DoH ARM'S LENGTH BODY: MID-YEAR ASSURANCE STATEMENT

This statement concerns the condition of the system of internal governance in Northern Health and Social Care Trust as at **30 September 2025**.

The scope of my responsibilities as Accounting Officer for the Northern Health and Social Care Trust, the overall assurance and accountability arrangements surrounding my Accounting Officer role, the organisation's business planning and risk management, and governance framework, remain as set out in the Governance Statement which I signed on 26 June 2025. The purpose of this mid-year assurance statement is to attest to the continuing effectiveness of the system of internal governance. In accordance with Departmental guidance, I do this under the following headings.

1. Governance Framework

The Governance framework as described in the most recent Governance Statement continues in operation. The Audit Committee and the other Board Committees which include Remuneration, Charitable Trust Funds Advisory and Outcomes and Assurance Committees have continued to meet and to discharge their assigned business. Minutes of their meetings, together with board meeting minutes containing the Committees' reports, are available for Departmental inspection to further attest to this.

2. Assurance Framework

The Integrated Governance and Assurance Framework, which operates to maintain, and help provide reasonable assurance of the effectiveness of controls, has recently been reviewed in conjunction with the Chair of Trust Board. The revised Integrated Governance and Assurance Framework Committee Strategy was approved by Trust Board in April 2025 and became operational in May 2025 with ongoing implementation throughout the reporting cycle. Minutes of Outcomes and Assurance Committee meetings are available to further attest to the continued operation of the framework, with draft minutes of Outcomes and Assurance Committee meetings subsequently tabled at each Trust Board meeting for noting.

3. Risk Register

I confirm that the Principal Risk Document (details those risks that could compromise achievement of the Trust's Principal Corporate Objectives) and the Corporate Risk Register have been regularly reviewed by the Outcomes and Assurance Committee and that risk management systems/processes are in place throughout the organisation. As part of the board-led system of risk management, the Principal Risk Document is presented to the Outcomes and Assurance Committee. Any relevant matters are escalated to Trust Board via the committee report to the Board. The Corporate Risk Register is presented annually to the Outcomes and Assurance Committee, for discussion and approval.

In addition, I confirm that Information Risk continues to be managed and controlled as part of this process.

4. Performance against Business Plan Objectives/Targets

The Strategic Outcomes Framework (SOF) and System Oversight Measures (SOMs) were published by SPPG in November 2024 and the Trust submitted a response on 30 Jan 2025. I confirm satisfactory progress towards the achievement of the objectives and targets set out in this response with the exceptions as set out in this mid-year assurance report (see Internal Control Divergences).

Trust performance against these objectives and other escalated areas is monitored through the Support and Intervention Framework and through the Trust's Accountability and Performance Management Arrangements.

5. Finance

I confirm that proper financial controls are in place to enable me to ensure value for money, propriety, legality and regularity of expenditure and contracts under my control, manage my organisation's budget, protect any financial assets under my care and achieve maximum utilisation of my budget to support the achievement of financial targets.

I confirm compliance with the principles set out in MPMNI and the Financial Memoranda which includes:

- safeguarding funds and ensuring that they are applied only to the purposes for which they were voted;
- seeking Departmental approval for any expenditure outside the delegated limits in accordance with Departmental guidance;
- preparation of business cases for all expenditure proposals in line with FD(DoF)11/20 Better Business Cases NI and Departmental guidance and ensuring that the organisation's procurement, projects and processes are systematically evaluated and assessed;
- accounting accurately for the organisation's financial position and transactions;
- securing goods and services through competitive means unless there are convincing reasons to the contrary; and
- procurement activity should be carried out by means of a Service Level Agreement with a recognised and approved Centre of Procurement Expertise (CoPE)

6. Information Governance – General Data Protect Regulation (GDPR) & Data Protection Act (DPA) 2018

I can confirm that my organisation has taken appropriate steps and is carrying out the necessary actions to ensure ongoing compliance with GDPR and DPA 2018.

7. Environmental, Medical Device Management and Estates Infrastructure Safety Governance (Trusts only)

In respect to Environmental, Medical Device Management and Estates Infrastructure Safety Governance, I confirm that my organisation has controls in place to enable it to meet the requirements of all extant statutory obligations upon it, that it complies with all standards, policies and strategies set by the Department and all applicable guidance set by other parts of government. Any significant control divergences are reported below together with an outline of action plans in place to address these divergences.

