Northern Health and Social Care Trust

Assurance Framework

Principal Risks and Controls Document

2019/20

NOVEMBER 2019

MOVEMENT SINCE PREVIOUS PRINCIPAL RISK DOCUMENT (PRD)

ITEM	PRINCIPAL RISK	MOVEMENT SINCE PREVIOUS PRD (AUGUST 2019)	
		Changes to Risk Rating	
		Previous Risk Rating	New Risk Rating
1	ID 1049 Mental Capacity Act – now incorporated in ID 1061		
5	ID 870 Insufficient Nursing Home Beds – deescalated to Corporate Risk		
10	ID 1000 EU Exit	12	9

PRINCIPAL OBJECTIVES

The NHSCT Corporate Plan 2013-2014 to 2015-2016 outlines the Trust's Principal objectives as follows:

Objective 1: To provide safe and effective care.

Objective 2: To create a culture of continuous improvement that supports the delivery of health and social care that exceeds recognised quality standards and meets performance targets.

Objective 3: To use all of our resources wisely.

Objective 4: To have a professional management culture with effective leadership, development of staff and teams that deliver.

Objective 5: To involve and engage service users, carers, communities and other stakeholders to improve, shape and develop services.

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1	ID: 1061 (incorporating pension and MCA risks) There is a risk that the stability of the Trust workforce and the provision of services will be negatively impacted upon following the implementation of a number of large scale projects/requirements within the organisation. There is however a limitation as to how much the Trust can manage and mitigate the risk and the impact on service delivery Implementation of the Mental Capacity Act By the 2nd December 2019 the Trust must	5	4	20	1	Trust leads and formal project management structures are already in place for encompass, the Causeway/Glens MDT model, Transformation and the implementation of the Mental Capacity Act. Recruitment and service stability will form a part of these discussions with mitigation potentially in place for each project. Recruitment and service stability also forms part of a wider standalone Mental Capacity Act Risk that was added to the Corporate Risk Register on the 28th August 2019. The potential Impact of the pension regulations on medical activity is currently being investigated by staff within the Medical Directorate. A live risk in relation to this issue was added to the Corporate Risk Register on the 12th August 2019. In respect of the impending industrial action, a contingency plan has been developed in conjunction with divisional leads and the Trusts Emergency Planning and Business Continuity Manager and has been submitted to HCSB at the beginning of November. Further work is underway with divisional leads to ensure that planning remains effective, active and responsive. Engagement with local trade unions	The workforce and service implications of Transformation have been acknowledged from the outset and where possible backfill posts were put in place to ensure that existing services remained unaffected as staff moved into transformation posts. The workforce and service implications of Encompass, the Causeway/Glens MDT model, Transformation and the implementation of the Mental Capacity Act are all now under live consideration through existing project management arrangements. The potential Impact of the pension regulations on medical activity has already been raised with the Chief Medical Officer, DoH Finance and is to be raised with HSC Superannuation Scheme Advisory Board		Action will be updated once agreed as a new risk	

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	have sufficient numbers of staff identified, trained and clinical and administrative processes in place to ensure legal compliance in situations where the care of a patient or client amounts to a deprivation of liberty under the new code. Implementation of the Encompass System The encompass project will require significant Trust resources to implement, including input into the design process and training for end users. The project carries with it a large regional recruitment					is planned to agree principles for the management of IA and to agree structures and arrangements to effectively manage all local action across the Trust.				

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	component made up of both temporary and permanent posts which Trust staff could choose to apply for. Implementation of Digital Shared Services The Digital Shared Services project is aimed at remodelling the way ICT services are delivered across the five Trusts. This may result in significant change for Trust ICT staff and could potentially impact on retention and recruitment of staff. Implementation of the Causeway and Glens MDT model.									

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2	ID: 905 Limitation in capacity to respond to unscheduled care demand.	4	5	20	1	The controls described below reflect a part of the normal operational management of hospital and community services: Site Co-ordination Model in place on both sites to maximise flow of patients. Winter and Easter resilience planning processes in place. Active recruitment for medical and nursing vacancies. Recruitment and retention premia in place for Causeway Consultants. Three permanent consultant appointment to Causeway ED as of October 2019. Regional Group including Directors of HR, Finance and Nursing representatives from Trusts met with DoH colleagues on 31 May 2019. Regional project to incentivise bank is to be led by DoH with HSC involvement. TMG to be briefed; it is anticipated correspondence will be issued in the near future, with work to gather pace during June 2019. The Trust will look to develop an internal group to progress work, to include Service Directors (refer to Item 2).	Hospital Early Warning Score text and email alerts as required in response to site escalation (AAH only) (I). Attainment of 48 hour complex discharge target (I). Daily report from Site Co-ordination Model (AAH and CAU) (I).	1. Recognised deficit in bed capacity on the AAH sit 2. Over dependence on locums and agency staff (refer to Principal risk 2 regarding nursing workforce).	1 - 24 bedded unit for Antrim Area Hospital site commissioned, and operational from July 2019. The opening of this ward has resulted in the temporary de-commissioning of EAU resulting in a net increase in bed capacity on the site of 12 beds to increase to 24 beds by December 2019. 72 bedded Business Case with the HSCB for consideration. Letter of support in principle received from the Director of Commissioning, HSCB. Developing and strengthening Ambulatory Care opportunities across both sites with the development of Direct Assessment Unit (DAU) in Causeway and programmed treatment unit AAH. Acute Assessment unit / Acute led medical model commenced late September. Aim to manage medical take and invoke ambulatory pathways where possible. 2 - Proactive medical and nursing recruitment ongoing regionally, nationally and internationally. Proposal to convert agency spend to permanent nursing posts in	Divisional Director of Medicine & Emergency Medicine

