Northern Health and Social Care Trust

ASSURANCE FRAMEWORK
Principal Risks and Controls Document 2023/24

January 2024

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 November 2023	
		Changes to Risk Rating	
		Previous Risk Rating	New Risk Rating

Northern Health and Social Care Trust

Principal Risk Document - Summary Report

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

Item	ID	Lead Division	Risk Title	Untreated Risk Rating	Rating (current)	Risk level (current)	Rating (Target)	Risk Level (Target)	Months Since Rating Changed	Opened	Date of Last Review
1	952	Surgery & Clinical Services	Access to Planned Care/Procedures	25	20	EXTREME	16	HIGH	31	21/11/2017	26/01/2024
8	28	Finance	Failure to Breakeven	25	20	EXTREME	10	HIGH	6	20/02/2008	07/03/2024
2	324	Paediatrics, Women's Services & Corporate Support	Healthcare Associated Infections	25	16	HIGH	12	HIGH	48	15/03/2011	24/01/2024
3	1049	Mental Health, Learning Disability & Community Wellbeing	Mental Capacity Act	25	16	HIGH	12	HIGH	51	28/08/2019	05/02/2024
4	780	Paediatrics, Women's Services & Corporate Support	Nursing Vacancies	25	16	HIGH	12	HIGH	48	16/01/2015	23/01/2024
7	851	Paediatrics, Women's Services & Corporate Support	Dysphagia	20	16	HIGH	10	HIGH	63	19/05/2016	25/01/2024
6	67	Strategic Planning, Performance and ICT	Information Governance	20	16	HIGH	9	MEDIUM	57	31/05/2008	23/01/2024
9	909	Strategic Planning, Performance and ICT	Information Security	20	16	HIGH	9	MEDIUM	80	11/07/2017	22/01/2024
5	905	Medicine & Emergency Medicine	Unscheduled Care Demand	25	16	HIGH	8	HIGH	48	26/06/2017	25/01/2024

9 Principal Risks

Northern Health and Social Care Trust

Return to PRD Summary Report

ID	Opened	Lead Division	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Principal Objectives	New and Existing Controls	Assurances Internal (I) External ('E)	Gaps in controls and / or assurances	Actions to Close Gaps	Consequence (Target)	Likelihood (Target)	Rating (Target)	Risk level (target)	Date of Last Review
952	21/11/2017	Surgery & Clinical Services	In a number of Acute specialties there is a risk that patients' conditions will deteriorate whilst waiting for an outpatient appointment, diagnostic investigation or theatre based procedure. Outpatient specialties with long waiting times are ENT, Gastroenterology, General Surgery, Dermatology, Gynaecology, Rheumatology, Neurology. Womens Health Physiotherapy and OAS. Diagnostics areas include Endoscopy (GI & General Surgery), Radiology, Histopathology, Echocardiography and Hysteroscopy. Inpatient and Day Case areas are General Surgery, ENT, Gynaecology, Breast Surgery, Dental and Pain Management.	Major (4)	Almost Certain (5)	20	EXTREME	2 & 3	Establishment of virtual clinics to complement face to face clinics. Continued utilization of the independent sector providers. Alternative ways of assessment eg Photo triage for Dermatology, establishment of GAU (gynae assessment unit) to provide direct access to assessment and treatment for urgent gynae care or deterioration in conditions; Other new ways of working - Rheumatology - including improved patient pathways, enhanced communication with and information for patients and GPs. Risk stratification applied to specific specialities eg as using Qfit for GI and general surgery, low risk clinics for red flag breast. Prioritisation of IP/DC using FSSA - weekly meeting in Trust feeding into weekly meeting for region. Breast two weekly management meetings to assess demand and maximise capacity. Regional process for radiology to move longest waits to capacity across all Trusts. Weekly endoscopy meeting for maximizing capacity including backfill of all available endoscopy sessions. Maximising use of IP/DC theatre facilities in Causeway for general surgery, breast surgery, ENT, dental, gynae and pain procedures. Use of Day case facility in regional centre at Lagan Valley Hospital for ENT and general surgery procedures. Introduction and roll out of active clinical referral triage. Dermatology actively utilize IS to support management of gap in demand/ capacity this is managed centrally by NHSCT corporate performance team. Dermatology use photo triage system Rheumatology have commenced the introduction of active triage to optimise patient experience and best use of resources	Delivery of volumes identified in the recovery plan (I)(E). Monthly divisional performance review meetings and bi-monthly accountability reviews with Director of Operations and Director of Finance (I) Evidence of non chronological management ie seeing patients according to risk level rather than length of time waiting, in higher risk specialties (I) Maximisation of utilization of waiting list funding when it becomes available (I) Clinical risk raised at each of the HSCB/Trust service issues/Performance Review meetings to press need for investment (E) Waiting list money is starting to be made available for WLI and ISP activity. Increasing number of staffed theatre and endoscopy lists becoming available for surgical specialities Protocols in place for patients transferring to the Independent Sector for assessment and treatment.	1. Elective demand greater than pre covid levels in many specialties. 2. Still insufficient clinical capacity due to lack of funding in identified specialties. 3. Still no procurement framework to secure IS provider. Trust using existing contracts and direct award contracts (DACs) to access IS Providers. 4. Demand for unscheduled/emergency care at pre-Covid levels resulting in further pressures on clinical teams, inpatient beds, IP theatres. 5. No/ reduced allocation of waiting list initiative funding.	MEDICINE AND EMERGENCY MEDICINE SPECIFIC SERVICE ACTIONS NEUROLOGY - Update Neurology jan 23 - NHSCT meeting with SET 10th November to discuss if job plans for new post can be adjusted in any way to encourage recruitment and +/- discuss if any support can be added from SET. Meeting with BHSCT Director for Neurology 31st October to discuss current joint post. Current locum finished August no current plans for locum but plans to commence Jan 24 Update 25.01.24 - Working with SPPG due to no regional support to recruitment of consultant posts. Meeting with SET and BHSCT to ascertain if assistance available. Reinstatement of locum for 3 months. Review of current job plan. request to commissioner for neurology meeting March 24. RHEUMATOLOGY Rheumatology continues with active triage. DERMATOLOGY Update may 23 - ongoing SP work and discussion with SPPG re centralisation of waiting lists. Update July 23 - continues to see increasing demand- focus on red flag activity and regional agreement for 30 referrals per month across other Trusts with the exception of WHSCT. recruitment of consultant but will not commence post until 2024 due to fellowship opportunity. Using funding for additional middle grade support. No further change to update. update 25.01.24 - Dermatology demand continues to grow. Focus only on red flags. position deteriorating due to no waiting list funding. August 2023 - Dental - By the end of Q1 2023 Dental have 744 on the waiting list for assessment and 317 patients who are on the GA waiting list - a total of 1061 patients (which is a reduction of over 31%). Monthly referral rate for Q1 is on average 107 patients and capacity is approximately 104 cases per month. This is a significant improvement on previous but still places the service August 2023 - ENT - the number of adult patients being transferred out to IS per month for full pathway has reduced due to the urgent waiting time having significantly reduced. August 2023 - Gastro - remains same as previous update but no WLI in-house being undertaken as this was not identified as an in-house priority. August 2023 - Endoscopy - 20 patients per month are being transferred to IS. Alliance contract was extended from 1.7.23 until 31.12.23, plan is to treat 1653 patients during this period. WLI in-house continues with plan to treat 90 patients per month. In addition from September 2023 there will be regional capacity at LVH for 120 red flag new patients per month. August 2023 - Women's health physiotherapy - Risk remains although innovations to date have reduced the wait to 2 years and 7 months. August 2023 - Gynae services & hysteroscopy - Proactive work is ongoing with a focus to reduce gynaecology and hysteroscopy waiting times. Waiting list initiative funding continues to be utilised to maintain additional hysteroscopy lists against our funded core and to treat urgent patients in the independent sector. The recent reform of acute maternity services in the NHSCT has enabled the Consultant Obstetricians and Gynaecologists to split the previously joint rota. This will enable some avoidance of cancelled gynae lists for the Consultant of the Week in obstetrics and an ability to backfill lists which should see an improvement in performance, however some of this may be dependent on anaesthetic availability for inpatients and day cases. Referrals from primary care are also increasing and active triage continues. The appointment of the lead nurse for hysteroscopy has seen a positive impact in hysteroscopy waiting times, however funding for support staff has not yet been confirmed by SPPG. There is still a need to secure funding for the Gynae Assessment Unit in Antrim, outpatients with procedures (OPP) activity in the Meadows in Causeway and significant additional activity could be delivered in both the Meadows and the Eden Suite OPP facilities, (medical and nurse led), if funding was available. The Getting it Right First Time (GIRFT) regional review of gynaecology has made a number of recommendations to improve gynae performance both regionally and locally, however associated funding is required to realise these improvements. The introduction of pHPV screening for colposcopy will see a significant risk in referrals to the service. WLI funding has been made available to SPPG to address the immediate increase and regional discussions are on-going regarding recurrent funding for nurse led colposcopy services. Concern remains within the clinical teams regarding the 5% increase of clinical activity targets for 23/24 (against 2019 delivered activity) and the service continues to struggle to meet all targets. This is compounded by continued reduced theatre sessions compared to pre-pandemic allocations. August 2023 - Radiology - Radiology waiting times have continued to deteriorate. The Trust have recently been provided with additional funding to engage IS providers for urgent and RF CT and MRI during Q2 and Q3 – 2,080 MRI exams and 1,410 CT exams. We therefore anticipate a reduction in waiting times for RF and urgent categories in CT and MRI. Routine waiting times will continue to grow. August 2023 - Echo - WLI funding agreed until end of December for an additional 1050 scans. This is a reduction on previous WLI activity due to unavailability of locums. 1.0 WTE B7 post starting in August 23 which will assist increasing core capacity for planned Echo. Routine waiting time is 12 months. This will likely grow due to the reduction in WLI activity. Very limited capacity for routine patients.	Major (4)	Likely (4)	16	HIGH	25.01.2024

