Board Assurance Framework (BAF) Risk Document

INCLUDING - CORPORATE RISK REGISTER EXTRACT
QUARTER 2 2025 - 2026

South Eastern Health and Social Care Trust

Introduction

To ensure the Trust is carrying out its risk management responsibilities, which has included developing an Integrated Governance and Assurance Framework, a Board Assurance Framework (BAF) Risk Document, maintaining and reviewing the Corporate Risk Register, Risk Management Framework including Policy Statement as well as the dissemination of risk management training throughout the organisation, the Trust is required to have a risk appetite statement. This is requirement as part of the Annual Governance Statement and is an expectation of external auditors when reviewing the risk management of the Trust.

Purpose

The Board Assurance Framework' (BAF) Risk Document brings together in one place all of the relevant information on the risks relating to the Board's Strategic Objectives. The main aims of the BAF are to:

- Provide a clear and complete understanding of the risks faced by the Trust in the pursuit of its strategic objectives, the types of assurance in place, and consideration as to whether they are effective and efficient;
- Identify areas where there are gaps in assurance;
- Identify areas where assurance is duplicated, or is disproportionate to the risk of the activity being undertaken (is there potential for efficiency gains, reduction of duplication of effort and/or a freeing up of resource?);
- Identify areas where existing controls are failing and as a consequence unrecognised risks;
- Focus existing assurance resources; and
- Provide an evidence base to assist the organisation in the preparation of its annual governance statement.

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Quarterly Summary

The BAF Risk Document is designed to allow the Board to concentrate on that very limited number of top-level risks, but without restricting its freedom to maintain a watch on the full array of risks that may threaten the Trust's corporate objectives.

This brief summary will highlight the main changes to the risk registers in Q2 25/26.

Board Assurance Framework

There were no new risks added or closed on the BAF during Q2. Additionally there have been no significant changes in risk scores, with all remaining consistent with the previous quarter. As highlighted in the previous quarter, directorates were requested to provide a clear rationale for any BAF risks that have achieved their target score but remain on the register. This has now been taken forward, and the BAF template has been revised to include this detail. In addition, an assurance heat map has been developed to support oversight of all BAF and CRR risks, and this is also included within the quarterly BAF risk report. The Assurance Heat Map will visually show assurance coverage across key risks, highlighting areas of high risk or limited assurance. It will enhance oversight by revealing gaps, overlaps, and priorities, improving coordination among assurance providers and supporting risk-based decision-making.

Corporate Risk Register

There have been two risks added to the CRR in Q2.

- Management of Medical Devices
- Rise in volume and complexity of Prison population, on background of undercommisioning.

There were no CRRs closed in Q2, also there have been no significant changes in risk scores, with all remaining consistent with the previous quarter. Directorates were requested to provide a clear rationale for any CRR risks that have achieved their target score but remain on the register. This has now been taken forward, and information to include this detail will be provided in Appendix 3.

Directorate Risk Register

During Quarter 2, a total of **7 new risks** were added to the Directorate Risk Register, while **7 risks** were **closed**. Risk details can be found in Appendix 4. There is currently 152 open risks on the Directorate Risk Register that span a range of strategic and operational areas.

Update from Risk Register Review Group

Nil of note. All risk escalations progressed through the relevant committees to EMT.

South Eastern Health and Social Care Trust

Board Assurance Framework Summary Dashboard

BAF Dashboard 2025-26								
BAF Ref	Risk Description	Executive Lead	Page	Risk Score and Risk Appetite/Tolerance				
				Inherent	Previous	Current	Tolerance	Appetite
Strategic Objective - Timely Access to Care and Support								
BAF-01	Inability to achieve recurrent financial stability	Director of Finance & Estates	5	20	16	16		
BAF-03	Inability to deliver against the commissioned performance targets Trust wide	Director Planning, Performance & Informatics		25	20	20		
Strategic Objective - Safety, Quality and Experience of Care								
BAF-02	Inability to ensure the quality of the aged built environment and associated infrastructure	Director of Finance & Estates	7	25	25	25		
BAF-04	Inability to deliver seamless mental health acute in patient services on a single site consistent with best practice	Director of Adult Services & Healthcare in Prison	13	20	16	16		
BAF-05	Risk to delivery of services and patient safety due to significant workforce capacity challenges.	Director of People & Organisational Development	15	20	15	15		
BAF-07	Inability to provide safe and effective emergency care at Ulster Hospital	Director of Unscheduled Care, Medicine & Cancer	17	20	20	20		
Strategic Objective - Health, Wellbeing and Addressing Inequalities								
BAF-09	Inability to cope/meet the growing cyber threats	Director Planning, Performance & Informatics	22	25	20	20		

South Eastern Health and Social Care Trust

Board Assurance Framework Assurance Heat Map

Directorate	BAF Reference	CRR Reference	Risk Title	Assurance Level RAG			
				1st Line	2nd Line	3rd Line	Overall
Finance and Estates	BAF - 01	FE1-22/23	Inability to achieve recurrent financial stability				
Finance and Estates	BAF - 02	FE2-22/23	Inability to ensure the quality of the aged built environment and associated infrastructure				
Planning, Performance and Informatics	BAF - 03	PPI1-22/23	Inability to deliver against the commissioned performance targets Trust wide				
Adult Services and Prison Healthcare	BAF - 04	ASHIP2-22/23	Inability to deliver seamless mental health acute in patient services on a single site consistent with best practice				
People & Organisational Development	BAF - 05	HRCA1-22/23	Risk to delivery of services and patient safety due to significant workforce capacity challenges.				
Unscheduled Care, Medicine & Cancer	BAF - 07	HS1-22/23	Inability to provide safe and effective emergency care at Ulster Hospital				
Planning, Performance and Informatics	BAF - 09	PPI2-22/23	Inability to cope/meet the growing cyber threats				

Assurance RAG rating (suggested in HM Treasury guidance) on the effectiveness of controls from assurance work undertaken has been applied using the key below:-

HIGH	High - Controls in place assessed as adequate/effective and in proportion to the risks
MEDIUM	Medium - Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
LOW	Low - Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
INSUFFICIENT	Insufficient information at present to judge the adequacy/effectiveness of controls
N/R	Not relevant

Board Assurance Framework Risk Document 2025-2026						
BAF-01 Finance & Estates	**Title**	**Inability to achieve recurrent financial stability**			**Lead Director**	**Wendy Thompson**
Risk Grade	**Consequence**	**Major**	**Likelihood**	**Likely**	**Risk Grade/Score**	**High (16)**

Risk Description		
CAUSE	**EFFECT**	**OUTCOME**
Demand outstripping capacity	Inescapable pressures and savings not materialising	A failure to achieve statutory break-even requirement.

BAF Risk Detail					
Corporate Objective	**Timely Access to Care and Support**	**Risk Category**	**Financial**		
Board agreed Risk Appetite		**Within Board Risk Appetite/Tolerance?**	**Yes**	**Board Response**	**Treat**
Board agreed Risk Tolerance					

BAF Risk Journey					
Inherent Score	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Risk Owner Target Score**
Extreme (20)	High (16)	High (16)			
Risk Direction	⟷	⟷			
Has Risk Owner Target Score been met?	**No**	**If YES – provide Rationale for Inclusion**			

Controls	Assurances			Evidence
	1st Line	**2nd Line**	**3rd Line**	
Standing financial instructions	Signed off at Trust Board			Standing Financial Instructions reviewed as appropriate by Trust Board
Delegated budgetary management	All budget holders have access to budget system			All budget holders have access to view the Collaborative Planning system which holds budget for their area.
Delegated approval levels for expenditure	All Employees have approved SODA limits			Finance systems Admin team maintain register
Regular financial reporting at Board, director and budget holder level		Trust Board Reports & EMT Reports		Financial position reported monthly at directorate level SMT, also at Finance Focus groups and Trust Board.
Monthly reporting to SPPG/DOH			Monthly reports to SPPG and DoH	Monthly Monitoring Return reporting Trust forecast position submitted day 15 each month to SPPG, and on to DoH
Financial business partner model supporting directorate	Detailed packs at Ad & Dir level reported monthly			Detail of directorate position reported monthly and at a granular level for discussion at Finance SMT.
Enhanced Monitoring of Savings through SIF Level 3			Regular SIF meetings with SPPG	Regular SIF meetings with SPPG & Trust Board member being scheduled where progress on savings plans will be monitored. 5 workstreams and Delivering Value Board convene monthly.

Progress against planned actions:					
We continue to monitor the Trust position and identify opportunities for savings to move closer to a breakeven position. We are working with an external consultants to explore all options and work closely with SPPG to improve the financial position.					
Gaps in Controls	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
Emerging Inescapable pressures due to breakdown of placements and increases in acuity, leading to costs higher than funded.	Continued engagement with SPPG and DoH to secure additional funding. Longer term planning to achieve a more sustainable model and reduce costs	Wendy Thompson	Ongoing	Monitored & reported on monthly	Ongoing
Inescapable demand exceeding current levels leading to increasing costs beyond current levels.	We continue to monitor and forecast costs & activity across the Trust reporting monthly to SPPG and flagging areas of concern.	Wendy Thompson	Ongoing	Monitored & reported on monthly	Ongoing
Gaps in Assurance	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**

Board Assurance Framework Risk Document 2025-2026						
BAF-02Finance & Estates	**Title**	**Inability to ensure the quality of the aged built environment and associated infrastructure**			**Lead Director**	**Wendy Thompson**
Risk Grade	**Consequence**	**Catastrophic**	**Likelihood**	**Likely**	**Risk Grade/Score**	**Extreme (20)**

Risk Description

CAUSE	EFFECT	OUTCOME
• **Funding Constraints** – Insufficient capital investment in estates infrastructure along with competing Trust priorities for limited budgets (e.g. clinical services, Net Zero, equipment, staffing, technology, 6 facet survey). • **Ageing Infrastructure** – There is a significant amount of ageing infrastructure across the Trust this includes building and specialised engineering systems. Older buildings have complex, legacy systems that are costlier to maintain and becoming obsolete (e.g. UHD Main Ward Block, LVH Main Ward Block). • **Impact of evolving Statutory Legislation** – New compliance requirements following updates to legislation and best practice guidance have increased the scope and complexity of required works. Many healthcare buildings and engineering systems were not built to meet current standards. (e.g. Fire Safety legislation reforms following Grenfell, Cyber Security reforms including NIS Regulations). • **Regulatory & Bureaucratic Delays** – Delays in approvals for funding of works this includes procurement hurdles and complex tendering processes. (e.g. New Procurement Act, Award of 3Rd Party Service & Maintenance Contracts). • **Operational Pressures** – 24/7 hospital operations make it difficult to schedule major works without disrupting care. Limited decant areas available for works to progress in clinical areas to bed pressures. (e.g. UHD MH Ward 27, ACH GP In-Patient Ward, Fire Safety Upgrades) • **Strategic Uncertainty** – Awaiting outcomes of reconfiguration of services or redevelopment plans may cause deferred maintenance. Uncertainty about the future use of specific sites or buildings. (e.g. Mental Health 3-1 building, UHD Paediatric Theatres, and other strategic projects). • The Estates Directorate Incident Response Plan has been highlighted to Trust Risk Management to emphasise the need for service areas to have effective arrangements in place through their Directorate	• **Patient Safety** – Increased risk of injury, infection or harm due to falling infrastructure (e.g. leaks, fire safety issues, HVAC failure). • **Service Disruption** – Interruptions to clinical services, ward closures and delays in treatment would necessitate enactment of their Directorate Incident Response Plan. • **Compliance Risk** – Potential breach of statutory legislation, British Standards and best practice healthcare guidance • **Financial Costs** – Emergency repairs, legal claims and higher energy consumption. • **Staff Wellbeing** – Low morale, poor working conditions and reduced productivity. • **Strategic Limitations** – Delays to estate development, reduced capacity to meet future demands. • **Cyber Security** – Increased risk with regards cyber security as many of our existing engineering systems connected to the network do not meet the required cyber security requirements and are becoming obsolete	There is a risk the Trust will not be able to ensure the quality of the aged built environment and associated infrastructure which poses a sustained risk to patient safety, operational continuity and regulatory compliance. Despite recognition of the issue, efforts to reduce the extreme risk have been hindered by a combination of financial, operational, legislative and strategic factors. The potential outcomes for the risk include: • Risk of permanent harm/disability or death to a person. • Failure to meet professional standards or statutory obligations. • Regional or national adverse media publicity due to a patient safety or service disruption issue. • Collapse or disruption to a clinical service and financial loss to the Trust. • Loss/interruption resulting in catastrophic damage or loss to a service.

Incident Response Plan. This ensures risks arising from *'the quality of the aged built environment and associated infrastructure'* can be mitigated.		

