medic Leads. Action added re plan to support Encompass go Live.
Quality of Care	1216	Director of unscheduled care, medicine, Cancer and Clinical Services	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	32	No change	0	Actions listed with future due dates	[10/04/2025] Work ongoing to split the ED risk 1) ED environment in Altnagelvin and 2) the hospital flow risk re DTA's.
Regulation & Compliance	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	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	32	No change	0	Actions listed with future due dates	[10/04/2025] 7/04/2025 To be reviewed in June 2025 to consider if risk can be downgraded to directorate level. Job plan discussions are ongoing to avoid the negative impact on endoscopy sessions delivered by surgeons, to be completed by 30 April 2025. Three consultants were in training, one completed training 7th March 2025, the two remaining consultants have a possible completion date of 30 April 2025 and 30th June 2025. Three nurse endoscopist trainees, two will complete training by end of August 2025 and one by August 2026. Utilise capacity from ISP when funding becomes available and endoscopy regional DPC in Lagan Valley and Omagh.

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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
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	15	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. The Trust has complied with its obligations to provide a Financial Plan and Contingency Savings Plan for 2024/25. The Trust had effectively communicated it's ambition to deliver £24m of low and medium impact savings in 2024/25 which resulted in a deficit of £35m. SPPG provided £31.5m of deficit funding to the Trust leaving a deficit of £3.5m. The Trust completed the mid year assessment of the financial plan and taking into account new cost pressures, non recurrent opportunities and the lower than planned MORE savings, the Trust deficit was subsequently revised to £1.345m. The Trust repeated the comprehensive review of the financial plan in November 24 and whilst the Trust continues to be challenged in relation to expenditure and with some work-streams in our savings plan, the Trust has benefited from increased income above levels originally indicated and is therefore in a position to manage to deliver a break-even position. There are a number of risks: i. Unfunded demographic growth resulting in increased financial pressures above forecast; ii Sustained levels of escalation of operational capacity in our acute and mental health hospital setting; iii. Achievement against savings targets.
Quality of Care	1254	Director of Human Resources & 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	31	No change	2	Actions listed with future due dates	[19/02/2025] Bespoke recruitment events ongoing where required i.e. Nursing Assistants, Adult Learning Disability, Homecare and Supported Living. Enniskillen still remains a challenging location to fill vacancies. Admin Band 2 and Band 3 are also difficult to recruit to Trustwide. ERST are considering hosting a Western Trust careers day in Enniskillen promoted via Social Media.
Regulation & Compliance	1288	Director of Performance, Planning and Corporate Services	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	32	No change	0	Actions listed with future due dates	[04/04/2025] Delivery of BLM schemes now completed for 24/25. A number of scoping exercises are being undertaken to develop the 25/26 BLM plan.
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	32	No change	0	Actions listed with future due dates	[03/04/2025] Whilst the NISTAR rota still has vacancies it has improved from the December/January rota, with most improvements noted in the Neo Natal tier. A second consultant has been called in to cover, while NISTAR were unavailable. We had challenges in getting the transport ventilator attached to the transport incubator in the SWAH. This will be resolved when the works are completed in April.
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	36	No change	0	N/A	10/04/2025 Proposal to de-escalate to be considered by CMT 15.04.25

