ASSURANCE FRAMEWORK
Principal Risks and Controls Document 2023/24

August 2023

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 June 2023	
		Changes to Risk Rating	
		Previous Risk Rating	New Risk Rating
1180	Causeway Hospital Maternity & Transport Risk (This Risk has been de-escalated to a Corporate Risk)	12	15
28	Failure to Breakeven	15	20

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	25	21/11/2017	07/08/2023
2	324	Paediatrics, Women's Services & Corporate Support	Healthcare Associated Infections	25	16	HIGH	12	HIGH	42	15/03/2011	04/08/2023
3	1049	Mental Health, Learning Disability & Community Wellbeing	Mental Capacity Act	25	16	HIGH	12	HIGH	44	28/08/2019	27/07/2023
4	780	Paediatrics, Women's Services & Corporate Support	Nursing Vacancies	25	16	HIGH	12	HIGH	42	16/01/2015	27/07/2023
5	905	Medicine & Emergency Medicine	Unscheduled Care Demand	25	16	HIGH	8	HIGH	43	26/06/2017	07/09/2023
6	67	Strategic Planning, Performance and ICT	Information Governance	20	16	HIGH	9	MEDIUM	51	31/05/2008	28/07/2023
7	851	Paediatrics, Women's Services & Corporate Support	Dysphagia	20	16	HIGH	10	HIGH	57	19/05/2016	02/08/2023
8	28	Finance	Failure to Breakeven	25	20	EXTREME	10	HIGH	0	20/02/2008	04/09/2023
9	909	Strategic Planning, Performance and ICT	Information Security	20	16	HIGH	9	MEDIUM	74	11/07/2017	27/07/2023

9 Principal Risks

Northern Health and Social Care Trust

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. Womens Health Physiotherapy 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.	MEDICINE AND EMERGENCY MEDICINE SPECIFIC SERVICE ACTIONS NEUROLOGY - Update Neurology jan 23 - 2 neurology consultant post currently advertised. locum remains in post who is seeing mainly outpatients. only one day of ward sessions available at present. all other referrals going via reg phone in BHSCT for advice. meeting with SPPG feb 23. (May 23) Ongoing discussion with SPPG. Neurology posts currently re-advertised prioritisation of waiting lists RHEUMATOLOGY Update 30.01.23 - Rheumatology has introduced active triage to optimise patient experience and best use of resources. Update August- Rheumatology continues with active triage. DERMATOLOGY Update may 23 - ongoing SP work and discussion with SPPG re centralisation of waiting lists. Update July 23 - continues to see increasing demand- focus on red flag activity and regional agreement for 30 referrals per month across other Trusts with the exception of WHSCT. recruitment of consultant but will not commence post until 2024 due to fellowship opportunity. Using funding for additional middle grade support Update 1.2.23 Endoscopy - Patients transferred out to IS are on hold due to them awaiting sign off to allow their new unit to open. In sourcing has been delayed due to discussions between Trust and provider regarding contract, anticipated start date 11 Feb 2023. Echo - WLI clinics ongoing until funds exhausted in March 2023. All routine and majority planned valve surveillance patients seen currently in WLI clinics. High risk that no routine/planned patients will be seen beyond March 2023. Longstanding demand/capacity gap due to inadequate funded core staffing levels. On target to carry out 4000 additional Echos through in house WLI by March 2023. Despite the huge number of patients seen via WLI clinics, wait times remain .12 months due to sizeable and growing demand/capacity gap. 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. Dental - waiting list currently at >1400 and out monthly rate of referral is 2.5 times our monthly capacity. Gynae & hysteroscopy - Efforts to shorten the wait time for gynaecology and hysteroscopy procedures have been ongoing, including the implementation of additional hysteroscopy lists through waiting list initiative, transferring patients who have been waiting the longest to the independent sector, conducting additional telephone review clinics, active triage, clinical validation and nurse led clinics as part of the waiting list initiative. Recent resignation of middle tier doctor who has 0.5PA for hysteroscopy, however this should be offset by the recent appointment of a clinical lead nurse for hysteroscopy. It is expected to result in further improvement and a significant reduction in waiting times for hysteroscopy procedures in the coming months. Histopathology - GS Approx. 250 cases awaiting report following CPS outsourcing this week; >50% of these are urgent or red flag cases; unsuitable for referral. Review of additional PAs/points payments for consultant to encourage additional reporting, especially of speciality areas. • Outsourcing approx. 300-500 cases per week; approx. 10-20% are red flags (reviewed by pathologist to assess if this is clinically appropriate to outsource) • 1 locum consultant retired (as 31.01.23) • 1 locum consultant remains (6 reporting PAs, approx. 24 hours per month) • 1 consultant pathologist (FT) due back from maternity leave at the end of February • 1 staff grade clinician (PT) due to start at the end of February General Surgery & Breast surgery - A new buddy system between Belfast and Northern Trust, will see Breast Surgery increase the number of referrals from Northern to Belfast from 5 every other week to 20 per week from 20/2/23. This will have an impact in the near future, on the waiting list. A new Middle Grade is also recruited to Breast which will have an impact on activity. 14 breast patients for reconstruction sent to the Independent Sector for procedure. For General Surgery there are currently no further issues, lack of theatre time is impacting on operating time, which is affecting performance. General Surgery use of Independent Sector to address waiting list and use of In House WLI to assist with this. 23.3.23 - Women's health physiotherapy is the greatest risk within physiotherapy service - currently 3 year waiting list. Reconfigured resource but still have staffing challenges of a small specialised team. Training and developing staff across services to support clinical validation of the waiting lists.	Major (4)	Likely (4)	16	HIGH	07/08/2023