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Return to PRD Summary Report

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324	15/03/2011	Paediatrics, Women's Services & Corporate Support	Good infection prevention and control (IPC) practices and high standards of environmental cleanliness are essential to ensure that people who use the Trust services receive safe and effective care. Following the declaration of the Clostridium Difficile Outbreak in 2008, the Trust has worked to deliver a plan aligned with the Trust Infection Prevention and Control Strategy. The Strategy describes the key themes to support staff and the Trust in meeting the current and future demands for quality standards by minimising risk and integrating IPC into core business. However, despite these measures, the risk of increased incidence and outbreak of healthcare acquired organisms, which has the potential to disrupt services and cause an adverse outcome for patients and staff, remains. In addition WHO declared a global pandemic on 11/03/2020. The first presumptive case of COVID-19 was confirmed in Northern Ireland on 27/02/2020. Whilst community transmission has reduced we still have the potential for patients to be admitted following exposure to COVID-19 or may become positive after admission. There is an increased risk of outbreaks of COVID-19 where LFT/swabs are not taken as per procedure and LFT results are inaccurately interpreted / recorded leading to delays in isolation protocols for COVID-19 patients.	Major (4)	Likely (4)	16	HIGH	1	Application of policies and procedures - National IPC guidance implemented (including testing Review of policies, procedures and plans:- • Infection Prevention Control (IPC) Corporate Strategy reviewed 2021-2024 including IPC reporting structure with additional Bronze reporting structure when required. • Trust Cleaning Manual of cleaning procedures and advice on levels of cleaning required. • Access to Regional Infection Control Manual via Staffnet. • IPC Training Strategy and Delivery Plans for each Directorate / Division. IPC training available on new Learning Management System • Additional training for locum and agency medical and nursing staff where indicated. Training for block booking agency staff implemented and ongoing where possible Use of 'Fast Fact' information sheets for staff Safety Huddles Easy to use App for antimicrobial prescribing available for all prescribing staff Communication/education to staff and visitors regarding risk of Norovirus, Respiratory viruses.	CAS 2022/2023 score for IPC 96% (Replacement for these standards remains under review with the DoH) (I). Daily monitoring and reporting of confirmed HCAI cases (I). Mandatory reporting to PHA of C-Diff, MRSA Bacteraemia and Gram Negative Bacteraemia and monitoring against annual (PFA) targets (E) – rates higher than the expected trajectory for CDI (40 against target of 37) and MRSA (12 cases against target of 5) as at Jan 2024. 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 due to need for COVID-19 testing and results or availability of appropriate beds and isolation/cohort depending on IPC requirements. Safe Placement of augmented care patients is still an issue on Antrim site; inappropriate number of augmented care rooms. 2. Sustained demand for hospital and care home access 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. Antimicrobial Resource Kit (Ark) Project commenced November 2018. Medical Director and Lead Doctor for IPC to engage with Respiratory Medicine for some focused work to deal with antimicrobial stewardship. SAMHRHAI meetings have restarted, chaired by CMO. Regional update on AMS awaited. Pilot to commence in Surgery. 2. Re audit of ventilation using CO2 monitoring in Antrim and Causeway Hospitals completed. However identified improvements for some ward areas remain outstanding	Major (4)	Possible (3)	12	HIGH	24/01/2024	26/02/2020

IRAT admission and assessment tool for patients at risk of infection.
Regional guidance has been updated to no longer require those who are exposed to cases of COVID19 in the hospital to be cohorted and isolated. However, the Trust will continue to cohort and isolate these patients and where this is not possible due to unscheduled pressures, a risk assessment will be undertaken to prioritise cases for isolation
Operational and corporate dynamic risk assessments to manage positive results of COVID19/outbreaks HCAI and capacity issues.
Where children are admitted to hospital due to being very ill with COVID19. In these cases the parents are either also positive or are contacts. Parents will want to stay or visit their child; IPC risk assessments are completed on individual cases to reduce risk of spread of COVID19 where there are gaps in the national guidance for carers or parents who are contacts/positive.
Twice daily attendance at site Hub by IPC Nursing team to advice on safe patient placement.
CDI and Antimicrobial Stewardship ward rounds in Causeway Site and Antrim site.
On-call IPC and microbiology rota 7 day week/24 hour microbiology laboratory service.

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.

Electronic Laboratory and Antimicrobial Surveillance (LAMPS) systems to monitor alert organisms / antibiotic stewardship and compliance reporting (I).

Monitoring of compliance with Antimicrobial Policy and stewardship rounds. ARK Project commenced November 2018 (I). (Still in place)

Audit of CDI Management and Ribotyping of CDI (I).

Results of water testing (I).

4. Post infection reviews have shown that C-Diff cases are related to high antibiotic usage in the community. Additionally there is an observed increased incidence of gram negative bacteraemias.

5. 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.

6. Surveillance system required for IPC still outstanding No regional funding for system available; work ongoing to ensure encompass meets needs of IPC/surveillance purposes.

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. Process to be established for divisional review of incidents relating to LFD testing and onward reporting to IPECHC. Divisions to report progress on recent incidents to IPCECH. No incidents identified or reported to date.

Daily attendance by IPCN's at both Antrim and Causeway Site Safety meetings to report current status and highlight any IPC risks.
IPC Link Nurse and Link Worker system Trust-wide
Highly visible IPC Nurse presence in all in-patient clinical settings, auditing, monitoring and challenging any poor practice.
Intensive cleaning programme by Rapid Response Teams in Acute and Community facilities.
Level 2 cleaning team in AAH developed during winter pressures has been maintained.
Programme of leadership walkabouts to identify and address estates and cleaning issues have recommenced within acute sites
Water testing for Legionella and Pseudomonas as per Water Safety Plan/Policy.
IPC involvement and guidance in new builds and refurbishments.
The Trust is working with BSO Pals to ensure there is a stable supply of masks and PPE
Health care worker and patient testing for COVID 19 with subsequent contact tracing.
Implementation of revised testing guidance and PPE in place (March 2023).
Training videos on LFT are available and competencies must be completed by staff. Written process for completing a swab also provided to staff. LFT Training pack available and provided to staff. All positive LFD tests must be followed up with a PCR test to confirm results.
Revised schedule of Post Infection Reviews at strategic level agreed. Incident Management Teams to help assess actions and learning acquired from outbreaks.
Post Infection Review Process for all Staph Aureus bacteraemia and C diff.
Outbreak control meetings held when required and updates communicated to PHA; meetings chaired by IPC Doctor.or Assistant Director of IPC
Nosocomial death review panel established and chaired by Medical Director; Assistant Director IPC attends to provide information on COVID status throughout patient journey

Augmented Care Group meetings held with clinical staff to ensure training and competencies of staff in these high risk areas.
Self-assessment of IPC in Neo-natal Unit and Intensive Care Unit as per RQIA recommendations.
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.
PPE group review of supply and monitoring of FIT testing compliance levels and any variances identified in Trust
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.

