Western Health and Social Care Trust

TRUST BOARD ITEM: BRIEFING NOTE

Meeting Details:	5th June 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; 1. ID947 – consider escalation to Corporate Risk. Briefing note attached. • Material changes; 2. ID 1612 – Risk to WHSCT achieving the proposed encompass Go Live date due to safety concerns. • Summary report for action;

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	- All action plans have been reviewed within 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 5th JUNE 2025

There are 24 risks on the Corporate Risk Register as approved at Trust Board 1st May 2025.

Summary

- Proposed New Risk;

  1. ID947 – Medical Staffing deficit – AMHDS. Briefing note attached.

- Proposal to close risk;

  2. ID 1612 – Risk to WHSCT achieving the proposed encompass Go Live date due to safety concerns.

- Summary report for action;

  - All action plans have been reviewed within quarter.

Proposed New Risk

1. ID 947 – Medical Staffing deficit – AMHDS.

   Due to the lack of Senior Medical staff in the AMHDS Directorate, there is insufficient capacity to deliver safe and effective care across all services. This is more likely to result in poorer than expected outcomes for patients, longer waiting list, longer waiting times for treatment and risk of harm to self and others. We require consultants to have CCT or equivalent, in order to be accredited to enact Mental Health Legislation. Further information provided in separate briefing note attached.

   Responsible Director: Director of Adult Mental Health and Disability Services.

Proposal to close risk;

2. ID1612 – Risk to WHSCT achieving the proposed encompass Go Live date due to safety concerns. Proposal to close this Corporate Risk, based on recent successful implementation of Encompass within Western Trust.

   Responsible Director: Director Performance, Planning and Corporate Services.

Summary Report for Action;

- All action plans have been reviewed within 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 28.05.25

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.	11	No change	0	Actions listed with future due dates	[01/05/2025] Fire KPI's achieved for 2024/2025 are as follows: Percentage Fire Training Completed - 80% Percentage Fire Risk Assessments Completed - 72% Nominated Fire Officer Training - 130% Number of Fire Occurrences - 13
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	44	No change	0	Actions listed with future due dates	[02/05/2025] There are 70 unallocated cases at 31 March 2025. For Gateway Service this is due to staff shortages as a result of annual, maternity and sick ness absence. In FIS this is also due to absence of 50% with an increase in referrals. F&CC Enniskillen are also working at 50% capacity which has led to an increase in unallocated cases.
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	14	No change	0	Actions listed with future due dates	[16/05/2025] New Release of Information Module implemented in May and adopted by IG Department and key staff across the Trust. New Scanning Bureaus established in Medical Records within Altnagelvin, Omagh and SWAH to quality assure template and other specialist EPIC documents which are being scanned into EPIC. New Scanning Documentation policy developed for all electronic systems.
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.	17	No change	1	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	33	No change	0	Actions listed with future due dates	[20/05/2025] Current flow in EDs is worse currently than previous updates. ED Altnagelvin looking at additional nurse cover for the ED waiting room and trialing early consultant led, post triage review to expedite investigations etc in an attempt to improve time to be seen. We are currently working out logistics of this. The service manager will share in due course.
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	33	No change	0	Actions complete- to be considered for de-escalation June 2025	[12/05/2025 12.05.2025 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 June 2025. Three consultants were in training, two completed their training by 30 April 2025, one remaining consultant has a possible completion date of 30th June 2025. Three nurse endoscopist trainees, two will complete training by end of August 2025 and one by August 2026. The service will continue to utilise capacity from ISP when funding becomes available and endoscopy regional DPC in Lagan Valley and Omagh. Encompass implementation would have an impact on the endoscopy activity delivered as the capacity is reduced whilst staff are learning how to use the new system.

