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

This statement concerns the condition of the system of internal governance in Northern Health and Social Care Trust as at **30 September 2026**.

The scope of my responsibilities as Accounting Officer for the Northern Health & Social Care Trust the overall assurance and accountability arrangements surrounding my Accounting Officer role, the organisation's business planning and risk management, and governance framework, remain as set out in the Governance Statement which I signed 29 May 2026. The purpose of this mid-year assurance statement is to attest to the continuing effectiveness of the system of internal governance. In accordance with Departmental guidance, I do this under the following headings.

Governance Framework

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

Assurance Framework

An Assurance Framework, which operates to maintain, and help provide reasonable assurance of the effectiveness of controls, has been approved and is reviewed by the Trust Board. Minutes of Outcomes and Assurance Committee meetings are available to further attest to the continued operation of the framework, with draft minutes of Outcomes and Assurance Committee meetings subsequently tabled at each Trust Board meeting for noting.

Risk Register

I confirm that the Principal Risk Document (details those risks that could compromise achievement of the Trust's Principal Corporate Objectives) and the Corporate Risk Register have been regularly reviewed by the Outcomes and Assurance Committee and that risk management systems/processes are in place throughout the organisation. As

part of the board-led system of risk management, the Principal Risk Document is presented to the Outcomes and Assurance Committee for discussion and approval, most recently on 17 September 2026.

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

Performance against Business Plan Objectives/Targets

The Draft Strategic and Operational Planning Guidance 2026/27 was formally issued to the Trust on 12 February 2026, with the Trust's response submitted in May 2026, setting out its planned approach to delivering the required financial savings and performance against the outlined targets.

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

A Strategic Workforce Planning Oversight Framework is in place to coordinate and strengthen the Trust's approach to strategic workforce planning. The framework provides corporate oversight of key areas including workforce supply and demand, vacancy management, recruitment and retention, agency and locum expenditure, and workforce affordability, supporting alignment between workforce, service and financial planning. Wider workforce risks and associated mitigating actions are monitored through the Trust's established governance structures, including the People and Culture Committee, with assurance and escalation to Trust Board as appropriate. While significant workforce and financial pressures remain, these complementary arrangements support the active management of risk and the delivery of safe and sustainable services.

Finance

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

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

- safeguarding funds and ensuring that they are applied only to the purposes for which they were voted;

- seeking Departmental approval for any expenditure outside the delegated limits in accordance with Departmental guidance;

- preparation of business cases for all expenditure proposals in line with FD(DoF)11/20 Better Business Cases NI and Departmental guidance and ensuring that the organisation's procurement, projects and processes are systematically evaluated and assessed;

- accounting accurately for the organisation's financial position and transactions;

- securing goods and services through competitive means unless there are convincing reasons to the contrary; and

- procurement activity should be carried out by means of a Service Level Agreement with a recognised and approved Centre of Procurement Expertise (CoPE)

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

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

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

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

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

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

External Audit Reports

The Trust received the final Report To Those Charged With Governance in August 2026. This contained three external auditor's recommendations, all of which were accepted. The priority of the recommendation denotes the seriousness:

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

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

	Recommendation	Target Date	Priority	Management Response
1	**Direct Award Contracts** We recommend that where a DAC is required for engagement with ISPs, the Trust should ensure that approval is obtained in a timely manner and in advance of services being delivered and expenditure being incurred.	31st October 2026	2	Accepted DACs will be a standing agenda item on Trust Procurement Board, we will monitor the number, value and approvals timeframe of these, with specific attention to retrospective DACs.

