SET Assurance Framework Report No. 1 - CRR: Principal Objectives and Board Reports
As at 30 June 2020

ID	Principal objectives	Description	Risk level (current)	Controls in place	Positive Assurances	Gaps in controls	Gaps in assurance
EMT Director: Adult Services & Prison Healthcare							
2768	Ensure safety, improve quality and test experience	Risk of being unable to deliver Prison Healthcare's services fully in line with best practice/ recognised processes and guidelines due to: - the challenging complex environment; - working in a host environment; - the necessity to effectively collaborate with multiple agencies; - significant challenges in recruitment to Band 5 nursing posts; - volume of correspondence/work in litigious environment; - fluctuation in numbers of people in custody. resulting in potential adverse patient outcomes (including deaths in custody), unsatisfactory external reviews/inquest outcomes and negative publicity	EXTREM	Prison Healthcare Reform on-going. Corporate oversight of PHC reform. Rolling Recruitment and retention programme. Revised Management Structure for Prison Healthcare. Governance arrangements. NIPS/SET Strategic and Operational meetings. SET Prison Healthcare Improvement Plan. Weekly Senior Team meetings chaired by Assistant Director. Internal Audit. Key Prison healthcare performance indicators agreed and monitored via balanced scorecard. Prison healthcare staff attendance at Safer Custody programme. Trust policies and procedures. Serious Adverse Incident notification, investigation, outcomes and action planning. Action plans regarding RQIA recommendations/Serious Adverse Incident reports/Ombudsman	Accountability Review (internal). Balanced scorecard performance. RQIA Unannounced visits ongoing. Internal Audit. Health Needs Analysis. Introduction of ISO procedures. Appraisal monitoring system in place. Mandatory training system in place. Budgetary work complete to progress recruitment. Accreditation-Investors in People.	Clinical Addictions Service unable to provide full service due to staffing levels. Primary Care Band 5 nursing posts not permanently recruited. Demand is exceeding capacity regarding governance processes eg completion of SAI reviews within timeframe/investigations/Implementation of audit recommendations/SAI and external report recommendations/ISO processes completion	Limited Implementation of previous audit recommendations/SAI and external report recommendations due to demand outstripping capacity. Repeat recommendations on occasion.

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				reports/NICE Guidelines. In house GP provision across three sites. In house psychiatry and addiction services across three sites. In house pharmacy provision across three sites. Mental health system in place for triage and assessment of referrals. Quality Improvement initiatives developed across all prison sites. Membership of 5 Nations health in detention collaboration to share best practice.			
2773	Ensure safety, improve quality and test experience	Acute mental health inpatient accommodation (with the exception of the MHIPU, Downe Hospital) does not comply with all Royal College of Psychiatrists/AIMS standards. The geographical isolation of each of the inpatient units creates significant clinical risks and concern for the safety and wellbeing of patients and staff. The RQIA escalated their concerns to the Trust in January 2019 regarding the mixed model of care within Ward 27, Downshire Hospital.	HIGH	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 of observation are an assessed requirement as per the Trust Observation	Overall, RQIA Inspections and reports have been positive with the exception of Ward 27 DSH indicating an interim PICU solution.	The M.H. programme is continually reviewing environment, systems and therapeutic inputs to ensure safety. This cannot compensate however for the lack of a single, purpose-built mental health facility	Given the dispersed nature of our inpatient units, this increases risks especially when there are significant incidents, staffing deficits, patient transitions across the Trust to PICU beds and out of Trust admissions.

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				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. 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. Increase in Trust security personnel and their presence across all 4 sites across the 24 hour care period. 3:1 Outline Business Case accepted by the DoH with agreement to move to the design stage communicated to Trust. 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. EMT has endorsed the RQIA mandate to develop an interim solution to the current service provision within Ward 27 Downshire Hospital. The design of the new 6 bedded PICU annex has been agreed and submitted to the Planning Department.			

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				Enablement work has commenced within Ward 27 Downshire pending major construction of the annex once planning has been agreed.			
2774	Ensure safety, improve quality and test experience	Inability to provide appropriate and robust governance arrangements and assurances across all Independent Sector Providers to assure the Trust of the safe and effective delivery of services and compliance with contract terms and conditions/ legislation.	HIGH	Daily monitoring of incidents and complaints received. Central reporting of complaints and incidents for Independent Sector Providers. Contract assurance processes. - Incidents and complaints - Quality issues - Monitoring - Provider contract meetings - Validation work - Key worker review - Permanent placement team intelligence Independent sector Provider Forums. Monthly - Operational incident/ complaint/ Adult Safeguarding review. Quarterly - Adult Social Care Forum - across Directorates, Chaired by AD. Quarterly reports and analysis of Complaints / Incidents / Adult Safeguarding referrals. Quarterly contract monitoring processes and annual contract review meetings.	Established Quarterly Social Care Governance Forum - chaired by AD Older People (Year 1) as a sub-committee of SQIIC. Established monthly operational governance forum - cross Directorate. Trust IS Governance Review completed and phase 1 of investment implemented to strengthen appropriate teams. Centralised reporting and escalation of all IS related issues via contracts. Escalation approach developed for action. Performance notice process implemented and associated actions taken to performance related issues.	Phase 2 of IS Governance investment needs to be completed to put the appropriate identified staff in place. Ensure all operational Directorates are active participants. Ensure that all services provided by the independent sector have the appropriate contracts in place and are subject to standardised monitoring processes. All staff responsible for engaging with the independent sector need to attend awareness training.	Some services used no not have a contract in place and may not therefore be subject to the same monitoring activity.
2775	Ensure safety, improve quality	The Department of Health, requires H&SC Trusts to	MED	Mental Capacity Act (NI) 2016.	Dedicated lead Director identified. Project team and structure	Financial uncertainty. Recruitment of Medics for	System Infrastructure and records management.