Northern Health and Social Care Trust

Return to PRD Summary Report

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324	15/03/2011	Paediatrics, Women's Services & Corporate Support	Good infection prevention and control (IPC) practices and high standards of environmental cleanliness are essential to ensure that people who use the Trust services receive safe and effective care. Following the declaration of the Clostridium Difficile Outbreak in 2008, the Trust has worked to deliver a plan aligned with the Trust Infection Prevention and Control Strategy. The Strategy describes the key themes to support staff and the Trust in meeting the current and future demands for quality standards by minimising risk and integrating IPC into core business. However, despite these measures, the 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, remains. 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. There is an increased risk of outbreaks of COVID-19 where LFT/swabs are not taken as per procedure and LFT results are inaccurately interpreted / recorded leading to delays in isolation protocols for COVID-19 patients.	Major (4)	Likely (4)	16	HIGH	1	Application of policies and procedures - National IPC guidance implemented (including testing Review of policies, procedures and plans:- • Infection Prevention Control (IPC) Corporate Strategy reviewed 2021-2024 including IPC reporting structure with additional Bronze reporting structure when required. • 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. IPC training available on new Learning Management System • Additional training for locum and agency medical and nursing staff where indicated. Training for block booking agency staff implemented and ongoing where possible Use of 'Fast Fact' information sheets for staff Safety Huddles Easy to use App for antimicrobial prescribing available for all prescribing staff Regular comms re: social distancing, hand washing and symptom alert are issued in accordance with the Safer Working Group. Communication/education to staff and visitors regarding risk of Norovirus, Respiratory viruses IRAT admission and assessment tool for patients at risk of infection. 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. However, the Trust will continue to 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 Operational and corporate dynamic risk assessments to manage positive results of COVID19/outbreaks HCAI and capacity issues. 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. Twice daily attendance at site Hub by IPC Nursing team to advice on safe patient placement. CDI and Antimicrobial Stewardship ward rounds in Causeway Site and Antrim site. 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. Daily attendance by IPCN's at both Antrim and Causeway Site Safety meetings to report current status and highlight any IPC risks. IPC Link Nurse and Link Worker system Trust-wide Highly visible IPC Nurse presence in all in-patient clinical settings, auditing, monitoring and challenging any poor practice. 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. Programme of leadership walkabouts to identify and address estates and cleaning issues have recommenced within acute sites Water testing for Legionella and Pseudomonas as per Water Safety Plan/Policy. IPC involvement and guidance in new builds and refurbishments. The Trust is working with BSO Pals to ensure there is a stable supply of masks and PPE Health care worker and patient testing for COVID 19 with subsequent contact tracing. Implementation of revised testing guidance and PPE in place (March 2023). Training videos on LFT are available and competencies must be completed by staff. Written process for completing a swab also provided to staff. LFT Training pack available and provided to staff. All positive LFD tests must be followed up with a PCR test to confirm results. Revised schedule of Post Infection Reviews at strategic level agreed. Incident Management Teams to help assess actions and learning acquired from outbreaks. Post Infection Review Process for all Staph Aureus bacteraemia and C diff. Outbreak control meetings held when required and updates communicated to PHA; meetings chaired by IPC Doctor or Assistant Director of IPC . Nosocomial death review panel established and chaired by Medical Director; IPC Lead Nurse attends to provide information on COVID status throughout patient journey 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. Safer working group established and chaired by Director of Nursing/Infection Prevention and Control. IPC Environmental Hygiene committee now reporting to Strategic IPC which reports into Trust Assurance Framework. Each Directorate presents IPC plan and review of IPC incidents including LFD testing at IPCECH. PPE group review of supply and monitoring of FIT testing compliance levels and any variances identified in Trust IPC Doctor and IPC Lead Nurse both members of new regional HCAI working Group hosted by PHA. SAMHRAI group hosted/chaired by Chief Medical Officer DoH established IPC Doctor and IPC Lead Nurse both members. IPC Annual report includes performance, surveillance and control measures in place to reduce HCAI.	