	Recommendation	Target Date	Priority	Management Response
2	**Approval of CTF Expenditure** We recommend that all CTF expenditure forms are signed off by two Officers in line with NHSCT's delegated levels of authority and that signatures are dated.	31st October 2026	2	Accepted CTRE form to be updated to include section for two Officers to sign and date in line with the updated policy and authorisation levels. Procedure documents will be updated to reflect the requirement for CTF expenditure forms to be fully completed
3	**Issuance of employment contracts** We recommend that in accordance with legislative requirements, employment contracts are issued to new starters within 2 months of their start date.	31st October 2026	2	Accepted The Trust will introduce periodic sample checks of new starters to confirm whether written employment contracts have been issued within the statutory timeframe. The sample checks will be proportionate to the volume of recruitment activity processed by the Trust and will be used to identify any exceptions, themes or process issues requiring corrective action. The Trust will also explore the feasibility of developing exception-based reporting within existing systems to identify cases where the issuing of a contract may be approaching the statutory timeframe. Where system reporting is not currently available, the periodic sample check process will provide a proportionate assurance mechanism. The requirement to issue contracts within the statutory timeframe will also be reinforced with the relevant HR team.

Internal Audit

I confirm implementation is being proactively progressed of the accepted recommendations made by Internal Audit, with 82% fully implemented at the mid-year review and 16% partially implemented, with only 2% not yet addressed. The Financial Governance Team works with Divisions including offering guidance and support on the action and evidence required to implement and close recommendations.

There were 76 recommendations reviewed as part of the mid-year follow up process, 40 of these recommendations were significant which caused limited assurance reports previously. 18 of the 40 recommendations were implemented during the follow up period.

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

RQIA and Other Reports

I confirm implementation of the accepted recommendations made by RQIA, and that the Trust has received no final RQIA Review reports since April 2026.

No new RQIA reviews have commenced.

Since April 2026, the Trust has received 31 reports relating to routine inspections (announced and unannounced) of Trust facilities. In 10 of the facilities inspected no areas were identified for improvement. Areas for improvement were identified for 21 facilities inspected, for which Improvement Plans have been completed and returned to RQIA. Progress against improvement plans is monitored by the Divisional Governance Teams.

NIAO Audit Committee Self-Assessment Checklist

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

Board Governance Self-Assessment

I confirm completion of a Board Governance Self-Assessment Tool compliant with Chapter 5 of the NIAO Board Effectiveness Good Practice Guide 2022 and that action plans will be implemented to address any issues. I also confirm that any relevant issues will be reported to the Department.

Internal Control Divergences

I confirm that my organisation meets and has in place controls to enable it to meet the requirements of all extant statutory obligations, that it complies with all standards,

policies and strategies set by the Department; the conditions and requirements set out in the Partnership Agreement, other Departmental guidance and guidelines and all applicable guidance set by other parts of government. Any significant control divergences are reported below.

New Divergences

Budget Position and Authority

Northern Ireland entered the 2026/27 financial year without an agreed Executive Budget. Whilst the Department of Finance has issued planning assumptions to departments, a final Budget for 2026/27 has not yet been agreed.

The Trust continues to operate within the funding assumptions notified by the Department of Health and Strategic Planning and Performance Group. This Internal Control Divergence will remain open until a final Budget and associated statutory authority arrangements for 2026/27 are in place.

Progress on Prior Year Control Issues – Ongoing

Residential Childcare and Placement Availability

Residential Care and Foster Care placement availability is challenging on a regional and local level and there continues to be a significant reduction in enquiries to the regional Foster Care Recruitment Team for the Northern Trust area. There has been a sustained increase in the number of Looked After Children within the Trust area in the last 3 years. In September 2023, there were 807 Looked After Children, and by 7 September 2026, the number had increased to 899 (an increase of 11.4%). Whilst the majority of young people continue to be provided with appropriate care placements, an increasing number of young people with challenging and complex needs have been cared for in unregulated arrangements. RQIA had served an Improvement Notice on the Trust given that the persistent pattern of operating unregistered Children's Homes, and there is a continued reliance upon unregistered Children's Homes to meet the placement needs of the increasing Looked After Children population.