BAF Risk Detail					
Corporate Objective	**Safety, Quality and Experience of Care**	**Risk Category**	**Patient Safety/Clinical**		
Board agreed Risk Appetite		**Within Board Risk Appetite/Tolerance?**	**No**	**Board Response**	**Treat**
Board agreed Risk Tolerance					

BAF Risk Journey					
Inherent Score	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Risk Owner Target Score**
Extreme (25)	**Extreme (25)**	**Extreme (25)**			
Risk Direction	⟷	⟷			
Has Risk Owner Target Score been met?	**No**	**If YES – provide Rationale for Inclusion**			

Controls	Assurances			Evidence
	1st Line	**2nd Line**	**3rd Line**	
The Estate Service Department (ESD) assess the condition of the Trust building portfolio using the 6 facet survey technique (currently suspended due to saving plans). Backlog maintenance spend is prioritised using this this benchmark data and a risk based approach to help ensure the safety and condition of the Trust building portfolio. However spend can often be limited by access to live areas.	• External consultants completing survey' s and Risk Assessments • Building, Land, Plant and Fire Organisational Controls Assurance Standards	• CE Accountability Review • Trust sub-committees, Estates SMT and safety groups • CAFM and Compliance Software e.g. Micad, ZetaSafe	• Statutory Inspections such as NI Building Control, NIFRS, HSENI, etc. • Independent audits such as BSO, AEs, external consultants, etc.	• Information saved and uploaded to Estates software systems. • Scheduled and recorded assurance meetings with Estates SMT. • Reports provided to relevant assurance groups in line Trusts Integrated Governance and Assurance Framework such as but not limited to the Fire Safety Sub-Committee, Water Safety Group, Ventilation Safety Group, Medical Gas Committee and Electrical Safety Group.
Statutory inspections and reporting is used to ensure statutory compliance is being achieved. This includes inspections from but not limited to NI Building Control, Northern Ireland Fire (NIFRS), Rescue Service and the Health & Safety Executive NI (HSENI), RQIA, Competent Persons for both lifts and pressure systems.	*As Above	*As Above	*As Above	*As Above
External independent audits and reporting is used to ensure statutory and best practice compliance is being achieved. This includes audits from but not limited to BSO, Independent Authorising Engineers (AEs), Fire Safety Consultants and other 3rd party consultants.	*As Above	*As Above	*As Above	*As Above
Trust Staff within the facilities are best placed to identify and highlight potential safety issues. Reporting of faults by Trust Staff through the Computer Aided Facilities	*As Above	*As Above	*As Above	*As Above

Management System MICAD alerts Estates to immediate risks so that cation can be taken to reduce the risk to the staff/public.				
The implementation of a Computer Aided Facilities Management System called Micad helps supports strategic maintenance planning and response to defects across the estate. This helps prioritise work across buildings and systems enhancing reporting and monitoring tools.	*As Above	*As Above	*As Above	*As Above
The implementation of a Compliance Management System called ZetaSafe helps support a centralised database for estates building and engineering assets which tracks statutory and regulatory checks through the use of barcode technology (e.g. fire alarms, water safety, emergency lighting)	*As Above	*As Above	*As Above	*As Above
Enhanced governance and reporting for building and engineering systems. Regular reporting to committees and groups in line with the Trusts Integrated Governance and Assurance Framework. This includes reporting to groups such as but not limited to the Fire Safety Sub-Committee, Water Safety Group, Ventilation Safety Group, Medical Gas Committee and Electrical Safety Group. SET Policies in place associated with the management of specialist engineering systems (e.g. Low & High Voltage, Medical Gas, Ventilation, Lifts and Water Safety).	*As Above	*As Above	*As Above	*As Above
The procurement and award of specialist sub-contractors for the delivery of service and maintenance contracts for building and engineering systems/equipment across the Trust. This helps ensure statutory and best practice compliance is being achieved with regards maintenance activities.	*As Above	*As Above	*As Above	*As Above
Staff training and competency is continuously updated for professional development in regulatory changes, fire safety, building and engineering systems. Department staff training matrix in place to ensure correct prioritisation and compliance.	*As Above	*As Above	*As Above	*As Above

Progress against planned actions:

Gaps in Controls	Required Action	Action Lead	Target Completion	Monitoring	Progress
Significant shortfall in funding to address backlog maintenance risk for the Trust.	Approximately £4M/year allocated to address backlog maintenance. Current high risk backlog costs are approximately £17M. Total backlog costs approximately £287M.	Ryan Conlan	31 March 2026		

	Consultants to be appointed to undertake review of 6 facet survey on an annual basis. (Suspended due to savings plans). Compliance with HTM05-03 Part K (re: fire compartmentation ppms and corrective maintenance) is not currently achievable due to funding constraints, this was raised to the fire safety sub-committee in the Q2 meeting. Spend to be prioritised to address high risk backlog.				
Appropriate fire safety management at ward/department level assists with reducing the risk associated with the identified fire maintenance backlog risk, as it helps improve fire risk awareness to ensure staff are ready, able and aware of evacuation procedures in the event of a fire situation. Fire safety management non-compliance such as insufficient staff fire training, insufficient fire warden' s assurance and failure to close out management fire risk assessment actions at Ward/Department level increases the effect in the event of a fire.	Presenting fire management safety risks to the Fire Safety Sub Committee and EMT through the Annual Fire Safety Report and statutory audit findings. Reporting on fire safety audit actions and fire risk assessment recommendations by Fire Safety Sub Committee.	Jonathan Bradshaw	31 March 2026		
Reduce delays in the award of Regional Service & Maintenance Contracts by BSO PALs	BSO PALs to prepare business case and secure additional resource to improve delivery. Regional Estates Procurement Group to report status at Procurement and Supply Chain Board. Increase in the reliance of DACs and use of National Frameworks in the interim.	Jonathan Bradshaw	31 March 2026		
Impact of evolving Statutory Legislation – New compliance requirements following updates to legislation have increased the scope and complexity of required works. In particular updates to fire safety guidelines has placed additional responsibilities on the Estates Department which requires additional staffing resource to manage appropriately. Such as appointing Authorised Persons, Authorising Engineers and completion of new primary fire risk assessments for all buildings across the estate.	A review to be completed of the new HTM 05-01 Part K guidance to identify the gaps in control. A proposal document to be submitted to WT indicating the requirements to meet the guidance.	Jonathan Bradshaw	31 July 2025		
Faults/defects with building and engineering systems throughout the trust estate not reported via the estates fault reporting system by Trust Staff	Quarterly all user email reminders and communications issued to staff to highlight the importance or reporting faults.	Ryan Conlan	31 March 2026		
Gaps in Assurance	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
The ability to close out recommendations from independent audit reports due to lack of backlog funding available to address issues identified. E.g. Authorising Engineer audits for specialist engineering systems.	Continue to highlight and escalate by way of reporting to committees and groups in line with the Trusts Integrated Governance and Assurance Framework	Ryan Conlan	31 March 2026		
The ability to close out fire safety management non-compliance risks to assist with addressing the fire	Continue to highlight and escalate by way of reporting to committees and groups in line with the Trusts Integrated Governance and Assurance Framework		31 March 2026		

maintenance backlog risk. E.g. staff training completion rates.		Jonathan Bradshaw			

Board Assurance Framework Risk Document 2025-2026						
BAF-03 Planning, Performance & Informatics	**Title**	**Inability to deliver against the performance targets Trust wide**			**Lead Director**	**Helen Moore**
Risk Grade	**Consequence**	**Major**	**Likelihood**	**Almost Certain**	**Risk Grade/Score**	**Extreme (20)**

Risk Description

CAUSE	EFFECT	OUTCOME
Pressures including investment, staffing capacity, financial challenges, increased demand.	There is a risk the trust will not be able to deliver against the Performance targets set meaning the Trust will not see every patient / client in a timely fashion.	Regulatory interventions, declining quality of services, risks to patient and client care outcomes.

BAF Risk Detail

Corporate Objective	**Timely Access to Care and Support**	**Risk Category**	**Service Continuity/Targets, Objectives & Service Provision**		
Board agreed Risk Appetite		**Within Board Risk Appetite/Tolerance?**	**No**	**Board Response**	**Treat**
Board agreed Risk Tolerance					

BAF Risk Journey

Inherent Score	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Risk Owner Target Score
Extreme (25)	**Extreme (20)**	**Extreme (20)**			
Risk Direction	⟷	⟷			
Has Risk Owner Target Score been met?	Choose an item.	**If YES – provide Rationale for Inclusion**			

Controls	Assurances			Evidence
	1st Line	2nd Line	3rd Line	
Daily/ weekly/ monthly performance monitoring	Y			Reports and qlik apps
Director led monthly performance improvement meetings with operational services		Y		Minutes of meetings
Integrated performance management report tabled at Trust Board		Y		Minutes of meetings
Performance reviewed at internal and external accountability meetings (with DoH)			Y	Minutes of meetings
Monthly clinical coding reports and audits		Y		Monthly reports
Mortality reporting and benchmarking with CHKS			Y	Minutes of meetings / monthly reports
IS monitoring		Y		Minutes of meetings
Internal Director led forums e.g. Cancer, USC, Elective Care		Y		Minutes of meetings
SIF process (at Director and CE / NED levels)			y	Escalation templates / minutes of meetings

Progress against planned actions:

Gaps in Controls	Required Action	Action Lead	Target Completion	Monitoring	Progress
Current lack of clarity regarding new performance metrics from SPPG e.g System oversight measures and funded capacity'	Trust continues to escalate to SPPG e.g. at monthly Performance and Finance meetings				
Gaps in Assurance	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**

Board Assurance Framework Risk Document 2025-2026						
BAF – 04 Adult Services &Healthcare in Prisons	**Title**	**Inability to deliver seamless mental health acute in patient services on a single site consistent with best practice**			**Lead Director**	**Rachel Gibbs**
Risk Grade	**Consequence**	**Major**	**Likelihood**	**Likely**	**Risk Grade/Score**	**High (16)**

Risk Description

CAUSE	EFFECT	OUTCOME
MH inpatient units are all in separate locations and are not purpose built for mental health acute care – Lisburn, Downe, Downshire & Ulster Hospitals	The Trust is currently unable to deliver seamless mental health acute in patient services on a single site consistent with best practice	Staff unable to provide inter-ward support due to geographical location e.g. in emergencies, staffing shortages; wards are not designed for mental health acute care; mix of single, double and 4-bedded accommodations enhance risks and are unacceptable re: patient privacy / dignity; service users experience out-of-area admissions more frequently/transfer risk bias thereby increasing risks and delaying discharges

BAF Risk Detail

Corporate Objective	**Safety, Quality and Experience of Care**	**Risk Category**	**Patient Safety/Clinical**		
Board agreed Risk Appetite		**Within Board Risk Appetite/Tolerance?**	**No**	**Board Response**	**Treat**
Board agreed Risk Tolerance					

BAF Risk Journey

Inherent Score	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Risk Owner Target Score
Extreme (20)	**High (16)**	High (16)			
Risk Direction	⟷	⟷			
Has Risk Owner Target Score been met?	**No**	**If YES – provide Rationale for Inclusion**			

Controls	Assurances			Evidence
	1st Line	**2nd Line**	**3rd Line**	
• All patients receive a risk screening assessment and where risk has been identified, a comprehensive review of the risk is completed by the multidisciplinary team and a management plan developed to address any risk identified. • Each ward manager is required, as a minimum, to undertake a six monthly environmental risk assessment within their service, inclusive of an anti-ligature assessment of the environment. • All patients are subject to general observation and have a 30-minute check as a minimum standard. Increased levels	• Environmental Risk Assessment Reports • Ligature • Fire risk assessments completed	• Performance Charts reporting on inpatient pressures and activity and continue to return Regulatory reports to SPPG. • Increased assurance via the Patient Flow Team and daily checklist	RQIA Inspection Reports – last inspection concluded September 2024 in Acute Mental Health & November 2024 in Dementia and Mental Health Over 65.	

of observation are an assessed requirement as per the Trust Observation Policy. • Relevant lessons learnt from SAI reviews, Estates & Facilities alerts and Learning Letters are implemented. • All acute mental health wards have new static alarm systems recently installed and linked to neighbouring wards with the exception of ward 27 UHD as it is does not have a neighbouring mental health ward. • Provision of CCTV coverage to monitor and review incidents within our wards; two-way radios are provided to enhance staff communication outside of the main ward area. • DoH has approved Task & Finish financial allocation for interim improvements to acute mental health accommodation pending the new 3:1 build; this work has commenced. • Introduction of Body Worn Camera Pilot (September 2023) • New PICU opened in September 2023.		• Inpatient Governance Meeting Monthly • Daily check in huddles with ward managers		

Progress against planned actions:

No progress due to agreement in principal funding for a new build not allocated from commissioners

Gaps in Controls	Required Action	Action Lead	Target Completion	Monitoring	Progress
• Bed Capacity Pressures • Nursing Workforce Pressures • Unable to predict the needs for 1:1 observations for inpatients March 2025 - The Trust has inquired with SPPG if they could consider providing money for design fees which would help visually understand the proposals and use of beds in the new site. June 2025 – This continues to be a priority for Mental Health and the risk identified will remain until SPPG approved funding to enable progression. The approved relocation of Ward 27 in the interim will bring some improvement for those patients as increased number of single rooms, located on ground floor and beside acute medical hospital but not adequate overall.	• Daily MDT service pressure meetings • On-going recruitment drives • Daily review of 1-1 observations • Ongoing environmental risk assessments • To date no further correspondence has been received. Further escalation will be discussed with AD/Director/Finance.	HOS/ clinical services manager AD/Director	ongoing		

September 2025 - There has been no further development in respect of Business Case and still remains a priority for MH services to have a new acute inpatient facility at the Ulster Site that meets the needs of patients. Centralisation will improve patient flow and timely access to medical care as and when required. This will improve continuity in staff resource due to geographically able to cover and assist in times of high demand. The relocation of Ward 27 is progressing - sitting with Planning and Estates for design and layout to inform the action plan required to proceed and number of staff/patients that will occupy the ward.					
Gaps in Assurance	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
Early indicator audits not completed for all wards	Early indicator audits to be completed and action plans developed and ongoing review	**Jennifer Kinsella**	**Ongoing**		On track
An assurance audit by all wards	Head of Service will be bringing to Inpatient Governance that an assurance audit takes place on the environmental risk assessment and that they are being reviewed as stipulated and concerns escalated. Clinical Acute service Managers along with Nurse Governance Lead to take forward and present findings.	**HoS Acute Inpatient**	**Ongoing**		

Board Assurance Framework Risk Document 2025-2026						
BAF – 05 People & Organisational Development	**Title**	**Risk to delivery of services and patient safety due to significant workforce capacity challenges.**			**Lead Director**	**Claire Smyth**
Risk Grade	**Consequence**	**Moderate**	**Likelihood**	**Likely**	**Risk Grade/Score**	**High (15)**

Risk Description

CAUSE	EFFECT	OUTCOME
The inability to attract and retain the required and representative workforce talent and skills	There is a risk that the Trust fails to recruit, retain, train and develop an engaged and effective workforce	Unsustainable services and unsafe staffing levels posing a risk to delivery of services and patient safety.