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 new COVID regional dashboard (E) under review at present by PHA

Trust IPC Covid-19 Contact tracing database (I)

Internal audit report of infection control reporting and assurance to Trust Board - Satisfactory assurance level (Sept 2022) (I)

IPCN Ward/facility visit reports.

No incidents relating to LFD testing identified or reported.

7. There is no coded field on NIECR to record test results. Results are recorded as free text in the COVID Specialty area of the Progress Notes.

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1049	28/08/2019	Mental Health, Learning Disability & Community Wellbeing	The Department of Health, requires H&SC Trusts to proceed with a partial implementation of the Mental Capacity Act (NI) 2016 (MCA) for the purpose of providing a statutory framework for the Deprivation of Liberty from the 02nd December 2019 with full implementation by December 2020. The NHSCT have been unable to fully implement MCA and as a result the following risks exist. 1a. Failure in the implementation of MCA arrangements would impact adversely on performance and consequently patient safety and care. 1b. There is a further financial risk given the gap between the funding identified for this regionally and the Trust's preliminary cost estimates 1c. Criminal liability offences within section 269 came into force on 31 May 2021. There is therefore a Corporate Risk for the Trust and personal risk to staff as failure to comply with Sections of the Act could result in prosecution of staff or claims for damages against the Trust for illegally depriving of their liberty. 1d. There is a reputational risk to the Trust due to the possible breach of Article 6 (Human Rights) legislation.	Major (4)	Likely (4)	16	HIGH	1, 2, 3, 4 & 5	1a.MCA Programme Board established, chaired by the Director of Mental Health, Learning Disability and Corporate Wellbeing (MHLDCW) with representatives from all relevant Divisions to support the effective implementation of the MCA and to promote and inform best practice. Trust engaged with regional arrangements to share practice and develop agreed solutions to the implementation of the MCA in both the short and medium term. Initial scoping exercise updated to identify the numbers of service users subjected to DOLs who need to be presented to panel, as well as a projection of new applications per year. Governance arrangements developed to inform decisions and recording processes. Action plans developed for all relevant Divisions. 1b.Financial Oversight of MCA spend, both recurrent and additional spend. Monitoring by Internal Audit Ongoing recruitment of retired medical and non medical staff to carry out the tasks including assessments, extensions and Panel work Staff training made available. 1c.The Trust has established structures and arrangements to ensure compliance with the MCA. B7 DLS solicitor provides assurance re meeting legal thresholds for Review Tribunal cases. QA process of all information prior to being shared within and outside of Trust Emergency Provisions Process within MCA legislation. 1d.MCA Programme Board established and governance arrangements and structures developed to ensure compliance with the MCA. Monitoring of All risks associated with MCA under the Trust Risk Management process	The Trust is engaging with regional arrangements established to share practice and develop agreed solutions to the implementation of the MCA both short term and medium term. These include: • an overall regional group comprising the director leads identified in each Trust, an Information T&F group, a Business Case T&F group and HR T&F group. • NHSCT co-chairs a Regional Multi-Agency MCA Implementation Group with the Office of the Attorney General NI (NIOAG). Membership includes NIOAG, The Review Tribunal (RT), DoH, DLS, all Trusts and RQIA. • The Trust led Regional Workshops along with DoH, with representation from other Trusts and other agencies / stakeholders to share and agree a consistent approach / processes. The Trust achieved full compliance with the completion of DoLs for all identified legacy cases by 31 May 2021. Learning continues to be shared throughout the process. The RQIA have advised the Trust of their intention to undertake a monitoring role during implementation to assure that robust arrangements are in place for the MCA implementation. Training is monitored and reviewed by Service Managers with oversight from MCA Governance Lead.. Plans are in place for the completion of extensions– this will be monitored on a monthly basis - there have been 3 breaches to date. Where possible staff will continue to work to maintain this level of compliance.	Criminal liability offences within section 269 came into force on 31 May 2021. Trusts could be facing corporate liability proceedings and Trust staff at various levels could be facing criminal proceedings for any service user deprived of their liberty who is not detained in accordance with the MCA or other relevant statute. A scoping of all day care facilities has commenced. There were a significant number of DoLs required, and these should be completed by end of September 2022. A ruling in a recent appeal case from the Special Educational Needs & Disability Tribunal (SENDIST) to the High Court stated that Trusts are responsible for the completion of DoLs for young people attending educational settings where they are deprived of their Liberty. This will have a significant impact on Children's Services. The time required to complete the forms, provide further information including a Statement under Rule 6 as directed by the RT,and possibly present evidence at Oral hearings, is much greater than initially anticipated, and is having a major impact operationally across the Trust. There may not be a sufficient Medical resource to complete the required extension authorisations over the coming months. Three of the other Trusts are now recruiting medical staff at the higher tariff rate than regionally agreed £200. This will challenge the NHSCT medical supply. Discussions in regards to Inter-trust working for ASW and Medical staff are ongoing, however no agreement has been reached Extension authorisations will be prioritised over the coming months and therefore there will be a delay in completion of medical reports for new applications. The 4th surge of the Covid pandemic continues to have a major impact operationally and is further reducing the capacity to complete MCA assessments / reports. There is an ongoing shortage of staff, particularly nursing and social work staff, across all divisions. Staff are required to provide operational cover across services for staff absences due to Covid. A Local Enhanced Service arrangement (LES) with GPs has been offered by HSCB to be put in place with Trusts seeking this option. Response to date indicates that only 2 GP practices within NHSCT area are prepared to take up the LES and neither of these practices have complete the required training There is a significant disparity in the number of cases estimated by the DoH and the number of cases estimated by the Trust (and evidenced throughout the test period and initial months of implementation) that will require referral to the Review Tribunal (RT) via the Attorney General's Office. The default position of the RT will be to hear cases on paper; however it is possible that they may require an oral hearing following a review of the papers. There are currently approximately 35-40 Statements under Rule 6 required in a monthly period, with an increase in requests for oral hearings having been experienced over the last few months. The Trust has been unable to permanently recruit sufficient additional staff to undertake the assessments and complete applications because the funding is not yet recurrent. There is a gap between funding available and the full costs required to cover activity.	There is a significant disparity in the number of cases estimated by the DoH and the number of cases estimated by the Trust (and evidenced throughout the test period and initial months of implementation) that will require referral to the Review Tribunal (RT) via the Attorney General's Office. The default position of the RT will be to hear cases on paper; however it is possible that they may require an oral hearing following a review of the papers. There are currently approximately 35-40 Statements under Rule 6 required in a monthly period, with an increase in requests for oral hearings having been experienced over the last few months. The Trust has been unable to permanently recruit sufficient additional staff to undertake the assessments and complete applications because the funding is not yet recurrent. There is a gap between funding available and the full costs required to cover activity. Extension authorisations will be prioritised over the coming months, monitored on a monthly basis And therefore there will be a delay in completion of medical reports for new applications. There may not be a sufficient Medical resource to complete the required extension authorisations. Three of the other Trusts are now recruiting medical staff at the higher tariff rate than regionally agreed £200. This will challenge the NHSCT medical supply. Discussions in regards to Inter-trust working for ASW and Medical staff are ongoing, however no agreement has been reached. There are currently approximately 35-40 cases listed for hearing by the Review Tribunal in a monthly period requiring a Statement under Rule 6. This new activity has been considered within the IPT. Bank staff who were previously completing these statements are now required to complete extension authorisations and therefore these are currently being completed by the services Work is underway to develop a training plan / guidance document for acute wards within the Holywell site. This is in the initial stages, however engagement with all staff groups represented at MDT level is underway. Addition of MCA training at relevant levels remains outstanding on mandatory training matrix – this is a regional issue Update July 2023 - Policy has been signed off regionally, now waiting to be approved through NHSCT policy group. A spot check of financial management, DoLs and monitoring / review arrangements is being taken forward by the Trust Care Management Group. A cycle of audits is currently being reviewed by the Trust Care Management Steering Group. Training materials are now available to all staff via Pagetiger which can be accessed either via Staffnet or QR code scan. This has been circulated widely and feedback has been positive Trust training is now being recorded on HRPTS. There is no update on a system to collate DoH training on the HRPTS system, and this training log is maintained locally within teams. Scoping is completed on a monthly basis to capture e-learning activity within teams, and is added to HRPTS. Update Nov 2023 - Policy has been approved by NHSCT Policy Group. The MCA service has developed new systems via MS teams and the MCA database which have decreased significantly the amount of time staff have to spend preparing to complete extensions. There has also been a review of the reports to be completed for the RT and this is also now streamlined meaning improved timescales for reports to be completed. MCA Service has been able to recruit additional sessional medics, with pressures reduced as consequence Update Feb 2024: *Medics* – The Trust have recruited a number of bank medics who assist in	Major (4)	Possible (3)	12	HIGH	05/02/2024	03/12/2019