CAS 2022/2023 score for IPC 96% (Replacement for these standards remains under review with the DoH) (I). Daily monitoring and reporting of confirmed HCAI cases (I). Mandatory reporting to PHA of C-Diff, MRSA Bacteraemia and Gram Negative Bacteraemia and monitoring against annual (PFA) reduction targets (E) – rate lower than the expected trajectory for CDI (37 against target of 49) and MRSA (7 cases against target of 7) as at year end March 2023. 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). External inspections by RQIA and Nosocomial Cell in February 2021 (E). 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. Electronic Laboratory and Antimicrobial Surveillance (LAMPS) systems to monitor alert organisms / antibiotic stewardship and compliance reporting (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). Results of water testing (I). Survey of ventilation in Antrim and Causeway Hospitals completed (I) – findings positive. Review of nosocomial deaths related to COVID 19 by Nosocomial Death Review Panel (I) Access to new COVID regional dashboard (E) under review at present by PHA Trust IPC Covid-19 Contact tracing database (I) Internal audit report of infection control reporting and assurance to Trust Board - Satisfactory assurance level (Sept 2022) (I)	1. Delays in patient pathways due to need for COVID-19 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. Sustained demand for hospital and care home access results in Trust facilities operating at >100% Occupancy alongside reduced patient flow and there are significant challenges for managing IPC considerations and potential for nosocomial infection. 3. 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. 4. Post infection reviews have shown that C-Diff cases are related to high antibiotic usage in the community. Additionally there is an observed increased incidence of gram negative bacteraemias. 5. Second stage Post Infection Reviews paused due to clinical pressures. First stage reviews ongoing. 6. 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. 7. 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. 7 day service on Antrim Hospital site stood down end March 2023. On call 24/7 continues. 8. There is no coded field on NIECR to record test results. Results are recorded as free text in the COVID Specialty area of the Progress Notes. 9. There is currently no Corporate oversight of incidents relating to LFD testing.	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. This has now been replaced/deferred with a modular build of 48 beds including 8 additional side rooms with expected completion by June 2023. 2. Additional training for locum and agency medical and nursing staff 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. Antimicrobial Resource Kit (Ark) Project commenced November 2018. Medical Director and Lead Doctor for IPC to engage with Respiratory Medicine for some focused work to deal with antimicrobial stewardship. SAMHRHAI action plan now awaited Feb 2023 to set direction for region on Antimicrobial stewardship. 5. 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 was planned for 2022 however creating capacity to undertake work is now planned when decanting into new 48 beds modular wards. 6. An audit to review infection control reporting and assurance to Trust Board commenced in June 2022 and has now been completed; assurance level satisfactory with some recommendations regarding timeliness of Annual IPC report and inclusion of Covid 19 activity and impact to be addressed. Ongoing and annual report underway; draft report due to present to Strategic IPC in coming week 7. Process to be established for divisional review of training compliance and onward reporting to IPECHC. 8. Process to be established for divisional review of incidents relating to LFD testing and onward reporting to IPECHC.	Major (4)	Possible (3)	12	HIGH	04/08/2023	26/02/2020

