Belfast Health and Social Care Trust

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Assurance Framework
Principal Risks and Controls
2017-2018

October 2017

INDEX

De-escalated Risks		Date

Area of Risk	Existing Controls	Assurance Internal (I) External (E)	Gaps in controls and/or assurances	Action and Timeframe	Reports / Evidence
Objective: Safety & Quality					
Ref. SQ01 **There is a risk that when the adult ED becomes very busy, waiting times to be seen by a doctor can exceed the standard prescribed according to the patients Manchester Triage category. This can lead to a risk that there could be a delay in diagnosis/ intervention/ treatment. When there is exit block and delays in transfer to appropriate wards, crowding can also impact on patient safety within the department thereby increasing the risk of a sub-optimal or adverse outcome and a poor patient experience.** Lead Directorate: Unscheduled & Acute Care Created March 2011	Unexpected outcomes/deaths are reviewed to understand if delays in being seen by a doctor contributed and if need be the SAI process is triggered so that any learning can be identified. Extended working hours by existing consultants using enhanced payments as an incentive. Annualised job plans for RVH ED consultants. Offer of extra shifts to registrars/middle grades for out of hours shifts to allow doubling up. Additional consultants appointed and ongoing locums to cover medical grade doctors and backfill consultant absence. Escalation and enhanced capacity plan agreed. Cross-cover arrangements for the Mater site are being undertaken where possible from consultants based in RVH ED. Elective work may be cancelled in times of extreme pressure in ED. The decision to cancel is made on the balance of risk. A Clinical Assessment Unit (CAU) was set up in RVH in July 2015 which has significantly enhanced patient flow within the ED. This model has also been applied to Mater Hospital where a 6-bedded medical assessment facility was also developed during 2016. During November 2015 safety concerns were raised by Mater ED staff regarding the ability to manage patients out of hours. As a result, the NIAS Ambulance	Regular SEA investigations being undertaken There has not been an SAI in the Mater since the relocation of paediatric attendances to RBHSC ED. This Risk is discussed and monitored at Unscheduled Care Directorate SMT and IMPACT on a regular basis.	Despite active recruitment, there is an ongoing shortage of middle grade/registrar doctors that make it difficult to respond to service pressures and reduces the resilience of rotas with a dependency on locum middle grades. Despite active recruitment, due to consultant staff leaving, maternity leave & retirements in Mater ED there is reduced consultant workforce on that site and securing Medical cover, particularly at night, has become an increased risk. There is an over-reliance upon locum cover. Cancellation of elective work due to periods of extreme pressure in ED.	The following actions are put in place to mitigate the risk: There is a will to build upon previous efforts to improve the experience of our ED patients, and the experience our ED staff. Safety is a primary concern, but we know that long waits in ED jeopardise safety, and so Flow through our EDs is an important factor. With shorter waits, we can provide a better Quality of patient care, and with less overcrowding, staff can be more Productive. A Micro-Design Team (MDT)has been established, led by Eoghan Ferrie, and a process has started to train the team in the skills, methods and tools of Healthcare Systems Engineering"(HCSE). A series of workshops, facilitated by Simon Dodds and Ken Fullerton was arranged during September 2017: • Flow Design, A "hands on" experience of system analysis, diagnosis, design and delivery • Resilient Design, Coping with variability: design in an unscheduled care environment • Design Team training, Bespoke training for the Micro-Design Team • Vitals Charts®, Production and interpretation of time based data for system diagnosis Our plan is to have the ED team trained up to do Gantt and run charts (both are explained in the Flow Design workshop) of the patients' experiences of their ED journey by the end of October, and to have completed and analysed charts for the RVH Minors area, which is relatively less complex, by the end of Nov 2017. Then we can extend to the	Adverse Incident Reports SAI reports and learning letters Active overseas recruitment process Escalation Plans

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	Protocol has been updated, and regular medical and anaesthetic SPR night time cover on the Mater Site has been secured. A review was also undertaken of paediatric attendances to the Mater ED to ensure that patients are seen in the right place at the right time. Agreement was reached that these patients should be temporarily treated at RBHSC ED. An Ambulatory Care Unit on the RVH site has been fully operational since December 2015. This Unit should improve patient flow across the site. The Trust appointed a Physician Associate in Aug 2016. The Trust has established a central 'Control Room'. The Site Co-ordinator has delegated responsibility from the Chief Executive for the operational management of the Site to set the patient flow rhythm for the organisation. Daily tasks include: Utilise predictive data to plan for the day and week ahead, 2 hourly performance meetings with clear outcomes and targets , assisting clinical teams to resolve issues which are causing patient delays across the entire patient journey, ensuring early optimisation of patient discharge including full utilisation of discharge lounges , optimisation of admission avoidance schemes e.g. RAPS, prioritise and redirect some clinical priority diagnostics and AHP demands, interfacing with Hospital Social work and Community teams to ensure timely and effective patient discharge, ensuring communication of site status, unscheduled pressures and elective admission, in an expedient, widespread, visible and accurate manner.			other ED areas The Trust has embarked on ongoing recruitment of ED middle grade doctors, ENPs, ANPs and Physicians Associates. The Trust is also exploring accommodation options to commission a CAU within the Mater ED for this winter. The Trust is planning to commence pre-consultation on paediatric attendances at MIH, early in 2018. The Trust has produced a Winter Resilience Plan for 2017/18 and Project Charter, which outlines demand and capacity assumptions, escalation triggers, agreed KPIs, multiple quality improvement initiatives and an outline of known risks and mitigation.	

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Ref. SQ04 **There is a risk of harm to patients from Health Care Associated Infections (HCAIs)** Lead Directorate: Nursing & User Experience Created 2007	<u>Assurance Structure</u> Reduction in the harm caused from HCAI is discussed weekly with the Chief Executive. The Lead Director for Infection Prevention and Control (IP&C) reports to Trust Board, and all Directors account for their performance. The Trust Quality Improvement Plan 2016/17 lists reduction in the harm caused to patients from HCAIs as the first Primary Driver. Progress on this Plan is discussed monthly at the Safety Quality Steering Group (SQSG). IP&C Committee is now incorporated into the Terms of Reference of the SQSG. The IP&C Committee is held every 6 months. The HCAI Improvement Team meets monthly, and is chaired by the Lead Director for IP&C. The overarching HCAI Improvement Plan is reviewed annually and is the basis for the Plans developed by Directorate Teams. Plans are discussed at HCAI Improvement Team meetings and at Directorate Governance meetings. In this year (2016/17) we have developed a Plan on a Page with an accompanying walk-round assurance tool. The Antimicrobial Steering Group meets 3 times per year and reports on progress at HCAI Improvement Team and IP&C Committee meetings. <u>Policy</u> A range of Policies and Guidelines have been developed and shared. Policies and other information related to	Trust Quality Improvement Plan Graph Sets (I) HCAI Improvement Team Graph Sets (I) Directorate Balanced Scorecards include detail on Hand Hygiene, Environmental Cleanliness and other Audits (I) Independent Audits undertaken by IP&C Team, Antimicrobial Pharmacists and others (I) Controls Assurance scores (I and E) RQIA Reviews (E) PHA mandatory reporting(E) Internal audit assignment plan 2016/2017 This risk is discussed at:- Antimicrobial Steering Committee HCAIIT meetings Infection Prevention and Control Committee	Inconsistent application of best practice across the Trust, particularly in relation to:- Risk assessment on admission and transfer; Identification and treatment of patients with MRSA; Isolation on suspicion of infection: Appropriate sampling of diarrhoea; Prudent antimicrobial prescribing and regular review; Clean clutter free Wards and Departments; Consistent adherence to the Dress Code policy Use of PPE and effective Hand Hygiene. Limitations associated with self-auditing. Insufficient capacity to provide independent auditing and preventative work by IPCNs. Gaps in RCA process and assurance that learning is shared and embedded within and across all Directorates. Insufficient WTE antimicrobial pharmacists to audit policy and review practices.	<u>Policy</u> • The RCA process and Policy is currently being reviewed. Timeframe: Dec 2017 • The Hand Hygiene Policy has been updated. • Uniform and dress code policy sent for Equality screening Mar 2017- Equality screening raised some issues, policy to be reworded – Timescale Nov 2017. • ANTT policy updated Mar 2017 <u>Audit</u> Ward Entrance Boards have been rolled out across Adult Acute Inpatient Wards on the RVH site. An ongoing programme of rolling out the ward entrance boards has been developed. Boards have been put up in RJMS and MLU MIH. Further roll out in MIH and MPH by Dec 2017. The Boards include detail on Environmental Cleanliness audit scores, Hand Hygiene Audit scores, as well as information on "days since a patient acquired MRSA bacteraemia and C Difficile. <u>Training</u> The mandatory IPC eLearning programme for clinical staff was launched in Sep 2015. This training is required 2 yearly. IPC mandatory training eLearning for non-clinical staff launched in Oct 2016. Two new IPCNs have been appointed. One vacancy has been filled from waiting list. Internal audit carried out audit on 'Plan on a Page' and walkround tool and antimicrobial stewardship in Oct 2016. Final report now in and recommendations have been accepted. Action plan in place and immediate actions have been completed. Action plan has been updated to end Sep 2017. With reference to 'insufficient WTE Antimicrobial pharmacists'; the Team have developed a Consultant Medical 'link' system to complete audits and review practices. An Antimicrobial App has been developed and is available to all staff 24/7 on the Hub. Antimicrobial ward teams being set up to	IP&C Annual Report Trust Board and Committee Minutes and Reports. Policy committee minutes Executive Management Team minutes. SQSG minutes. HCAI Improvement Team minutes. Directorate Team minutes. SQSG Graph Sets. HCAI Improvement Team Graph Sets. Infection Prevention and Control Committee Controls Assurance standard Auditing scores. RCA themes. Policies. Training records. RQIA Reports and action plans. PHA Reports. Internal audit report and action plan.