BAF Risk Detail

Corporate Objective	**Timely Access to Care and Support**	**Risk Category**	**People**		
Board agreed Risk Appetite		**Within Board Risk Appetite/Tolerance?**	**Yes**	**Board Response**	**Treat**
Board agreed Risk Tolerance					

BAF Risk Journey

Inherent Score	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Risk Owner Target Score
Extreme (20)	**High (15)**	**High (15)**			
Risk Direction	⟷	⟷			
Has Risk Owner Target Score been met?	**No**	**If YES – provide Rationale for Inclusion**			

Controls	Assurances			Evidence
	1st Line	**2nd Line**	**3rd Line**	
People and Culture	People and Culture Steering Group Senior HR Meetings EMT Trust JNF and LJNF with TUs	People and Culture Committee (Directors and NED Board membership) Regional HR workstreams	External Audits Investor in People Re-accreditation Process and Review	People and Culture Information (People Plan & People Reports per Directorate and Trust) DoH Workforce Strategy/ OH Review/ Regional Recruitment review Investor in People Reports Reward and Recognition Toolkit Absence Rate, Toolkit, training and action plans/ reports to DoH & target Flexible working policy including pension flexibilities in place and regular monitoring of uptake Trust HR Policies & procedures including embedding Open, Just and Learning Culture Appraisal and mandatory training uptake reports /stats

Recruitment Attraction and Retention Agency Cessation Nursing Bank Reform Medical Locum Reform	Attraction and Retention Group International Recruitment Project Group Regional Recruitment programme Agency Reduction Oversight Group (AROG) - Local Regional Bank Reform Work Recruitment Events (per service area/ Trust wide)	People and Culture Committee Feedback to EMT Regional Recruitment Customer Forum Agency Reduction Implementation Group (ARIG) – regional Internal Audit	External Audits	Attraction and Retention framework (in draft) International recruitment progress (medics, & nursing – ongoing and AHPs being considered) Output from HSC regional recruitment programme following PA Report Agency Reduction Controls including Retinue (report on medical locum usage) Regular Corporate Bank Report on Nursing/ Healthcare assistant activity Recruitment toolkit and training Performance reports on Recruitment Shared Services DoH quarterly returns on vacancies Ability to reallocate staff across units Workforce controls measures (requisitions approvals by Finance) Output from Recruitment Events - increase of applicants
Digital Health Encompass	Encompass Optimisation Group Trust Governance Assurance & Digital Group	Regional People and Workforce Group Regional BSI	Regional BSF	Output from functional groups/decision making
Equip (HRPTS replacement programme)	Equip programme (regional)	Local Equip Steering Group Equip Design Authority	Equip Programme Board	Governance structures and controls in place regionally for Equip & Encompass
EDRMS (efiling replacement project)	Digital Health - Portfolio Design Board	EDRMS SRO		Governance structures and controls in place regionally for EDRMS

Progress against planned actions:

Gaps in Controls	Required Action	Action Lead	Target Completion	Monitoring	Progress

Gaps in Assurance	Required Action	Action Lead	Target Completion	Monitoring	Progress

Board Assurance Framework Risk Document 2025-2026						
BAF – 07 Unscheduled Care, Medicine & Cancer	**Title**	**Inability to provide safe and effective emergency care at Ulster Hospital**			**Lead Director**	**Marc Neil**
Risk Grade	**Consequence**	**Major**	**Likelihood**	**Almost Certain**	**Risk Grade/Score**	**Extreme (20)**

Risk Description

CAUSE	EFFECT	OUTCOME
Demand on inpatient patient bed and community services is greater than available funded capacity.	Due to lack of available in-patient beds and community services, patient flow from ED to wards, and from hospital to community is restricted. This leads to congestion within the Emergency Department with prolonged times for patients to be seen, risk for those patients waiting to see a doctor and delays in ambulance handover. This risk is influenced by factors across the hospital and community system.	Compromises in patient safety for both patients awaiting in ambulances to be handed over and for those waiting to be seen within the department. Delays for patients awaiting transfer to the ward can delay their ongoing management. Ambulance handover delays will further compromise the availability of NIAS crews to respond to calls within the community.

BAF Risk Detail

Corporate Objective	**Safety, Quality and Experience of Care**	**Risk Category**	**Patient Safety/Clinical**		
Board agreed Risk Appetite		**Within Board Risk Appetite/Tolerance?**	**No**	**Board Response**	**Treat**
Board agreed Risk Tolerance					

BAF Risk Journey

Inherent Score	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Risk Owner Target Score
Extreme (20)	Extreme (20)	Extreme (20)			
Risk Direction	⟷	⟷			
Has Risk Owner Target Score been met?	No	If YES – provide Rationale for Inclusion			

Controls	Assurances			Evidence
	1st Line	2nd Line	3rd Line	
Site Co-ordination 7 days/week from 8am to 8pm providing senior leadership around patient flow in and out of the hospitals (covers Ulster, Downe and Lagan Valley Hospitals)	Control Room Meetings at 9am, 11:30 and 15:00	Hospital and Community Flow Oversight Group	RCC Affiliate	Standard Operating Procedure for Control Room Control Room - Operational Policy V21 24.4.24.docx
Use of Non-Designated Beds (NDB) to provide additional in-patient bed capacity	Control Room Meetings at 9am, 11:30 and 15:00 to provide oversight and decision	NDB Protocol		Non-designated Bed Protocol Reflected in action note from Control Room Meeting

	making around use of NDB			
Extended senior medical cover over in ED to 11pm and 24/7 Band 7 Nurse in Charge	Review of rotas by Clinical Director Unscheduled Care and Lead Nurses	Escalation of gaps in cover to Nursing Bank office and to Rota Co-ordinator for Locum over		Medical and Nursing rotas
Phone First models in place for Ulster MIU, Downe and LVH UCC	Provides direction of patient to the right service and avoiding unnecessary ED attendance	Data provided by DUC for MIU Phone at Ulster Hospital	SPPG oversight of activity	DUC Data
Discharge Lounge open 6/7 with senior nurse in charge to facilitate early release of acute bed capacity	Oversight of provision by Lead Nurse and Clinical Manager for Unscheduled Care	Discharge lounge activity for previous day reviewed at morning Control Room meeting	RCC affiliate review of use and pathway to Discharge Lounge during site visits	Encompass activity data
Preventing admissions to Ulster ED through NMS ambulatory hubs (SDEC)	Provision managed through service teams. Directory of SDEC provision available via Page Tiger	SDEC regional group established to standardise approach and develop encompass data reports	Review of Trust SDEC provision by GIRFT/SPPG in April 2025	Link to directory of alternatives to ED Link to ED Alternatives
Discharge Hub provides oversight and management of patients with complex discharge	Discharge Hub twice daily review of complex delays meetings.	Action list to facilitate discharge planning/discharges highlighted by email and at Control Room meetings	Twice weekly regional review of Trust Complex Delays by RCC	Action list emailed following Control Room meetings Notes of RCC Twice Weekly meetings
Rigorous implementation of the NIAS Category 1 release	ED Nurse in Charge, NIAS HALO, Patient Flow and Site Co-ordinator/On-call manager supports release of crew. NIAS Cat 1 release protocol followed	Escalation of any delays in release from NIAS Control Room to on-call manager/Director on-call	Monthly Trust and NIAs Interface meeting established to review any issues.	NIAS Cat 1 Release SOP Cat 1 release SOP 121224.pdf
Introduction of Ambulance triage to ensure ambulance patients have timely access to triage and personal care should there be a delay in transfer into department	Nurse in Charge and HALO have daily oversight of ambulance arrivals and those waiting	NIAS average handover times report shared weekly with Trust	Monthly Trust and NIAs Interface meeting established to review any issues.	Ambulance Triage SOP effective from 18th February 2025

	for triage or personal care		RCC daily oversight of ambulance arrivals and time to handover	Ambulance Triage SOP jan 2025 v2.doc
ED space has been maximised for patient placement within the department.	ED Operational Policy provides escalation plan for splitting of cubicles and inclusion of Crisis Trolley space.	Staffing versus capacity reviewed by Nurse in Charge and issues escalated to Lead Nurse if there is need to downturn any trolley space		ED Standard Operating Procedure Emergency Department SOP (20
Adverse Incident Reporting policy in place	Datix incident reporting mechanism in place for staff to report incidents	Unscheduled Care Governance group review trends associated with reported incidents and associate actions	SAI incidents reviewed by SPPG	Unscheduled Care Governance meeting notes
Twice daily Post Take Ward Round with senior AMU Nurse support	All new patients for admission review in the morning and late afternoon	Morning Post Take Medical Ward Round supported by Band 7 AMU Nurse supporting admission avoidance through access to Acute Hub where possible		Nursing and Medical rotas **7 July 25 Update** - An additional Consultant will be recruited into the Acute Medical Team to support a move towards a live PTWR (from £2 million Unscheduled Care funding)
Review of Nurse staffing model within ED being facilitated by Nursing Workforce Team, reflective of the 50 average patients waiting for admission daily within the department	Review outcomes to be discussed with AD Nursing Workforce and AD Unscheduled Care in May 2025 to agree way forward			Feedback will be provided when available
Senior Medical Staff rotate through UHD ED, Downe UCC and LVH UCC providing increased resilience in terms of staffing model across Trust Emergency and Unscheduled Care provision	Clinical Director and Assistant Clinical Director provide oversight of cover arrangements across all sites and alter allocations if required to	Any issues escalated to AD Unscheduled Care and agreement to provide locum support when required		Medical rotas

	maintain service provision			
ED Transfer team	Nurse and porter available during the day to facilitate transfers of patients for diagnostics or transfer to ward	Cover for Transfer Team reviewed by Nurse in Charge ED and Lead Nurse		ED Nursing Roster Also being included in review of ED Nursing Staffing model (noted above)
Trust wide Hospital and Community Flow Oversight Group with overarching Locality Plan 25/26	Fortnightly oversight group	Operational groups for Hospital and Community meet fortnightly to review Locality Plan	RCC Affiliate representative on Trust Hospital and Community Flow Oversight Group	Trust Locality Plan 25/26 (previously 24/25)

Progress against planned actions:

Additional update as of 7 July 2025:

New Urgent Care Centre

The Minor Injury Unit at Ulster Hospital has now closed and an urgent Care centre opened on floor below Emergency Department. The UCC opened on 19 June 0225. While there are no additional staffing attached with this move, the adjacency with ED facilitates greater opportunities for patients to move between both units.

Ambulance Handover Times

As part of the regional Support and Escalation Framework, Ambulance Handovers greater than 2 hours have been escalated for all Trusts from Level 2 to Level 3. Continued focus on the above actions will continues to prioritise. With high levels of non-designated beds in place, high medically fit numbers and average of 50 DTAs in ED, the handover times during the latter part of this quarter have deteriorated. As necessary, this is escalated to RCC o request support from neighbouring Trusts to reduce the risk of other longer ambulance delays.

Reducing time in ED now a Level 3 SIF with particular focus on reducing 12-hour ED delays.

Additional update for Quarter 2 - 16 October 2025

- During September 2025 the 3pm Control Room meeting has an earlier slot of 2:30 which provides a little more time in the afternoon to address any outstanding actions to support patient discharge
- To support the financial recovery plan NDBs in three wards were reduced (downturn of 12 NDBs). This will be monitored closely to ensure unscheduled care pressures are managed appropriately
- Due to low usage of Discharge Lounge on Saturdays, this Saturday opening time has been stopped
- Recurrent funding has been made available through the Unscheduled Care pressures £2 million investment. These allocations will be monitored through the Trust Locality Plan
- Safer Care monitoring of patient acuity of DTAs in ED is ongoing to inform review of ED Nurse staffing
- Regional workshop on Ambulance Turnaround Times was held on 29 August 2025. Expectation that Trusts work towards reduction of wait times – 4hrs in September, 3hrs in October 2.5hrs November and 2hrs by December. Turnaround continues to be a challenge at the Ulster site and system wide actions to address are contained within the Trust Locality Plan

Gaps in Controls	Required Action	Action Lead	Target Completion	Monitoring	Progress
Current in-patient capacity not meeting demand, therefore long waits for patients awaiting admission and ambulance handover delays	Outcome of regional demand / capacity review awaited from RCC	Feedback on outcome of regional demand capacity will be fed back to Director of Unscheduled Care, Medicine and Cancer. **RCC/SPPG**		Updates will be provided by RCC and SPPG (weekly Director's meeting).	