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								3. Reduction in the allocation of F1s and F2s to the NHSCT.	Causeway ED progressing. 3 - F1 mitigation plan in place, proposal to extend Hospital at Night submitted to Medical Director and Director of Nursing for consideration and further development/ agreement. Doctors in training steering group convened with Divisional Subgroups	
								4. Reduction in the attainment in the 48 hour discharge target.	4 - Trust Discharge Group jointly chaired by MEM and CC work-stream within RAMP to improve discharge planning.	
								5. Absence of ACAH (Acute Care at Home) Outreach model in the NHSCT area.	5 - Phase 4 ACAH model i.e. outreach to Antrim/ Ballymena areas not funded through transformational monies. This element is unlikely to be realised in the foreseeable future.	
								6. Reduction in the number of nursing home placements across the NHSCT area.	6 - Anticipatory Care Model being developed in the CAU Locality to support Care Homes. East Antrim LES in place as part of ICP workstreams. Flex availability of private nursing home places for short term rehabilitation to augment intermediate care capacity as required Seeking to secure increased tariff rate on a consistent regional basis to support	

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									sustainability.	
								7. Inability to sufficiently expand Domiciliary Care.	7 - Procure additional rapid response domiciliary care to cover all localities. Continue to work with all providers to maintain current capacity within the Independent Sector.	
								8. Non availability of HALO over 7 day period.	8 - Second HALO funding secured until March 2020. However there remains no cover for planned and unplanned leave hence not full 7 day cover. NIAS support on Causeway site being explored as part of winter planning.	
								9. Lack of regional approach to escalation.	9 - Director MEM contributing to Regional Working Group to develop regional approach. All Trusts working towards implementation of HEWS. Director MEM continuing to influence a Regional Escalation approach. Regional escalation policy currently being reviewed.	

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3	ID: 780 Non-compliance with regional guidance on nurse staffing levels. Reduced ability to recruit to permanent vacancies in the context of a National shortage of registrants alongside an inability to recruit to temporary vacancies. There is an increase in the number of nursing vacancies within the Trust. This consequently leads to the increased use of agency nurses.	5	4	20	1	<u>Recruitment updated November 2019</u> • Robust recruitment programme of registered nurses and non-registered staff is ongoing with prioritisation on frontline staff. • Trust internal processes to expedite vacant nursing posts to Shared Services • Open file for Band 5 Staff Nurses with bi-weekly interviews being held on Antrim & Causeway Sites. • All recruitment opportunities are exploited such as local and national University Job Fairs, Recruitment Fairs, RCN Congress and targeted recruitment days. • Participation in regional initiative to recruit International nurses. Region has appointed an additional provider for International Nurse Recruitment. Expedited processes exist within the Trust to process without delay front line nursing posts. • Meeting will be arranged with Shared services to explore the performance indicators for Nurse Recruitment (E). <u>Development / Retention of Staff</u> • Promotion of Secondments to the	Monthly monitoring of staffing levels against agreed levels (I). Monitoring of recruitment timeline from e-requisition raised to appointment of staff member (I). Nursing workforce AD is a member of the BSO Customer Service Liaison group (E). Triangulation and close monitoring of trends / concerns in relation to clinical incidents / Key Performance Indicators (KPIs) with staffing / vacancies (I). Monitoring of block booking deployments within Nursing Governance (I).	1. <u>Recruitment / Development / Retention of Staff</u> • There has been no significant Capital investment in the NHSCT resulting in no additional revenue for improved staffing levels. • There is a low level of specialist ward areas within both acute sites resulting in 1:1.3 nurse:bed ratio only in the majority of areas. • Adult branch nursing students from Queen's University (QUB) do not have placements within the NHSCT, therefore reducing our ability to recruit students from QUB. • There is a national shortage of nurses. 2. <u>Agency Staff</u> • The continued number of nurse vacancies will result in the use of expensive non-contract agencies which contributes to an unsustainable workforce.	Recruitment • Use of Data to inform the targeting of recruitment and to monitor the level of substantive Nurse hours in each division • Robust on-boarding of new recruits with regular contact from operational teams to prevent attrition. • Considerable work has taken place to improve processes and interface with BSO • Processes improved and applied to validate the Current Band 5 waiting lists within the Trust. Agency staff: Regional Group including Directors HR/Finance/Nursing reps from Trusts reviewing the agency spend and working with the DoH on workforce utilisation and cessation of NCA strategies. Funded Delivering Care levels compliance in Trust is 96% Safety Briefings including staffing situation at ward and site level daily. Strengthening clinical leadership with the uplift of nursing staff from Band 5 to Band 6 Clinical Ward Sister /	Executive Director of Nursing

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						Open University (OU) Nursing programme for Band 3 staff. • Preceptorship model implemented to facilitate new registrants through their first 6 months. • 6 Nursing MSc Students commenced in September 19. • Internal Transfer policy implemented to facilitate / enable the retention of Nursing staff. • Successful implementation of a Transformation Project to uplift 42 Band 5 nurses to Band 6 Clinical Sister/Charge Nurse. A development programme for these nurses in the Trust is ongoing. • Future Nurse / Future Midwife will be implemented in September 2020. • 5 Nurses/Midwives have been funded for the Global Leadership development programme to commence in January 2020. • 20 Frontline Nurse sand Midwives will be supported during 2020 to take part in the Nightingale challenge programme. • 3 ANP's graduated in October 2019. • Post Reg Training and Development Commissioning plan for September 2020 is in draft with named nurses committed to modules, short			Charge Nurse. Daily reporting of staff levels using Ward Quality Indicator Nursing Toolkit and the Site Co-ordination report. The E-rostering Qlikview App is now live, enabling managers to view up-to-date staffing rotas on mobile devices. A Band 3 Senior Nursing Assistant Clinical Development Programme has been implemented Band 6 nurse appointed to bank office for training and development. Revalidation rate 18/19 is 96%	

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						courses and specialist practice qualifications. <u>Nurse Bank / Agency Staff</u> • Block booking of agency staff in an attempt to stabilise teams.				