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	IP&C, including the Adult Antimicrobial Guide, are available for staff 24/7 on the IP&C link on the Trust Hub. <u>Audit</u> There is on-going peer and independent auditing of a range of issues and practices, including environmental cleanliness and hand hygiene. Focused independent auditing is undertaken where required. These include MRSA screening and management of patients with C difficile and MRSA. Root Cause Analysis (RCA) of particular infections and learning shared. <u>Training</u> There is on-going training in relation to IP&C, including Aseptic Non-Touch Technique (ANTT).		Insufficient uptake of training and assessment, in particular ANTT. There is a gap in the process for training and assessment of medical staff. Medical staff in some areas are training and assessed by nursing staff.	increase communication between medical, nursing and pharmacy staff. Timeframe for all areas Dec 2017. Baseline audits have been carried out. A business case for ward pharmacists is being presented to the Board Timeframe- March 2018. Attendance at all training is continuously monitoring HRPTS and via HCAIIT. Online presentation available on the intranet. Some areas have Medical staff assessors. Issue of ANTT training and assessment and recording of same for medical staff was highlighted in the internal audit report. Discussions are ongoing with NIMDTA. Timeframe Sep 2017.	HCAIIT minutes re walkround reports.

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Ref. SQ08 **Potential that patients are not reviewed as clinically indicated and could lead to clinical consequences and harm to patients.** Lead Directorates: **Performance Planning & Informatics** Unscheduled and Acute Care Surgery & Specialist Services Specialist Hospitals & Women's Health Adult Social & Primary Care Created May 2010	If a patient's condition deteriorates while they are waiting for a review appointment, their GP can contact the Trust to expedite the appointment. Regular monitoring reports are circulated monthly to review backlog figures. The total backlog at end of March 2017 was 51,559 a reduction of 2,502 (4.6%) from March 2016 with 63% of patients waiting longer than 3 months. At the end of September 2017 this has increased by 2,368 (4.4%) to 56,429. Of this backlog, 34,343 (61%) were waiting more than 3 months. Clinical validation of some review lists is taking place with patients being discharged to the care of their GP where clinically appropriate. Good Practice Guidelines for the management of Review Outpatients have been re-circulated to medical staff. Selected specialties are developing more detailed review guidelines specific to their area e.g. Gynaecology, Endocrinology, Neurology, Rheumatology.	Ongoing Directorate monitoring and Executive Team / Trust Board (I) and HSCB (E) reporting arrangements BSO Internal Audit (E) undertook a review of the Management of Waiting Lists (Review Appointments) within the Trust in August 2015 and provided satisfactory assurance. Updates related to this risk are discussed at the Trust Elective Steering group	Additional resources required to facilitate reduction in review backlog. Further alternative ways to manage demand required e.g. discharge patients back to GP with advice. Request for Advice (RFA) function being considered for relevant specialties as an alternative to OP referral. Further development of review protocols with clinical staff.	Implementation of review partial booking has supported further reductions in the review backlog by reducing the DNA rates. Text appointment reminders now contain the cost of a missed appointment. The DNA rate for review patients has reduced from 12.1% in August 2013 to 8.6 % at the end of September 2017. New posters have been developed for waiting areas with the strap line of "Keep it or Cancel it". Discussions have taken place with the Clinical lead and Service manager for Orthopaedics re ongoing validation of the review backlog. The Trust Outpatients Modernisation project is focusing on improving patient access, standardising care, streamlining administration, maximising use of the current infrastructure and using technology to enhance service delivery. e.g. through virtual triage clinics, one stop shop clinic models (red flag Thyroid), alternative pathways with primary care (Cardiology ECHO project commenced Nov 2016). The Trust received additional non-recurrent Elective Access funding of approximately £2m in 2016/17. Some of this funding was used to provide additional review outpatient appointments. 2 new Respiratory consultants and 1 locum were appointed in the Mater where some of the largest backlogs occur. The Respiratory review backlog in the Mater has decreased by 50% from 1,440 in March 2016 to 719 at the end of September 2017. At the end of March 2017, in Respiratory at the Mater, the longest backlogged patient waiting should have been seen in August 2015.	Performance Management reports to Executive Team and Trust Board & HSCB Regular review backlog monitoring
Potential that patients do not receive their first outpatient appointment or inpatient/day case treatment within an	Outpatients At the end of September 2017, 74% of routine patients (72,506) on the Trust Outpatients waiting list were waiting longer than 9 weeks. Of these, 31%	Ongoing Directorate monitoring and Executive Team / Trust Board (I) and HSCB (E) reporting	Additional resource required to meet demand and capacity gaps. Further alternative ways to	The Trust has developed an elective access improvement plan and proposals have been development for increasing Trust treatment capacity which includes investment in Trust pre-assessment services and theatres infrastructure,	Performance Management reports to Executive Team, Trust Board & HSCB

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appropriate timescale which could lead to clinical consequences and harm to patients.	(30,671) patients were waiting more than 52 weeks for an appointment. Controls in place: • Referral triage processes in place to determine clinical urgency. Those patients triaged as red flag / urgent receive priority appointments. • If a patient's condition deteriorates while they are on a waiting list, their GP can contact the Trust to expedite the referral. • Extra capacity is secured based on clinical need for urgent new patients when additional funding is available. • New models of managing new patients are being explored and implemented where appropriate e.g. virtual triage clinics where patients can be returned to their GP with advice, providing more appropriate care and reducing waiting times. • Some patient validation of long waiting patients has taken place in Neurology, Ophthalmology and Orthopaedics with approx. 20% of patients being removed from the waiting list. <u>Inpatients</u> At the end of September 2017, 67% of patients (21,870) on the Trust Inpatient/Day Case waiting list were waiting longer than 13 weeks. Of these, 18% (5,906) patients waited longer than 52 weeks Controls in place: • Patients are clinically prioritised on inpatient waiting lists. • Extra capacity is secured based on clinical need for IPDC patients when additional funding is available.	arrangements(I) Updates related to this risk are discussed at the Trust Elective Steering group Reporting is also provided to Trust Board.	manage demand required e.g. discharge back to GP with advice	Resources required to support the proposals are being discussed with the HSCB. The Trust received some additional non-recurrent Elective Access funding to the end of Mar 2017 to enable additional outpatient assessments and some treatments to be delivered in-house. Additional elective access funding has been limited in 2016/17 and as demand exceeds current capacity there continues to be a growth in waiting lists.	