While average ambulance handover times have improved over past 15 months, a consistent improvement with all handovers being less than 2 hours has yet to be achieved. **Quarter 2 2025/26** Ambulance Handover times at Ulster site have deteriorated during September 2025	Hospital and Community Flow Locality Plan 25/26 provides detail of the system wide actions being taken to reduced ED congestion, reduce Ambulance Handover times. **Quarter 2 2025/26** Above ongoing. Hospital and Community Flow oversight chair, CM Dickson now replaced by Veronica Clelland	Marc Neil and Clare-Marie Dickson co-chair Hospital and Community Flow Oversight Group	March 2026	Fortnightly review of Locality at Trust Hospital and Community Flow Oversight Group	
NMDITA Senior Higher Level Trainee allocation WTE is below expected level leaving gaps in the overnight rota. Current mitigation of Consultants, Speciality Doctors and other trainees providing out of hours cover is difficult to sustain	- Increase in NMDITA Higher Level Trainee allocation – previously escalated to NMDITA - Increasing trust employed Speciality Doctor level doctor with night cover included in their role - Reviewing other options. **Quarter 2 2025/26** - Interviews held for Specialty Doctors in ED at Ulster Hospital. Two posts offered with waiting list to address other pending gaps. Currently with Finance to convert Consultant PAs to fund posts from wait list and increase resilience.	B McFetridge A Dobbin	August 2025		
Gaps in Assurance	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**

Board Assurance Framework Risk Document 2025-2026						
BAF – 09 Planning, Performance and Informatics	**Title**	**Inability to cope/meet the growing cyber threats**			**Lead Director**	**Helen Moore**
Risk Grade	**Consequence**	**Major**	**Likelihood**	**Almost Certain**	**Risk Grade/Score**	**Extreme (20)**

Risk Description

CAUSE	EFFECT	OUTCOME
Lack of investment and resource across Cyber and Business as Usual staff groups required to bolster the Trust cyber defences and the increased appetite from external threat actors.	There is a risk that the Trust is unable to cope/meet the growing cyber threats	Increased risk to the Trust ability to provide direct Patient/Client care due to clinical & administration information systems being compromised. Potential for Trust to not be fully compliant with Network Information Systems (NIS) Regulations.

BAF Risk Detail

Corporate Objective	**Safety, Quality and Experience of Care**	**Risk Category**	**Patient Safety/Clinical**		
Board agreed Risk Appetite		**Within Board Risk Appetite/Tolerance?**	**No**	**Board Response**	**Treat**
Board agreed Risk Tolerance					

BAF Risk Journey

Inherent Score	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Risk Owner Target Score
Extreme (25)	**Extreme (20)**	**Extreme (20)**			
Risk Direction	⟷	⟷			
Has Risk Owner Target Score been met?	Choose an item.	**If YES – provide Rationale for Inclusion**			

Controls	Assurances			Evidence
	1st Line	**2nd Line**	**3rd Line**	
Technical: • HSC Digital Services Security Infrastructure • Trust Digital Services Security Infrastructure • Trust Staff Secure Remote Access • Managed Digital Services (servers and systems owned and controlled by Trust Digital Services Department) Data & System backups • Server / Client software updates (patching) • Network segmentation (partitioning) • External Penetration (PEN) Testing (method of gaining access/breaching the security of an IT system) reports and recommendations	**Level 1** • Digital Health and Information Governance Sub Committee • Governance Assurance Committee • Trust Board • Audit committee • Vulnerability Management Group • Cyber Security Oversight Group	**Level 2** HSC SIRO Forum for shared learning and collaborative action planning and delivery HSC Planning/Strategic Direction Contract Management & Reviews	**Level 3:** Internal audit Assessment against ISO27001, CESG Cyber Essentials Guide IT Self-Assessment Against NCSC 10 Steps Technical Risk Assessments or Penetration Tests NIS Assessment	Technical: • HSC Tactical Recommendations as part of regional Cyber work plan and reviews • Trust Developed Work plan to support Digital Services Security Infrastructure • Scheduled Backups conducted, Checked, Test restores, tamper proofed for Cyber security, Managed in Controlled Environment Data Centres • Weekly Endpoint Security Dashboard Monitoring (discussed at quarterly CSOG) • Tactical recommendation overview provided as a reassurance for the region. • Trust Policies

• Technology used regionally across BSO and Trusts such as Checkpoint Software (Remote logon) and Two Factor Authentication • Extended Support Contract with MS for Out of Support Servers/SQL Servers	• Regional Digital Health & Care Board • Regional Cyber Security Programme Board • IG Oversight Group • Digital Services Senior Management Team • CSOG Meetings review of Cyber KPI Dashboard. • Vulnerability Management Group Monthly Meeting	Information Governance Advisory Group (IGAG) Regional Cyber Programme Board – Regional Organisational Controls Assurance programmes for both Digital Services and IG	Data Access Agreements & MoU's Development of Service levels DPIAs Supplier / Partner Framework	○ Regional Information Security Policy; ○ Suite of Information Security All User & Technical Standards ○ UK General Data Protection Regulation (UKGDPR) and the Data Protection Act 2018.
Governance • Network Information Systems (NIS) Cyber Assessment Framework (CAF) and Bi-Monthly Compliance Meeting to scrutinise the action plan. • User account management processes in place. • HSC Information Security, Policy, Standards, HR Disciplinary Policy, Records Management Policy (2021), Guidelines • Vulnerability Management Groups (VMGs), Corporate Risk Management Group (RMG), Trust Cyber Security Oversight Group (CSOG), Emergency Preparedness & Business Continuity Sub-committee (EP&BCSC), Trust Board, NIS Working Group. • All corporate risks reviewed Quarterly, and update provided Quarterly to Trust Board • Change Advisory Board (CAB) (Local and Regional)	As Above	As Above	As Above	Governance: • Internal audit / NIS Cyber Assessment Framework Self-Assessment and Controls Assurance Assessment • 14 out of 46 NIS CAF recommendations closed • Digital Services Vulnerability Management Groups (VMGs) regularly reviews and assesses Cyber threats and vulnerabilities • Digital Services Security regularly reviews and assesses service submitted Security Questionnaire • The NID (Network Infrastructure Design Group) - this regional group meets monthly to discuss all regional network related strategies including the review of regional cyber report (ANSEC), technical debt (£5.7 million SET as of 22nd Sept 2025), wired/wireless networking, network security and segmentation. • Regional HSC Operational Telecoms Group (Quarterly) has been established to provide a vehicle for discussion of issues and be a support network for colleagues to facilitate problem solving and sharing of good practice • Trust Policies

• Regional Oversight Governance Groups - Cyber Programme Board, Regional Cyber Leads • Regional and Local Incident Management reporting policies/procedures • Organisation Controls Assurance Standard • Datix for Incident and Risk Management • Regional & Trust Level CIRP in place • Corporate Business Continuity plan, Directorate Incident Responses Plans • DPA (2018) and GDPR Legislation, NIS Legislation • Information asset register				○ Regional Information Security Policy; ○ Suite of Information Security All User & - Technical Standards ○ UK General Data Protection Regulation (UKGDPR) and the Data Protection Act 2018.
People: • Information Governance (IG) & Cyber Security Training (Mandatory) and regional Metacompliance Training • Corporate Induction (Staff Welcome Pack) • Staff Communication and Awareness Plan • Cyber team all have ISC2 CC (Certified in Cybersecurity) and are working towards various accredited cyber related qualifications via the CBTNuggets platform such as CompTIA Cybersecurity Analyst CySA+ (funding for examination tbc) Best endeavour approach used to access Cyber expertise out of hours	As Above	As Above	As Above	People: • As part of the Regional Cyber Programme, several Regional Cyber Phishing Exercises have been carried out • 2022/23 Internal Audit - Cyber Training and Vulnerability Management - all actions implemented and accepted/closed • Mandatory IG and Cyber Security Training Reporting Available • Staff Communications - Keep Everyone In the Loop – Cyber Tips and Tricks • Regional E-Learning programme (Metacompliance) • Business Continuity (Desktop Exercise completed Feb 25 to test cyber response and Business Continuity Trust wide) • Trust Policies • Regional Information Security Policy; ○ Suite of Information Security All User & Technical Standards ○ UK General Data Protection Regulation (UKGDPR) and the ○ Data Protection Act 2018. • Limited assurance as to availability of cyber team during out of hours cyber incident
Supply Chain: • Data protection impact assessment (DPIA) (joint exercise trust/supplier) which includes	As Above	As Above	As Above	Supply Chain: • Trust Assurance Framework - Vulnerability Management Groups (VMGs), Corporate Risk Management Group (RMG), Trust Cyber Security Oversight

regular meeting process between Digital Services and Information Governance to agree actions • Digital Services Contract Management Review • Digital Services Technical & Security Questionnaire • Cyber Supplier assurance framework under review regionally • Any new cloud hosted products/services that have been procured are risk assessed through the DPIA process. Supplier's accreditations are evaluated during this process. • Any products/services that are procured through Digital Services are subject to project/operational managers review of the technical questionnaire. Formation of Technical Design Authority to be implemented going forward. • 3rd Party Contracts/ Data Access Agreements / Data Sharing Agreements - to support the legal contract • 3rd Party Secure Remote Access - technical process carried out by Digital Services e.g. Server Access remote access • Regional Data Protection Impact assessments are reviewed via the Regional IG Network Group which meets on a fortnightly basis. Any DPIAs of concern would be escalated to the DHIG and/or the Senior Information Risk Owner by exception only. SET (local) DPIA's are reviewed by the IG Department in conjunction with the relevant Service lead and will require Assistant Director/Information Asset Owner (IAO) approval prior to implementation of new process. Any concerns or issues identified by Information Governance with local DPIAs would be raised with the IAO and Senior Information Risk Owner.				Group (CSOG), Emergency Planning & Business Continuity Strategy Forum, Information Governance Steering Group Meetings, Corporate Governance Sub-committee (CGSG), Digital Health & Information Governance sub-committee, Corporate Controls Committee, Trust Board. • Technical Design Authority Implemented • Trust Policies (Digital Services/IG Policies) • Regional Information Security Policy; • Suite of Information Security All User & Technical Standards • Data Protection & Confidentiality Policy, • UK General Data Protection Regulation (UKGDPR) • Data Protection Act 2018. • Supply chain audit completed in Jan 2025

• The IG Oversight Group which reports to the DHIG held its inaugural meeting on 28/2/2025. DPIAs will be included this Sub Committee's Programme of Work				

Progress against planned actions:

Gaps in Controls	Required Action	Action Lead	Target Completion	Monitoring	Progress
Technical: Local Gaps in control • Lack of Funding to reduce technical debt • Lack of funding for required pen testing • Inability to obtain 100% coverage on security updates (patching) for managed and unmanaged systems • Out of Support Servers / Operating Systems (including Servers and Endpoints) • Out of Support SQL Servers	Technical: Local Gaps in control • Secure funding to reduce technical debt and as appropriate required pen testing • Commission and implement programmes of work / business as usual to ensure systems, services and associated infrastructure are in support / upgraded • Continue implementation of regional cyber security programme board priorities and internal Audit recommendation	Assistant Director for Digital Services	Ongoing relative to required investment	Digital Health & Information Governance Subcommittee	£300K allocation to support refresh of Storage Regional Oct Monitoring Round - £5.7M Bid to DOH by DHCNI
Corporate Gaps in control • Unable to detect and correct vulnerabilities and/or threats on all Non-Managed Digital Services equipment on Trust network (e.g. Radiology modalities, cameras, door access, medical devices) • Non-Managed Digital Services (servers and systems owned and controlled by Non-Digital Services Department) Data & System backups • Inability to carry out full system restores of large Trust based systems due to service and technical elements	Corporate Gaps in control • Continue to push for approval of the Regional Cyber Security Programme Business Cases to secure tools and most importantly resources to progress actions. • Trust wide escalation of cyber exercises – Corporate Cyber exercise conducted Feb 25	Assistant Director for Digital Services	April 2026	Cyber Security Oversight Group	
Independent Gaps in control • A security operation centre (SOC) is a control which is part of an internal audit	Independent Gaps in control	Assistant Director for Digital Services	April 2026	Digital Health & Information Governance Subcommittee	Interim tactical Wazuh Solution available

recommendation. The implementation of the SOC / SIEM is pending resource regionally • There is no regional monitoring of "Alerting" and thereby no reassurance on performance across the region or notification of potential breaches.	• Influence and support the development of a Regional SOC/SIEM Business Case. • As an interim develop a Trust level Monitoring Strategy that is based on 'Best Endeavours' relative to extant cyber resources and associated monitoring tools.				
Governance: Local Gaps in Control • Adherence to and compliance with Leavers and Movers • Supplier Framework - Resource required by SEHSCT. • Corporate Caps in Control Assurance that each critical service requires Business Impact Assessments to be completed	Governance: Local Gaps in Control • Joiner, Movers, Leavers Programme of Work initiated by OWD led by David Cairnduff • Await Regional Supplier Framework 2.0 version to be released to HSC for Trust implementation • Compliance relative to Independent Control Assurance needs to be maintained by all Trust Services	All Trust Services	April 2026	Digital Health & Information Governance Subcommittee	
Independent Gaps in Control • The Trust have received an independent report from the Competent Authority in relation to the Network Information Systems (NIS). The Cyber Assessment Framework (CAF) made recommendations against several objectives including Managing Security Risk; Protecting against Cyber Attack; Detecting Cyber Security Events; and minimising the impact of Cyber Security Incidents. These recommendations have been incorporated into the Cyber Security work plan.	Independent Gaps in Control • Investment in Trust Wide NIS Capability including NIS Team & awareness / adherence to regulations across all essential services	All Trust Services	2028	Digital Health & Information Governance Subcommittee	Regular Compliance meetings with DOF including presentation of progress on recommendations.
People: Corporate Gaps in Control • Progress required to meet KPI of 80% for Information Security and Cyber Awareness Training • Increase buy-in from Services to agree maintenance window with Digital Services regarding their departmental systems • MFA (Multi Factor Authentication) Uptake	People: Corporate Gaps in Control • Continue to ensure compliance with KPI of 80% for Information Security and Cyber Awareness Training • Implement pathfinder MFA project to bolster 2 factor authentication • Complete / Finish Joiners, Movers, Leavers Work stream • Continue to influence in terms of the opportunity to bolster Out of Hours support for Trust information	All Trust Services	April 2026	Digital Health & Information Governance Subcommittee	