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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	22	No change	0	Actions listed with future due dates	[09/04/2025] [07.04.2025] - At present there are 18 Consultants inclusive of the 4 Breast Consultants who provide a Trust wide service across all of our sites. All new consultants are recruited on a Trust wide contract basis and our existing consultants have all been job planned to deliver services across ALT,OHPCC & SWAH. There are 2 further consultants for which we are awaiting start dates - it is envisaged that these will both take up post in late May 2025. This will bring our total consultant body within General Surgery to 20wte within the coming months. As a result of this recruitment there is now consistent weekly IP and Daycase Sessions within the SS - OHPCC - 8 weekly Daycase Sessions and SWAH - 4 weekly IP Sessions and 7 Weekly Daycase Sessions. Outpatient sessions across the southern sector are also now being reviewed to increase to 7 Outpatient Clinics per week in OHPCC and 4.5 Clinics per week in SWAH. Due to the number of sessions across each site there is a consultant on site in our Sothern Sector on a daily basis. Within our Staff Grade level recruitment also took place and we have now filled out positions Trust wide allowing for the removal of any dependency on Agency. Service are now viewing the ROTA for this grade of staff Trust wide to allow for rotation also across our sites.
Quality of Care	1409	Director of unscheduled care, medicine, Cancer and Clinical Services	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	27	No change	0	Actions complete - consider for de-escalation/ closure	[10/04/2025] 07/04/2025 - commencement of the side by side project in ED SWAH from 28/05/2024 and ED ALT from March 2025- additional beds in Rathview House will see a reduction in Mental health patients waiting in either ED.
Health & Safety	1469	Medical Director	Health & Safety Risk to Staff as a result of Violence and Aggression	12	HIGH	16	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.	1	4	0	Actions listed with future due dates	[10/04/2025] Risk rating has increased as agreed in March 2025, from Major (4) x Possible (3) = 12 to Major (4) x likely (4) = 16. This proposed increase is based on the level of incident reporting throughout the Trust, and current lack of security currently provided within our ED departments to help mitigate the risk. The risk rating has increased also due to incidents of homelessness on our site and antisocial behavior resulting in increased security risk. New actions have been added to the action section of this risk to help implement the current proposal approved by CMT on 4th March 2025.
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	10	No change	0	Actions listed with future due dates	[09/04/2025] [07/04/2025] Following a recent recruitment campaign, one candidate has been shortlisted for interview on 11 April 2025 for a Consultant H&N Surgeon post. While this represents progress, there remains no substantive Consultant in post at present. The anticipated appointment of a Locum Consultant earlier this year has not materialised. Interim arrangements for H&N service provision continue to remain in place. The Trust is also progressing with recruitment of a substantive OMFS Consultant post; however this does not address the H&N workforce gap locally or at a regional level.
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	10	No change	0	N/A	10.04.25 Proposal to close at CMT 15.04.25
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	8	No change	0	Actions listed with future due dates	[09/04/2025] The Western Trust 30 day GLRA will take place on 10 April 2025. This will determine the Trust's overall status, identify risks and mitigations to address issues identified at 30 days before go live. Go live preparations continue with command arrangements including rotas being finalised and support for bronze hubs confirmed. [25/03/2025] Trust 60 Day GLRA took place on 7 March 2025. A RAG assessment was completed within each of the following areas; Trust wide, Directorates and Preparation and Enables. At each GLRA any risk to go-live is identified, assessed and mitigations/actions required to address are agreed. Overall status identified the following areas as amber; people readiness, pharmacy, HR, End User Device, Integration and Helpdesk and Support, Admin and Clerical Assurance, Reporting, Polices and Change Impact. It is noted that significant areas of work which can only be completed nearer to live these include; training and familiarisation of staff and all of the aspects of data migration. The 30 Day GLRA will take place on 10 April 2025.