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SQ14 **There is a risk that the Trust cannot quality assure and provide accurate reporting returns for social work and social care activity relating to the discharge of Statutory Functions.** Lead Directorates: Children's Community Services Adult Social and Primary Care Created 2007	The individual Associate Directors of Social Work are responsible for the collation and assurance of information to be included in their respective Service Area Annual Statutory Functions and six-monthly Corporate Parenting Reports. PARIS has been implemented in Adult Services. Interim Statutory Functions and Corporate parenting reporting assurance procedures have been implemented. The first phase of a Corporate Information Service-led review of statutory functions data collation and quality assurance arrangements across adults and children's social care services has been completed. The review sought to scope the range of issues impacting on community services information reporting infrastructure and capacity with a particular focus on measures required to optimise PARIS functionality, data governance and reporting.	Returns relating to social care service delivery are monitored by the HSCB on an ongoing basis. Social Care Steering Group (Associate Directors of Social Work)	Across both adults and children's social care there has been a significant reliance on manual information reporting systems and processes. This has resulted from an under-investment in information management systems, governance and analytics across community services. While the PARIS system has been operationalised in Adult Social and Primary Care, there have been ongoing problems in drawing down reports from the system including those required for inclusion in the Annual Statutory Functions report. Children's social care services is currently progressing the phased implementation of PARIS.	**CHILDRENS SERVICES** The regional nature of PARIS implementation across children's social care services has necessitated the regional standardisation of business and related data inputting processes. Ongoing difficulties in the development of software, its subsequent testing, where necessary re-configuration, re-testing and uploading have continued to present major logistical and resource demands and have resulted in a number of delays in and re-scheduling of implementation. In light of these factors, the projected date for implementation of children's social care services on PARIS has been re-scheduled on a number of occasions during the current reporting period. This situation has been compounded by the difficulties in retaining a core ICT resource base to support PARIS implementation and challenges associated with the "going live" of the ECR platform to facilitate cross-Trust searches and access to the Child protection and Looked After Children Registers. Current capacity pressures in the gateway Service are directly linked to the need to maintain two information systems, SOSCARE and PARIS, pending extending difficulties in resolving a range of software and other technical issues across ECR configuration and PARIS. Substantial work has taken place to prepare for the migration of SOSCARE data onto the ECR platform and its subsequent uploading onto the PARIS system when ready. This work is ongoing with a particular focus on data cleansing. The Directorate has committed a significant resource to support the testing of migration software, which is crucial to the implementation process. The delivery of training to the workforce is a crucial dimension of the implementation process. This has and continues to provide significant logistical and	Documentation related to PARIS implementation structures in children's social care services (Project Board and project Group reports and minutes).

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				operational service delivery challenges for the Directorate. The system provider has recently advised of the need for a further upgrade of PARIS to facilitate the next phases of the implementation process, which will necessitate a further delay with immediate implications for associated project costs and ICT workforce retention. Revised implementation timeline: March 2018. Children's Community Services Directorate has established an Information Manager post. The postholder will have responsibility for providing an information management and analytics service to the Directorate.Ongoing **ADULT SERVICES** Significant difficulties with regard to PARIS reporting functionality in Adult Services have presented substantial challenges across all Service Areas. There is a pressing need to address this matter both in the context of statutory functions and wider Directorate reporting requirements. OPS has invested in two information management posts and is currently engaged in a Service Area-wide review of information collation and information governance processes. It has been agreed that a Community Services Information Group chaired by the Corporate Information Service will take forward the following: ➢ The prioritisation of key PARIS information reporting requirements to meet current and future planning and performance management returns for community services. ➢ The development and oversight of the implementation of a programme of work to deliver against these priorities. This will include building confidence in PARIS as a reliable and efficiency reporting tool.	

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				➢ Ensuring requirements for high data quality are understood and promoting standards for system use. ➢ Identifying training required for staff to support self-sufficiency in reporting. ➢ Identifying resources required to improve input quality and reporting efficiency from PARIS ➢ Reviewing mechanisms to reduce reporting of community information via manual sources.	
Ref. SQ30 **Risk of harm due to capacity to deliver a comprehensive anaesthetic service across the Trust because of high number of vacancies and maternity leave. This has significantly impacted on the junior doctor rota.** Lead Directorate: Unscheduled & Acute Care Created June 2013	NIMDTA recruit and advise Trust of relevant postings and gaps throughout the year. Internal solutions developed to manage and monitor the rotas: 1) Locum staff used to fill gaps in rota. 2) Use of agency to backfill posts. 3) Where no junior doctors are available mechanisms have been set in place for Consultant Anaesthetists to cover junior doctor shifts. 4) Possible recruitment opportunities sought. NICCATs rota has been fully vacant from 1 Nov 2014 in order to mitigate against other rota gaps. BHSCT has recently procured and implemented electronic medical e-rostering. This has helped to identify gaps and reduce errors in rotas. 11 Consultant Anaesthetists have been recruited substantively. Of the 11 appointed, 7 are currently locums working within the BHSCT, 4 are additional to the service. These staff will commence duty over the next 3 months 5 Clinical Fellows were appointed in Jan 17, 4 took up post in Feb 17, 1 is due to	All 6 slots on the NICCaTs rota are vacant and gaps are covered using locum shifts. This reduces the number of gaps on resident rotas. The Junior doctor rota gaps are being maintained through HSC e-locums. Currently discussed at senior management team within ACCTSS, CCMT, ACCTSS Assurance group and various local meetings.	There are currently 9 gaps in the rotas for the February - August 2017 rotation. The September 2017 to February 2018 rota is not published yet, but the current 9 gaps are likely to persist.	Gaps are being covered via internal and agency locums as required and are regularly advertised amongst all relevant Consultants. The College training committee is aware and currently discussing rota allocation in the context of NI. BHSCT has worked with CCaNNI to develop an IPT for a Consultant led NICCAT's and NISTAR service. This piece of work is now complete and has identified a number of options to help manage the risk. 6 clinical fellows (in post) and 1 specialty doctor (start 1 November) have been recruited to Critical Care RVH following recurrent investment made available as part of the move to Phase 2B. Additional Locum consultant anaesthetists are being recruited to cover a high level of maternity leave. Recruitment is ongoing. 5 additional Specialty Doctors are being recruited to cover the remodelling of services on the Mater site and provide additional support to the out of hour's rotas. 2 of these posts have been filled (October 2017). The remaining posts are to be re-advertised. The service is undertaking an international medical recruitment exercise with Dr Adams from BCH Anaesthetics sitting on panels to recruit doctors from Europe. This is due to begin soon and will potentially be recruit doctors in the next 1-2 years.	Anaesthetic Rotas are reviewed weekly by anaesthetic coordinator; issues are escalated to Service Manager, Co-Director and Clinical Directors. Regular communication with Trust Senior Management Team.