Northern Health and Social Care Trust

Return to PRD Summary Report

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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. The NHSCT have been unable to fully implement MCA and as a result the following risks exist. 1a. Failure in the implementation of MCA arrangements would impact adversely on performance and consequently patient safety and care. 1b. There is a further financial risk given the gap between the funding identified for this regionally and the Trust's preliminary cost estimates 1c. Criminal liability offences within section 269 came into force on 31 May 2021. There is therefore a Corporate Risk for the Trust and personal risk to staff as failure to comply with Sections of the Act could result in prosecution of staff or claims for damages against the Trust for illegally depriving of their liberty. 1d. There is a reputational risk to the Trust due to the possible breach of Article 6 (Human Rights) legislation.	Major (4)	Likely (4)	16	HIGH	1, 2, 3, 4 & 5	1a.MCA Programme Board established, chaired by the Director of Mental Health, Learning Disability and Corporate Wellbeing (MHLDCW) with representatives from all relevant Divisions to support the effective implementation of the MCA and to promote and inform best practice. Trust engaged with regional arrangements to share practice and develop agreed solutions to the implementation of the MCA in both the short and medium term. Initial scoping exercise 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 developed to inform decisions and recording processes. Action plans developed for all relevant Divisions. 1b.Financial Oversight of MCA spend, both recurrent and additional spend. Monitoring by Internal Audit Ongoing recruitment of retired medical and non medical staff to carry out the tasks including assessments, extensions and Panel work Staff training made available. 1c.The Trust has established structures and arrangements to ensure compliance with the MCA. B7 DLS solicitor provides assurance re meeting legal thresholds for Review Tribunal cases. QA process of all information prior to being shared within and outside of Trust Emergency Provisions Process within MCA legislation. 1d.MCA Programme Board established and governance arrangements and structures developed to ensure compliance with the MCA. Monitoring of All risks associated with MCA under the Trust Risk Management process	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.	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. Extension authorisations will be prioritised over the coming months, monitored on a monthly basis And therefore there will be a delay in completion of medical reports for new applications. There may not be a sufficient Medical resource to complete the required extension authorisations. 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. There are currently approximately 35-40 cases listed for hearing by the Review Tribunal in a monthly period requiring a Statement under Rule 6. This new activity has been considered within the IPT. Bank staff who were previously completing these statements are now required to complete extension authorisations and therefore these are currently being completed by the services Work is underway to develop a training plan / guidance document for acute wards within the Holywell site. This is in the initial stages, however engagement with all staff groups represented at MDT level is underway. Addition of MCA training at relevant levels remains outstanding on mandatory training matrix – this is a regional issue Update July 2023 - Policy has been signed off regionally, now waiting to be approved through NHSCT policy group. A spot check of financial management, DoLs and monitoring / review arrangements is being taken forward by the Trust Care Management Group. A cycle of audits is currently being reviewed by the Trust Care Management Steering Group. Training materials are now available to all staff via Pagetiger which can be accessed either via Staffnet or QR code scan. This has been circulated widely and feedback has been positive Trust training is now being recorded on HRPTS. There is no update on a system to collate DoH training on the HRPTS system, and this training log is maintained locally within teams. Scoping is completed on a monthly basis to capture e-learning activity within teams, and is added to HRPTS.	Major (4)	Possible (3)	12	HIGH	27/07/2023	03/12/2019