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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
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	16	No change	0	Actions listed with future due dates	23/05/2025] 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.
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	32	No change	3	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. Medical recruitment also continues to be challenging. Alternative solutions to agency staffing are being addressed including Clinical Fellows and an increase in IMTs to address gaps at resident doctor level. Medical and dental recruitment continues to be hosted largely on Healthdaq with the extended reach for advertising and the applicant tracking facility both supporting extending applicant pools. Proposals to target job fairs and speciality conferences for hard to fill specialities are being progressed. The International Recruitment Bespoke Recruitment Campaign to Mumbai at the end of September 2024 focused on “hard to fill” consultants and SAS doctors. It proved a successful project, as at 17 February 2025 a total of 55 posts were offered as a result of the campaign, of these 33 posts have been accepted (14 Consultant, 18 SAS and 1 Clinical Fellow). To date 14 doctors have commenced employment with a further 2 arrived and completing pre-employment checks.
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	33	No change	0	Actions listed with future due dates	[01/05/2025] Work has commenced with an independent specialist to undertake a condition survey of 20% of the Trusts Estate. Results will be used to measure the backlog maintenance liability.
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	33	No change	1	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	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	23	No change	0	Actions listed with future due dates	[14/05/2025] The position remains unchanged, the Recruitment at Consultant and Middle grade has now paused at this time as the service is fully resourced at these grades. Job planning is approaching completion to ensure NS and SS Consultant and Middle grade delivered elective activity is balanced. Royal College approval has now been received to allow the SWAH based Staff Grade’s to apply for Specialty Dr posts which will provide the opportunity to operate independently and acquire admissions rights – recruitment process is currently being initiated. The Middle grade rota for General Surgery is now also Trust wide in line with GS Trust Wide service delivery this will ensure, through rotation across sectors, there is a resilient middle grade tier with exposure to scheduled and unscheduled care across sectors.

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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
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	28	No change	0	Actions complete - consider for de-escalation/ closure	20/05/2025 - no change to current risk and action plan, Current mitigations are in place and effective however due to capacity in the ED still remains a high risk. [20/05/2025] SWAH - The risk was reviewed for SWAH and comments from previous updates remain valid. Mental Health services provide cover in the Emergency Department if there are 3 or more mental health patients requiring admission. If they cannot provide cover they have agreed to pay for additional staff in ED to provide that cover.
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	No change	0	Actions listed with future due dates	[23/05/2025 The most recent MOVA group met on 20.05.25, and an update from the work group streams relating to TOR and action plans were received. Updates were provided to the group in relation to the security proposal.
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	11	No change	1	Actions listed with future due dates	[09/04/2025 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.
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	9	No change	0	Actions complete - consider for de-escalation/ closure	[16/05/2025] A 15 day GRLA event took place on 23 April 2025. This was the final Go Live Readiness Assessment for Western Trust CMT and encompass PMO Team. The meeting reviewed key risks and mitigations required for Go Live. Command and control arrangements for Encompass go-live (including soft live) were stood up on Tuesday 6 May 2025. This include 4 bronze hubs located in ALT, SWAH, Omagh and Gransha. Silver and Gold located in Trust Headquarters. After a final Go Live Readiness Assessment at 3:00am to ascertain any critical risks to go live, the WHSCT went live successfully on 8th May 2025 at 4am. Command and Control arrangement remain in place supported by EPIC and the regional encompass team. Work will now commence to support the Trust's transition to stabilisation.
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	8	No change	0	Actions listed with future due dates	[09/05/2025] ARBD demand/capacity exercise out for consultation- due to encompass colleagues have requested extension to this. Deadline for response= Wednesday 14th May 2025. Business case currently with Estates and Finance for final amendment- this will then be shared with colleagues for consultation before going to CMT for final sign off
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	5	No change	0	Actions listed with future due dates	[10/04/2025]- 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	5	No change	0	Actions listed with future due dates	[23/05/2025] Management of this complex case is ongoing. MDT meetings reviewed 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	4	No change	1	Actions listed with future due dates	[29/04/2025] The tender has now closed. The Trust has received submissions from 11 bidders. The CAG has now commenced the assessment process. Outcomes will be known in June/July 2025 [estimated].

WHSCT Corporate Risk Register 28.05.25

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	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	4	N0 change	1	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	4	No change	0	Actions complete - consider for de-escalation/ closure	[12/05/2025] No change to risk status. We continue to liaise with ward 22 for access to the 8 funded cardiology beds. The consultants continue to complete morning pick up rounds in ED to triage the cardiology patients for admission and ensure the most unstable is transferred to the first available bed.
Quality of care	1694	Director of surgery, Paediatrics and Women's Health	ENT Consultant Workforce	12	High	12	High	9	MEDIUM	5	Low	To be reviewed at next Trust Board Workshop	0	No change	0	Actions listed with future due dates	[07/05/2025] New Corporate risk Approved at TB on 01.05.25
quality of care	1692	Director of surgery, Paediatrics and Women's Health	Paediatric Consultant Workforce SWAH	16	High	16	High	12	High	5	Low	To be reviewed at next Trust Board Workshop	0	No change	0	Actions listed with future due dates	[07/05/2025] New Corporate risk Approved at TB on 01.05.25