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	take up post in August 17. 2 of the clinical fellows are leaving in July 17 resulting in 2/3 fellows in place as of August 17. 7 posts were fully funded 2 Specialty doctors were appointed to cover the Mater site and took up post during the first quarter of 2017.				
Ref SQ33 **There is a risk that children are being treated in areas where clinical teams do not have the necessary training, including vulnerable children training.** Lead Directorate: **Director of Specialist Hospitals & Women's Health** Created May 2010	Telephone support available from paediatric registrar in RBHSC. Consultant support also available as required. Up to 14 years old treated in RBHSC. Most 14-16 year olds with chronic conditions (e.g. renal, CF, haem/onc, complex neuro) are treated in RBHSC. Clinical chemistry and pharmacy available for telephone support for fluid prescribing and medication. Staff training in Vulnerable Adults and Children Over 90% of children are treated in RBHSC or other paediatric wards within the Trust e.g. ENT and orthopaedics. If children attend an adult ED, contact is made with RBHSC for appropriate advice and support.	Review of Incident forms (I) Performance management framework (I) The Trust has a number of meetings with the PHA and the HSCB regarding the service demand and infrastructure required to facilitate the uplift in RBHSC to include up to 16 years.	No capacity currently within RBHSC for this service. Unpredictability and range of specialist services where young people are treated. New Children's Hospital plan to increase to age 18	A review of accommodation in RVH is ongoing to identify a 6-8 bedded area to cohort patients aged 14 to 16 years of age. This review is linked to the reconfiguration of services in RVH. A paper was presented to Executive Team in July 2015 with further development in the interim for the new Children's Hospital. Commissioners have indicated that the development of an adolescents' area must be delivered within existing revenue. However, the nurse-to-bed ratio for children and young people is higher than the nurse-to-bed ratio for adults. Therefore, additional resources will be required for both nursing and medical staff in order to staff this area safely. The BHSCT and the Commissioners continue to work together to identify the resources required and this will be considered against Ministerial priorities. The Trust Quality Improvement Workshop recognised this as a key priority	Incident forms RQIA Review Baseline Assessment of care of children under 18 admitted to Adult Wards in NI - Action plan

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Ref SQ34 **There is a risk that if the Trust cannot complete actions to fully resolve concerns raised relating to patient tracking, supervision, workload and handover for doctors in general internal medicine posts, trainee doctors will be withdrawn throughout medicine resulting in inability to safely deliver acute medical take, support AMU, medical specialties inc OPD, and Hospital at Night.** Lead Directorate: Medical Director Created Oct 2014	Group set up under the MD and Director of Unscheduled Care to ensure actions are progressed and improvements embedded within medicine and related specialities. Actions identified and being addressed from the Deanery Report Action Plan. Further updated action plan submitted to NIMDTA on 27 Mar 2015. Agreed support for Practitioner Assistants to remove tasks with limited educational value from trainees and increase educational opportunities.	Report to External Reports/Reviews Group (I) Ongoing enhanced NIMDTA/GMC monitoring and support. (E) External Review Reports Group	A number of actions remain ongoing	NIMDTA Action Plan being worked through to address key recommendations. NIMDTA/GMC held a 2nd enhanced visit on 9 Oct 2015 for General Medicine in BCH, RVH and the Mater. Their report was received in Nov 2015. After the Trust's LEP Report submitted in April 2016, NIMDTA advised in June 2016 that three red-rated actions out of 42 remain outstanding. These three issues relate to patient transfer and handover between BCH and RVH. Compliance with use of the Medical Handover sheet for RVH transfers to BCH has been assessed with an Audit (on-going) and there have been some signs of improvement. Documents are available on the Hub and on-going education of all relevant staff continues. NIMDTA has required no further update from Trust as they, along with the GMC will be holding an enhanced monitoring visit of General Medicine on 7 Oct 2016. The report that results from this visit will determine if they still consider there to be a risk in these areas and will determine the impact on training posts. NIMDTA visited the Trust on 7 Oct 2016 and the interim report and action plan indicates that these are no longer areas of significant concern. GMC visited the Trust as part of the regional inspection programme. Initial feedback is positive with no major issues identified. NIMDTA will be visiting the Trust on 23rd November 2017 and is proposing that this visit will focus on the specific enhanced monitoring items, to establish if the improvements have been sustained to enable a recommendation to be made to the GMC to remove the EM status.	GMC report Report to External Reports/Reviews Group

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Ref SQ36 **There is a risk to the delivery of operational services across the Trust and to patient safety due to considerable delays currently being experienced in the recruitment of posts by the regional recruitment service.** Lead Directorate: Human Resources Created Jun 2016	Regular meetings take place with the Recruitment Shared Services, including: ▪ Operational meetings with the Service Delivery Manager; ▪ Customer Forums with the Head of Recruitment Shared Services; ▪ Ad hoc meetings with senior staff including the BSO Head of Shard Services. Guidance has been produced and training and support is available from HR for Trust managers to ensure delays within the Trusts control are minimised. A regional Strategic Resourcing Network has been established to take forward implementation of the recommendations of the Recruitment Task & Finish group, to progress work on streamlining processes and to deliver continuous improvement in recruitment end to end activity.	KPI reports produced and monitored at BSTP Programme Board.	Risk of bed closure as a result of staff shortages Increased utilisation of off contract agency and bank staff to fill vacancies. This has a cost implication for the Trust. Regional recruitment service is not meeting performance indicators as agreed regionally regarding recruitment of staff.	Senior HR representatives continue to meet with Directorate Leads regarding any Recruitment & Selection issue which are recorded and shared directly with RSSC. The Senior Managers, Co-Director and Director of HR raise and escalate issues with regional colleagues to the Head of Recruitment, RSSC. Timescale: ongoing Performance Reports are provided to Directors including performance of RSSC against regionally agreed KPIS and Time to Fill Reports which provide detailed information on length of time from requisition to final offer, highlighting key areas for improvement within the Trust (managers and HR). Further reports have been developed to include detailed analysis on delays to ensure proactive action can be taken within the Trust and RSSC Timescale: ongoing Senior HR Manager continues to liaise with Senior Nursing colleagues to ensure prompt action in regard to all appointments of nursing staff to minimise any possible delays in pre-employment health checks, interim support from retained recruitment to occupational health. Timescale: ongoing Regional meetings are ongoing to ensure issues and delays are minimised and to provide a forum for escalation via the newly established Strategic Resourcing Network. A range of key workstreams has been established with HR AD Leads and Senior Manager Co-ordinators across the region to take forward a number of actions. Monthly Customer Forum meetings have been reviewed and restructured to ensure specific feedback on Shared Service Performance against agreed KPIS is provided and addressed. This also provides a mechanism to ensure issues within the Trust are highlighted and proactively addressed. Timescale: ongoing	