Northern Health and Social Care Trust

Return to PRD Summary Report

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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. 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 • Investment in photography and videography has been undertaken to support recruitment activities. • 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 processes to recruit students have been streamlined and further improved. AD Workforce, Learning & Regulation , NHSCT is the regional Chair • 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 ongoing service 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 and co-ordinated by PEF team • Preceptorship model continued for new registrants in their first 6 months. New regional preceptorship model has been launched with the implementation progressing in Trust. Focused awareness sessions and information being shared across the Trust July/August 2023. • 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 2023 finalised with named nurses committed to modules, short courses and specialist practice qualifications shared with the universities. **Nurse Bank / Agency Staff** • Risk assessment of all areas to ascertain when non-contract agency usage can cease. Weekly oversight through NCA core group continues. • Ward Sister's toolkit developed to guide access agency. • New framework has been approved and implemented on 15 May 23 is being managed by Trust oversight group and regional groups. A phased introduction over three months has been agreed	**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 of unfilled nursing shifts and levels of bank/agency fill escalated within divisions • 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 NMTG Theme Two **Nurse Bank / Agency Staff** • Monitoring of block booking deployments within Nursing Governance (I). • Daily Monitoring of bank/agency fill rates (I) • Weekly and monthly review of agency usage	**Recruitment** • There is a national shortage of nurses. leading to vacancies both temporary and permanent • There is a 13.4% (June 23) vacancy rate in Band 5 nurses and midwives • 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. • Limited resource to focus on retention on staff **Nurse Bank / Agency Staff** • The continued number of Nurse vacancies will result in the use nursing agency workers from new contract framework • Introduction of new framework is being managed by Trust oversight group and regional groups. A phased introduction over three months has been agreed • 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 Nurse bank not available Sat & Sun	**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. Regional group established to initiate recruits into mental health areas and to complete MH OSCE, first arrivals could be by Nov 23. • 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 • Review of Delivering Care under review by CNO – phases paused. Group established to lead on the refresh of delivering care model. Group chaired by eDON from Northern Trust. • 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. Monitoring for completion of PPE to continue and be progressed by safe staffing lead • 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 complete and Framework launched – currently being implemented in the Trust • 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** • New Regional Framework for Contract Agency has been approved and plan to implement with Trust planning to comply to the new framework over a phased approach. • Work has commenced to review Non-Contract Agency spend and support a reduction to stabilise and strengthen nursing teams • Leadership Centre review of Nurse Bank is now complete. Report is with EDoN for consideration.	Major (4)	Possible (3)	12	HIGH	27/07/2023	27/02/2020

