



## TRUST BOARD COVER SHEET

	<p><i>The cover sheet purpose is to provide the Trust Board/Committee with a clear summary of the paper being presented, how it impacts on the people we serve, key matters for attention and the ask of the Trust Board/Committee</i></p> <p><i>The Accountable Director must satisfy themselves that the cover sheet is accurate and fully reflects the paper. The expectation is that the Accountable Director has read and agreed the content of both the cover sheet and paper.</i></p>	
<b>Meeting and Date of meeting</b>	<p style="text-align: center;">Trust Board Thursday 29<sup>th</sup> January 2026</p>	
<b>Title of paper</b>	<p style="text-align: center;">SHSCT Major Incident – IT Outage Incident Review Group Outcome Report</p>	
<b>Accountable Director</b>	<b>Name</b>	<p style="text-align: center;">Ms Elaine Wilson</p>
<b>Report Author</b>	<b>Position</b>	<p style="text-align: center;">Director of Planning, Performance &amp; Informatics</p>
<b>This paper sits within the Trust Board role of:</b>	<b>Name</b>	<p style="text-align: center;">Caroline Brown</p>
<b>This paper is presented for:</b>	<b>Email</b>	<p style="text-align: center;">Caroline.brown@southerntrust.hscni.net</p>
<b>This paper sits within the Trust Board role of:</b>	<p style="text-align: center;">Accountability</p>	
<b>This paper is presented for:</b>	<p style="text-align: center;">Assurance <i>(Notes on completion at end of document)</i></p>	
<b>Links to Trust Strategic Priorities</b>  	<input type="checkbox"/>  <input checked="" type="checkbox"/>  <input checked="" type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>	<p>Collaborative Working</p> <p>Learning Organisation</p> <p>Safety, Quality &amp; Experience</p> <p>Community First</p> <p>Whole-Life Approach</p>

## **1. Reason for Presentation of Paper / Report**

The attached Incident Outcome Report summarises the findings of the independently chaired Incident Review Group (IRG) in respect to the major incident arising from the unexpected Information Technology (IT) outage incident experienced by the Southern Health and Social Care (HSC) Trust (the Trust) on the 17th September 2025. The incident had an adverse impact on the operational services of the Trust, resulting in the cancellation of 1,647 patient appointments and the step up of an ambulance divert away from the Trust's two acute hospital sites.

The report summarises the review structures established and the work undertaken to identify the technical root cause of the IT outage incident and its impact. The report also summarises the findings in regard to the effectiveness of the Trust's emergency planning and business continuity structures and procedures and associated internal and external communications both during and following the incident.

A key priority of this learning focussed review was to ensure that key learnings and associated recommendations for improvement are captured and actively shared with the wider HSC. The report provides an overview of the learning implementation work undertaken to date, along with conclusions and recommendations for continued improvement and business continuity resilience, both within the Trust and across the wider health and social care sector in Northern Ireland, moving forward.

In this regard it should be noted that the Trust has not waited for the final reporting of this review exercise to commence the process of sharing and embedding the important learnings from the incident, with relevant regional learning already having been shared with other HSC Trusts and a number of early recommendations implemented.

## **2. Detailed summary of paper contents:**

The paper commences with the Foreword from the Independent Chair of the IRG, Professor Graham Evans, who is a specialist in the area of health and care digital leadership and transformation, having held a number of Executive Director level digital services roles across his 20+ years in the health and care sector in England.

It then progresses to provide the background to the IT outage incident and summarises the robust governance structures that were established within the Trust to undertake a thorough review of the incident, namely the independently chaired IRG and its four sub-groups which are as follows:

- Technical Root Cause Analysis
- encompass business continuity arrangements
- Major Incident Response, including general emergency planning business continuity arrangements
- Communications, internal and external

The paper provides an overview of the scope of work of the IRG and each of its sub-groups, (with Terms of Reference attached as appendices) and proceeds to identify the key findings and learnings collated through the sub-groups, along with the findings of a review of the Trust's digital governance arrangements.

It also provides the findings regarding the regrettable impact of the incident on patients and service users, summarising the number and type of cancelled appointments, the arrangements applied to reschedule the cancelled appointments, and wider feedback from patients and service users in respect to the incident.

