Northern Health and Social Care Trust

ASSURANCE FRAMEWORK
Principal Risks and Controls Document 2025/26

November 2025

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 2025	
		Changes to Risk Rating	
		Previous Risk Rating	New Risk Rating
851	There is a risk of choking on food by service users with Eating, Drinking and Swallowing difficulties (Dysphagia) or with suspected difficulties. There are also risks re deteriorating health eg due to aspiration pneumonia / malnutrition or dehydration.	16 (High)	15 (Extreme)

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Principal Risk Document - Summary Report

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

ID	Lead Division	Risk Title	Untreated Risk Rating	Current Risk Rating	Target Risk Rating	Movement in grading of Current Risk Rating	Months Since Rating Changed	Opened	Date of Last Review
1327	Medicine & Emergency Medicine	IF the neurology service remains unable to recruit consultant staff to existing vacancies THEN as such there is a risk to neurology service patients' RESULTING that conditions will deteriorate whilst waiting for an outpatient appointment, diagnostic procedure.	25 Extreme (Almost certain 5 x Catastrophic 5)	25 Extreme (Almost certain 5 x Catastrophic 5)	12 High (Possible 3 x Major impact 4)	↔ Unchanged	14	05/09/2024	29/10/2025
952	Surgery & Clinical Services	IF demand for inpatient, day case, outpatient and diagnostic services in a number of specialties outstrips our capacity to provide these services THEN service users will have to wait longer for treatment RESULTING in poorer outcomes for our service users.	25 Extreme (Almost certain 5 x Catastrophic 5)	20 Extreme (Almost certain 5 x Major impact 4)	16 High (Likely 4 x Major impact 4)	↔ Unchanged	2	21/11/2017	31/10/2025
28	Finance	There is a risk that the Trust will be unable to meet its statutory duty to break-even. This is driven by rising demand, workforce shortage and reliance on Agency Staffing, increase acuity and unfunded demographic growth. This could lead to formal escalation by DoH, damage the Trust's reputation, constrain operational flexibility and reduce the Trust's capacity to deliver safe, high-quality services and lead to unplanned service change.	25 Extreme (Almost certain 5 x Catastrophic 5)	20 Extreme (Likely 4 x Catastrophic 5)	10 High (Unlikely 2 x Catastrophic impact 5)	↔ Unchanged	9	20/02/2008	03/12/2025
851	Paediatrics, Women's Services & Corporate Support	There is a risk of choking on food by service users with Eating, Drinking and Swallowing difficulties (Dysphagia) or with suspected difficulties. There are also risks re deteriorating health eg due to aspiration pneumonia / malnutrition or dehydration.	20 Extreme (Likely 4 x Catastrophic 5)	15 Extreme (Possible 3 x Catastrophic 5)	8 High (Unlikely 2 x Major impact 5)	↑ Increased	2	19/05/2016	28/10/2025
780	Executive Director of Nursing, Midwifery & AHPs	There is a risk that the continued reliance on agency workers to fill nursing shift gaps across acute and community teams will impact negatively on safe and effective care delivery and financial resource for the Trust.	25 Extreme (Almost certain 5 x Catastrophic 5)	16 High (Likely 4 x Major impact 4)	12 High (Possible 3 x Major impact 4)	↔ Unchanged	69	16/01/2015	27/10/2025
1281	Strategic Planning, Performance & ICT	IF encompass is not fully stabilised & optimised across the Trust THEN the benefits such as increased patient & service user safety & satisfaction by improved information sharing & connectivity are at risk.	20 Extreme (Almost certain 5 x Major 4)	16 High (Likely 4 x Major impact 4)	12 High (Possible 3 x Major impact 4)	↔ Unchanged	24	30/10/2023	27/10/2025
905	Medicine & Emergency Medicine	AS unscheduled care is facing significant pressures with demand on ED care, patient acuity and significant systemic limitations in hospital flow there is a THEN there is a risk to patient safety RESULTING in and including treatment delays, decline in the quality of care, and increased patient morbidity and mortality.	25 Extreme (Almost certain 5 x Catastrophic 5)	16 High (Likely 4 x Major impact 4)	8 High (Unlikely 2 x Major impact 4)	↔ Unchanged	70	26/06/2017	04/12/2025
324	Paediatrics, Women's Services & Corporate Support	Patients, staff and visitors are at risk from the spread of healthcare-associated infections despite IPC practices, testing procedures and high standards of environmental cleanliness. Preparedness for future pandemics remains a risk for the Trust.	25 Extreme (Almost certain 5 x Catastrophic 5)	16 High (Likely 4 x Major impact 4)	9 Medium (Possible 3 x Moderate impact 3)	↔ Unchanged	17	15/03/2011	29/10/2025
909	Strategic Planning, Performance & ICT	Information security is vital to NHSCT care delivery and asset protection. If a cyber incident should occur without the proper security controls this could significantly compromise and disrupt systems, data, and services.	20 Extreme (Likely 4 x Catastrophic 5)	16 High (Likely 4 x Major impact 4)	9 Medium (Possible 3 x Moderate impact 3)	↔ Unchanged	101	11/07/2017	28/10/2025
67	Strategic Planning, Performance & ICT	IF the Trust is unable to comply fully with Information Governance legislation (FOI, DPA, RM) THEN there is a risk to the security and lawful use of personal information and Trust corporate (business sensitive) information RESULTING in harm/detriment to service users, Trust reputational risk, legal action by individuals and regulatory action by the Information Commissioner's Office.	20 Extreme (Almost certain 5 x Major 4)	16 High (Likely 4 x Major impact 4)	9 Medium (Possible 3 x Moderate impact 3)	↔ Unchanged	79	31/05/2008	28/10/2025
902	Children & Young People's Division	IF there are no care placements for children needing admission to care THEN they will be placed in temporary unregulated arrangements RESULTING in ongoing RQIA formal action, complaints, & legal challenge	20 Extreme (Likely 4 x Catastrophic 5)	12 Medium (Likely 4 x Moderate impact 3)	6 Low (Possible 3 x Minor impact 2)	↔ Unchanged	12	01/06/2017	30/10/2025

11 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	Date current rating changed
1327	05/09/2024	Medicine & Emergency Medicine	IF the neurology service remains unable to recruit consultant staff to existing vacancies THEN as such there is a risk to neurology service patients' RESULTING that conditions will deteriorate whilst waiting for an outpatient appointment, diagnostic procedure.	Catastrophic (5)	Almost Certain (5)	25	EXTREME	1, 2, 3, 4 & 5	Waiting list validation exercises complete. Introduction and roll out of revised clinical triage. Agreement with BHSCT to accommodate previous locum doctor's patients with MRIs results and pending results needing actioned - This does not include waiting list patients Trust actions to date as of 29.10.25 • Continued attempts to secure Locum Consultant Neurologists via agency. • Triage process in place to ensure new referrals are categorised by presenting complaint. • Care of 100 active review patients taken over by BHSCT in June 2025. Discussion with BHSCT regarding opportunities for further support, however, Trust not able to offer further help at this time. • Agreed with SPPG and at February 2025 and July 2025 regional meetings that readvertising substantive Consultant posts would not have any likelihood of success in view of regional workforce position. • Approximately 100 patients currently being reviewed by SEHSCT in relation to their diagnostic results and patients requiring valproate review are being seen in conjunction with SEHSCT. • Further discussions are taking place in relation to some support for headache referrals via a GP with Special Interest who has conducted similar work whilst in SEHSCT. Provisional start date September 2025. • Further discussions are taking place with SEHSCT regarding the feasibility of support for first seizure referrals as currently NHSCT have no first seizure clinic. Best practice is that these patients should be seen within 14 days of first seizure; NHSCT patients are waiting up to four years. • NHSCT action plan shared with SPPG in July 2025. Concerns raised regarding lack of specialist nursing support which could offer a nurse led alternative pathway for some cohorts of patients. • Trust Board updated regarding the risks June 2025. SPPG actions to date • December 2023 - Meeting with NHSCT to discuss concerns • March 2024 - Neurology Regional Meeting in regards regional pressures • August 2024 - Meeting SPPG Director and NHSCT Acute Director re deteriorating position. Agreed to progress a further regional meeting to seek collaborative solutions • August 2024 - NHSCT submits Early Alert • November 2024 – Further meeting with NHSCT due to concerns. Agreed to escalate regional alliance to seek support and escalated to Chief Operating Officer, SPPG • February 2025 - Regional meeting and discussion re alliance • April 2025 – SPPG attended meeting with NHSCT and BHSCT to explore support available. Support identified as noted earlier. • April 2025 - Alliance Meeting did not go ahead due to professional concerns raised. • July 2025 – SPPG site visit; actions taken by NHSCT discussed • August 2025 – Neurology Regional Governance Meeting • August 2025 – correspondence to Trusts requesting nomination of a Neurology Alliance co-chair • 01 Oct 2025 – First meeting of Regional Neurology Alliance. Actions for short / medium / longer term stabilisation discussed. An action plan has been agreed for short and medium term stabilisation and a series of sub groups established to take forward. Throughout this time, there has been ongoing dialogue with SPPG and progress with regards the establishment of a regional alliance.	Monthly divisional performance review meetings and bi-monthly accountability reviews with Director of Operations and Director of Finance (I) Clinical risk at each of the SPPG/Trust service issues/Performance Review meetings to press need for investment. Early alerts raised with SPPG (E)	1- Review of job plans to: maximize management of non-chronological management i.e. seeing patients according to risk level rather than length of time waiting, in higher risk specialties & maximize utilization of waiting list funding when it becomes available (I):		Major (4)	Possible (3)	12	HIGH	29/10/2025	05/09/2024

