Northern Health and Social Care Trust

ASSURANCE FRAMEWORK
Principal Risks and Controls Document 2022/23

November 2022

PRINCIPAL OBJECTIVES

The NHSCT Corporate Plan outlines the Trust's Principal objectives as follows:

Objective 1: Build Northern Partnerships and Integrate Care.

Objective 2: Continue to Improve Outcomes and Experience.

Objective 3: Deliver Value by Optimising Resources.

Objective 4: Nurture Our People, enable our talent and build our Teams.

Objective 5: Improve population health and address health and social care inequalities.

Movement since previous Principal Risk Document (PRD)

Item	Principal Risk	Movement since previous PRD August 2022	
		Changes to Risk Rating	
		Previous Risk Rating	New Risk Rating
28	Failure to Breakeven	15	10
1180	Causeway Hospital Maternity & Transport Risk (moved from Corporate Risk Register)	12	12

Northern Health and Social Care Trust

Principal Risk Document - Summary Report

Red Risks added from last Principal Risk Document
Blue Risks to be de-escalated/removed from Principal Risk Document

Item	ID	Lead Division	Risk Title	Untreated Risk Rating	Rating (current)	Risk level (current)	Rating (Target)	Risk Level (Target)	Months Since Rating Changed	Opened	Date of Last Review
1	952	Surgery & Clinical Services	Access to Planned Care/Procedures	25	20	EXTREME	16	HIGH	16	21/11/2017	31/10/2022
2	324	Paediatrics, Women's Services & Corporate Support	Healthcare Associated Infections	25	16	HIGH	12	HIGH	33	15/03/2011	03/11/2022
3	1049	Mental Health, Learning Disability & Community Wellbeing	Mental Capacity Act	25	16	HIGH	12	HIGH	36	28/08/2019	04/11/2022
4	780	Paediatrics, Women's Services & Corporate Support	Nursing Vacancies	25	16	HIGH	12	HIGH	34	16/01/2015	30/11/2022
5	905	Medicine & Emergency Medicine	Unscheduled Care Demand	25	16	HIGH	8	HIGH	33	26/06/2017	20/10/2022
6	67	Strategic Development & Business Services	Information Governance	20	16	HIGH	9	MEDIUM	42	31/05/2008	01/11/2022
7	851	Paediatrics, Women's Services & Corporate Support	Dysphagia	20	16	HIGH	10	HIGH	49	19/05/2016	28/10/2022
8	1080	Finance	COVID-19	25	12	HIGH	8	MEDIUM	3	03/03/2020	14/11/2022
9	28	Finance	Failure to Breakeven	25	10	HIGH	10	HIGH	0	20/02/2008	02/12/2022
10	1000	Finance	EU Exit	15	12	HIGH	6	LOW	4	09/07/2018	03/11/2022
11	909	Strategic Development & Business Services	Information Security	20	16	HIGH	9	MEDIUM	64	11/07/2017	01/11/2022
12	1180	Paediatrics, Women's Services & Corporate Support	Causeway Hospital Maternity & Transport Risk (moved from Corporate Risk Register)	15	12	HIGH	4	LOW	15	02/09/2021	29/11/2022

12 Principal Risks

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Return to PRD Summary Report

ID	Opened	Lead Division	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Principal Objectives	New and Existing Controls	Assurances Internal (I) External ('E)	Gaps in controls and / or assurances	Actions to Close Gaps	Consequence (Target)	Likelihood (Target)	Rating (Target)	Risk level (target)	Date of Last Review
952	21/11/2017	Surgery & Clinical Services	In a number of Acute specialties there is a risk that patients' conditions will deteriorate whilst waiting for an outpatient appointment, diagnostic investigation or theatre based procedure. Outpatient specialties with long waiting times are ENT, Gastroenterology, General Surgery, Dermatology, Gynaecology, Rheumatology, Neurology and OAS. Diagnostics areas include Endoscopy (GI & General Surgery), Radiology, Histopathology, Echocardiography and Hysteroscopy. Inpatient and Day Case areas are General Surgery, ENT, Gynaecology, Breast Surgery, Dental and Pain Management.	Major (4)	Almost Certain (5)	20	EXTREME	2 & 3	Establishment of virtual clinics to complement face to face clinics. Continued utilization of the independent sector providers. Alternative ways of assessment eg Photo triage for Dermatology, establishment of GAU (gynae assessment unit) to provide direct access to assessment and treatment for urgent gynae care or deterioration in conditions; Other new ways of working - Rheumatology - including improved patient pathways, enhanced communication with and information for patients and GPs. Risk stratification applied to specific specialities eg as using Qfit for GI and general surgery, low risk clinics for red flag breast. Prioritisation of IP/DC using FSSA - weekly meeting in Trust feeding into weekly meeting for region. Breast two weekly management meetings to assess demand and maximise capacity. Regional process for radiology to move longest waits to capacity across all Trusts. Weekly endoscopy meeting for maximizing capacity including backfill of all available endoscopy sessions. Maximising use of IP/DC theatre facilities in Causeway for general surgery, breast surgery, ENT, dental, gynae and pain procedures. Use of Day case facility in regional centre at Lagan Valley Hospital for ENT and general surgery procedures. Introduction and roll out of active clinical referral triage. Dermatology actively utilize IS to support management of gap in demand/ capacity this is managed centrally by NHSCT corporate performance team. Dermatology use photo triage system Rheumatology have commenced the introduction of active triage to optimise patient experience and best use of resources	Delivery of volumes identified in the recovery plan (I)(E). Monthly divisional performance review meetings and bi-monthly accountability reviews with Director of Operations and Director of Finance (I) Evidence of non chronological management ie seeing patients according to risk level rather than length of time waiting, in higher risk specialties (I) Maximisation of utilization of waiting list funding when it becomes available (I) Clinical risk raised at each of the HSCB/Trust service issues/Performance Review meetings to press need for investment (E) Waiting list money is starting to be made available for WLI and ISP activity. Increasing number of staffed theatre and endoscopy lists becoming available for surgical specialities Protocols in place for patients transferring to the Independent Sector for assessment and treatment.	1. Elective demand greater than pre covid levels in many specialties. 2. Still insufficient clinical capacity due to lack of funding in identified specialties. 3. Still no procurement framework to secure IS provider. Trust using existing contracts and direct award contracts (DACs) to access IS Providers. 4. Demand for unscheduled/emergency care at pre-Covid levels resulting in further pressures on clinical teams, inpatient beds, IP theatres. 5. The ongoing pandemic situation of escalation in ICU beds requiring the further downturn of elective work to redeploy nurses from theatre predominantly to provide sustainable ICU during surge 6. Need to maintain national Covid restrictions and Covid compliant pathways has resulted in less patients being seen in OP departments, less patients being appointed to radiology/diagnostic sessions and less patients through IP/DC lists. The requirement for dedicated/separate elective IP pathways with separate staff and facilities (theatres and beds) creates staffing pressures and inefficient use of resources and a decrease in inpatient beds available for all four surgical specialties. 7. There is ongoing work in Antrim Hospital site to create an interim ICU which has reduced the number of general surgical inpatient beds. 8. The 'C5' phase of the ICU refurbishment has further reduced ward space for elective patients.	MEDICINE AND EMERGENCY MEDICINE SPECIFIC SERVICE ACTIONS NEUROLOGY - The recruitment process has been unsuccessful and an urgent meeting with the commissioner, Belfast Trust and South Eastern Trust is planned for 17th December 21 Update 01.02.22 Meeting with Commissioner and SMT agreed to proceed with NHSCT posts as regional approach not successful. working with HSCB and regionals colleagues to take forward. RHEUMATOLOGY Update 23.03.22 - Rheumatology have commenced the introduction of active triage to optimise patient experience and best use of resources Trust workshop arranged 7th April to consider further rollout to other services DERMATOLOGY Update 23.03.22 High volume MEGA clinics trialed - and access to additional funding being considered for future MEGA clinics In April 22 outpatient clinics being restructured to allow for additional red flag patients to be seen. This will be evaluated at month end. Update 4.5.22 Gynaecology - Mitigations include additional hysteroscopy lists under WLI, longest waiter activity to IS, additional telephone review clinics, active triage and clinical validation and some nurse led under WLI. Echocardiography - In house WLI ongoing and funding agreed until end of June 2022. No ISP for echo so options to address wait times through non recurrent WLI funding are very limited. HSCB/SPPG engagement ongoing. HSCB/SPPG updated at meeting in March 2022. No recurrent funding available to address staffing shortages. Wait times for routine Echo continue to rise. Now at 18 months for routine Echo. In house WLI capacity saturated. Further deterioration in wait times inevitable and unpreventable until funding secured for permanent staffing and training posts. Dental - waiting list currently at >1400 and out monthly rate of referral is 2.5 times our monthly capacity. Endoscopy - From the beginning of May 2022 the Endoscopy service is delivering 84% of pre covid activity in house. There continues to be a 23% reduction in available nursing staff due to maternity leaves and vacancies. 240 patients (to allow for ROTT rate) per month are being sent out to the IS. The current backlog is 6000 patients (this is a combination of new and planned). The service has capacity weekly for 227 patients. This will only meet new demand and not deal with backlog. WLI lists are being undertaken per month. In sourcing is also being discussed to help deal with the current backlog. Radiology - Radiology - Waiting lists for Radiology continue to deteriorate. NHSCT is engaged with HSCB, IS providers and local HSC Trusts in an effort to reduce waiting times as much as possible. Histopathology - Backlog currently increasing in histopathology. Current backlog of approx 1200 cases. waiting for reporting so risk remains high. Clinical lead has received approval to outsource more reporting work and to use consultant locum which again will help to reduce the risk posed. OAS - Continuing to work with the Regional Orthopaedic Network to reduce waiting. The service will see an additional 400 foot and ankle patients as part of the Network. Clinic templates have been redesigned to meet our SBA volumes. The new templates include virtual and telephone review clinics. We have created reviews for our injection therapy patients and patients will now be booked within 6 weeks of attending. Electronic sign off of radiology reports was successfully piloted in 2021/2022 and is now part of normal operating procedures. Electronic triage is planned for later this year and will streamline the triage process. Regionally orthopaedic referrals will be triaged electronically via CCG with all Trusts. To date we now receive our referrals via CCG from MPH, previously these had been scanned paper referrals. Out standard operating procedures have been updated and will continue to be updated whe we implement Etriage. Pain Management - Consultant in Causeway continues with outpatient clinics and has been doing some additional WLI outpatient clinics and day surgery lists to help with the backlog. Core Pain in Causeway DPU is still not up to capacity due to some staffing difficulties. Daycase and outpatient sessions have been reinstated in Antrim, Whiteabbey and Mid Ulster Hospital - core funded levels. UPDATE FROM MEM on 03.08.22 - Risk remains unchanged from MEMs perspective - awaiting final confirmation of 48 beds. All MEM Teams remain under significant pressure related to unscheduled care and complex delays, attainment continues to deteriorate. Update 31.10.22: Echo - in house WLI maximised and ongoing whilst locum availability. 2000 additional scans completed since April 2022. No change in wait times. No ISP available for Echo WLI. Critical requirement to address demand and capacity gap with permanent staffing resource. All efforts to address this through SPPG and demography funding have failed to date. Loss of locums to permanent posts elsewhere will result in loss of IP Echo capacity and loss for planned chemotherapy/valve surveillance Echo. Briefing paper outlining situation submitted for SMT review September 2022. Pain Management - all three pain Consultants have recommenced all their outpatient and day case sessions. Continue to bid for additional WLI pain sessions depending on nursing and Consultant availability to address shortfalls. ENT - 200 urgent/routine new outpatients per month are being transferred out to the independent sector. Gastro - 120 urgent new outpatients per month are being transferred to the independent sector. Urgent slots on clinic templates have been flipped to red flag due to the significant backlog. Some in house WLI work is being undertaken - 48 red flag patients per month. Endoscopy - 200 patients per month are being transferred to the independent sector. 90 patients are being treated per month via WLI inhouse lists. Alliance Surgical have been appointed to undertake in-sourcing due to commence on 1 December 2022. Plan is for 800 patient to be treated in a 12 week period.	Major (4)	Likely (4)	16	HIGH	31/10/2022