• Adherence to and compliance with Joiners, Movers, Leavers • OOH cover/capability for cyber-attack is based on best endeavour	systems (informed by regional programme including evolve)				
Supply Chain: Local Gaps in Control • Previously agreed (non-Digital Services Managed) Contracts may not reference Cyber Security and Data Protection clauses • Non-Digital Services Managed Contracts need a Trust Information Governance Clause included (Physical controls i.e. environment, equipment) • Lack of adoption of the entire Supplier Management Framework due to lack of funding for required resource	Supply Chain: Local Gaps in Control • Work effectively with partner or supplier organisations during recovery from a cyber-attack/incident on that partner / supplier organisation to seek assurance of cyber posture before re-engagement of data flows and / or services • Await Regional Supplier Framework 2.0 version to be released to HSC for Trust implementation	All Trust Services	April 2026	Digital Health & Information Governance Subcommittee	
Gaps in Assurance	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
Technical: Local Gaps in Assurance • External factors impacting on diversion of Digital Services technical resources and skills which are outside Trust control e.g. HSE security event or major global vulnerabilities • Delays in the implementation of the HSC Technical Recommendations and local work plans due to resource/funding and available skills sets • There will always be versions of software that will not be up to date at various points in time e.g. Legacy Systems	Technical: • Review and implement previous Internal Audit & NIS recommendations • Increased hardening of HSC digital infrastructure informed by recent cyber-attacks in private and public sector. Regional Internal cyber security audit 2023/24.	Assistant Director for Digital Services	Ongoing relative to required investment	Digital Health & Information Governance Subcommittee	
Corporate Gaps in Assurance • It is not technically possibly to restore full systems - services need to be made aware of this and include this issue in their own business continuity plans and risk registers	Corporate • Continued upgrade of Trust infrastructure including servers and associated systems to ensure same are in support and reduce degree of vulnerability to potential cyber attack	Assistant Director for Digital Services	Ongoing relative to required investment	Digital Health & Information Governance Subcommittee	

• Unable to have consistent software updates of critical/core servers due to disruption to services • Unable to have consistent software updates, and/or end-point scanning exclusion lists applied, for critical core servers due to requests from Third Parties • The services will also have to include this as a Directorate Risk on their own risk registers Independent Gaps in Assurance • There is computer related equipment (PCs, medical devices etc.) on the Trust Digital Services Network which is not fully known nor 'segmented' (partitioned) as per 3rd party and Internal Audit (IA) recommendations.	• Continue to enhance Trust NIS compliance including formal audit in 2026 with full compliance achieved by 2028 • Bi-Monthly compliance confidence review meetings with DOF Competent Authority				
Governance: Local Gaps in Assurance • Supplier Framework - Resource required by SEHSCT. Corporate Gaps in Assurance: • Lack of awareness of the Cyber element of non-Digital Services managed tendering processes within the Trust	Governance • Adopt a Risk Management approach across Trust services for legacy systems/services that are unable to invest in required upgrades. • Continued utilisation of the Cyber Security Oversight Group to promote shared ownership of the Cyber Risk	Assistant Director for Digital Services	April 2026	Digital Health & Information Governance Subcommittee	Directorates advised to develop and maintain Risks associated with legacy systems
People: Corporate Gaps in Assurance • Gap in Funding for and experience of Cyber Staff within Trust • Gap in assurance that services provide sufficient time to reboot/patch Digital Services equipment • Assurance has increased in cyber skills due to increase in staff training (KPI is 80%) • Staff using unapproved and unsupported communication tools on personal devices i.e. Instant messaging solutions for patient care containing Trust data • Succession Planning	People • Continue to develop staff awareness in relation to Cyber • Continue to invest in Cyber Staff including resource and professional development • Continue to invest in the professional development of staff including mandatory Cyber and Information Governance training plus specialist training for Digital Services staff (Cyber and Business as Usual)	Assistant Director for Digital Services	Ongoing relative to required investment	Digital Health & Information Governance Subcommittee	Cyber Staff awareness campaign ongoing coupled with focus on mandatory training

• Limited arrangements for OOH cover/capability for cyber incident as based on best endeavour					
Supply Chain: Local Gaps in Assurance: • The process for adopting the Supplier Management Framework will take time and resource to implement and accept within the HSC. • Reluctance on the part of Third Parties to accept the processes and procedures put in place by Trust/HSC regarding Cyber Security, • Competency of the Third-Party Suppliers where there is a gap with their level of Digital Services/Cyber skills	Supply Chain • Create Technical Design Authority process and associated scrutiny group to assure security by design and functional correctness in procurement. • Implement the Regional Supplier Framework Review 2.0 (subject to this being published in year) • In event of a supply chain cyber incident monitor supplier organisations and reconnect as appropriate through regional Digital Services management process. Produce EMT brief for each incident	Assistant Director for Digital Services	April 2026	Digital Health & Information Governance Subcommittee	Technical Design Authority process and associated scrutiny group established

APPENDIX 1 Board Assurance Framework and Corporate Risk Register Correlation

Directorate	BAF REF	CRR REF	Title
Finance and Estates	BAF - 01	FE1-22/23	Inability to achieve recurrent financial stability
Finance and Estates	BAF - 02	FE2-22/23	Inability to ensure the quality of the aged built environment and associated infrastructure
Planning, Performance, and Informatics	BAF - 03	PPI1-22/23	Inability to deliver against the commissioned performance targets Trust wide
Adult Services and Prison Healthcare	BAF - 04	ASHIP2-22/23	Inability to deliver seamless mental health acute in patient services on a single site consistent with best practice
People & Organisational Development	BAF - 05	HRCA1-22/23	Risk to delivery of services and patient safety due to significant workforce capacity challenges.
Unscheduled Care, Medicine & Cancer	BAF - 07	HS1-22/23	Inability to provide safe and effective emergency care at Ulster Hospital
Planning, Performance and Informatics	BAF - 09	PPI2-22/23	Inability to cope/meet the growing cyber threats
	CRR Only		
AHP, Nursing Midwifery, User Experience	HRCA2-22/23		Inability to maintain a satisfactory linen decontamination service
People & Organisational Development	HRCA3-22/23		Performance within Recruitment Shared Services Centre
Children's Services and Social Work	CSSW1-22/23		Inability to provide appropriate safe staffing required in Lakewood Regional Secure Care centre
Children's Services and Social Work	ASHIP5-22/23		ASW- Statutory Function Role
Children's Services and Social Work	CSSW2-24/25		Impending Social Work Industrial Action
Surgery, Elective Care, Maternity & Paediatrics	HS2-22/23		Inability to provide adequate QA performance testing of X-ray equipment due to limited RMPS resources
Adult Services and Prison Healthcare	AD/DIS/RR7		Closure of MAH in absence of commissioned community infrastructure and LD strategy or service model
Primary Care & Older People Services	PCOP4-22/23		Inability to manage historical CHC cases from both SEHSCT and regional perspective
Primary Care & Older People Services	PCOP6-24/25		Special Schools AHP Workforce pressures – Children with Special Educational Needs
Surgery, Elective Care, Maternity & Paediatrics	SECMP1-22/23		Inability to provide safe and effective intrapartum care at Free Standing Midwifery Led units (FMLUs) and at home births
Surgery, Elective Care, Maternity & Paediatrics	SECMP2 -23/24		Inability to provide a regional Second Trimester Surgical Termination of Pregnancy Service at South Eastern Trust.
Finance and Estates	FE4-24/25		Trust Fire Safety Management
Planning, Performance and Informatics	PPI4-24/25		Encompass Stabilisation
Adult Services and Prison Healthcare	ASHIP5-24/25		Addictions
Children's Services and Social Work	CSSW3-25/26		Lack of Short Break Provision and Volume of Unallocated Cases Added Q1 25/26
Finance and Estates	FE5-25/26		Non Compliance with Public Contract Regulations 2023 in relation to Purchased Healthcare Added Q1 25/26
Finance and Estates	FE6-25/26		Non Compliance with Public Contract Regulations 2023 in relation to social care contracts Added Q1 25/26
Finance and Estates	FE7-25/26		Medical Devices Added Q2
Adult Services and Prison Healthcare	ASHIP6-25/26		Rise in volume and complexity of Prison population, on background of undercommisioning Added Q2

APPENDIX 2 – Corporate Risk Register

Adult Services and Prison Healthcare

CRR Reference	ASHIP5-25/26	Risk Title	Addictions	Current Risk Level	Extreme
Quarterly Update					
Currently appealing judicial review outcome. Recruitment ongoing, 1.8 WTE band 6 in recruitment process. Continue to work through waiting list. Magilligan waiting list reducing with additional band 6 Practitioner now in post. Exploring impact on activity with Adept and proposed 5 % reduction in contract. Exploration of changes in OST prescriptions and impact on pharmacy costs with increase in Buvidal prescribing.					
Previous Quarterly Update					
Outcome of relief hearing of judicial review is still pending. Longest wait and numbers waiting continue to reduce, with waiting list lowest since Feb 2021. Positive recruitment to 2.0 WTE Addictions Practitioner, however 1.0 WTE was in existing EOI so net increase in staffing of 1.0 WTE Addictions Practitioner. This includes recruitment to Magilligan, which is historically difficult to recruit to due to geographical area 1:8 WTE Band 6 post and 0.75 WTE Band 3 going out for recruitment Inescapable pressures, highlighting Addictions risk and performance, was sent to Improving Health in Criminal Justice Group/Committee co-chairs in Q1 (16.05.25) Discussion regarding performance also at Quarterly performance meeting on 17.05.25. Due to direction to provide 5% cost savings, it is likely that AD: EPT contract will be impacted, with reduced activity as a result Increased frequency of patients being switched from one form of OST, and patients into and out of CSU to another leading to increased pressure on service Pressures within Primary care, challenging further increase in caseload					

CRR Reference	AD/DIS/RR7	Risk Title	Closure of MAH in absence of commissioned community infrastructure and LD strategy or service model	Current Risk Level	High
Quarterly Update					
CATU business case has been resubmitted to SPPG and awaiting funding for revenue costs. Capital costs have been agreed in Trust and work will proceed to tender. In absence of funding agreement LD service has agreed a phased approach to assessment and treatment offering some wraparound support throughout afternoons and evenings. Discussions re retraction of MAH funding are ongoing regionally and focusing currently on LD Psychiatry from BHSCT to SET Further BC has been submitted in relation to final three service users resettlement plans. Additional staffing contingency is required to allow Vianstown to progress and to date there is no regional community Forensic placement to support the SET service user. There has been no agreement in relation to the BC for an LD Inpatients Unit within SET despite the strategic direction under current consultation, LDSM.					
Previous Quarterly Update					
CATU capital works have been submitted for tender processing. Final business case has been submitted to SPPG for capital and revenue ISS recruitment remains a priority to stabilize Community services Discussion ongoing with BHSCT re LDMH Psychiatry commissioning arrangements					

CRR Reference	ASHIP625/26	Risk Title	Rise in volume and complexity of Prison population, on background of under commisioning	Current Risk Level	Extreme

Quarterly Update

2nd July 2025 Third of 3 Joint Ministerial visits to Prisons, written and verbal briefing raised issues around population rise and commissioning.
7th July 2025 Response from SPPG regarding query from HIP AD around HIP medication budgets to be aligned with community pharmacy budgets, advising that this is not being considered.
7th July 2025 request by SPPG, to rework the inescapable pressures paper submitted ""to include SET HIP Team actions to mitigate the current service risk, including the impact monitoring and timescales of these actions"".
Meeting undertaken on 8th August, with outcome for HIP Pressures paper to be submitted (submitted 19th August). Meeting 22nd August meeting with SPPG, to discuss HIP Pressures paper with outcome being a workshop, arranged for 13th October.
Outcome of meeting of 13th October, was no immediate in year monies likely, and guidance to follow from SPPG for reworking of HIP pressures paper.
Exploration by SPPG regarding regional growth monies, and high cost drugs budget.
Approval via EMT, for at risk additional 10 WTE nurses to reduce clinical risk, and financial risk of use of agency, and commenced mid-September.
The number of Datixweb incidents has increased by 54% from Q2 last year and nearly 200% increase from Q2 2021/2. HIP encompass Go Live 6th November.

Discussions with NIAS around supporting paramedics to be transferred from agency to substantive staffing, to reduce financial risk not progressed due to NIAS workforce challenges.

Previous Quarterly Update

N/A Risk Added

CRR Reference	ASHIP2-22/23	Risk Title	Inability to deliver seamless mental health acute in patient services on a single site consistent with best practice	Current Risk Level	High

Quarterly Update

There has been no further development in respect of Business Case and still remains a priority for MH services to have a new acute inpatient facility at the Ulster Site that meets the needs of patients. Centralisation will improve patient flow and timely access to medical care as and when required. This will improve continuity in staff resource due to geographically able to cover and assist in times of high demand. The number of Datixweb incidents has increased by 54% from Q2 last year and nearly 200% increase from Q2 2021/2. HIP encompass Go Live 6th November.

Discussions with NIAS around supporting paramedics to be transferred from agency to substantive staffing, to reduce financial risk not progressed due to NIAS workforce challenges.

Previous Quarterly Update

MH continue to champion and advocate the need for new purpose build acute inpatient facility on the Ulster Hospital site to promote the safety and well-being of their patients. The service replies promptly to any requests for additional information. There is currently nothing outstanding to respond.

Children's Service and Social Work

CRR Reference	ASHIP5-22/23	Risk Title	ASW- Statutory Function Role	Current Risk Level	High

Quarterly Update

1. No change as no additional funding allocated to Trusts. RESWS are no longer taking over delegated responsibility after 5pm if a detained patient is still waiting for a bed. For protracted waits the expectation is Trusts are to stay with patients. RESWS advise cannot be held with a patient if other requests come in and have limited resource.