The Trust has implemented an action plan in an effort to minimise further use of this type of arrangement with wide ranging actions e.g. Placement Support Hub for fragile placements; enhanced support for Foster Carers; increase in recruitment of Foster Carers and seeking to identify resource for an additional kinship team. The Placement Support Hub has been very successful, significantly reducing the number of placement

breakdowns and the need for Looked After Children to be placed in unregistered children's homes. The Trust has further plans to increase placement capacity and reduce the escalation of emergency situations to care admissions. However, the benefits of these initiatives on placement availability are likely to take time to materialise. With respect to children with a disability, Whitehaven has now reopened with reduced capacity for residential short breaks, because one young person is currently accommodated there. Eden View remains closed to short breaks due to ongoing workforce shortages. The Trust is acutely aware of the impact this has on families and young people and continues to work towards reopening services for this cohort of young people at the earliest juncture. Two young people with a disability are currently being cared for in an unregistered children's homes with sustained efforts being made to find alternative placements.

Aseptic Facilities

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

The NI Regional Quality Assurance Service undertakes audits of all aseptic units against UK national standards. The Antrim Pharmacy and Laurel House cancer unit aseptic facilities were rated as overall HIGH risk to patient safety in the 2022/23 audits. Re-audits have been completed in 6-monthly intervals, and the risk rating has remained as HIGH for both facilities. These facilities are more than 25 years old and do not meet the national standards for aseptic preparation; they require urgent investment to prevent them presenting unacceptable risk to patient safety. A Pharmaceutical Quality System (PQS) has been established which records and reviews the microbiological and environmental monitoring of the facilities. Monthly 'high risk facility' meetings are held to review all aspects of the management and monitoring of the facilities and agreed actions recorded. In January 2026, Side 1 of the Laurel House unit was closed to allow remedial works to the ceiling. Subsequently, air pressure differentials were found to be outside required limits, necessitating engineering works to replace HEPA filters and improve air pressure performance within Side 1. Ceiling vinyl repairs in Side 1, Isolator Room 1, have been delayed pending completion of these works. Should Side 1 be required to invoke contingency arrangements, the room could be used following risk assessment and a reduction in the expiry date of aseptically prepared products. Laurel House Side 2 continues to meet required standards and remains in routine use.

The PQS demonstrates that the facilities are currently maintaining a level of control in terms of the fabric and finishings and environmental monitoring. There is active engagement with the Capital Development team, and a preferred location and design of a new build has been prepared which would combine both Trust facilities into one unit. A regional review of aseptic services has been completed which includes the development of a Strategic Outline Case for NI Trust Pharmacy Aseptic Services to address the rising demand in cancer services and unmet need. The regional capital investment proposal included replacement facilities for the Trust, and the requirement has been added to the Trust's capital plan. Whilst the Trust has undertaken preliminary design work it awaits a decision in relation to capital funding.

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

Dysphagia

Dysphagia management and the risks associated with the provision of food and drinks to people diagnosed with dysphagia, continues to be an area of focus and remains a principal risk to the Trust. The Trust Dysphagia Group provides leadership across the Trust to drive and embed key actions such as the implementation of the Food and Drink Safety Pause, prior to serving meals or drinks.

This group has also progressed actions to implement all of the recommendations for HSC Trusts set out in the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Report 'Hard to Swallow', and the RQIA of the Implementation of Recommendations to reduce Choking Incidents in the Trust.

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

An Internal Audit of Dysphagia Management was conducted in 2023/24, providing limited assurance and an action plan to take forward the recommendations of the report is overseen by the Trust Dysphagia Group. Further progress has been made during 2026 in strengthening electronic monitoring arrangements for role-specific dysphagia training compliance, improving the Trust's ability to monitor compliance and target areas requiring additional support.

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

Recruitment and Retention

The Trust continues to experience significant workforce challenges across a number of professions, including nursing, social work and medical. Although progress has been made in a number of areas, vacancies and difficulties in securing and retaining staff continue to present a risk to the delivery of safe and sustainable services.