8. Conflict, Bullying and Harassment operational policy and the Raising a Concern in the Public Interest (Whistleblowing) HSC Framework

In respect of the Conflict, bullying and Harassment operational policy and the Raising a Concern in the Public Interest (Whistleblowing) HSC Framework, I confirm that my organisation has in place clear, up to date and fit for purpose operational policies and procedures in place in respect of both policy areas. Appropriate levels of Board oversight and scrutiny is undertaken by the Board, the People & Culture Committee and the Audit Committee.

9. External Audit Reports

The Trust received the final Report To Those Charged With Governance in August 2025. This contained three external auditor's recommendations, all of which were accepted. The priority of the recommendation denotes the seriousness:

- Priority 1 – significant issues for the attention of senior management, which may have the potential to result in material weakness in internal control.
- Priority 2 – important issues to be addressed by management in their areas of responsibility.
- Priority 3 – issues of a more minor nature, which represent best practice.

The three recommendations are laid out in the below table and I confirm work is on-going to implement the external auditor's accepted recommendations.

	Recommendation	Target Date	Priority	Management Response
1	**Fixed Asset Proposal** We recommend that the Fixed Asset Register is updated on a timely manner to reflect any fixed asset disposals.	31st July 2025	3	Accepted These assets will be disposed in July 2025, controls around disposal process have been enhanced to avoid a re-occurrence

2	**Approval of CTF Expenditure** We recommend that CTRE forms are signed off by two Officers in line with NHSCT's delegated levels of authority. Where one Officer is covering the position of both Fund Manager and Assistant Director, a second approval should be provided by a Trust Director.	31st March 2026	3	Accepted CTF Policy and associated templates (including CTRE form) are being updated in 2025/26 and this recommendation will be reflected in the updated versions
3	**Holiday Pay Provision** Going forward, prepare a sensitivity analysis which shows how the estimate would change with reasonably possible changes in the assumption.	31st March 2026	3	Accepted The Trust will continue to work with DoH and regional Trusts' colleagues to ensure any assumptions applied are reasonable, based on latest available information, and where appropriate subject to sensitivity analysis calculations and disclosures

10. <u>Internal Audit</u>

I confirm implementation is being proactively progressed of the accepted recommendations made by Internal Audit, with 71% fully implemented at the mid-year review and 26% partially implemented, with only 3% not yet addressed. The Financial Governance Team works with Directorates including offering guidance and support on the action and evidence required to implement and close recommendations.

At the mid-year recommendations in respect of cyber compliance were separately reported, as these are regional in nature and resolution therefore not solely within the power of the Trust.

There are 67 prior year recommendations, of which 60 are only partially implemented and 7 not implemented but all have actions planned against them. 37 of these were in relation to significant findings: 1 priority 1, 33 priority 2 and 3 not prioritised. At the mid-year position last year there were 58, of which 2 were priority 1, 54 priority 2 and 2 not prioritised. The priority 1 recommendations are highlighted in the table below:

Audit Report	Year	Recommendation	Progress Update September 2025
Management of General	2024/25	Triaging Performance	

Surgical Triage		The management and organisation of triage sessions already included in job plans, needs enhanced and performance managed to ensure Consultant triage time is defined and activity levels are monitored. Triage capacity should be evaluated and compared with demand, with an action plan then developed if necessary to close any demand/capacity gap.	Development of enhanced reporting from Encompass is underway to aid with rota management A framework for monitoring and performance management has been developed by the service.

11. RQIA and Other Reports

I confirm implementation of the accepted recommendations made by RQIA, and that the Trust has received one final RQIA Review report since April 2025:

- Inspection of Outpatient Departments

No new RQIA reviews have commenced.

Since April 2025, the Trust received 16 reports relating to routine inspections (announced and unannounced) of Trust facilities. Areas for improvement were identified for 10 facilities inspected, for which improvement plans have been completed and returned to RQIA. Progress against improvement plans is monitored by the Divisional Governance Teams. In 6 of the facilities inspected no areas were identified for improvement.

Other Reports

I confirm that the Trust is not in receipt of any other inspection reports since April 2025.

12. NAO Audit Committee Checklist

I confirm completion of the NAO Audit Committee Checklist and that action plans will be implemented to address any issues. I also confirm that any relevant issues will be reported to the Department.

