Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this leadership role. The competencies concerned are given in the NHS Leadership Qualities Framework, details of which can be accessed at nhsleadershipqualities.nhs.uk Particular attention will be given to the following:

- Self Belief
- Self Management
- Seizing the future
- Drive for results
- Leading change through people
- Holding to account
- Effective and strategic influencing

The following additional clarification is provided:

*"senior role" is defined as experience gained at Assistant Director, Team Manager or Team Leader or at a minimum of Administrative and Clerical Band 7 or equivalent.

**"significant" is defined as contributing directly to key corporate objectives of the organisation.

September 2007

Other Information:

Downloads: SHSCT rpa

Instructions: Instructions for Completing Application Form

Southern Health and Social Care Trust
Assistant Director of Cancer and Clinical Services
Band 8C

Job Description

JOB SUMMARY

The jobholder will be responsible to the Director of Acute Services for the delivery of high quality care to patients in the Trust's Cancer and Clinical Services Division. He/She will be responsible for the operational management of all specialties and departments in the division. In addition to cancer, this will incorporate clinical services such as critical care, theatres, anaesthetics, radiology, pharmacy, laboratories, psychology, outpatients and infection control in Craigavon Area Hospital, Daisy Hill Hospital and other settings as appropriate. He/She will collaborate closely with senior clinicians and other disciplines to implement the objectives of the Trust's Delivery Plan and ensure effective multidisciplinary working. He/She will provide clear leadership to all staff in the division and will be responsible for effective financial management and the efficient use of all resources. The jobholder will also support the Director of Acute Services with long term planning and service reform initiatives.

As an Assistant Director, the jobholder will be a member of the directorate's senior management team and will therefore contribute to policy development in the directorate and the achievement of its overall objectives.

KEY RESULT AREAS

Service Delivery

- lead multidisciplinary teams and oversee the co-ordination of all processes to ensure the delivery of high quality and equitable care to patients in the Trust's cancer and clinical services division.
- ensure the successful implementation of all DHSSPS, HSSA and commissioning priorities and targets in the division with a particular emphasis on those relating to waiting times and the establishment of agreed treatment schedules.
- work closely with senior clinicians and other senior managers in the Trust to secure an appropriate balance between hospital and community based services and achieve an integrated approach in reducing inappropriate hospital admissions and lengths of stay.

- contribute to the development of robust clinical and professional networks within the division and across the Trust.

Quality and Governance

- ensure that the needs of patients and their carers are at the core of how all specialties in the division deliver their services and are in accordance with DHSSPS Quality Standards for Health and Social Care and other relevant requirements.
- ensure high standards of governance in the division to include compliance with controls assurance standards, the assessment and management of risk and the implementation of the DHSSPS's Safety First framework.
- ensure the division complies with all professional, regulatory and requisite standards.
- ensure the division meets all targets for the prevention and control of healthcare associated infection and standards of environmental cleanliness.
- ensure all recommendations from the RQIA and other regulatory bodies are implemented within requisite timescales.
- ensure the management of complaints within the division comply with HPSS Complaints and Trust Procedures and are underpinned by transparency and a culture of continuous improvement.
- lead on the implementation of quality initiatives such as Investors in People and Charter Standards in the division.

Service Planning and Development

- promote innovation and change to underpin the modernisation of the division's services and oversee the implementation of initiatives such as HQS or similar.
- assist the Director of Acute Services with the development of a strategic plan for the delivery of acute hospital care to the Trust's population in line with regional strategies and priorities.
- work closely with commissioners and relevant stakeholders to secure their commitment and involvement in the development and implementation of planning initiatives and service reforms.
- liaise closely with senior planning staff on service and capital development initiatives and ensure adherence to targets set by the HSSA and the Trust's corporate and delivery plans.
- act as a member of the directorate's senior management team and contribute to its policy development processes.
- represent the division and/or directorate in Trust and/or regional planning teams as appropriate.

Financial and Resource Management

- responsible for the management of the division's budget and the meeting of all financial targets by each specialty.
- ensure the effective implementation of all Trust financial policies and procedures in the division which will include ensuring the safe custody of patients' property and accounts and the use of endowments and gifts.
- participate in contract and service level negotiations with commissioners.
- ensure the effective management, use and maintenance of all physical assets in the division.

People Management

- provide clear leadership to staff within the division and ensure all specialties have a highly skilled, flexible and motivated workforce.
- work closely with senior human resources staff to take forward the development and implementation of workforce planning and modernisation initiatives.
- ensure that management structures and practices in the division support a culture of effective team working, continuous improvement and innovation.
- ensure the effective implementation of all Trust people management policies in the division and the achievement of all relevant targets such as relating to the management of sickness and absenteeism, turnover etc.
- ensure the effective management of staff health and safety and support in the division.

Information Management

- ensure the effective implementation of all Trust information management policies and procedures in the division.
- ensure the division's systems and procedures for the management and storage of information meet internal and external reporting requirements.

Corporate Responsibilities

- develop and maintain working relationships with other directorate colleagues to ensure achievement of Trust objectives.
- establish collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure the Trust effectively discharges its functions.
- contribute to the Trust's overall corporate governance processes to ensure the development of an integrated governance framework for the Trust that assures safe and effective care for patients and clients and complies with public sector values and codes of conduct, operations and accountability.