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780	16/01/2015	Paediatrics, Women's Services & Corporate Support	There are incidents of non-compliance with regional guidance of safe nurse staffing levels in accordance with Delivering Care Policy. Current system does not provide robust assurance of safe staffing levels. There is a National shortage of registrants leading to vacancies both temporary and permanent. Ongoing challenges with centralised recruitment processes creates undue delay in filling vacancies in a timely manner. Vacancies have led to added pressure points within nursing teams, leading to sickness absence and retention of existing staff. This consequently leads to the increased use of bank/agency nurses with associated increased cost and reduced continuity of care.	Major (4)	Likely (4)	16	HIGH	1, 2 & 3	**Recruitment** • Use of Data to inform the targeting of recruitment and to monitor the level of substantive Nurse hours in each division • Robust targeted rolling recruitment programme of registered nurses and non-registered staff is ongoing with prioritisation of frontline staff. Bi-Monthly Rolling adverts for B5 and quarterly rolling advert for B3 and B2. Face to face and virtual interviews being held with immediate job offers made. • Investment in photography and videography has been undertaken to support recruitment activities. Social media posts shared on Trust platforms each month promoting areas with critical vacancies identified by Divisional nurse • Trust internal processes streamlined to expedite vacant nursing posts to Shared Services. • Processes improved and applied to validate the Current Band 5 waiting lists within the Trust and maximise recruitment • Robust on-boarding of new recruits with regular contact from operational teams to prevent attrition • All recruitment opportunities exploited including career fairs, local and national University Liaison. OU roadshows to promote this training route. Students who wish to work in Northern Trust have been allocated permanent posts on completion of registration and have been invited to join nurse bank. • Regional processes to recruit students have been streamlined and further improved. AD Workforce, Learning & Regulation , NHSCT is the regional Chair • Regional International Nurse Recruitment contract has been signed off with one agency supporting the recruitment activity. Additional regional funding secured to increase International Nurse Recruitment to end of 2024. The arrival numbers have been reduced back to 2 nurses every other month MH International Nurse Recruitment has commenced with NHSCT accepting 2 nurses every other month. • International Nurse Recruitment numbers are regularly reviewed with Divisional Nurses and current number of vacancies. **Delivering care safe staffing** • Agency and bank staff supplementing core staffing to manage ongoing service pressures • Monitoring of compliance with Professional Assurance Framework in order to identify deviations from the expected professional norm • Central coordination of nursing resource during periods of high volume activity • Individual ward safety brief meeting and a site meeting are carried out every morning • SQE app auditing safe staffing level pilot in surgical wards • E-rostering tips information sheet and face to face E-rostering education sessions with input from finance department currently being piloted in surgical wards **Development / Retention of Staff** • Training and induction programmes for registered nurses and HCA staff developed and co-ordinated by PEF team • Preceptorship model continued for new registrants in their first 6 months. New regional preceptorship model has been implemented in Trust. • Promotion of Secondments through virtual roadshows to encourage application to the Open University (OU) Nursing Programme for Band 3 staff. • Internal Transfer policy operational to facilitate / enable the retention of Nursing staff. • Future Nurse Future Midwife standards and proficiencies implemented • Consultant and Advanced Nurse Practitioner roles promoted and supported through delivering care funding • Post Reg Training and Development Commissioning plan for September 2024 finalised with named nurses committed to modules, short courses and specialist practice qualifications shared with the universities. • • Funding provided for 5 months from DoH until March 24 to support newly qualified nurses and internationally education nurses new to the Trust. A workforce clinical facilitator (1 WTE) and 2 workforce clinical educators are in post (1.5 WTE) **Nurse Bank / Agency Staff** • Monitoring of agency use continues and is reported regionally and through Trust Utilisation Group • New nurse agency framework has been approved and implemented on 15 May 23 • Managers toolkit developed to raise awareness of new regional agency framework and the process for obtaining additional staff through the bank office	**Recruitment** • Fortnightly reporting of current vacancies and stage of recruitment of staff progressing from conditional offers (I) • Monitoring of regional allocation of international nurses and arrivals (I) • Monitoring of recruitment timeline from e-requisition raised to appointment of staff member (I). • Nursing Workforce works closely with local HR Resourcing Lead and department and also BSO RSSC **Delivering care safe staffing** • Ward Quality Indicator Nursing Toolkit ensuring daily reporting of staffing levels in site co-ordination report • Report of unfilled nursing shifts and levels of bank/agency fill escalated within divisions • Twice weekly staffing reports requested from divisions to outline unfilled shifts and monitor skill mix • Monthly monitoring of staffing levels against agreed levels (I). Updates provided by Divisional Nurse regarding staffing levels and concerns • Triangulation and close monitoring of trends / concerns in relation to clinical incidents / Key Performance Indicators (KPIs) with staffing / vacancies (I). • Work ongoing to review safe staffing levels using workforce tools (I) by Nursing Workforce team. Divisional workforce clinics have been set up by the Safe Staffing Lead Nurse who will formulate action plans to assist in highlighting trends and support required **Development / Retention of Staff** • Nursing workforce AD is member NMTG Theme Two **Nurse Bank / Agency Staff** • Monitoring of block booking deployments within Nursing Governance (I). • Daily Monitoring of bank/agency fill rates (I) • Weekly and monthly review of agency usage	**Recruitment** • There is a national shortage of nurses. leading to vacancies both temporary and permanent • There is a 7.3% (January 24) vacancy rate in Band 5 nurses and midwives. - Good intake of newly qualified nurses secured in Sept/Oct 23 which has supported a reduction in vacancies. • Ongoing corporate recruitment and bespoke recruitment campaigns have limited reach as opposed to recruitment through specialised recruitment agencies. • There is currently only one agency supporting the recruitment activity on the Regional International Nurse Recruitment contract for Adult internationally educated nurses (IENs). There are currently 5 agencies supporting the recruitment of MH IENs • 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 besoke support provided **Delivering care safe staffing** • There are incidents of non-compliance with regional guidance of safe nurse staffing levels in accordance with Delivering Care Policy. Current system does not provide robust assurance of safe staffing levels. • There is a low level of specialist ward areas within both acute sites resulting in 1:3 nurse:bed ratio only in the majority of areas. • Review of Phase 1 paused as under review by CNO. Regional group established to review and refresh delivering care. **Development / Retention of Staff** • Vacancies 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 **Nurse Bank / Agency Staff** • The number of Nurse vacancies will impact on the continued use of nursing agency workers from new contract framework • Nurse Bank is not available Sat & Sun normally but there is a limited service to provide support during winter pressures • 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.	**Recruitment** • Discussions have commenced with CNO office regarding the potential for a National Recruitment Campaign • Work is ongoing with regional Student Streamlining Group to further improve recruitment processes • Regional discussions with other international agencies to support International Nurse Recruitment contract ongoing. Regional group established to initiate recruits into mental health areas and to complete MH OSCE, first arrivals to NHSCT were in Nov 23. Challenges regarding attraction of MH IENs to NI more agencies have been brought on board, now working with 5 agencies. **Delivering care safe staffing** • Normative staffing levels have been established for each acute ward. Regional rebasing exercise commenced Nov 22 • Review of Delivering Care under review by CNO – phases paused. Group established to lead on the refresh of delivering care model. Group chaired by eDON from Northern Trust. • Work commenced to review nurse utilisation and staffing in designated acute wards • Exploration of options commenced to enable overview of safe staffing levels across sites SQE app now approved and being piloted in surgical wards. Results are to be analysed. • Developing E-rostering tips information sheet and face to face E-rostering education sessions with input from finance department currently being piloted in surgical wards **Development / Retention of Staff** • 2024 Education Commissioning Cycle has completed with first scoping exercise completed. Regional work to ensure the three categories are addressed; maintaining current services, educate the workforce with skills to ensure they can adapt to the transformation of services and provide continuous professional development. • Currently developing a proposal for a nurse and midwife toolkit to support succession planning **Nurse Bank / Agency Staff** • Work has commenced to review Agency spend and support a reduction to stabilise and strengthen nursing teams • Leadership Centre review of Nurse Bank is now complete. Business case submitted to Finance. Regional group established to look at Regional Bank Reform	Major (4)	Possible (3)	12	HIGH	23/01/2024	27/02/2020