2. There is no formal after 5pm service and is very haphazardous. Staff who participate is from good will.

3. No change - this is limited to 3 senior staff. Needs reviewed as impacting day time cover as affects other areas of work being covered. Exploring if other support can be provided by relevant 8a managers.

4. Two redeployed staff joining the ASW team permanently from December 25. Another one needs to be recruited permanently and will go out to advert. There is only funding for x3.0wte.

Previous Quarterly Update

N/A Risk Added

CRR Reference	CSSW2-24/25	Risk Title	Impact of ongoing Social Work industrial action	Current Risk Level	Extreme

Quarterly Update

- Ongoing work and negotiations between the Trusts and Unions regarding the Industrial Action
- The Directorate continues to develop and implement continency plans to respond to Industrial Action to ensure that the levels of risk are mitigated against
- Update in regards to proposed case load capping; there has been no further action taken in regards to this proposed action
- There remains to be ongoing recruitment activity across sub directorates to improve staffing in areas.
- There remains to be the ongoing improvement work streams in Children's Services which is focusing on improving outcomes for children and young people as well promoting more robust delivery of safe and effective care.

Previous Quarterly Update

- Ongoing work and negotiations between the Trusts and Unions regarding the Industrial Action
- The Directorate continues to develop and implement continency plans to respond to Industrial Action to ensure that the levels of risk are mitigated against
- There were concerns in regards to proposed industrial action relating to capped case loads in safeguarding. The AD for Safeguarding produced an analysis that the impact of this industrial action would have in regards to the increase in risk for children and young people known in the service.
- The outcomes of this report was shared to SMT and EMT as well as with regional colleagues
- Agreed that if the capped case loads were to be implemented, the Directorate would seek legal advice from DLS regarding the concerning impact on the safety of families by this Industrial Action.

CRR Reference	CSSW1-22/23	Risk Title	Inability to provide appropriate safe staffing required in Lakewood Regional Secure Care centre	Current Risk Level	High

Quarterly Update

-The capping of beds remains to be ongoing. The centre is currently capped at 12 The RND assessment tool continues to be utilised to evidence base the centre's capacity
-SET have escalated concerns onto the Support Intervention Framework as level 2.
- The ongoing reduction in occupancy is supporting to reduce risk; however, there remain to be ongoing challenges due to the ongoing complex needs of the young people residing in Secure Care
-Early alert issued on 12/9 due to concerns about the secure doors and delay in outsourcing secure doors, impact on environmental safety for staff and young people.
Estates have prioritised reinforcement solutions in the interim until key doors are replaced
Estates have asked for contractor to complete a health check on PIN system
-Staffing levels continue to be a concern with staff on sick leave/deployment/investigations
- Focus is on recruiting staff/training staff
-SET will be leading a Regional on Workshop 6/10 to look at expectations from Trust regarding the service specification and contingency solutions regarding staffing/Training of staff
-EMT briefed weekly
-Trust Board briefing submitted

Previous Quarterly Update

- Update remains to be ongoing as per previous quarters
- Commissioning statement has been agreed with SPPG and implemented within the service
- Increase in level of risk due to increased complexity in the presenting needs of young people in Secure Care. This resulted in an increase in assaults on staff, increased staff sickness and impact on delivery of safe and effective care
- Secure Care enacted the escalation process to SPPG to support with reducing the occupancy levels in the home due to the complexity in the service and the reduced staffing numbers
- Secure Care worked with SPPG to reduce occupancy. The Risk, Needs and Dynamics risk assessment tool was utilised to support with this alongside weekly meetings with SPPG to review occupancy

CRR Reference	CSSW3-25/26	Risk Title	Lack of Short Break Provision and Volume of Unallocated Cases	Current Risk Level	Medium

Quarterly Update

- There has been an ongoing recruitment drive within CwD Service which has focused recruiting a range of staff for various roles across the service.
- The new roles are focused on extending the service and being able to open additional short break facilities for young people in the CwD Service.
- The recruitment drive has been successful in recruiting the majority of posts; however, there will need to be a mop up recruitment day.
- There is ongoing work with Estates and other relevant departments to focus on opening a new facility - Redwood. This will ease the pressure on the current residential facilities and will enable the provision of short break stays.
- There is also ongoing work across the current residential facilities to improve the quality of care being provided to the young people who reside there.
- There has been inspection activity in 2 of the residential homes which has resulted in failures to comply being issued to one home and Serious Concerns being raised about another home.
- Additional staff have been allocated to support the service. An additional Band 8B HOS has been seconded to take responsibility for CwD residential and the existing HOS will focus on CwD community services. The HOS for governance was also tasked with focusing on ensuring improvement for the Failure to Comply notices.
- The outcomes from this focus on CwD services has been positive and the FTCs have been lifted from the home.
- Improvements and learning continue to be spread and scaled across the CwD residential Services.

Previous Quarterly Update

N/A Risk Added

Finance and Estates

CRR Reference	FE1-25/26	Risk Title	Inability to achieve recurrent financial stability	Current Risk Level	High
Quarterly Update					
To date the Trust has identified £32.5 of savings to address the Phase 1 target. Work remains ongoing both internally and with the external support. SPPG updated regularly on progress.					
Previous Quarterly Update					
External Support has been secured to work towards full achievement of required savings target for the Trust in 25/26. Diagnostic phase in process and Q2 will see implementation of said plans. To date, Trust has identified £25.4m of £38m target. Work ongoing internally to further savings.					

CRR Reference	FE7-25/26	Risk Title	Management of Medical Devices	Current Risk Level	Extreme
Quarterly Update					
Risk Added Q2					
Previous Quarterly Update					
N/A					

CRR Reference	FE5-25/26	Risk Title	Non Compliance with Public Contract Regulations 2023 in relation to Purchased Healthcare	Current Risk Level	High
Quarterly Update					
Trust continue to engage in regional groups to progress compliance. DoF leading regional group on Region Wide EOI processes and exploring trialling of compliant procurements					
Previous Quarterly Update					
Added Q1 25/26					

CRR Reference	FE6-25/26	Risk Title	Non Compliance with Public Contract Regulations 2023 in relation to social care contracts	Current Risk Level	High
Quarterly Update					
Trust continues to work on all regional groups to progress this matter.					
Previous Quarterly Update					
Added Q1 25/26					

CRR Reference	FE4 - 24/25	Risk Title	Trust Fire Safety Management	Current Risk Level	Extreme

Quarterly Update

(i) Q2: on-going
(ii) • Q2: Q1 work on-going
• Internal Audit 2021-22 re: Directorate Fire Warden Assurance was closed out in Q2.
(iii) EMT paper review delayed - Directorate responsibility and funding is still under consideration, resolution early Q3.
(iv) • EMT paper for the proposed new Trust training arrangements was presented in Q2.
• In Q2 the Estate Services Department undertook a review of HTM05-03 Part K (please see under Item (v).
• Estates aiming to establish a new fire safety group to deal with the fire risk assessment aspects of PEL(24)01. The first meeting of this group is proposed for Q3.
• Attendance at fire safety sub-committee will be kept under review and ongoing.
(v) • Attendance at fire safety sub-committee will be kept under review and ongoing.
• The new HTM 05-03 Part K introduces two key recommendations that have significant implications for Trust fire safety governance. These are: (i) the requirement to undertake Primary Fire Risk Assessments (PFRA) across the estate and (ii) the appointment of Authorised Persons (Fire Safety Maintenance) to oversee the planned preventative maintenance (ppm) and corrective maintenance of life safety fire protection systems. While these systems are generally in place, they currently exclude fire compartmentation. Due to legacy issues and the absence of comprehensive fire safety documentation (fire strategy reports/drawings and cause-and-effect matrices etc.) the cost to establish the necessary baseline fire safety information to support PFRA is estimated at approximately £3.3 million. The recurring annual costs associated with maintaining fire compartmentation are approximately £2.5 million. Given the extent of capital investment required and the current financial pressures facing the Trust, it was recommended at the meeting that compliance with Part K be escalated to this and the aged Corporate Risk Register and Board Assurance Framework. Estates reiterated to the meeting that the most effective control measure to reduce fire risk remains fire prevention, supported by adequately trained staff across the Trust.

Previous Quarterly Update

(i) • Fire training continues to be promoted quarterly through Trust email. Staff are also reminded through LMS when their training has lapsed. Training attendance with the exception of Fire Wardens remains poor. • Fire training improvements needed was raised at the Q1 fire safety sub-committee to Directorate Fire Champions and to escalate through their line management for resolution. • Finance & Estates advised in Q1 by internal audit that ongoing monitoring will continue until mid-year. • Paper to EMT on the potential to develop a bespoke e-learning healthcare course for general fire is underway for issue in Q2.
(ii) • 2024-25 Estates led audit data was reviewed in Q1 and fire safety manual record keeping remains poor. This is corroborated by the fire risk assessment local management actions returns which are 44% completion rate. • Local fire risk governance improvements needed was raised at the Q1 fire safety sub-committee to Directorate Fire Champions and to escalate through their line management for resolution.
(iii) Process formalised. Final paper to EMT early Q2.
(iv) Estates preparing a number of papers in 2025-26 on the issues with achieving compliance. Fire Training paper presented to fire safety sub-committee in Q1. This focused on the Staff Training Needs Analysis.
(v) Attendance at fire safety sub-committee will be kept under review.

People and Organisational Development

CRR Reference	HRCA3-22/23	Risk Title	Performance within Recruitment Shared Services Centre	Current Risk Level	Medium
Quarterly Update					
The Vacancy control process continues to be applied and monitored. Recruitment training continues, with the online training fully imbedded and face to face training fully attended. We continue to work with service to workforce plan and support through recruitment processes.					
Previous Quarterly Update					
Vacancy control measures have been put in place leading to a reduction in posts advertised. Regular communication has been issued in relation to recruitment training which has led to training sessions being well attended. We continue to work with the service to workforce plan effectively, reviewing hard to fill posts on a regular basis.					

CRR Reference	HRCA1-22/23	Risk Title	Risk to delivery of services and patient safety due to significant workforce capacity challenges.	Current Risk Level	High
Quarterly Update					

Nursing

The Trust continues to proactively recruit to nursing/midwifery posts across all fields of practice. The Nursing Workforce team work alongside areas that have recruitment/retention challenges and there is a significant reduction in vacancies. However, it should be noted that this is based on funded establishment and is not reflective of the current need based on an increase in demand and complexity of patients.

Medical

No requirement to develop action plans as medical recruitment is performing satisfactorily. All Trusts are experiencing significantly high levels of applications for some Junior Clinical Fellow post's and there remains challenges with some hard to fill Consultant level posts. Services are actively being encouraged to consider the different recruitment options to help reduce agency spend and improve service continuity.

Social Work

The latest round of regional recruitment closed on 16th September with 148 applicants shortlisted. Interviews are scheduled for 6 – 9th October with local matching commencing 20th October. Successful candidates will be offered the opportunity to join the Trust's Social Work Bank list. Following regional recruitment there will be opportunity to undertake bespoke recruitment in areas that still have vacancies. The Trust has worked to complete recruitment of the 2025 NQSW cohort with 37 job offers made this year (15 NQSWs are now working in the children's safeguarding teams which had been a hard to fill service area). The Trust will be recruiting a social work and social care coordinator for the corporate bank, with the aim of increasing the usage of bank members of staff. Utilising DoH funding the Trust are also recruiting a Senior Social Worker within the Learning & Improvement Team whose focus will be on attraction, recruitment, retention and wellbeing of staff. This post will strengthen recruitment activity already being undertaken, as well as starting to develop retention and wellbeing strategies in key areas of the Trust.

AHPs

A regional group has been created for the international attraction of AHPS. The group is currently scoping out the benefits of international recruitment verses the challenges to determine appetite. Local and regional waiting lists remain in place.

Previous Quarterly Update
Nursing While there are still areas of nursing that have significant shortage such as mental health, there is a significant reduction in vacancies. However, it should be noted that this is based on funded establishment and is not reflective of the current need based on an increase in demand and complexity of patients. Medical No requirement to develop action plans as medical recruitment is performing satisfactorily. Demand for recruitment has increased and is expected to increase further over the coming months in preparation for Resident Doctor changeover in August. Regionally, all Trust's are experiencing significantly high levels of applications for some Junior Clinical Fellow post's and there remains challenges with some hard to fill Consultant level posts. Social Work The regional recruitment planner continues to be operational and runs to end December 2025 for all Band 6 social work posts. There is an opportunity over the Summer period for the Trust to complete bespoke recruitment campaigns for posts which remain "hard to fill". These vacancies will be determined upon completion of the graduate entrant process for newly qualifying Band 5 social workers in June. To date 33 wte vacancies have been filled across adult and children's services, with potential for a further 5 positions to be successfully matched. Bank social work recruitment continues on a rolling basis with the most recent cohort of successful applicants progressing through the relevant HR checks and processes. The Trust are also planning to undertake a recruitment exercise for Band 7, Bank Social Work staff. AHPs Work remains ongoing with regards the attraction and retention of AHPs across each profession and a considerable number of vacancies remain across professions. Local and regional Waiting Lists remain in place for entry level posts. The Trust Careers Fair – a great place to work took place on Saturday 1st March this helped with advertising posts. A scoping exercise has commenced to review an international recruitment program. "

AHP, Nursing Midwifery, Support Services

CRR Reference	NUEX2-25/26	Risk Title	Inability to maintain a satisfactory linen decontamination service	Current Risk Level	High

Quarterly Update

Meetings with estates and support services ongoing. Laundry PPM schedule still not available to laundry management
Finance continue to analyze cost of downtime and investigating potential options to stabilise Trust-wide supply of linen with senior management
Ongoing Estates interventions have led to less down this quarter but a number of essential pieces of equipment still remain out of service therefore affecting daily turnaround times

Previous Quarterly Update

Estates have sourced an alternative sub-contractor that has commenced snagging and addressing long standing issues with machinery and sensors from installation.