A Strategic Workforce Planning Oversight Group has been established to provide corporate oversight and coordination of the Trust's strategic workforce planning programme. The Group brings together the key strands of work relating to workforce supply and demand, vacancy management, recruitment, retention, temporary staffing, agency and locum expenditure, and workforce affordability. Its purpose is to strengthen the use of workforce intelligence, support the development and delivery of sustainable workforce plans, ensure alignment between workforce, service and financial planning, and provide a clear route for the monitoring and escalation of workforce risks and required actions.

The Trust continues proactive recruitment across nursing and nursing assistant roles, with targeted activity in areas that are consistently difficult to staff. Engagement with university students through information sessions, careers fairs, interview preparation workshops and positive practice learning experiences has supported recruitment from recent newly qualified nurse campaigns. While the nursing and nursing assistant vacancy position has improved, delays in completing pre-employment checks and clearing successful candidates to take up post are affecting the timely conversion of recruitment activity into substantive appointments. These delays are being monitored and escalated through the relevant regional and Trust governance arrangements.

Work continues to stabilise the substantive nursing workforce and reduce reliance on temporary and agency staffing. The Nurse Stabilisation Group oversees the effective use of available funded nursing and midwifery resources, with a focus on workforce stability, patient safety, efficiency and financial benefit. This is supported by enhanced electronic rostering arrangements, strengthened training and managerial accountability, monitoring of nursing hours and agency usage, and participation in the regional pilot of Safer Nursing Care Tools for acute and mental health inpatient wards.

Targeted action through the Medical Workforce Recruitment Group has reduced the Trust's medical vacancy rate from 18.3% in March 2025 to 12.1% in June 2026, notwithstanding continuing recruitment and service pressures. The Trust has also progressed an international medical recruitment contract to support recruitment in Radiology and is exploring further opportunities. Following implementation of the Regional Medical and Dental Agency Framework in March 2026, governance arrangements for the approval, procurement and extension of agency locums have been strengthened, improving oversight and assurance over locum expenditure and usage.

Existing medical workforce governance groups are being consolidated into a Medical Workforce Reform Group, which will provide focused oversight of workforce sustainability, recruitment, workforce reform and the reduction of agency locum expenditure. Standardised reporting and assurance arrangements will strengthen accountability while retaining divisional responsibility for workforce planning and locum usage. The Trust also continues to work collaboratively with NIMDTA through the Single Lead Employer arrangements to improve the employment experience of doctors and dentists in training.

The Trust appointed 48 social workers during summer 2026 through regional recruitment and the controlled use of appointments in anticipation of emerging vacancies. However, 18 posts remain unfilled, and the overall vacancy position is increasing. Recruitment activity has therefore not yet delivered a corresponding reduction in social work vacancies. Mitigating actions include targeted recruitment, central vacancy monitoring, phased deployment, divisional oversight and participation in the Department of Health and NISRA safer staffing gap analysis. Longer-term measures include increased regional training places and alternative entry routes, supported by retention initiatives such as mentoring, Schwartz Rounds and targeted support for teams experiencing particular pressures.

These measures provide assurance that workforce risks are subject to active management and senior oversight. However, vacancies, recruitment and candidate clearance timescales, workload pressures, staff mobility, workforce affordability and increasing service demand remain significant risks. These will continue to be monitored and escalated through the Strategic Workforce Planning Oversight Group and the Trust's established corporate governance arrangements

Financial Breakeven Position

The Trust has engaged with the Department of Health (DoH) and Strategic Planning and Performance Group (SPPG) throughout the 2026/27 Financial Planning process. As part of the Department's Reset Programme, all Trusts were required to deliver savings

equivalent to 4% of expenditure in 2026/27 together with addressing any underlying financial deficits carried forward from previous years.

The Trust identified an opening financial challenge of £53.8m, and developed savings plans to address this position. These plans have been presented to Trust Board in phases throughout 2026 and have received SPPG and Ministerial approval where required. Following approval of the Phase 2 savings programme, the Trust has identified £50.0m of approved savings measures, reducing the original planning gap to £3.8m.