Northern Health and Social Care Trust

PRD Summary Report'!A1

ID	Opened	Lead Division	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Principal Objectives	New and Existing Controls	Assurances Internal (I) External ('E)	Gaps in controls and / or assurances	Actions to Close Gaps	Consequence (Target)	Likelihood (Target)	Rating (Target)	Risk level (Target)	Date of Last Review	Date current rating changed
905	26/06/2017	Medicine & Emergency Medicine	Unscheduled care is facing significant demands with increasing ED attendances, patient acuity and significant limitations in hospital flow. The situation is further impacted by a general reduction in system capacity which is resulting in unacceptable delays in the ED departments. This is exacerbated with the continued pressures of managing within COVID -19 guidelines and restrictions mainly in relation to Infection Prevention and Control which has led to reduced capacity within the acute, overcrowding emergency department, community and Independent sectors further reducing bed and service availability. The delays seen in the ED departments are related to system wide issues across the whole patient journey, through the secondary care system and in managing safe, effective discharge particularly for those who require onward care arrangements. Whilst this issue is not unique to NHSCT, changes made in other Trusts or services in response to pandemic management has also impacted on NHSCT demand.	Major (4)	Likely (4)	16	HIGH	1	The controls described below reflect a part of the normal operational management of hospital and community services: Site co-ordination model in place on both sites to maximise flow of patients. Full capacity and escalation plan in place 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. NIAS service improvement Focused medical model with emphasis on senior decision making. Active recruitment for medical and nursing vacancies. Regional Group looking at incentivization for bank staff and use of non-contracted agency. NB: Covid payments now ceased As of 02.05.22 Regional task and finish group established to develop strategic commissioning direction across all Trusts for neurology services. COVID Surge plans revisited, changes to swabbing as per IPC guidelines. Update of Major incident plan to incorporate full capacity protocol. Update sessions have taken place with a desktop exercise carried out with Senior Team.	Hospital Early Warning Score text and email alerts as required in response to site escalation (AAH only) (I). Attainment of 48 hour complex discharge target (I). Daily report from Site Co-ordination Model (AAH and CAU) (I).	1 - Recognised deficit in bed capacity on the AAH site. This has been compounded by COVID 19 infection control processes and protocols making placement of patients more complex whilst Covid19 swabbing requests have reduced still require swabbing availability. Delayed community discharges are contributing to the demands on the unscheduled care flows. Reduced availability of domiciliary care, Covid and exposed to covid pathways are challenging to secure at times of increased incidence . Significant delays with patients who require close supervision or display challenging behaviours. Site coordination model continues with extreme focus on discharge pathways. Community escalation meetings in place to encourage coordinated response. 48 beds additionality now in place A6 and A7. Re-modelling of Acute wards to improve flow carried out. 2- Over dependence on locums and agency staff. 3 - Reduction in the allocation of F1s and F2s to NHSCT. Ongoing recruitment for junior medical staff continue however this is an ongoing situation with recruitment issues. 4 - Reduction in the attainment of the 48 hour discharge target; impacted by the availability of community placement which is dependent on patient need. Overall Trust wide pathways group chaired by Director of ops. 5- Absence of ACAH (Acute Care at Home) outreach model in the NHSCT area. Ongoing efforts made through anticipatory care to create additional support to nursing homes. This is a community lead workstream 6- Reduction in the number of nursing home placements across the NHSCT area. This issue has again be further exacerbated by COVID 19 complexities of patient placement. This is a community led workstream Increase in number of patients needing enhanced care. 7 - Inability to sufficiently expand Domiciliary Care. This is a community workstream under renewing our vision. 8 - Non availability of HALO over 7 day period to provide site link with NIAS service improvement plan in place with NIAS to improve handover and flow although reduced during periods of leave. 9 - NIAS demand not based on sites capacity. 11 - patient delays increasing with patients requiring inpatient MH beds, both at ward level and ED. A prioritisation tool has been implemented by Mental Health team and acute link via MHLS 12 - ongoing liaison with BHSCT re: fracture delays, both at ward level and ED. This was identified as part of learning from a major incident	1 - Recognised deficit in bed capacity on the AAH site. This has been compounded by COVID 19 infection control processes and protocols making placement of patients still more complex as respiratory candidates still need ruled out as Covid 19. This still requires additional isolation space for patients. ED minors remains displaced to ambulatory corridor on Bfloor but RESET to ED being planned . Ambulatory area Direct Assessment Unit/ PTU frequently being used at times of pressure to house inpatients. Reduced availability of domiciliary care, Covid and exposed to covid pathways are challenging to secure. Significant delays with patients who require close supervision or display challenging behaviours. Increase in patients requiring High cost placements and therefore associated increase in acute hospital delays 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. Business case submitted to SPPG for roles of Lead trusted Assessor and trusted Assessor (temporary until end of year). 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 2- Over dependence on locums and agency staff. Additional ED consultants recruited. Risk continues as over dependency at junior grades due to NIMDTA gaps and limitations of recruiting to permanent posts. (please refer to principle risk 2 regarding nursing workforce) 3- Absence of ACAH (Acute Care at Home) outreach model in the NHSCT area. Ongoing efforts made through anticipatory care to create additional support to nursing homes. This is a community lead workstream 4- Reduction in the number of nursing home placements across the NHSCT area. This issue has again be further exacerbated by COVID 19 complexities of patient placement. This is a community led workstream 5 - Inability to sufficiently expand Domiciliary Care. This is a community workstream. 6 - Non availability of HALO over 7 day period. 7- Impact of Mater hospital change in profile. BT36 now belfast catchment. NIAS however continue to send increased numbers to Antrim. 8 - patient delays increasing with patients requiring inpatient MH beds, both at ward level and ED. - establishment of interface group with MH team and a prioritisation tool to manage clinical risk by Mental Health Team. 9 - ongoing liaison with BHSCT re: fracture delays, both at ward level and ED. Regional work commenced on whiteboard visibility for fracture delays however no recent update. This pathway was point of major incident learning Nov 22.	Major (4)	Unlikely (2)	8	HIGH	25/01/2024	21/02/2020