- adhere to the Trust's corporate planning, policy and decision making processes as a member of the directorate's senior management team and ensure the Trust's objectives and decisions are effectively communicated.
- lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

General Management Responsibilities

- participate in the Trust's Staff Development and Performance Review Scheme. Review individually on a regular basis the performance of immediately subordinate staff. Provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.
- ensure that the review of performance identified above is performed for all levels of staff within the Trust in accordance with the Trust Board's policy.
- maintain good staff relationships and morale amongst the staff reporting to him/her.
- where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.
- delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results.
- participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
- take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.
- promote the Trust's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for whom he/she has responsibility.

This job description is subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the Assistant Director of Cancer and Clinical Services works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Director of Acute Services.

GENERAL RESPONSIBILITIES

Employees of the Trust will be required to promote and support the mission and vision of the service for which they are responsible and:

- at all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.

- demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- comply with the Trust's No Smoking Policy.
- carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.
- adhere to equal opportunities policy throughout the course of their employment.
- ensure the ongoing confidence of the public in service provision.
- comply with the HPSS code of conduct.

March 2007

Southern Health and Social Care Trust
Assistant Director of Cancer and Clinical Services

Personnel Specification

Knowledge, skills and experience required:

Applicants must provide evidence by the closing date for application that they are a permanent employee of either Armagh and Dungannon, Craigavon Area Hospital Group Trust, Craigavon and Banbridge Community HSS Trust or Newry and Mourne HSS Trust and have:

- university degree or relevant professional qualification and worked for at least 2 years in a senior management role in a major complex organisation.

OR

- have worked for at least 5 years in a senior management role in a major complex organisation.

AND

- delivered against challenging performance management programmes for a minimum of 2 years in the last 6 years meeting a full range of key targets and making significant improvements.
- worked with a diverse range of stakeholders, internal and external to the organisation, to achieve successful outcomes for a minimum of 2 years in the last 6 years.
- a proven track record of people management, governance and organisational skills for a minimum of 2 years in the last 6 years.
- a full current driving licence with access to a car or access to a form of transport to meet the mobility needs of the post.

SHORTLISTING

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified. Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this leadership role. The

competencies concerned are given in the NHS Leadership Qualities Framework. Particular attention will be given to the following:

- Self Belief
- Self Management
- Seizing the future
- Drive for results
- Leading change through people
- Holding to account
- Effective and strategic influencing

The following additional clarification is provided:

"senior management" is defined as experience gained at Director, Assistant Director or equivalent to mean reporting directly to a Director.

"major complex organisation" is defined as one with at least 200 staff or an annual budget of at least £50 million and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders;

"significant" is defined as contributing directly to key corporate objectives of the organisation.

March 2007

Southern Health and Social Care Trust
Assistant Director of Integrated Maternity and Women's Health
Band 8C

Job Description

JOB SUMMARY

The jobholder will be responsible to the Director of Acute Services for the delivery of high quality care to patients in the Trust's Integrated Maternity and Women's Health Division. He/She will be responsible for the operational management of all specialties and departments in the division which will include gynaecology, maternity, obstetrics and neonatal services in Craigavon Area Hospital, Daisy Hill Hospital and other settings as appropriate. He/She will collaborate closely with senior clinicians and other disciplines to implement the objectives of the Trust's Delivery Plan and ensure effective multidisciplinary working. He/She will provide clear leadership to all staff in the division and will be responsible for effective financial management and the efficient use of all resources. The jobholder will also support the Director of Acute Services with long term planning and service reform initiatives.

As an Assistant Director, the jobholder will be a member of the directorate's senior management team and will therefore contribute to policy development in the directorate and the achievement of its overall objectives.

KEY RESULT AREAS

Service Delivery

- lead multidisciplinary teams and oversee the co-ordination of all processes to ensure the delivery of high quality and equitable care to patients in the Trust's maternity and women's health division.
- ensure the successful implementation of all DHSSPS, HSSA and commissioning priorities and targets in the division with a particular emphasis on those relating to patient safety and access targets.
- work closely with senior clinicians and other senior managers in the Trust to ensure effective co-operation and seamless service delivery in maternity and neonatal services.

- contribute to the development of robust clinical and professional networks within the division and across the Trust.

Quality and Governance

- ensure that the needs of patients and their carers are at the core of how all specialties in the division deliver their services and are in accordance with DHSSPS *Quality Standards for Health and Social Care* and other relevant requirements.
- ensure high standards of governance in the division to include compliance with controls assurance standards, the assessment and management of risk and the implementation of the DHSSPS's *Safety First* framework.
- ensure the division complies with all professional, regulatory and requisite standards.
- ensure the division meets all targets for the prevention and control of healthcare associated infection and standards of environmental cleanliness.
- ensure all recommendations from the RQIA and other regulatory bodies are implemented within requisite timescales.
- ensure the management of complaints within the division comply with HPSS and Trust complaints procedures and are underpinned by transparency and a culture of continuous improvement.
- lead on the implementation of quality initiatives such as Investors in People and Charter Standards in the division.