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Return to PRD Summary Report

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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, Diabetes, Cardiology, Gynaecology, Rheumatology, Fracture Liasion, 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 facilty 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. No/ reduced allocation of waiting list initiative funding.	MEDICINE AND EMERGENCY MEDICINE SPECIFIC SERVICE ACTIONS NEUROLOGY - Update 05.06.25 and ongoing - refer to risk 1327 RHEUMATOLOGY - continues with active triage. DERMATOLOGY - Update 29.10.25 no further progress with regionalistion. Team continue to use WLI funding to address redflag waits Update November 2025 - Gynae/hysteroscopy - Alternative ways of assessment – GAU continues to provide direct assessment and treatment of urgent gynae care or deteriorating conditions; but is somewhat restricted due to the increased capacity at ward level and at times unable to provide daily ambulatory care via GAU, this is subject to change and reviewed daily. Gynae & Hysteroscopy – Efforts to reduce waiting lists, validation both admin and clinical in general gynae and hysteroscopy using WLI initiative has been utilised. Hysteroscopy and NL hysteroscopy/colposcopy had been impacted greatly by encompass and long term absence of Nurse specialist. Both matters now been reconciled and ongoing work to reduce RF and routine hysteroscopy evident in waiting times. SPPG have funded a Nurse Hysteroscopist/ Colposcopist, however support staff not fully funded creating a gap in services. There are plans to develop a duplicate role and funding approved Nov 2025, this too has a 10hr deficit per week for support staff in band 5 and band 2/3. In planning – implementation of OP cystoscopy and botox bladder clinics in Eden suite to be developed – only 1 clinic currently moved, as funding source required. An agreed number of patients have now been sent to the Independent Sector for IP and OP long waiters. Two newly appointed gynae/obstetric Consultants in post but not all procedural clinics operational due to lack of support staff – this has been raised with Provider Collaborative (PC) and a bid submitted to support this. PC have plans for 3 PAs to support enhanced clinical triage. Menopause PIFU starting Nov 2026 with plans to introduce PIFU skins and Post-op in place of reviews. Eden Suite and The Meadows outpatient, these clinics remain underfunded for support staff both clinical and clerical this is an area of concern with potential burnout of support staff, a bid has been submitted to PC for staffing. REG25 nurses x 2 appointed to Gyn ward AAH as part of a Trust initiative to reduce the amount of agency, this will provide nurses with core gynae skills that will be transferable between IP and OP setting depending on demand once preceptor phase is over. SCS Update October 2025 - Risk reviewed. IPTs currently being drafted for elective care framework monies. SCS specialties: Histopathology - Situation not improved, Clinical capacity remains a core challenge. Regional reporting if approved may mitigate the risk however await decision by year end. Dental - Patients will not get Oral Health Screenings of Residential Homes, Special Schools, LD facilities etc in a timely way. This had been significantly impacted by Covid and has been compounded by the introduction of Encompass and the lack of software / hardware available. The Haiku software developed for Adult screening is slowly being trialled with regards which device it is best used on. No pathway has yet been organised for the equivalent Children's Screening. This has led to and will continue to lead to significant delays in this being undertaken by the service. Refer to risk 1425 with regard staff shortages. General Surgery/Breast Surgery - Breast waiting lists continues to increase, however the Regional Red Flag breast waiting list initiative commenced 8/5/25. This will see SET centrally manage the RF breast waiting list which will allow a patient to be offered a vacant slot throughout the region in order to address. We have no control over this aspect and this is centrally managed by SET. This has lead to a drift from 4 weeks RF waiting for an OP appointment to 8.5 weeks. Also additional WLI sessions have been offered by SPPG to reduce RF waiting lists before the launch of the regional list, this activity has been taken up by all breast consultants. Overall GS colorectal waiting times are affected due to a reduction in the number of colorectal surgeons in Antrim, the increase in referrals, the challenges of theatre availability due to staffing issues. The theatre utilisation group has been established to address under-utilisation of theatres. Work has been ongoing to actively remove patients from colorectal surgeons who are non-colorectal patients in order to have these patients treated by non colorectal surgeons. Action to fully utilise peripheral sites lists, by pooling and allocating these patients to any operators using these sites who may struggle to fill these lists from their own waiting lists. The outcome of this ongoing exploit will assist in reducing waiting times and lists. Significant validation has been undertaken removing a number of the longest waiters from the waiting lists, this ongoing. Full use of WLI initiatives both internally and via the Independent Sector continue to be used as funding permits. Pain - Pain position remains much the same. Capacity for day case lists is 20 per week based on 42weeks. Demand outstrips capacity. ENT: Waiting times continue to increase, with particular pressure on tonsillectomy pathways. Work is underway to progress plans for targeted intervention in this area, including exploring elective recovery initiatives. Gastroenterology: Performance remains on trajectory to meet quarterly targets. This demonstrates consistent throughput despite high referral volumes. Endoscopy (Diagnostics): Endoscopy services continue to address the demand through In-House Waiting List Initiative (WLI) sessions. Radiology: • Q1/2 WLI now almost completed. Q3 WLI ongoing and will be completed. Although CT waiting times have significantly reduced, this has had minimal impact in reduction of waiting times in ultrasound and MRI. • Significant concern remains regarding ongoing deterioration of waiting times. Focus will be on: 4. MRI longest waits. 5. Maintaining CT longest waits. 6. Ultrasound longest waits. RBCs for CT and MRI complete and to be allocated in March 2026 on a 3 year phased basis. This will have moderate impact on MRI, however, there will be no impact on elective CT waiting lists due to ongoing acute pressures. Physio & OAS - Pelvic Health Physiotherapy. Waiting times now sit at 1 year 1 month. The demand capacity gap has stabilised but is vulnerable to staffing changes within a small team and any small changes/ temp gaps impact waiting times. MSK is the same The OAS waiting time has increased to 35 weeks for routine appointments. There is no wait for urgent appointments. Capacity was affected over the summer by staff sickness. Staffing sits at 94.8%. Review appointments waiting times are affected by radiology diagnostic waiting times. OAS is going through a service review which will involve looking at staffing. Clinical Physiology - There is no change for ECHO - WLI is still ongoing.	Major (4)	Likely (4)	16	HIGH	31/10/2025	05/09/2025

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28	20/02/2008	Finance	If current pressures (demand, acuity, workforce) continue without sufficient funding or adequate savings plans, then the organisation will fail its statutory duty to break-even. This will result potentially in formal DoH escalation, reputational damage, the need for savings to reduce the level of services delivered and an inability to deliver safe, high quality and reliable services to the population.	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. Financial planning and slippage review The Trust has maintained financial control internally through ongoing budget management processes, along with Delivering Value 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 SPPG and DoH representatives. From 2024/25 the Trust is introducing Finance Focus meetings which will further oversight on financial performance through the establishment of Finance Focus meetings with Divisions to provide to provide to the Executive Team and Trust Board assurance and accountability for each Division in the Trust on the management and stewardship of their finances as set out in the Trusts Standing Financial Instructions and other policies set out within them. This will be a collaborative approach between the Divisions, HR and Finance to find solutions to the financial challenges within the context of accountability and budgetary control and set against the backdrop of service and workforce challenges.	The Trust has maintained financial control internally through ongoing budget management processes, along 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. 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 Resources Committee are regularly updated on the Financial Position of the Trust and will receive regular updates from the Delivering Value Programme Board and The Finance Focus meetings.	The Trust has delivered a Breakeven Position for 2024/25 financial year. The 2025/26 financial planning process with SPPG commenced in late 2025 with indicative allocations. The Trust submitted an officer draft Financial Plan in February, based on Indicative allocations provided by SPPG & PHA, which shows a projected deficit of £41m for the year to 31 March 2026. The movement from the 24/25 Breakeven projection to this opening gap in 25/26 is due to a number of factors, most notably: • Removal of Deficit Funding (£31m); • Additional Unfunded Growth Pressures of £16m; • Partially offset by further Recovery Plan Savings in 24/25 of £6m. Following further engagement with SPPG, this gap was reduced to £35m, to take account of further funding of specific pressures and the ongoing joint monitoring of cost trajectories during the financial year. Following further savings, engagements with SPPG and deficit funding of £12.9m this reduced the Gap to a deficit of £18.1m. This is part of a Region wide gap and the DoH have asked all Trusts to develop a break-even plan by mid-September setting out how this can be delivered for 2025/26 and also for 2026/27. The Trust identified a further £10.7m of Savings and Cost Avoidance schemes that could be introduced with low or moderate service impact which reduced the deficit to £7.3m. Further scenarios with High or Catastrophic service impact were also presented to SPPG, DoH and the Minister to cover this remaining £7.3m deficit - these were not approved by Trust Board and they were not approved by the Minister. The Executive approved a 2025/26 Pay Award for all HSC staff, there is not sufficient funding to cover this cost and therefore this will increase the deficit in Trusts.	The Trust continues engagement with DoH/SPPG with regard to scale of the underlying recurrent financial deficit facing the Trust as it looks toward 2025/26 financial year. The Trust has presented a draft Recovery and Contingency Plan to SPPG, setting out the range of Recovery Measures that are possible to mitigate some of the projected deficit, but also setting out potentially Extreme or Catastrophic measures that may be required to Breakeven within the current indicative funding. This process will be subject to further detailed review with DOH and SPPG over coming weeks. The Trust continues to work with DOH and SPPG, and will fully engage with the Permanent Secretary initiative to establish a System Financial Management Group, and will contribute to the range of workstreams to be taken forward on a regional and collaborative basis It is expected that a Regional Plan will be formulated by mid summer, including a confirmed ask of Trusts of their contribution to the overall plan. A Systems Financial Management Group has been established by the DoH. This group has developed a number of workstream to look at both short-term measures and longer term measures to deliver savings Regionally.	Catastrophic (5)	Unlikely (2)	10	HIGH	03/12/2025	10/03/2025