13. Board Governance Self-Assessment Tool

I confirm completion of the Board Governance Self-Assessment Tool and that action plans will be implemented to address any issues. I also confirm that any relevant issues will be reported to the Department.

14. Internal Control Divergences

I confirm that my organisation meets and has in place controls to enable it to meet, the requirements of all extant statutory obligations, that it complies with all standards, policies and strategies set by the Department; the conditions and requirements set out in the Management Statement and Financial Memorandum (MSFM), other Departmental guidance and guidelines and all applicable guidance set by other parts of government. Any significant control divergences are reported below.

Progress on Prior Year Control Issues – Ongoing

Residential Childcare and Placement Availability

Residential Care and Foster Care placement availability is challenging on a regional and local level and there continues to be a significant reduction in enquiries to the regional Foster Care Recruitment Team for the Northern Trust area. There is a sustained increase in the number of Looked After Children within the Trust area, with a 9.3% increase between 31 March 2024 (815) and 1 September 2025 (891). Whilst the majority of young people continue to be provided with appropriate care placements, an increasing number of young people with challenging and complex needs have been cared for in unregulated arrangements. RQIA had served an improvement notice on the Trust given that the pattern of operating unregistered Children's Homes has persisted, and there is a continued reliance upon unregistered Children's Homes to meet the placement needs of the increasing Looked After Children population. The Trust had implemented an action plan in an effort to minimise further use of this type of arrangement with wide ranging actions e.g. Fostering Support Hub for fragile placements; enhanced support for Foster Carers; increase in recruitment of Foster Carers and seeking to identify resource for an additional kinship team. The Trust has further plans to increase placement availability, however

these will require time to implement, and it is unlikely to avoid additional emergency unregulated arrangements in the intervening period. With respect to children with a Disability, Whitehaven has now reopened with reduced capacity for residential short breaks, given one young person is currently accommodated. Eden View remains closed to short breaks due to ongoing workforce issues. The Trust is acutely aware of the impact this has on families and young people and continues to work towards reopening services for this cohort of young people at the earliest juncture.

Aseptic Facilities

Aseptic processing is the manipulation of sterile medicinal starting materials and components in such a way that they remain sterile and uncontaminated whilst being prepared for presentation in a form suitable for administration to patients. As such, it is a critical and high-risk process that must be carried out by highly trained staff in facilities with pharmaceutical clean rooms and associated equipment (e.g. isolators, laminar airflow cabinets) that comply with the current standards of Good Manufacturing Practice (GMP).

The NI Regional Quality Assurance Service undertakes audits of all aseptic units against UK national standards. The Antrim Pharmacy and Laurel House aseptic facilities were rated as overall HIGH risk to patient safety in the 2022/23 audits. Re-audits have been completed in 6-monthly intervals and the risk rating has remained as HIGH for both facilities. These facilities are more than 25 years old and do not meet the current standards for the design and construction of clean rooms; they require urgent investment to prevent them presenting unacceptable risk to patient safety. A Pharmaceutical Quality System (PQS) has been established which records and reviews the microbiological and environmental monitoring of the facilities. Monthly quality management meetings are held to review all aspects of the management and monitoring of the facilities and agreed actions recorded. The PQS demonstrates that the facilities are currently maintaining a level of control in terms of the fabric and finishings and environmental monitoring. There is active engagement with the Capital Development team and a preferred location and design of a new build has been prepared which would combine both Trust facilities into one unit. A regional review of aseptic services has been completed which includes the development of a Strategic Outline Case for NI Trust Pharmacy Aseptic Services to address the rising demand in cancer services and unmet need. The regional capital investment proposal included replacement facilities for the Trust and the requirement has been added to the Trust's Capital plan. Whilst the Trust has undertaken preliminary design work it awaits a decision in relation to capital funding.

The risk of not providing replacement facilities to the standard is that a decline in the ageing facilities coupled with the potential loss of environmental and microbiological control would lead to significantly reduced assurances of providing safe aseptic products for immunocompromised patients. In operational service delivery terms this would significantly jeopardise and likely prevent Pharmacy from being able to provide aseptic services to Northern Trust patients (outpatients and inpatients). There are no contingency facilities available in NI.