Service Planning and Development

- promote innovation and change to underpin the modernisation of the division's services and oversee the implementation of initiatives such as HQS or similar.
- assist the Director of Acute Services with the development of a strategic plan for the delivery of acute hospital care to the Trust's population in line with regional strategies and priorities.
- work closely with commissioners and relevant stakeholders to secure their commitment and involvement in the development and implementation of planning initiatives and service reforms.
- liaise closely with senior planning staff on service and capital development initiatives and ensure adherence to targets set by the HSSA and the Trust's corporate and delivery plans.
- act as a member of the directorate's senior management team and contribute to its policy development processes.
- represent the division and/or directorate in Trust and/or regional planning teams as appropriate.

Financial and Resource Management

- responsible for the management of the division's budget and the meeting of all financial targets by each specialty.
- ensure the effective implementation of all Trust financial policies and procedures in the division which will include ensuring the safe custody of patients' property and accounts and the use of endowments and gifts.
- participate in contract and service level negotiations with commissioners.
- ensure the effective management, use and maintenance of all physical assets in the division.

People Management

- provide clear leadership to staff within the division and ensure all specialties have a highly skilled, flexible and motivated workforce.
- work closely with senior human resources staff to take forward the development and implementation of workforce planning and modernisation initiatives.
- ensure that management structures and practices in the division support a culture of effective team working, continuous improvement and innovation.
- ensure the effective implementation of all Trust people management policies in the division and the achievement of all relevant targets such as relating to the management of sickness and absenteeism, turnover etc.
- ensure the effective management of staff health and safety and support in the division.

Information Management

- ensure the effective implementation of all Trust information management policies and procedures in the division.
- ensure the division's systems and procedures for the management and storage of information meet internal and external reporting requirements.

Corporate Responsibilities

- develop and maintain working relationships with other directorate colleagues to ensure achievement of Trust objectives.
- establish collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure the Trust effectively discharges its functions.
- contribute to the Trust's overall corporate governance processes to ensure the development of an integrated governance framework for the Trust that assures safe and effective care for patients and clients and complies with public sector values and codes of conduct, operations and accountability.

- adhere to the Trust's corporate planning, policy and decision making processes as a member of the directorate's senior management team and ensure the Trust's objectives and decisions are effectively communicated.
- lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

General Management Responsibilities

- participate in the Trust's Staff Development and Performance Review Scheme. Review individually on a regular basis the performance of immediately subordinate staff. Provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.
- ensure that the review of performance identified above is performed for all levels of staff within the Trust in accordance with the Trust Board's policy.
- maintain good staff relationships and morale amongst the staff reporting to him/her.
- where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.
- delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results.
- participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
- take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.
- promote the Trust's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for whom he/she has responsibility.

This job description is subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the Assistant Director of Integrated Maternity and Women's Health works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Director of Acute Services.

GENERAL RESPONSIBILITIES

Employees of the Trust will be required to promote and support the mission and vision of the service for which they are responsible and:

- at all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.

- demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- comply with the Trust's No Smoking Policy.
- carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.
- adhere to equal opportunities policy throughout the course of their employment.
- ensure the ongoing confidence of the public in service provision.
- comply with the HPSS code of conduct.

March 2007

Southern Health and Social Care Trust
Assistant Director of Integrated Maternity and Women's Health

Personnel Specification

Knowledge, skills and experience required:

Applicants must provide evidence by the closing date for application that they are a permanent employee of either Armagh and Dungannon, Craigavon Area Hospital Group Trust, Craigavon and Banbridge Community HSS Trust or Newry and Mourne HSS Trust and have:

- university degree or relevant professional qualification and worked for at least 2 years in a senior management role in a major complex organisation.

OR

- have worked for at least 5 years in a senior management role in a major complex organisation.

AND

- delivered against challenging performance management programmes for a minimum of 2 years in the last 6 years meeting a full range of key targets and making significant improvements.
- worked with a diverse range of stakeholders, internal and external to the organisation, to achieve successful outcomes for a minimum of 2 years in the last 6 years.
- a proven track record of people management, governance and organisational skills for a minimum of 2 years in the last 6 years.
- a full current driving licence with access to a car or access to a form of transport to meet the mobility needs of the post.

SHORTLISTING

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified. Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this leadership role. The

competencies concerned are given in the NHS Leadership Qualities Framework. Particular attention will be given to the following:

- Self Belief
- Self Management
- Seizing the future
- Drive for results
- Leading change through people
- Holding to account
- Effective and strategic influencing

The following additional clarification is provided:

"senior management" is defined as experience gained at Director, Assistant Director or equivalent to mean reporting directly to a Director.

"major complex organisation" is defined as one with at least 200 staff or an annual budget of at least £50 million and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders;

"significant" is defined as contributing directly to key corporate objectives of the organisation.

March 2007

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

JOB TITLE	**Executive Director of Nursing, Midwifery & Allied Health Professionals**
LOCATION	**Trust Headquarters, Craigavon Area Hospital**
ACCOUNTABLE TO	**Chief Executive**

JOB SUMMARY

The Director of Nursing, Midwifery & Allied Health Professionals (AHP) is an Executive Director and member of the Trust Board, and a key member of the Trust's Senior Management Team. The postholder will have a professional line of accountability to the Chief Nursing Officer, Department of Health.

The postholder will be the visible champion for nursing, midwifery and AHPs within the Trust, and will represent the Trust on all related matters across the HSC. The post holder will play a leading role in driving improvement in quality and safety of the services that are provided across the Trust.