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4	ID: 67 The Trust has challenges in achieving the required levels of Information Governance (IG). There is a risk to the safe protection of service user information and the Trust's reputation. There is a secondary risk of regulatory action by the Information Commissioner's Office (ICO).	4	4	16	1 & 3	Information Governance Management Framework in place (Information Governance Forum, Senior Information Risk Officer, Personal Data Guardian, Assurance policies, structures and an IG Action Plan). Processing Personal Information Policy and Procedures, supported by departmental procedures as required. Mandatory Training at various levels. Underachievement of IG and POPI mandatory training is escalated to and reviewed at Accountability meetings. Awareness materials for public and staff. High level of expertise and robust processes in IG Department. Divisional Action Plans are a standing agenda item on Directorate Accountability meetings and IG figures are included in the Divisional Scorecards to monitor compliance. IG Action Plan developed for 2019/20 with key priorities for the IG work programme.	Quarterly senior team monitoring of IG, POPI and ICT security training compliance and it is raised at Divisional Accountability Reviews and forms part of the Performance Report at Trust Board (I). Incidents and complaints are reviewed routinely at IG Forum (I). The new Information Management Assurance Checklist (IMAC) has been completed for 2018/19, with all areas compliant with the exception of the risks assessments not being fully completed (E). Internal Audit carried out an IG audit across all Trusts with a specific focus on GDPR. The final report has been issued and this resulted in 'Limited' assurance, with one Priority 1 finding in respect of 52% of Information Asset Risk Assessments completed at the time of the audit (E). The Trust's Learning Alerts	1. Compliance with mandatory training for Trust staff as at 30th Sept 2019, is 89% for IG Awareness (increase of 3% on last quarter) and 83% for POPI (no change on last quarter). A target of 85% has been set by the Senior Executive Team. ICT Security compliance at the end of Sept 2019 was 84% (increase of 3% on last quarter). 2. The number of IG incidents reported during the quarter ended 30th Sept 2019 was 73, an increase of 12 on previous quarter. Three incidents have been reported to the ICO since April 2019, two of which has been closed by the ICO. The third incident was reported on 4th November and the Trust is awaiting initial communication from the ICO. 3. Learning from IG incidents needs to be further embedded in practice and evidenced.	1. The IG Department are providing monthly reports to Divisional IAOs on IG incidents which identify incident hot spots / trends and any learning or actions that can be shared. A quarterly IG Incident Analysis Report will be tabled for review at IG Forum meetings (with effect from July 2019) and corporate actions agreed to minimise or mitigate IG related risk. 2. Outstanding Risk Assessments have now been completed. There are 568 assets on the Information Asset Register. 3. Work is ongoing on developing a Business Case for Records Management scoping exercise, which will include an information audit. The audit will further enhance the Trust's	Divisional Director of Strategic Development & Business Services

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							System is in place to share learning from incidents (I)	4. There were 5 IG related complaints received during the quarter ended 30th September 2019. 5. Risk Assessments have now been fully completed for all assets on the Information Asset Register.	Information Asset Register, as well as informing the direction of a Records Management Strategy for the Trust. 4. A review of the DPA / FOI request process has been carried out which identified the need for additional resource to support this function. Temporary additional resource is now in place which is resulting in a gradual increase in compliance. An interim target of 75% compliance with 20 days by 31st December has been put in place, with a 95%+ target to be achieved by 31st March 2020. Internal processes are also being reviewed to identify any efficiencies to be gained in workflow processes. Findings and recommendations from this review will be reviewed at IG Forum in January 2020. 5. The Trust is working with DLS and regional colleagues to progress appropriate contractual clauses. The IG Department is supporting Divisions through the tendering process by undertaking data flow mapping exercises which inform the tender specifications & future contracts. A briefing paper identifying the challenges	

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								6. There is a need for the Trust to set out a 5 – 10 year Strategic Plan for Records Management. Investment will be required to support this plan including engaging in an Independent Review of paper records storage. This will enable the Trust to verify the accuracy of the Information Asset Register, update Risk Assessments and devise a Risk Management Plan. 7. Current compliance with requests for information under DPA and FOI legislation are 86% and 54% respectively as at quarter end September 2019 (previously 89% and 53% at quarter end June 2019). 8. GDPR came into force on 25 May 2018 along with the new Data Protection Act 2018. A GDPR Implementation Action Plan was prepared based on 12 key steps recommended by the ICO. All actions have been addressed; however the work in relation to contracts is	and a Trust action plan is being prepared to take the Trust to a state of compliance with GDPR contractual requirements. 6. A number of information governance policies have been reviewed and are with the Policy Committee for approval and circulation. The outstanding POPI Policy and General Procedures document, and Guidance for IAOs and IAAs are currently being finalised and will be complete by 30th Dec 2019.	

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								ongoing. This piece of work is significant and it will take some time to complete, and additional resources will be required to progress this. This is a priority for the IG Department, with a Trust action plan being prepared to take the Trust to a state of compliance with GDPR contractual requirements. POPI policies and procedures are being updated to reflect the changes as a result of GDPR and privacy notices have been updated.		

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5	ID: 324 There is a risk of an outbreak of healthcare associated organisms which has the potential to disrupt services and cause an adverse outcome for patients.	4	5	20	1	Review of policies, procedures and plans:- • Infection Prevention Control (IPC) Corporate Strategy 2017-2020 including IPC reporting structure. • Trust Cleaning Manual of cleaning procedures and advice on levels of cleaning required. • Access to Regional Infection Control Manual via Staffnet. • IPC Training Strategy and Delivery Plans for each Directorate / Division. • Visiting Policy (2 per bed) by operational clinical teams. Use of 'Fast Fact' information sheets for staff Safety Huddles. On-call IPC and microbiology rota (24 hour) 7 day week/24 hour microbiology laboratory service. Intensive cleaning programme by Rapid Response Teams in Acute and Community facilities. IPC Link Nurse and Link Worker system Trust-wide. IPC involvement and guidance in new builds and refurbishments. Weekly communication bulletin with other NI Trusts and PHA on regional IPC alerts and incidents. IRAT admission and assessment tool for	Rolling audit / feedback programme of compliance with hand hygiene and clinical practice care bundles including Antiseptic Non Touch Technique (ANTT) using regional audit tools (I). Rolling programme using Regional Cleanliness audit tools for Environmental Cleanliness and Clinical Practices including augmented care (I). Validation audits of self-assessment audits for Augmented Care areas - NNU, ICU (Antrim and Causeway), and additionally for C7, Macmillan Unit, A4 Renal in-patient area, Renal Unit. A programme of leadership walkabouts to identify and address estates and cleaning issues (I). CAS February 2019 score for IPC 98% (Replacement for these standards remains under review with the DoH) (I). Electronic Laboratory and Antimicrobial Surveillance (LAMPS) systems to monitor alert organisms / antibiotic stewardship and compliance reporting (I).	1. Bed occupancy rate on both acute sites ranges from 98% - 130% resulting in additional beds on occasion and challenges with appropriate patient placement in wards and departments to manage the IPC risk. The pathway for augmented care patients within Acute hospitals is compromised due to lack of single room accommodation. 2. The current reliance on locum and agency medical and nursing staff presents a level of risk with regard to assurances in maintaining IPC standards and compliance with IPC policies. 3. Implementation of learning from second stage Post Infection Reviews requires wider dissemination across the Trust. 4. Regional Point Prevalence Survey – preliminary results of PPS indicate concerns regarding antimicrobial prescribing and inappropriate use of antibiotics in relation to the rest of the NI region. Clinical	1. Pathway for augmented care patients to be reviewed. Increase number of single rooms that are of augmented care standard. A Capital Business Case has been submitted for the cost of adding 72 beds to the AAH site with an interim 24 beds opened in July 2019. 2. Additional training where indicated. Training for block booking agency staff implemented. 3. Process for dissemination to be agreed. 4. Antimicrobial Resource Kit (Ark) Project commenced November 2018. Medical Director and Lead Doctor for IPC to engage with Respiratory Medicine for some focused work to deal with antimicrobial stewardship.	Executive Director of Nursing