Payments to Medical Staff and Job Planning

There continues to be an improvement in collaborative working between the Office of the Medical Director and Operational Divisions. It has provided better oversight of the job planning process with monthly progress reports produced, and timely resolution to over/underpayments for medical staff and services. The outcome achieved was a Trust improvement with 91.85% of Consultants and 90.99% of Specialty and Specialist (SAS) Doctors having a job plan in place as at April 2025, with continual work progressing into 2025/26. Of the 8 Internal Audit recommendations (from a limited assurance audit in relation to Payments to Medical Staff and Management of Job Planning in 2023/24), 5 have now been implemented, 1 has been partially implemented and the date for implementation of the 2 remaining recommendations is January 2026.

In August 2025, communication was issued to all Operational Directorates to undertake a programme of monitoring Consultants Job Plans. This responsibility sits within the Operational Directorates and is aligned to the Internal Audit recommendations pertaining to job plans.

Management of Medical Devices

Following a limited assurance Internal Audit on Management of Medical Devices in 2023/24, management has agreed actions to address Internal Audit recommendations, including validating the Trust's Medical Device Asset Management System (eQuip), for all assets for which the Trust has responsibility. Servicing requirements have been updated on the new eQuip system. A number of actions have been partially implemented and communication with internal audit remains.

A replacement medical device programme has been established for current need within the Trust. This 15 year rolling programme will require approximately £40m capital funding. This has been raised with the Department of Health Investment Directorate to establish a process to take forward.

Joint Advisory Group (JAG) Accreditation

The Endoscopy Service at Whiteabbey Day Procedure Unit received notification from JAG on 28 January 2020, advising that, "'the service had not been able to demonstrate adherence to JAG standards and accreditation had been withdrawn." Full JAG assessment will be required to regain accreditation. The service continues to work through the JAG standards to allow consideration for full accreditation. There are a number of areas in which the service does not meet the standards and work continues towards achieving these.

The JAG on Gastrointestinal Endoscopy is not a mandatory requirement for performing endoscopy, but is a quality assurance body that sets standards for endoscopy services in the UK. The Trust Endoscopy service recognises the value that JAG accreditation brings in terms of external validation, assurance of quality, and continuous improvement; on this basis the service will continue to work towards accreditation and complete self-assessments against each of the standards, this will help service benchmark against the national standard and identify areas for further development. It is anticipated that this internal control divergence will be closed at year end.

Dysphagia

Dysphagia management and the risks associated with the provision of food and drinks to people diagnosed with dysphagia, continues to be an area of focus and remains a principal risk to the Trust. The Trust Dysphagia Group provides leadership across the Trust to drive and embed key actions such as the implementation of the Food and Drink Safety Pause, prior to serving meals or drinks. The Trust Dysphagia Group has progressed actions to implement all of the recommendations for HSC Trusts set out in the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Report 'Hard to Swallow', and the RQIA of the Implementation of Recommendations to reduce Choking Incidents in the Trust.

The Clinical Education Centre regional eLearning programme is now available for staff working with adults and children (excluding neonates, where bespoke training materials are available).

An Internal Audit of Dysphagia Management was conducted in 2023/24, providing limited assurance and an action plan to take forward the recommendations of the report is overseen by the Trust Dysphagia Group. Significant progress is being made regarding

manually reporting on training compliance, however it is hoped that an electronic solution will be found.

Regrettably, the Trust was advised by the Health and Safety Executive NI in August 2023, that it had referred a further incident, which occurred in March 2022, to their Major Investigation Team, relating to the death of a patient associated with an episode of choking. This investigation remains ongoing and a number of Trust staff have been interviewed.

Recruitment and Retention

There continues to be ongoing and significant workforce challenges across nursing, social work, and medical staffing within the Trust, with ongoing challenges to secure staffing across these professions. This remains a risk to the delivery of sustainable services.