WHSCT Corporate Risk Register 24/04/2025

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	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	7	No change	0	Actions listed with future due dates	[03/04/2025]presented to CMT on 25.3.25 (please see documents for presentation outline). WIthin same, challenges and risks with current pathways outlined. Follow up with CMT re IPT requested. Request to finalise same with finance made.
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	4	No change	0	Actions listed with future due dates	[10/04/2025] 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.
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	4	No change	2	Actions listed with future due dates	[20/02/2025] Management of this complex case is ongoing. MDT meetings reviewing on a weekly basis.
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	3	No change	1	Actions listed with future due dates	[19/03/2025] The tender is set to close on Tuesday 25 March 2025. Once closed, the CAG will be given 6 - 8 weeks to undertake their individual and consensus scoring. Once outcomes are known [and we do not receive a legal challenge against our intention to award contracts from an aggrieved unsuccessful bidder] the Trust will establish a dedicated transition team to transfer business from losers to winners on a lot by lot basis. This team will provide regular updates on progress to the Domiciliary Care Oversight Group. The transition team will establish regular linkage with the community social work teams and put a communication plan in place. Martin & Bernie will ensure the establishment of the transition team.
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	3	N0 change	0	Actions listed with future due dates	[18/04/2025] Ongoing meeting with BSO, customs and logistics. DLS, 3rd May next meeting, to review the transport agreement. 24th April meeting with Sothern Ireland blood bikes. In relation to contract, responsibility remains with WT, awaiting transport agreement conclusion, for consideration and progression with DLS. However, DLS remain consistent in advice regarding Ultravires - Trust requires legal authority for this service, but it is currently without it.
Quality of care	1653	Director of unscheduled care, medicine, Cancer and Clinical Services	NSTEMI IN ED	20	Extreme	20	Extreme	10	MEDIUM	5	Low	To be reviewed at next Trust Board Workshop	3	No change	0	Actions listed with future due dates	[10/04/2025 07/04/2025 - There are no new updates for NSTEMI ED We review the discharges daily from ward 22 with the aim of having 8 Cardiology patients in ward 22 to allow Cardiology flow from ED. Given site pressures and the considerable number of DTOC this is not always possible.

		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)
1	19/11/2008	20	Extreme (Red)	15	Extreme (Red)	8	High (Amber)	Director of Performance Planning and Corporate Services	Planning & Performance - Facilities Management	Safe & Effective Services.	Fire Risks	As a result of the nature, use and condition of Trust owned, leased, occupied or unoccupied premises there is a risk of fire which could result in injury or death to staff, clients or public, damage to property, financial loss or loss of service.	Fire Safety Policy, procedures and manual. Including: Site specific fire emergency plans for SWAH and ALT. Departmental fire procedures in place for all areas. Staff Training and awareness. Mandatory Fire Safety awareness training. Recording and reporting of Fire Safety Mandatory Training Nominated Officers appointed and trained. Reporting of all fire incidents, unwanted fire alarms. Regional Fire Managers Group Nominated Officer Fire Safety Log Books Trust Fire risk assessments Recommendations from Resulting fromInspections of 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 hold appropriate external accreditation. Every Directorate to develop a Fire Risk within their Directorate Risk Register to ensure that all fire risks are managed appropriately. Engagement with Directors and	Not all staff are trained in mandatory fire safety awareness training. Potential exists for Premises to be operational without a Nominated Fire Officer in the Department Regional Group meetings are infrequent Not all Fire Risk Assessment are completed within designated Timeframe. Target is 100% Infrequent Drills due to competing Pressures. Financial Constraints Competing priorities Ageing Estate and deteriation of physical infrastructure Working with service to ensure service delivery/care is not impacted. Not all Directorates have included fire on their directorate risk register. Current risks not aligned to the corporate risk ID01. Systems are currently not in place for annual attendance at Directorate SMT's. Space limitations wihtin Trust footprint. Stock control management at a service level. Limited opportunities for management walkarounds Firestopping defects still present on	Fire Safety Policy, procedures and manual. Including: Site specific fire emergency plans for SWAH and ALT. Departmental fire procedures in place for all areas. These policies are corporate documents that apply to all staff within the Trust. Contractual obligation under the employment contract. Monthly reports provided to Business managers for distribution to HOS/AD's to identify staff compliance. Fire risk assessment audits. Fire Safety Working Group. Monthly drilldown of nominated fire officers throughout the Trust. Incidents are investigated by the Trust incident management process. Learning is cascaded both locally and regionally. Oversight over regional learning and good practice To ensure that nominated fire officer are aware of their fire safety responsibilities in each department/premises. Monitored through Fire risk assessment audits. Fire risk assessments are completed by Trust Fire safety advisors Freqency is dependent on criticality of premsies	Accuracy of Learn HSCNI reporting of mandatory training compliance Potential Exists for Premises to be operational without a Nominated Fire Officer in the Department None adherence to Learning Incomplete Documentation within fire safety log books Failure to sustain recommendations on a long term basis Failure to Update Fire Safety Controls assurance Action Plan. No scheduled intrusive	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 attend all Directorate SMTs bi-annually Head of Specialist Services and Fire Manager to attend Directorate
6	21/09/2009	25	Extreme (Red)	12	High (Amber)	8	High (Amber)	Director of Family and Children	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 always be allocated a Social Worker in a timely manner and it is likely that children may experience harm as a result of Trust staff not being able to provide appropriate support and implement safe plans. It is acknowledged that currently there is huge pressure on frontline social work teams in Children's Services, amid significant vacancy levels due to recruitment and retention challenges. All unallocated cases are reviewed in line with the Operational Guidance for the Management and Monitoring of Unallocated/Waiting List Social Work Cases in Children's Services (August 2023). This Guidance aims to support the safe management of cases where the decision has been made that social work involvement is needed, but the case cannot be allocated to a named social worker at that time.	Ongoing action to secure recurring funding. Update meetings between F&CC ADs and Director. Performance Management Review is being undertaken by HSCB with all 5 Trusts focusing on Unallocated cases and timescales Early Help staff returned to their substantive posts within gateway to increase the ability to allocate Principal Social Work redeployed will monitor Action Plan and progress to stabilise team Service Managers and Social Work Managers monitor and review unallocated cases on a weekly basis. Service and SW Managers constantly prioritise workloads.	Inability to get sick leave covered inability to recruit and retain social workers Principal Social Workers review unallocated cases regularly HSCB have drafted a regional paper to secure additional funding for Unallocated Cases. Delays in recruitment	Feedback given to Performance & Service Improvement for accountability meetings with HSCB. Quarterly governance reports to Governance Committee. Up-dates by Director to CMT and Trust. Action Plan to review and Address Risks within FIS Enniskillen Delegated Statutory Functions	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 close interventions were ongoing support is no longer required and no assessed risk Principal practitionerposts in hard to fill areas has been successful in retaining staff In areas we have full staffing levels