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	and test experience	deliver partial implementation of the Mental Capacity Act (NI) 2016 (MCA) for the purpose of providing a statutory framework for the Deprivation of Liberty (DoL). This phase of implementation commenced on 2 December 2019 with full implementation proposed for December 2020. The Trust has established a Service Model and associated structures required to deliver our statutory obligations. An administrative team has been appointed on a temporary basis and a comprehensive training programme has been put in place, initially delivered by the Leadership Centre (Sept - Dec 2019) and more recently delivered by the Trust. The Trust has commenced completion of capacity assessments and Trust Panel authorisations for community placements (legacy cases and current cases) and has commenced Short Term Detention authorisation processes for hospital based clients. There are a significant number of legacy cases (N = >3000) and current cases which require to be processed through DoL Safeguards. The Service has encountered challenges in staff		Code of Practice and Forms. Regulations associated with the Act. Programme Management arrangements have been established to include a Programme Board and Project Implementation Team. A Project Implementation Manager and admin team have been appointed through Expression of Interest (EOI's) recruitment. Arrangements for the appointment of medical practitioners, ASWs and other Panel members have been progressed. A significant number of Trust staff have completed training through CEC; eLearning and Trust delivery. A scoping exercise to identify service users who meet the criteria for DoL Safeguards has been completed. A Trust workshop and associated Action Plans for each Directorate have been commenced.	established. Project Plan - Gantt chart developed. EOIs for Trust panels/medical reports. Governance arrangements developed.	Trust panels/medical reports. MCA knowledge and experience.	Information governance. Policies and procedures.

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		recruitment, most notably medical practitioners, and in the completion of required assessments due to staff competing demands. This situation has been further exacerbated due to restrictions caused by COVID 19. The Trust is unlikely to deliver the Department statutory requirement for all legacy cases to be completed by December 2020. There is also a significant difficulty in achieving requirements under the Act for current cases in both Hospital and community settings. Failure to deliver this target will result in a breach of statutory requirements thus impacting on patient safety and care, and the professional reputation of the Trust.					
Number of records for Adult Services & Prison Healthcare			**4**				
EMT Director: Children's Services &Social Work							
2776	Ensure safety, improve quality and test experience	The Regional Secure Care Centre, Lakewood provides Secure care for up to a maximum of 16 young people aged from 12 to 18 years. Children referred to the Secure care admissions panel, must meet the criteria set out in the Children's Order(Northern Ireland) 1995	MED	1. Provision of secure environment and potential to minimise access to drugs in community 2. Scoping of additional security measures eg. CCTV/Body Worn cameras and Searching as utilised in JJC and other secure children's home 3. Meetings held with	Positive engagement has taken place with the Department and the HSCB, with a view to identifying additional resources to support the Lakewood team in managing the profile of young people with a drugs profile	Control measures are in place.	The development and Quality improvement plan have only been recently developed and a period of implementation and monitoring is required

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		Art 44 in regards to the risk of going missing and experiencing significant harm to self and others unless kept in Secure accommodation. Following a regional review of specialist residential childcare facilities, the DOH/DOJ are leading the design phase for the development of a new Secure Campus. During September 2019 a new Multi-Agency Regional Restriction of Liberty Panel was established to allocate placement based on assessment of greatest need. The Panel is independently chaired by a HSCB employee who advises SET of the outcome of the panel and decision regarding the young person to be admitted. Whilst the panel is working effectively to determine the young person deemed to be at greatest risk regionally, the new arrangements have increased risk for SET as the profile of young people prioritised for admission has changed resulting in higher numbers of older male adolescence aged 16/17 with a history of chronic drug misuse, propensity for violence and at times under paramilitary threat. Young people of this		Hydebank, Woodlands and Lakewood staff to share best practice interventions 4. Meetings held with RQIA, DOH and HSCB and action plan developed to enhance engagement with young people in regards to harm from drug misuse and review of health services in both Lakewood and Woodlands 5. Staffing Levels deployed to ensure safe supervision 6. Provision of a Therapeutic support team 7. Provision of CAMHS and DAHMS in-reach services 8. Partnership working with PSNI, YJA and probation 9. Therapeutic Model adopted within the Trust 10. Staff trained in trauma informed Relational approaches 11. Staff have dedicated training and awareness in drug intervention 12. Staff trained in Therapeutic crisis intervention 13. Revision of the discharge pattern for young people preparing to exit Lakewood to reduce graduated exit plans and reduce young people's capacity to access drugs			