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						patients at risk of infection. Post Infection Review Process for all Staph Aureus bacteraemia and C diff. Communication/education to staff and visitors regarding risk of Norovirus and Influenza. Water testing for Legionella and Pseudomonas as per Water Safety Plan/Policy. Augmented Care Group meetings held with clinical staff to ensure training and competencies of staff in these high risk areas. Self-assessment of IPC in Neo-natal Unit and Intensive Care Unit as per RQIA recommendations. Daily attendance by IPCN's at both Antrim and Causeway Site Safety meetings to report current status and highlight any IPC risks. Easy to use App for antimicrobial prescribing available for all prescribing staff. Outbreak of Carbapenemase Producing Enterobacterales identified April 2019. Two cases of OXA-48 producing Klebsiella pneumonaie and one case of OXA-48 producing E. coli. Outbreak Control Group convened and chaired by Director of Infection	6 weekly IPC Environmental Hygiene Performance and Assurance Committee (reports into Trust Assurance Framework) (I). Daily monitoring and reporting of confirmed HCAI cases (I). Monitoring of compliance with Antimicrobial Policy and stewardship rounds. ARK Project commenced November 2018 (I). Audit of CDI Management and Ribotyping of CDI (I). Highly visible IPC Nurse presence in all in-patient clinical settings, auditing, monitoring and challenging any poor practice (I). Mandatory reporting to PHA of C-Diff, MRSA Bacteraemia and Gram Negative Bacteraemia and monitoring against annual (PFA) reduction targets (E). Participation in Regional Surveillance programmes for C Section wounds and Device-associated Infection Surveillance in Critical Care Units (E).	concern around the over prescription of Tazocin. 5. Reduction of antimicrobial pharmacy hours.	5. Concerns regarding the reduction of antimicrobial pharmacy hours have been escalated by Consultant Microbiologist to Head of Pharmacy (June 2017) and also by the Director of Infection Prevention and Control (May 2018).	

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						Prevention and Control. Outbreak stood down July 2019	Regional Point Prevalence Survey (PPS) HCAI and antimicrobial use (E). External inspections by RQIA (E). Joint Food Hygiene Standards and Kitchen inspections with Environmental Health Officers (E).			

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6	ID: 952 In a number of Acute specialties there is a risk that patients' conditions may deteriorate whilst waiting for an outpatient appointment or procedure and that a delay in diagnosis may cause harm. The specialties this currently impacts are: Neurology, Rapid Access Chest Pain, Diagnostics (Endoscopy, Radiology and Cardio-pulmonary Physiology), General Surgery, Colorectal Surgery, Breast Surgery,	5	4	20	1 & 2	<u>Neurology</u>: Regional Task and Finish Group established to develop strategic commissioning direction across all Trusts. MS Nurse Specialists augmented to deliver disease modifying drugs within the NHSCT. With regard to General Neurology, exploring options to maintain and develop Neurology Services in NHSCT, recognising that there is significant inequity in capacity across NI. HSCB has committed that they will fund a third post in NHSCT (and not fund elsewhere until NHSCT has a minimum of three Consultants, or equivalent). However, current recruitment potential is non-existent. A model is being developed as a networked solution. <u>Breast Surgery</u> All opportunity for additional red flag clinics optimised and delivered (evidenced by the overdelivery noted above): Breast Surgeons removed from all elective and emergency surgery commitments (temporarily) to facilitate delivery of additional activity. Additional Theatre sessions delivered for confirmed cancer operations. Bi-weekly capacity/demand meetings to analyse capacity and identify live opportunity to fully utilise resource and deliver additionality. Backfill of core sessions during periods of summer annual leave. Dedicated scheduler now	Delivery of all core SBA volumes monitored on a monthly basis – service actions taken when delivery threatened (I). Monthly cancer performance meeting between Director and HSCB (E) Monthly divisional performance review meetings and bi-monthly accountability reviews with Director of Operations and Director of Finance (focusing on delivery of core work) (I). Evidence on non-chronological management ie. seeing patients according to risk level rather than length of time waiting, in higher risk specialties (I). Maximisation of utilisation of waiting list funding (I). Clinical risk raised at HSCB / Trust service issues / Performance Review meetings to press need for investment (E). Reduce numbers waiting in particular areas such as BRACA patients.	1. There is still insufficient clinical capacity due to lack of funding in some specialties resulting in patients waiting longer than acceptable times for an appointment / treatment. For breast – RF OP demand – 399 average/month. Capacity is 319 and Insufficient capacity for breast surgery operations leading to increased waiting time for risk reducing surgery for patient with high genetic risk of developing breast cancer and also delayed breast reconstruction.	1. Work with HSCB to agree measures to address gaps in commissioned activity and to secure funding for current unfunded demand. To ensure a more formalised approach to waiting list validation, the HSCB will provide additional non-recurrent funding for administrative support (a Band 4 administrative post) to undertake validation of the OP and IP/DC waiting lists during 2019/20. The individual will be responsible for validating the waiting lists and removing those patients who should not be on the waiting list, e.g. had already been seen/treated, admin error etc. This initiative will be a pilot, with the initial focus on those specialties identified in phase 2 of the Day Case Elective Care Centres ie general surgery, endoscopy, urology, gynaecology, orthopaedics and ENT. Paediatrics will be outside the scope of the initial pilot. This work will be co-ordinated by an identified manager within the Performance Management	Divisional Director of Medicine & Emergency Medicine, Divisional Director of Surgery & Clinical Services