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49	06/10/2009	16	High (Amber)	20	Extreme (Red)	6	Medium (Yellow)	Director of Performance Planning and Corporate Services	ICT Services	Safe & Effective Services.	The potential impact of a Cyber Security incident on the Western Trust						
284	13/12/2010	16	High (Amber)	12	High (Amber)	6	Medium (Yellow)	Director of Performance Planning and Corporate Services	Planning & Performance - Performance Mgmt	Governance	Risk of breach of Data Protection legislation through loss, mishandling or inaccessibility of personal or sensitive personal inf	The Trust faces reputation and financial risk from non-compliance across all Directorates with the UK GDPR, Data Protection Act 2018, DoHNI's Good Management, Good Records and the Public Records Act 1923. The risk comprises a number of key factors which increases the level of risk for the Trust: • Insecurely sharing or accessing the personal data of clients, patients and staff without a legislative basis under UKGDPR or supporting 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 completed in December 2010. band 3 post in place Review of regional IG training available on HSC Learning completed and updated to provide	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.	No gaps in assurance identified	Band 3 0.5 post inceased to full time Recruitment of Band 4 Information Governance Development of information leaflet for Support Services Staff to increase awareness of information governance Review of regional e-learning IG training Establishment of Regional Records Man Group Development of IG action plan to be finalised through IGSG Recruitment of band 5 IG post to support DPA Development of IG information leaflet for support staff Review of Primary (acute) records storage in AAH Restructure of IAO process Review of Secondary storage in Maple Villa Production of Records Storage guidance for home working staff working from home New secondary storage facility in the southern sector Recruitment of IG Team leader post Review of improvement plan (up to April 2025) Introduction of Infreemation for IG