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324	15032011	Paediatrics, Women's Services & Corporate Support	There is a risk of increased incidence and outbreak of healthcare acquired organisms which has the potential to disrupt services and cause an adverse outcome for patients and staff. In addition WHO declared a global pandemic on 11/03/2020. The first presumptive case of COVID-19 was confirmed in Northern Ireland on 27/02/2020. Whilst community transmission has reduced we still have the potential for patients to be admitted following exposure to COVID-19 or may become positive after admission.	Major (4)	Likely (4)	16	HIGH	1	• Application of policies and procedures - National IPC guidance implemented (including testing guidance) • Increased observation of clinical practices • Acute IPC forum held 6-weekly to monitor performance • Each Directorate presents IPC plan at IPECH • Revised schedule of Post Infection Reviews at strategic level agreed. • CDI and Antimicrobial Stewardship wardrounds in Causeway Site and Antrim site • Antimicrobial stewardship improvement project to be implemented • Review of policies, procedures and plans:- • Infection Prevention Control (IPC) Corporate Strategy reviewed 2021-2024 including IPC reporting structure with additional Bronze reporting structure for Covid 19 daily meetings • 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. • Regional Visiting Policy • DOH Gold/PHA Silver/Trust Bronze has been established in response to Covid 19 management. • Safer working group established and chaired by Director of Nursing/Infection Prevention and Control. • Observational visit to ward areas by IPC team. Outbreak control meetings chaired by IPCD co-ordinated when required. Use of 'Fast Fact' information sheets for staff Safety Huddles. Nosocomial death review panel established and chaired by Medical Director; IPC Lead Nurse attends to provide information on covid status throughout patient journey On-call IPC and microbiology rota (24 hour) 7 day week/24 hour microbiology laboratory service. IPCN increased on site presence across Trust 6/7 days and enhanced on call service for Antrim and Causeway localities. Intensive cleaning programme by Rapid Response Teams in Acute and Community facilities. Level 2 cleaning team in AAH developed during winter pressures has been maintained. IPC Link Nurse and Link Worker system Trust-wide. Further training dates scheduled. 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 patients at risk of infection. Twice daily attendance at site HUb by IPC Nursing team to advice on safe patient placement Post Infection Review Process for all Staph Aureus bacteraemia and C diff. Communication/education to staff and visitors regarding risk of Norovirus, Influenza and Covid 19. Water testing for Legionella and Pseudomonas as per Water Safety Plan/Policy.	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. Programme of leadership walkabouts to identify and address estates and cleaning issues have recommenced within acute sites CAS 2021/2022 score for IPC 96% (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). Daily monitoring and reporting of confirmed HCAI cases (I). 6 weekly IPC Environmental Hygiene Performance and Assurance Committee (reports into Trust Assurance Framework) (I) Monitoring of compliance with Antimicrobial Policy and stewardship rounds. ARK Project commenced November 2018 (I). (Still in place) 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). Results of water testing (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). Regional Point Prevalence Survey (PPS) HCAI and antimicrobial use (E). Joint Food Hygiene Standards and Kitchen inspections with Environmental Health Officers. This is now conducted virtually. (E). Regular meeting of Trust Bronze and Bronze planning group. Regular reporting to Exec team/SMT. PPE group to review supply and monitors FIT testing compliance levels and any variances identified in Trust. IPCHEC meets and reports through assurance structure Incident Management Teams to help assess actions and learning acquired from outbreaks. Outbreak Management meetings led by IPC Doctor and Senior Nurse. External inspections by RQIA and Nosocomial Cell in February 2021. Access to new COVID regional dashboard. Review panel of COVID related deaths set up to commence case reviews and learning captured/shared. Survey of ventilation in Antrim and Causeway Hospitals completed – findings positive. Review of nosocomial deaths related to COVID 19 by Nosocomial Death Review Panel.	1. Delays in patient pathways due to need for COVID19 testing and results or availability of appropriate beds and isolation/cohort depending on IPC requirements. Safe Placement of augmented care patients is still an issue on Antrim site; inappropriate number of augmented care rooms. 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. The Trust C-Diff rate is currently higher than the expected trajectory. Post infection reviews have shown that this is related to high antibiotic usage in the community. Additionally there is an observed increased incidence of gram negative bacteraemias. 4. Second stage Post Infection Reviews paused due to clinical pressures. First stage reviews ongoing. 5. Regional Point Prevalence Survey – Results of PPS indicate concerns regarding antimicrobial prescribing and inappropriate use of antibiotics in relation to the rest of the NI region. Clinical concern around the over prescription of Tazocin. 6. Operational pathways to manage positive results of COVID19 adjusted according to surge phase and number of patients presenting. 7. The Trust is working with BSO Pals to ensure there is a stable supply of masks and PPE. 8. Supply chain availability of FFP3 Masks dictates recurrent FIT testing requirements based on supply of mask type. 9. IPC Nursing workforce under pressure to sustain the increased presence and response to Trust acute and community facilities/teams and Independent Sector care homes. There has been no additional funding from 01st April 2022 to maintain a 7 day service or to support in-reach into independent sector homes, although there is a regional expectation that we will maintain this. This is placing significant pressure on the resources available within the IPC team. No further funding provided as yet to provide a 7 day on call service and on site presence at weekends (Antrim Hospital). 10. Surveillance system required for COVID19 awaiting regional agreed position and procurement. No regional funding for system available; work ongoing to ensure encompass is fit for IPC/surveillance purpose but will not be available for at least 4-5years. 11. The Trust is currently working outside Regional guidance during outbreaks where all staff are not asked to complete PCRs but instead asked to complete LFTs unless directed otherwise by the Outbreak Control team. We are commencing daily testing for patients awaiting admission in ED week commencing 13th June 2022. 12. Regional guidance has been updated to no longer require those who are exposed to cases of COVID19 in the hospital to be cohorted and isolated.	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 and ongoing where possible. 3. First stage post infection review still continue and any significant concerns escalated to senior teams. 4. Medical Director and Lead Doctor for IPC to engage with Respiratory Medicine for some focused work to deal with antimicrobial stewardship. 5. Regular Bronze trust meetings ongoing. Patient Pathways developed and agreed by Executive Team/ ICU project and refurbishment meetings weekly at present. 6. Director of Nursing IPC Strategic group has been established to consider strategic matters at this period of the surge. 7. Regional HCAI meeting and IPC cell established – regional discussion, issues and learning shared 8. Sustained demand for hospital and care home access, results in Trust facilities operating at >100% Occupancy alongside reduced patient flow and exit block there are significant challenges for managing IPC considerations and potential for nosocomial infection. 9. Programme of leadership walkabouts to identify and address estates and cleaning issues have recommenced within acute sites. Numbers who attend has been reduced to minimise footfall in line with IPC guidance 10. Re audit of ventilation using CO2 monitoring in Antrim and Causeway Hospitals to be completed. Upgrade of ventilation in B Floor Antrim to further improve ventilation is planned for 2022. 11. Regional guidance has been updated to no longer require those who are exposed to cases of COVID19 in the hospital to be cohorted and isolated. The Trust will continue cohort and isolate these patients and where this is not possible due to unscheduled pressures, a risk assessment will be undertaken to prioritise cases for isolation 12. An audit to review infection control reporting and assurance to Trust Board commenced in June 2022. 03/11/2022 - No further update	Major (4)	Possible (3)	12	HIGH	03/11/2022

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.
Health care worker and patient testing for COVID 19 with subsequent contact tracing including Lateral Flow Testing.
IPCN Lead linking weekly with regional IPC cell to ensure consistency across the region.

Regular comms re: social distancing, hand washing and symptom alert are issued in accordance with the Safer Working Group.
Outbreak control meetings held when required and updates communicated to PHA; meetings chaired by IPC Doctor.

Where children are admitted to hospital due to being very ill with COVID19. In these cases the parents are either also positive or are contacts. Parents will want to stay or visit their child; IPC risk assessments are completed on individual cases to reduce risk of spread of COVID19 where there are gaps in the national guidance for carers or parents who are contacts/positive.
IPC Doctor and IPC Lead Nurse both members of new regional HCAI working Group hosted by PHA.

Where it is not possible to isolate all patients who are exposed to COVID19 due to unscheduled pressures, a risk assessment is undertaken to prioritise cases for isolation.