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		nature continue to attempt to procure drugs either whilst out on Trust visits or to their home community or by being supplied by visitors such as family members. Meetings have commenced with DOH and HSCB to address the increased risk to SET and requirement for SET to retain governance in respect of admissions to ensure clarity as to whether each proposed admission can be safely managed in the context of the profile of young people in Lakewood. SET is scoping the potential to implement additional security measures such as use of CCTV and searching which will require endorsement from RQIA, HSCB and DOH.					
Number of records for Children's Services &Social Work				**1**			
EMT Director: Finance & Estates							
2754	Continue to improve	Management of savings and pressures to achieve recurrent financial balance.	EXTREM	Budgetary Control System in place - online drill down access available. Corporate Score Card introduced. Key Financial Adviser for each Senior Budget Holder. Clear Lines of Accountability between Directors and Assistant Directors for budgetary management.	Trust Financial Reports. Performance management reports.	Continued close scrutiny and monitoring of expenditure reports by Directors. Earlier identification of potential shortfalls in deliverability of savings plans. Earlier agreement with HSCB around savings plans / funding available. Uncertainty re HSCB role in agreement of plans.	None identified.

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				Standing Financial Instructions approved by Trust Board. Internal/External Audit Reports. SET Finance and Audit Committees in operation with regular reports to Trust Board. Monthly Finance Board Reports /monitoring returns to HSCB. Project Management Arrangements for identified savings plans. No new services developed without funding as per Departmental Circular. Cost Pressure Monitoring / income budget reports / early highlighting of pressures. Board Policy on New Drugs/Treatment Regimes. Monthly financial Accountability Reviews with Directors and Assistant Directors. Monthly financial performance packs. Financial management review of all recruitment prior to approval. Clear agreement of forecast with operational senior team.		Timeliness of agreement of TDPS.	
2755	Ensure safety, improve quality and test experience	Risk posed to the Trust due to the ageing estate, specifically: 1. Need to improve protection against the potential of legionella (and other water-borne risks)	EXTREM	Statutory Inspections. Preventative maintenance programmes. Compliance with Controls Assurance Standards. Compliance with relevant guidance with regard to	Accountability Review (internal). Accountability Review (external). Controls Assurance Standard. Statement of Internal Control. External Audit.		None identified.

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		outbreak at Ulster Hospital and other sites. 2. Need to improve protection against the potential of infection due to sewage leaks in the Ulster Hospital caused by deteriorating foul drainage pipe work. This pipe work, on several occasions, has fractured causing spillage of raw sewage into the hospital. This has the obvious risk of spreading infection. The issues regarding the failure of infrastructure within the main ward block at the Ulster Hospital may be extended for a period of 3 to 4 years if a decision to move beds from the Care of the Elderly (Functional Suitability B standard) to MWB (Functional Suitability Dx standard) is taken. 3. Risk occurring as a direct result of structural, external enveloping and building services failure at the Paediatric block and Paediatric theatres, Ulster Hospital. 4. Failure of mechanical and electrical systems i.e. site heating services at both the Ulster Hospital and Ards Hospital leading to compromised patient care. 5. The ageing estate, particularly the Ulster Hospital, also has significant risk of fire safety - both in fabric of		Legionella - HTM 04 and HSE Guidance Document L8. Estates attendance at the Trust's Water Safety Group. Development of the Water Safety Plan. Use of "Zetasafe" software for the management of water safety. CERI Davis Scores/Reports. Permits to work/safe systems of work. Remedial work undertaken at the Ulster and Ards hospitals. Continuing bids to the Department for energy funding for upgrading M&E systems. Spillage procedures. Internal pipe work examinations. Internal pipe work cleaning (limited due to risk of further fracturing pipe work). Encasement/sealing of fractured pipe work. Estates building appraisal reports. Health Technical Memorandum (HTM) Guidance. Relevant Legislation. Fire risk assessments. Fire Nominated / Deputy Nominated Fire Officer training, general awareness training. Fire safety measures. Fire risk assessment remediation work. Fire simulation exercises.			

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		building and evacuation issues.		Authorising Engineer Audits. Ventilation Upgrades. Extended Zetasafe use for enhanced compliance management. Engineering upgrades.			
Number of records for Finance & Estates				**2**			
EMT Director: Hospital Services							
2762	Ensure safety, improve quality and test experience		HIGH	Narrative awaited			
2763	Ensure safety, improve quality and test experience		HIGH	Narrative awaited			
2764	Ensure safety, improve quality and test experience		MED	Narrative awaited			
Number of records for Hospital Services				**3**			
EMT Director: Human Resources & Corporate Affairs							
2756	Ensure safety, improve quality and test experience	There is a current global and local shortage of Nurses specifically Band 5 and Medical workforce within recognised hard to fill posts specifically medical specialties. This directly impacts on the ability of the Trust to meet current and future workforce requirements. External influencing factor is the impact of the HMRC	EXTREM	- DOH Workforce Strategy - Professional Guidance - Telford, Royal College, NI Delivering Care (N&M) - Delivering Care: Nurse Staffing in Northern Ireland - Temporary Staff Contracts - Professional Director Advisory Role - Managerial Controls - VFM Studies	DoH. Royal Colleges. SSI. NMC. NISCC. BSO Pension Branch.	Lack of systematic workforce planning. Provision of Information on staffing levels. Pension issue is outwith HSC control - requires HMRC solution.	None identified.