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1183	27/11/2019	25	Extreme (Red)	15	High (Amber)	6	Medium (Yellow)	Director of Adult Mental Health and Disability Services	Directorate-wide (Risk Register Use only)	Governance., Safe & Effective Services.	Where MCA processes are not being followed, patients may be deprived of their liberty, without having the relevant safeguards in place	Where MCA processes are not being followed, there is the risk that patients may be deprived of their liberty, without having the relevant safeguards in place, with the result that individual staff may be held criminally liable with appropriate sanctions, including financial penalties and imprisonment. For patients that lack capacity and for whom safeguards are not in place, there is the risk that statutory services may not be delivered. Emergency provisions should be considered where deemed appropriate, to support continuing service delivery until the safeguards are approved. Where emergency provisions apply, fully authorisations are required to be urgently followed up. The Department of Health, requires H&SC Trusts to proceed with a partial implementation of the Mental Capacity Act (NI) 2016 (MCA) for providing a statutory framework for the Deprivation of Liberty from the 2nd December 2019 with full implementation by December 2020	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 DoIS 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. Rotas for panel activity and short-term authorisation to be developed. Ongoing communication with the Unions. Communication Plan to be developed - draft to be presented at
1216	15/04/2020	15	Extreme (Red)	15	Extreme (Red)	6	Medium (Yellow)	Director of Unscheduled care, Medicine, Cancer and Clinical Services	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

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1219	30/04/2020	20	Extreme (Red)	20	Extreme (Red)	6	Medium (Yellow)	Director of Unscheduled care, Medicine, Cancer and Clinical Services	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	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.
1236	21/08/2020	16	High (Amber)	16	High (Amber)	6	Medium (Yellow)	Director of Finance, Contracts and Capital Development	Finance	Ensuring Stability of Our Services	Stabilisation of Trust Financial position	In 2024/25 the Trust has opened with a forecast deficit of £59m as a consequence of a poor budget settlement for HSC in 2024/25, unfunded demographic growth in 2023/24 and 2024/25 and a recurrent reduction to Trust baseline budget in 2023/24 of £24.1m without effective time to enable planning and implementation of recovery actions. The Trust has complied with its obligations to provide a Financial Plan and Contingency Savings Plan for 2024/25. The Trust has effectively communicated it's ambition to deliver £23.1m 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. The Trust conducted a review of the financial plan in September and a further review in November. The outcome of the reviews is that we are in a strong position to deliver breakeven in 2024/25.	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

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1254	18/01/2021	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 provided to key stakeholders Trust Governance Arrangements - People Committee Use of Bank/Agency/Locum Staff through Locum's Nest. Single Employer Project Group	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)	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	BSO Shared Service not meeting statutory or procedural deadlines resulting in, for example, delays in recruitment Inability of NIMTDA to fill all posts. Insufficient number of social work student applications to the University Degree Course in rural areas. (Risk 1109) Insufficient training places being procured by Department of Health to meet the demands of medical and nursing workforce. HMRC	Looking After our People Growing for the Future Belonging to the HSC New Ways of Working
1288	08/04/2021	12	High (Amber)	12	High (Amber)	6	Medium (Yellow)	Director of Performance Planning and Corporate Services	Trust-wide (Risk Register use only)	Ensuring Stability of Our Services, Improving the Quality and Experience of Care	Risk of failure to meet regulatory standards and compliance associated with Trust infrastructure and estate.	There is a risk of deterioration in the Trust Estate due to ageing and lack of capital investment in the maintenance of building services infrastructure and physical environment which could lead to loss of service and non-compliance with regulatory and statutory standards (e.g. water, electrical, asbestos and physical infrastructure).	Monitoring and review by PSI SMT of directorate risks including water, electrical, fire safety, vacant estate asbestos and physical infrastructure. Should a critical issue materialise further funding can be sought from DOH or existing funding reprioritised to address the new critical issue Estates Strategy 2015/16-2020/21 Annual review of building condition (3i) and creation of prioritised BLM list. 2022/23 Backlog maintenance programme developed and implemented Continual bidding for funding to address backlog maintenance 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 24/25 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