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851	19/05/2016	Paediatrics, Women's Services & Corporate Support	There is a risk of choking on food by service users with Eating, Drinking and Swallowing difficulties (Dysphagia) or with suspected difficulties. (There are also risks re deteriorating health eg due to aspiration pneumonia / malnutrition or dehydration)	Catastrophic (5)	Possible (3)	15	EXTREME	1& 3	1. Trust Dysphagia Support Team (DST) DST established to driving forward and leading significant service improvement within NHSCT and regionally and to address the recommendations outlined in the following: o SQR/SAI/2021/075 o RQIA May 2022 review o NCEPOD Hard to Swallow? Learning for improvement Changes to local Datixweb reporting categories and subcategories to support more accurate reporting of dysphagia incidents have been implemented. An additional reporting sub category to capture food safety and quality incidents has been added. NHSCT Trigger list developed to support incident reporting (now adopted regionally). Review of dysphagia and choking incidents is a standing agenda item at the Trust Dysphagia Group. Divisional representatives report on related incidents which have occurred across their division. Learning, from across the Trust, is considered and shared in this way. Divisional reps have been given access to a Dysphagia incident dashboard on Datixweb. 2. SLT Assessment of Service Users 3. Meal Times Matter Framework: Multidisciplinary discussion In relation to up-to-date SLT Recommendations for Eating, Drinking and Swallowing (REDS) on case by case basis for high risk service users, including liaison with DLS if necessary. Protection of mealtimes • The Mealtime Coordinator is clearly identifiable to all staff • 'Food and Drink Safety Pause' implemented by all relevant staff before the serving of any meals, drinks or snacks. Discussion includes of all four key elements: REDS Allergens Supervision Nutrition/Hydration Care and catering staff are included • Food / snack / drinks service areas are supervised at all times - level of supervision, as per SLT Recommendations Communication • Swallow 'alert' for services users with a known diagnosis of dysphagia added to NIECR and now available on Epic. • REDS documents uploaded to a regionally agreed location on NIECR and is now available on Epic for patients assessed after Nov 7th 2024. The requirement to review NIECR for patients with potential dysphagia risks is included in the latest version of the dysphagia policy and with the move to Epic the EDS alert signposts staff to review Epic for patients assessed after Nov 2024 and NIECR for those assessed between June 2023 and Nov 2024. • A regional transfer transfer process on Epic is available across the all HSC Trusts • Process in place for sharing individuals' EDS needs with families/carers/visitors • The most recent safety brief/huddle/handover records clearly document the communication of all service users' individual EDS needs. • Individual service users' SLT Recommendations for EDS are clearly displayed at the bedside, or other agreed place appropriate to the setting • Nil by Mouth signs are completed fully and accurately Meal / Snack provision • Meals and snacks are served according to the person's choice Food and drink served matches the recommended *IDDSI level • Functionality of meal ordering tablet has been updated to ensure full traceability of meals ordered and the requirement for staff to confirm dietary requirements have been checked, by selecting a tick-box, prior to proceeding to record a meal order • 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. • Catering teams are piloting in house preparation of dysphagia meals • Snack lists for hospital and community agreed and available on Staffnet at different IDDSI levels.	Trust Dysphagia Support Team (DST) 1.Trust 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 2.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 SLT Assessment of Service Users 1.SPPG completed capacity demand analysis for SLT Band 5 & 6 posts 2.Monitoring of vacancies and active recruitment of professional staff in SLT to minimise gaps in the availability of SLT in adult teams 3.Monitoring of Waiting list times for SLT assessment / review 4.Regional live dashboard managed by PHA available to Trust AHP Leads, Dysphagia Support Team Leads and SLT Managers to access performance Meal Times Matter Framework: 1.All elements included in Meal Time Matters (MTM) Audit – completed across all areas (excluding Homecare and Supported living – both services have access to bespoke dysphagia audit tools) 2.Review of Incidents and Complaints 3.Internal Audit Completed on Management of Dysphagia – Acute Hospital Setting – Limited Assurance Provided. Staff training / resources 1.Compliance with policies covered by Meal Time Matters (MTM) Audit – completed across all areas (excluding Homecare and Supported living – both services have access to bespoke dysphagia audit tools) 2.Review of Incidents and Complaints 3.Monitoring of training data by Lead Nurses / Team Leads / Divisions via Dashboard developed to assist in monitoring compliance with Dysphagia Training. Quarterly training completion reports. (completion reports are available from the Trust Dysphagia Group shared folder) 4.Training of Homecare workers kept under review by relevant managers 5.Internal Audit Completed on Management of Dysphagia – Acute Hospital Setting – Limited Assurance Provided.	SLT Assessment of Service Users • Additional SLT Posts will sustain ongoing demand for assessment however will not address the current backlog. Waiting times for SLT assessment are reducing but continue to exceed 600 days (Ministerial target is 13 weeks). Clients may experience harm (malnutrition, chest infection, aspiration pneumonia, choking) while waiting for assessment. • Regional live dashboard managed by PHA has not been updated recently Meal Times Matter Framework • Ongoing investigation by H&S exec in relation to SAI • Secure storage of thickeners to prevent unauthorised access - Audit in Antrim and Whiteabbey Hospitals has demonstrated that there is not full compliance with safe storage of thickeners. • Reporting of incidents relating to dysphagia management – this is inconsistent across Divisions • The SLT Regional EDS (REDS) recommendations document is now available on NIECR since May 2023. However, we cannot be certain staff will check NIECR on admission to wards. It should also be noted that agency staff and students do not have access to NIECR • Relevant policy needs to be updated to reflect the need to review NIECR for patients with potential dysphagia risks – this is included in the latest version of the dysphagia policy • Ongoing investigation by H&S exec in relation to SAI • Secure storage of thickeners to prevent unauthorised access - Audit in Antrim and Whiteabbey Hospitals has demonstrated that there is not full compliance with safe storage of thickeners. • Reporting of incidents relating to dysphagia management – this is inconsistent across Divisions • The SLT Regional EDS (REDS) recommendations document is now available on NIECR since May 2023. However, we cannot be certain staff will check NIECR on admission to wards. It should also be noted that agency staff and students do not have access to NIECR. • Relevant policy needs to be updated to reflect the need to review NIECR for patients with potential dysphagia risks – this is included in the latest version of the dysphagia policy • The Trust Dysphagia Group is currently working on initiatives to improve communication of EDS recommendations across all Divisions and also at the point of transfer/discharge from the acute setting in the Trust. A regional transfer document is currently being considered, for example, as a result of learning from the DAMES* Project undertaken in Belfast HSC Trust and may be further escalated through Encompass Workstreams. Until such measures are implemented however, there remains a risk that REDS are not appropriately communicated when a patient is discharged from the acute setting. • A small number of issues were noted across ward visits where nursing assessment booklets was not fully populated in respect of sections relevant to dysphagia. There was also a small number of instances where signage above patient beds and ward whiteboard did not reflect the accurate IDDSI level for the patient – these patients did not receive incorrect food however due to the safety pause process. • The Mealtimes Matter framework has not been fully implemented in NHSCT Emergency Departments. This is being progressed by the Mealtimes Matter Steering Group Staff training / resources • Dysphagia NI have provided some training guidance but currently there is no mandated training for staff recruited through agencies. The Regional Dysphagia NI Partnership has not yet provided an action plan to Trusts regarding standardisation of dysphagia care training to all specific staff groups therefore NHSCT have proceeded with a Trust Plan but have been unable to fully mandate training by staff recruited through agencies. • Across the 10 wards visited by IA, the local records held to support training uptake was poor, inconsistent and lacked formality or structure and could not be easily or accurately relied upon. Uptake of training appeared low across some of the wards visited. • There is a lack of visibility and reporting corporately and at individual ward level on the number of staff trained against the total number of staff to be trained. The Director of Nursing also has a lack of assurance in this regard. Manual exercise to collate compliance across wards in September 2025 demonstrated only an average of 60% compliance across Divisions.	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 have been incorporated within the Trust wide Dysphagia Action Plan and implemented. Currently, this action plan is driven by shared learning from local and regional incident analysis and key stakeholder feedback, ensuring improvement efforts are focused on areas of highest risk. The Dysphagia Action plan is now embedded within the Trust's broader Nutrition Action Plan. This strengthens opportunities for shared learning, collaborative improvement efforts and integrated delivery of nutritional and dysphagia care. 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. NHSCT SLT department has provided information to the PHA regarding staffing levels. There has been no further work by the PHA or DOH re demand capacity analysis. Risk Management 2. a. Regional work on the reporting of dysphagia-related incidents and regional shared learning is ongoing b. A Trustwide resource to guide staff in capturing sufficient detail within reports to inform learning and improve safety has been developed and shared with the community care dysphagia subgroup for comment c. The Food and Drink Safety in ED Task & Finish Group are progressing work with the Emergency Departments to develop and implement the Mealtimes Matter Framework. Staff Training Programme 3. A Trust Task and Finish group has also been established with staff from across Divisions to develop a Trust agency induction/orientation guide. Food safety awareness can be added to the induction/orientation guide to remind ward staff to advise agency staff on their first shift about the food and drink safety pause and anything else relevant. 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. Regional eLearning now applicable to children and young people excluding neonates. 5. The PHA and the HSC Trust Dysphagia Support Teams are developing a regional training programme for catering staff. 6. Work is ongoing to develop more robust process for capturing compliance.	Catastrophic (5)	Unlikely (2)	10	HIGH	28/10/2025	29/08/2025

Storage
• 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.