		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	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date
1	19/11/08	20	Extreme (Red)	15	Extreme (Red)	8	High (Amber)	Director Performance, Planning and Corporate Services	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 AD's re fire safety. Housekeeping and space utilisation Fire Stopping of SWAH PFI Facilities. Program of fire stopping working underway.	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 SWAH site. Difficulties in recruitment of trained fire officers. Currently 25% vacancy (1/4) Evidence of staff, visitors and patients not adhering to smokefree	Fire Safety Policy, procedures and manual. Including: Site specific fire emergency plans for SWAH and ALT. Departmental fire procedures in place for all areas. These policies are corporate documents that apply to all staff within the Trust. Contractual obigation under the employment contract. Monthly reports provided to Business managers for distribution to HOS/AD's to identify staff compliance. Fire risk assessment audits. Fire Safety Working Group. Monthly drilldown of nominated fire officers throughout the Trust. Incidents are investigated by the Trust incident management process. Learning is cascaded both locally and regionally. Oversight over regional learning and good practice To ensure that nominated fire officer are aware of their fire safety responsibilities in each department/premises. Monitored through Fire risk assessment audits. Fire risk assessments are completed by Trust Fire safety advisors Freqency is dependent on criticality of premsies. Inspections by external bodies (both planned and athoc basis). Partnership working with multi-discipinary agencies included RQIA and NIFRS. Assurance Provided to	Accuracy of Learn HSCNI reporting of mandatory training compliance Potential Exists for Premises to be operational without a Nominated Fire Officer in the Department None adherence to Learning Incomplete Documentation within fire safety log books Failure to sustain recommendations on a long term basis Failure to Update Fire Safety Controls assurance Action Plan. No scheduled intrusive surveys programmed. Directorates FIre Safety Risk currently not reviewed at fire safety group and at SMT's. Irregular meetings of Task and Finsh Group and poor representation at walkarounds. Funding for smoke-free warden retracted.	Emergency Lighting replacement Implement fire safety improvements Implement Fire Safety Improvements - 18/19 NIFRS to speak with clients implement fire safety improvement works 17/18 Fire safety objectives review for 16/17 Fire Safety Report 15/16 Priority list of firecode works to be prepared Fire Improvement Works 14/15. Implementation of Directorate Action Plans. Fire Improvement Works 15/16 Hospital Fire Storage Working Group to be set up	31/03/2021 31/03/2021 31/03/2019 30/09/2018 31/03/2018 30/06/2016 30/06/2016 31/07/2016 31/03/2015 31/12/2015 31/03/2016 31/03/2024 30/04/2024 30/06/2024 30/09/2017 30/06/2025 31/03/2024 31/03/2017 03/01/2024 31/12/2023 31/03/2021 30/09/2025 31/03/2023 30/06/2022 25/04/2022 30/09/2025 30/09/2024 21/12/2022 30/06/2023 30/06/2023 30/06/2023 30/09/2024 31/08/2025 30/06/2022

		Initial Risk		Current Risk		Target Risk											
ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date
6	21/09/09	25	Extreme (Red)	12	High (Amber)	8	High (Amber)	Director of Social Work/Director of Childrren and Families	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	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	29/09/2023 30/09/2020 01/11/2018 31/07/2025 31/07/2025 31/07/2025 31/07/2025 31/07/2025 31/07/2025