The postholder will advise the Trust Board, Chief Executive and the Senior Management Team on all issues relating to nursing, midwifery and allied health professions policy and related statutory requirements, professional practice and workforce requirements. S/he will be responsible for setting a strategy for these professions, ensuring a skilled and flexible workforce that is supported and able to deliver the highest level of compassionate care.

The postholder will be responsible for providing strong professional leadership and for ensuring effective systems and processes for good governance are in place. The postholder will, on behalf of the Chief Executive, hold operational directors to account for the implementation of these systems and processes.

The postholder also has executive responsibility for driving forward the Trust's strategy for Infection Prevention and Control and will manage the Infection Prevention and Control Nursing Team, and with other Directors, play a lead role in ensuring patient safety.

As a member of the Trust Board and the Senior Management Team s/he will have both individual and corporate leadership responsibility for the governance of the Trust and

compliance with legal requirements, and contribute fully to the development, delivery and achievement of the Trust's corporate objectives.

From a service delivery perspective, the postholder will have direct responsibility for functional support services to patients and clients, in addition to a further defined operational service brief *(to be confirmed following organisational restructuring)*. S/he will lead the strategic planning and delivery of these services and ensure effective multidisciplinary and team working ensuring the most efficient use of resources within and across divisions. S/he will provide clear leadership and oversee the management of all staff involved in providing these services.

KEY RESULT AREAS

PROFESSIONAL LEADERSHIP

1. To provide the Trust Board with expert nursing, midwifery and AHP advice.

2. Provide highly visible and inspiring professional leadership for nursing, midwifery and AHP staff throughout the Trust, championing a professional and open culture which empowers staff to consistently deliver high quality, safe and effective care, acting as a role model for the behaviours and high professional standards expected.

3. Develop and maintain effective relationships with the Nursing & Midwifery Council (NMC) and the Health & Care Professions Council (HCPC) which support the regulation and standards of practice of the nursing & midwifery and AHP workforces respectively.

4. Actively contribute to and influence the work of the Chief Nursing Officer (DOH) and the Public Health Agency (PHA), taking the delegated lead on key themes as requested.

5. Ensure ongoing engagement with the nursing, midwifery and AHP workforce to encourage continuous development and improvements in patient care.

6. Work closely with the Director of Human Resources & Organisational Development, Medical Director and other Directors to integrate learning into clinical practice, develop teams and individuals and promote leadership and development.

7. Ensure, in collaboration with the Director of Human Resources & Organisational Development, that workforce plans are developed and implemented to ensure the

effective and efficient provision of care in the Trust and the recruitment and retention of a high quality workforce.

8. Work closely with colleagues to enhance communication and working relationships between clinical leaders and senior managers and ensure that opportunities to improve services are harnessed.

PROFESSIONAL NURSING & AHP GOVERNANCE AND QUALITY

1. Ensure that the needs of patients, clients and their carers are at the core of the way the Trust delivers its services.

2. Ensure that practice and service development is underpinned by the most up to date evidence and research.

3. Ensure high standards of governance for the Trust's nursing, midwifery and AHP services including the assessment and management of risk.

4. Ensure the Trust's nursing, midwifery and AHP services comply with all professional regulatory and requisite standards and the discharge of statutory functions.

5. Establish clear lines of accountability for nursing and AHP standards and practice in operational directorates, to the Executive Director role.

6. Ensure that robust performance management arrangements are in place and implemented within directorates for Nursing and AHPs.

7. Ensure the defining and monitoring of performance standards in contracts/service level agreements with independent service providers.

8. Promote high standards of nursing, midwifery and AHP practice and provide advice and support to ensure the development of a quality culture with a focus on continuous improvement.

9. Support innovation and change to underpin the modernisation of services.

10. Ensure the effective facilitation and quality assurance of pre and post registration education and training, and work with other agencies on the commissioning of education programmes.

11. Work in partnership with the Medical Director and other members of the Trust's Senior Management Team to ensure the integration of learning from complaints, incidents and claims into service delivery within the Trust.

12. Ensure effective arrangements are in place for the prevention and control of healthcare associated infection.

SERVICE DELIVERY

1. Drive multi-disciplinary team working to deliver high quality services with particular emphasis on patient/user centred care and infection prevention and control.

2. Ensure the development of strategic plans for the delivery of services within the remit of the post, in line with corporate objectives, regional and / or national strategies / priorities and all legislative requirements, ensuring they are well managed, operationally effective and safe, underpinned by a strong service and quality ethos which places patients and clients at the forefront of service delivery.

3. Management of the Trust's Management of Violence & Aggression (MOVA) Team, ensuring that the Trust continues to develop and implement policies, procedures and strategies aimed at preventing and managing violence and aggression at work.

4. Engage with a range of external organisations securing positive collaborative working relationships with representatives of Trade Unions, Professional Bodies, DoH and the regional Health and Social Care Board/Public Health Agency as well as representing the Trust on national and regional forums.

5. Responsible for ensuring that professional nursing, midwifery and non-clinical support staff groups work in an integrated way across the Trust.