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SQ37 **There is a risk to maintaining high quality effective clinical care in acute and community settings due to nursing shortages** Lead Directorate: Nursing & User Experience Created Apr 2017	Nursing and Midwifery bi-monthly workforce group. Ongoing nurse recruitment with an open file on HSC Recruit. Suppression of requirement for Directorate scrutiny for B5 posts. Directorates identify priority/risk areas and efforts are made to prioritise recruitment into these posts. Targeted recruitment in advance of scheduled university graduations. Attendance at QUB and UU jobs fairs. Regional participation at key UK jobs fairs. Regional recruitment of international nurses. Internal Voluntary Transfer Policy, to reduce staff turnover. To date 350 staff from the family of nursing have been facilitated to transfer to posts within the Trust. Use of temporary workforce to augment nurse vacancies to agreed level e.g. as per Delivering Care or national standards Policy on Use of Bank and Agency supported by Risk Assessment Tool.	RQIA reports e.g. ED/AMU RVH (E) Commissioner involvement and support in workforce modernisation and development. (E) Delivering Care returns bi- annually (E) Review of Older people's services (E) Support for areas experiencing high levels of Vacancy compounded by absence (I) Senior Nursing and Midwifery Workforce Steering Group reviews risks associated with nursing and midwifery workforce at bi-monthly meeting(I)	National and International shortage of nurses. Availability of staff especially for hard to recruit areas Candidate preference creating difficulties in hard to fill posts. Supply from Contracted nursing agencies exceeds demand leading to use of 'Off Contract' agencies.	Annual one-stop nursing jobs fair Validation of nursing vacancy waiting list. Proposal for development of Band 5 Nursing rotational programme to commence in Jan 2018. A further international nurses' recruitment campaign has just ended. Output from these has to date not yielded sufficient supply but the numbers are expected to increase in the coming months. Use of Off-Contract agencies monitored. Report on the Use of Off-Contract Agencies reviewed at Executive Team. Policy on Use of Bank and Agency re-issued. Consider possibility of incentivising Nurse Bank pay rates – Nov 2017 Revisit a national approach to maximum hourly rates of pay for agency in line with the NHS England standard rate. Maximise staff utilisation with effective rostering Proposal to extend Bank Office hours (this was operational at times of Trust Escalation). Enhanced student placement numbers, from a baseline of 646 undergraduate nursing places, increasing by 100 in each of the years 2016/2017 and 2017/2018. Return to Practice numbers across the 5 Trusts for the years 2016/2017 and 2017/2018 Is 48 annually. Consider new enhanced support roles to support and assist the nursing family. Any such roles would require appropriate training and supervision.	When all new Registered Nurse recruits are in post there will be 275 Registered Nurse Vacancies (position Sept 2017). Additionally there are 140 Band 2/3 nursing vacancies. Paper outlining rotational programme drafted for comment and then ratification. To date 17 EU and non-EU nurses have joined BHSCT, 7 of whom are now NMC registered. We expect there to be 3 staff to register each month from here on. Workforce meeting bi-monthly. Director of Nursing meetings with Directorate Senior Teams to identify nursing workforce priorities and agree action plans to address same. Bi Annual Nursing and Midwifery Workforce Report to Executive Team - Report due Oct 2017. MORE processes. Workforce trends. Workforce utilisation

Area of Risk	Existing Controls	Assurance Internal (I) External (E)	Gaps in controls and/or assurances	Action and Timeframe	Reports / Evidence
					reports. Health Roster reports. Extended hours built into Trust Bank and Agency business case (due Oct 2017). Provision of assurance to CNO that BHSCT can accommodate increased student numbers. Trust nursing and midwifery staff will participate in regional working group and report through the Nursing and Midwifery Workforce Steering Group.

Area of Risk	Existing Controls	Assurance Internal (I) External (E)	Gaps in controls and/or assurances	Action and Timeframe	Reports / Evidence
Ref SQ38 **Failure of Electrical Supply** **There is a risk of harm to patients and the provision of Clinical Services in the event of an NIE electrical supply failure** Lead Directorate: Finance & Estates Created May 2017	All Hospital sites have standby electrical generators. All generators are regularly serviced and tested in accordance with manufacturers' recommendations. IPS / UPS (Isolated power supply / Uninterruptible power supply) systems have been provided in a number of critical locations (these systems provide a backup electrical supply in the intervening seconds between the loss of mains electricity and our standby electrical generators starting up and supplying the building. The duration of this interruption can be up to 15 seconds and it is accepted that the consequences of such an interruption could be detrimental to the health of a patient undergoing a healthcare procedure). All IPS / UPS systems are regularly serviced in accordance with manufacturers' recommendations. Electrical failures are investigated and corrective action taken as necessary.	HTM 06-01 Contract review meetings. Governance Steering Group	There is the need to review all locations where engineering systems are employed in the provision of healthcare where an electrical power failure may result in harm to a patient. Areas may include Theatres, ICU, HDU, Critical Care wards, MRI, interventional angiographic rooms, PET and CT scanner rooms etc. The outcome may require the installation of additional IPS /UPS systems. Staff should know which electrical power points are serviced by IPS/UPS systems and only use these points to service clinical engineering systems.	Estates and a nomination from the Medical Director's office shall identify and prioritise locations where invasive procedures are being undertaken and where a momentary power loss may cause a significant risk to the health of a patient (October 2017). Estate Services shall survey the locations to scope the works required (March 2018). Estates shall prepare Business Cases for the funding of the additional IPS / UPS systems (May 2018). Estates have met with the associated Medical Directors; the AMDs have agreed to provide a prioritised list of locations which require UPS. Estates are awaiting this prioritised list.	SAI 17 15 SAI 17 16

Area of Risk	Existing Controls	Assurance Internal (I) External (E)	Gaps in controls and/or assurances	Action and Timeframe	Reports / Evidence
Ref SQ39 **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, checking critical registers) or data contained within. This may result in the need to cancel appointments and treatments, or divert emergency/essential clinical or other**	**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, Process** • 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 • System Admin Charter • Information Security Guidance for System Managers	IT Self-Assessment (IA) against NCSC 10 Steps Technical Risk Assessments, or Penetration Tests HSC SIRO Forum – HSC Planning/Strategic Direction ICT Steering Group / Information Governance Board 1718 Internal Audit – Cybersecurity	Insufficient corporate recognition and ownership of cyber security threat as a service delivery risk Insufficient User Awareness of impact of personal behaviours in relation to cyber threat Full extent of gaps are not understood at this point - gap analysis required to capture true extent of vulnerabilities	1. Agree baseline benchmark (e.g. NCSC 10 Steps to Cybersecurity) – **Completed** 2. Carry out a self-assessment exercise against baseline benchmark including risk assessment of key cyber security gaps/threats identified – **Dec 2017** 3. Commission an independent assessment of compliance against baseline – **Mar 2017** 4. Develop a Cyber Security Strategy and Action Plan to address the most significant areas of risk, focusing on strengthening governance & policy, improving process & education, investing time and resources on Cyber Intelligence and monitoring **Regional activity - ongoing as part of HSC Cyber Security Programme** 5. Revisit Business Continuity Planning within context of wide-scale local & regional service disruption during cyber security incident – **Local actions – Completed /** **Regional activity - ongoing as part of HSC Cyber Security programme.** 6. Introduce routine reporting to Trust Board (or other equivalents (local and regional)) on reported incidents/near miss, and other agreed indicators **Local actions – Dec-17 /** **Regional activity – ongoing as part of HSC Cyber Security Programme** 7. Work with colleagues across the region to develop and share learning, techniques, protocols and staff guidance, including User Awareness Campaign and System Managers/Admin training – **Regional activity – ongoing as part of HSC Cyber Security Programme** 8. Plan "faux" cyber security exercises to test user behaviours, service continuity / disaster recovery plans **Regional activity – ongoing as part of HSC Cyber Security Programme**	HSCNI Cyber Security Self-Assessment Consultancy Assignment Final Report 2016/17 (08/05/17) Technical Risk Assessment / Penetration Test Reports Trust Assurance Reporting: IGB & ICT Steering Groups, Risk Register Review Group Mandatory Data Protection Training Content - contains Cyber Security Messages & Education Directorate Scorecards - Performance Reporting on Mandatory Training Compliance

Area of Risk	Existing Controls	Assurance Internal (I) External (E)	Gaps in controls and/or assurances	Action and Timeframe	Reports / Evidence
services. **The significant business disruption could also lead to increased waiting lists, delayed urgent clinical interventions, suboptimal clinical or social care 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.** Lead Directorate: Performance, Planning & Informatics Created Jun 2017					

Area of Risk	Existing Controls	Assurance Internal (I) External (E)	Gaps in controls and/or assurances	Action and Timeframe	Reports / Evidence
Ref SQ40 **There is a risk that the Trust will not be providing timely, appropriate, high quality care to patients due to a lack of infrastructure and protocols for the regional HEMS service. Without a regional protocol the Trust has no clear guideline for repatriating patients from other Trust areas who arrive in Belfast via the HEMS service. This could have a knock-on effect on unscheduled care patient flow and resources to treat other critically ill patients in the Trust.** Lead Directorate: Unscheduled and Acute Care Created Jun 2017	A regional protocol is being developed at present. There are arrangements for other pre-existing service provision for repatriating patients from other Trust areas. Operational Control Room has been established in the Royal Hospital site and a local trauma team are in place. Internal process to cohort trauma patients together in identified area.	Regional Trauma Network updated on risk and shared responsibility. Improved performance of Control Room following regional review/exercise led by Seamus McGuire. This Risk is discussed and monitored at Unscheduled Care Directorate SMT and IMPACT on a regular basis.	Regional protocol to be developed for managing and repatriating patients from the HEMS. Staffing and other resources to be provided to meet service need. There is no regional guidance for managing paediatric trauma patients.	Bids were submitted during the summer to Commissioner by Trust Planning and Performance team, and subsequently funding was allocated for enhanced theatre and ICU provision. Issues still outstanding include a robust regional repatriation policy and funding for dedicated trauma beds. Clinical Director has been appointed to manage medical staff in this service.	N/A at present.