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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 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 There is on-site training / role play within SWAH ED and paediatrics regularly. This is also replicated in AAH but not as frequently.	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.	NISTAR are implementing call recording so that all requests for transfer will be available if required for evidence	No gaps in assurance identified	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
1320	15/09/2021	12	High (Amber)	20	Extreme (Red)	8	High (Amber)	Director of Children and Family	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	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	No gaps in assurance identified	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

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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 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	No gaps in assurances identified	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
1409	01/07/2022	25	Extreme (Red)	16	High (Amber)	9	Medium (Yellow)	Director of Unscheduled care, Medicine, Cancer and Clinical Services	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	No gaps in assurances identified	Meetings Workforce Improvement Meetings

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1423	17/08/2022	12	High (Amber)	12	High (Amber)	8	High (Amber)	Director of Children and Family	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	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.	DLS assisting with adjustments to current WHSCT contract with HSE and SLA with Cu Chulainn.	Need for further negotiations and buy in from HSE. Currently no Departmental oversight. There is no express departmental direction nor policy, nor any cross border governmental agreement, which would provide policy and governance cover for the Trusts provision of this all Ireland service.	Recent audit completed of all returned track back labels for quality •DLS have provided a Draft Transport Agreement •Engagement with BSO PaLS. •Engagement with Logistics UK 'Member Advice Centre - MAC'. •DLS support and advice re appropriate adjustments required for the contract. •There has been no SAI's regarding the delivery of DEBM •No reported incidents regarding service delivery in the last 5 years. •DLS have not identified any clinical governance risks in relation to the operational delivery of the service. •WHSCT Milk Bank works under the Northern Ireland Clinical Excellence (NICE) Guidelines that recommend the use of the Hazard Analysis Critical Control Point principles. •Regular meeting with Blood Bike Groups (RoI). •Yearly audits by Environmental Health, Omagh & Fermanagh Council.	•HSE agreement to the amended contract •There is no express departmental direction nor policy, nor any cross border governmental agreement, which would provide policy and governance cover for the Trusts provision of this all Ireland service.	Develop Business Case Secure Funding ROI Units Training of staff progress transport agreement Progress work required in relation to contract
1469	06/01/2023	12	High (Amber)	16	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	no gaps in assurances identified	Adopt and imbed regional MOVA policy in Trust Policy and Procedures Draft business case to expand resources for Safety Intervention Training Increase security within ED Implement "Powers to remove from HSC premises"