The Trust continues to take the following actions:

- proactive nurse recruitment across Trust services, with sustained effort to recruit to areas that are challenging to staff consistently;
- proactive engagement with university students, through information sessions, careers fairs and positive practice learning experience, has supported positive recruitment of newly qualified nurses for September 2025;
- international nurse recruitment, which has continued to provide a steady number of arrivals since 2017; 282 internationally-educated nurses arrived in the Trust between April 2017 and January 2025, 267 of them have been employed through the regional recruitment programme, with 15 internationally educated nurses being recruited locally and supported through Observed Structured Clinical Examination. Of the 282, 270 have been placed on the NMC register, three are currently awaiting NMC PIN;
- medical recruitment campaigns;
- ongoing participation in the regional Medical and Dental Agency Framework Group which was established to review the current framework, assess the level of agency/locum utilisation within Trusts, detailing areas of high agency demand in advance of the new framework procurement process for Regional Medical/Dental Agency staff;
- ongoing review of medical locum usage via Retinue and in-house, working collaboratively with all Divisions, reviewing medical workforce and plans to reduce locum spend via recruitment solutions, International Medical Recruitment, CESR and other recruitment campaigns;

- under the Social Work Workforce Review 2022, there was a recommendation to increase university places by 60 per year in order to address the historic deficit in the workforce. During this reporting period the Department of Health has only agreed to an additional 40 places on the social work degree course, however there is an expectation that this initiative is to support further roll out of Multi-Disciplinary teams in primary care. The Trust recognises that any potential increase to the actual workforce will now not be realised until at least 2028. The demand for workforce continues to grow with new posts being introduced to implement policy / legislation and growth of services. The insufficient supply of a workforce as well as the growth of the profession, continues to create significant challenges with vacancies continuing at high levels in front line teams. The Trust appointed 49 new social workers in July 2025, however new vacancies will remain unfilled due to cyclical recruitment and annual entry point for newly qualified social workers;
- ongoing review of the efficiency of nursing resources and appointment of a safe staffing lead nurse;
- review and monitoring of utilised nursing hours to assess the usage of contract agency;
- a Nurse Stabilisation Group has been established to develop and lead the planning and actions required to achieve maximum effectiveness of the Trust's available funding / resources associated with the Nursing and Midwifery Workforce (Funded Staffing Level) to deliver Trust workforce stability, patient safety and financial benefits realisation;
- new electronic rostering system in place for those who had existing rosters. Improved functionality and oversight will be available to support monitoring of safe staffing and efficiency and utilisation of nursing hours;
- progressing a regional refresh of Delivering Care;
- a new social work research project focusing on positive retention indicators has begun within the Trust and in partnership with Queen's University Belfast and the Office of Social Services at the Department of Health. Drawing on new research led by the University of East Anglia (UEA), the Trust is piloting a "theory of change" model aimed at improving retention through strengthened professional identity and peer support. The UEA model, aligned with findings from the 2020 All-Ireland Study, highlights the critical role of professional identity in staff retention. The new retention initiative centres on timely, reflective, and compassionate support during critical care episodes. Research indicates that when these episodes are resolved constructively, they lead to personal and professional growth. Left unresolved, however, they contribute to burnout, disengagement, and workforce exit; and

- collaborative work with NIMDTA, through the Single Lead Employer process, to deliver an improved employment experience for Doctors and Dentists in Training.

Payroll and Recruitment Services

The Payroll Shared Services Centre (PSSC) has received a Satisfactory Internal Audit Assurance in 2024/25, previously they had consistently received Limited Internal Audit Assurance since 2014/15.

The Payroll Quality Improvement Project continues with six strands addressing the remaining recommendations. The Payroll Quality Improvement Project aims to improve the quality and accuracy of payroll processing in specific areas of service delivery.

The Trust continues to participate annually in the following governance structures in support of these strands;

- Shared Services Regional Customer Services Forum; and
- Regional Payroll Customer Services Forum, in order to monitor operation, progress and governance of key decisions in relation to payroll.

The recovery of overpayments is a particularly difficult issue and the retained payroll function within the financial accounting team liaise routinely with PSSC with regard to actions to be taken and the scope and value of these.

The Staff in Post (SIP) verification process is operated by the Trust to facilitate the early identification of payroll error, so reducing the occurrence of overpayments and minimising the value and potential irrecoverability, where these do occur inadvertently. For 2025/26, compliance rates for Divisions are Quarter 1 96% and Quarter 2 95%.

Recruitment Shared Service (RSS) also received a Satisfactory Internal Audit Assurance for 2024/25.

Depending on Internal Audit assurance at year-end this recommendation may be suitable to close.

Financial Breakeven Position

The Trust has engaged with DoH and SPPG over the 2025/26 Financial Plan period, submitting an initial plan in February 2025 with a deficit estimated at £41m. Following additional notification of allocation and review of pressure estimates this deficit reduced to

£35m in April 2025. Additional Savings were identified in June and DoH confirmed deficit funding of £13m; reducing the deficit to £18.1m.