4. Staff training / resources

Policies
• Dysphagia Management and Choking Reduction Policy (Adults) - revised in June 2021 to strengthen the recommendations in the SQR/SAI/2021/075 and further reviewed in October 2024
• Paediatric Dysphagia Management and Choking Risk Reduction Policy – revised in July 2022 to include the SQR key learning recommendation

Resources
• Dysphagia Information staff booklet for staff working with adults with eating, drinking and swallowing
• Swallow Aware 'fast facts' card
• Dysphagia Resources Page on Staff net for all HSC Staff
• IDDSI food / fluid level posters learning letter (including a complaints template) 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. A bespoke, rolling dysphagia training programme is in place for NHSCT Homecare Staff.
• Fundamentals of Care in Eating, Drinking & Swallowing document to support the management of service users with suspected EDS difficulties who are awaiting assessment has been shared and will be included in the revised policy.

Staff Training Programme
• Dysphagia training is mandatory 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.
• Training matrix developed for defined staff groups and incorporates new regional eLearning programmes developed by CEC and NHSCT eLearning for catering and support staff
• Dysphagia Awareness training sessions provided by Adult SLT and Dysphagia Support Teams to NHSCT and IS staff
• Regional dysphagia eLearning programme, developed by Trusts, PHA and CEC, and hosted on the Learn HSCNI site available for HSC staff working with adults and children and is incorporated into the NHSCT Policy
• Refresher dysphagia training available for all homecare staff
• Dysphagia NI in collaboration with the CEC have recently launched universal introductory swallowing awareness eLearning and a targeted swallow awareness programme. The latter is aimed at those groups of staff who require mandatory training as recommended by RQIA. These eLearning programmes are now available to IS staff
• Additional training provided by Dysphagia Support Team in response to bespoke requests.
• Food safety awareness is now added to the IR35 (training record, record of compliance) that all agency workers must complete on behalf of their agency and provides assurance to Trusts that agency staff meet the mandatory training requirements. This requirement is now included in the regional nursing agency contract. All agency nursing and nursing assistant staff must have completed dysphagia training.
• Initial compliance figures have been collated manually and reported at Nutrition Steering Group in September 2025. This will be repeated annually. Target compliance rate agreed as 95%

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780	16/01/2015	Executive Director of Nursing, Midwifery & AHPs	Regionally there is an improving vacancy position for registered nursing staff being reported, but the unregistered staffing vacancies are becoming more challenging to fill. The Trust vacancy position reflects the regional position, Registered Nurse vacancy levels are improving but there remain significant gaps in non-registrant vacancy position. Despite this improving position the Trust continue to experience a high reliance on agency workers both registrant and non-registrant due to the increasing workforce demands and acuity needs of patients. The regional position is that there will be a phased reduction in nursing agency utilisation across HSCNI. A regionally developed action plan has been agreed and agency reduction is key focus for Agency Reduction Implementation Group (ARIG). This continued reliance on agency workers to fill shift gaps across acute and community teams impacts negatively on safe and effective care delivery and financial resource for the Trust. This also reduces the ability to strengthen and stabilise nursing teams. There is also a risk that that divisions will be unable to ensure safe staffing levels due to the requirement to meet regional action plan for reduction in nursing agency utilisation, potentially leading to the requirement to close beds, impacting on the flow of hospital admissions from the ED and increasing ambulance handover times.	Major (4)	Likely (4)	16	HIGH	1, 2 & 3	Recruitment • Planned recruitment activity • Additional recruitment based on acuity assessments, workforce reviews, agency utilisation and attrition agreed via SMT for autumn 2025 (Posts coded as REG25). 166 posts agreed with 110 allocated. Band 5 recruitment event Saturday 11th October 2025 with 107 successful candidates. Good intake of newly qualified nurses secured in Sept/Oct 25 with 120 nurses joining the NHSCT which has supported a reduction in vacancies. Next cohort of students due to join Trust in Spring 2026 • Regular meeting with operational managers to review vacancies and ensure requisitions raised in a timely manner • Analysis of substantive Nurse midwifery hours / vacancy data in each division • Safe Staffing Lead Nurses works closely with Divisional Nurse to promote areas with critical vacancies identified • Hard to recruit to areas are monitored and supported as required • Safe Staffing Lead Nurses works closely with Corporate Communications to ensure adequate and suitable social media posts are promoted in line with recruitment advertisements. Photography reviewed and kept up to date to support any recruitment activities. • 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 the Nurse Bank. • Streamlining of recruitment processes. • 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 • Internal Voluntary Transfer policy operational to facilitate / enable the retention of nursing staff • Promotion of career pathways - Consultant Nurse and Advanced Nurse Practitioner roles promoted and supported through delivering care funding and now embedding into their roles • Absence Management Policy • Temporary clinical workforce education team support NQNs to transition from student to registered nurse Nurse Bank / Agency Staff • Capacity within the Nurse Bank has increased since April 2025, with the addition of an office manager and an increase to the admin support team managing day to day operational commitments. • Electronic Roster Management Policy and Obtaining Nursing & Midwifery Staff policies • Corporate Scrutiny process in place for approval of Block Bookings • Regional Agency Framework in place • Additional staff obtained through Nurse Bank ensuring adherence to policies / framework • Nurse Stabilisation group established with Divisional Directors chaired by Executive Director of Nursing. Director of Operations in attendance • Review of agency spend ongoing with increasing targets for reduction in order to achieve minimum possible levels • Block Bookings monitored and shared with Finance on a monthly basis • Financial reports provided to each Divisional Director highlighting utilised nursing hours and reliance on nurse agency • Delivering Values monitoring incorporated into reports and meeting • Review of Incidents and Complaints Safe staffing / Nurse Stabilisation • Delivering Care recommendations for nurse to bed ratio • 8a Lead Nurse for safe staffing and utilisation commenced post in August and also has responsibility for professional oversight in Bank Office • Agency and bank staff supplementing core staffing to manage ongoing service pressures • Operational daily reporting of staffing levels to site co-ordination • Gaps in staffing that are not filled are assessed by operational managers during safety brief and site meetings and staff shortages will be addressed on a site basis to ensure safe staffing. • Reporting of unfilled nursing shifts and levels of bank/agency fill escalated within divisions to Nursing Workforce and Nurse Bank • Weekly monitoring and reporting of staffing levels by Community Care (not on rostering system) • Operational escalations to corporate nursing if there is a concern regarding staffing and skill mix • Deviations from safe staffing are escalated to Executive Director of Nursing through Operational Directors and escalation meetings. • Triangulation and close monitoring of trends / concerns in relation to clinical incidents / Key Performance Indicators (KPIs) with staffing / vacancies • Vacancies raised to support areas which are reliant on high agency use to meet acuity needs • Work ongoing to review safe staffing levels using workforce tools, Telfords and Safer Nursing Care tool 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. • Joint Nursing workforce and finance workshops held with divisions regarding workforce, budgets, staffing and nurse utilisation. • Additional Band 5 posts have been identified across all fields of practice and across the Trust by finance and nursing workforce to support stabilisation of nursing teams and have been agreed and reviewed by Divisions for active recruitment. • Trust Nurse Stabilisation group chaired by Executive Director of Nursing and