Northern Health and Social Care Trust

PRD Summary Report'!A1

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	Date current rating changed
905	26/06/2017	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. 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. Focused medical model with emphasis on senior decision making. Winter and Easter resilience planning processes in place now ceased, focused on reset of processes. 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 revisited, changes to swabbing as per IPC guidelines. Update of Major incident plan to incorporate full capacity protocol. Update sessions have taken place with a desktop exercise carried out with Senior Team	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 whilst Covid19 swabbing requests have reduced still require swabbing availability. 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 at times of increased incidence . 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. 48 beds additionality now in place A6 and A7. Re-modelling of Acute wards to improve flow carried out . 2- Over dependence on locums and agency staff. 3 - Reduction in the allocation of F1s and F2s to NHSCT. Ongoing recruitment for junior medical staff continue however this is an ongoing situation with recruitment issues. 4 - Reduction in the attainment of the 48 hour discharge target; impacted by the availability of community placement which is dependent on patient need. Overall Trust wide pathways group chaired by Director of ops. 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- 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 - Inability to sufficiently expand Domiciliary Care. This is a community workstream under renewing our vision. 8 - Non availability of HALO over 7 day period to provide site link with NIAS service improvement plan in place with NIAS to improve handover and flow although reduced during periods of leave. 9 - NIAS demand not based on sites capacity. 11 - patient delays increasing with patients requiring inpatient MH beds, both at ward level and ED. A prioritisation tool has been implemented by Mental Health team and acute link via MHLS 12 - ongoing liaison with BHSCT re: fracture delays, both at ward level and ED. This was identified as part of learning from a major incident	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 still more complex as respiratory candidates still need ruled out as Covid 19. This still requires additional isolation space for patients. ED minors remains displaced to ambulatory corridor on Bfloor but RESET to ED being planned . Ambulatory area Direct Assessment Unit/ PTU frequently being used at times of pressure to house inpatients. 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. Increase in High cost placements Site coordination model continues with extreme focus on discharge pathways. 48 bed capacity project has delivered A6 and A7. 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. 48 bed capacity still leaves a bed capacity gap. Review of ambulatory pathways ongoing and links with primary care Working group established to look at reattenders to ED improvement plan developed with NIAS Implementation of Trusted assessor role (temporary) now ceased Relocation of discharge lounge to allow management of 6 patients in current discharge lounge from Jan to April now stood down. Commencement of safer patient flow project to focus on MDT assessment, ward round decision making and Home for 1pm. Ongoing work with SPPG in relation to NMS pathways key 1-5 Urgent Care pathways funded for both ED and Ambulatory Service Causeway 2- Over dependence on locums and agency staff. Additional ED consultants recruited. Risk continues as over dependency at junior grades due to NIMDTA gaps and limitations of recruiting to permanent posts. (please refer to principle risk 2 regarding nursing workforce) 3- 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 4- 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 5 - Inability to sufficiently expand Domiciliary Care. This is a community workstream. 6 - Non availability of HALO over 7 day period. 7- Impact of Mater hospital change in profile. BT36 now belfast catchment. NIAS however continue to send increased numbers to Antrim. 8 - patient delays increasing with patients requiring inpatient MH beds, both at ward level and ED. - establishment of interface group with MH team and a prioritisation tool to manage clinical risk by Mental Health Team. 9 - ongoing liaison with BHSCT re: fracture delays, both at ward level and ED. Regional work commenced on whiteboard visibility for fracture delays however no recent update. This pathway was point of major incident learning Nov 22.	Major (4)	Unlikely (2)	8	HIGH	07/09/2023	21/02/2020

Northern Health and Social Care Trust

Return to PRD Summary Report

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67	31/05/2008	Strategic Planning, Performance and ICT	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 2022/23(E). 4. Internal Audit carried out a recent IG audit in June 2021. The 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 June 2023, was 83% for IG Awareness and 82% for POPI. Cyber Security was 75%. A Senior Executive Team target of 85% remains in place. 2. The number of IG incidents reported during the quarter ended June 2023 was 57. There were no incidents notified to the ICO during this quarter nor any awaiting assessment with the ICO. 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 was 1 IG related complaint received during the quarter ended 30th June 2023. All existing assets in the (621) Information Asset Register have had risk assessments completed and new assets are subject to the DPIA process. 4. There was 1 IG related complaint received during the quarter ended 30th June 2023. All existing assets in the (621) Information Asset Register have had risk assessments completed and new assets are subject to the DPIA process. 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 . 7. Current compliance with requests for information under DPA and FOI legisation are 53% (for standard 30 day requests) and 74% respectively as at quarter end June 2023(previously 52% and 74% at quarter end Dec 22). Complex DPA requests compliance as at end of June 2023 increased to 61% (increase of 38%).	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 existing information assets on the IAR have had a risk assessment completed. New information assets are subject to a DPIA. 3. Progress in respect of the Trust's IG Improvement Plan is monitored and reviewed by IG Forum. The priorities 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 is now 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) was concluded by 31st March 2023. A longer term RM Strategy and Action Plan is in development for April 2023/March 2024. 5. Compliance with information requests remain challenging. Legislative compliance is 100% with the relevant timescales. Trust overall compliance as at 30th June 2023 is 53% for DPA and FOI 74%. Complex DPA requests compliance as at end of June 2023 has increased to 61% (an increase of 38%). Services are under pressure to respond to requests for personal information due to competing priorities of service delivery and limited capacity to undertake the tasks required to process SARs. Main areas of challenge are Antrim Medical Records Dept and CYP Division. Antrim Medical Records have recruited additional resources and have streamlined processes to deal with their absence related backlog. CYP have also identified some additional resource to undertake SAR related tasks as overtime where possible. Information Governance Department are recruiting temporary additional resources to further enhance capacity for requests related activity. A proposal which was taken to Trust Clinical Council to remove the need for Consultant sign off for the majority of acute related Subject Access Requests was approved (subject to additional checks put in place). The revised process once implemented will 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 implemented a new Requests Case Management solution for SAR requests (previously implemented for FOI requests) that will automate and further improve the processing of information requests. 6. The Trust continues to work with DLS and regional colleagues to progress appropriate contractual clauses in procurement exercises. The IG Department is supporting Divisions participating in tendering processes with data flow mapping exercises and completion of DPIAs to inform tender specifications and reflect these in contracts. Work is ongoing with Divisions to identify information sharing with external organisations and a review of the arrangements in place to underpin the sharing, these are being recorded in a Trust's Information Sharing Register. This is an ongoing BAU review to ensure that the sharing is appropriate and compliant with GDPR requirements. DLS have been consulted on the Trust's approach and the proposed risk based approach to progressing the above. 7. All information governance policies have now been updated and approved in line with the Policy Framework process.	Moderate (3)	Possible (3)	9	MEDIUM	28/07/2023	17/05/2019