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67	31/05/2008	Strategic Planning, Performance and ICT	The Trust has challenges in achieving the required levels of Information Governance (IG). There is a risk to the safe protection of service user information and the Trust's reputation. There is a secondary risk of regulatory action by the Information Commissioner's Office (ICO).	Major (4)	Likely (4)	16	HIGH	1 & 3	1. Information Governance Management Framework in place (Information Governance Forum, Senior Information Risk Officer, Personal Data Guardian, Assurance policies, structures and an IG Action Plan). 2. Processing Personal Information Policy and Procedures, supported by departmental procedures as required. 3. Mandatory Training at various levels. 4. Underachievement of IG and POPI mandatory training is escalated to and reviewed at Accountability meetings. 5. Awareness materials for public and staff. 6. High level of expertise and robust processes in IG Department. 7. Divisional Action Plans are a standing agenda item on Directorate Accountability meetings and IG figures are included in the Divisional Scorecards to monitor compliance. 8. Trust IG Action Plan developed with key priorities for the IG work programme.	1. Quarterly senior team monitoring of IG, POPI and ICT security training compliance and it is raised at Divisional Accountability Reviews and forms part of the Performance Report at Trust Board (I). 2. Incidents and complaints are reviewed routinely at IG Forum (I). 3. The Information Management Assurance Checklist (IMAC) has been reported as compliant for 2023/24(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).	1. Compliance with mandatory training for Trust staff as at 31st December 2023, was 86% for IG Awareness and 81% for POPI. Cyber Security was 81%. A Senior Executive Team target of 85% remains in place. 2. The number of IG incidents reported during the quarter ended December 2023 was 72. There are currently no incidents with the ICO for review. 3. Learning from IG incidents continues to be identified and shared but there is a continuing requirement to further embed this practice and evidence the actions taken. 4. There were 3 IG related complaints received during the quarter ended 31st December 2023. All existing assets (625) on the Information Asset Register have had risk assessments completed and new assets are subject to the DPIA process. 6. There is a need for the Trust to set out Strategic Plan for Records Management. Investment may be required to support this plan including undertaking a review of paper records storage. This will enable the Trust to verify the accuracy of the Information Asset Register, update Risk Assessments and devise a Risk Management Plan. Strategic records management will now be monitored via IG Forum, with a Trust RM Operational Group being established to develop and deliver on a range of RM related tasks . 7. Current compliance with requests for information under DPA is 80% (for standard 30 day requests) and 81% for FOI requests as at quarter end December 2023(previous qtr compliance was 80% DPA and 78% FOI). Complex DPA requests (90 days) compliance as at end of December 2023 decreased to 78% (decrease of 4%).	1. The IG Department is providing regular reports to Divisional IAOs on IG incidents which identify incident hot spots / trends and any learning or actions that can be shared. A quarterly IG Incident Analysis Report is tabled for review at IG Forum meetings and corporate actions agreed to minimise or mitigate IG related risk. 2. All existing information assets on the IAR have had a risk assessment completed. New information assets are subject to a DPIA. 3. Progress in respect of the Trust's IG Improvement Plan is monitored and reviewed by IG Forum. The priorities inform the Divisional IG Action Plans. 4. Work is ongoing on in developing a Records Management Strategy, which will identify a number of mid to long-term actions to be undertaken within the Trust. Strategic records management is now monitored via IG Forum. The HSCR Committee has been stood down and an RM Operational Group has been established. A ToR has been developed and delivery of a short-term action plan (approx 6 months duration) was concluded by 31st March 2023. A longer term RM Strategy and Action Plan is in development for April 2023/March 2024. 5. Compliance with information requests remain challenging. Legislative compliance is 100% with the relevant timescales. Trust compliance as at 31st December 2023 is 80% for DPA (for standard 30 day requests) and FOI 81%. Complex DPA requests (90 days) compliance as at end of December 2023 has decreased to 78% (a decrease of 4%). Services are under pressure to respond to requests for personal information due to competing priorities of service delivery and limited capacity to undertake the tasks required to process SARs. Main areas of challenge are CYP Division. CYP have introduced a centralised Divisional process (for the majority of SAR requests) and have identified some additional resource to undertake SAR related tasks as overtime where possible. A proposal which was approved by Trust Clinical Council to remove the need for Consultant sign off for the majority of acute related Subject Access Requests has been implemented. Divisional level reporting has been implemented for FOIs and this is to be introduced for DPA requests. The implementation of a new Requests Case Management solution for SAR requests (previously implemented for FOI requests) continues to contribute to improved and efficiency of request related tasks. 6. The IG Department is supporting Divisions participating in tendering processes with data flow mapping exercises and completion of DPIAs to inform tender specifications and reflect these 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 GDPR requirements.	Moderate (3)	Possible (3)	9	MEDIUM	23/01/2024	17/05/2019

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											8. GDPR came into force on 25 May 2018 along with the new Data Protection Act 2018. A GDPR Implementation Action Plan was prepared and all actions have been addressed; however the work in relation to contracts is ongoing - this was identified as a P2 recommendation by Internal Audit and the action in respect of this has now been completed. Any new service procurement or system implementation that includes the processing of personal information is subject to the DPIA process and ICT Security review to prior to commencement to ensure all risks have been identified, controls implemented to mitigate/minimise including the appropriate underpinning GDPR compliant documentation (e.g. contract/DSA/MoUs etc.)	7. All information governance policies have now been updated and approved in line with the Policy Framework process. 8. The increase in the number of staff Homeworking due to the current climate has been identified as an additional risk factor. The Trust has put in place a number of measures to reduce this e.g. Trust Policy on Flexible Working, Guidelines on Homeworking, IG Newsletter with a Homeworking section and a Broadcast email highlighting the outlining the key IG considerations when required to undertake Homeworking. 9. A communication plan to raise awareness with staff and highlight good information governance practice is in place, which consists of targeted messages via Broadcast emails, IG Newsletters, Screensavers, content in Core Brief, with the objective of reducing IG incidents.						
											9. Progress against the Trust's IG Action Plan is monitored and reviewed by Information Governance Forum on a quarterly basis. 10. The Trust's main off-site records storage supplier (Iron Mountain) is no longer on the regional Framework. 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 July 2025. 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						
												14. In August 2023 BSO Internal Audit concluded an audit on Management of Medical Records. The audit was rated "Satisfactory" with 6 recommendations identified - 4 Priority 2s and 2 Priority 3s, with only 1 remaining Priority 2 (which is in relation to contracts with Off-site storage providers) to be implemented by 30/4/2024.						