attended by Divisional Directors. Reports to Delivering Value Project Board • Detailed risk assessment completed of areas with ongoing analysis. Specific focus on areas with block bookings and high ad hoc agency utilisation. Risks identified include existing vacancies and skills and capacity versus demand. • The information within the Agency Reduction Plan correlate alongside the data from the Risk Assessments from Nursing Workforce and quality assurance has been completed with finance for comparison. • Work ongoing to review safe staffing levels using workforce tools 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 • Areas for agency reduction have been RAG rated in an agreed phased approach between July 2025 and March 2026 Rostering • New Electronic Roster System, Allocate, implemented for all areas previously using Roster-pro • Electronic Roster Management Policy • Rostering Principles - Tips for Effective Rostering and face to face E-rostering education sessions provided during roll out. • Training developed to include Nurse Accountability and Systems • Elbow support provide by nursing workforce during Optima roll out with continued support and audit of roster usage . • Roster System Analyser shows basic KPI information for Roster Managers to review prior to Roster sign-off • Joint Nursing Workforce and Finance workshops held with Divisions regarding workforce, budgets, staffing and nurse utilisation. • 1.0 wte Band 7 project support secured until March 2026.	Recruitment • Substantive nurse / midwifery hours • Recruitment activity levels • Monthly vacancy levels • Attrition rates / Number leavers • Absence data • Number voluntary transfers • Number staff attending induction programmes / professional development courses / training • Monitoring of recruitment timeline from e-requisition raised to appointment of staff member Nurse Bank / Agency Staff • Number block bookings • Monthly usage of Nurse Bank and Agency (reports from Allocate) • Daily Monitoring of bank/agency fill rates • Monitoring of shift allocation to reflect block booking database with Optima data • Financial Reports of Nursing Utilisation and Agency Usage • Delivering Value Reports • Report of Incidents and Complaints • Update on Internal Audit Recommendations - Management of Use of Agency Staff Workers - Nursing and Non-Nursing Frameworks 2023/24 Safe Staffing / Nurse Stabilisation • Daily / weekly report of staffing levels • Report of unfilled nursing shifts and levels of bank/agency fill • Reports of monthly hours, additional hours and absence hours (from Allocate) Financial Reports or Nursing Utilisation and Agency Usage • Number deviations from safe staffing escalated • Baseline safe staffing levels as indicated by workforce tools • Report of Incidents and Complaints • Tracking of additional Band 5 posts Rostering • Reports of monthly hours, additional hours and absence hours (from Allocate) • Training data • Update on Internal Audit Recommendations - E Roster 22-23	Recruitment • There is a 8.4 (Sept 2025) rate in Band 5 nurses and midwives however staffing needs are not reflected as needs outweigh agreed staffing levels. • Ongoing challenges with centralised recruitment processes creates undue delay in filling vacancies in a timely manner • There continues to be areas which are challenging to recruit to these are monitored and bespoke support provided • B2 and B3 vacancies remain challenging to recruit to and therefore the use of agency has been higher where vacancies remain. Other contributing factors that have impacted the increase of agency have been due to a surge in enhanced care beds • Challenges in filling temporary posts • Limited resource in nursing workforce and HR resourcing to support recruitment activity • Recruitment processes and CoS requirements for Band 2 are challenging as a number of Band 2 allocated to posts may not be eligible for CoS resulting in the need for more recruitment cycles Nurse Bank / Agency Staff • The Nurse Bank are filling approximately 13,000 shifts per month, with approximately half being agency shifts • As at Year End 24/25, all Internal Audit Recommendations for Management of Use of Agency Staff Workers - Nursing are now regarded as implemented for Nursing staff (some remain as not / partially implemented for non-Nursing staff) • Nurse Bank is not available Sat & Sun normally but there is a limited service to provide support during winter pressures. Following any successful recruitment this will be reviewed and consideration given to expansion of opening hours. • 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. The Nurse bank is under resourced and has limited capacity to effectively manage the day to day operational role or enable service development and improvement. Any successful recruitment should support and address this gap. • Onboarding process now to include encompass requirements which will cause a delay in onboarding new agency workers and bank staff. The bank office have also seen a decrease in shift fill post encompass. This will continue to be monitored and escalated as required. However shift fill has stabilised again over Spring / Summer 2025 • Updated Obtaining Additional Staff and Rostering policies are currently in final draft for presentation to Policy Committee (although same guiding principles apply as current versions) Safe staffing / Nurse Stabilisation • 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 • Divisional updates reported at Nurse Stabilisation Group – demonstrating continued high reliance in agency in comparison to nursing hours worked • Regular finance reports issued to Divisional Managers regarding utilised nursing hours – agency hours not yet reducing in line with Phased implementation Plan • Current rostering system does not provide robust assurance of safe staffing levels. This will be addressed for rostered areas with the roll out and implementation of Safe Care module of the roster system. This is planned for summer 2025. • Rostering system not yet implemented for Community Care • Delivering Care policy currently being refreshed. Current Delivering care recommendations for nurse to bed ratio do not meet the required need and will be reviewed as part of the regional work to review the policy. Nursing Workforce AD involved in regional meetings and group. • Nursing workforce data is indicating a higher nurse to bed ratio is required for the areas which have been reviewed to ensure safe staffing to deliver safe and effective care. • Benchmarking limited as not all HSC Trusts using safe care. This will progress in 2025. Also variations of specialities and wards add difficulties to benchmarking • Temporary vacancies and higher acuity patients have led to added pressure points within nursing teams, leading to sickness absence and retention of existing staff. • Limited resource to focus on retention of staff • Currently unable to provide report on whether leavers have left post for career progression within NHSCT	Recruitment • Work is ongoing with regional Newly Qualified Nursing Group to further improve recruitment processes. NQN regional recruitment underway for Sept/Oct 25 – applications close 1st May Delivering care safe staffing • Normative staffing levels have been established for each acute ward. Regional rebasing exercise commenced Nov 22 and currently being repeated. • Refresh of Delivering Care – Review of Phase 1 paused as under review by CNO. Group established to lead on the refresh of delivering care model. Regional workshop held to shared draft refresh document. Comments returned to DoH draft paper in Dec 2024. Awaiting any update from DoH for work to progress. • Work completed to review nurse utilisation and staffing across divisions using recognised nursing workforce tools. Report being prepared with finance and AD Nursing Workforce. • Safe Care functionality on Allocate system, required to give oversight of daily staffing, not yet rolled out. Due to delays daily staffing reports have been set up by systems team for some over view by Corporate Nursing. This has been escalated through Nurse Stabilisation Group and Delivering value, Director SPPICT Development / Retention of Staff • Currently developing a proposal for a nurse and midwife toolkit to support succession planning Nurse Bank / Agency Staff • Management of change process has commenced to move Nurse Bank to seven day model – no agreed outcome to date. • Regional group established to look at Regional Bank Reform. Nurse Workforce AD chair or one sub group Rostering Principles • Page Tiger to be developed to assist managers. Licence purchased and development ongoing • Work has commenced to review demand templates to ensure in line with FSL, review and correction of time balances and Lead Nurse approval of roster • Further audit for 25/26 is nearing completion with draft report available end of October 2025.	Major (4)	Possible (3)	12	HIGH	27/10/2025	27/02/2020