Area of Risk	Existing Controls	Assurance Internal (I) External (E)	Gaps in controls and/or assurances	Action and Timeframe	Reports / Evidence
SQ41 **Significant reduced access to Domiciliary Care as a result:** **1. There is a risk patients will not have the necessary support at home** **2. Hospital bed capacity will reduce due to delayed discharge** **Domiciliary tendering process has provoked serious instability in the sector evidenced by multiple requests from Providers to hand back cases due to large numbers of staff giving notice.** Lead Directorate Adult Social & Primary Care	Increased recruitment in Statutory Home Care Service Engaged with additional Providers - now added to Contract Provider list. Increase RAPS service (Oct 17) Implemented twice weekly collective telephone conference calls to prioritise high risk cases. Developed an information system to capture daily activity/demand & flow. Service users being offered Self Directed Support in the form of Direct Payments in lieu of Dom Care service.	Ongoing Directorate monitoring and Executive Team / Trust Board (I) and HSCB (E) reporting arrangements(I) Unmet needs list audited fortnightly to determine decrease/increase in demand. Information on demand, flow & /services secured recorded daily on ALAMAC system.	There have been complications with tendering process, which has impacted on domiciliary providers' ability to meet trust demand due to inability to recruit sufficient workforce.	Review existing statutory homecare staff hours with view to increase current capacity – Nov 2017 Additional night run within IDSS to create capacity to meet existing demand Nov/Dec 2017 Carry out an urgent review & reduction of current unmet domiciliary care (40% by Dec 2017) Review longstanding >3 months domiciliary caseload exiting reablement and reduce by 20% by Dec 2017. Set up MDT review team to review all historic domiciliary care caseload against regional criteria Oct/Nov 2017 Introduce a panel approach to review all domiciliary referrals Oct 2017 Creation of domiciliary care worker bank register Nov/Dec 2017 Communicate with all key stakeholders Nov 2017	Current waiting list for Domiciliary Care increasing. Monthly Service Performance Management reports SMT and practitioners. Fortnightly meetings unsure collective leadership focus & problem solving approach Regular monitoring & review of unmet need lists. Marked increase in complaints & MLA queries regarding Domiciliary Care which are emotive. Number of FOI received and responded. Adverse Incident Reports

Area of Risk	Existing Controls	Assurance Internal (I) External (E)	Gaps in controls and/or assurances	Action and Timeframe	Reports / Evidence
Objective: Modernisation					
Objective: People					
Ref. P01 **Mandatory Training** **Potential risk of harm to users, staff and plant; or legal action, if staff have not completed / updated mandatory training** Lead Directorate: ALL Created 2007	Updated Statutory and Mandatory Training Policy in place from April 2015. The Trust has identified best practice in terms of compliance with the current policy and this has been showed cased throughout the organisation by way of video blog. Use of local Risk Registers to support improved compliance. Development and implementation of Directorate Mandatory Training days, cohorting generic elements and maximising attendance. Introduction of alternative methods of training e.g. elearning packages such as Being Open.	Internal Audit report (E) IIP (E) Controls Assurance (I&E) Performance Management Framework(I) Mandatory Training Group, chaired by the Directors of UAC & PPI	IA review provided limited assurance, identifying a number of areas requiring action. Lack of in-house technical support for development of eLearning and modernised learning.	The findings and recommendations from the IA review in 2014 have been fully considered by the organisation and the management response was submitted in Dec 2014. Directorates will address the gaps in line with the required timeframes – as specified on the action plan. Progress is being monitored via the Learning Development and Education committee. An update report from the LDE Committee was presented to Executive Team in November 2015, which resulted in agreement to reconsider the Terms of Reference and constitution of the Statutory and Mandatory training group under the chairmanship of 2 Trust Directors. An updated project plan is in place and is currently being implemented. The plan includes the extended provision of and ready access to modernised learning approaches, a policy review of core mandatory training for all staff, development of an options appraisal for a learning management system and an outline proposal for a 'front load' approach to the delivery of mandatory training for all new employees. These are significant workstreams and whilst progress has been made further work on these will continue throughout 2017/18. Departments responsible for delivery of mandatory training continue to work with ICT & and other external providers to develop digital versions of their training programmes were feasible. Timeframe – Ongoing To further support the use of digital learning an LMS Options Appraisal has been completed. The report will be October.	Internal Audit reports IIP reports to executive team Co-Directors HR / Nursing Education reporting to Executive Team Training Uptake performance monitoring reports

Area of Risk	Existing Controls	Assurance Internal (I) External (E)	Gaps in controls and/or assurances	Action and Timeframe	Reports / Evidence
			HRPTS is not fully deployed across the Trust and does not yet contain a complete record of historical attendance at mandatory training.	HRPTS has been deployed to all identified training providers to record training attendance and enable performance management of staff attending mandatory training. Whilst the required IT infrastructure is largely in place to support full deployment and use of HRPTS a small number of PCs (28) have been identified as still requiring installation within ASPC Directorate. An implementation plan is in draft pending agreement.	
			Lack of resource to complete input of training records to HRPTS	All training providers now have access to undertake their administration and recording of Statutory and Mandatory training on HRPTS. The last monitoring returns from Training Providers, reported to LDE, indicate that the majority (96%) are using HRPTS to administer and record training. Training Providers have also progressed the recording of historic records, with 94% confirming they have completed the recording of historic records. The training providers responsible for the remaining programmes have indicated that they are unable to update to HRPTS as the records are stored elsewhere and there is a lack of resource to update and maintain HRPTS. This has been escalated to the relevant SROs and SM Working Group to seek agreement on the way forward.	
			Audit findings in respect of Fire Training and Data Protection training There is an increased risk of a potential breach of legislation due to loss, unauthorised use, destruction or disclosure of personal data.	All Service Managers have received fire safety information for induction of bank/agency staff. All Service Managers have received a copy of the Fire warden training register for their areas of responsibility to identify any shortfalls. Promotion of 'Walk/talk' through drills is ongoing. All directorates have received information on staff whose fire training has expired (Jun 2017 and Aug 2017).	