Whilst significant local action has been taken, the Trust's financial position continues to be impacted by a number of factors. These include net demographic growth pressures of £9.8m included within the approved Financial Plan, together with the £22.9m difference between the 6% budget retraction applied by SPPG and the 4% savings target set for Trusts. Combined with the remaining £3.8m unaddressed planning gap, these factors contribute to a forecast deficit position of £36.5m at Month 5.

In addition, during the first half of 2026/27 the Trust has experienced financial pressures in excess of those reflected within the approved Financial Plan assumptions. These include demographic and service demand pressures above those included within the financial plan, increased energy costs and growing expenditure associated with High-Cost Drugs. The financial impact of these pressures continues to be assessed and may place further pressure on the Trust's forecast financial position during the remainder of the year.

The approved savings plans represent a significant programme of change and delivery remains challenging. Several schemes are inherently difficult to implement and carry significant delivery risk, particularly where they involve service change, workforce measures, or are dependent on regional decisions, commissioner support or wider system actions. There remains a material risk that approved savings measures will not be delivered in full or within the required timescales.

Even with full implementation of the approved savings programme, the Trust's ability to break even in 2026/27 remains challenging and, without full delivery of savings plans and mitigation of the additional financial pressures emerging during the year, it is unlikely that the Trust will break even in 2026/27. The Trust will continue to engage with SPPG and DoH and to monitor and review costs as the year progresses.

There remains a recurrent deficit that will require the Trust, in partnership with SPPG and DoH, to deliver a Recovery Plan. Delivery will require recurrent savings as well as service transformation, productivity improvement and reform, including actions arising from the Reset Programme and development of the Neighbourhood Care Model. This will be challenging to deliver and will require the Trust to work with other Trusts, SPPG and DoH to achieve recurrent financial break-even, particularly in those areas that require regional enablers, commissioner support or wider system solutions.

Cyber Security

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

As an Operator of Essential Services (OES) the Trust has completed a Cyber Assessment Framework (CAF) self-assessment 3.2 for the Network and Information Systems (NIS) Competent Authority in May 2025. The Trust also completed an external audit against this CAF 3.2 in August 2026 as specified by the Competent Authority and awaits the report which will indicate where the Trust requires action to meet the requirements of CAF 3.2. Further focus will be required as the Trust transitions to CAF 4.0.

There has been a significant rise in third-party breaches that are taking considerable resources to deal with to determine the potential clinical risk to the Trust and supply chain. With the increased threat level due to Frontier AI, we envisage this to have an ongoing impact to service while dealing with the increase of incidents locally and regionally.

The Trust ICT Department has completed an external audit for ISO27001 in June 2026 and continues to be accredited. The non-affordability of the Business Case for a Regional Security Operations Centre and SIEM solution is an ongoing risk.

Neurology

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

The first joint Northern / Belfast Trust Consultant Neurologist post aimed at addressing the Consultant deficit in the Trust took up post at the start of March 2021. The Trust has since secured funding for two further Consultant Neurologists but has been unable to appoint to these posts. The Trust continues to have a presence from Consultant Neurologists from the Belfast Trust and active support from the Belfast Neurology Team.

Recruitment remains an issue and the Trust has submitted this challenge as part of the Support and Intervention Framework with SPPG. The Trust is also actively engaged in the Neurology Alliance created by SPPG to address Neurology stability and reform.

While the Trust has had periods of locum cover, this causes an increased issue with need for supervision that cannot be provided on site and when a Locum Consultant leaves post it can create a waiting list of patients who do not have a named Consultant. In conjunction with regional colleagues this cohort of patients have had their care now transferred to other Trusts.

The Trust is currently working with the South Eastern Trust to establish an arrangement to provide Consultant Neurology cover from their team but funded from the Northern Trust. Currently the service has a Locum Consultant Neurologist providing support to outpatient clinics with governance arrangements provided by the South Eastern Trust. In addition, two joint appointment Consultant Neurologist posts with the South Eastern Trust are currently being recruited to with interviews scheduled for September 2026. This service remains at risk until this arrangement can be established and substantive staff are in place.