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851	19/05/2016	Paediatrics, Women's Services & Corporate Support	There is a risk of choking on food by patients / clients diagnosed with dysphagia or with suspected dysphagia. (There are also risks re deteriorating health eg due to aspiration pneumonia / malnutrition or dehydration)	Major (4)	Likely (4)	16	HIGH	1 & 3	**Assessment** • HSCB have previously completed capacity demand analysis which indicates a capacity shortfall of 4 band 6 SLTs to meet ongoing demand. These posts have been advertised as band 5/6 training posts. All posts are now filled and the post holders have recently completed dysphagia competencies to enable them to independently assess and treat dysphagia. • Monitoring of vacancies and active recruitment of professional staff in SLT to minimise gaps in the availability of SLT in adult teams. • Waiting list times for SLT assessment / review are monitored. Longest waits are slowly reducing. A regional dysphagia waiting times dashboard is now available. **Risk Management** • Multidisciplinary discussion on case by case basis for high risk service users, including liaison with DLS if necessary. • Risk Management checklist for patients / clients who do not wish to eat commercially prepared texture modified meals to enable provision of alternative texture modified meal. Snack lists for hospital and community agreed and available on Staffnet at different IDDSI levels. • PHA has established the Regional Multi-disciplinary and Multi-agency Adult Dysphagia Group (Dysphagia NI) to action the recommendations within the SQR-SAI-2021-075, May 2022 RQIA review, the PHA Choking Improvement Plan and the PHA Thematic Review of Choking on Food. A sub group of this working group has guided the introduction of standardised International Dysphagia Diet Descriptors initiative (IDDSI). • The well-established, Trust wide, cross divisional Dysphagia Group, have developed an action plan to ensure the SQR, RQIA and NCEPOD key learning recommendations are addressed within adult and paediatric services. The groups meets bi-monthly. • Trust Dysphagia Support Team. (2.0 WTE currently funded) to progress the recommendations from the SQR letter, RQIA Review (May 2022), NCEPOD, 10,000 Voices, the PHA choking improvement plan and the Thematic Review. It has recently been confirmed there will be recurrent funding of 139k from April 2024 • Implementation of the Dysphagia Management and Choking Reduction Policy (Adults) which has been revised and reissued in June 2021 to strengthen the recommendations in the SQR/SAI/2021/075. • The Paediatric Dysphagia Management and Choking Risk Reduction Policy has been revised to include the SQR key learning recommendations and approved in July 2022. • A range of new NHSCT resources (developed by the Dysphagia Support Team in conjunction with the Trust Dysphagia Group) have been rolled out across divisions and have been shared with agencies in November 2021. These resources include a staff booklet, posters and A5 swallow aware 'fast facts' card which highlight the key recommendations from SQR-SAI-2021-075 and learning from local incidents to support staff. New, visual IDDSI food / fluid level posters have been distributed • The regional Mealtimes Matter audit tool was implemented across all settings apart from Homecare and Supported Living, who have access to bespoke dysphagia audit tools. • A learning letter (including a complaints template) has been shared through divisions re the process for raising concerns regarding the consistency of the ready-prepared meals for special texture modified diets. • 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. • The Dysphagia Information staff booklet for staff working with adults with eating, drinking and swallowing difficulties was revised in November 2021 and is available to home care staff. • The food and drink safety pause was rolled out across all acute hospital settings (including mental health inpatient settings) on 01/04/2022, community care settings on 01/07/2022 and within Homecare in September 2022. The regionally agreed Mealtimes Matter Audit is currently undertaken each month across all areas to provide assurance re: safety pause implementation. • In June 2022, adult SLT teams began to add an NIECR swallow 'alert' for services users with a known diagnosis of dysphagia. Uploading of the REDS documents to a regionally agreed location on NIECR began in May 2023 to assist other staff to identify presence of dysphagia. This is available for staff with NIECR access to view and print, if required. **Staff Training Programme** • Training Needs Analysis completed for social care staff in Mental Health / Learning Disability in community settings. • Trust Exec team have endorsed that dysphagia training will be a mandatory requirement for all staff providing care or services to adults who are at risk of dysphagia. This includes the line managers of these staff groups and catering and support services staff. • Trust Dysphagia Group has developed a training matrix including mandatory dysphagia awareness training for defined staff groups. • Trust Dysphagia Group has developed a training matrix including mandatory dysphagia awareness training for defined staff groups. • Monitoring of education uptake by Lead Nurses / Team Leads. Divisions are able to access training completion reports from the Trust Dysphagia Group shared folder. • The SPPG / PHA led Dysphagia NI has endorsed a regional PHE dysphagia awareness E-Learning programme which is available on the HSC learning platform to HSC staff and to staff in independent care sector. 4130 NHSCT staff have completed the dysphagia e-learning programme to date. • The Adult Speech and Language Therapy Team continue to provide monthly live dysphagia awareness training sessions via MS Teams to NHSCT and IS staff. Between January 2023 and December 2023 this training was delivered to 266 NHSCT Staff and 109 IS staff • Between January 2023 and December 2023 the Dysphagia Support team has provided dysphagia awareness training to a further 464 Trust and 76 IS staff. • Training of Homecare workers to be kept under review by relevant managers • A programme of refresher dysphagia training for all homecare staff, delivered jointly by SLT and Dysphagia Support Team, commenced in October 22. To date 828 Homecare staff have been trained. This programme continues throughout 2023/24. • The Trust Dysphagia Support Team continue to provide additional training capacity and respond to bespoke requests for training. • A Dashboard had been developed to assist in monitoring compliance with Dysphagia Training. Quarterly training completion reports now available and saved on the Trust Dysphagia Group shared drive	• NHSCT are compliant with the direction to use of IDDSI across all care settings and on all systems. • There is a NHSCT Trigger list to support incident reporting (now adopted regionally) Dysphagia related incidents are reviewed by the DST/SLT service lead and reports are shared and discussed with Divisional Reps at the Trust Dysphagia Group. Divisional reps cascade learning within their divisions at appropriate divisional meetings. • NHSCT representation on the Regional Multi-disciplinary and Multi-agency Adult Dysphagia Group (Dysphagia NI) established by PHA to action the recommendations within the SQR-SAI-2021-075, May 2022 RQIA review, the PHA Choking Improvement Plan and the PHA Thematic Review of Choking on Food. A sub group of this working group has guided the introduction of standardised International Dysphagia Diet Descriptors initiative (IDDSI). • The well-established, Trust wide, cross divisional Dysphagia Group, have developed an action plan to ensure the SQR, RQIA, NCEPOD and 10,000 voices report key learning recommendations are addressed within adult and paediatric services. The groups meets bi-monthly. • The Trust Dysphagia Group considers Trust compliance with recommendations set out in the NCEPOD report: 'Hard to Swallow?' for patients diagnosed with Parkinson's.	There were 29 recommendations (53 actions) made from the SQR letter, RQIA Review (May 2022), NCEPOD, 10,000 Voices, the PHA choking improvement plan and the Thematic Review that require implementation. **Assessment** 1. Additional 4 Band 6 SLT posts will sustain ongoing demand for assessment however will not address the current will backlog. Waiting times for SLT assessment are reducing but continue to exceed 600 days. Clients may experience harm (malnutrition, chest infection, aspiration pneumonia, choking) while waiting for assessment. **Risk Management** 1. No effective system to have complete assurance about: a. The traceability of meals – functionality of menu tablets has improved but not fully to achieve IA recommendations b. Secure storage of thickeners to prevent unauthorised access - recent Audit in Antrim and Whiteabbey Hospitals has demonstrated that there is not full compliance with safe storage of thickeners. c. Reporting of incidents relating to dysphagia management – this is inconsistent across Divisions. 2. The original proposal was a DST of 5.0WTE. However, NHSCT was originally only funded for 3.0WTE. This funding allocation was further reduced to 2.0WTE in 2022. This is a 33% reduction in staffing allocation which has reduced the capacity of this team in their work to address dysphagia risks. Trust has written to PHA. The NHSCT has received an allocation letter from SPPG indicating that recurrent funding of 139k will be available from 1st April 2024 . This will allow a small uplift in the staffing resource to allow for some assistant / administration hours. 3. 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. **Staff Training Programme** 1. Dysphagia NI have provided some training guidance but currently there is no mandated training for staff recruited through agencies. The Regional Dysphagia NI Partnership has not yet provided an action plan to Trusts regarding standardisation of dysphagia care training to specific staff groups therefore NHSCT have proceeded with a Trust Plan but have been unable to fully mandate training by staff recruited through agencies. 2. A NHSCT paediatric dysphagia training matrix and dysphagia training programme is currently being developed alongside a range of training resources for staff working with children and young people at risk of dysphagia. Recently Dysphagia NI has agreed to incorporate some paediatric strands within its work stream. A regional approach is required to standardise the training offered and resources developed for HSC staff working with children with/at risk of dysphagia.	The Trust Dysphagia Group has developed a Trust wide Dysphagia Action Plan which incorporates the 29 recommendations (53 actions) from the SQR letter, RQIA Review (May 2022), NCEPOD, 10,000 Voices, the PHA choking improvement plan and the Thematic Review **Assessment** 1. Working towards reducing waiting time to Ministerial target of 13 weeks. RQIA have recommended HSC trusts and commissioners should work together to review the capacity and capability of multidisciplinary teams, with a particular focus on SLT, to meet the needs of the patient population and ensure that timely assessment and intervention is provided, where required. NHSCT SLT department has provided information to the PHA regarding staffing levels. **Risk Management** 2. a. Meetings held with Catering / IT User Group to escalate concerns in relation to functionality of the Menu tablet and WiFi connection. A software update to the Trust catering management system, will enable the use of alternative, updated, tablets which will improve functionality and ensure mandatory recording of patient details. Update delayed, first phase should be deployed by end-February 2024, and phase 2 in Q4 2023/24. b. Regional patient safety alert HSC (SQSD) 6/15 Risk of Death from asphyxiation by accidental ingestion of fluid/food thickening powder has been disseminated on 3 occasions (Dec 2015, Aug 2016 & Dec 2016) and is reflected in the adult and paediatric NHSCT Dysphagia Management Policies. Safe storage of food/fluid thickener is audited regularly within acute settings by the Pharmacy Service. The regionally agreed Mealtimes Matter audit tool was implemented in NHSCT in March 2023 in all areas, except for Homecare and Supported Living. These services have bespoke dysphagia audit tools in place. Results in relation to secure storage of thickening powder need to be reviewed c. NHSCT Trigger list developed to support incident reporting (now adopted regionally). Regional work is ongoing to standardise the reporting of incidents. A task and finish group is addressing how the DatixWeb system can be improved to support more accurate reporting of nutrition and dysphagia-related incidents. Proposed changes have been agreed by the DatixWeb user group in June 2023, pending implementation. **Staff Training Programme** 3. A regional approach is needed to address dysphagia training for agency staff, this needs to be set out as a requirement within the regional contract and a mechanism sought to ensure compliance by non-contract agencies. 4. A NHSCT paediatric dysphagia training matrix and dysphagia training programme is currently being developed alongside a range of training resources for staff working with children and young people at risk of dysphagia. PHA have recently agreed to lead some regional work for paediatrics which includes development of a paediatric REDS document and a regional Paediatric dysphagia training programme for HSC staff. This training will be included in a dysphagia training matrix which is being developed for Paediatrics in NHSCT.	Catastrophic (5)	Unlikely (2)	10	HIGH	25/01/2024	14/11/2018