Northern Health and Social Care Trust

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											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 was identified as a P2 recommendation by Internal Audit and the action in respect of this has now been completed. Any new service procurement or system implementation that includes the processing of personal information is subject to the DPIA process and ICT Security review to prior to commencement to ensure all risks have been identified, controls implemented to mitigate/minimise including the appropriate underpinning GDPR compliant documentation (e.g. contract/DSA/MoUs etc.) 9. Progress against the Trust's IG Action Plan is monitored and reviewed by Information Governance Forum on a quarterly basis. 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. DACs are in place to govern BAU storage until removal occurs.	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. 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. 10. Recent cyber incidents in HSC partner organisations, have further 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. A Priority 2 recommendation from an Internal Audit regarding GDPR compliant contracts is considered complete as at 30th June 2023. 12. Divisions have been encouraged to continue their focus on increasing mandatory training compliance. 13. The Trust has approved a decision (Senior Exec Team 15/6/23) to continue with the storage of existing records in Iron Mountain and not proceed with an exit at this time. This position will be reviewed in July 2025. A DAC is in place to govern ongoing storage and BAU service during this intervening period.						

Northern Health and Social Care Trust

Return to PRD Summary Report

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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. Longest waits are slowly reducing. A regional dysphagia waiting times dashboard is now available. **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).	• 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).	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 are reducing but continue to exceed 600 days. Clients may experience harm (malnutrition, chest infection, aspiration pneumonia, choking) while waiting for assessment.	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** 2. 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, will enable the use of alternative, updated, tablets which will improve functionality and ensure mandatory recording of patient details.	Catastrophic (5)	Unlikely (2)	10	HIGH	02/08/2023	14/11/2018
									• 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 • The regional Mealtimes Matter audit tool was implemented across all settings apart from Homecare and Supported Living, who have access to bespoke dysphagia audit tools. • 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.	• 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. • The Trust Dysphagia Group considers Trust compliance with recommendations set out in the NCEPOD report: 'Hard to Swallow?' for patients diagnosed with Parkinson's.	**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. The original proposal was a DST of 5.0WTE. However, NHSCT was originally only funded for 3.0WTE. This funding allocation was further reduced to 2.0WTE in 2022. This is a 33% reduction in staffing allocation which has reduced the capacity of this team in their work to address dysphagia risks. Trust has written to PHA. 3. The SLT Regional EDS (REDS) recommendations document is now available on NIECR since May 2023. However we	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) and is reflected in the adult and paediatric NHSCT Dysphagia Management Policies. Safe storage of food/fluid thickener is audited regularly within acute settings by the Pharmacy Service. The regionally agreed Mealtimes Matter audit tool was implemented in NHSCT in March 2023 in all areas, except for Homecare and Supported Living. These services have bespoke dysphagia audit tools in place. Results in relation to secure storage of thickening powder need to be reviewed c. NHSCT Trigger list developed to support incident reporting (now adopted regionally). Regional work is ongoing to standardise the reporting of incidents. A task and finish group is addressing how the DatixWeb system can be improved to support more accurate reporting of nutrition and dysphagia-related incidents. Proposed changes have been agreed by the DatixWeb user group in June 2023, pending implementation.						
									• 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. Uploading of the REDS documents to a regionally agreed location on NIECR began in May 2023 to assist other staff to identify presence of dysphagia. This is available for staff with NIECR access to view and print, if required. **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.		**Staff Training Programme** 1. Dysphagia NI have provided some training guidance but currently there is no mandated training for staff recruited through agencies. 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. Recently Dysphagia NI has agreed to incorporate some paediatric strands within its work stream. A regional approach is required to standardise the training offered and resources developed for HSC staff working with children with/at risk of dysphagia.	**Staff Training Programme** 3. 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. 4. 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. PHA have recently agreed to lead some regional work for paediatrics which includes development of a paediatric REDS document and a regional Paediatric dysphagia training programme for HSC staff. This training will be included in a dysphagia training matrix which is being developed for paediatrics in NHSCT.						
									• 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 from the Trust Dysphagia Group shared folder. • 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. 3465 NHSCT staff have completed the dysphagia e-learning programme between October 2020 and March 2023. • 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 March 2023 the Dysphagia Support team has provided dysphagia awareness training to a further 914Trust 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, commenced in October 22. To date 430 staff have been trained. This programme continues throughout 2023. • The Trust Dysphagia Support Team continue to provide additional training capacity and respond to bespoke requests for training. • A Dashboard had been developed to assist in monitoring compliance with Dysphagia Training. Quarterly compliance reports now available and saved on the Trust Dysphagia Group shared drive								