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1049	28/08/2019	Mental Health, Learning Disability & Community Wellbeing	The Department of Health, requires H&SC Trusts to proceed with a partial implementation of the Mental Capacity Act (NI) 2016 (MCA) for the purpose of providing a statutory framework for the Deprivation of Liberty from the 02nd December 2019 with full implementation by December 2020. Failure in these arrangements would impact adversely on performance and consequently patient safety and care. The additional processes required in relation to the Act may also adversely impact patient safety and care. There is a further financial risk given the gap between the funding identified for this regionally and the Trust's preliminary cost estimates and a further risk in relation the impact of the additional processes on patient care and on care management reviews within the Permanent Placement Team. The Trust has established structures and arrangements to ensure compliance with the MCA however the requirements of further areas of implementation alongside those of the Attorney General's Office and the Mental Health Review Tribunal are more onerous than anticipated. The additional work involved is placing considerable work burden on stretched staff resources and systems and further could potentially compromise the Trust's ability to complete the required assessments / court reports under the Act The offence of unlawful detention came into force on 31st May 2021. Following the expiry of MCA Coronavirus Act Temporary Provisions on 25 March 2022 Trust panels will no longer be able to sit virutally. The DoH has advised that all panels need to be done in person – this could have an impact as members of the panel who are retired may not wish to travel to meet in Holywell to authorise 1-2 applications. Section 48 (the need for a mandatory referral to the Review Tribunal if there has not been one in two years) and Section 50 (the need for a review of the DOLS at a six month point of the subsequent extension) are the most recent areas of challenge for Trusts, with Section 50 being the most likely to place the Trust at risk in terms of compliance. A high number of NHSCT cases are at this point currently, resulting in approximately 60 reviews per month being projected. Whilst work has been completed in regards to the accompanying documentation, each review requires a contact with the service user, and is therefore labour intensive.	Major (4)	Likely (4)	16	HIGH	1, 2, 3, 4 & 5	Programme Management arrangements have been established to include a Programme Board and Project Implementation Team with established Terms of Reference and Chairs. Assistant Director Learning Disability Mental Health / Professional Social Work Lead, Professional ASW MCA Coordinator, MCA Implementation Lead, Office Manager and Administrative Assistant have been appointed permanently. MCA Governance Lead and Administrative assistant are also employed via an EOI. ASWs have been identified to chair the panels and Nurses / AHPs, and Medics have been identified as the second and third panel members. A number of staff including senior management are working additional hours in order to complete extensions, Rule 6 reports etc An additional Hospital Social Worker and staff member to complete capacity assessments have been recruited to assist with MCA in the acute setting. Implementation Leads for MCA in Mental Health Older People, Community Care Division, Learning Disability and in Acute Hospitals have been appointed. 0.6wte Medical Practitioner has commenced secondment as clinical lead to complete medical assessments for cases that are not open to a consultant. Due to pressures in the hospitals this medic has not always been available to complete MCA work 2 additional Sessional Medical Practitioners have been engaged and are each working 1 day/week (7 in total working either 1 or 2 days / week) Staff training is available via ELearning to ensure practitioners across teams and services complete requisite training to level 4a. Bespoke in-house training has also been delivered within services. A sufficient number of trust staff have completed the training to carry out the required duties under the Act. Regional and Trust Training working groups have been established. From September onwards staff trained in the first tranche will have to complete Level 1-4 (and level 5 where appropriate) refresher training. Initial scoping exercise has been updated to identify the numbers of service users subjected to DOLs who need to be presented to panel, as well as a projection of new applications per year. Governance arrangements have been developed to inform decisions and recording processes. Action plans have been developed for all relevant Divisions. Trust Operational Guidance has been developed for use in draft form to be finalised. Where it is not practicably possible to complete a full DoL authorisation, cases are managed under the emergency provisions of the Act. Correspondence to staff and documentation for care homes has been agreed and disseminated regionally. The use of virtual panels has proved beneficial in completing authorisations of applications. The Trust reverted to in person panels from 25 March 2022.	The Trust is engaging with regional arrangements established to share practice and develop agreed solutions to the implementation of the MCA both short term and medium term. These include: • an overall regional group comprising the director leads identified in each Trust, an Information T&F group, a Business Case T&F group and HR T&F group. • NHSCT co-chairs a Regional Multi-Agency MCA Implementation Group with the Office of the Attorney General NI (NIOAG). Membership includes NIOAG, The Review Tribunal (RT), DoH, DLS, all Trusts and RQIA. • The Trust led Regional Workshops along with DoH, with representation from other Trusts and other agencies / stakeholders to share and agree a consistent approach / processes. The Trust achieved full compliance with the completion of DoLs for all identified legacy cases by 31 May 2021. Learning continues to be shared throughout the process. The RQIA have advised the Trust of their intention to undertake a monitoring role during implementation to assure that robust arrangements are in place for the MCA implementation. Training is monitored and reviewed by Service Managers with oversight from MCA Governance Lead. Plans are in place for the completion of extensions– this will be monitored on a monthly basis - there have been 3 breaches to date. Where possible staff will continue to work to maintain this level of compliance.	Criminal liability offences within section 269 came into force on 31 May 2021. Trusts could be facing corporate liability proceedings and Trust staff at various levels could be facing criminal proceedings for any service user deprived of their liberty who is not detained in accordance with the MCA or other relevant statute. A scoping of all day care facilities has commenced. There were a significant number of DoLs required, and these should be completed by end of September 2022. A ruling in a recent appeal case from the Special Educational Needs & Disability Tribunal (SENDIST) to the High Court stated that Trusts are responsible for the completion of DoLs for young people attending educational settings where they are deprived of their Liberty. This will have a significant impact on Children's Services. The time required to complete the forms, provide further information including a Statement under Rule 6 as directed by the RT,and possibly present evidence at Oral hearings, is much greater than initially anticipated, and is having a major impact operationally across the Trust. There may not be a sufficient Medical resource to complete the required extension authorisations over the coming months. Three of the other Trusts are now recruiting medical staff at the higher tariff rate than regionally agreed £200. This will challenge the NHSCT medical supply. Discussions in regards to Inter-trust working for ASW and Medical staff are ongoing, however no agreement has been reached Extension authorisations will be prioritised over the coming months and therefore there will be a delay in completion of medical reports for new applications. The 4th surge of the Covid pandemic continues to have a major impact operationally and is further reducing the capacity to complete MCA assessments / reports. There is an ongoing shortage of staff, particularly nursing and social work staff, across all divisions. Staff are required to provide operational cover across services for staff absences due to Covid. A Local Enhanced Service arrangement (LES) with GPs has been offered by HSCB to be put in place with Trusts seeking this option. Response to date indicates that only 2 GP practices within NHSCT area are prepared to take up the LES and neither of these practices have complete the required training There is a significant disparity in the number of cases estimated by the DoH and the number of cases estimated by the Trust (and evidenced throughout the test period and initial months of implementation) that will require referral to the Review Tribunal (RT) via the Attorney General's Office. The default position of the RT will be to hear cases on paper; however it is possible that they may require an oral hearing following a review of the papers. There are currently approximately 35-40 Statements under Rule 6 required in a monthly period, with an increase in requests for oral hearings having been experienced over the last few months. The Trust has been unable to permanently recruit sufficient additional staff to undertake the assessments and complete applications because the funding is not yet recurrent. There is a gap between funding available and the full costs required to cover activity. Plans are in place for the completion of extensions – this will be monitored on a monthly basis. Scoping of the requirement for DoLs for those service users in day care facilities has commenced however it has not been possible to progress assessments due to current the lack of resources. The position will be reviewed at end November 2021. Those cases scoped will be managed under the emergency provisions of the Act pending full authorisation.	The Trust achieved full compliance with the completion of DoLs for all identified legacy cases by 31 May 2021. The volume and complexity of ongoing work in relation to new authorisations, extension work, and legislative reviews (which result in additional legal reporting requirements) consistently increasing. Although additional hours continue to be offered to core staff members, with available bank staff members being utilised to full capacity, there continues to be consistent pressure across the system as a whole. Criminal liability offences within section 269 came into force On 31 May 2021. Trusts could be facing corporate liability proceedings and Trust staff at various levels could be facing criminal proceedings for any service user deprived of their liberty who is not lawfully detained in accordance with the MCA or other relevant statute. Ensuring that applications / emergency provisions are considered and commenced if necessary immediately when a DoL occurs, will protect staff / the Trust from liability. Correspondence to staff and documentation for care homes was agreed and disseminated regionally, and Trade unions have been in ongoing discussions with Trusts regionally. A Regional Training sub-group has been established to consolidate training and to consider further training requirements. ELearning modules have been revised and submitted to DoH for approval. Trust leads and MCA Governance lead are considering best ways to advertise training and make it available to both the Trust and private sector staff. Additional funding was provided by DoH and was used for training in March 2022. The recent BSO audit has highlighted concern in regards to the long term use of emergency provisions, without proceeding to full authorisation. Numbers of emergency provisions which are more than 10 weeks old are high across the Division, with Learning disability and MHOP having the most significant numbers (circa 100). Difficulties in proceeding with full TPA have been highlighted by both services; staff time is consumed by the identification of new DoLs and initiation of emergency provisions, completion of an extensive number of Rule 6 reports, and also extension work, to ensure no breaches occur. Following the implementation of offences, there has been a noted increase in the number of referrals by the facilities for DoL applications for residents who were not scoped initially as requiring a DoL but whose situation has changed and they now meet the criteria for a DoL – these will be treated as new cases. A register detailing all residents currently under a DoL and referral letter have been agreed regionally and have been disseminated. A care home register is maintained by the Core MCA team, and this is checked on a monthly basis to ensure that new cases are identified, and that leavers can be discharged where necessary. This information is often not disseminated to the named worker, and therefore not passed on to MCA team, which increases the risk of DoL not being discharged in a timely manner. The Trust will work with DoH to challenge decision that Trusts are responsible for the completion of DoLs for young people attending educational settings where they are deprived of their Liberty and place responsibility on Education Authorities to complete this work. This has been added to Regionals Strategic Advisory Group agenda to obtain support in finding resolution, and advice has been sought from DLS in this regard three of the other Trusts are now recruiting medical staff at the higher tariff rate than regionally agreed £200. This may challenge the NHSCT medical supply. A letter has been sent out to recent retirees inviting them to complete an expression of interest for Sessional Medical Practitioner Post and an advertisement for bank sessional medic posts has resulted in x2 appointments.	Major (4)	Possible (3)	12	HIGH	04/11/2022