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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
28	20/02/2008	Finance	Failure to achieve statutory break even position.	Catastrophic (5)	Likely (4)	20	EXTREME	2, 3 & 5	Financial Accountability arrangements. Process for monitoring budget and formulation of corrective action plans. Robust monitoring and forecasting. Income agreed with Commissioners and monthly meetings with SPPG Finance colleagues to discuss cost pressures. Process for budget setting. Recurrent savings proposals identified by directorates and monitored monthly. Implementation of contingency arrangements, with appropriate approvals, if required to secure a breakeven position. Monitoring of Savings plans if required. Confidence and Supply planning and slippage review The Trust has maintained financial control internally through ongoing budget management processes, along with RAMP and project management arrangements (I). Director accountability arrangements (I). Monthly Director accountability meetings with Director of Finance and Deputy Chief Executive (I). Trust Board receive regular Financial Performance Report setting out progress against the Financial Plan (I). Monthly and Annual financial reporting and external audit (E). The Trust has established a Delivering Value Programme board with the aim of overseeing progress on various Trust efficiency programmes with under the headings of Productivity, Cost Containment and Sustainability. The Trust Performance and Finance Committee will receive regular updates on the work of the Delivering Value Programmes, with an initial focus Agency Reduction (Nursing and Medical) and on Enhanced Care. Discussions continue with HSCB and DoH representatives. From 2024/24 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 agains t the backdrop of service and workforce challenges.	The Trust has maintained financial control internally through ongoing budget management processes, along with RAMP and project management arrangements (I). Director accountability arrangements (I). BI-Monthly Director accountability meetings with Director of Finance and Deputy Chief Executive (I). The finance/performance accountability forum was established in Sept 2019 which meets quarterly and is chaired by a non executive director. A range of topics are reviewed The medical Scrutiny Committee examines the utilisation of locums and recruitment of a range of vacant posts by Directorate. The Trust is recording all expenditure associated with Covid 19, and details are recorded on the monthly monitoring return for review by SPPG and DoH. It is assumed that all costs associated with Covid 19 will be fully funded. Discussions continue with SPPG and DoH representatives. 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 Perforamnce and Finance Committee are regulalrly updated on the Financial Position of the Trsut and will receive regualr updates from the Delivering Value Programme Board and The Finance Focus meetings.	As in previous years, the Trust achieved a Breakeven position for 2022/23 due to a combination of Non-Recurrent Savings measures within the Trust and non-recurrent funding from DoH/SPPG. In addition DoH/SPPG fully funded the COVID response including PPE, No More Silos, Nightingale at Whiteabbey as well as Transformation initiatives. However it should be noted that the majority of this funding was provided non-recurrently. The Trust therefore is carrying financial risk until such time as funding is secured or a decision is made to stand down projects. In 2023/24 Financial Planning the Trust , in conjunction, with DOH and SPPG colleagues had projected a significant deficit on Core services, with further commitments arising in 2023/24 due to demand pressures and a range od unavaidable costs, In addition, SPPG have sought savings measures to the value of £29m to contribute to the overll HSC financial plan. The overall financial position remains subject to detailed and regular review and the Trust is taking steps to achieve savings (of which measures to the value if £23m have been identified, although these will be challenging to deliver. In the months to September the Trust secured additonal funding from DOH amd a further £11m of Deficit Support funding in October. However, the Trust also identified increasing financial risks, mainly due to demand pressures in Unscheduled Care, and increasing number of Enhanced Care packages required to favilitate discharges from Antrim, Causeway and Holywell. In addition the expected impact of Winter Pressures added to the financial gap. In late October the Trust informed DOH that the revised projected net gap in the financial plan for rhe year to March 2024 is now **£17.9m** With regard to planning for 2024/25 On 5 January, the Trust provided an assessment of the financial gap The Trust estimate of the opening financial position, as at 1 April 2024 and amounted to an estimated gap of £70.2m. The movement from the 23/24 out-turn projection of £17.5m to this opening gap in 24/25 is due to a number of factors, most notably: • Non repeatable SPPG Funding (£12.5m) The submission on 5 January included a range of potential measures identified by the Trust to offset the financial Gap of £70.2m. • FYE of 23/24 Service Pressures (£20.0m) • High Cost Drugs (£5.0m) • Non repeatable Trust Savings, including technical adjustments (£15m) The submission on 5 January included a range of potential measures identified by the Trust to offset the financial Gap of £70.2m. The Trust is already taking steps to progress implementation of the measures identified with a No, Minor or Moderate impact (@ £7.5m). It should be recognised that any measures in the Major or Extreme categories would require Ministerial support and public consultation.	The Trust continues engagement with DoH/SPPG with regard to scale of the underlying recurrent financial deficit facing the Trust as it looks toward 2023/24 financial year. The main areas on ongoing engagement relate to: (1) Savings Gap (currrently estimated at £6m); (2) COVID spend (currently estimated at £4m); (3) Service Pressures (@ £11m). Significant other cost pressures may continue to arise during the course of the year, most notably with regard to Unscheduled Care, Community Placements and High Cost Packages in Community, Mental Health and Learning Disability. In October DOH sought a Contingency Plan from the Trust in order to seek a substantial (50%) reduction in the financial gap. The Trust considered possible options for consideration but, in reporting these options, set out the High and potential Catatstrophic impact of implementing such measures at such a late stage of the financial year as we entern the challenging winter months. The Trust continues to engage with SPPG with a view to arriving at an agreed funding or cost containment strategy in line with the development of the overall HSC Delivering Value initiative although it would be expected that this would be part of a longer term HSC Recovery Plan. Following the return of the NI Assembly it is expected that enough resources have been allocated to DOH to address pressures in 2023/24, however we wait confirmation of hwo DOH will seek to handle this funding in year end accounts. The Trust will seek to continue engagement with SPPG colleagues on the overall HSC financial postion and with the Regional Delivering Value Programme Board to identify opportunities to seek to impriove productivity and improve cost control across key service areas.	Catastrophic (5)	Unlikely (2)	10	HIGH	07/03/2024	04/09/2023

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909	11/07/2017	Strategic Planning, Performance and ICT	Information security across the HSC is of critical importance to delivery of care, protection of information assets and many related business processes. If a Cyber incident should occur, without effective security and controls, HSC information, systems and infrastructure may become unreliable, not accessible when required (temporarily or permanently), or compromised by unauthorised 3rd parties including criminals. This could result in unparalleled HSC-wide disruption of services due to the lack of/unavailability of systems that facilitate HSC services (e.g. appointments, admissions to hospital, ED attendances) or data contained within. This may result in the need to cancel appointments and treatments, or divert emergency/essential clinical or other services. The significant business disruption could also lead to increased waiting lists, delayed urgent clinical interventions, suboptimal clinical outcomes and potentially bring liabilities for the Service. It could also lead to unauthorized access to any of our systems or information (including clinical/medical systems), theft of information or finances, breach of statutory obligations, substantial fines and significant reputational damage.	Major (4)	Likely (4)	16	HIGH	2	The following controls are in place: Technical Infrastructure • HSC security hardware (e.g. firewalls) • HSC security software (threat detection, antivirus, email & web filtering) • Server / Client Patching • 3rd party Secure Remote Access • Data & System Backups. Policy and Processes • Regional and Local ICT/Information Security Policies • Data Protection Policy • Change Control Processes • User Account Management processes • Disaster Recovery Plans • Emergency Planning & Service • Business Continuity Plans • Corporate Risk Management Framework, Processes & Monitoring • Regional & Local Incident Management & Reporting Policies & Procedures. User Behaviours • Influenced through Induction Policy • Mandatory Training Policies • HR Disciplinary Policy • Contract of Employment • 3rd party Contracts • Data Access Agreements. Increased patching regime in place and now BAU Sophos Intercept X on all desktops and Servers Recruitment of the ICT Security and Governance Team now complete	ISO270001 certification achieved 2015/2016 and renewed 2022 for 6th consecutive year, Internal Audit / IT Dept self-assessment against 10 Steps towards NCSC Technical risks assessments and penetration tests.	Gap analysis completed regionally and cyber security position well understood along with improvement actions required. Strategic business case in draft form and under discussion with DHCNI and DoH. Insufficient User Awareness of impact of personal behaviours in relation to cyber threat.	The Regional Business Case in progress to strengthen security arrangements across all organisations, and we are part of that, and this is still ongoing. Vulnerability scanning of critical network assets is conducted monthly. Report findings and action plan is currently being worked on. 3rd Party Risk assessments to take place to understand and mitigate the risk associated with 3rd party access	Moderate (3)	Possible (3)	9	MEDIUM	22/01/2024	11/07/2017