Acute Mental Health Inpatient Bed Pressures

Pressures on mental health inpatient bed capacity have been noted on the Corporate Risk Register since 2017 and continue throughout 2026-2027. These pressures present an associated risk and continued negative impact in the areas of patient safety, experience, therapeutic outcomes and staff experience. The Royal College of Psychiatrists Guidance recommends 85% occupancy level for Mental Health inpatient wards; however, the Trust overall occupancy frequently runs in excess of 100%, with additional contingency beds routinely required across all admission wards. Over-occupancy increases patient safety risks as a result of violence and aggression, incidents of self-harm and patients absconding from the wards and potentially coming to harm or risking public safety.

Patient flow across mental health beds has been limited, due to both the acuity of the patient population with high levels of detained patients on each ward and an associated longer length of stay in treatment. In addition, at the end of the treatment journey, there are insufficient placements in the community to meet the needs of those people with complex mental health needs and dementia, leading to patients being delayed in their discharge. As a result of reduced flow, it has frequently been necessary to operate a waiting list for admissions to a mental health inpatient bed. A regionally developed clinical prioritisation tool is used to determine the order of admissions. Due to these bed

pressures and insufficient inpatient beds, patients are often being managed in Emergency Departments, general hospital wards and in the community. These delays are associated with risks to the patient, to staff and to the public.

Mitigating actions remain in place, including daily huddles, weekly bed management meetings, weekly regional meetings, strengthened discharge planning with facilitated early discharge input and ongoing work with community providers to increase placement capacity. In 2026/27, an Emergency Department diversion pathway has been developed in partnership with the Northern Ireland Ambulance Service to support early assessment and timely, skilled decision making. Work is ongoing within the Trust on an Acute Mental Health Quality Improvement initiative, aimed at reducing length of stay. To date, this work has contributed to a reduction in overall numbers of delayed discharges, while also streamlining the admission process via a single point of access workstream. A Facilitated Early Discharge Practitioner was put in place in 2025/26 to support early discharge from inpatient care to Home Treatment Team. Engagement fora have been established to engage, prepare and support providers, regarding the likely future needs of Trust community placements, particularly those more complex requirements. As a result of this engagement, additional enhanced care and dementia beds have been opened by local providers. These beds have supported more timely and sustained discharges for some individuals, and engagement with providers continues.

Emergency General Surgery

The Trust held a public consultation on proposals to reconfigure General Surgery services between 23 August and 29 November 2024. The Trust consultation outcomes report was presented to Trust Board on 22 May 2025 which received approval and was subsequently submitted to the Department of Health the following day for consideration by the Minister for Health. SPPG commissioned GIRFT (Getting it Right First Time) to independently review the proposed Reconfiguration of General Surgery – this review was completed at the end of March 2026, and several recommendations were identified which the Trust is progressing. The Trust continues to work with SPPG with regard to the information required to enable a decision to be made.

Estate Risk

The age, condition and nature of the Trust Estate, continues to pose potential risks which are exacerbated by limited capital investment in major renewal and replacement projects. In line with best practice throughout the UK, the Trust commissions independent ‘Six Facet’ surveys annually to assess the condition of the estate. The most recent survey carried out in March 2026 has estimated a backlog maintenance liability of

£260m. This information forms part of the Trust's annual Property Asset Management Plan, which is submitted to the Property Management Branch at the DoH. The Trust receives an annual capital allocation from the DoH specifically for backlog maintenance. The Estates Department prioritises this funding on risk reduction works in key areas like building fabric, mechanical and electrical infrastructure, fire safety, asbestos, lifts etc.

In 2026/27 this allocation was £5.2m. With this relatively low level of investment, the trend is for the backlog maintenance liability to increase year on year as buildings and plant continue to deteriorate. The Trust Estates Department continues to maintain all buildings and plant whilst highlighting any concerns and escalating risks as they become apparent. One such risk, which is on the Trust's Corporate Risk Register, is the electrical infrastructure at Antrim Area Hospital. A planned upgrade has now received confirmation of funding by DoH and is being designed. This scheme, when complete, will reduce the electrical risk and potential failure of medical devices on the Antrim Hospital site.