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780	16/01/2015	Paediatrics, Women's Services & Corporate Support	There are incidents of non-compliance with regional guidance of safe nurse staffing levels in accordance with Delivering Care Policy. Current system does not provide robust assurance of safe staffing levels. There is a National shortage of registrants leading to vacancies both temporary and permanent. Ongoing challenges with centralised recruitment processes creates undue delay in filling vacancies in a timely manner. Due to self-isolation requirements and the incidence of COVID19, there are short notice cancellations of shifts which cannot be filled. COVID-19 pressures continue to impact on demand for nursing workforce and requirement to redeploy to meet emerging needs. Ongoing corporate recruitment and bespoke recruitment campaigns have limited reach as opposed to recruitment through specialised recruitment agencies. Recruitment to EA Locality for all community posts particularly challenging at present. Vacancies have led to added pressure points within nursing teams, leading to sickness absence and retention of existing staff. This consequently leads to the increased use of bank/agency nurses with associated increased cost and reduced continuity of care.	Major (4)	Likely (4)	16	HIGH	1, 2 & 3	**Recruitment** • Use of Data to inform the targeting of recruitment and to monitor the level of substantive Nurse hours in each division • Robust targeted rolling recruitment programme of registered nurses and non-registered staff is ongoing with prioritisation of frontline staff. Ongoing rolling adverts. Recommencement of face-to-face recruitment events for B5, B3, B2 have commenced. Monthly Band 5 recruitment with face to face and virtual interviews being held with immediate job offers made • Trust internal processes streamlined to expedite vacant nursing posts to Shared Services. • Processes improved and applied to validate the Current Band 5 waiting lists within the Trust and maximise recruitment • Expedited processes exist within the Trust to process new starts at risk without delay into front line nursing posts. Robust on-boarding of new recruits with regular contact from operational teams to prevent attrition • All recruitment opportunities exploited including career fairs, local and national University Liaison. OU roadshows to promote this training route. Students who wish to work in Northern Trust have been allocated permanent posts on completion of registration and have been invited to join nursing bank. • Regional International Nurse Recruitment contract has been signed off with one agency supporting the recruitment activity. Additional regional funding secured to increase International Nurse Recruitment to end of March 2023. This will facilitate the recruitment of 350 nurses regionally - with NHSCT receiving 10 International Nurses per month to end of March 2023. **Delivering care safe staffing** • Agency and bank staff supplementing core staffing to manage winter pressures • Monitoring of compliance with Professional Assurance Framework in order to identify deviations from the expected professional norm • Central coordination of nursing resource during periods of high volume activity • Individual ward safety brief meeting and a site meeting are carried out every morning • Funding provided for uplift in 57.6 wte staff 21/22 year – implementation group established to monitor and drive compliance with recruitment processes to maximise in year spend. Majority of recruitment has been achieved with 98.5% of posts secured **Development / Retention of Staff** • Training and induction programmes for registered nurses and HCA staff developed by PEF team • Preceptorship model continued for new registrants in their first 6 months. Currently being reviewed under a regional model • Promotion of Secondments through virtual roadshows to encourage application to the Open University (OU) Nursing Programme for Band 3 staff. • Internal Transfer policy operational to facilitate / enable the retention of Nursing staff. • Successful implementation of a Transformation Project to uplift 41.75 Band 5 nurses to Band 6 Clinical Sister/Charge Nurse to promote retention. • Future Nurse / Future Midwife implementation plan on track. • Consultant and Advanced Nurse Practitioner roles promoted and supported through delivering care funding • Post Reg Training and Development Commissioning plan for September 2022 submitted with named nurses committed to modules, short courses and specialist practice qualifications. **Nurse Bank / Agency Staff** • Block booking of agency staff stabilise teams is on-going.	**Recruitment** • Fortnightly reporting of current vacancies and stage of recruitment of staff progressing from conditional offers (I) • Monitoring of regional allocation of international nurses and arrivals (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). **Delivering care safe staffing** • Ward Quality Indicator Nursing Toolkit ensuring daily reporting of staffing levels in site co-ordination report • Report to bronze of unfilled nursing shifts and levels of bank/agency fill • Twice weekly staffing reports to outline unfilled shifts and monitor skill mix • Monthly monitoring of staffing levels against agreed levels (I). Updates provided by Divisional Nurse regarding staffing levels and concerns • Triangulation and close monitoring of trends / concerns in relation to clinical incidents / Key Performance Indicators (KPIs) with staffing / vacancies (I). • Work ongoing to review safe staffing levels using workforce tools (I) by Nursing Workforce team. Divisional workforce clinics have been set up by the Safe Staffing Lead Nurse who will formulate action plans to assist in highlighting trends and support required **Development / Retention of Staff** • Nursing workforce AD is member of regional nurse retention taskforce (E) **Nurse Bank / Agency Staff** • Monitoring of block booking deployments within Nursing Governance (I). • Daily Monitoring of bank/agency fill rates (I)	**Recruitment** • There is a national shortage of nurses. leading to vacancies both temporary and permanent • There is a 11.4% (Nov 22) vacancy rate in Band 5 nurses • Ongoing corporate recruitment and bespoke recruitment campaigns have limited reach as opposed to recruitment through specialised recruitment agencies • There is currently only one agency supporting the recruitment activity on the Regional International Nurse Recruitment contract • Ongoing challenges with centralised recruitment processes creates undue delay in filling vacancies in a timely manner • Recruitment to EA Locality for all community posts particularly challenging at present • Funding had been secured to appoint a peripatetic team of nurses on acute hospital sites. However action stood down due to inability to attract nurses to peripatetic roles **Delivering care safe staffing** • There are incidents of non-compliance with regional guidance of safe nurse staffing levels in accordance with Delivering Care Policy. Current system does not provide robust assurance of safe staffing levels. • There has been little significant Capital investment in phase 1 nursing within the NHSCT resulting in additional agency revenue spend to improve 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. **Development / Retention of Staff** • Vacancies have led to added pressure points within nursing teams, leading to sickness absence and retention of existing staff. • Trust PEF team requires development and resourcing to manage the Induction of Band 2/3 and clinical support of new graduates Band 5 coupled with increased student allocations. **Nurse Bank / Agency Staff** • The continued number of Nurse vacancies will result in the use of expensive non-contract agencies which contributes to an increase in transient workforce. • Reporting to bronze of unfilled nursing shifts and levels of bank/agency fill • Processing of agency invoices contracted out to BSO August 2021. A high proportion still being returned to the Trust due to errors on the shifts being logged on the system by operational managers. This is creating additional capacity pressures for the Nurse Bank. This is being reviewed monthly through reporting from finance	**Recruitment** • Discussions have commenced with CNO office regarding the potential for a National Recruitment Campaign • Work is ongoing with regional Student Streamlining Group to further improve recruitment processes • Regional discussions with other international agencies to support International Nurse Recruitment contract ongoing • Business Case submitted for Trust to commence bespoke International Nurse Recruitment moving forward • Considerable work has taken place to improve processes and interface with BSO use of regional dashboard. Bi-monthly meetings of the BSO Customer Service Liaison group yet to recommence **Delivering care safe staffing** • Normative staffing levels have been established for each acute ward. Regional rebasing exercise commenced Jan 22 • Delivering Care Phase 1 and Phase 2 review, led by PHA, has commenced regionally. Expert Reference Groups established Sept 22 with Trust reps and Workforce Leads sitting on regional meetings • Implementation group established to monitor and drive compliance with recruitment processes to maximise in year (21/22) spend for uplift in 57.6 wte staff • Work commenced to review nurse utilisation and staffing in designated acute wards • Exploration of options commenced to enable overview of safe staffing levels across sites **Development / Retention of Staff** • Trust Preceptorship model currently being reviewed under regional model. Regional Review of pre and post registration support commenced • Implementation plan for Future Nurse Future Midwife currently on track • 2023 commissioning cycle has commenced with first scoping exercise underway. Regional work progressing to ensure a 3 year cycle is addressed with a pilot of two divisions – LD and District Nursing to aim to streamline processes and also ensure the three categories are addressed; Maintaining current services, educate the workforce with skills to ensure they can adapt to the transformation of services and provide continuous professional development. **Nurse Bank / Agency Staff** • Review of Regional Framework for Contract Agency has been completed and will proceed to invite regional tender • Work has commenced to review Non-Contract Agency spend and support a reduction to stabilise and strengthen nursing teams • New Business/Governance Manager recruited to bank office to start on 5/12/22. • Leadership Centre commissioned to undertake review of Nurse bank. Review commenced	Major (4)	Possible (3)	12	HIGH	30/11/2022