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	Gastro, Dermatology, Physiotherapy (related to 'women's health physio), Pain Service and Radiology & Histopatholog y Reporting backlog, Rheumatology and Breast Surgery..					appointed to optimise all available capacity. Nurse bank support secured to maintain backfill optimisation. Update November 2019 – situation remains the same. General Surgery & Colorectal surgery – excessive waiting time for new Red Flag outpatient appointments due to demand being much greater than capacity. Rapid Access chest pain - There is on-going difficulty with 'inappropriate' referrals, however agreement of referral criteria and necessary pre-referral investigations has not been reached regionally, as part of the 'banner' of the CCG referral system. Urgent referrals are currently being seen within 3 weeks Those re-triaged as routine by a Cardiology Staff Grade are waiting 14 weeks for an appointment, 220 patients currently on the list. <u>General Controls for all specialties (tailored as per specific issue):</u> Maximise activity of core SBA volumes through close operational and performance management. Prioritise patients in line with clinical need. Book patients in chronological order within priority categories. Make use of non-recurrent elective access funding where available to target areas of high clinical priority and long waits.		2. Due to lack of a dynamic purchasing system there is no ability for the Trust to set up elective Independent Sector (IS) contracts.	and Service Improvement Directorate who will be responsible for co-ordinating the validation work programme and providing regular outcome reports on the number of patients validated and removed. Waiting list for new patients in gastro, ENT and general surgery validated for patients waiting over 52 weeks – 23% discharge rate achieved. Commencement of validation new outpatient waiting list for rheumatology, gynaecology, pain and thoracic medicine over 52 weeks in next quarter. Reform and Modernisation Programme (RAMP) work stream reviewing practice across all elective specialties to maximise ability to meet demand appropriately within current resource. 2. Contribute to regional work to secure the dynamic purchasing framework for IS. When funding is identified maximise additional in-house activity and where appropriate ensure any IS contracts are fully maximised.	

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						Develop alternative service delivery models where appropriate. Consultant level triaging in all specialties. Review of cancer incidence in routine referral categories. Targeting of non-recurrent money to known high risk areas. Focusing in Quarters 1 and 2 on red flag patients. Routine patients to be considered by HSCB for funding later in the year. Awaiting confirmation of funding to be received. Standard procedures; all high risk, urgent, red flag and MDM cases are prioritised at quality control check out and presented to Consultants for reporting without delay. Breast - 3 breast surgeons removed from general surgery on call rota. Two x weekly breast planning meeting. Plan to reduce waiting time for BRACA gene patient - 13 week wait by November 2019. Support received from BHSCT for 20 patients. 14 day waiting time well improved. Histology backlog - Consultant review; all cases being placed in the backlog are reviewed by the Pathologist of the Day to help identify any case that may be at higher risk. Update November 2019 – ongoing. Recruitment has successfully appointed three substantive Consultants. In addition, Trust and extra-contractual locums have been agreed for reporting work. Additional work - existing Consultant Pathologists are undertaking additional backlog reporting work on a		3. An increase in red flag referrals across key clinical specialties. 1. Neurology - waiting times to include BHSCT Trust in-reach - Causeway - Routine referrals 4 years, Urgent referrals 2 years and 10 months. Antrim (NHSCT Consultant) Routine referrals 2 years and 6 months, Urgent referrals 14 weeks. To note AAH is partially dependent on BHSCT in-reach and Causeway totally dependent on BHSCT in-reach to deliver services. 2. Physiotherapy – there is insufficient funding for specialist trained 'women's health' physiotherapists, resulting in gaps. MSK position is no longer a risk as	To review funded arrangements for outpatient dermatology clinics and review and maximize use of skill mix within dermatology teams, to address red flag patients. Use of independent sector for review appointments invoked from September 2019. 3. Neurology - Reconfigured clinics in consultation with BHSCT whereby new referrals will be seen in Belfast. This will increase capacity marginally 4. Continuing to plan with BHSCT a regional model for service delivery. 5. Physio - Maximise the general physio workforce to address less complex womens health physio, thus mimising gap and consider ways that the skills gap can be addressed	

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						weekly basis where possible. Physiotherapy - Position has improved significantly as a result of regular additional work clinics. There is now a focus on improving the physiotherapy sub-speciality of women's health.		position has improved significantly as has rheumatology physiotherapy. 6. Rapid Access Chest Pain - not commissioned to meet level of demand together with inability to recruit to cardiology staff grade and locum cover. 7. General Surgery & Colorectal surgery - red flag outpatient referrals are not currently triaged. All booked to red flag slots.	internally. 6. Cardiology - The Trust introduced a Cardiology triage system as a level of risk management due to the extended waiting time. RACP patients also seen as part of core cardiology general outpatients to address backlogs Additional clinic space secured on adhoc basis Review of CAU workforce to utilise alternative model for clinic in CAU area completed – nurse resource secured, medical recruitment commenced. Review of model Antrim site to consider alternative ambulatory pathways – planning same day or next day assessment for referrals from Emergency Department, with roll out to GP's following pilot. 7. Breast – Other Trusts asked for RF breast assessment – positive response received from SET and BT. Also risk reducing surgery being undertaken 1/month – backlog will be cleared by November 2019 – will progress onto breast delayed reconstruction.	