Area of Risk	Existing Controls	Assurance Internal (I) External (E)	Gaps in controls and/or assurances	Action and Timeframe	Reports / Evidence
Objective: Resources					
Ref. R03 **Recent Internal Audit findings and the Trust's own assessments highlight the Trust does not have adequate assurance that Fire Safety Management Procedures are effectively embedded throughout the organisation. Therefore, in the event of an incident, there is a risk that some service areas will be unable to effectively manage the situation.** Lead Directorate: Finance & Estates Created 2017	Fire Safety Policy Governance Arrangements Fire evacuation plans/emergency preparedness Current programme of fire risk assessment reviews across the estate. Fire warden training and general fire training programme Maintenance of fire safety systems Fire evacuation drills Re. Roll out of walk/talk through training Resources available to meet demand of walk-through training. Communication sent to all wards in BCH and RVH to advise of the availability of this training. Re. Regular review of fire risk assessments. An additional Fire Officer has been appointed to complete more on-site inspections. Fire Safety now included in Leadership Walkround template.	Controls Assurance (I&E) Internal Audit NI Fire and Rescue Service Audits RQIA Governance Steering Group	Not all areas have evacuation plans Lack of awareness within bank/agency staff. Lack of appointed fire wardens and attendance at general fire safety training. Lack of skilled resource to deliver training.	Ensure all areas complete fire evacuation plans Timeframe: Oct 2017 All sleeping and high-risk areas were confirmed in Jan 2017, non-sleeping risk areas to be completed by Sep 2017. Awaiting confirmation of same. Induction brief template prepared by Estates for Bank / Agency staff. Copy sent to Service Managers and Fire Wardens. Fire Manual includes briefing template. Timeframe: complete Increase the representation of Fire Wardens. Information on trained Fire Wardens collated. To be shared with relevant Senior Managers. Timeframe: Oct 2017. Information was shared in Jun'17	Internal Audit reports NIFRS reports RQIA reports Controls Assurance assessment

Area of Risk	Existing Controls	Assurance Internal (I) External (E)	Gaps in controls and/or assurances	Action and Timeframe	Reports / Evidence
Ref. R04 **Financial Stability- achievement of statutory breakeven target** Lead Directorate: Finance & Estates Created Nov 2014	Annual Financial Plan included in Trust Delivery Plan. Monthly financial monitoring and reporting and year-end forecasting. Regular meetings with Commissioners re. funding. Provision of financial management training to budget holders.	Controls Assurance (I&E) Accountability Review (I) Trust Board (I) HSC and DOH (E)	The Trust only received its 2017/18 allocation in July 2017 with the first draft TDP submitted 15th August 2017. This means that any gaps in year have to be recovered in a shorter period of time. Risk of slippage in planned savings/contingencies or emergence of unanticipated cost pressures in the remainder of the year.	The Trust submitted a draft high level 2017/18 financial plan to DoH on 14 February 2017 based on its recurrent brought forward budget, recurrent expenditure and anticipated new cost pressures for 2017/18. This identified a significant projected deficit. Trust received its funding allocation for 2017/18 in July 2017 and submitted a draft TDP to HSCB on 15 August. Indicating a £44.4m deficit before service impact measures. The Trust has gone out to consultation on all savings including service impact. The deficit would be reduced £31.4m after these. Further reductions have been made to the deficit in the intervening period through review of pressures and additional funding to reduce the gap to £13.6m Outcome of the consultation is due w/c 09/10/17 and subsequently further guidance from HSCB and DOH on how to resolve any remaining gaps.	Trust TDP and Financial Plan Monthly finance reports Trust Board and Executive Team minutes Performance meetings with PHA/HSCB/ DoH MORE Programme Accountability Board minutes.

Abbreviations

AER	-Automatic Endoscope Reprocessor	MDEA	-Medical Devices Equipment Alert
ACDP	-Advisory Committee on Dangerous Pathogens	MDM	-Multi Disciplinary Meeting
Aircon	-Air Conditioning	MIH	-Mater Infirmorum Hospital
BCH	-Belfast City Hospital	MPH	-Musgrave Park Hospital
BHSCT	-Belfast Health & Social Care Trust	MRSA	-Methicillin-resistant Staphylococcus aureus
BILD	-British Institute of Learning Disability	NICE	-National Institute for Health and Clinical Excellence
BLG	-Board Liaison Group	NIFRS	-Northern Ireland Fire & Rescue Service
BSO	-Business Services Organisation	NISCC	-Northern Ireland Social Care Council
CA	-Controls Assurance	NNU	-Neonatal Unit
CAMHS	-Child & Adolescent Mental Health Services	NPSA	-National Patient Safety Agency
CCAD	-Central Cardiac Audit Database	PCP	-Personal Contribution Plan
CD	-Controlled Drugs	PCSS	-Patient Client Safety Services
CJD	-Creutzfeldt-Jakob Disease	PDF	-Personal Development Framework
CMO	-Chief Medical Officer	PE	-Pulmonary Embolism
CNO	-Chief Nursing Officer	PfA	-Priorities for Action
CSICU	-Cardiac Surgery Intensive Care Unit	PHA	-Public Health Agency
CTPA	-Computed Tomographic Pulmonary Angiography	PMSID	-Performance Management & Service Improvement Directorate
DHSSPSNI	-Department of Health, Social Services & Public Safety Northern Ireland	PROACT-SCIP	-Positive Range of Options to Avoid Crisis and use Therapies - Strategies for Crisis Intervention and Prevention
DNAR	-Do Not Attempt Resuscitation	PTL	-Priority Treatment List
DPU	-Day Procedure Unit	QUB	-Queens University Belfast
D&T	-Drugs & Therapeutic	UIC	-Ulster Independent Clinic
ED	-Emergency Department	RCA	-Root Cause Analysis
EQC	-European Quality Commission	RJMS	-Royal Jubilee Maternity Service
ET	-Executive Team	RQIA	-Regulation and Quality Improvement Authority
EWS	-Early Warning Scores	RSI	-Repetitive Strain Injury
EWTD	-European Working Time Directive	RVH	-Royal Victoria Hospital
HDU	-High Dependency Unit	SAI	-Serious Adverse Incidents
HEIG	-Health Estates Investment Group	SBA	-Service & Budget Agreement
HR	-Human Resources	SBAR	-Situation, Background Assessment & Recommendation
HRMS	-Human Resources Management System	SCART	-Statutory Compliance Audit and Risk Tool
HSCB	-Health & Social Care Board	SIC	-Statement of Internal Control
IA	-Internal Audit	SIT	-Safety Improvement Team
ICT	-Information & Communications Technology	SMT	-Senior Management Team
ICU	-Intensive Care Unit	SOD	-School of Dentistry
IF	-Intestinal Failure	SQA	-Standards Quality & Audit
IIP	-Investors in People	SQSG	-Safety & Quality Steering Group
IP	-Inpatient	SSCT	-Specialist Services Commissioning Team
IPC	-Infection Prevention Control	ST	-Specialist Trainee
IPT	-Investment Proposal Template	STORM	-Skill Training on Risk Management
IR	-Incident report	TYC	-Transforming Your Care
IS	-Independent Sector	UPS	-Uninterruptible Power Supply
LCG	-Local Commissioning Group	VTE	-Venous Thromboembolism
LDT	-Live Donor Transplant	WTE	-Whole time equivalent
LIN	-Local Intelligence Network		

Appendix 1

Risk Comparison Check (Principal Risk Document & Corporate Risk Register)