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											Rostering • As at Year End 24/25, all Internal Audit Recommendations for E Roster 22-23 are now regarded as implemented – Further audit for 25/26 is nearing completion with draft report available end of October 2025. • Updated Rostering policy • Further training resources to be developed - Page Tiger resource to be developed to assist managers. • Reporting on KPIs (not yet available from system. RosterPerform reporting tool will be investigated after Loop / SafeCare completion to see what further reporting functionality it can provide, including KPI reports on top of existing Sickness, Unavailability, Timesheet reports. • Further resources required to future proof system - 2 x 1.0 wte Band 7 Professional Leads and 2 x 1.0 wte Band 5 Data Analysts – proposal sent to Finance • Not yet reporting on Rostering Systems and Accountability training – this will be reported to Nurse Stabilisation Group and Delivering Value Project Board						

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1281	30/10/2023	Strategic Planning, Performance & ICT	The encompass programme has implemented an integrated, electronic Health and Care Record system across all five Healthcare Trusts. The system supplier is Epic. Implementation has introduced a very significant change for the Northern Trust and risk remains in a number of areas: • Leadership Capacity: The successful stabilisation & optimisation of encompass will require significant commitment from NHSCT leadership. If NHSCT leadership do not have capacity to support and drive the programme stabilisation/optimisation activities and necessary business change, there is significant risk to achieving the full benefits of the programme. • System Design: If the system design does not adequately reflect the range of services provided by NHSCT then it will not meet the needs of frontline staff, resulting in staff resorting to workarounds and/or paper-based processes with an impact on productivity and a reduction in time available for patient/client care. • Training: BAU Training needs to be in sufficient depth and role appropriate to ensure staff can complete critical workflows upon taking up post. If training is not appropriate onboarding and moving staff will be ill equipped for their duties. Appointed Affiliated Users need to be managed appropriately to ensure timely access to training ahead of taking up post. Lack of training or inappropriate training will put system adoption at risk with staff either resorting to workarounds with an impact on productivity and a reduction in time available for patient/client care or inefficient use, leading to data quality issues, reporting errors and poor staff experience. • Productivity: The Trust risks reputational damage and waiting times will be adversely affected if activity stabilisation and productivity levels are not adequately achieved within planned timescales. • Staff engagement: Continued staff engagement around the new workflows is critical to ensure stabilisation. Staff may disengage from the new workflows, resort to workarounds with a resulting impact on productivity and a reduction in time available for patient/service user care. • Role Impact: A number of roles have been significantly impacted by the implementation of encompass. Others moderately impacted and a further set of roles partially impacted. Work is ongoing to identify these roles and mitigate the impact by either redeployment, retraining or moving to net new roles. The risk for the Trust is that if not all roles are identified or there are insufficient opportunities for redeployment to existing or new roles, there will be a negative impact on staff in these roles leading to staff discontent, low staff morale and reputational damage to the Trust. • Reporting: If encompass does not meet the reporting needs of the Trust from Day 1 onwards then information required for safe and efficient senior decision-making will be absent. Areas such as Site Co-ordination, Patient Flow and care home placements will be negatively impacted, risking an increase in length of stay and delay in discharge processes. This in turn will negatively affect the capacity in Unscheduled Care and cause major delays and overcrowding in Emergency Departments with inherent risk to patients. • Digital Care Safety The move to a new way of working digitally raises the risk of staff, unfamiliar with the new system making errors, resulting in incorrect care/treatment for patients. This includes the management of in-basket messaging, work queues and orders. • Regional Archiving Solution: The absence of an archiving solution in place for encompass implementation in the Trust poses a significant burden on the Trust ICT Department. Responsibility for the continued management of ageing legacy systems, whilst ensuring encompass moves into BAU will stretch ICT resources considerably. Ageing systems also create an ongoing and increasing risk to data quality with associated Information Governance and Cyber Security risks. The ongoing support and maintenance costs of these systems in read only format (post encompass) necessitates support contract arrangements to be extended, this is expected to lead to increased costs from existing suppliers which cannot be mitigated at present. There is also a risk suppliers may have no appetite to maintain these ageing systems. A lack of investment from suppliers will result in systems falling behind on patch cycles and updates, leading to increased risk of cyber security vulnerability.	Major (4)	Likely (4)	16	HIGH	2	Leadership Capacity: • Trust encompass Optimisation Board meets bi-monthly to direct and oversee the stabilisation and optimisation phases of implementation. It provides assurance to the Trust Executive Team and the Northern Trust Board, that key stabilisation issues are being progressed in a timely way, provides high-level Trust oversight of all aspects of the optimisation phase and ensures that emerging risks and issues are being appropriately managed. It monitors the progress of on-going / new areas requiring design / re-design. • Operational Divisions have established Stabilisation/Optimisation Groups that meet monthly/fortnightly. • The Trust Digital Clinical and Social Care Safety Workstream has been established and is led by the Exec Director of Nursing, Midwifery and AHPs, Divisional Director of Paediatrics, Women's Services and Corporate Support. • The Trust Benefits Workstream has been established, led by the Operational Director and is meeting bi-monthly. System Design: • The Trust retain subject matter experts to sit on regional design groups, where required. • The Trust have nominated representatives to the new Pathway Councils who will oversee the prioritisation of Optimisation projects across the region. • The Trust encompass Optimisation Board Training: • The Trust Onboarding and Training Workstream has been established, led by HR Assistant Directors. • An onboarding process for Divisions to manage new starts and position moves is in place with HR. • The Trust HR Director is Co-Chair of the Regional People & Workforce Planning Group. Productivity: • The Trust Operational Processes Group has been established, led by the Director of Operations, it meets fortnightly. • Divisional Stabilisation Groups will continue to work with the Trust encompass Optimisation Board to ensure ongoing issues are addressed and services achieve planned activity stabilisation timescales. • Trust encompass Personalisation & Optimisation Working Group has been established, chaired by the Director of SPPICT. Staff Engagement: • Corporate Communications continue to promote encompass activities through various media channels. • Professional Leads and Digital Transformation Leads continue to actively engage with and support their respective professional areas. Role Impact: • The Trust encompass Admin Lead continues working closely with the Workforce Impact Lead from the Programme. • The Trust HR AD for Workplace Relations is a member of the Programme People & Workforce Planning Group • The Trust People Transition Group has been established, led by the HR Assistant Director. Reporting: • A Trust Reporting Oversight Group has been established with membership from Trust, Regional encompass, DHCNI and Epic. • The Trust Activity Stabilisation and Performance Reporting Workstream has been established, led by the Performance, Reform, Quality Improvement Assistant Director. • The Trust Data Quality and Statutory Reporting Workstream has been established, led by the Informatics Assistant Director. Regional Archiving Solution: • Impact of this risk has been shared with the Chief Digital Information Officer for Northern Ireland.	• Regional encompass Programme Board papers/minutes • Trust Optimisation Board papers/minutes • Professional Advisory Council papers/Minutes • Trust encompass Escalation Log to track outstanding build/issues • Trust encompass Digital Clinical & Social Care Safety Group Minutes and encompass Datix repository • Trust encompass SLT Action Log • Trust rolling six months communication plan • CEQ Letter regarding Trust funding position to the Permanent Secretary, Chief Digital Information Officer for N Ireland and Regional Programme SRO.	Gaps in controls/assurances • Leadership Capacity Encompass stabilisation and the embedding of sustainable change across the organisation will require significant effort from Divisional Leadership. However continued efforts are critical to ensuring the digital transformation sticks and becomes embedded in the Trust culture. • System Design Continued Trust engagement in system design and configuration is required beyond Go-Live to ensure encompass continues to develop and improve its functionality to meet the emerging needs of the Trust. The pressures of completing areas of build to address issues in SHSCT & WHCT post go-live may result in a lack of regional input and agreement regionally to address issues in the 'live' Trusts. • Training Identifying resources to deliver in-Trust 'Thrive' developmental training. • Releasing staff for the recommended annual Thrive training (recommended 4hrs) annually, may prove difficult due to service pressures and a high Trust vacancy rate across professions such as Nursing • Productivity There are continuing difficulties in comparing pre and post live activity levels due to different activity definitions in encompass than legacy systems. • Staff Engagement Maintaining staff engagement with significantly reduced encompass Digital Transformation Leads and PMO team from 5 months post go-live will prove challenging. • Reporting Whilst significant progress has been made since the Trust Go-Live, there are still gaps in reporting and difficulties reporting with confidence on 7 SDP areas and 5 areas that have not as yet been reported on. There are still significant build requirements needed from Epic/encompass which mean that Dementia and District Nursing reports cannot be submitted regionally or by NHSCT. Antimicrobial consumption and HCAI data require further work with encompass team and SPPG to be able to submit. 3/9 Critical Priority Returns are yet to be submitted, 25/56 High priority returns and 27/30 med/low priority returns are yet to be submitted (as of 01.07.25) SOM's Q1 25/36 remain unsubmitted.	Action plan in place, to be reviewed bi-monthly at encompass Optimisation Board. Summary of Actions: All Working Groups in the Optimisation Governance Structure are to report through to the Trust encompass Optimisation Board. 1. The Trust encompass Optimisation Board oversees the stabilisation risk actions and Optimisation related risk actions and reports to the Trust Board and Trust Resource Committee. 2.Trust HR Director Co-chairs the Regional People & Workforce Planning Group. A Trust People Transition working group manages and monitors administration posts that are impacted by encompass. 3. Reporting, significant work via sprints has been done with the Regional Cogito Team and Epic to establish a suite of reports to meet the Trust's needs. Validation of reports is ongoing. Information Team have established a pathway for services to request new reports. 4. The Trust encompass Personalisation & Optimisation Working Group has been established to develop a personalisation and optimisation strategy to maximise staff efficiency on the system and increase productivity. 5. The Trust encompass Governance Structure has transitioned to an Optimisation model as the Programme moves towards the Optimisation Phase with 7 key priorities identified: Safety, Data, Productivity, Benefits, Transformation & Service Improvement, Infrastructure and My Care.	Major (4)	Possible (3)	12	HIGH	27/10/2025	06/11/2023

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	If unscheduled care continues to face significant pressures with demand on ED care, patient acuity and significant systemic limitations in hospital flow there is THEN a continued risk to patient safety RESULTING in and including treatment delays, decline in the quality of care, and increased patient morbidity and mortality	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, continues with extreme focus on discharge pathways. Community escalation meetings in place to encourage coordinated response. Community discharge group chaired by Director of Operations. Full capacity and escalation plan in place Update of Major incident plan to incorporate full capacity protocol. Update sessions have taken place with a desktop exercise carried out with Senior Team. 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. Regional Control Centre NIAS service improvement group Focused medical model with emphasis on senior decision making. Active recruitment for medical and nursing vacancies. Delivering Value workstream focusing on nurse stabilisation COVID swabbing as per IPC guidelines and outbreak management. Unscheduled care reform board.	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). Reporting to RCC (E)	Alternatives to Emergency Departments - Hospital at Home service Alternatives to Emergency Departments - Expand SDEC services Emergency Departments - Trust/ NIAS service improvement plan Emergency Departments - Unscheduled Care Clinical Programme Board Hospital Flow - Streamlining community discharge planning approach Hospital Flow - Winter plan for 7 day per week service Hospital Flow - Extension community beds Care Home and Home Care Processes/ Engagement - Trusted Assessor / Real time care app Care Home and Home Care Processes/ Engagement - Early review team	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. Ambulatory area Direct Assessment Unit/ PTU frequently being used at times of pressure to house inpatients, reducing ambulatory capacity. 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 patients requiring High cost placements and therefore associated increase in acute hospital delays - lack of dementia 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 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. Trust will fund roles of Lead trusted Assessor and trusted Assessor (temporary until end of year). Proposed Trusted Assessor Role will streamline the transition from hospital into a care home setting by improving the quality of the documentation used to facilitate admission to a care home, reducing the number of face to face assessments required to facilitate a care home admission and improve relationships with care homes. Lead Trusted Assessor role will also coordinate the training and application by acute staff of the tested EPCO model and will oversee the patient management to a safe level ready for discharge and co-work with care homes any outreach review and support arrangements. 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 Update 05.06.25 - update funding received from SPPG which would be focused towards development of hospital at home. Community lead - COE team will be medical model. Update 05.08.25 - likely commencement date September 25 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. Update 05.06.25 - regional collaborative workstream chaired by CE. Looking at nursing home demand and capacity and associated workstreams The Trust has experienced a reduction of 68 Gen Nursing Beds in the past 6 months, however has gained 23 DE Nursing beds in Ratheane PNH of which 10 are enhanced, and a further 10 DE Enhanced Residential Beds. A new home in Carrickfergus will be opening in January 2026 which will provide an additional 112 beds. The majority of these will be DE categorisation. 5 - Inability to sufficiently expand Domiciliary Care. This is a community workstream. Since September 25, a further 252hrs of capacity, equivalent to 24 full packages of care, has been commissioned. Work continues to expand and to ensure all existing hours are effectively utilised. Financial controls are in place. Revised commissioning processes have been introduced to ensure all available capacity is targeted at those in greatest need and to support hospital flow. Work ongoing to ensure any POC not being effectively utilised are reviewed. 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. Update 05.06.25- from implementation of epic - BT36 number appear to have reduced. 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. As before	Major (4)	Unlikely (2)	8	HIGH	04/12/2025	21/02/2020