6. Ensure along with other Directors that robust performance management arrangements are developed and implemented.

Southern Health and Social Care Trust

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FINANCIAL AND RESOURCE MANAGEMENT

1. Be accountable for the management of the Directorate's budget (pay and non pay) and the meeting of all financial targets by each division and service.

2. Advise and assist the Trust Board and Chief Executive in determining its expenditure on clinical and non-clinical services.

3. Lead and ensure effective use of educational commissioning arrangements.

4. Advise and assist in the development of capital investment strategies across the Trust, ensuring these reflect and contribute to meeting targets set by the DoH/HSCB and the Trust's Corporate Plan.

LEADERSHIP & PEOPLE MANAGEMENT

1. Provide exemplary and visible leadership and promote a strong positive model of valuing staff, effective communication and engagement so as to enable staff to perform to the best of their abilities to deliver high quality care and support and be involved in the transformation agenda.

2. Provide leadership in the development and implementation of workforce modernisation initiatives within the Directorates.

3. Promote and maintain highly positive working relationships with trade union colleagues and ensure effective engagement with them in planning for and implementing service transformation.

4. Ensure that management structures and practices in the Directorate are fit for purpose and support a culture of effective team working, collective leadership, continuous improvement and innovation, always striving to remain focused on person-centred care for citizens of the Trust's area.

5. Ensure the effective implementation of all Trust people management policies in the Directorate and the achievement of all relevant targets such as relating to corporate mandatory training, personal development plans, the management of sickness and absenteeism, turnover etc.

6. Ensure the Directorate has a robust workforce strategy to enable all service changes and plans.

7. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.

8. Maintain staff relationships and morale amongst the staff reporting to him/her.

9. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

10. Participate, as required, in the selection and appointment of staff in accordance with procedures laid down by the Trust.

11. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

CORPORATE & COLLECTIVE LEADERSHIP

1. Demonstrate exemplary standards of corporate leadership and share a collective responsibility for all Trust corporate decisions, initiatives and the effective implementation and communication of same.

2. Actively promote a culture of collective leadership within the Trust, and across organisational boundaries, in line with the four key components of the *HSC Collective Leadership Strategy*.

3. Share a collective responsibility for the Trust's financial performance and the achievement of all quality, safety and other legislative requirements.

4. Share a collective responsibility for the Trust's overall corporate governance processes to include the implementation of an integrated governance framework that assures safe and effective care for patients and clients and complies with public sector values and codes of conduct, operations and accountability.

5. Lead by example, to ensure the Trust demonstrates respect through its culture and actions, for all aspects of diversity in the population it serves and the staff who provides the services.

6. Share a collective responsibility for the Trust's corporate planning, policy and decision making processes as a member of the Directorate's senior management team and ensure the Trust's objectives and decisions are effectively communicated.

7. Continually strive to develop self and improve capability in the leadership of the Trust and its staff.

8. Lead by example in practicing the highest standards of conduct in accordance with the Code of Conduct for HSC Staff.

9. Participate in the Director on-call rota.

EMERGENCY PLANNING AND BUSINESS CONTINUITY

1. Lead on the development, testing and review of relevant emergency response and business continuity plans to ensure a state of emergency preparedness for the provision of a proportionate, effective response to emergency situations and business continuity issues.

General Requirements

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

3. Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

4. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

5. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

6. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004 and the General Data Protection Regulations (GDPR). Employees are required to be conversant with the Trust's policy and procedures on records management and to seek advice if in doubt.

7. Take responsibility for his/her own ongoing learning and development, including full participation in Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

8. Represent the Trust's commitment to providing the highest possible standard of the patient/client experience and services delivered by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Chief Executive.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

Southern Health and Social Care Trust

Quality Care - for you, with you

PERSONNEL SPECIFICATION

JOB TITLE: Executive Director of Nursing, Midwifery & AHPs

September 2019

Notes to applicants:

1. *You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Shortlisting will be carried out on the basis of the essential criteria set out in Section 1 below, using the information provided by you on your application form.*
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

ESSENTIAL CRITERIA

SECTION 1: The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.

Factor	Criteria	Method of Assessment
Experience / Qualifications/ Registration	1. On the NMC Live Register. 2. Degree or Masters level qualification in a health related subject 3. A minimum of three years' experience in a senior management[1] role in a major complex organisation[2] AND clear significant[3] personal evidence of:- • managing major service improvement and transformation; • implementing financial control; • high level leadership and people management skills; • effective governance and risk management; • building strategic relationships with external agencies / partners	Shortlisting by Application Form

[1] ***'senior management'*** *is defined as experience gained at Director, Assistant Director or equivalent in a major complex organisation*
[2] ***'major complex organisation'*** *is defined as one with at least 200 staff or an annual budget of at least £50 million and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders*
[3] ***'significant'*** *is defined as contributing directly to professional nursing/midwifery* **and** *key corporate objectives of the organisation concerned.*

Southern Health and Social Care Trust

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Other	Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. This criteria will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post	Shortlisting by Application Form
Selection / Interview stage		
Candidates shortlisted and invited for further stages of selection will be assessed using the nine dimensions of leadership behaviour as specified in the ***NHS Healthcare Leadership Model*** *(which can be found at http://ww.leadershipacademy.nhs.uk/resources/healthcare-leadership-model)*. Shortlisted candidates will need to demonstrate that they have the required knowledge, skills, competencies and values to be effective in this role.		