The delay in capital funding being secured for the next phase of the Birch Hill development (New Mental Health Hospital) increases the reliance on, and risks associated with, maintaining the existing Holywell Hospital estate. The site is subject to a number of significant estate-related challenges, and, without adequate investment, its condition will continue to deteriorate. This increases the risk of service disruption, infrastructure failure and reduced resilience.

During 2025/26, continued significant pressures were also experienced on the revenue servicing and maintenance budgets, thus increasing potential risks to the safety of medical equipment, infrastructure and deterioration of the environmental condition of the Estate.

Changes to legislation, Health Technical Memoranda (HTMs) and Health Building Notes (HBNs), together with the increasing impacts of climate change, continue to place additional pressure on Estates maintenance revenue budgets. While the return of Health Estates to the Department of Health has enabled Trust staff to communicate such pressures, including the funding required to enable compliance, the lack of funding will have an overall long-term impact on the physical estate.

Waiting List Initiative Procurement

In common with the other provider Trusts, the Trust does not have a compliant route to the procurement of Independent Sector Elective Access activity. The Trust spent approximately £25m on this activity in 2025/26, procured through Direct Award

Contracts. The Trust has escalated this gap along with the need for development of a regional COPE for Independent Sector Elective Access activity and a compliant procurement mechanism. While the Trust has agreed internal processes for selecting providers and assessing value for money, the ongoing and extensive use of Direct Award Contracts, carries a risk of legal challenge which could significantly impact the Trust's ability to procure waiting list initiative activity.

Reporting from encompass

Significant progress has been made since encompass go-live in November 2024, and the Trust continues to work very closely with the Department of Health, the central encompass team and Epic to support further development of the required reports for statutory, regulatory and performance reporting. Once built these have required extensive data validation, much of which is ongoing with close liaison with SPPG and Hospital Information Branch. Similar issues have been experienced by other Trusts post go-live. A regional reporting oversight process continues with representation from the Department of Health and SPPG. System build and data quality work is ongoing, with senior oversight internally.

General Surgery Triage

Internal Audit provided an unacceptable assurance in relation to the Management of General Surgery. The audit identified significant delays in triaging of red flag and urgent referrals and a lack of effective management contributing to the triage backlog. The audit made 3 recommendations for improvement. Management action has been identified to address the recommendations, and work is ongoing to ensure surgical triage is completed with no delays to patient pathways. Internal Audit has completed a re-audit of surgical triage in 2025/26, and significant improvements have been made, and assurance has now moved to limited assurance. Management actions and ongoing monitoring are in place with presentation of triage reports monthly at Trust Board.

Cellular Pathology Services

It is estimated that between 70 to 80% of clinical diagnoses and around 95% of all clinical pathways depend on a pathology result right through from the GP surgery to the operating theatre and this service is therefore critical to the operation of the HSC.

In order to ensure continuity of this critical service delivery in February 2026 the DOH Accounting Officer authorised the award of a contract for the delivery of cellular pathology services in the absence of a DoF-approved business case. Vital equipment supporting this service had reached or was close to reaching end of life and this posed a significant risk to service continuity. The two options available were to either award the contract renewal based on 2023 tender prices that expired at the end of March 2026 or to recommence a lengthy procurement process, requiring the use of an estimated 70 plus Direct Award Contracts in the interim, likely at a higher cost and continuing to expose the service to an unacceptable level of risk.

Whilst falling short of the evidence normally required to support an expenditure decision, evidence was assembled that strongly supports the decision to award the tender to protect this critical service delivery. Department of Finance was also advised of the situation prior to award of the contract and an attempt made to secure its approval. However, in the absence of a compliant business case this was not possible. This contract has a duration of 8 years, and the Trust plans to also spend £15.4m in future years.

A number of lessons have already been learned from this process, not least the benefits of the development of a robust business case to support future expenditure decisions and the need to have appropriate project management structures in place. A comprehensive review of lessons learned is underway.