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324	15/03/2011	Paediatrics, Women's Services & Corporate Support	Patients, service users, staff and visitors are at risk from the spread of healthcare-associated infections (HCAIs) which can arise from poor environmental and equipment cleanliness, lack of IPC knowledge among staff and non-compliance with standard and transmission-based infection control precautions (including hand hygiene and use of PPE), a poorly designed and poorly maintained healthcare estate and inappropriate antimicrobial prescribing and stewardship. In addition, lack of timely implementation of control measures, inadequate monitoring and surveillance of HCAI can increase the risk of outbreaks, compromise patient safety, increase patient suffering, accelerate antimicrobial resistance and prolong hospital stays. In some patient cases acquisition of HCAI can lead to long-term disability or death and increased legal liability for the organisation. There is also a risk that the organisation would be inadequately prepared to deal with a patient(s) presenting with a High Consequence Infectious Diseases (HCID) or novel pathogen which may cause future pandemics.	Major (4)	Likely (4)	16	HIGH	1	Application of policies and procedures for HCAI and communicable diseases - 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 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 •Communication/education to staff and visitors regarding risk of Norovirus, Respiratory viruses. • IRAT admission and assessment tool for patients with high risk of infection available on Epic system for admission only. • 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	CAS outdated and replaced with the below reporting assurances. 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) targets (E) – target methodology agreed and set by PHA as quarterly rates per 100,000 bed days. 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. (E) External inspections by RQIA and Nosocomial Cell in February 2021 (E).	1. Delays in patient pathways 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 alongside reduced patient flow out of ED results in Trust facilities operating at >100% Occupancy including use of additional/Lower Acuity beds. There is potential for increased risk of nosocomial infections/outbreaks particularly when there is overcrowding or capacity pressures across hospital sites. 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.	1. Medical Director and Lead Doctor for IPC to agree and establish roles and relationships to ensure prescribers have access to the relevant data and improvement support with antimicrobial stewardship. SAMHRHAI meetings have restarted, chaired by CMO. Following Meeting with PHA Jan 2024 Trust has been asked to submit a one year action plan in relation to HCAI, IPC structures and AM stewardship/consumption; this work is also in line with launch of regional AMS strategy. Work to be taken forward by the Trust in 2025/26 is as follows; • Review the connection between the current stewardship team and clinical teams; ensure prescribers have access to the relevant data and improvement support. • Review outbreak management process and procedures post Covid-19 to allow more focus on prevention strategies for HCAI and more implementation of quality improvement. • Work in partnership with the encompass team to get accurate antimicrobial consumption data for the NHSCT. Current LAMPS system will remain and will take data feed from new WYNPATH system.	Moderate (3)	Possible (3)	9	MEDIUM	29/10/2025	07/06/2024
									• Operational and corporate dynamic risk assessments to manage positive results of COVID19/outbreaks HCAI whilst also managing capacity issues. • Where children are admitted to hospital 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 advise on safe patient placement. • Antimicrobial Stewardship ward rounds in Causeway Site and Antrim site where possible however this is microbiology and AM Pharmacy resource dependant • On-call IPC and microbiology rota 7 day week/24 hour microbiology laboratory service. • 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. • Rapid Response cleaning team in AAH developed during winter pressures has been maintained.	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, Modular Build. Patient Environmental Leadership Walkabout (PELW) programme collaboration of Domestic Services, IPC and Estates. Electronic Laboratory and Antimicrobial Surveillance (LAMPS) systems to monitor alert organisms / antibiotic stewardship and compliance reporting (I). Now moving to Epic system with surveillance and contact tracing capabilities. Monitoring of compliance with Antimicrobial Policy and stewardship rounds. ARK Project commenced November 2018 (I). (Still in place)	4. Post infection reviews have shown that C-Diff cases are related to high antibiotic usage. Additionally there is an observed increased incidence of gram negative bacteraemias. Gap in support to clinical teams to ensure quality improvement with antimicrobial stewardship. 5. Previous 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. Concerns continue regarding antimicrobial usage in some Trust areas; antimicrobial team undertaking pilot to reduce consumption and inappropriate prescribing. Data collection on Encompass for antimicrobial consumption and prescribing is still under validation and there is slow progress in providing data that can be used for improvement.	2. Re audit of ventilation using CO2 monitoring in Antrim and Causeway Hospitals completed. However, identified improvements for some ward areas remain outstanding. Estates Services prioritising work hopefully for completion by end 2026. 3. Process to be established for divisional review of training compliance and onward reporting to IPECHC. Divisions to completed training needs analysis. Statutory and mandatory training for IPC now on LMS system and work ongoing to capture training attendance etc. 4. IPC practice audit programme information previously taken from manual recording insertion and care of indwelling devices such as peripheral lines and catheters etc. Some initial concerns following encompass Go Live regarding documentation and management of indwelling devices. Infection Risk Assessment Tool and V&D risk assessment tool not in place on encompass for patient after initial admission assessment. Not built into Bugsy system as not required by other Trusts who have previously gone live. Ongoing work with encompass team to improve device management documentation and developing the						
									• 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. • Implementation of revised testing guidance and PPE in place (Feb 2024). Patient testing for COVID 19 with subsequent contact tracing continues as per regional guidance. Health care worker testing no longer required unless part of outbreak control. • 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. • 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. Learning shared at strategic and operational levels. • Nosocomial death review panel established and chaired by Medical Director; Assistant Director IPC attends to provide information on COVID status throughout patient journey. Review completed in January 2024.	Audit of CDI Management and Ribotyping of CDI (I). Results of water testing (I). Review of Ventilation and CO2 monitoring by Estates (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 regional Respiratory Virus report by PHA Contact tracing capability on Epic system Autoflagging of infection risk patients on Epic System. Internal audit report of infection control reporting and assurance to Trust Board - Satisfactory assurance level (Sept 2022) (I) IPCN Ward/facility visit reports. No incidents relating to LFD testing identified or reported. Annual round table discussions and assessment with PHA on IPC structure and HCAI targets.	6. Surveillance now to be captured on encompass however some gaps in numbers and cases captured; work ongoing to ensure encompass meets needs of IPC/surveillance purposes. NHSCT still has LAMPS system in place to assist with surveillance reporting and monitoring. 7. IPC practice audit programme information is currently taken from manual recording of care of devices such as peripheral lines and catheters etc; concerns regarding gaps in documentation and management of indwelling devices on Epic system.	existing NHSCT Infection Risk Assessment Tool for IPCN use that will be available only to NHSCT IPC team on Epic. Meeting with encompass team has taken place and work ongoing to build risk assessment capability. 5. Ongoing work at regional HCID PPE group in collaboration with BSO and MOIC to review new UK guidelines and recommendations for PPE ensemble; Region updated with Trust progress and learning shared with regional colleagues; AD IPC attended Train the Trainer HCID course. Remainder of IPC Team to attend in November 2025. Roll out of new HCID training to commence Dec 2025/ Jan 2026.						

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									• Divisions report progress on recent incidents relating to LFD testing and onward reporting to IPECHC • 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. • IPC Environmental Hygiene committee now reporting to Strategic IPC which reports into Trust Assurance Framework. Each Division/Directorate presents IPC plan and review of IPC incidents including LFD testing at IPCECH. • IPC Doctor and Assistant Director both members of regional HCAI working Group hosted by PHA; TOR, membership and governance structure under review currently by PHA • SAMHRAI group hosted/chaired by Chief Medical Officer DoH established IPC Doctor and Assistant Director both members. • IPC Annual report includes performance, surveillance and control measures in place to reduce HCAI. Improvements to Covid-19 surveillance and reporting in Annual report implemented as per internal Audit recommendations. • Current LAMPS system will be phased out to be replaced with Encompass platform; IPC Doctor and AD IPC both on regional groups to validate replacement. • AD IPC attended HCID Train the Trainer course for HCID PPE in May 2025; Remainder of IPC team undergoing (HCID) training Nov 25 AD IPC liaising with Emergency planning Team NHSCT to review Pandemic Policy and HCID Pathway and Policy.		8. Pandemic and HCID readiness; Trust pathways developed for potential HCID. Although M Pox derogated to non-HCID; further training is still required on HCID pathway to enable staff to feel confident and practiced in HCID PPE use. PHA aware of Trust position and is similar to regional position of other Trusts. Pandemic Trust Corporate plan needs updated, agreed and aligned with HCID pathway. Trust to take part in National and regional exercise Pegasus to test pandemic planning. 9. Infection risk assessment too (IRAT) not in place on Epic system for patient after initial admission assessment. Not built into Bugsy application as not required by other Trusts who have previously gone live.						