As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed. Successful applicants may be required to attend for a Health Assessment

THE TRUST IS AN EQUAL OPPORTUNITIES EMPLOYER

Reference Number:

Southern Health and Social Care Trust
Associate Medical Director – Surgery/Elective Care

Job Description

JOB SUMMARY

The appointee will provide clinical leadership in the Acute Services Directorate, Surgery/Elective Care Division for: medical people management; reform and modernisation, patient and client safety, quality and standards; medical education and research governance.

- To contribute strategically as a member of the Directorate Management Team
- To provide clinical leadership to relevant medical staff in the Directorate and promote the corporate values and culture of the Trust.
- Ensure excellent communication between clinicians, Directorate management team and the Medical Directors Office
- To take responsibility for performance management including appraisal of designated clinicians
- To provide leadership to medical staff to enhance collaboration on Reform and Modernisation agenda

KEY RESULT AREAS:

Strategy Development:

- Contribute to strategy development as part of Directorate Senior Management Team.
- To advise the Management Team of Directorate priorities and pressures and contribute to the development of an Annual Directorate Management Plan and Trust Delivery Plan

Service Delivery

- To function as a member of the Directorate management team with responsibility to contribute to strategic development and operational excellence.
- Provide clinical leadership in developing responses to specific access targets and in the reform and modernisation of services within the directorate
- Use the resources of the Directorate to deliver, in both quality and quantity, the activity and targets agreed for the Directorate
- To support the Trust in planning a response to major incidents and outbreaks.

Professional Leadership

- To develop and lead a team of Clinical Directors and Specialty Leads to assist the Trust in the redesign, modernisation and improvement of service delivery and ensure a senior professional clinical lead on the major Trust facilitiesl
- To identify and make provision for the training and development needs of designated medical staff in the Directorate and facilitate research activity in the Directorate
- To ensure the highest standards of clinical effectiveness and medical practice in the Directorate, including the implementation of local and national recommendations including NICE guidelines, RQIA Reports, Independent Reviews, College Guidelines and Regional and National Reports
- Contribute as an effective member of Directorate Governance Committee
- To place Patient Safety at the centre of Directorate activity

Medical Education and Research

- Be responsible for the delivery and development of Medical Education and Research within the Directorate

Leading the Medical Team

- Be responsible for performance management, including appraisal and review of job plans, professional regulation for designated medical staff and to ensure that personal and professional development plans are in line with corporate objectives

- Implement the consultant contract, within the Directorate, ensuring the contract supports modernisation, quality improvement and achievement of access targets

- Provide leadership in the effective implementation and monitoring of Modernising Medical Careers and The New Deal for Junior Doctors.

- Ensure that doctors within the Directorate comply with arrangements for the assessment of fitness for clinical work and be responsible within the directorate for professional standards and regulation of doctors

- Ensure that a process is in place within the directorate for proper appraisal of all grades of doctors, including locum tenens, in line with regional guidance.

- Take part in the recruitment process for new doctors or ensure that other colleagues do so effectively

- Influence the modernisation of the workforce as systems for delivering care change

- Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

Quality & Information Management

- Support the development of clinical indicators and outcome measures relevant to the Directorate clinical specialities.

- Ensure a programme of multi-professional clinical audit is implemented within the Directorate that supports the Trust integrated governance strategy and support the development of benchmarking activities within the Directorate

- Support the implementation of the Trust adverse incident reporting and complaints handling mechanisms within the Directorate

Collaborative Working

- Actively promote the development of clinical and professional networks across primary, secondary and social care.

- Liaise with clinical colleagues to ensure that activities across the Trust are appropriately co-ordinated and integrated

- Promote and develop effective multi-professional team working and communication.

Corporate Responsibilities

- maintain good staff relationships and morale amongst the staff reporting to him/her.
- where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.
- delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results.
- participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
- take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.
- promote the Trust's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for whom he/she has responsibility.

This job description is subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the Associate Medical Director – Surgery/Elective Care works. Other duties of a similar nature and

appropriate to the grade may be assigned from time to time by the Medical Director/ Director of Acute Services.

GENERAL RESPONSIBILITIES

Employees of the Trust will be required to promote and support the mission and vision of the service for which they are responsible and:

- at all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- comply with the Trust's No Smoking Policy.
- carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.
- adhere to equal opportunities policy throughout the course of their employment.
- ensure the ongoing confidence of the public in service provision.
- comply with the HPSS code of conduct.

July 2007

Southern Health and Social Care Trust
Associate Medical Director – Surgery/Elective Care

Personnel Specification:

Title of Post: **Associate Medical Director – Surgery/Elective Care**

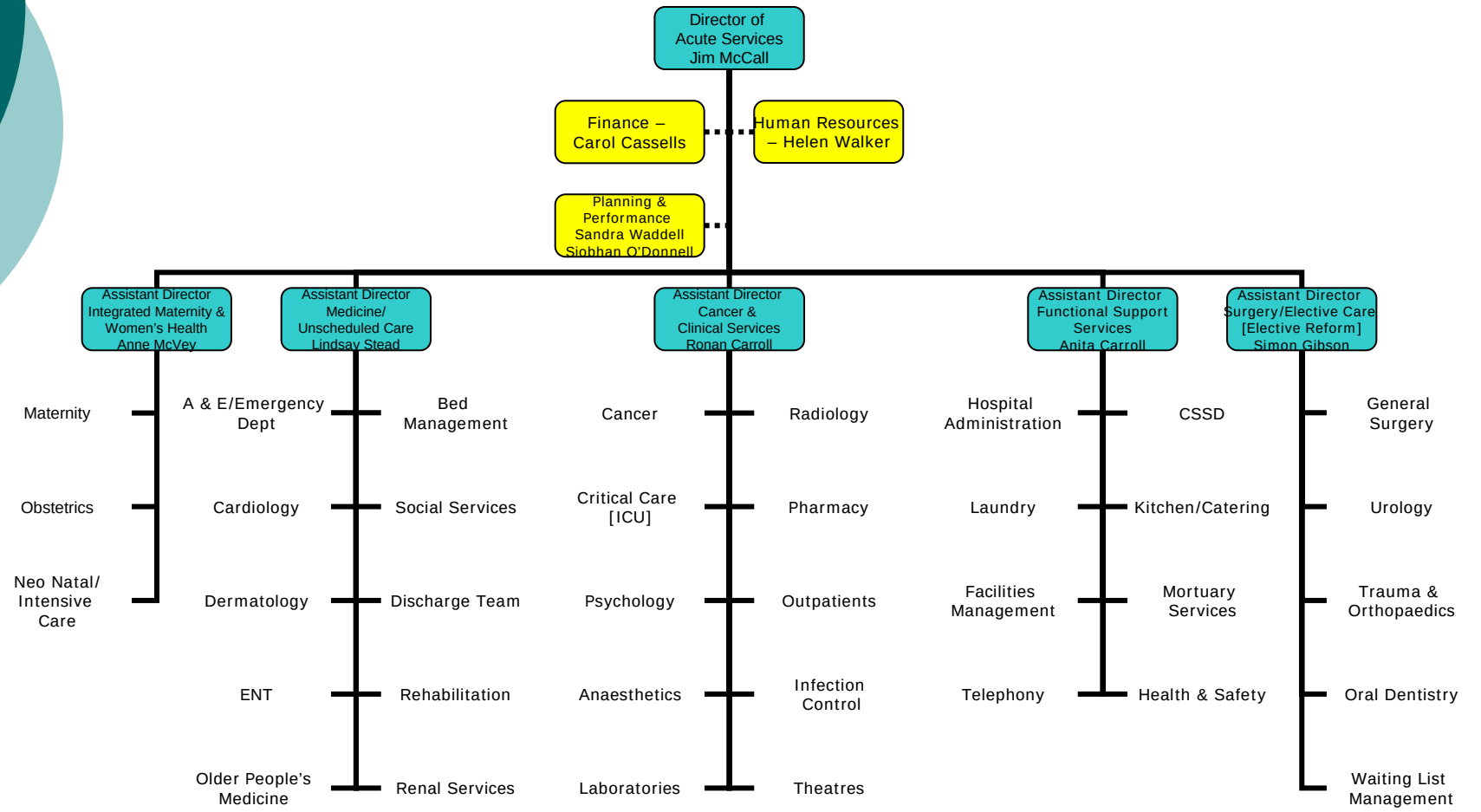
Knowledge, skills and experience required:

- Hold a medical or dental qualification, GMC registration and specialist accreditation.
- Demonstrate evidence of leadership within a team that led to successful service development and/or quality improvement.
- Demonstrate evidence of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.
- Have excellent communication skills, both orally and in writing.
- Be prepared to undertake clinical management development.