In concluding the paper outlines that the Trust, along with its HSC and technology partners, worked in a responsive manner to minimise the duration of the incident restoring services within one business day and demonstrating strong foundations in emergency planning, business continuity, and communications. Furthermore, it commends the work of the clinical and operational teams in delivering an outstanding, patient-first response, demonstrating exceptional professionalism and adaptability in activating business continuity plans and maintaining patient safety throughout the IT outage.

However, the incident has also provided rich learning, highlighting opportunities to further strengthen preparedness, resilience, and communications, particularly during IT system outages. Recommendations and next steps in this regard are set out within the final sections of the report.

### **3. Areas of improvement/achievement:**

The incident, while regrettable, has resulted in a rich learning opportunity for the Trust in terms of approaches to Major Incident planning and business continuity during the event. In this regard it is acknowledged that the implementation of the encompass patient record system in May 2025 has added a new aspect to the Trust's emergency planning and business continuity arrangements. Work continues to ensure this is fully embedded as a core element of the Trust's wider emergency and business continuity planning and the learnings and recommendations from this incident have already improved the Trust's preparedness in this regard.

Relevant regional learning has also been shared with other HSC Trusts and a number of early recommendations implemented enabling improvements at an HSC wide level.

### **4. Areas of concern/risk/challenge:**

The occurrence of the IT Outage has been a considerable area of challenge for the Trust, however the outcomes of the detailed review exercise outlined in this report will serve to reduce the risk and / or impact of a similar incident occurring in the future.

<b>5. Impact on Statutory Duties: Provide details on the impact of the following and how.</b>	
<b><i>Financial Impact</i></b>	<b><i>Safety and Quality Impact</i></b>
Yes, there are Financial Impacts	Yes, there are Quality, Safety or Experience Impacts
<b>6. Risk Assessment (Risk level and state if a risk assessment be completed)</b>	
<p>The work of the IRG in reviewing the digital governance of the Trust has noted recommendations in regard to further strengthening areas of the risk register related to digital data and technology, including operational dependency.</p> <p>The review of the management and ownership of this risk is currently underway, including the review of the digital/information asset ownership within the Trust.</p>	
<b>7. Other Business Intelligence/data (If appropriate)</b>	
N/A	
<b>8. Impact: Provide details on the impact of the following and how. If this is N/A you should explain why this is an appropriate response.</b>	
<b>Corporate Risk Register</b>	As noted above under Risk Assessment
<b>Board Assurance Framework</b>	This Incident Outcome Report is to be shared with Trust Board.
<b>Equality and Human Rights</b>	There are no known equality or human rights issues arising from this document.

### **Trust Board Role Fulfilment**

<b>Strategy</b>	<i>Papers in this category should address forward-looking priorities, long-term objectives, or service transformation. These are typically focused on shaping the future of the organisation and will often involve decisions on direction, investment, or innovation.</i>
<b>Culture</b>	<i>These papers aim to influence or reflect the values, behaviours, and staff or patient experiences within HSC. They may relate to leadership development, equality, diversity and inclusion, staff engagement, or initiatives intended to reinforce our organisational ethos.</i>
<b>Accountability</b>	<i>Papers falling into this area relate to governance, assurance, performance monitoring, compliance, and risk. They provide evidence that responsibilities are being fulfilled, standards are being met, and corrective actions are being taken where necessary.</i>

### **Reasons for Paper Presentation**

<b>Approval</b>	<i>Used when an item requires a formal agreement or endorsement by the meeting / committee members. Examples are approving minutes, budgets, proposals or policies.</i>
<b>Assurance</b>	<i>Used when an item can be measured against a certain criteria / standard. Examples are a project is on course with delivery or financial targets are being met.</i>
<b>Information</b>	<i>Used when an item is presented for the purpose of updating or informing the attendees without requiring a decision or action, such as reports, updates, or announcements.</i>
<b>Discussion</b>	<i>Used when an item is listed primarily for open discussion, brainstorming or gathering input from the members without requiring an immediate decision.</i>