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		regulations in relation to pensions resulting in increased risk adverse events and / or sub optimal outcomes for patients and clients.		- Use of Bank/Agency Staff - Recruitment and Retention Strategy - Regional Strategic and Implementation Groups established to consider WFP implications from TYC and other reform initiatives - Safety Standards - Periodic reports on staff turnover/stability - Assessment of recruitment difficulties - Ability to reallocate staff across units - Absence control - Locum/Temp staff recruitment contracts - Trust workforce control measures - Balanced Scorecard systems - Trust Workforce Reform Group - OWD Steering Group - Internal Monitoring - Health and Wellbeing Strategy - Retire and Return Policy - Resilience Training - Stress Policy - Internal Move Policy - International Recruitment Project Group - Review of Existing Locum Framework - Single Employer Project Group - eLocum System/alternative system, if adopted. - Ongoing regional work with HSC Pension Branch - Pension information			

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				sessions for high earners			
2757	Ensure safety, improve quality and test experience	The current laundry cannot implement the BS EN 14065 as per HTM01-04 neither can it continuously provide a reliably effective linen decontamination service to meet the needs of both internal and external users due to the age (40+ year old) of the decontamination equipment and inadequate building infrastructure.	HIGH	Contingency arrangements documented in SOP for business continuity to address major equipment failures and maintenance requirements. If replacement parts are no longer commercially available parts are either manufactured, or where possible, recycled from old machinery. Enabling works for new laundry ongoing however has been hindered by coronavirus and need for PPE to be stored in area designated for the new laundry therefore an emergency stock of bedding, sterile packs , reusable scrub suits is retained to maintain business continuity in event of service failure. Reciprocal continuity agreement in place with Lilliput (laundry provider) in event of service failure. Risk assessments and SOP performed for operation of laundry equipment and processes. Staff are rotated through the laundry department to have regular breaks to ensure they are not exposed to high temperature and high noise duties for prolonged periods of time. Private Clinic have a 24hr emergency stock at their	External Accreditation ISO 9001:2015. Risk assessments. Decontamination Sub Committee. Laundry Project Group Minutes. Service provision has been maintained by additional purchases of new linen and extra spend on S&W for overtime payments to manage frequent equipment failures over the past year.	Critical parts cannot be sourced & stored; due to the age of equipment many single points of failure exist that require bespoke parts fabricated to maintain a basic level of operational throughput.	EMT Briefing Paper. Accountability Review Meetings. Budgetary performance. Risk issues log Phase B project. Inability to implement BS EN 14065.

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				site in event of a failure in service. Extension of operational hours to cover an additional 9.5 hrs Night shift staff split into two shifts to cover Sunday night to Friday morning .16:00 to 20:00 by CSSD staff. Additional extension of operational hours covering 16:00-20:00 by CSSD staff to process high number of scrub suits required by the Trust due to coronavirus.			
Number of records for Human Resources & Corporate Affairs				**2**			
EMT Director: Planning, Performance & Informatics							
2765	Ensure safety, improve quality and test experience	Performance and Service Delivery Targets: Waiting Lists Inability to deliver against the commissioned performance targets Trust wide (Commissioning Plan Direction/Commissioning Plan/Service & Budget Agreement) due to increased financial constraints within health and social care, increased elective demand, consequence of Covid-19 and impact of growth within unscheduled care resulting in reduced capacity to deliver elective services. This is resulting in increased waiting times to access certain services to investigate, diagnose, and treat. This causes	EXTREM	Service Budget Agreement reviewed regularly with Service and HSCB/ LCG. Predictive analysis of unscheduled demand and impact on capacity to deliver elective care regularly reviewed including Trust Bed profile. Enhanced Performance Management Framework in place. Enhance Performance and Finance Sub Committee in place. Daily / Weekly / Monthly Performance Monitoring. Director level Performance Monitoring & Improvement meetings, and Action Logs. Introduction of Trajectories for specific specialities.	Accountability Reviews. Strategic EMT. Monthly performance review meetings. HSCB Performance/Monitoring Reports. Performance against Ministerial priorities. Corporate and Directorate Scorecards. Finance and Performance Committee standing agenda item. Trust Delivery Plan. Trust Management Plan. Accountability reviews. Augmented Trust Board reporting aainst Outcomes. Information and Coding Audits. Internal Audit. Contract compliance processes. Trajectories monitoring.	Need to gain commitment from HSCB to agree a development plan for review of SBA document. Continue to highlight to HSCB/ LCG areas where definitions and currencies need reviewed e.g. new models of care. Continue to negotiate with HSCB/ LCG to address demand / capacity gap for range of specialities as capacity not keeping up with demand. Continuous need to review and refine data quality. Continue to review and update reporting of performance to Trust Board. Need to review, improve and streamline processes associated with the	Ability to deliver on Minister's Vision in absence of political systems and full budget. Indications from HSCB in respect of further investment and potential savings plans required in 2018/19.