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ID	Opened	Lead Division	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Principal Objectives	New and Existing Controls	Assurances Internal (I) External ('E)	Gaps in controls and / or assurances	Actions to Close Gaps	Consequence (Target)	Likelihood (Target)	Rating (Target)	Risk level (Target)	Date of Last Review
905	28/06/2017	Medicine & Emergency Medicine	Unscheduled care is facing significant demands with increasing ED attendances, patient acuity and significant limitations in hospital flow. The situation is further impacted by a general reduction in system capacity which is resulting in unacceptable delays in the ED departments. This is exacerbated with the continued pressures of managing within COVID -19 guidelines and restrictions mainly in relation to Infection Prevention and Control which has led to reduced capacity within the acute, overcrowding emergency department, community and Independent sectors further reducing bed and service availability. The delays seen in the ED departments are related to system wide issues across the whole patient journey, through the secondary care system and in managing safe, effective discharge particularly for those who require onward care arrangements. Whilst this issue is not unique to NHSCT, changes made in other Trusts or services in response to pandemic management has also impacted on NHSCT demand.	Major (4)	Likely (4)	16	HIGH	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. Regional Group looking at incentivization for bank staff and use of non-contracted agency. NB: Covid payments now ceased As of 02.05.22 Regional task and finish group established to develop strategic commissioning direction across all Trusts for neurology services. COVID Surge plans Update of Major incident plan to incorporate full capacity protocol.	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 site. This has been compounded by COVID 19 infection control processes and protocols making placement of patients more complex and in addition to this is the reconfiguration of ICU beds to A1 location. other limiting factors are the requirement for a respiratory and non-respiratory ED and requirement for patient Covid 19 swabbing and associated time-lag for receipt of results which limits ability for decision making of bed placement Delayed community discharges are contributing to the demands on the unscheduled care flows. Reduced availability of domiciliary care, Covid and exposed to covid pathways are challenging to secure. Significant delays with patients who require close supervision or display challenging behaviours. Site coordination model continues with extreme focus on discharge pathways. Community escalation meetings in place to encourage coordinated response. Community discharge group chaired by Acute and Community Directors. Update 20.10.22 - NMAB now being delivered in portacabin outside DAU. Work commenced on the 48 beds with predicted delivery by end of Feb23.	1 - 24 bedded unit for Antrim Area Hospital operational. EAU now B5 and functioning. Development of medical model and ambulatory pathways. Ongoing communication with laboratory services to ensure rapid processing of COVID 19 swabs relating to admission and discharge of patients. Wards reprofiled following COVID 19 surge to manage COVID and Non-COVID patients. Rapid testing now in place ED, not yet 24hrs which still causes delays 72 bedded Business Case with the HSCB for consideration. Letter of support in principle received from the Director of Commissioning, HSCB. Business currently being reviewed by DOH 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, initially using 10 beds, expanded to 22 beds in January 2020. Aim to manage medical take and invoke ambulatory pathways where possible. May 21 review of all ambulatory pathways /Frailty/cardiology/surgery ED interfaces. The revised medical model, whilst initially very productive has been impacted by the management of COVID patients. May 21 Model reset and meeting with key stakeholders Focused medical model with emphasis on senior decision making. No more silos phone first working with Dalriada Urgent Care to promote patients ringing for advice / direction before attending ED. Effort to reduce ED crowding. Right place right treatment first time. Medical beds will be impacted between April and August with ongoing works to create ICU in C6. Final net loss from September 21 reduction of 8 beds across medicine and 12 beds surgical. Cross divisional mitigation group in place Already net loss of 3 beds to accommodate isolation in ward a3 Update 03.11.21 - currently MEM running 6 additional beds in gynae and 6 additional beds in discharge lounge. Discharge lounge remains displaced and not able to manage patients who are assistance of one. Discharge lounge capacity also reduced due to social distancing requirements. Update 01.02.22 Further added pressure in NMAB treatment now running out of new discharge lounge with COVID pathway 10 beds in PTU area reduces ambulatory opportunists PTU trying to manage activity thorough DAU and old discharge lounge when NMAB service not running New discharge lounge open 24th December to accommodate beds.	Major (4)	Unlikely (2)	8	HIGH	20/10/2022
											2- Over dependence on locums and agency staff. Additional ED consultants have been approved for Antrim. (please refer to principle risk 2 regarding nursing workforce) AsAt 20.10.22 - reamains same. no change. ongoing.	2 - Proactive medical and nursing recruitment ongoing regionally, nationally and internationally. Focused recruitment for nursing vacancies being planned. Will see impact by year end. medical efforts continue around recruitment, consultant posts readvertised. Focus required on remaining locum posts. Specific focus on Causeway - workstream established under renewing our vision.				
											3 - Reduction in the allocation of F1s and F2s to NHSCT. Ongoing recruitment for junior medical staff continue however with winter and COVID pressure this is an ongoing situation with recruitment issues.	3- F1 mitigation plan in place, proposal to extend Hospital at Night sitewide to be progressed by Director of Nursing. Doctors in training steering group convened with Divisional Subgroups				
											4 - Reduction in the attainment of the 48 hour discharge target; impacted by the complexity of community placement which is dependent on patient or main care giver COVID status. Overall Trust wide pathways group chaired by Director of ops.	4 - Trust Discharge Group jointly chaired by MEM and CC revisiting workstreams and agreeing revised workplan to improve discharge planning and in line with no more Silos priorities.				
											5- Absence of ACAH (Acute Care at Home) outreach model in the NHSCT area. Ongoing efforts made through anticipatory care to create additional support to nursing homes. This is a community lead workstream	6 - Anticipatory Care Model developed in the CAU Locality to support Care Homes, expanding from 4 homes to 10 by the end of March 2020. East Antrim LES in place as part of ICP workstreams. Initial reports evidence both models are reducing reliance on urgent care. This initiative has been impacted through COVID pandemic and revised model to be developed. This is a community led workstream. Community working on developing COVID pathways and Non-COVID pathways in private sector / primary care community hospitals				
											6- Reduction in the number of nursing home placements across the NHSCT area. This issue has again be further exacerbated by COVID 19 complexities of patient placement. This is a community led workstream	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. This is community led. update 04.03.22 Delayed community discharges are contributing to the demands on the unscheduled care flows. Reduced availability of domiciliary care, Covid and exposed to covid pathways are challenging to secure. Significant delays with patients who require close supervision or display challenging behaviours. Site coordination model continues with extreme focus on discharge pathways. Community escalation meetings in place to encourage coordinated response. Community discharge group chaired by Acute and Community Directors				
											7 - Inability to sufficiently expand Domiciliary Care. This is a community workstream.	9- Director MEM contributing to Regional Working Group, regional escalation policy revised and disseminated mid December 2019. Daily regional calls in place December to end of February. HEWS operational in all 5 Trusts. Director MEM continuing to influence a Regional Escalation approach. Director MEM and Director Operations involved				
											8 - Non availability of HALO over 7 day period. Additional HALO gives 16hrs per day although reduced during periods of leave	10 - Negotiations ongoing with commissioners in relation to neurology services. As anticipated a neurology advice line commenced from the 1st July 2020, giving consultants in the Northern Trust direct access to BHSCT neurologist for advice on inpatient admissions, with a direct admission and repatriation process. Business governance arrangement being finalised for start date in early September. First joint appointment has been made (BHSCT & NHSCT) with the successful candidate commencing in February 2021. This will provide 3-4 clinical sessions per week into Antrim Hospital. Interim position will cover - : Triage of referrals / Two clinics per week / 2 x 2 hour ward rounds per week / Reinstatement of GP email query pathway Specialist neurologist appointed. Locum visiting consultant for limited sessions to screen urgent referrals and triage remaining referrals.				

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											9 - Lack of regional approach to escalation. 10 - Current permanent consultant neurologist retires from service on 30th June 2020. Locum visiting consultant for limited sessions to screen urgent referrals and triage remaining referrals. We continue to work in partnership with Belfast and potential for neurologist to commence Feb 21. Locum continues, new post commences Feb 21. As of 02.05.22 no new post holder commenced - in process of advertising once funding is agreed with commissioner for 2 Consultant posts. 11 - Change in guidance on Covid-19 isolation and swabbing in the community. IPC guidelines currently remain unchanged within Trust. Presently, Covid absences remain a concern and have significant impact on service delivery. 12 - patient delays increasing with patients requiring inpatient MH beds, both at ward level and ED. 13 - ongoing liaison with BHSCT re: fracture delays, both at ward level and ED.	Neurology liaison nurse started at the end of January and induction now complete. This nurse will coordinate Neurology inpatient demand in Northern Trust and work directly with the new consultant who is commencing post at the start of March 2021. Arrangements remain in place with BHSCT to support unscheduled care which will continue even after new consultant takes up post. The previously agreed triage process is also still in place though this function (and review of diagnostic results) will transfer to new consultant once they commence in post. The Trust is actively working with HSCB and BHSCT to try to develop attractive joint posts for Trainees due to CCT this year and next year. And is also seeking to secure a locum (with clinical governance support from BHSCT) to help support the new consultant until further joint posts are secured with BHSCT. This work remains in progress. 11. potential for 48 beds additional capacity on Antrim site 03.08.22 Risk remains unchanged - awaiting final confirmaiton of 48 beds. All MEM Teams remain under significant pressure related to unscheduled care and complex delays, attainment continues to deteriorate.					

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67	31/05/2008	Strategic Development & Business Services	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).	Major (4)	Likely (4)	16	HIGH	1 & 3	1. Information Governance Management Framework in place (Information Governance Forum, Senior Information Risk Officer, Personal Data Guardian, Assurance policies, structures and an IG Action Plan). 2. Processing Personal Information Policy and Procedures, supported by departmental procedures as required. 3. Mandatory Training at various levels. 4. Underachievement of IG and POPI mandatory training is escalated to and reviewed at Accountability meetings. 5. Awareness materials for public and staff. 6. High level of expertise and robust processes in IG Department. 7. Divisional Action Plans are a standing agenda item on Directorate Accountability meetings and IG figures are included in the Divisional Scorecards to monitor compliance. 8. Trust IG Action Plan developed with key priorities for the IG work programme.	1. 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). 2. Incidents and complaints are reviewed routinely at IG Forum (I). 3. The Information Management Assurance Checklist (IMAC) has been reported as compliant for 2020/21(E). 4. Internal Audit carried out a recent IG audit in June 2021. The draft audit report has been issued with a 'Satisfactory' assurance. 5. The Trust's Learning Alerts System is in place to share learning from incidents (I).	1. Compliance with mandatory training for Trust staff as at 30th September 2022, was 83% for IG Awareness and 83% for POPI. Cyber Security compliance was 72%. A Senior Executive Team target of 85% remains in place. 2. The number of IG incidents reported during the quarter ended September 2022 was 54. There was one incident notified to the ICO during August 2022 but this has subsequently been closed by the ICO with no regulatory action. 3. Learning from IG incidents continues to be identified and shared but there is a continuing requirement to further embed this practice and evidence the actions taken. 4. There were 3 IG related complaints received during the quarter ended 30th Sept 2022. All assets in the (621)Information Asset Register have had risk assessments completed	1. The IG Department is providing regular 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 is tabled for review at IG Forum meetings and corporate actions agreed to minimise or mitigate IG related risk. 2. All information assets on the IAR have had a risk assessment completed. 3. Progress in respect of the Trust's IG Improvement Plan is monitored and reviewed by IG Forum. a revised 2-year plan with priorities is in development. The priorities will inform the Divisional IG Action Plans. 4. Work is ongoing on in developing a Records Management Strategy, which will identify a number of mid to long-term actions to be undertaken within the Trust. Strategic records management will now be monitored via IG Forum. The HSCR Committee has been stood down and an RM Operational Group has been established. A ToR has been developed and delivery of a short-term action plan (approx 6 months duration) is underway. 5. Compliance with information requests remain challenging. Legislative compliance is 100% with the relevant timescales. Trust compliance as at 30th Sept 2022 is 61% for DPA and FOI 73%. Complex DPA requests compliance as at end of June 2022 has improved to 64%. Services are under pressure to respond to requests for personal information due to competing priorities and service delivery, however work is underway with the MH and WCF Divisions to improve this compliance by reviewing and streamlining processes. There is also a proposal to remove the need for Consultant sign off for the majority of acute related Subject Access Requests which should contribute to improved Trust compliance with legislative timescales. Divisional level reporting has been implemented for FOIs and this is to be introduced for DPA requests. The Trust has purchased a Requests Case Management solution that will automate and further improve the processing of information requests.	Moderate (3)	Possible (3)	9	MEDIUM	01/11/2022