In September 2025 the Permanent Secretary wrote to all Trusts requesting a plan for break-even for 2025/26 which identified a graduated level of savings and savings scenarios. The Trust identified a plan to deliver £7.3m of low and moderate savings, which would have minimal or no impact to staffing or services. In addition, a further £4.4m of high-level savings scenarios were identified. These either had a risk associated with them in deliverability or had a high impact on staff and service users. Finally, £6.4m of Catastrophic Savings scenarios were identified, these would have catastrophic impact on services and staff and the HSC system.

These savings scenarios have been prepared as part of the Trusts Statutory Duty to Break-Even and Circular HSC(F) 37 2023 'HSC Break-Even and Financial Recovery'. As part of that circular there are responsibilities for other key stakeholders including DoH and SPPG Commissioning leads. In addition, delivery of this plan in full and achievement of the Trusts statutory duty to break-even would leave the Trust at odds with its statutory duty to involve and consult, and DoH guidance would be required. The Trust submitted a response reflecting these scenarios and the above questions to the Department of Health on 23 September 2025 and requested direction on the actions that the DoH was approving.

The Trust Board approved submission to the Permanent Secretary as a considered and appropriate response in line with the Trusts responsibility to break even on the 25 September 2025. Approval was also on the condition that:

- Any high or catastrophic measures within the submission would need commissioner approval before being considered for implementation.
- All measures approved by the commissioner for implementation would require equality and rural needs screening and impact assessment if required.
- The Trust Board would take cognisance of its statutory duties of involvement, consultation and staff engagement alongside its statutory duty to break even before giving approval to any measures approved by SPPG for implementation.

Even with full implementation of this plan the Trust's ability to break-even in 2025/26 would be challenging and without full implementation it is unlikely that the Trust will break-even in 2025/26. The Trust will continue to engage with SPPG and also to monitor and review costs as the year progresses.

There remains a recurrent deficit that will require the Trust, in partnership with SPPG and DoH, to deliver a Recovery Plan. Delivery will require recurrent savings as well as in-year contingency measures and deficit funding from DoH. This will be challenging to deliver and will require the Trust to work with SPPG and DoH over this period to achieve a recurrent financial break-even, particularly in those areas that require regional enablers or commissioner support.

Cyber Security

The Trust continues to work with colleagues through the Regional Cyber Security Programme Board to address issues highlighted from external assessment and audit, to take common, consistent actions to monitor and continually strengthen cyber security issues.

As an Operator of Essential Services (OES) the Trust has completed a Cyber Assessment Framework (CAF) self-assessment for the Network and Information Systems (NIS) Competent Authority in May 2025. The Trust must also complete an external audit by the end of 2026 as specified by the Competent Authority. The Trust meets with the Competent Authority monthly to discuss progress against the Network and Information Security recommendations and the ongoing programme of work identified in the CAF. The Trust has brought in staff, “at risk,” to manage the ongoing legal requirement both within ICT and Governance, and a request for funding has been submitted to Digital Health and Care NI (DHCNI). Further staffing requirements regarding Operational Security still need to be addressed.

The Trust ICT Department has achieved the updated ISO27001 and was most recently externally audited and accredited in July 2025. An ongoing risk is the lack of momentum regarding the Business Case approval for a Regional Security Operations Centre and SIEM solution.

Neurology

The Trust is committed to the sustainability of the neurology service, in conjunction with regional colleagues and SPPG, but continues to find it difficult to secure sufficient resource to adequately meet demand.

The first of the joint Northern / Belfast HSCT Consultant Neurologist posts aimed at addressing this took up post at the start of March 2021. The Trust has secured funding for two further Consultant Neurologists but has been unable to appoint to the posts. The Trust continues to have a presence from Consultant Neurologists from the Belfast Health and Social Care Trust and active support from the Belfast Neurology Team, which is providing real time neurology telephone advice to support Trust medical teams caring for inpatients in both Antrim and Causeway hospitals. This includes the ability to transfer patients to the Belfast Trust if necessary. A locum consultant neurologist was supplying some support virtually to assist in reducing the outstanding reviews, however this locum ceased working with the Trust in August 2023 and despite ongoing advertising of a locum vacancy, no suitable candidates have been identified.