Meetings have occurred between Dir of Finance and Dir of NUE along with Estates and Support Services to monitor duration of downtime, cause of downtime, impact and costs.

Finance are analysing cost of downtime and investigating potential options to stabilise Trust-wide supply of linen with senior management

Some initial progress has been observed indicating the interventions may have led to less downtime but too early to determine with confidence.

PPM schedule still to be shared by Estates

Primary Care and Older Peoples Service

CRR Reference	PCOP4-22/23	Risk Title	Inability to manage historical CHC cases from both SEHSCT and regional perspective	Current Risk Level	High
Quarterly Update					
15/09/2025: Drafted email sent to DOH on behalf of older peoples services requesting a form of words as to how to respond, response awaited.					
Previous Quarterly Update					
16/7/25: Formal notification received by DOH on 17 1 24 that COPNI have appealed the outcome to the Supreme court. Outcome awaited					

CRR Reference	PCOP6-24/25	Risk Title	Special Schools AHP Workforce pressures – Children with Special Educational Needs	Current Risk Level	High
Quarterly Update					
EA data indicates continued significant growth in children requiring a special school/specialist placement for the 25/26 school year. Whilst numbers are still to be confirmed for SET this is likely to be c140 additional children for this school year. There have also been additional Specialist classes set up in mainstream schools bringing the SET number to 18 along with 6 special schools across 8 sites. This geographical spread continues to pose challenges for AHP service delivery. Following the meeting with CAHPO in June 2025 a task and finish group was not set up. PHA continue to lead on work scoping AHP needs of special school children commencing with those with complex needs on community children's nurses caseloads. SEN Coordinator, SEN Project Lead and SLT HOS continue to engage in meetings regarding this piece of work. It is to establish a baseline of AHP assessed needs which SPPG have requested. An Impact Briefing paper has been drafted which indicates that since September 2022 there has been a 500% increase in the number of specialist provisions in mainstream opened to cater for the lack of special, school places. The numbers of children placed in these settings ha grown from 32 in September 2022 to 169 in September 2025 (428% increase). SLT and Physiotherapy Special School caseloads have increased by 30% and 25% respectively since September 2022. In an attempt to address the assessed needs of children and meet statutory requirements staff from community AHP teams are supporting children which will impact on elective waiting lists. Calculations for OT and SLT indicate a projected shortfall in clinical hours across the school year of 897 hours per SLT to 935.5 hours per OT working in special schools and specialist mainstream placements. This means that new and review encounters are delayed, parent and staff training and support is reduced or not delivered, home visits including those to children's residential and short break settings will not be offered. Only children with assessed needs in highest priority groups will receive AHP services to ensure safe and effective service delivery.					
Previous Quarterly Update					
AHP ADs and AHP Children's Service leads met with the CAHPO, PHA and SPPG on 10th June to highlight pressures and gaps in services for children. A task and finish group is to be convened. SET Children's AHP Leads continue to engage with PHA and EA. EA are to contact to set up a trust specific meeting to look at additional numbers of children for 25/26 school year. Requests have come in from EA for 2 additional mainstream provisions along with additional classes being added to existing mainstream provisions. SET AHP Children's leads and SEN Project Lead continue to move forward with new models of service delivery and review of the regionally agreed prioritization document. New Sp-EYFs will be unable to be covered and children will remain on community caseloads for the new school year. All teams are under pressure to deliver services to the growing numbers of children and schools combined with other workforce issues such as maternity leave and sickness absence.					

Planning, Performance and Informatics

CRR Reference	PPI4-24/25	Risk Title	Encompass Optimisation	Current Risk Level	High

Quarterly Update

eOG continues to meet on 3rd Wednesday of each month to manage escalated issue that have come too satisfactory conclusion, through established process. These issues are now logged on regional Joint issues register which drives the top issues section of eOG
Additionally eOG received updates on standing strategic agenda items such as (HR, Digital Safety, Health in Prison Go-live and Work Q Management).
Trust has provided nominations for Pathway councils, which will continued to iterate and develop into the BAU governance structure for the programme. Invites have begun to be issued by teh regional team from these.
Trust engaged in encompass Regional Reporting Oversight Group and relevant sub groups to support improvements in reporting across the programme with regards both operational and statutory reporting.

Previous Quarterly Update

eOG continues to meet on 3rd Wednesday of each month to manage escalated issue that have not met satisfactory conclusion, through established process.
Additionally eOG received updates on standing strategic agenda items such as(HR, Digital Safety, Health in Prison Go-live and Work Q Management)
Trust engaged with regional BAU Workshop process, 3 workshop have take n place with further dates to be scheduled.
Trust engaged in encompass Regional Reporting Oversight Group and relevant sub groups to support improvements in reporting across the programme with regards both operational and statutory.

CRR Reference	PPI1-22/23	Risk Title	Inability to deliver against the commissioned performance targets Trust wide	Current Risk Level	Extreme

Quarterly Update

The introduction of the SOMs has continued to expand the Trust's performance monitoring arrangements. This will continue as the confidence and data quality of the data within the encompass system increases. Those SOMs with high or medium confidence are reported as part of the Trust Board performance monitoring arrangements. Monthly operation directorate performance meetings provide a mechanism to discuss performance issues with the operational services and advise issues for escalation to SPPG. Internal performance monitoring continues with current focus on long waiters across all specialties, but especially Gynae as part of the Provider Collaborative, Hospital at Home reporting and unscheduled care. The Trust continues to be represented on regional groups relating to data quality, data standards and performance.

Previous Quarterly Update

Currently the Trust is publicly performance monitoring through ministerial targets and legacy Service Delivery Plan arrangements while awaiting the finalisation of the System Oversight Measures (SOMs). The first tranche of SOMs are due to be reported on for quarter 2. The Performance department works closely with the SPPG and other Trusts on the development of these metrics. These will then be reported publicly through the Trust Board process.Internal performance monitoring continues, with the Performance department involved in targeted areas for example, Hospital at Home, Hospital and Community Flow and long waits oversight and implementation groups. The monthly operational directorate performance meetings provide operational services the opportunity to discuss potential performance strategies including escalation through the SPPG Support and Intervention Framework. The Trust continues to be represented on regional groups relating to data quality, data standards and performance.

CRR Reference	PPI2-22/23	Risk Title	Inability to cope/meet the growing cyber threats	Current Risk Level	Extreme

Quarterly Update

30/9/25 - - Action plan sections (what we have done in the Q2 / what we plan to do in Q3):

Technical Action Update
Secured £300K for investment in Technical Debt and re-profiled / updated our Technical debt register (£5.7 million SET as of 22nd Sept 2025). Regional Oct Monitoring Round - £5.7M Bid to DOH by DHCNI
Project Ongoing to upgrade unsupported infrastructure and systems including use of ESU / ARC
Development and implementation of Internal Audit recommendations including support of the development of HSC 25/26 Internal Audit Plan
Technical Design Authority Implemented

Corporate Gaps Update
Contributed to the revalidation of the regional SOC/SIEM Business Case Options
Trust attended Regional Cyber Exercise 30th May 2025
Digital Services CIRP Review / Cyber Exercise complete in April / May 2025
NIS Compliance Programme of Work including Digital Services NIS Workshop and continued development of capability relative to NIS CAF Assessment
Bi-Monthly NIS Compliance Meetings with Competent Authority continuing
Trust representation on NIS Audit Contract Adjudication Group and development of Request For Information to potential supplier
Interim tactical Wazuh Solution available

Independent Gaps Update
Contributed to the revalidation of the regional SOC/SIEM Business Case Options
Trust CIRP developed and approved by Trust Cyber Security Oversight Group (CSOG)
Interim Trust SIEM solution developed and evolving
Regular Compliance meetings with DOF including presentation of progress on recommendations

Governance Gaps Update
Joiners, Movers, Leavers Programme Work stream begun with initial focus on encompass
Trust Services advised via CSOG & Business Partners meetings of the need to develop service level Business Continuity Plans for systems that may be at risk
CSOG have met three times since their formation

People Gaps Update
Cyber Awareness ongoing including Phishing campaign in June 2025 (results pending)
Professional Development of Cyber Staff continues via Appraisal Process
Staff Communications - Keep Everyone In the Loop – Cyber Tips and Tricks

Supply Chain Update
Trust level collaboration continuing in the development of Regional Supplier Framework 2.0
Engagement with BT as a friendly supplier to understand how greater assurance can be gained from Supply Chain
Inaugural meeting of Technical Design Authority (TDA) in May 2025

Previous Quarterly Update
30/6/25 - Action plan sections (what we have done in the Q1 / what we plan to do in Q2): Technical Action Update Secured £300K for investment in Technical Debt and re-profiled / updated our Technical debt register (From £6.2M to £8.3M Q1 2025) Project Ongoing to upgrade unsupported infrastructure and systems including use of ESU / ARC Development and implementation of Internal Audit recommendations including support of the development of HSC 25/26 Internal Audit Plan Corporate Gaps Update Contributed to the revalidation of the regional SOC/SIEM Business Case Options Trust attended Regional Cyber Exercise 30th May 2025 Digital Services CIRP Review / Cyber Exercise complete in April / May 2025 NIS Compliance Programme of Work including Digital Services NIS Workshop and continued development of capability relative to NIS CAF Assessment Bi-Monthly NIS Compliance Meetings with Competent Authority continuing Trust representation on NIS Audit Contract Adjudication Group and development of Request For Information to potential supplier Independent Gaps Update Contributed to the revalidation of the regional SOC/SIEM Business Case Options Trust CIRP developed and approved by Trust Cyber Security Oversight Group (CSOG) Interim Trust SIEM solution developed and evolving Governance Gaps Update Joiners, Movers, Leavers Programme Work stream begun with initial focus on encompass Trust Services advised via CSOG & Business Partners meetings of the need to develop service level Business Continuity Plans for systems that may be at risk CSOG have met three times since their formation People Gaps Update Cyber Awareness ongoing including Phishing campaign in June 2025 (results pending) Professional Development of Cyber Staff continues via Appraisal Process Supply Chain Update Trust level collaboration continuing in the development of Regional Supplier Framework 2.0 Engagement with BT as a friendly supplier to understand how greater assurance can be gained from Supply Chain Inaugural meeting of Technical Design Authority (TDA) in May 2025

Surgery and Elective, Maternity and Paediatrics

CRR Reference	HS2-22/23	Risk Title	Failure by the Regional Medical Physics agency to meet the Trust SLA	Current Risk Level	Medium

Quarterly Update

Equipment continues to be maintained in accordance with manufacturer's recommendations and service contracts in place.
Limited RMPS resource continues to also support other IRMER compliance activities (e.g. advice on compliance, support and advice on incidents, optimisation activities, risk assessment, advice on equipment etc.) in the Trust.
RMPS have employed new staff and hope the RMPS service will start to offer more support over the coming months although time is required to sign new staff off as competent to carry out duties
RSM is engaging in regular 6 monthly meetings with the RMPS at the Radiology Safety Sub Committee meetings (last meeting on 30th April 2025).A review of the SLA contract with RMPS is held yearly (last meeting 29th May 2025)
Fortnightly incident review group meetings have been set up with the MPE & Modality Leads to regularly review all incidents.
An annual calendar of Image Optimisation Team (IOT)Meetings has also been devised to include the MPE & each modality imaging team

Previous Quarterly Update

Equipment continues to be maintained in accordance with manufacturer's recommendations and service contracts in place.
Limited RMPS resource continues to also support other IRMER compliance activities (e.g. advice on compliance, support and advice on incidents, optimisation activities, risk assessment, advice on equipment etc.) in the Trust.
RMPS have employed new staff and hope the RMPS service will start to offer more support over the coming months although time is required to sign new staff off as competent to carry out duties
RSM is engaging in regular 6 monthly meetings with the RMPS at the Radiology Safety Sub Committee meetings (last meeting on 30th April 2025).A review of the SLA contract with RMPS is held yearly (last meeting 29th May 2025)

CRR Reference	SECMP1-22/23	Risk Title	Inability to provide safe and effective intrapartum care at Free standing Midwifery Led Units (FMLUs).	Current Risk Level	High

Quarterly Update

Risk Remains unchanged.
Existing control measures remain in place. Mandatory training and staff rotation to the Ulster Maternity Hospital continues. Recruitment across all area of midwifery continues, monthly meetings with HOM in relation to staffing issues and vacancies.

Previous Quarterly Update

Risk Remains unchanged.
Existing control measures remain in place. Mandatory training and staff rotation to the Ulster Maternity Hospital continues.
Recruitment across all area of midwifery continues, monthly meetings with HOM in relation to staffing issues and vacancies.

CRR Reference	SECMP2 -23/24	Risk Title	Inability to provide a regional Second Trimester Surgical Termination of Pregnancy Service at South Eastern Trust.	Current Risk Level	Medium

Quarterly Update

Risk unchanged:
Update
One Consultant now fully trained to provide terminations up to 23+6weeks.
Second Consultant continues on maternity Leave, due to return early 2025.
One Specialty Doctor now trained to operate on women up to 13+.

Update
Support & mentorship available if needed from third party provider (BPAS).
Formal arrangements (SLA) with Homerton NHS Trust awaiting sign-off by Homerton.
Draft SLA with Kings College London for review/comment.