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		potential increased risk for patient/ service user clinical outcomes.		Corporate Scorecard and Dashboard presentation reported monthly to Trust Board. HSCB/DOH Monitoring Reviews. Engagement with Commissioners - performance activity and how the Trust manages risks in performance are regularly shared with the Commissioner. Where possible, solutions are identified and implemented. Accountability Reviews (Chief Executive and DOH). Qlikview monitoring of Elective Service Budget Agreement. Independent Sector performance monitoring arrangements including Director/ EMT oversight. Investment proposals now developed with activity information. Planning and Service Improvement activity. Reform portfolio aligned to strategic and Directorate priorities aligned to Corporate Plan/ Draft Programme for Government and Quality Improvement and Innovation Approach. Coding audits and monitoring. Mortality reporting. Monitoring of Domiciliary Care activity.		Procare system and Domiciliary Care contracts. Co-ordinated prioritisation of local need and allocation of resource. Regional reform impact on local reform. External and political influences on ability to reform.	
2766	Ensure safety,	Information security	HIGH	TECHNICAL	HSCNI Cyber Security.	Insufficient corporate	Regular reporting to

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	improve quality and test experience	across the HSC is of critical importance to delivery of care, protection of information assets and many related business processes. If a Cyber incident should occur, without effective security and controls, HSC information, systems and infrastructure may become unreliable, not accessible when required (temporarily or permanently), or compromised by unauthorised 3rd parties including criminals. This could result in unparalleled HSC-wide disruption of services due to the lack of /unavailability of systems that facilitate HSC services (e.g. appointments, admissions to hospital, ED attendances) or data contained within. The significant business disruption could also lead to increased waiting lists, delayed urgent clinical interventions, suboptimal clinical outcomes and potentially bring liabilities for the service. It could also lead to unauthorised access to any of our systems or information (including clinical /medical systems) theft of information or finances, breach of statutory obligations, substantial fines and significant reputational		INFRASTRUCTURE HSC security hardware (e.g. firewalls). HSC security and SET software (threat detection, antivirus, email & web filtering). Server / Client Patching. 3rd party Secure Remote Access. Data & System Backups. POLICY, PROCESS Regional and Local ICT/Information Security Policies. Data Protection Policy. Change Control Processes. User Account Management processes. Disaster Recovery Plans. Emergency Planning & Service/Business Continuity Plans. Corporate Risk Management Framework, Processes & Monitoring. Regional & Local Incident Management & Reporting Policies & Procedures. USER BEHAVIOURS - INFLUENCED THROUGH: Induction Policy. Mandatory Training Policies. HR Disciplinary Policy. Contract of Employment. 3rd party Contracts / Data Access Agreements.	Self-Assessment Consultancy Assignment FInal Report 2016/17 (08/05/17). Technical Risk Assessment/Penetration Test Reports. Trust Assurance Reporting: IGB & ICT Steering Groups, Risk Register Review Group. Directorate Scorecards - Performance Reporting on Mandatory Compliance. ICT Internal Audit 18/19. ICT Internal Audit 20/21.	recognition and ownership of cyber security threat as a service delivery risk.	internal committees, EMT and Trust Board. Regular internal and external reporting of assurance.

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		damage.					
2767	Ensure safety, improve quality and test experience	Inability to sustain the transformation portfolio and its associated outcomes and benefits as a result of funding restrictions; and the potential impact of this on patients, clients, staff and the Trust's wider reform agenda. TRANSFORMATION The risk that the continued progress in the delivery of the Transformation of Health and Social Care (HSC) services is not made due to: - Failure to secure funding beyond the lifetime of Transformation funding in 2020/21. - Inability to retain sufficient and appropriate workforce into 2020/21 to continue transformation programmes. - Risk of incurring additional at risk costs to continue projects beyond 31/03/20 without formal confirmation of funding from Department of Health (DOH) and Health and Social care Board (HSCB). - External influences which delay or stop continued reform / transformation, for example the risk posed by impact of Covid-19. - Trust resource and capacity to continue to manage report and evaluate ongoing reform /	HIGH	Trust membership of Transformation Implementation Group (TIG), Directorate of Planning representative at Transformation Operational Group (TOG) and other regional reform forums. Trust Directors working closely with regional partners, DOH and Commissioners to plan for 2020/21 through a range of different fora. Assistant Directors and Project Leads working closely with regional partners and Commissioners to plan and prioritise for transformation sustainability in their areas. Trust virtual Transformation team working closely with regional partners in relation to 2020/21 prioritisation exercise to ensure regional consistency in terms of sustainability priorities. Progress reports prepared and presented to Executive Management Team (EMT) and to Trust Board. Key risks and issues included in Executive reporting. Corporate Team (virtual) co-ordinate Transformation	Accountability Reviews. Strategic EMT. Monthly performance review meetings. HSCB Performance/Monitoring Reports. Trust Delivery Plan. Trust Management Plan. Augmented Trust Board reporting against Outcomes. Internal Audit. Development of measures that are SMART for each reform investment opportunity.	Continue to engage with regional reform groups and other partners and stakeholders in relation to influencing transformation sustainability and prioritisation outcomes. Continuous need to review potential outcomes from investment to realise reform, and increased emphasis on the outcomes of evaluation activity as decisions are taken regionally on project sustainability. External and political influences on ability to reform.	Ability to deliver on Transformation agenda in absence of full sustainability budget. Indications from HSCB in respect of further investment and potential savings plans required in 2020/21 and financial impact of Covid19.