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49	06/10/09	16	High (Amber)	20	Extreme (Red)	6	Medium (Yellow)	Director Performance, Planning and Corporate Services	Safe & Effective Services.	The potential impact of a Cyber Security incident on the Western Trust	Information security across the HSC is of critical importance to the delivery of care, protection of information assets and many related business processes. Without effective security and controls; compromises can arise from technology and people which can lead to breaches of Data Protection Act and Network and Information Systems (NIS) regulations. A Cyber incident will directly impact on the delivery of patient/client care. Compromises can arise from; (1). NON Managed Trust	(1).PEOPLE CONTROLS - (1). Cyber Security Training , (2).Information Governance,(IG) Mandatory Training, (3). Staff Contract of Employment (2).GOVERNANCE CONTROLS - (1). Network Information Systems (NIS) Cyber Assessment Framework (CAF) (2). User account management processes (Standard Operating Procedure - SOP) (3). HSC Information Security, Policy, Standards, Guidelines and Standard Operating Procedures (SOPs) (4). Trust Cyber Governance Oversight Group (COG), Risk Management Group (RMG),Vulnerability Management Group (VMG), Corporate Governance Sub-committee (CGSG) (5). Change Advisory Board (CAB) (Local and Regional) 6). Regional Oversight Governance Groups - Cyber Programme Board, Regional Cyber Leads (7). Regional and Local Incident Management reporting policies/procedures (8). Regional Cyber Programme Board (Trust - SIRO / AD for ICT Rep) (9). Controls Assurance Standard (10). Datix and Risk Management (11). Emergency Planning & Service Business Continuity Strategic Forum	GAPS IN PEOPLE CONTROLS : (1). Insufficient User Uptake of ICT Security and cyber awareness training and instructions, in particular user behaviour (e.g Not rebooting ICT Equipment when prompted) . (2). Insufficient buy-in from Services to agree maintenance window with ICT with regard to their departmental systems (3). Cyber Training is not mandatory GAPS IN GOVERNANCE CONTROLS: Local Assurance (1). Leavers and movers processes (2). Technical Disaster Recovery Plan 3). Resource for contracting function to cover governance elements and that GDPR is correct (4). Supplier Framework - Resource required by WHSCT (5). SOP for Information Asset Handling Corporate Assurance (1). WHSCT have not adopted the HSC ICT Security Policy (2). Review of Regional Cyber Incident Plan is required Independent Assurance (1). The Trust have received an independent report form the Competent Authority in relation to the Network Informations Systems (NIS). The Cyber Assessment Framework (CAF) made recommendations against a number of objectives	PEOPLE ASSURANCE: (1). As part of a Regional Cyber Programme, a Regional Cyber Phishing Exercise has been carried out (2). Mandatory IG Training Reporting Available (3). Contract of Employment Provides assurance that staff can be held to account (4). Regional E-Learning programme (Metacompliance) (5). Business Continuity (Desktop Exerecises undertaken by Staff) GOVERNANCE ASSURANCE: (1). Internal audit / IT Dept self-assessment against National Cyber Security Centre (NCSC) 10 Steps towards Cyber Security (2). ICT Vulnerabilty Management Group (VMG) regularly reviews and assesses Cyber threats and vulnerabilities (3). ICT Security Review meetings regularly reviews and assesses service submitted ICT Security Questionnaire (4). The regional Network Infrastructure Group (N.I.G) has been set up to discuss all regional network related strategies including the reviewing the regional cyber report (ANSEC), technical debt, wired/wireless networking, network security and segmentation. (5). HSC Operational Telecoms Group has been established to provide a vehicle for discussion of	(4). Staff using unapproved and unsupported communication tools on personal devices i.e Instant messaging solutions for patient care containing trust data GAPS IN GOVERNANCE ASSURANCE: Local Assurance (1). Newly Established Groups e.g. COG will take time to get established in terms of process (2). Work to be carried out in co-ordinating Regional and Trust Governance arrangements (3). Sucession Planning (4). Lack of consistent contribution from Trust Services in completion of NIS Assessments thereby resulting in reduced compliance. GAPS IN TECHNICAL ASSURANCE: Local Assurance (1). External factors impacting on diversion of ICT technical resources and skills which are outside Trust control e.g. HSE security event or major gloabal vulnerabilities (2). Delays in the implementation of the HSC Technical Recommendations and local work plans due to resource/funding and available skills sets. (3). There will always be versions of software that will not be up to date at various points in time e.g. Legacy Systems Corporate Assurance (1). It is not technically possibly to restore full systems - services need to be	Implementation of cyber security work plan which has been agreed with the Region. Recruitment of Band 7 Cyber Security Manager. Recruitment of Band 6 to support implementation of Cyber Security Action Plan. Full implementation for Metacompliance across the Trust with regular course updates being issued thereafter. Introduce routine reporting to Trust Board (or other equivalents (local or regional)) on reported incidents/near miss, and other agreed	30/09/2025 31/03/2019 31/03/2019 31/03/2020 31/08/2018 30/09/2025 30/09/2025 30/09/2025 30/09/2025