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									Support received from BHSCT for 20 patients. 14 day waiting time well improved. 8. General surgery & colorectal surgery – establish consultant level triage of all red flag outpatient referrals. Establish a direct to test pathway bypassing the need for an outpatient appointment. 9. Utilising existing frameworks where they exist eg within dermatology/radiology.	

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7	ID: 427 Risk of harm to the safety or wellbeing of staff, service users or others affected by the Trust's undertakings.	4	2	8	1,2, 3 & 4	Implementation of recognised hierarchy of control, including elimination, substitution, local control measures and training. Health Improvement and well-being initiatives, for example, 'I-matters' website which provides health and well-being advice and guidance for staff. Occupational Health assessment and advice. Employee Assistance Programme through Inspire. GRANT implemented in September 2015. RAANT implemented in September 2016. Key points at Health and Safety Committee – GRANT, learning from incidents and COSHH. Focus at Divisional Accountability meetings on Health & Safety (H&S). Increased capacity within the Health & Safety Team. A Workforce Health and Well-being Strategy 2018 – 2020 has been developed in partnership with Trade Unions. It outlines the approach the Trust will take to proactively improve the health and well-being of staff and is underpinned by a Health and Well-being Action Plan.	Self-assessments against H&S and other Controls Assurance Standards having an H&S content (I&E). Incident reporting and analysis (I). Investigation of incidents and dissemination of learning across Trust (I). Internal Audit has completed audit of compliance with COSHH Policy – recommendations addressed (I&E). GRANT – KPI of 95% completion – achieved as at 31 March 2019 (I). RAANT – KPI of 90% completion – achieved as at 31 March 2019 (I). RIDDOR reporting (E). Sample COSHH audits by H&S Advisor (I) and Independent Consultant (E). KPI of 90% compliance – achieved as at September 2018 and sustained March / April 2019.	1. A comprehensive risk assessment and control process has been established; however, there are still some identified gaps, for example, in exposure monitoring eg. nitrous oxide. 2. Additional focus required at Divisional Governance meetings, with particular attention on poor performance identified by completion of RAANT. 3. Smoke Free Policy was due for review in January 2019. Implementation of the Smoke Free Policy has presented significant challenges and there is non-compliance with this policy. 4. KPIs for GRANT and RAANT not achieved as at May 2019. 5. A Strategy for reducing the level of challenging behaviour, violence and aggression is to be developed.	GRANT overall completion is 89% (October 2019) - KPI 95%. RAANT overall completion is 88% (October 2019) - KPI 90%. Failure to achieve the targets will be escalated via Divisional Governance Leads. A further progress report will be obtained every 3 months for those Divisions which did not achieve the targets Audit of COSHH updated position during September/October 2019 95% compliance – KPI 90 The Trust is also participating in a regional group regarding violence and aggression chaired by DOH Social Work team. The Occupational Health and Well-being team is leading a piece of work exploring stress experienced within the workforce. A Trust-wide stress survey will be carried out in September 2019. Focus groups are underway exploring sources of stress and mediating factors. Analysis of this data will enable the Trust to develop proposals in response to the findings of this work.	Executive Director of Nursing

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						A Challenging Behaviour Working Group was established in January 2019, jointly chaired by the Executive Director of Nursing and Executive Director of Social Work. This Group has established, following a literature review, that it is likely that between 50 and 60% of incidents of violence and aggression are going unreported. The trends identified above are likely to be due to a combination of this under-reporting and a result of the measures which the Trust has in place. It is noted that violence and aggression is now the most reported incident type within the Trust as per the quarterly RM report for quarter ended 30 Sep 19.			The Trust continues to remain involved in the Regional Healthier Workplaces Network led by the PHA. The Trust has signed up to the Staff Health and Well-being Charter and the Mental Health Charter (Equality Commission for NI). Challenging Behaviour Working Group to develop and oversee Strategy for reducing the level of challenging behaviour, violence and aggression. The Working Group has agreed to promote better reporting of incidents of violence and aggression. Work on the first phase of a toolkit for managers and staff nearing completion with a launch expected in the early part of 2020.	

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7	ID: 851 Risk of choking on food by patients / clients diagnosed with dysphagia or with suspected dysphagia who are waiting for full SLT assessment and are at additional risk of aspiration pneumonia, chest infection or malnutrition. Patients / clients diagnosed with dysphagia and have an SLT care plan recording texture modified food / fluids may be provided with / choose to eat the wrong texture of food / wrong consistency of fluids. During the transition from the use of National Patient Safety Agency	4	4	16	1,2, 3 & 4	<u>Assessment</u> Waiting list times for SLT assessment / review are monitored. HSCB has recently completed capacity / demand analysis which indicates a capacity shortfall of 4 Band 6 SLTs to meet ongoing demand. Implementation of the Dysphagia Management and Choking Reduction Policy (Adults) PHA has established the Regional Multi-disciplinary and Multi-agency Adult Dysphagia Group to action the recommendations of the PHA Thematic Review of Choking on Food. A sub-group of this Working Group has guided the introduction of standardised International Dysphagia Diet Descriptors Initiative (IDDSI). <u>Risk Management</u> Risk Management checklist for patients / clients who do not wish to eat commercially prepared texture modified meals. Snack lists for hospital and community agreed and available on Staffnet at different IDDSI levels. A Learning Letter (including a complaints template) has been shared through Divisions in relation to the process for raising concerns regarding the consistency of the ready-prepared meals for special texture modified diets.	Incident Reporting Policy (I). Investigation of incidents and dissemination of learning across Trust (I). Incidents of non-compliance with ordering the recommended textured diets are recorded by catering staff on Datix (I) Re-audit of practice within hospital sites commenced January – April 2018 (I). NHSCT representatives nominated to Regional Group to consider recommendations from regional Thematic Review (E).	<u>Assessment</u> 1. Waiting times for SLT assessment continues to exceed 450 days. Clients may experience harm (malnutrition, chest infection, aspiration pneumonia, choking) while waiting for assessment. <u>Risk Management</u> 1.No effective system to have complete assurance about: a. The traceability of meals – functionality of menu tablets remains problematic. b. Secure storage of thickeners to prevent unauthorised access.	<u>Assessment</u> 1. Working towards reducing waiting time to Ministerial target of 13 weeks by June 2019. However, capacity shortfall of 4.0wte Band 6 posts has been identified to meet ongoing demand. SLT service improvement plan in place to reduce DNA rate; to target admin support; to develop individual work plans for staff; to move towards partial booking all of those continuing. Paper has been presented to SMT outlining the shortfall to meet demand. <u>Risk Management</u> 1. a. Meetings held with Catering / IT User Group to escalate concerns in relation to functionality of the Menu tablet and WiFi connection. A software update to the Trust Catering Management system, due towards the end of the year, will enable the use of alternative, updated tablets which will improve functionality. b. Regional Patient Safety Alert HSC(SQSD)6/15 Risk of Death from Asphyxiation by Accidental Ingestion of Fluid/Food Thickening Powder	