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		transformation activity without funding for additional project management resources from DOH. - Stakeholder buy-in to mainstreaming transformation programmes is not secured. - Risk of ceasing, or slowing projects in 2020/21 as a result of lack of funding, and the impact of this on patients/clients and staff in post across services. Additionally, risk to the Trust 'reputation of ceasing services which patients and clients have availed of for the past two years.		programme as part of the business partnering approach. Regular engagement with Local Commissioning Leads and regional leads (programme specific). Stakeholder engagement carried out where appropriate, which includes rural needs and equality screening, as well as involvement in project evaluation. Included as an agenda item for Accountability Reviews (Chief Executive and DOH Ground Clearing). Transformation portfolio checked for alignment to strategic and Directorate priorities from Trust Corporate Plan/ Draft Programme for Government and Quality Improvement and Innovation Approach. Process in place for monitoring of activity and income. Ongoing project monitoring and evaluation including the completion of Post Project Evaluations (PPE).			
Number of records for Planning, Performance & Informatics			**3**				
EMT Director: Nursing, Primary Care & Elderly							
2758	Ensure safety, improve quality and test experience	Risk of Healthcare-associated Infection including emerging multi-resistant	HIGH	IPC Strategy 2019-2022. Clinical Service Leads /link persons to support the Infection Control Team.	SET IPC Strategy. Alert Surveillance systems in place (includes MRSA Bacteraemia and Clostridium difficile infection	The fabric of some of the Trust Estate continues to pose problems for ensuring infection	Insufficient resource to support a seamless outpatient antimicrobial treatment team to treat

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		microorganisms, outbreaks of COVID-19 leading to prolonged length of stay, poor patient outcomes and negative public perception. Pressures due to COVID-19 from January 2020.		Antimicrobial Management guidelines. Antimicrobial Improvement Plan. SET IPC Policies/Guidelines/ Internet access to the Northern Ireland Regional Infection Control Manual, up to date COVID-19 guidance on iconnect. Trust COVID-19 Groups/ workstreams with IPC input. IPC representation on Capital Development and involvement and Estate Services led renovations to improve IPC and isolation facilities in facilities. IPC team Microbiologists and Antimicrobial Pharmacists. Education, training for frontline staff limited to the management of COVID-19 patients. Escalation/Outbreak plan and other specific emergency plans for example, Ebola, and Influenza. Water Safety Plan and Committee. Ventilation Committee established June 2020. eWhiteboards and eDams in acute wards to flag patients with infection or colonised with multi-resistant organisms and C difficile and COVID-19.	reporting to the Health Protection Agency (HPA) web Directorates and to Trust Board. Surveillance of gram-negative blood stream infections. Surveillance of COVID-19 and contact tracing. Restricted antibiotic surveillance and monitoring system in place (Antimicrobial Management team. Antimicrobial Stewardship Committee and improvement plan. MRSA Screening regional recommendations reflected in Trust Guidelines. Post-infection review of C.difficile and MRSA bacteraemia via the Trust's incident reporting systems and shared learning. Laboratory has attained CPA Accreditation. Consultant Medical Microbiologists and a Speciality Doctor in Microbiology, IPC team & Antimicrobial Pharmacists. Patient Flow Policy and Outbreak/ Escalation Plan and other COVID plans. eWhiteboards and eDams on acute wards to assist in identification and management of patients with infection or colonised with resistant organisms including COVID-19. Water Safety Committee and Safety Plan. Establishment of Trust COVID Liaison Group 12/2/20. IPC monitoring of the practice within COVID areas.	prevention and control and environmental cleanliness. On-going sewage leaks. Adequate isolation facilities are not available in all areas (side room capacity has in part be resolved for some acute care areas. Continued staffing pressures may prevent on-going release of staff for mandatory COVID-19 infection control training/update and attendance at relevant meetings as appropriate. Mandatory IPC training and improvement work has been stood down exception COVID-19 and PPE training. Unable to provide a robust Outpatient Antimicrobial Service to permit early discharge, keep patients out of hospital and ensure that they receive antimicrobials at home. IPCN service has been reviewed to provide some cover over the weekend.	patients in the community to reduce or avoid hospital admission. Limited Consultant Microbiologist cover which will become critical over the summer months. Limited IPC nursing team given additional work-streams as part of Covid-19 which include clinical and surveillance work.
2759	Ensure safety,	Demand for Domiciliary	HIGH	Regular Community Care	Performance and Improvement	None identified.	None identified.