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											6. There is a need for the Trust to set out Strategic Plan for Records Management. Investment may be required to support this plan including undertaking a 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. Strategic records management will now be monitored via IG Forum, with a Trust RM Operational Group being established to develop and deliver on a range of RM related tasks .	6. The Trust is working with DLS and regional colleagues to progress appropriate contractual clauses and procurement exercises. The IG Department is supporting Divisions participating in tendering processes with data flow mapping exercises and completion of DPIAs to inform the tender specifications & future contracts. An action plan has been prepared to take the Trust to a state of compliance with GDPR contractual requirements and work is ongoing with Divisions to identify information sharing with external organisations and a review of the arrangements in place to underpin the sharing. Divisions have been tasked with identifying external sharing of personal information for inclusion in a Trust register. These will be reviewed to ensure that they are appropriate and compliant with GDPR requirements. DLS have been consulted on the Trust's action plan and the proposed risk based approach to progressing the above.					
											7. Current compliance with requests for information under DPA and FOI legisation are 57% (for standard 30 day requests) and 73% respectively as at quarter end June 2022(previously 60% and 81% at quarter end Match 2022). Complex DPA requests compliance as at end of Sept 2022 increased to 64% (increase of 10%).	7. All information governance policies have now been updated and approved in line with the Policy Framework process.					
											8. GDPR came into force on 25 May 2018 along with the new Data Protection Act 2018. A GDPR Implementation Action Plan was prepared and all actions have been addressed; however the work in relation to contracts is ongoing. This piece of work is significant and an additional resource has been identified to lead on this. This remains a priority for the Trust, and is included within the Trust's IG Action Plan.	8. The increase in the number of staff Homeworking due to the current climate has been identified as an additional risk factor. The Trust has put in place a number of measures to reduce this e.g. Trust Policy on Flexible Working, Guidelines on Homeworking, IG Newsletter with a Homeworking section and a Broadcast email highlighting the outlining the key IG considerations when required to undertake Homeworking.					
											9. Progress against the Trust's IG Action Plan is monitored and reviewed by Information Governance Forum on a quarterly basis.	9. A communication plan to raise awareness with staff and highlight good information governance practice is in place, which consists of targeted messages via Broadcast emails, IG Newsletters, Screensavers, content in Core Brief, with the objective of reducing IG incidents.					

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											10. The Trust's main off-site records storage supplier (Iron Mountain) is no longer on the regional Framework. The Trust will be required to move these records to another supplier covered by the Framework. This exercise may take several years as there are approximately 60,00 boxes of records stored with Iron Mountain.	10. The recent cyber incidents in HSC partner organisations, have highlighted the need to develop a Regional IG Cyber Incident Response Plan and undertake work within Trusts to ensure that all partner organisations information sharing arrangements are adequate and meet the legislative requirements under GDPR. DHCNI have not yet identified temporary funding to resource the Incident Response Plan. 11. The recent audit by Internal Audit has provided an outcome of 'Satisfactory' Assurance with 7 recommendations (5 P2s and 2 P3s). As at 30th September, 6 recommendation actions have been fully implemented and 1 partially implemented. 12. Divisions have been encouraged to focus on increasing mandatory training compliance. 13. Divisions are validating their quantities of records in off-site in preparation of an exit from Iron Mountain. DACs have been prepared to govern the intervening period. The Trust is working with PaLs to obtain a start date and timeframes for records to exit Iron Mountain. The Trust is developing an action plan for review/removal of the records. This is likely to span several years. Iron Mountain continue to provide a BAU service to the Trust in the interim.					

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851	19/05/2016	Paediatrics, Women's Services & Corporate Support	There is a risk of choking on food by patients / clients diagnosed with dysphagia or with suspected dysphagia. (There are also risks re deteriorating health eg due to aspiration pneumonia / malnutrition or dehydration)	Major (4)	Likely (4)	16	HIGH	1 & 3	**Assessment** • HSCB have previously completed capacity demand analysis which indicates a capacity shortfall of 4 band 6 SLTs to meet ongoing demand. These posts have been advertised as band 5/6 training posts. All posts are now filled and the post holders have recently completed dysphagia competencies to enable them to independently assess and treat dysphagia. • Monitoring of vacancies and active recruitment of professional staff in SLT to minimise gaps in the availability of SLT in adult teams. • Waiting list times for SLT assessment / review are monitored. **Risk Management** • Multidisciplinary discussion on case by case basis for high risk service users, including liaison with DLS if necessary. • Risk Management checklist for patients / clients who do not wish to eat commercially prepared texture modified meals to enable provision of alternative texture modified meal. Snack lists for hospital and community agreed and available on Staffnet at different IDDSI levels. • PHA has established the Regional Multi-disciplinary and Multi-agency Adult Dysphagia Group (Dysphagia NI) to action the recommendations within the SQR-SAI-2021-075, May 2022 RQIA review, the PHA Choking Improvement Plan and 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). • The well-established, Trust wide, cross divisional Dysphagia Group, have developed an action plan to ensure the SQR, RQIA and NCEPOD key learning recommendations are addressed within adult and paediatric services. The groups meets bi-monthly. • Trust Dysphagia Support Team. (2.0 WTE currently funded) to progress the recommendations from the SQR letter, RQIA Review (May 2022), NCEPOD, 10,000 Voices, the PHA choking improvement plan and the Thematic Review. This team is funded through transformation monies and funding has been extended until March 2023 • Implementation of the Dysphagia Management and Choking Reduction Policy (Adults) which has been revised and reissued in June 2021 to strengthen the recommendations in the SQR/SAI/2021/075. • The Paediatric Dysphagia Management and Choking Risk Reduction Policy has been revised to include the SQR key learning recommendations and approved in July 2022. • A range of new NHSCT resources (developed by the Dysphagia Support Team in conjunction with the Trust Dysphagia Group) have been rolled out across divisions and have been shared with agencies in November 2021. These resources include a staff booklet, posters and A5 swallow aware 'fast facts' card which highlight the key recommendations from SQR-SAI-2021-075 and learning from local incidents to support staff. New, visual IDDSI food / fluid level posters have been distributed. • Each service area has access to bespoke dysphagia audit tools to measure compliance with SQR recommendations. • A learning letter (including a complaints template) has been shared through divisions re the process for raising concerns regarding the consistency of the ready-prepared meals for special texture modified diets. • Homecare staff are not permitted to assist with the feeding of newly referred clients with a SLT care plan until trained. • The Dysphagia Information staff booklet for staff working with adults with eating, drinking and swallowing difficulties was revised in November 2021 and is available to home care staff. • The food and drink safety pause was rolled out across all acute hospital settings (including mental health inpatient settings) on 01/04/2022, community care settings on 01/07/2022 and within Homecare in September 2022. A programme of audit is currently underway across all areas to provide assurance re: safety pause implementation. • In June 2022, adult SLT teams began to add an NIECR swallow 'alert' for services users with a known diagnosis of dysphagia to assist other staff to identify presence of dysphagia. **Staff Training Programme** • Training Needs Analysis completed for social care staff in Mental Health / Learning Disability in community settings. • Trust Exec team have endorsed that dysphagia training will be a mandatory requirement for all staff providing care or services to adults who are at risk of dysphagia. This includes the line managers of these staff groups and catering and support services staff. • Trust Dysphagia Group has developed a training matrix including mandatory dysphagia awareness training for defined staff groups. • Monitoring of education uptake by Lead Nurses / Team Leads. Divisions are able to access training completion reports. • The SPPG / PHA led Dysphagia NI has endorsed a regional PHE dysphagia awareness E-Learning programme which is available on the HSC learning platform to HSC staff and to staff in independent care sector. 2322 NHSCT staff have completed the dysphagia e-learning programme between October 2020 and August 2022. • The Adult Speech and Language Therapy Team continue to provide monthly live dysphagia awareness zoom training sessions to NHSCT and IS staff. Between January 2021 and October 2022 this training was delivered to 615 NHSCT staff and 152 IS staff. • Between January 2022 and October 2022 the Dysphagia Support team has provided dysphagia awareness training to a further 492 Trust and IS staff. • Training of Homecare workers to be kept under review by relevant managers • A programme of refresher dysphagia training for all homecare staff, delivered jointly by SLT and Dysphagia Support Team, has commenced in October 22. To date 100 staff have been trained. • The Trust Dysphagia Support Team continue to provide additional training capacity and respond to bespoke requests for training.	• NHSCT are compliant with the direction to use of IDDSI across all care settings and on all systems. • There is a NHSCT Trigger list to support incident reporting (now adopted regionally) Dysphagia related incidents are reviewed by the DST/SLT service lead and reports are shared and discussed with Divisional Reps at the Trust Dysphagia Group. Divisional reps cascade learning within their divisions at appropriate divisional meetings. • NHSCT representation on the Regional Multi-disciplinary and Multi-agency Adult Dysphagia Group (Dysphagia NI) established by PHA to action the recommendations within the SQR-SAI-2021-075, May 2022 RQIA review, the PHA Choking Improvement Plan and 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). • The well-established, Trust wide, cross divisional Dysphagia Group, have developed an action plan to ensure the SQR, RQIA, NCEPOD and 10,000 voices report key learning recommendations are addressed within adult and paediatric services. The groups meets bi-monthly. • Task and Finish Group has been established to consider Trust compliance with recommendations set out in the NCEPOD report: 'Hard to Swallow?' for patients diagnosed with Parkinson's.	There were 29 recommendations (53 actions) made from the SQR letter, RQIA Review (May 2022), NCEPOD, 10,000 Voices, the PHA choking improvement plan and the Thematic Review that require implementation. **Assessment** 1. Additional 4 Band 6 SLT posts will sustain ongoing demand for assessment however will not address the current will backlog. Waiting times for SLT assessment continues to exceed 763 days. Clients may experience harm (malnutrition, chest infection, aspiration pneumonia, choking) while waiting for assessment. **Risk Management** 1. No effective system to have complete assurance about: a. The traceability of meals – functionality of menu tablets has improved but not fully to achieve IA recommendations b. Secure storage of thickeners to prevent unauthorised access - recent Audit in Antrim and Whiteabbey Hospitals has demonstrated that there is not full compliance with safe storage of thickeners. c. Reporting of incidents relating to dysphagia management – this is inconsistent across Divisions. 2. Only 2.0 WTE of the original proposal of 5.0WTE for the Dysphagia Support Team included in the RCB currently funded. This is a 33% reduction in staffing allocation which has reduced the capacity of this team in their work to address dysphagia risks. 3. The EDS recommendations issued by SLT should be accessible to all members of the MDT and incorporated into electronic alert systems e.g NIECR as per RQIA May 2022 review. In June 2022, adult SLT teams began to add an NIECR swallow 'alert' for services users with a known diagnosis of dysphagia to assist other staff to identify presence of dysphagia. The SLT Regional EDS (REDS) recommendations document is not yet available on NIECR. NHSCT is awaiting the release of a digital version of the REDS and a regionally agreed process to align the placement of the REDS in NIECR taking account the different trust systems (LCID /PAS). It should also be noted that agency staff do not have access to NIECR. **Staff Training Programme** 1. The Regional Dysphagia Steering group has not yet provided an action plan to Trusts regarding standardisation of dysphagia care training to specific staff groups therefore NHSCT have proceeded with a Trust Plan but have been unable to fully mandate training by staff recruited through agencies. 2. A NHSCT paediatric dysphagia training matrix and dysphagia training programme is currently being developed alongside a range of training resources for staff working with children and young people at risk of dysphagia. There is no regional group with strategic overview of this work. A regional approach is required to standardise the training offered and resources developed for HSC staff working with children with/at risk of dysphagia. 3. Scoping of current demand for training for Homecare staff due to recent staff turnover and the requirement to provide refresher training every 2 years has identified a further 800 staff who require training in this cohort.	The Trust Dysphagia Group has developed a Trust wide Dysphagia Action Plan which incorporates the 29 recommendations (53 actions) from the SQR letter, RQIA Review (May 2022), NCEPOD, 10,000 Voices, the PHA choking improvement plan and the Thematic Review **Assessment** 1. Working towards reducing waiting time to Ministerial target of 13 weeks. RQIA have recommended HSC trusts and commissioners should work together to review the capacity and capability of multidisciplinary teams, with a particular focus on SLT, to meet the needs of the patient population and ensure that timely assessment and intervention is provided, where required. **Risk Management** 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 and ensure mandatory recording of patient details b. Regional patient safety alert HSC (SQSD) 6/15 Risk of Death from asphyxiation by accidental ingestion of fluid/food thickening powder has been disseminated on 3 occasions (Dec 2015, Aug 2016 & Dec 2016) however assurance cannot be obtained regarding the safe storage of thickeners. Availability/storage of thickening powders is included in some current audit programmes and will be rolled out to all with the implementation of the regional Mealtimes Matter audit tool. c. NHSCT Trigger list developed to support incident reporting (now adopted regionally). Regional work is ongoing to standardise the reporting of incidents. This work and a pilot IQI project to improve reporting is currently on hold due to COVID-19 but will be resumed during phase 3 of reset plans 2. NHSCT have written to PHA regarding their concerns regarding the reduction in funding for the Dysphagia Support Team (Transformation Project) received in 2021/22 resulting in a 33% reduction in staff resource. 3. Adult SLT teams have begun to add an NIECR swallow 'alert' for services users with a known diagnosis of dysphagia to assist other staff to identify presence of dysphagia. However, alignment of the placement of the REDS in NIECR taking account the different trust systems (LCID /PAS) cannot progress pending availability of the SLT Regional EDS (REDS) recommendation on NIECR. NHSCT is awaiting the release of a digital version of the REDS and a regionally agreed process **Staff Training Programme** 1. A regional approach is needed to address dysphagia training for agency staff, this needs to be set out as a requirement within the regional contract and a mechanism sought to ensure compliance by non-contract agencies. 2. A NHSCT paediatric dysphagia training matrix and dysphagia training programme is currently being developed alongside a range of training resources for staff working with children and young people at risk of dysphagia. There is no regional group with strategic overview of this work. A regional approach is required to standardise the training offered and resources developed for HSC staff working with children with/at risk of dysphagia. 3. Dysphagia Support Team is currently working with Homecare manager to review current demand for training due to recent staff turnover and the requirement to provide refresher training every 2 years. This will be delivered jointly by SLT and Dysphagia Support Team between October 22 and December 22. 100 staff trained to date. 4. Work is ongoing to develop a dashboard to assist in monitoring compliance with Dysphagia Training.	Catastrophic (5)	Unlikely (2)	10	HIGH	28/10/2022