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	(NPSA) UK texture descriptors to the International Dysphagia Diet Standardisation Initiative (IDDSI) there may be increased risk as manufacturers are not changing labels at the same time.					Staff are aware that where there are any issues in mapping previous UK descriptors to IDDSI descriptors, the case must be referred to SLT. All Trust systems have switched from NPSA to IDDSI. The lead for Domiciliary Care is now a Dysphagia Champion. Recruitment of a Trust Dysphagia Support Team. 3.0wte now funded of the original 5.0wte included in the RCB <u>Staff Training Programme</u> In the last reporting period 2,425 Northern Trust staff from catering, social care and nursing have accessed some form of training in Dysphagia Awareness. 134 Trust staff and 402 Independent Care Home Staff accessed training this reporting period. In addition, approximately 1,400 Trust staff attended IDDSI training in October / November 2018. E-Learning available on IDDIS is now available on Regional HSC E-learning Platform. Trust Dysphagia Group has agreed the requirement for a 3 yearly update on Dysphagia Awareness training. <u>Homecare</u>		c. Monitoring of incidents relating to dysphagia management.	has been disseminated on 3 occasions (December 2015, August 2016 and December 2016); however, assurance cannot be obtained regarding the safe storage of thickeners. Consideration to be given to including availability /storage of thickening powders as a possible audit for the assurance audit programme. c. Service Lead will undertake an analysis of incidents relating to dysphagia management, along with the Trust Corporate Risk Manager, with an initial report to be discussed at Trust Dysphagia Group at end of June 2019 and trigger lists for the reporting of these incidents agreed. Regional work is also ongoing to standardise the reporting of incidents. The Trust Dysphagia Group continues to meet to agree priorities associated with the updated Dysphagia Management and Choking Reduction Policy (Adults) which has been approved by CSCPG and is available on Staffnet from July 2019. A re-audit of practices is currently being planned to assess compliance with the revised policy.	

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						831 Homecare Workers have received training in Dysphagia Awareness. This is approximately 81.5% of the staff. Homecare staff are not permitted to assist with the feeding of newly referred clients with a SLT care plan until trained. Dysphagia Information Awareness Leaflet issued to home care and community staff which was revised in March 2018 to include IDDSI and redistributed. Training of Homecare workers to be kept under review by relevant managers. Development of Trust Dysphagia Policy for Children has been completed Nov 2019.		2. The Regional Dysphagia Steering Group has not yet provided an Action Plan to Trusts regarding standardisation of dysphagia care (awareness, training, identification, assessment and management). It has been established that a neighbouring Trust and Paediatrics services are continuing to use outdated terminology. 3. It is unlikely that the regional transformation project will be able to deliver the expected level of improvements with respect to incident management due to delays at regional level in the project.	3.Recruitment to the Dysphagia Support Team (Transformation Project) is progressing. It has progressed for 3 staff. The support will progress the recommendations from the Regional Dysphagia Steering Group and the Thematic Review. A letter has been drafted for issue to the PHA raising concerns about the use of outdated terminology by a neighbouring Trust and in Paediatrics. A response was received from DON (PHA) the regional implementation group has been recalled to consider the issues raised. 4. A further audit of dysphagia practice against the July 19 policy is being planned for November 2019. A selection of facilities from all programmes of care will be audited.	

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8	ID: 28 Failure to achieve statutory breakeven position.	5	3	15	2, 3 & 5	Financial Accountability arrangements. Process for monitoring budget and formulation of corrective action plans. Robust monitoring and forecasting. Income agreed with Commissioners and monthly meetings with HSCB Finance colleagues to discuss cost pressures. Process for budget setting. Recurrent savings proposals identified by directorates and monitored monthly. Implementation of contingency arrangements, with appropriate approvals, if required to secure a breakeven position. Monitoring of Savings plans if required. Confidence and Supply planning and slippage review. The Trust has maintained financial control internally through ongoing budget management processes, along with RAMP and project management arrangements (I). Director accountability arrangements (I). Monthly Director accountability meetings with Director of Finance and Deputy Chief Executive (I). A new finance/performance accountability forum has been established which will commence in Sept 2019. A medical Scrutiny Committee has also been	The Trust has maintained financial control internally through ongoing budget management processes, along with RAMP and project management arrangements (I). Director accountability arrangements (I). Bi-Monthly Director accountability meetings with Director of Finance and Deputy Chief Executive (I). A new finance/performance accountability forum has been established which will commence in Sept 2019. A medical Scrutiny Committee has also been established which will examine the utilisation of locums and recruitment of a range of vacant posts. The Trust has submitted a draft high level financial plan for 2019/20 which is indicating a £13.7m deficit in year. This includes a shortfall against the cost controls/savings targets of £9.058m that have been given to the Trust by the HSCB. Consideration is being given to high impact proposals to address the 2019/20 savings shortfall. Discussions continue with HSCB and DoH	In 2018/19 Trust has taken forward a significant range of projects in support of Transformation funded via regional Confidence and Supply Funding. 2019/20 funding for the majority of Transformation Schemes has now been confirmed, with @ £0.5m funding remaining to be confirmed. HSCB confirmed 2019/20 allocations on 28 June 2019. These allocations included Trust Savings Target of £9.1m, including £1.2m in respect of Pharmacy Savings, £0.2m for Car Parking and £7.7m Core Savings. The Trust identified further pressures, most notably increased Employer's Superannuation costs associated with Auto-Enrolment, Winter Pressures and Revenue Pressures. The Trust currently projects a shortfall in year of £13.7m, including: - Cost Pressures (£7m); - Savings Gap (£6.7m).	The Trust continues to liaise with Transformation Project Leads in respect of potential funding to cover any funding gaps on Transformation in 2019/20. This will be followed by further extensive engagement on the funding arrangements in respect of these schemes from April 2020. The Trust has submitted a Draft Financial Plan to HSCB setting out the financial position of the Trust, projecting a gap of £13.7m in the year to March 2020. This includes steps to address the Savings Gap brought forward from 2018/19 (£8.5m). The Trust continues engagement with DoH/HSCB with regard to scale of the financial pressures identified in 2019/20. A range of measures, including potentially High Impact measures, will then be developed to address these gaps in conjunction with DoH and HSCB.	Executive Director of Finance