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	improve quality and test experience	Care continues to grow due to demography which presents financial pressures and concerns regarding capacity to meet demand. Potential growth in the demand in community following the COVID -19 pandemic. Recruitment to both Independent sector and to the SET Domiciliary Care Service has been challenging and workforce issues are impacting on the ability of the service to meet the level of demand.		Forum chaired by Director of Finance. Robust financial information provided by Divisional Accountant on monthly basis. Weekly Finance Allocation Meetings. Robust application of Regional Access Criteria for Domiciliary Care. Regular review of Waiting List Information. A Single Domiciliary Care Referral Hub to source domiciliary care packages. Monitor number of domiciliary care packages not sourced. Expand SET in house domiciliary care workforce.	Meeting (Monthly). Accountability Review (Internal). Community Care Forum. Finance Focus Group meetings. Waiting List Meetings (Weekly) viz a viz Budget.		
2760	Ensure safety, improve quality and test experience	If current capacity limitations and activity levels across all Trust services remain or increase, the Trust may not be able to meet the increased demand placed on management of Coronavirus (Covid-19) patients, resulting in possible harm to patients, clients and staff.	HIGH	Infection Prevention & Control (IPC) Service Delivery Plan. IPC Strategy 2019-2022. Clinical Service Leads /link persons to support the Infection Control Team. Antimicrobial Management guidelines extended to include Covid 19. Antimicrobial Improvement Plan. SET IPC Policies/Guidelines/ Internet access to the Northern Ireland Regional Infection Control Manual. IPC representation on Capital Development and involvement in Estate Services led renovations to improve IPC and isolation facilities in Trust buildings.	SET Trust COVID-19 Strategic Liaison Group established 12/02/20 & workstreams covering all operational directorates including: PHC, Childrens Services. And addressing risk in child and adult safeguarding services. SET IPC Strategy. Consultant Medical Microbiologists and a Speciality Doctor in Microbiology, IPC team & Antimicrobial Pharmacists for expert advice. Patient Flow Policy and Outbreak/ Escalation Plan other COVID-19 emergency plans. eWhiteboards and eDams on acute wards to assist in identification and management of patients with infection or colonised with resistant organisms including COVID-19. eWhiteboard to assist in the identification and management of patients requiring various modes of	The fabric of some of the Trust Estate continues to pose problems for ensuring infection prevention and control and environmental cleanliness. Adequate isolation facilities are not available in all areas (side room capacity has in part been resolved for some acute care areas). Trust laboratory cannot undertake COVID-19 Testing samples go to Belfast Trust - will have implications once testing increases to include discharges to private care homes. IPC training and audit has been stood down given the demand on the service as a result of COVID-19.	Corporate Control Committee structures in place but have not met during the peak in Coronavirus cases; need to reesumte Insufficient nursing resource to support a sustained service as the recruitment campaign for international nurses has also been paused and this has had an added impact. Uncertainty as to how many staff will be available to manage COVID-19 patients. Lack of certainty regarding the number of care homes who will be impacted by COVID-19 and who will require support and the maintenance of care for residents.

ID	Principal objecti	Description	Risk level (	Controls in place	Positive Assurances	Gaps in controls	Gaps in assurance
				IPC team. Escalation/Outbreak plan and other specific emergency plans for Covid19. eWhiteboards and eDams in acute wards to flag patients with infection. Surveillance of COVID-19 cases. CoSHH risk assessment in place. Surge Plans in place. Chief Executive video broadcasts. Daily sitreps to HSC Silver. Workforce Helpline. Staff wellbeing helpline. HR policies and procedures. Engagement with Trade Unions and weekly meetings. HSC campaign and protocols for redeployment. HR oversight and input to staffing and employment issues Implementation of a regional staff risk assessment tool to assist managers with assessing and recording staff increased risk of severe illness due to Covid 19. Staff testing centres. Daily staff updates issued via all user emails. Support for testing in the independent sector. Daily IPC rounds in COVID-19 areas. Covid Hubs on 3 sites across Trust to assess patients in community.	oxygen ventilatory support. Daily sitreps to HSC Silver. Trust Daily review of cases being managed across acute care. Review estate /environment and measures to improve infection control and separate areas in specific wards and departments. Estates accessing BOC hourly consumption TEL data and converting to flow chart on iconnect (12 Hour Lag time). Monitoring the case presentations in both staff and patient to identify early any local outbreaks or clusters. Use of risk assessments and control measures in place. Reporting and investigation of incidents. Central point for supply of PPE to Independent Sector. Provision of testing to residents and staff. Daily work stream meeting to review care home sector. Implementation of Regional Care home surge plan. Induction and training pathway for in-reach staff. Training support offered to Independent Providers - Echo. IPC measures agreed to mitigate risk in working across sectors. Enhanced Care at Home in-reach to care homes. GP and Consultant support into Care Homes and escalation decisions. Covid-19 Domiciliary Care Teams established. Additional hours purchased from 3 IS providers to support covid-19 domiciliary care teams and to support care in care homes. Daily review of requests for care	A lack of additional resource to manage community screening and subsequent management. Environmental challenges in ED to facilitate appropriate isolation facilities. Gaps in regional /national supply issues on commodities/medicine etc. A lack of guidance on pathways for specialties (regional/national). Challenges re provision of appropriate PPE. Awaiting additional equipment (regional). Uncertainty in relation to the number of staff who will be available to provide sufficient care across the acute and community sector. Estates Dept have requested upgrade to Duty/Standby VIE C11 panels and vaporisers in order to accommodate early possession of ASB. As Covid Quality Improvement measure they are also planning installation of 3 x VIE flow meters and 3 x sub-meters to aid LIVE monitoring of local usage in CCU, ASB & IWB. Lack of certainty regarding the number of care homes who will be impacted by COVID-19 and who will require support and the maintenance of care for residents. Need for escalation of	Need for escalation of care in residential homes where there is not a nursing staff compliment to manage increased care needs. No laboratory facility for testing patients for COVID-19 within the Trust including those discharged to nursing homes.