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1080	03/03/2020	Department of Finance and Operations/Deputy Chief Executive	Risk to the provision of Trust services during the response to the COVID-19 pandemic, including post surge, reset and planning for potential future surge. The rebuilding of services/capacity presents challenges to maintaining safe and effective care and the ongoing COVID-19 restrictions.	Major (4)	Possible (3)	12	HIGH	1 & 3	A Trust COVID-19 Bronze command and control structure has been established and remains in place. The frequency of meetings were increased to daily (7 days per week) over the build up to and over the Surge 3 period. Bronze meetings are curently held once per week with associated SIT reports, but remain responsive to increasing should this be required. Bronze meetings consider Situation Reports from Acute Sites, Community Divisions including updates on issues such as Oxygen & ICU Capacity. with specific reports on ICU capacity. The Bronze group also consider various workstreams, including Testing, Safe Working, PPE, Workforce and Communications.	Regular (weekly) Bronze meeting where any COVID-19 issues can be escalated.	Plans ongoing to meet requirements of Rebuilding Health and Social Care in a continued COVID compliant manner, and monitoring against Pre-COVID capacity. This is monitored and reported via Project Reset Service Delivery group. This impact on service capacity as a result of the requirement to rebuild in a COVID compliant manner has had significant impact across a wide range of services including Elective and Unscheduled Hospital services as well as Community Health and Social Care settings. Quarterly reports maintained in terms of predictions and attainments against rebuilding plans	A regional template to be agreed and adopted to inform decision making over resumption of services. Trust delivery of services following resumption continues to be closely monitored. Robust internal monitoring systems in place to quantify service impacts.	Minor (2)	Likely (4)	8	MEDIUM	14/11/2022
											Subsequent surges in COVID activity and associated impact on flexing ICU beds regionally will further impact ability to deliver elective services	Regional monitoring of elective activity impacts included in Critical Care Regional Group with HSCB representation to Department. CANNI Critical Care Escalation plan agreed with Antrim at 10 beds until CRITON Level 4 when there is an expectation of 14 beds which will significantly impact ability to deliver elective activity on the Antrim site Escalated ICU capacity has been consistently required from August 2021 until Mid-February 2022, resulting in associated impacts on Elective capacity. ICU capacity now in a 10 bedded footprint with funded establishment increased to 7.5 equivalent Level 3 beds - Regional winter planning through CAANI awaited.					
											The Trust has also been managing a range of Outbreaks across various work settings resulting in the loss of staff in line with COVID guidance and Self Isolation requirements. This has resulted in some reduction of service but priority and critical services have been maintained.	Each Outbreak is closely monitored for the duration of the isolation period, invoking Director level oversight where appropriate. This process includes regular review of impact on service and assurance that essential services and critical needs are maintained.					
											Recognised deficit in bed capacity on the AAH site has been compounded by COVID 19 infection control processes and protocols making placement of patients more complex other limiting factors are the requirement to maintain a lower risk pathway for elective cancer and urgent surgical patients, a respiratory and non-respiratory ED and requirement for patient COVID19 19 swabbing and associated time-lag for receipt of results which limits ability for decision making of bed placement	Bed utilisation closely coordinated to manage risks between ED and Ward levels, taking account of the shortage of side rooms on the Antrim site. The Trust continues work to reduce the placement delays arising from the patient COVID19 19 swabbing and processing of results processes, rapid swabbing opportunities maximised for patients requiring assessment, admission and to facilitate timely discharge. Additional side room capacity created within the Antrim Site to enhance flows. The Trust has contributed to the Regional Surge Planning in respect of ICU and Respiratory capacity at Director level Regional consideration is being given to the development of a similar model to oversee Unscheduled Care Pressures. Following Business Case Approval, construction has commenced on Interim Ward Accommodation (48 Beds) at Antrim Area Hospital, with the first ward expected to be available by March 2023.					
											A significant proportion of the Trust's planned activity was stood down/scaled back/changed during the first, second and third Coronavirus surges. This has resulted in a risk that some patients and service users are waiting longer to access services, and this delay could in some cases result in harm.	Rebuild plans are now in process of being re-established in response to reduction in COVID-19 demand. Progress monitoring in place, with learning from COVID embedded in maximising virtual opportunities. Revised IPC Guidance from PHA in May 2022 to be implemented, supported by a dynamic risk assessment apporach, with a view to maximising core activity across all settings from summer 2022.					
											Further overall reduction in beds on the Antrim Site to complete ICU refurbishment	Mitigation plan in place internally and regionally and daily monitoring of flow in place ICU successfully relocated to C6 early October. Completion of remaining minor works ongoing and due for completion by end of November to release the site formally into revised footprint Revised footprint realised as of Mid October 2021 with an overall decrease of 20 beds on Antrim Site which has been mitigated by investment in EMSU and a temporary increase of 10 medical beds as part of winter surge planning and relocation of discharge lounge to out patients area					

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The Trust has recently been asked to put in place arrangements, in line with regional requirements, to implement the COVID 19 Vaccination Programme, including securing a suitable location, establishing appropriate vaccine storage & distribution arrangements, identifying the required workforce (Pharmacy, Vaccinators, Admin Support, Management and Medical support) and put in place appropriate governance and monitoring arrangements.

The Trust has fully contrinited to the Regional Vaccination programme since December 2020, including First, Seconfd and Booster programmes, and Boosters for Immunosuppressed patients. An Oversight group was been established to coordinate the required response. This group had put in place appropriate Project Management and Clinical leadership supported by Work streams on Accommodation, Operations, Primary Care, Governance/Information and Communications. This group continues to oversee the Trust Programme in line with regional guidance and instructions and is currently maintaining a low key service profile, in line with demand.

The Trust is currently developing the COVID Booster Programme for Aumumn 2022, to include the annual Flu programme. The target group for the Trusts is in two categories.
1. Mobile Teams: meeting the Booster requirements for Care Homes, Housebound, Supported Living and Schools;
2. Mass Vaccination Centre: providing to identified Immunosuppressed patient and meeting the Booster needs for all Front Line Staff, and Front Line staff.
DoH will also soon be engaging with Trusts and other partners to scope the requirements for a commissioned Vaccination programme from April 2023 onward.