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ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date
284	13/12/10	16	High (Amber)	12	High (Amber)	6	Medium (Yellow)	Director Performance, Planning and Corporate Services	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	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 more robust training fro staff. Data Protection & Confidentiality Policy. Information Governance SIRO and IAO Framework.	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)	31/03/2019 31/03/2019 31/03/2019 31/12/2020 30/09/2020 30/09/2020 31/12/2020 30/09/2020 30/08/2025 31/03/2025 30/08/2025 31/12/2021 31/03/2025 31/07/2025 01/06/2022 31/07/2025 31/03/2023

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ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date
1183	27/11/19	25	Extreme (Red)	15	High (Amber)	6	Medium (Yellow)	Director Adult Mental Health & Disability Services	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	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	31/12/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2020 29/10/2021 31/03/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2021 30/07/2021 28/06/2024 30/06/2023 31/03/2023 08/05/2025 28/03/2025 30/04/2024 30/11/2022 30/11/2022 31/03/2024 31/03/2026 30/06/2024 30/06/2024 30/09/2025 30/09/2025 30/11/2022 30/11/2022
1216	15/04/20	15	Extreme (Red)	15	Extreme (Red)	6	Medium (Yellow)	Director of Unscheduled Care, Medicine, Cancer & Clinical Services	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	31/03/2022 30/06/2025 28/02/2022

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1219	30/04/20	20	Extreme (Red)	20	Extreme (Red)	6	Medium (Yellow)	Director of Unscheduled Care, Medicine, Cancer & Clinical Services	Safe & Effective Services.	Lack of endoscopy capacity for endoscopy to meet the demand which impacts on Patient outcomes	Lack of endoscopy capacity, has resulted in breaching of the two week red flag wait /9 week urgent and routine wait and surveillance targets for endoscopy. The lack of timeliness for endoscopy will lead to delayed diagnosis of cancer and poor outcome for these patients as evidenced in SAI's.	Telephone pre assessment of colonoscopy on-going to improve list utilisation and reduce DNA rates Independent sector was utilised to deliver 250 surveillance colonoscopies from January to March 2020. Further use of Independent Sector to be explored post Covid -19 Surveillance waiting lists are being validated in line with new guidelines. Discussions have commenced with the commissioner to recurrently fund one of the posts in 20/21 to address the demand/capacity gap. The second post will be funded from a current vacancy. Training of 2 nurse endoscopists under transformation commenced in September 2018 - trainees were to be signed off by the end of 2020 the delay was due to Covid-19. Short-term provision by SE Trust to provide WT in IS tender 200 patients identified and moved to the independent sector.	Band 4 team lead recruited to manage waiting lists and oversee the scheduling team and processes. Encourage consultants to triage referrals in line with NICAN suspect cancer guidelines (Oct 2019) and utilise the urgent and routine categories. Additional funding for a second pre assessment nurse has been discussed with the commissioner- await confirmation in 2021 allocation	Waiting lists discussed monthly at the Endoscopy Users Group Clinical audits are completed annually to benchmark the service against National Standards. Monthly monitoring of waiting lists is carried out to identify longest waits and prioritise for scheduling.	The need for the Trust to invest further in the development of GI Trainees in line with the evidence base for modernisation, thereby proactively growing the team to meet future demand. The need to develop the service to include the inclusion of a hepatologist as part of the team in line with Royal College modernisation of gastroenterology training and service provision. The need to address the impact of a job plan which includes the medical on-call rota The need to urgently increase the consultant workforce and make the Trust an attractive opportunity for the next round of doctors in training due for recruitment April 2021	Explore the possibility of utilising the Independent Sector to address waiting lists. Need to review GI consultants job plan to reduce General Medicine commitment to increase availability for endoscopy lists. Secure funding for an additional pre assessment nurse to support list utilisation and reduce DNA rates. Recruit 2 trainee nurse endoscopist Recruitment of a further GI consultant to fill present vacancy and increase the medical team to 6 wte.	05/10/2021 30/10/2022 30/04/2023 30/06/2023 31/12/2024
1236	21/08/20	16	High (Amber)	16	High (Amber)	6	Medium (Yellow)	Director of Finance, Contracts & Capital Development	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	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	30/06/2025 30/06/2025 31/12/2024 31/12/2024 30/06/2025