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1601	11/06/2024	16	High (Amber)	16	High (Amber)	8	High (Amber)	Director of Surgery, Paediatrics and Women's Health	Surgical Services	Ensuring Stability of Our Services, Improving the Health of Our People, Improving the Quality and Experience of Care	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.	Recruitment for replacement head and neck consultant re-advertised, including IMR and global options explored. Validation process undertaken of retired consultant's lists with oversight by clinical Lead. Look back review for patients in the last 2 years that underwent thyroid surgery in Trust and via Independent Sector providers to include patients care and management. ENT locum consultant with experience in benign head and neck is managing a cohort of identified patients on theatre waiting list for begin disease until her contract ends on the 22/5/24. There will remain an active waiting list for benign head and neck surgery. The current ENT team does not have the skill set to operate on this cohort of patients. A red flag diagnostic service will continue to be delivered for investigation of patients presenting with new symptoms, and within the NICAN guidance, across the whole ENT clinical team as is current practice. Temporary informal arrangement in	Currently no ENT Head and Neck oncology trained consultant working in the Western Trust. At present there is no provision or pathway for patients following oncology treatment and surgical surveillance follow up. Those patient post 2 years are currently reviewed by speciality doctor. Those patients in first 2 years post treatment have been validated by Belfast Trust Head and Neck consultant and temporary clinics x 3 in place to review identified patients. Ongoing discussion via ENT regional meeting for this cohort of patients. Any retraction in funding will see the collapse of On Call rota. Current rota agreed at 1:7. Resulting in impact for wider hospital service to manage airway emergencies. Direct impact on training programme for registrars, as number of consultants reduced. We currently have 2 NIMDTA allocated registrars with job plans in line with national specialty training requirements which will not be met with only 3 permanent consultants. This will inevitably lead to the loss of a registrar and effect day time	Networked approach with regional colleagues with agreed referral pathway for new Head and Neck cancer patients and regional weekly MDT. Weekly service meetings. All waiting lists have been subjected to validation by a Consultant peer. Plan to continue focus on the recruitment and retention of consultant's surgeons for service delivery and sustainability with the Western Trust to provide the commissioned levels (SBA) for ENT. Networked approach with regional colleagues to include regional waiting lists, reach in/out activity. Monthly consideration of Trust position at RPOG in relation to the Trust Performance meeting with the SPPG. Monthly Business Unit meeting with Clinical lead, Service Manager, Assistant Director of operations and Nursing, and the Director. Monthly Acute Governance. These issues are formally discussed at the Trust performance meeting with SPPG.	No gaps identified	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
1602	11/06/2024	16	High (Amber)	16	High (Amber)	12	High (Amber)	Director of Community and Older People Services	COP - Primary & Community Care		Risk of no GP cover in Trust managed GP Practices	110 vacant sessions across 4 GP practices between 1 May 24 and 31 August 24, equivalent to 55 days without GP cover. In addition there are 162 sessions with only 1 GP, this is equivalent to 81 days. The Trust has lost 5 locum GPs from their pool as a result of 2 on maternity leave and 3 taking up posts elsewhere. The Trust is trying to manage 1 additional GP practice in Omagh locality with a reduced number of locums.					Develope salaried GP job description and T&C's Recruitment Process ANP post

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1612	22/07/2024	10	High (Amber)	10	High (Amber)	8	High (Amber)	Director of Performance Planning and Corporate Services	Directorate-wide (Risk Register Use only)	Ensuring Stability of Our Services, Improving the Quality and Experience of Care, Supporting and Empowering Staff	Risk to WHSCT achieving the proposed encompass Go Live date due to safety concerns	There is a risk to WHSCT achieving the proposed Go Live date due to safety concerns associated with service delivery, because of key readiness activities not being completed within the required timescales. A funding shortfall is anticipated to cover enabling works, staffing, preparatory activities and ICT devices and infrastructure.	Encompass Programme Plan Programme Board Readiness Assurance Group Operational Readiness Boards Change Impact Board People Change Readiness Workgroup Benefits Realisation Workgroup PMO Structure Epic Team Regional encompass Team Learning from other Trusts 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 Directorates for implemenation Recruitment of superusers to support Northern Trust go live Risk Summit to take place on 30 July 2024 with Southern Trust, and go
1629	19/09/2024	9	Medium (Yellow)	9	Medium (Yellow)	6	Medium (Yellow)	Director of Adult Mental Health	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.	•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

		Initial Risk		Current Risk		Target Risk											
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1647	21/11/2024	20	Extreme (Red)	20	Extreme (Red)	9	Medium (Yellow)	Director of Community and Older People 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 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	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
1653	09/12/2024	20	Extreme (Red)	20	Extreme (Red)	10	Medium (Yellow)	Director of Unscheduled care, Medicine, Cancer and Clinical Services	Acute - Emergency Care & Medicine	Ensuring Stability of Our Services	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.	Patients are identified by the Cardiology Consultants each day who are suitable to outlay to our step down beds in ward 22. The Cardiology Consultants attend ED each morning to identify and prioritise patients who need to come to the ward.	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.	Patient flow aware of priority list for admission.	Cardiology patients admitted following the morning post take will not be reviewed by a Consultant Cardiologist until the next morning due to staffing pressures	Action Plan