Update
Local Values Clarification Training can now be provided by SET staff as required. Sessions ongoing with new staff as required.

Update
Ongoing - Register of staff who are conscientious objectors maintained and held locally to include Medical, Nursing and Support staff.
Update
Ongoing - Retire and return contracts offered to all staff who are retiring.

Previous Quarterly Update

Update
One Consultant now fully trained to provide terminations up to 23+6weeks.
Second Consultant continues on maternity Leave, due to return early 2025.
One Specialty Doctor now trained to operate on women up to 13+.

Update
Support & mentorship available if needed from third party provider (BPAS).
Formal arrangements (SLA) with Homerton NHS Trust awaiting sign-off by Homerton.
Draft SLA with Kings College London for review/comment.

Update
Local Values Clarification Training can now be provided by SET staff as required. Sessions ongoing with new staff as required.

Update
Ongoing - Register of staff who are conscientious objectors maintained and held locally to include Medical, Nursing and Support staff.
Update
Ongoing - Retire and return contracts offered to all staff who are retiring.

Medicine, Unscheduled Care and Cancer

CRR Reference	HS1-22/23	Risk Title	Inability to provide safe and effective emergency care at Ulster Hospital	Current Risk Level	Extreme

Quarterly Update

- While there had been some improvement seen in Ambulance Handover time, this has become more challenging. Ambulance Handover included in the Trust SIF. Trust updated Locality Plan for 25/26 focuses on many actions around system flow of patients across Hospital and Community and will impact on any improvements to be seen in Ambulance Handover performance.
- Monthly meetings with NIAS and Trust continue with plans to move towards fortnightly meetings with RCC/NIAS continue. Phased approach to implementation of regional handover times with 2 hour to be achieved by December 2025.
- Still no change regarding NIAS shift patterns.
- Ongoing work on the actions with the Locality Plan for 25/26
- 2x workshops held in Q2 with Ward Managers focusing on system wide steps to consistent actions around patient flow.
- UCC currently open 8am-6pm, closing at 8pm.
- SET currently working with SPPG for additional funding to extend the opening hours and capacity for higher acuity patients, therefore, redirecting 35-40 patients a day from the busy ED.
- As winter approaches in Q3, service considering need to extend opening hours to include overnight. Finance approval needed to maintain overnight opening.
- Stable numbers in Q2, however increased risk going into Q3.
- Ongoing IPC input/support. These patients will be prioritised by ED to the Patient Flow Team to ensure timely transfer to base wards.
- All actions noted in previous quarters continue.
- All actions contained within the Trust Locality Plan 25/26 will focus on improvements directly impacting Ambulance Handover times.

Previous Quarterly Update

- Average ambulance handover has increased.
- Regional Support and Intervention framework is now Level 3 for Ambulance turn around times >2 hours. This level is now across all HSC Trusts. SPPG have provided an additional £2 million funding to support improvements in ambulance handovers <2 hours and against the 12 hour standard. The Trust have submitted proposals for this spend and are awaiting an allocation letter.
- No changes in NIAS shift patterns.
- Trust Locality plan continues.
- Workshops to be held in Q2 with ward managers, to support Patient Flow through the system.
- Urgent Care Centre opened on Ulster Hospital site on 19 June 2025.
- Paeds area have reverted to closing at midnight, and will be reviewed in Q2 as winter approaches.
- During June, there was a slight increase in the number of Covid presentations to ED. This continues to pose challenges particularly when the department is congested. Patients with a known IPC risk are prioritised after acuity, in terms of allocation to wards.
- Cover not always 24/7, as staff dependant.

Keeping patients more informed, regular observations and pain relief provided as needed.
Feedback has been positive, and reflected in reduced complaints about this issue.

NEW RISK ADDED AROUND NIAS WAITING TIMES:
- Regional Support and Intervention framework is now Level 3 for Ambulance turn around times >2 hours. This level is now across all HSC Trusts. SPPG have provided an additional £2 million funding to support improvements in ambulance handovers <2 hours and against the 12 hour standard. The Trust have submitted proposals for this spend and are awaiting an allocation letter.
- There has been increase in the average waiting times in this period.
- Ambulance triage nurse role continues to work effectively.
- Monthly meeting with NIAS Assistant Director and USC Assistant Director and Director.

Appendix 3 – CRRs that have achieved their target score but remain on the register

Reference	Grade	Title	Rationale for remaining on the CRR
ASHIP5-25/26	Extreme	Addictions	
NUEX2-25/26	High	Inability to maintain a satisfactory linen decontamination service	
CSSW1-22/23	High	Inability to provide appropriate safe staffing required in Lakewood Regional Secure Care centre	
SECMP2 -23/24	Medium	Inability to provide a regional Second Trimester Surgical Termination of Pregnancy Service at South Eastern Trust.	
HRCA3-22/23	Medium	Performance within Recruitment Shared Services Centre	

Appendix 4 Risks opened and closed Q2 25/26

During Q2, a total of 7 new risks were added to the Directorate Risk Register.

Directorate Risk Reference	Title	Date Risk Identified	Risk level (current)	Risk level (Target)
HS/MED/10	Inadequate Regional Thrombectomy Service Impacting SEHSCT Patients	15/09/2025	Extreme	High
AS/MH/12	53 Ardglass Road	02/09/2025	High	Medium
C&YPCS/CCS/05	Unaccompanied Asylum Seeking Children - racist unrest	20/08/2025	High	Medium
WACH/PHARM/06	Failure to resource the cleaning of the pharmacy aseptics suite	18/09/2025	Medium	Low
HR/GEN/011	Gender Identity and Expression Employment Policy	29/09/2025	Medium	Low
WACH/MAT/09	Medicines Over-labelled drugs and processes	12/09/2025	Medium	Low
AS/AD/15	Utilising an unregulated placement	02/09/2025	Medium	Medium

During Q2, a total of 7 risks were closed on the Directorate Risk Register

Directorate Risk Reference	Title	Date Risk Identified	Risk level (current)	Risk level (Target)	Closed date
LAB RA-81	New MYLA Server	18/04/2025	High	High	19/09/2025
HS2-25-26	NIAS Waiting Times	13/03/2025	High	Medium	08/07/2025
WACH/PAED/04	Risk of adverse events as No named consultant for safeguarding children & young people in post within SET	09/05/2023	High	Low	12/09/2025
HS/MED/03	S&EC/Patient Safety (ligatures)	18/04/2024	Extreme	Extreme	10/07/2025
AS/MH/08	Addiction Service Pressures	19/07/2024	Medium	Medium	16/07/2025
WACH/MAT/01	Inability to electronically archive Fetal Cardiotocograph tracings	05/05/2023	Medium	Medium	01/07/2025
HR/GEN/007	Failure to implement pension flexibilities	01/04/2024	Low	Low	03/07/2025

Appendix 5 – Risk Matrix and Risk Assessment Framework

RISK MATRIX & RISK ASSESSMENT FRAMEWORK

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Green	Low	Yellow	Medium	Amber	High	Red	Extreme
Manage by routine procedure		Management responsibility must be specified		Senior management attention needed		Immediate action required	

Risk Likelihood Scoring Table

Likelihood Scoring Descriptor	Score	Frequency (How often might it/does it happen?)	Time framed Descriptions of Frequency
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

(Based on AS/NZS 4360:2004 standard)

NB: These notes are for guidance only and should not prevent Directors from notifying the Corporate Governance Committee/ Governance Assurance Committee of frequently re-occurring green / yellow risks or bringing high priority red risks to the Corporate Governance Committee due to their urgent nature.

Risk Grading – Action Guidance

Green

Low risk. Identified risks which fall in the **green area** are deemed **low** acceptable risks and require no immediate action. These should be managed by routine procedure and must be monitored regularly at departmental level.

Yellow

Medium risk. Identified risks which fall in the **yellow area** are deemed **medium** risk to the Trust and may require further action within 12 months to reduce risk to an acceptable level. These would normally be actioned locally within Directorates and monitored by the relevant Local Governance Committee and entered on the Directorate Risk Register, as appropriate.

Amber

High risk. Identified risks which fall in the **orange area** are deemed **high** risk to the Trust and require further actions within 6 months to reduce the risk to an acceptable level. These risks and agreed action plans should be considered by the Local Directorate Governance Committee and risks that cannot be actioned or reduced locally should be forwarded to the Corporate Governance Committee (via the Assistant Director: Risk Management & Governance) for further consideration/actioning and entry on corporate risk register, if appropriate.

Red

Extreme risk. Identified risks which fall in the **red area** are deemed **extreme** risk to the Trust and must be reported to the Local Directorate Governance Committee. These risks require **immediate action** to reduce the level of risk and the relevant Director will ensure they are forwarded to the Corporate Governance Committee (via the Assistant Director: Risk Management & Governance) for further consideration / action as appropriate. The appropriate Director will ensure the implementation of a time monitored action plan and provide regular reports to the Corporate Governance Committee and/or the Governance Assurance Committee. These risks will be added to the corporate risk register, if appropriate.

Appendix 6 - Risk Appetite Statement

Risk Appetite Statement 2025-26

The South Eastern H&SC Trust (the Trust) recognises as a healthcare provider that risks will inevitably occur while providing high quality and inclusive care and treatment to patients, recruiting our people, owning, leasing, and maintaining premises and equipment, and managing finances.

As a result, the Trust endeavours to establish a positive risk culture within the organisation, where unsafe practice is not tolerated and where every one of our people feels committed and empowered to identify and correct and/or escalate system weakness.

The Trust Board is committed to ensuring an effective risk management system is in place to manage risks from operational to Board level and where is identified, robust mitigating action plans are put in place. The Trust recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, our people, including volunteers, members of the public and strategic partners.

As such the Trust:

- has a **low appetite** to accept risks that could materially provide a negative impact on quality, including poor quality care, treatment or unacceptable clinical risk, non-compliance with standards of poor clinical or professional practice;
- has a **low appetite** to accept any risk that could result in our people being non-compliant with legislation, or any frameworks provided by professional bodies; and
- will take measured and considered risks that does not compromise the safety of our people.

In contrast however the Trust has a greater appetite to take considered risks in terms of their impact on organisational issues. Therefore, the Trust:

- has a **moderate appetite** for taking risks that may adversely impacts our people;
- has a **moderate appetite** to accept risks that may impact on the achievement of financial breakeven, when balanced against risks to patient, our people's safety or quality of care.
- has a **moderate appetite** regarding pursuit of commercial development, collaboration, and partnerships, although, the preference is for safe delivery options that have a low degree of inherent risk and may only have limited potential reward; and
- has a **high appetite** for innovation and will take measured risks to maximise technological innovation and commercial opportunities.

The Trust commits to actively utilise the Risk Appetite Statement during any decision-making process and to review its Risk Appetite Statement on an annual basis and/or following any significant changes or events.

Risk Category	Risk Appetite	Risk Tolerance	Risk Appetite Statement
Legal/Statutory/Compliance (Service user, staff or visitor harm/compliance with laws and regulations)			We have a **LOW** appetite, and we will not take any risks which will impact on our ability to meet our legislator requirements or may compromise the H&S of our staff, patients or visitors.
Patient Safety/Clinical (patient care/physical, psychological harm/patient experience			We have a **LOW** appetite for risks which may compromise safety, however recognising that individual risk tolerance may on some occasions go above this if it is in the best interests of patients to accept some risk in order to achieve the best outcomes from individual patient care, treatment and therapeutic goals. We accept this and support our staff to work in collaboration with people who use our services to develop appropriate and safe care plans based on assessment of need and clinical risk.
Quality & Professional Guidelines/Standards (Statutory regulation e.g.GMC, NMC /guidance and best practice e.g NICE)			We therefore have a **LOW** appetite for risks which may compromise the quality of the care we deliver or could result in poor quality care, non-compliance with standards of clinical or professional practice or poor clinical interventions. We will take measured and considered risks to improve and delivery of quality outcomes where there is potential for long term benefit, however, we will not compromise the quality of care we provide or the safety of our staff, volunteers, or patients in our care.
People (Recruitment/staff in work/staff retention/innovation and new models of staffing/international recruitment)			We have a **MODERATE** appetite for risk taking that may adversely impacts on our people. We will take measured and considered risk that does not compromise the safety and to liberate the potential of our people, engaging with, supporting, and enabling our people to shape the culture of the organisation to enhance inclusion, staff safety and create a healthy workplace.
Financial (VfM/ sustainability/Standing Financial Instructions/Financial control/Fraud & Negligent Conduct/new ways of working)			We have a **MODERATE** appetite for measured risk to support growth whilst seeking to maximise the use of available resources and deliver value for money services. This may mean we will take measured risks to develop and provide high standards of health and social care whilst balancing our statutory duties to achieve financial break-even.
Reputation/Publicity (standards of conduct/ethics/service delivery/			We have a **MODERATE** appetite for risk taking that will enhance us to be an 'outstanding' organisation. We will not take any risks that will have a negative impact on the reputation of the Trust. The Trust will maintain high standards of conduct, ethics and professionalism at all times.

Service Continuity/ Targets, Objectives & Service Provision (Business continuity/cyber-attack/performance/maintenance of systems)			The delivery of Health and Social Care is a priority, and while it may not be possible to eliminate risk, there is a focus on ensuring that essential health and social care needs are met quickly and effectively. We therefore have a **MODERATE** appetite for risks which could result in Service/Business Interruption. We may however operate within our tolerance range for a period of time while mitigation plans are developed.
Innovation (Transformational projects/research/new technologies)			We have a **HIGH** appetite for innovation and will take measured risks to maximise technological innovation and commercial opportunities to improve patient outcomes, transform services and ensure value for money. We may operate in the tolerance range to allow the scoping of innovation projects to provide the planning and identify detail for change for a defined time period.