In response to the identified control divergence, the Trust is strengthening pre-procurement controls to ensure that procurement activity does not proceed without an appropriate, completed and formally approved business case in line with Trust business case guidance.

The Trust has also been engaging with BSO PaLS to strengthen the latest Service Level Agreement to set out clear responsibilities for both parties in terms of ensuring that relevant business cases are approved in advance of the procurement proceeding and PALS request for new tender documentation also seeks assurance concerning appropriate business case approval. These actions address the underlying control weakness and establish a more robust and consistent assurance framework across both local and shared service arrangements. Further to this SPPG are undertaking a review of the full decision, learning and recommendations from this report will be incorporated into the Trusts processes and policies – where necessary.

Business Continuity

In 2023/24 Internal Audit undertook an audit of Business Continuity. The Internal Audit report provided Limited Assurance and made 10 recommendations for improvement.

There were 3 significant findings and 3 key findings. In 2025/26, Internal Audit undertook a follow up audit on the recommendations from the 2023/24 audit. Whilst the follow up audit noted that 6 of 9 recommendations (1 recommendation from the previous audit was superseded) are fully implemented, 3 recommendations (including in relation to 2 of the significant findings), whilst demonstrating progress, remained partially implemented. In addition, testing of the plans needs to be further embedded across the Trust.

As of 30 September 2026, 99% of all Priority 1 services, up from 86% at the time of audit, now have a Business Impact Assessment/Business Continuity Plan completed in the new agreed format and there is regular reporting to and oversight of compliance by the Trust Executive Team. 1 recommendation remains partially implemented in relation to the testing of plans. Initial focus for testing is on Priority 1 services and a number of exercises to test plans have been delivered across these services, with others in planning. In addition, resources have been developed and made available for use by teams to allow for wider testing of all plans.

GMC Enhanced Monitoring Visit – General Surgery

General Surgery at Antrim Area Hospital is in ongoing enhanced monitoring with NIMDTA which commenced in December 2023 following a Deanery visit. There were 15 areas for improvement with 5 now closed and 10 ongoing. The issues are in relation to educational and clinical governance, patient safety, workload, trainee and trainer support and undermining behaviours. NIMDTA request regular updates on the Trust action plan and arrange 6 monthly follow-up meetings to monitor progress. The Deanery conducted a joint visit with NIMDTA in October 2024 and a further visit in 2025 and a number of areas of concern remain. NIMDTA continue to monitor the Trust's progress via the Trust's action plan, alongside additional deanery requirements, as part of their local monitoring processes. The service has engaged fully with NIMDTA to address the issues raised and is working with trainees to improve their training experience. Workload pressures within the team remains an area for concern and will not be fully addressed until the reconfiguration of General Surgery but interim measures such as additional staff and improved team structures have alleviated some of these pressures. The service has made significant progress in the identified areas for improvement and is taking positive steps towards closing off the remaining actions.

Inappropriate Access to Patient Records

The Trust is concluding its investigation into an incident of inappropriate access to patient records involving a number of staff. The incident has been reported to the

Information Commissioner's Office and HR processes have been instigated as appropriate in line with Trust policy. The Trust has an ongoing communication campaign for staff in place highlighting their responsibilities in regard to appropriate use and access of patient records. The Trust continues to undertake proactive and reactive system audits to seek assurances on appropriate access.

This is now managed through normal business processes, and it is proposed that the internal control divergence be closed.

Mid-Year Assurance Report from Chief Internal Auditor

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

Annual Assurance of Fitness of Accounting Officer

I confirm that I remain fit to carry out the role of Accounting Officer in accordance with MPMNI Chapter 3 and that any issues arising which question my ability to carry out the role (e.g. bankruptcy, disqualification, serious conflicts of interest, etc.) will be notified immediately to the Departmental Accounting Officer.

Signed: _____ *Date:* _____

CHIEF EXECUTIVE & ACCOUNTING OFFICER