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1656	12/12/2024	9	Medium (Yellow)	9	Medium (Yellow)	6	Low (Green)	Director of Nursing, Midwifery and AHP's		Supporting and Empowering Staff	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 Code. System function re-established on 30 May 2024.	WHSCT has procured a replacement E-Roster System. Implementation commencing March 2024 expected to be completed by September 2025 (18months). The Digital Services Team process a system back-up on a bi-monthly basis. This would maintain the data integrity up to the last update. Section 11 of the WHSCT Nursing and Midwifery Rostering Policy outlines the contingency arrangements in the event of roster system failure. Contingency measures tested during the Roster-Pro system outage 28 – 30 May 2024. Updated to reflect learning and need for more process directed instruction to Roster Managers. Updated Contingency measure communicated to all Roster Managers June 2024.	•No software maintenance support available from 30 Sept 2023. •No alternative electronic option to manage processing data on special duties enhancements to payroll.	•Roster-pro system functionality tested daily be E-Roster Team. •System back-up processed by Digital Services Team. •Nurse Bank Office produce weekly report on shifts bookings as back-up •Roster preparation will revert to paper based option. •ETM02 available for staff to record special duty enhancements to inform payroll	•Additional workload for line managers to approve numerous ETM02 claims for special duty enhancements.	Full Implementation of e-rooster software
1657	12/12/2024	20	Extreme (Red)	20	Extreme (Red)	8	High (Amber)	Director of Adult Mental Health and 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 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	Environmental :1.A seclusion area has been developed within Lakeview Hospital until the provision of a medium secure facility has been found 2.Installation of live stream only CCTV as an interim measure Policy/Regulation: 1.MDT working is in place and decisions are subject to MDT input (consider adding agreed frequency) 2.Daily huddles are in place 3.Application has been made to register Heather House facility as Adult Learning Disability facility 9 HH now closed) 4.Scoping of potential facilities throughout te region due to the urgent need to secure approporaite placement for assessment and treatment – ECR discussions ongoing 5.Identification of all revenue and capital funding requirements and preparation of business cases to secure funding – ECR application made and under review by SPPG – further information requested and provided frequently 6.ALD has sought legal advice from DLS 7.Updating of all risk assessments, forensic assessment and capacity assessments. Ensure all	Environmental: 1.The bespoke seclusion space does not meet the specification required of a medium secure unit. 2.There are ligature points and safety concerns present in this space 3.It does not have entrance with airlock control nor does it have airlock controls at living uits. 4.Although intercom has been installed, it is ineffective and creates a barrier to having a conversation with the patient which could cause client to dysregulate. 5.Bespoke space does not meeting building regulations 6.Sinks installed in the bathroom are not ant-vandal wash hand basins and do not have recessed taps. 7.There remains the potential for the patient to abscond from the bespoke seclusion space. This could have catastrophic consequences. 8.Hatch is not fit for purpose and poses a risk 9.The fence erected is not fit for purpose outside of Strule Ward as it is not anti-ligature. The lock on the gate is on the outside meaning that staff are unable to exit if required. 10.There is glazing on windows covered by heavy sheets of perspex except for door leading to garden from day room	•Daily MDT board meeting •Daily MH/LD planning meeting •Governance Oversight •SOP Heather House •Environmental Risk Assessment •Interim Seclusion Policy •RQIA Variation Document •Incident reporting/review •Legal Advice – DLS •ASG Policy &Procedure •MCA •Restrictive Practice Policy •PQC Risk Assessment •Incident Escalation protocol •Risk Management Policy •Ambulance/A&E Protocol •Generic H&S Risk Assessment •Ligature risk assessment •Live Stream only CCTV in place in seclusion space •CMT update •Updates to SPPG/DoH •SPPG/DoH •RQIA •DLS •Early Alerts •H&SE involvement (pre transition – 2 staff absences in 2022 – one case ongoing)	•RQIA intend to de-register the facility as a residential home and will not register facility as an Adult facility •Lack of future plan for R including the ECR	