Risk Comparison Check		
Principal Risk Document & Corporate Risk Register (October 2017)		
PR Doc	**Corp RR Ref**	**Principal Risk**
SQ01	AAS 025ED AAS 026ED AUC005	Risk re ED Waiting times can exceed can exceed the standard prescribed according to the patients Manchester Triage category leading to risk of delay in diagnosis/intervention - incorporating revised SQ01 (Staffing in ED) & P03 (Reliance on trainee doctors to deliver service, particularly OOH).
SQ04		Harm to patients from Health Care Associated Infections
SQ08		Potential that patients are not reviewed as clinically indicated; or receive first outpatient appointment or inpatient / day case treatment within an appropriate timescale.
SQ14		There is a risk that the Trust is not fulfilling its delegation of Statutory Functions within Social Work
SQ30	ACCTS16 & AUC005	Risk of harm due to capacity to deliver a comprehensive anaesthetic service across the Trust because of high number of vacancies and maternity leave. This has significantly impacted on the junior doctor rota.
SQ33		There is a risk that children are being treated in areas where clinical teams do not have the necessary training, including vulnerable children training.
SQ34	AUC005	There is a risk that if the Trust cannot complete actions to fully resolve concerns raised relating to patient tracking, supervision, workload and handover for doctors in general internal medicine posts, trainee doctors will be withdrawn throughout medicine resulting in inability to safely deliver acute medical take, support AMU, medical specialties inc OPD, and Hospital at Night.
SQ36		There is a risk to the delivery of operational services across the Trust and to patient safety due to considerable delays currently being experienced in the recruitment of posts by the regional recruitment service.
SQ37		Maintaining high quality effective clinical care in acute and community settings due to nursing shortages
SQ38		Risk of harm to patients and the provision of Clinical Services in the event of an NIE electrical supply failure
SQ39	ICT037	Risk to delivery of care, protection of information assets and many related business processes from a potential Cyber security incident.
SQ40		Risk that the Trust will not be providing timely, appropriate, high quality care to patients due to a lack of infrastructure and protocols for the regional HEMS service
SQ41	OPS023	Significant reduced access to Domiciliary Care
P01		Mandatory Training. Potential risk of harm to users, staff and plant; or legal action, if staff have not completed / updated mandatory training. Includes M03 Risk of non-compliance with Data Protection Legislation and P02 Attendance at Fire Awareness training.
R03	Fire3	Fire Safety. Further items of fire safety improvement works identified through fire risk assessments require to be addressed.
R04		Financial Stability - achievement of statutory breakeven target.
		Corporate Risks not on PR Document
	ACCTS32	A lack of standardised approach to defibrillator replacement and procurement within the Trust has resulted in numerous different types of defibrillators being in use across the Trust, resulting in a potential risk of lack of familiarity in utilization of the equipment which could cause potential delays or compromise patient safety.
	SHWH Mat038	There is a risk of insufficent regional neonatal cot availability which could result in mothers and babies having to be transferred out-of-region. The NICU is operating on 27 cots instead of the 31 which was recommended in the Troop report.
	CSS OH2	The COIS system is used for the electronic prescribing of chemotherapy and as an electronic patient record for Oncology. The system is old, unstable, performs poorly and has indifferent support arrangements. The infrastructure hardware and software platform is almost entirely unsupported meaning that should any component fail the ability of the IT department to recover system functionality is greatly compromised. The application software is supported by the supplier on a best endeavours basis. There is a high risk that the COIS system will fail and it will not be possible to retrieve functionality for the ongoing delivery of this regional service. Failure of the COIS prescribing system would cause significant delay in the administration of SACT as there are no hard copy prescriptions for all regimes in Pharmacy.
	BLP2	Disruption to service delivery as a result of failure of Buildings, Land, Plant and Utilities (water, gas, electricity supplies).
	SHWH Ortho040	There is a risk to the continuity of paediatric patient care due to the lack of appropriate medical cover for paediatrics in MPH.

Appendix 2

Risks Approved as Corporate but not recorded on Principal Risk Document

Risk No	Risk Log Date	Dir /Service Area /Specialty	Risk Description	Current Controls	CC	CL	CR Score	Risk Status	Proposed Action	Invest Required	RC	RL	RR Score
ACCTS 32	04/07/ 2016	ACCTSS - Resuscit ation Team	A lack of standardized approach to defibrillator replacement and procurement within the Trust has resulted in numerous different types of defibrillators being in use across the Trust. This has resulted in a potential risk of lack of familiarity in utilization of the equipment which could cause potential delays or compromise patient safety when resuscitation is required. Risks would also be enhanced for staff working across different wards or sites.	Resus officers are monitoring defibrillator use on their sites and consulting with the region as regards purchase of any new equipment. Staff have been advised that any new equipment should be procured from the regional framework. A draft business case has been prepared to help drive this piece of work forward.	MAJOR	POSS	12	HIGH	During 2017 Trust Resus committee are trying to agree a standardised approach and implementation plan for any new equipment purchased coupled with a replacement and training programme. A business case has been drafted and will be considered at the next Resus Committee meeting	100K minimum costs for equipment. Various other options are under consideratio n with a max cost of 1.7 million	MAJOR	UNLIKE	8

Risk No	Risk Log Date	Dir /Service Area /Specialty	Risk Description	Current Controls	CC	CL	CR Score	Risk Status	Proposed Action	Invest Required	RC	RL	RR Score
CSS OH2	01/07/ 2008	Cancer Services - Medical and Clinical Oncology	The COIS system is used for the electronic prescribing of chemotherapy and as an electronic patient record for Oncology. The system is old, unstable, performs poorly and has indifferent support arrangements. The infrastructure hardware and software platform is almost entirely unsupported meaning that should any component fail the ability of the IT department to recover system functionality is greatly compromised. The application software is supported by the supplier on a best endeavours basis. There is a high risk that this system will fail and it will not be possible to	RISOH EPR has been implemented in Oncology Services in BHSCT from April 2017. This includes the electronic patient record and all assessments. The historical information from COIS has also migrated into RISOH. COIS continues to be used as an electronic prescribing system. RISOH EPX (electronic prescribing element)for oncology is estimated to be implemented in November 2017. BHSCT have negotiated with CIS and they have agreed to extend COIS support until January 2018. The COIS database had also been migrated onto a new server which has removed	CATAS T	UNLIK E	10	HIGH	Phase 1 implementation of RISOH has completed in April 2017. Phase 2, which will follow later, is planned for completion in November 2017 will mean that RISOH will be implemented for electronic prescribing, at which point COIS will no longer be in use.	>£1,000,000	INSIGN	RARE	1

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			retrieve functionality for the ongoing delivery of this regional service. Failure of the COIS prescribing system would cause significant delay in the administration of SACT as there are no hard copy prescriptions for all regimens in Pharmacy.	the risk of it being delivered on unsupported hardware and the risk of unsupported high availability software, ie. Marathon.									
BLP2	19/05/2008	Estates	Disruption to service delivery as a result of failure of Buildings, Land, Plant and Utilities (water, gas, electricity supplies).	"Current level of funding available for capital works.		BLP2	19/05/2008	Estates	Disruption to service delivery as a result of failure of Buildings, Land, Plant and Utilities (water, gas, electricity supplies).	"Current level of funding available for capital works.		BLP2	19/05/2008
SHWHORTHO 040	17/04/2014	Trauma and Orthopaedics - Orthopaedics	There is a risk to the continuity of paediatric patient care due to the lack of appropriate medical cover for paediatric patients in MPH. This is due to an inability to meet the national Paediatric	"Locum specialty doctors employed to cover all Withers patients including paediatric patients.		SHWHORTHO 040	17/04/2014	Trauma and Orthopaedics - Orthopaedics	There is a risk to the continuity of paediatric patient care due to the lack of appropriate medical cover for paediatric patients in MPH. This is due to an inability to meet the national Paediatric and	"Locum specialty doctors employed to cover all Withers patients including paediatric patients.		SHWHORTHO 040	17/04/2014

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			and Anaesthetic care standards.						Anaesthetic care standards.				
SHWH MAT 038	25/03/ 2014	Women's and Maternity - Maternity Services	There is a risk that there will be insufficient regional neonatal cots availability which could result in mothers and babies having to be transferred out-of-region. The NICU is operating on 27 cots instead of the 31 which was recommended in the Troop report.	1) Function on 27 cots. 2) Use of unfunded bank and overtime hours. 3) HR continues to identify some additional funding. 4) Continue dialogue with commissioners. 5) Recent recruitment drive - 4 nurses appointed. Recruitment of 5 Nurses for NICU in December 2015. Daily communication via the regional neonatal network Recruitment of band 5 nurses from waiting list.4 neonatal Nurses to commenced	MODER	POSS	9	MEDIUM	1) Continue to have negotiations with commissioners. 2) Continue to operate on reduced cot capacity.		INSIGN	UNLIKE	2

Risk No	Risk Log Date	Dir /Service Area /Specialty	Risk Description	Current Controls	CC	CL	CR Score	Risk Status	Proposed Action	Invest Required	RC	RL	RR Score
				induction program in October 2016.Ongoing recruitment drive. An additional five neonatal nurses appointed in May 2017. Currently, shortlisting to fill remaining vacant posts. Daily evaluation of cot capacity as currently working on 25 cots as a result of high numbers of nursing registrants on maternity leave. Ongoing updates with the HSCB.									