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909	11/07/2017	Strategic Planning, Performance & 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 10th consecutive year, Internal Audit / IT Dept self-assessment against 10 Steps towards NCSC Technical risks assessments and penetration tests. NIS CAF and external audit.	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 is in progress to strengthen security arrangements across all organisations, and we are part of that, and this is still ongoing. We will continue to react and strengthen our security layers as a Trust within the guidance of ISO27001. Vulnerability scanning of critical network assets is conducted monthly. Report findings and action plans are currently being addressed by the Vulnerability Management Group. 3rd Party Risk assessments take place as part of DPIA assurance to understand and mitigate the risk associated with 3rd parties accessing Trust data which is seen as a major risk. This process is being further developed to use MetaPrivacy to have online assessments and tie all Data Processing and ICT Security together.	Moderate (3)	Possible (3)	9	MEDIUM	28/10/2025	11/07/2017

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67	31/05/2008	Strategic Planning, Performance & 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 collectively at IG Forum meetings (I). 3. The Information Management Assurance Checklist (IMAC) has been reported as compliant for 2024/25(E). 4. Internal Audit carried out an IG audit in 2021 which provided a 'Satisfactory' assurance, and an audit into the Management of Medical Records in 2023 which also provided a 'Satisfactory' assurance. 5. The Trust's Learning Alerts System is in place to share learning from incidents (I). 6. Staff hybrid/flexible/homeworking: The Trust has put in place a number of measures to reduce this e.g. Trust Policy on Flexible Working (including risk assessment tool), Guidelines on Homeworking, IG Communications outlining the key IG considerations when undertaking hybrid/flexible/homeworking, Guidance on secure printing when working flexibly across Trust sites/facilities	1. Compliance with mandatory training for Trust staff as at 30th September 2025 was 91% for IG Awareness and 75% for POPI. Cyber Security was 91%. A Senior Executive Team target of 85% remains in place. 2. The number of IG incidents reported during the quarter ended September 2025 was 128. From April 2025, 4 incidents have been notified to the ICO, with inappropriate access accounting for 2 of these incidents 3. Learning from IG incidents continues to be identified and shared across Divisions. SIRO has oversight of all ICO notified incidents and there is a process in place between SIRO/IG/IAOs to ensure that all remedial actions identified by Trust are implemented. 4. There were 4 IG related complaints received during the quarter ended 30th September 2025. 5. All existing assets on the Information Asset Register (hosted on MetaPrivacy) 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 is be monitored via IG Forum, with a Trust RM Operational Group established to develop and deliver on a range of RM related tasks . 7. Current compliance with requests for information under DPA is 86% and 79% for FOI requests as at quarter end September 2025. 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.)	1. The IG Department provides 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 (hosted on MetaPrivacy) have had a risk assessment completed. New information assets are subject to a DPIA. 3. Progress in respect of the Trust's IG Action Plan is monitored and reviewed by IG Forum. An IG Action Plan for the period 2025/2026 has been produced and the key priorities identified are on Divisional IG Action Plans. 4. Work is ongoing on in developing a Records Management Strategy, this will take account of the move from paper to electronic service user records (via encompass) and a plan for managing the existing paper records until the end of their retention period. Strategic records management is now monitored via IG Forum. 5. Compliance with information requests remain challenging. Legislative compliance is 100% with the relevant timescales. Trust overall DPA compliance as at 30th September 2025 is 86% and FOI 79%. Some Divisions continue to experience challenges to respond to requests for personal information within timescales, in particular the CYP Division. The Trust as at 30th September has 48 requests outside of timescale with the oldest request dating back to June 2021. The ICO has requested that the Trust develop and implement a SAR Recovery Plan and monitor monthly SAR compliance, with updates being provided quarterly to the ICO. The SAR Recovery Plan spans 12 months and has 8 identified areas which aim to improve Trust SAR Compliance and reduce the number of overdue requests. 6. The IG Department supports Divisions participating in tendering processes with data flow mapping exercises and completion of DPIAs to inform tender specifications and reflect these requirements in contracts. Work is ongoing with Divisions to identify and review information sharing arrangements with external organisations and these are being recorded in a Trust's Information Sharing Register. This is ongoing BAU to ensure that the sharing is appropriate and compliant with UK GDPR requirements. 7. All information governance policies have been reviewed and updated. 8. The Trust has put in place a number of measures to reduce the risks associated with staff hybrid/flexible/homeworking e.g. Trust Policy on Flexible Working (including risk assessment tool), Guidelines on Homeworking, IG Communications outlining the key IG considerations when undertaking hybrid/flexible/homeworking, Guidance on secure printing when working flexibly across Trust sites/facilities 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.	Moderate (3)	Possible (3)	9	MEDIUM	28/10/2025	17/05/2019

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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	Date current rating changed
											9. Progress against the Trust's IG Action Plan is monitored and reviewed by Information Governance Forum on a quarterly basis. An IG Action Plan for the period 2025/2026 will be produced in early 2025. 10. The Trust's main off-site records storage supplier (Iron Mountain) is no longer on the regional Framework. To move these records to a new supplier on the Framework would take several years and be very resource intensive and costly, as there are approximately 60,00 boxes of records stored with Iron Mountain. The Trust has approved a decision (Senior Exec Team 15/06/2023) to continue with the storage of existing records in Iron Mountain. The next framework will become operational from 01/08/2025 and the Trust will review the position at this time. A DAC is in place to govern BAU storage until removal occurs. A new contract with Iron Mountain has been put in place and this will be managed to ensure compliance with PGN 1/12.	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. Divisions have been encouraged to continue their focus on increasing mandatory training compliance. 12. 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 when the Framework is being retendered in July 2025. PaLs have extended this (with agreement from all HSC affected organisations) for a further 6 months while T&Cs are developed to ensure compliance with the Procurement Act 2023. An approved DAC is in place and the Trust has signed a Contract with Iron Mountain to govern ongoing storage and BAU service during this intervening period. This is being managed in accordance with PGN 1/12 13. In August 2023 BSO Internal Audit concluded an audit on Management of Medical Records. The audit was rated "Satisfactory" with 6 recommendations (4 Priority 2s and 2 Priority 3s) identified. All of these have been implemented. 14. Implementation of encompass and access for the majority of Trust staff has significantly increased the risk of inappropriate access to service user records. Continuous communication programme in place to remind staff of their responsibilities and the consequences of inappropriate access. Any incidents of inappropriate access are investigated via the Trust's Management of Adverse Incident Reporting Policy and are notified to the ICO. Further processes may be initiated such as Trust HR processes or onward reporting to professional bodies/PSNI.						

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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	Date current rating changed
902	01/08/2017	Children & Young People's Division	Article 21 of the Children (NI) Order 1995 places a duty on the Trust to accommodate the children in its care and to ensure there is a sufficient supply of suitable placements. The Order states that no child should be placed in secure accommodation, except in exceptional circumstances. Any child, for whom accommodation is provided for a continuous period of more than 24 hours, is considered a Looked After Child. There has been an 8% growth in the number of looked after children between 30-09-23 and 30-09-24 (807-v-875) meaning the required range and number of regulated placements cannot meet the pace of demand. There has been a decrease in the number of fostering enquiries to the regional fostering recruitment service. The placement demands are further compounded because the Trust has seen a 33% increase in the number of unaccompanied young people requiring accommodation and the Trust is currently supporting 58 young people. There has also been an increase in demand for full-time care placements for children with disabilities, with limited resource, leading to closure of respite beds in order to accommodate these children. There are current 24 children with disabilities identified as being on the edge of care. In an attempt to meet the emerging demands of children/young people who need to temporarily move from the family home, the Trust has had to respond to emergency situations by placing children/young people in a range of accommodation options that include: emergency foster placements; emergency kinship arrangements; temporarily increase the number of beds within mainstream children's homes; place children/young people in temporary housing arrangements, cared for by a rota of both registrant (professional social work) and non-registrant (social care support) child care staff; place children with disabilities in short break beds. None of the above arrangements has met the needs of the children/young people or their families, because they cannot offer the focused specialist assessment and care planning that is required. RQIA has indicated to the Trust that the temporary increase in numbers in mainstream children's homes to accommodate these types of emergency situations is outside the registered Purpose of Role and Function for the Homes, and that this is an inappropriate use of the Homes. In 2023-23, RQIA inspected the living arrangements of children and young people in unregistered emergency placements and concluded that these arrangements were in effect small children's homes, however they were not registered in the way statutory children's homes are, and therefore the Trust must cease these arrangements.	Moderate (3)	Likely (4)	12	MEDIUM	2	Policy - Application of Children (NI) Order 1995 regulations and guidance for Children in Need; Looked after Children and Child Protection Policies and Procedures. Guidance for Management of Bespoke Placements; Guidance – Bespoke; Increased Social Work visits for priority cases; specific risk strategy meetings and advance child in need reviews and case conferences where necessary. Pilot Band 5 roles to support fragile fostering placements. Alerts to RESWS for risk cases. Dedicated workforce coordinators to track vacancies and escalate recruitment. Developing property portfolio for 16+ homeless and unaccompanied young people	Escalation Panel meets regularly to keep cases under review, securing placements where possible. Identification of unregulated placements where risks escalate. Notification to Regional Emergency Social Work Service of high risk cases. Unregulated arrangements notified to SPPG. Increase in beds in Children's Homes approved by RQIA and ongoing communication with RQIA in relation to unregulated placements. 6 monthly Delegated Statutory Framework Reports (I & E); Monthly workforce return to SPPG (I&E)	1. Vacancy rates in frontline social work teams is a risk in assurance for ensuring the level of social work visits required can be consistently maintained 2. The requirements of RQIA approval for increase in children's homes bed provision presents a risk in relation to the ability of the service to respond to immediate placement needs 3. Action short of strike is ongoing 4. Increase in child protection cases 5. Demands in relation to supporting the needs of children with Disabilities	30/7/25 - Number of Looked After Children at 28/07/25 is 877 (an increase of 62 from 31/03/24). Four children are placed in three unregistered emergency placements. 4 of 9 Short break beds currently suspended. Business case for CWD submitted to SPPG to secure recurrent funding wef 01-04-25. Trust approved recruitment to staff posts at risk, pending allocation. RQIA action plan in progress. Business case being developed for support from North Yorkshire County Council to develop a plan to implemented No Wrong Door model.	Minor (2)	Possible (3)	6	LOW	30/10/2025	14/11/2024