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						established which will examine the utilisation of locums and recruitment of a range of vacant posts. The Trust has submitted a draft high level financial plan for 2019/20 which is indicating a £13.7m deficit in year. this includes a shortfall against the cost controls/savings targets of £9.058m that have been given to the Trust by the HSCB. Consideration is being given to high impact proposals to address the 2019/20 savings shortfall. Discussions continue with HSCB and DoH representatives. Trust Board receive regular Financial Performance Report setting out progress against the Financial Plan (I). Monthly and Annual financial reporting and external audit (E).	representatives. Trust Board receive regular Financial Performance Report setting out progress against the Financial Plan (I). Monthly and Annual financial reporting and external audit (E).	The Trust is required to develop a Savings Plan to address the Savings Gap, including potential High Impact Measures.		

9	ID: 1000 Potential that a 'no deal' EU Exit could result in a period of disruption in the supply chain post EU Exit, affecting key stocks and supplies and impacting on service delivery and patient care. Whilst originally potentially to be on 29/03/2019, the risk date was changed through extension agreement to 31/10/2019 and now has changed due to further political agreement to a delay until 31/01/2020 unless an agreement is finalised before then. On 16 April 2019 the Permanent Secretary issued a memo to all ALB Chief Executives advising that the Department will	3	3	9	1	The NHSCT has 3 representatives on the regionally-led DoH EU Exit Group for ALBs, including a Business Continuity and Emergency Planning representative at both the DoH ALBs group meeting and also the DoH Emergency Planning leads group. In addition, there are Assistant Directors representing on the Finance and HR Working Groups in relation to assessing and determining potential impacts. These representatives continue to work with regional colleagues to understand and respond to the risks. To agree the requirements for the planning and strengthening of business continuity arrangements within the NHSCT, there has been an Internal Working Group established for EU Exit with membership including divisional representation across the Trust. This group has planned meetings in place throughout the extension/delay period. The NHSCT will continue to work closely with DoH and other HSC bodies on this matter in planning for the EU exit in 2020. EU Exit briefing sessions delivered to all Trust divisional management teams. Assurance Statements forwarded from the Chief Executive to the Permanent Secretary to confirm Trust planning. BSO PaLS has implemented contingency arrangements and increased warehouse supplies by approximately 6 weeks' worth on top of their normal stock levels. Local	A Business Impact Analysis has been undertaken and Business Continuity Plans developed on the basis of risks identified (I). Trust EU Exit Lead and Emergency Planning Lead attended Executive Team on 14 February 2019 to provide update on contingency arrangements in place. Due to the delay the regular reporting planned to take place post EU Exit on 29 March 2019 is now stood down at present; however, the Trust has processes in place to respond should this change (I). Key staff, including roles of Divisional Directors and Divisional EU Exit Leads took part in a table-top exercise on 5 March 2019 to ensure all are aware of their responsibilities and action to be taken in respect of any EU Exit related issues, including arrangements for SITREPs (I). The Trust has also established planning arrangements to support the DoH C3 structure. The Trust has tested and has in place processes to discharge duties in the event of a stand up of these regional reporting structures (I). Trust Emergency Planning Lead attended a table-top exercise with DoH EP Branch for EP leads and continues to link with regional colleagues (E).	None further identified at this stage. The Trust continues to participate and respond to regional work in this area. There is a particular focus currently on the readiness for a no deal EU Exit of the Independent Social Care Provider Sector and appropriate assurances being sought.	Trust leads are planning for the local issues particularly working with the region in relation to stocks and supplies impacts and planning contingency measures. The Trust had put in place contingency local stocks for 29 March 2019 leave date. These contingency plans remain in place, with the Trust and HSC bodies now refining their plans for a 'no deal' exit, scheduled for 31 October 2019. With the extension this work is now continuing to the new date of 31/01/20.	Divisional Director of Medicine & Emergency Medicine

	not be enacting the 'no deal' contingency plans we currently have in place and will be considering the EU Exit work programme and re-planning for the October 2019 date, which subsequently happened. The DoH have over recent months had re-commenced their planning, contingency plans enacting etc for a potential no deal EU Exit risk occurring on 31/10/19 and have now informed ALBs that planning is now towards the 31/01/20 extension date. Until a deal is agreed and ratified, there remains a risk of a no deal exit, with that risk now being on 31/01/20.					divisional confirmation of contingency stocks for non-stock items. Medicines/Pharmacy supplies are also being dealt with outside of Trusts, at a national and regional level. Up-stocking of essential supplies had taken place for 29 March 2019 leave date, but is also now being maintained and rotated by divisions and managers as in line with regional instructions to approach and manage shelf life issues where applicable.. Additional storage had been secured by Estates to meet any additional requirements and this is continuing at present and will remain in place for the 31/01/20 date. Regular meetings of the Trust EU Exit Working Group which includes representation from Divisions, Finance. Governance (Emergency Planning) Estates, HR, Catering are planned to respond throughout the current delay period to 31 October 2019. EU Exit Strategic and Operational Business Continuity Plans have been reviewed and updated (these remain live documents). Trust leads are planning for the local issues particularly working with the region in relation to stocks and supplies impacts and planning contingency measures.	The Trust has also established planning arrangements to support the DoH C3 structure. The Trust has tested and has in place processes to discharge duties in the event of a stand up of these regional reporting structures (E).			