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28	20/02/2008	Finance	Failure to achieve statutory break even position.	Catastrophic (5)	Unlikely (2)	10	HIGH	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 SPPG 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 established which will examine the utilisation of locums and recruitment of a range of vacant posts. 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).	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). The finance/performance accountability forum was established in Sept 2019 which meets quarterly and is chaired by a non executive director. A range of topics are reviewed The medical Scrutiny Committee examines the utilisation of locums and recruitment of a range of vacant posts by Directorate. The Trust is recording all expenditure associated with Covid 19, and details are recorded on the monthly monitoring return for review by SPPG and DoH. It is assumed that all costs associated with Covid 19 will be fully funded. Discussions continue with SPPG and DoH representatives. The Trust has reported a small Surplus Position (£47k) for the year to 31 March 2022. Trust Board receive regular Financial Performance Report setting out progress against the Financial Plan (I). Monthly and Annual financial reporting and external audit (E).	As in previous years, the Trust achieved a Breakeven position for 2021/22 due to a combination of Non-Recurrent Savings meaesures within the Trust, non-recurrent funding from DoH/HSCB and Business As Usual Savings due to the continued downturn in core activity due to the Trust's Pandemic response. In addition DoH/HSCB fully funded the COVID response including PPE, No More Silos, Nightingale at Whiteabbey as well as Transformation initiatives. However it should be noted that the majority of this funding was provided non-recurrently. The Trust therefore is carrying financial risk until such time as funding is secured or a decision is made to stand down projects. In 2022/23 Financial Planning the Trust , in conjunction, with DOH and HSCB colleagues had projected a significant deficit on Core services, with further commitments arising in 2021/22 due to pressures such as COVID Response, Whiteabbey Nightingale, No More Silos in additon to Transformation schemes. This position has been subject to detailed and regular review in recent months and, through a combination of Non-Recurrent Savings and Cost Containement measures within the Trust, along with significant further funding confirmed by SPPG, the Trust, as 31 October, is projecting a breakeven piositon for the yeart to 31 March 2023. It should be noted at their remains a significant underlying recurrent defict position which will be subject to further review in coming months as financial planning for 2023/24 commences.	The Trust continues engagement with DoH/SPPG with regard to scale of the underlying recurrent financial deficit facing the Trust as it looks toward 2023/24 financial year. It should be noted that there remains a significant Recurrent Financial Deficit of @ £73.5m, including Core, COVID, Nightingale, No More Silos and Transformation. The Trust continues to enagage with SPPG with a view to arriving at an agreed funding or cost containment strategy in line with the developmen of an overall HSC Recovery initiative	Catastrophic (5)	Unlikely (2)	10	HIGH	02/12/2022

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1000	09/07/2018	Finance	The UK left the EU on 31 January 2020 and entered a transition period, as set out in the withdrawal agreement, which ended on 31 December 2020. The Northern Ireland Protocol came into effect following the end of Transition Period on 31 December 2020. Under the terms of the protocol, Northern Ireland remains in the EU single market for goods. There remains a risk of disruption to the supply chain following the end of the transition period, affecting key stocks and supplies and impacting on service delivery and patient care. Under the NI Protocol, NI will continue to follow EU rules and regulations for medicines and medical devices, whereas GB will not. This has implications for both the supply and regulation of medicines in NI.	Major (4)	Possible (3)	12	HIGH	1, 2 & 3	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. These meetings are now only ocurring when required. 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 continues to meet when required and communicates all emerging issues as and when arising. The NHSCT will continue to work closely with DoH and other HSC bodies to address any potential risks. EU Exit briefing sessions delivered to all Trust divisional management teams. Assurance Statements previously 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 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 continuning to meet following the end of transition period. 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. Stocks are being kept under review following the end of transition period. The Head of Pharmacy participates in the weekly Pharmacy Leaders Forum and the bi-monthly NI EU Exit / NI protocol programme board recently convened and chaired by the chief pharmaceutical officer.	A Business Impact Analysis has been undertaken and Business Continuity Plans developed on the basis of risks identified (I). This continues to be monitored and updated for any emergent issues. Trust EU Exit Lead and Emergency Planning Lead attended Executive Team on 14 February 2019 to provide update on contingency arrangements in place (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). 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). 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). Bronze arrangements for COVID-19 are being used for the escalation of any EU Exit related issues.	None further identified at this stage. The Trust continues to participate and respond to regional work in this area. Assurance was updated regarding Data transfers at request of DoH 31/07/2020 and Trust Information Governance provided the renewed assurance. Assurance re-sought December 2020 from divisions of having contingency stocks in place and 100% assurance achieved. There are a few areas being kept under review and these relate to primarily; - Dual Registration - Supplies, including Pharmacy - Cost implications Negotiations on medicine regulation and supply chain continue between DHSC and the EU There are derogations regarding food and parcels currently and these have been extended. There is potential for impact when these may end in October 2021 and this situation is being monitored by the regional EU Exit response and planning. Pharmaceuticals are being monitored regionally also. A Regional EU Exit / NI Protocol programme Board has been established in July 2021 with a focus on medicines and medical devices. The trust has communicated with staff on a number of occasions with the latest being 25/05/2021 regarding the EU Settlement Scheme and the deadline for applying being 30/06/2021. The Trust has also scoped the risk around the dual registration issue and is taking action where required in mitigating any risk that may result from this matter.	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 following the end of transition period. The current position is that following the End of Transition Period on 31 December 2020 the Northern Ireland Protocol came into effect. Under the terms of the protocol, Northern Ireland remains in the EU single market for goods. Northern Ireland will also apply EU customs rules at its ports, even though it is still part of the UK customs territory. DoH has reconvened their ALBs EU Exit Planning Working Group with latest meeting being Friday 03/02/2021. Next meeting planned for 17/02/2021. Trust group most recently met on Monday 19/01/2021 and Divisions reviewing key risk area of local stocks and BIAs. DoH has issued the updated Operational Readiness Plan to update guidance for Trusts. Service leads/divisions have updated their Business Impact Analysis (BIAs). Trust has updated the EU Exit Business Contingency Plan to reflect Operational Readiness Plan and BIAs Arrangements are in place for escalation of any EU Exit related issues via existing Bronze arrangements for COVID-19. Transition period has passed and contingency arrangements remain in place. Some small issues have been dealt with but nothing significant or causing impact to service delivery. Issues log set up.	Minor (2)	Possible (3)	LOW	6	03/11/2022

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ID	Opened	Lead Division	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Principal Objectives	New and Existing Controls	Assurances Internal (I) External ('E)	Gaps in controls and / or assurances	Actions to Close Gaps	Consequence (Target)	Likelihood (Target)	Rating (Target)	Risk level (Target)	Date of Last Review
909	11/07/2017	Strategic Development & Business Services	Information security across the HSC is of critical importance to delivery of care, protection of information assets and many related business processes. If a Cyber incident should occur, without effective security and controls, HSC information, systems and infrastructure may become unreliable, not accessible when required (temporarily or permanently), or compromised by unauthorised 3rd parties including criminals. This could result in unparalleled HSC-wide disruption of services due to the lack of/unavailability of systems that facilitate HSC services (e.g. appointments, admissions to hospital, ED attendances) or data contained within. This may result in the need to cancel appointments and treatments, or divert emergency/essential clinical or other services. The significant business disruption could also lead to increased waiting lists, delayed urgent clinical interventions, suboptimal clinical outcomes and potentially bring liabilities for the Service. It could also lead to unauthorized access to any of our systems or information (including clinical/medical systems), theft of information or finances, breach of statutory obligations, substantial fines and significant reputational damage.	Major (4)	Likely (4)	16	HIGH	2	The following controls are in place: Technical Infrastructure • HSC security hardware (e.g. firewalls) • HSC security software (threat detection, antivirus, email & web filtering) • Server / Client Patching • 3rd party Secure Remote Access • Data & System Backups. Policy and Processes • Regional and Local ICT/Information Security Policies • Data Protection Policy • Change Control Processes • User Account Management processes • Disaster Recovery Plans • Emergency Planning & Service • Business Continuity Plans • Corporate Risk Management Framework, Processes & Monitoring • Regional & Local Incident Management & Reporting Policies & Procedures. User Behaviours • Influenced through Induction Policy • Mandatory Training Policies • HR Disciplinary Policy • Contract of Employment • 3rd party Contracts • Data Access Agreements. Increased patching regime in place and now BAU Sophos Intercept X on all desktops and Servers Recruitment of the ICT Security and Governance Team now complete	ISO270001 certification achieved 2015/2016 and renewed 2022 for 6th consecutive year, Internal Audit / IT Dept self-assessment against 10 Steps towards NCSC Technical risks assessments and penetration tests.	Gap analysis completed regionally and cyber security position well understood along with improvement actions required. Strategic business case in draft form and under discussion with DHCNI and DoH. Insufficient User Awareness of impact of personal behaviours in relation to cyber threat.	The Regional Business Case in progress to strengthen security arrangements across all organisations, and we are part of that, and this is still ongoing. Vulnerability scanning of critical network assets is conducted monthly. Report findings and action plan is currently being worked on. 3rd Party Risk assessments to take place to understand and mitigate the risk associated with 3rd party access	Moderate (3)	Possible (3)	MEDIUM	9	01/11/2022

Northern Health and Social Care Trust

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1180	02/09/2021	Paediatrics, Women's Services & Corporate Support	The ability of the Trust to continue to provide safe, high quality obstetric care and training is compromised by challenges outside of the organisation's control (sustained decrease in birth rate in Causeway Hospital site and no neonatal unit, leading to lack of exposure to complex and obstetric emergencies by doctors and midwives affecting skills; inability to recruit Doctors and Midwives, and the need for different working patterns). Safety risks are also heightened because: - As a Consultant led unit, there remains potential for emergency attendance of a pregnant woman with complexity requiring urgent care and/or delivery of a pre-term infant (affecting maternity, paediatric and anaesthetic specialties) -There is no dedicated special care baby area with associated staff to care for an infant awaiting transfer - The Trust does not have a Midwifery Led unit - The medical rota is reliant on locum staff - There are gaps in the rota for specialist services that transfer babies that require specialist care between hospital sites. This means Trust staff have to transfer babies, leaving a gap within the Causeway site for the duration of the transfer (this affects medical and nursing staff in anaesthetics and paediatric specialities)	Major (4)	Possible (3)	12	HIGH	2	Short term action plan in place for Maternity Services; ongoing communication with regional network regarding transport issues. Enhanced Consultant Paediatrician on-call rota in place to provide cover when Trust transfers happen.	Senior management oversight and discussion at escalation meetings	Sustained reduction in birth rates at Causeway Hospital Site - Options for future delivery model undergoing public consultation Recruitment drives for Obstetric Medical staff have been unsuccessful leading to reliance on high cost locum cover	3/11/22 - Neonatal transfer continues to be required. Staffing gaps in NISTAR rota persist and the paediatric and maternity team in Causeway often undertake the transfer, depleting the acute site of staffing for the duration of the transfer and return of staff to base. Medical workforce levels remain depleted due to inability to attract applicants to recent recruitment of 2 consultants/gynaecologists. The unit remains reliant on locum cover for 40% of the rota. Work progressing in relation of ROV Maternity (awaiting ministerial approval prior to public consultation.)	Minor (2)	Unlikely (2)	LOW	4	29/11/2022