Northern Health and Social Care Trust

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	Date current rating changed
28	20/02/2008	Finance	Failure to achieve statutory break even position.	Catastrophic (5)	Likely (4)	20	EXTREME	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). 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 established a Delivering Value Programme board with the aim of overseeing progress on various Trust efficiency programmes with under the headings of Productivity, Cost Containment and Sustainability. The Trust Performance and Finance Committee will receive regular updates on the work of the Delivering Value Programmes, with an initial focus Agency Reduction (Nursing and Medical) and on Enhanced Care. Discussions continue with HSCB and DoH representatives.	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 2022/23 due to a combination of Non-Recurrent Savings measures within the Trust and non-recurrent funding from DoH/SPPG. In addition DoH/SPPG 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 2023/24 Financial Planning the Trust , in conjunction, with DOH and SPPG colleagues had projected a significant deficit on Core services, with further commitments arising in 2023/24 due to demand pressures and a range od unavaidable costs, In addition, SPPG have sought savings measures to the value of £29m to contribute to the overll HSC financial plan. The overall financial position remains subject to detailed and regular review and the Trust is taking steps to achieve savings (of which measures to the value if £23m have been identified, although these will be challenging to deliver. The Trust is awaiting formal allocations for 2023/24 and it is anticipated that a financial plan will be required by SPPG by the end of June. The Trust, therefore, faces the the joint challenges of (1), achieving financial savings to the value of £29m; (2) reducing and containing spend on COVID related costs to a signifcnatly reduced funding envelope; and (3) containing spend on new 2023/24 pressures within the contrained resource environment.	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. The main areas on ongoing engagement relate to: (1) Savings Gap (currrently estimated at £6m); (2) COVID spend (currently estimated at £4m); (3) Service Pressures (@ £11m). Significant other cost pressures may continue to arise during the course of the year, most notably with regard to Unscheduled Care, Community Placements and High Cost Packages in Community, Mental Health and Learning Disability The Trust continues to engage with SPPG with a view to arriving at an agreed funding or cost containment strategy in line with the development of the overall HSC Delivering Value initiative .	Catastrophic (5)	Unlikely (2)	10	HIGH	04/09/2023	04/09/2023

Northern Health and Social Care Trust

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)	Risk level (Target)	Rating (Target)	Date of Last Review	Date current rating changed
909	11/07/2017	Strategic Planning, Performance and ICT	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)	9	MEDIUM	27/07/2023	11/07/2017