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1254	18/01/21	16	High (Amber)	16	High (Amber)	8	High (Amber)	Director of Human Resources & Organisational Development	Ensuring Stability of Our Services, Improving the Quality and Experience of Care, Supporting and Empowering Staff	Inability to deliver safe, high quality and sustainable services due to workforce supply and disruptions	Due to an inability to attract, recruit and retain staff throughout the Trust, services may not be able to maintain sufficient staffing levels to sustain high quality safe services which may result in a reduction in service provision.	Trust Business Continuity Plans with full HR support on hospital / community workforce groups. Delivering Care: Nurse Staffing in Northern Ireland Organisation Development Steering Group Health and Wellbeing Strategy Engagement & Involvement Strategy DOH Workforce Strategy & Trust Workforce Strategy and key actions Policies - Rec & Selection Framework, Attendance at Work, Flexible Working, Redundancy and Redeployment, etc. HR Strategic Business Partner identified for each Directorate - targeted interventions in relation to absence, agency usage, temporary staffing and other identified Directorate priorities. (Risk 6, 1075) Pension information sessions Joint Forum, Joint LNC and Consultation Group Workforce Information reports provided to key stakeholders Trust Governance Arrangements - People Committee Use of Bank/Agency/Locum Staff through Locum's Nest. Single Employer Project Group Review of existing Locum Framework Regional Strategic and Implementation Groups established to consider WFP implications for reform initiatives	Occupational Health - absence of locums and increasing demands on team without additional resources. Low uptake of mandatory training and completed annual appraisal. Inability to follow normal policies and procedures during periods of Industrial Action and also during emergency situations such as Pandemic. Lack of co-ordinated information on agency staffing Due to demand in services compliance with Working Time Regulations and New Deal. BSO Recruitment Shared Service provides recruitment services for the Trust and there has been an increased delay in recruitment and dependence on them for related information. Inability of NIMDTA to provide required number of Junior Doctors for certain specialities and localities. (Risk 694) Difficulty in recruiting in rural areas and accessing cover when needed in those areas i.e. Domiciliary Care Workers. (Risk 547) Insufficient applicants for medical, nursing and social work posts. (Risks 6,1109) Process improvement required for consultant recruitment in order to ensure process works effectively.	Working Together Delivering Value Health check measurements on absence hours lost, mandatory training, appraisal, time to fill posts, job planning completion rate. Involvement Committee - Quarterly monitoring of staff engagement on initiatives that contribute to achievement of Trust Great Place ambitions (start life, live well and grow old). Pension Regulator Compliance Junior Doctors Hours monitored twice yearly and returns submitted to DOH. People Committee - Workforce Strategy, Recruitment and NIMDTA Allocation Updates twice per year. People Committee - Quarterly monitoring of Absence, Appraisal, Mandatory Training, Consultant Job Planning, Temporary Staffing, Agency Staffing, Turnover and Grievance/Disciplinary/Statutory Cases. RQIA Inspections of services which link to employment matters UK Border Agency Inspections on ad hoc basis. Audit assurance and progress reports in relation to Audit recommendations provided at least twice per year to internal audit. Professional Guidance - Telford, Royal Colleges, NI Delivering Care (N&M)	BSO Shared Service not meeting statutory or procedural deadlines resulting in, for example, delays in recruitment Inability of NIMTDA to fill all posts. Insufficient number of social work student applications to the University Degree Course in rural areas. (Risk 1109) Insufficient training places being procured by Department of Health to meet the demands of medical and nursing workforce. HMRC Regulations and impact for staff HSC Pension particularly high earners. Impact of McCloud and Sergeant Employment Law cases. Safe staffing model for social work. Lack of regional cap on medical agency rates Legal challenges to Terms and Conditions arising from changing employment law e.g. PSNI and Allocate Cases. Impact of Pay Strategy across all staff groups. Pay discussions are led by Department of Health Absence of alternative career pathways for social work and some specialist nursing roles. HSC Workforce Planning - lack of joined up action plan.	Looking After our People Growing for the Future Belonging to the HSC New Ways of Working	30/09/2025 30/09/2025 30/09/2025 30/09/2025