This leaves the service extremely vulnerable with no full-time Trust based consultant staff, i.e. the Trust has one part-time substantive consultant, against a backdrop of rising demand and a Regional Neurology Review which recognises inequitable access for patients to neurology services.

Attempts to recruit to the two vacant consultant posts have been unsuccessful. An Early Alert was submitted to SPPG on 28 August 2024. The Trust considers that the situation could move to the point of service collapse.

Following submission of the Early Alert a meeting was held with the Director and Assistant Director of Medicine and Emergency Medicine Division, Deputy Medical Director, the Director of Operations and SPPG. As a result of the meeting it was agreed that a regional workshop would be arranged.

A regional neurology workshop took place on 7 February 2025, chaired by SPPG with senior representation from each Trust, to discuss the future of a regional neurology service and to identify immediate help and support for the Trust. While the workshop was positive and productive, the Trusts awaits the short and medium-term plans from SPPG. The Trust has in the interim worked with Belfast and South Eastern Trust to secure limited neurology support. Regionally a Neurology Alliance meeting is organised for 1 October 2025 to address the continued issue in NHSCT. This has been submitted to SPPG as an escalation on the Support and intervention framework.

Acute Mental Health Inpatient Bed Pressures

Pressures on mental health inpatient bed capacity have been noted on the Corporate Risk Register since 2017. Bed pressures have continued to be sustained and significant over the course of 2025/26. These pressures pose an associated and continued negative impact in the areas of patient safety, experience, therapeutic outcomes and staff experience. The Royal College of Psychiatrists Guidance recommends 85% occupancy level for Mental Health inpatient wards, however the Trust overall occupancy frequently runs in excess of 100%, with additional contingency beds routinely required across all admission wards. Over-occupancy increases the risk in terms of patient safety, violence and aggression, incidents of self-harm and patients absconding from the wards and potentially coming to harm or risking public safety.

In addition, frequently throughout 2025/26 it has been necessary to operate a waiting list for admissions to a mental health inpatient bed. A clinical prioritisation tool that was developed regionally is used to determine the order of admissions. Patients awaiting a mental health admission, including patients being detained under the Mental Health Order (MHO), are being managed in Emergency Departments, general hospital wards and in the community. These delays create pressure in these areas and on Approved Social Work Services who are required to remain with them until a bed is available. Furthermore, due to the delay in access to assessment and treatment the individual's assessment and treatment is delayed.

Flow across mental health beds has been limited, due to both the acuity of the patient population, (which has led to longer length of stay) and to insufficient access to placements in the community, to meet the needs of those people with complex mental health needs and dementia. Work is ongoing within the Trust on an Acute Mental Health Quality Improvement initiative, aimed at reducing the length of stay for Mental Health Inpatient Services. To date, this work has contributed to a reduction in overall numbers of delayed discharges, while also streamlining the admission process via a single point of access work stream. Engagement fora have been established to engage, prepare and support providers, regarding the likely future needs of Trust community placements, particularly those more complex requirements. As a result of this engagement, additional enhanced care and dementia beds have been opened by local providers. These beds have supported more timely and sustained discharges for some individuals, and engagement with providers continues.

Emergency General Surgery and Elective Surgery

Following the publication, in June 2022, of the Department of Health's review of General Surgery in Northern Ireland, it became clear that Causeway Hospital was not commissioned in line with a number of standards, required to be able to deliver emergency general surgery in the longer term. To be able to meet these standards, surgical ambulatory services in Causeway Hospital have been developed resulting in the opening of the Surgical Ambulatory Unit in February 2024. The Trust held a public consultation on proposals to reconfigure General Surgery services between 23 August and 29 November 2024. The Trust consultation outcomes report was presented to Trust Board on 22 May 2025 which received approval and was subsequently submitted to the Department of Health the following day for consideration by the Minister for Health.

Estate Risk

The age, condition and nature of the Trust Estate, continues to pose potential risks which are exacerbated by limited capital investment in major renewal and replacement projects. In line with best practice throughout the UK, the Trust commissions independent 'Six facet' surveys annually to assess the condition of the estate. The most recent survey carried out in July 2025 has estimated a backlog maintenance liability of £245m. This information forms part of the Trust's annual Property Asset Management Plan, which is submitted to the Property Management Branch at the DoH. The Trust receives an annual capital allocation from the DoH specifically for backlog maintenance. The Estates Department prioritises this funding on risk reduction works in key areas like building fabric, mechanical and electrical infrastructure, fire safety, asbestos, lifts etc.