ID	Principal objecti	Description	Risk level (	Controls in place	Positive Assurances	Gaps in controls	Gaps in assurance
				Incident reporting policy, Health & Safety policy, IPC Policy. The Trust is represented in regional bed modelling group which is a subgroup of the CSO led epidemiology group. PPE Workstream: daily stocktake/surge forecast v demand. Fit-testing - both in house and use of private company to assist OH /PPE video/ face to face training, Posters. Intranet Covid19 updates to ensure information shared across the Trust. 12/02/20 establishment of Trust Coronavirus liaison group. Regional Sub groups established. Screening & assessment pathways and designated areas for confirmed Covid and suspected Covid patients. Guidelines on Management of COVID-19 as PHE guidance. Daily teleconference to Regional HSC Silver. Business continuity activated with Strategic Team meeting daily and as required, Silver ICR running in Trust HQ and Bronze teams in Directorates with regular scheduled meetings. Medical Gas Committee. Work to upgrade existing estates medical gas infrastructure : stand-by	packages and waiting list. All domiciliary care packages are RAG rated to criteria - Red listed created for essential care. Key worker review of packages of care stood down to ensure review calls and escalation of risk as necessary. Escalations of contracts issues/ concerns where required. Feedback from independent providers regarding support mechanisms. Independent Sector - Ordering process introduced and all PPE ordered and distributed via a central point in Contracts. Supplier PPE established with a forecast of stock required developed. Close monitoring of stock being issued against forecast.	care in residential homes where there is not a nursing staff compliment to manage increased care needs.	

ID	Principal objecti	Description	Risk level (	Controls in place	Positive Assurances	Gaps in controls	Gaps in assurance
				VIE brought online with purchase and commissioning of 3rd VIE tank on Ulster Hospital site. Hourly daily monitoring of oxygen demand on 3 main hospital sites and incorporation of graphs into Trust-wide daily Covid-19 Surveillance Report. The Trust is working with the DoH to accelerate the opening of the Ulster Hospital Acute Services Block should it be required to open in response to Covid-19. Increased frequency of liquid oxygen deliveries with refill point increased from 35% to 60%. RAG status for oxygen demand / supply with agreed escalation actions. eWhiteboard icon to assist in identification and management of patients receiving various modes of oxygen support. Representation at regional Oxygen Supply Group telecon (hospital and community). Oversight of oxygen usage in Primary care including nursing and residential homes. Liaison with BOC and PHA to ensure appropriate management of available oxygen equipment in primary care. Twice weekly telecon. Established processes for			

ID	Principal objecti	Description	Risk level (	Controls in place	Positive Assurances	Gaps in controls	Gaps in assurance
				appropriate review of all patients commenced on Oxygen therapy in primary care. Daily work stream meeting to review care home sector. Implementation of Regional Care home surge plan. Care Home Response team established to co-ordinate in reaching staff to care homes. Regular communication and information sharing with all Trust independent sector providers. Corporate control committee structures. Environmental Cleanliness, Food Safety, Decontamination Policy and Procedures.			
2761	Ensure safety, improve quality and test experience	Difficulty in recruiting sufficient GPs to maintain required GPOOH Service across 3 sites resulting in reduced local access for patients and clients.	HIGH	Introduced professional skill-mix with a view to reducing dependence on GP clinical staff where appropriate and providing a more balanced and sustainable workforce in the medium to long term (i.e. Nurse Practitioner, Paramedic, Pharmacist with Independent Prescribing). Utilising Nurse Practitioners as & when available, working towards a longer forecast rota for improved planning ahead. Monitoring the rota & raising alerts to GP workforce where gaps exist.	Working with commissioner to address deficit in GP staffing within OOHs services. Continuous monitoring of rota by senior manager, admin staff & medical managers. Contingency measures protocol. Engagement events with GP workforce. Provide L&D for GPs. Appeals (multi media). On-going text alerts. Manager's appeals. Monitoring vacant shift percentages. Open recruitment.	Reliance on GP Workforce. Trust own staff re Nurse Practitioners / Skill-mix. Several variables which we try to influence but cannot control. E.g. working preferences	None identified.

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				Cross sector triaging in times of pressure (staffing / demand). Contingency measures protocol developed to ensure all patients calling the OOHs services will continue to receive telephone advice and offered an appointment at an alternative base or a home visit, as deemed clinically appropriate. Flexible shift patterns to suit individual circumstances to appeal to wider workforce. Open GP recruitment. Regional review of GPOOHs payment rates on-going. Increased numbers for GP training places (however this will have a lead in time). Continue local incentive schemes developed specifically to target difficult to fill shifts. Remote triage. Harris text alert systems and telephone follow up by Managers to encourage doctors to take up unfilled shifts. Medical Managers providing additional cover in extreme situations however this is not sustainable. Engagement with GPs in OOHs & LMC colleagues to promote OOHs working.		

Number of records for Nursing, Primary Care & Elderly **4**

ID	Principal objecti	Description	Risk level (	Controls in place	Positive Assurances	Gaps in controls	Gaps in assurance

Total number of records **19**