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ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date
1288	08/04/21	12	High (Amber)	12	High (Amber)	6	Medium (Yellow)	Director Performance, Planning and Corporate Services	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 Develop BLM Plan 25/26 BLM and Capital Plan Project	30/06/2022 30/09/2021 30/04/2021 30/04/2021 30/09/2021 30/09/2021 31/03/2022 31/08/2021 31/07/2025 31/03/2022 30/05/2025 30/06/2022 30/09/2022 30/06/2024 31/10/2024 31/07/2025 30/04/2024
1307	16/06/21	25	Extreme (Red)	25	Extreme (Red)	6	Medium (Yellow)	Director of surgery, Paediatrics & Women's Health	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	30/06/2022 31/03/2022 31/03/2022 30/09/2025 30/09/2025

		Initial Risk		Current Risk		Target Risk											
ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date
1334	26/10/21	20	Extreme (Red)	15	High (Amber)	8	High (Amber)	Director of surgery, Paediatrics & Women's Health	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	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	01/09/2023 30/06/2025 30/06/2025 30/06/2025

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ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date
1409	01/07/22	25	Extreme (Red)	16	High (Amber)	9	Medium (Yellow)	Director of Unscheduled Care, Medicine, Cancer & Clinical Services	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	-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	03/07/2023 31/12/2024 31/12/2024
1423	17/08/22	12	High (Amber)	12	High (Amber)	1	Low (Green)	Director of Social Work/Director of Childrren and Families	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	31/12/2022 30/06/2023 31/12/2022 30/06/2023 01/09/2025 01/09/2025

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ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date
1469	06/01/23	12	High (Amber)	16	High (Amber)	4	High (Amber)	Medical Director	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 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	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"	30/11/2025 31/08/2025 31/10/2025 31/10/2025

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ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date
1601	11/06/24	16	High (Amber)	16	High (Amber)	8	High (Amber)	Director of surgery, Paediatrics & Women's Health	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	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 place for surgical pathway and discussion at regional head and neck MDM. Ongoing discussion with regional colleagues including Belfast Trust, Southern Trust and SPPG regarding	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 emergency cover for the WHSCT. Any mitigations outlined are short term solutions to deal with a number of patients outside their clinically indicated time for review.	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	30/06/2025 30/06/2025 30/06/2025 30/06/2025

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ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date
1629	19/09/24	9	Medium (Yellow)	9	Medium (Yellow)	6	Medium (Yellow)	Director Adult Mental Health & Disability Services	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	•Task and Finish and oversight group set up to scope current pressures and map potential solutions. •Business case as a result of work above to be submitted to commissioners •Review of delayed discharges •On-going review if incidents/SEAs/ SAIs •MDT discussion in regards to individual cases with escalation if case remains unallocated to Head of Service, Assistant Director and Director	•Commissioned Pathway for this Service User group	Review of Incidents Oversight of Delayed Discharges Case Conferencing Review of Complaints	•Commissioned pathway for this client goup	SCOPING EXERCISE TO BE COMPLETED COMPLETE ARBD RESEARCH CREATE REFERRAL CRITERIA REGIONAL WORK- LEAD TASK AND FINISH/OVERSIGHT GROUP BUSINESS CASE	29/08/2024 31/12/2024 23/10/2024 31/07/2025 31/07/2025 31/07/2025

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ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date
1647	21/11/24	20	Extreme (Red)	20	Extreme (Red)	9	Medium (Yellow)	Director Community & Older People's Service	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	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	30/06/2025 30/06/2025

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ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date
1653	09/12/24	20	Extreme (Red)	20	Extreme (Red)	10	Medium (Yellow)	Director of Unscheduled Care, Medicine, Cancer & Clinical Services	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	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	30/04/2025

		Initial Risk		Current Risk		Target Risk											
ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date
1656	12/12/24	9	Medium (Yellow)	9	Medium (Yellow)	6	Medium (Yellow)	Director 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	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	31/10/2025

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ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date
1657	12/12/24	20	Extreme (Red)	20	Extreme (Red)	8	Medium (Yellow)	Director Adult Mental Health & Disability Services	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	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 safety risk assessment are updated and care plans/safety plans 8.Regular communication with RQIA, SPPG and DoH – support from RQIA to manage in the short term only	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. This poses a risk 11.The patient's medications are being passed through a hatch in the door. The staff have limited visual contact and may not be able to ascertain if patient is fully compliant.	•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	Service redesign to include staffing skill mix	30/06/2025