In 2025/26 this allocation is £4.25m. With this relatively low level of investment, the trend is for the backlog maintenance liability to increase year on year as buildings and plant continue to deteriorate. The Trust Estates Department continues to maintain all buildings and plant whilst highlighting any concerns and escalating risks as they become apparent. One such risk, which is now on the Trust's Corporate Risk Register, is the electrical infrastructure at Antrim Area Hospital. A planned upgrade is currently at Design Stage 4, with the project scheduled for completion in late 2027. This scheme, when complete, will reduce the electrical risk and potential failure of medical devices on the Antrim Hospital site.

The delay in capital funding being allocated to the next stage of Birch Hill (new Mental Health Hospital) increases the risk of maintaining Holywell Hospital. There are significant concerns on the estate and without adequate funding this site will continue to deteriorate into the future.

During 2024/25, continued significant pressures were also experienced on the revenue servicing and maintenance budgets, thus increasing potential risks to the safety of medical equipment, infrastructure and deterioration of the environmental condition of the Estate.

Changes to legislation, Health Technical Memoranda and Health Building Notes put maintenance revenue budgets under further pressure. While the return of Health Estates to the Department of Health has enabled Trust staff to communicate such pressures, including the funding required to enable compliance, the lack of funding will have an overall long-term impact on the physical estate.

Budget Position and Authority

The Budget (No. 2) Act (Northern Ireland) 2025, which received Royal Assent on the 11th July 2025, provides the statutory authority for the Executive's 2025/26 expenditure plans. Following the re-establishment of the NI Assembly the production and approval of the NI Budget is much more secure and therefore the plan is that this divergence will close at the year-end.

Waiting List Initiative Procurement

In common with the other provider Trusts, the Trust does not have a compliant route to the procurement of Independent Sector Elective Access activity. The Trust spent approximately £11m on this activity in 2024/25, procured through Direct Award Contracts. The Trust has escalated this gap along with the need for development of a regional Centre of Procurement Expertise (COPE) for Independent Sector Elective Access activity and a compliant procurement mechanism. While the Trust has agreed internal processes for selecting providers and assessing value for money, the ongoing and extensive use of Direct Award Contract, carries a risk of legal challenge which could significantly impact the Trust's ability to procure waiting list initiative activity.

Reporting from encompass

Further to the Trust's encompass go-live on 7 November 2024, the Trust has worked very closely with the central encompass team and Epic to support the development of the required reports for statutory, regulatory and performance reporting. Once built these have

required extensive data validation, much of which is ongoing with close liaison with SPPG and Hospital Information Branch. Similar issues have been experienced by other Trusts post Go-Live. A regional reporting oversight group has been established with representation from the Department of Health and SPPG. System build and data quality work is ongoing, with senior oversight internally.

Contract Renewal Business Cases

The Trust has carried out an analysis of its processes concerning decision-making around new contracts and the extension or renewal of existing contracts. There are many departments in which adequate and proportionate processes are already in place. In some areas compliance with the circular will require new processes and this has been discussed and communicated at Senior Management Team. The Trust Revenue Business Case Policy will be updated to reflect this. It is anticipated that this internal control divergence will be closed at year end.

General Surgery Triage

Internal Audit provided an unacceptable assurance in relation to the Management of General Surgery. The audit identified significant delays in triaging of red flag and urgent referrals and a lack of effective management contributing to the triage backlog. The audit made 3 recommendations for improvement. Management action has been identified to address the recommendations and work is ongoing to ensure surgical triage is completed with no delays to patient pathways.

15. Mid-Year Assurance Report from Chief Internal Auditor

I confirm that I have referred to the mid-year Assurance report from the Chief Internal Auditor, which details the organisation's implementation of accepted audit recommendations.

16. Annual Assurance of Fitness of Accounting Officer

I confirm that I remain fit to carry out the role of Accounting Officer in accordance with MPMNI Chapter 3 and that any issues arising which question my ability to carry out the

role (e.g. bankruptcy, disqualification, serious conflicts of interest, etc.) will be notified immediately to the Departmental Accounting Officer.

Signed: *Date:*

CHIEF EXECUTIVE & ACCOUNTING OFFICER