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ID	Opened	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)	Responsible Director	Corporate Objectives	Title	Description	Controls	Gaps in controls	Assurance	Gaps in assurance	Description (Action Plan Summary)	Due date
1692	07/05/25	16	High (Amber)	16	High (Amber)	12	High (Amber)	Director of surgery, Paediatrics & Women's Health	Ensuring Stability of Our Services	Paediatric Consultant Workforce SWAH	Current vulnerabilities within this service; Cause We currently have gaps at consultant level with only 2 out of 6 substantive consultants working on the Out of Hours Rota (OOH rota). Events We have one consultant recently returned from long term sick but not working on the OOH rota. One consultant heavily weighted to community. Two consultants currently on long term sick. One requires DDRG involvement regarding continuation to work at Consultant level and one with no	•3wte locum Consultants in place covering current gaps. •Recruited 1wte Speciality Dr (IMR) to middle tier. Will review skill set in one years' time, query possibility CESR to progress to Consultant tier. •1wte temp 2 year fixed term contract advertised. •Job Description sent to Royal College for approval to recruit to a further permanent consultant. •Use of IMR	•Unable to offer Agency Drs sufficient hours between 9 – 5, Monday to Friday, due to the nature of the service, resulting in dissatisfaction with Agency Drs, impacting our ability to retain same. •Some IMR Drs require significant support and investment however are unable to practice independently on the OOH rota. •There continues to be a shortage of eligible candidates within the local area. Senior paediatric trainee Drs are not allocated to the SWAH, therefore there is less staff exposed to this unit, who may return for a consultant post.	•Ability to maintain a full rota. •Feedback from the Clinical Lead •Feedback from members (MDT) Nursing and Management within the Sub-Directorate.	No gaps identified	Escalate workforce challenges at the Child Health Partnership. Undertake a financial assessment to recruit a perm Consultant to reduce locum spend	30/09/2025 30/09/2025
1694	07/05/25	12	High (Amber)	12	High (Amber)	9	Medium (Yellow)	Director of surgery, Paediatrics & Women's Health	Ensuring Stability of Our Services	ENT Consultant Workforce	Cause: Gaps in ENT consultant workforce due to resignations, sabbatical, and reliance on locums. Event: Insufficient consultant cover for service demand and On Call provision. Effect: Increased patient waiting times, reduced on call cover, and service instability.	1. Locum Consultant Cover – Temporary locum and agency consultants engaged to fill gaps. 2. International Medical Recruits – Recently recruited international candidates with interviews scheduled for April 2025. 3. Triage and Prioritization – Clinicians prioritizing urgent and cancer patients to manage demand. 4. Mutual Aid Support – Engaging with regional networks for cross-cover support. 5. Waiting List Validation – Ensuring capacity is used effectively by removing patients no longer requiring treatment. 6. Ongoing Recruitment Efforts – Active recruitment campaigns for substantive consultant posts. 7. Escalation – Highlighting risks to senior regional counterparts (i.e. SPPG, PHA) to explore strategic solutions.	1.Reliance on Locums – Temporary cover is costly, unsustainable, and does not provide long-term service stability. 2.Substantive Recruitment Challenges – Difficulty attracting permanent consultants due to workforce shortages and regional competition. 3.Limited Rota Resilience – A 1:7 rota with gaps increases pressure on existing Consultants, impacting service sustainability. 4.Future Workforce Planning – No immediate succession planning for Consultant retirements or departures. 5.Impact of Sabbatical and Resignation – Further reduces capacity, worsening waiting times and emergency cover risks. 6.Cross-Cover Limitations – Limited availability of regional support due to similar pressures across Trusts. 7.Impact on Airway Management – potential implications for Hospital Airway Management due to the lack of medical cover.	1.Weekly Service Meetings 2.Emphasis on recruitment and retention of existing staff and identification of possible 3.Regional Support – engagement with SPPG, PHA and partner Trusts on existing issues	No gaps currently identified	Permanent Consultant Recruitment IMR Recruitment of x3 Consultant Potential Service Delivery Redesign Liaison with Regional Trusts for Support	30/05/2025 30/05/2025 31/08/2025 30/06/2025