SHORTLISTING

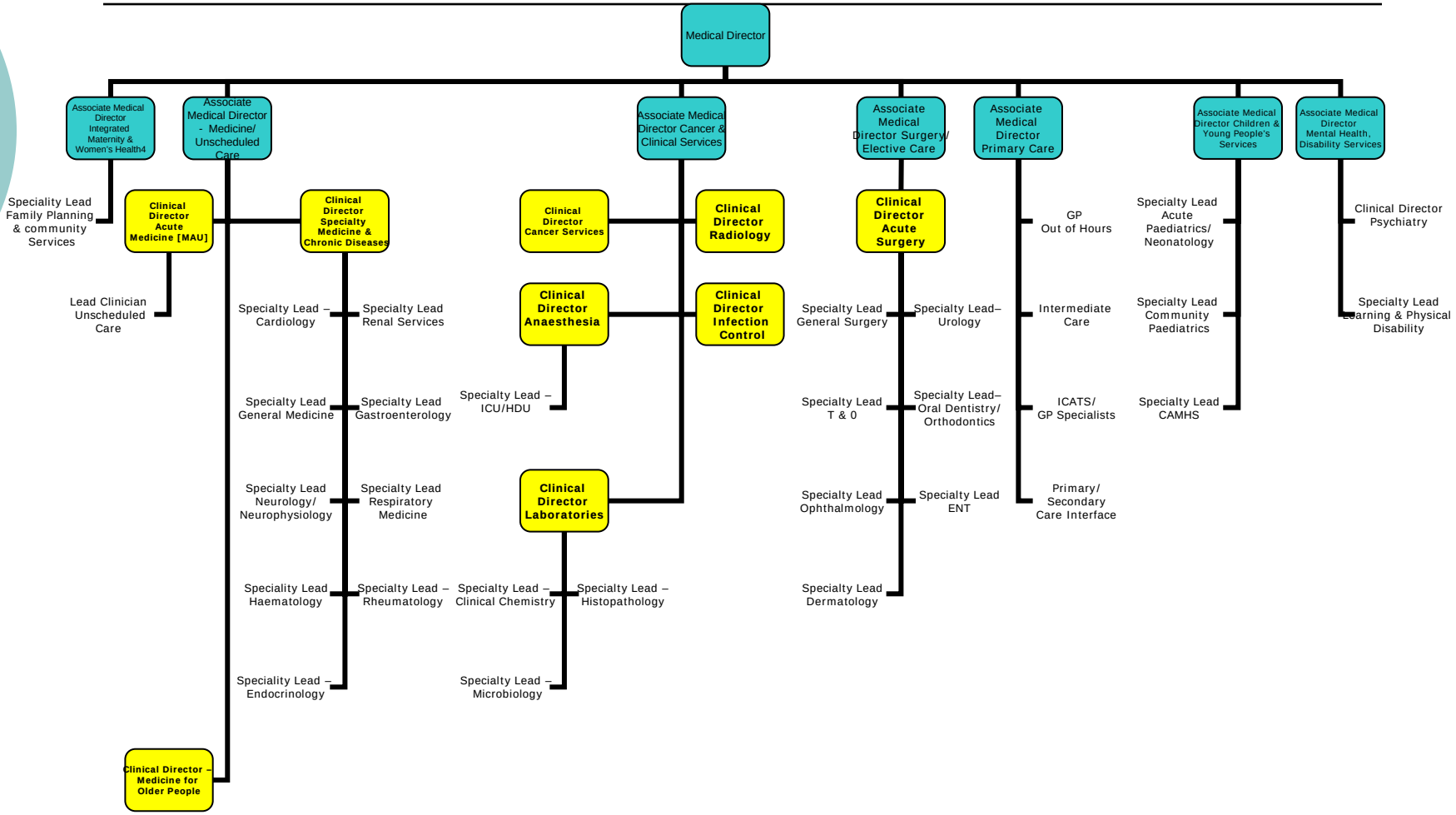
A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified

Directorate of Acute Services



Medical Management/Structures will be confirmed following appointment of Medical Director

Medical Directorate Structure



Southern Health and Social Care Trust

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JOB DESCRIPTION

Tile of Post:	Clinical Director – General Surgery Daisy Hill Hospital
Directorate/Division:	Acute Services Directorate
Responsible to:	Director of Acute Services
Operationally Responsible to:	Associate Medical Director
Accountable to:	Chief Executive
Hours:	Salaried Part Time position

KEY RESPONSIBILITIES

OPERATIONAL EFFECTIVENESS OF SERVICES

Operational Management

- Attends Directorate wide meetings with Service Director, AMD, and Assistant Directors etc.
- Holds a regular Divisional meeting for medical staff – often as Chair of meeting.
- First port of call for Assistant Directors for issues arising at Divisional level.

Service Development:

- Provides a medical perspective on protocols/pathways related to service improvements within the Division.
- Actively participates in discussions about service change and medical capacity.
- Leads the medical aspects of service change at Divisional level, and contributes to the implementation of required multi-disciplinary change.

Budgetary Awareness:

- Takes account of the financial implications when making decisions in conjunction with Assistant Directors and with the support of Finance staff. (for example, taking account

of medical staffing/locum costs within service delivery and development; cost of sickness absence, approval of doctors expenses etc).

GOVERNANCE AND PROFESSIONAL PRACTICE STANDARDS

Divisional Governance Forum

- Participates in Divisional governance activities/meetings, as agreed with Associate Medical Director.
- Working with the Trust/Directorate Governance manager to ensure effective clinical governance.
- Involved in complaints investigation and resolution, critical incident reporting and follow-up, risk management and audit.

Standards

- Providing advice to Assistant Director and colleagues on the application of existing and new standards and guidelines e.g. NICE, NSFs, Royal College Guidance etc.,
- Assisting in the preparation for external inspections.
- Working with relevant managers and colleagues on implementation plans to address issues highlighted by external audits/reviews (e.g. RQIA, CMOs office, Child Protection etc.,) overseeing development and roll out of implementation plans in conjunction with the Director/ADs.

Public Health and urgent operational issues

- Contributes to the roll out of contingency plans, working with identified leads and the Associate Medical Director. (e.g. Swine flu, hyponatraemia)

Education and Research

- Contributes to decisions to resolve tensions at Specialty level between the demands of service delivery and training.

Note: Some Clinical Directors have an education and training remit

MEDICAL MANAGEMENT

Appraisal

- Undertakes appraisal for a number of Consultant staff (usually 5-6).
- Assures AMD that appraisals have been completed and reports on common issues arising.

Job Planning

Participates in Job Planning as agreed with Associate Medical Director (delegated function).

Application of Medical HR policies

- Undertakes a management role in the application of relevant medical HR policies and the provision of advice to medical colleagues, in areas such as.
  - Annual leave
  - Study leave
  - Performance
  - Sickness

- Liaises with Human Resources for appropriate advice and support.

- May be the nominated person for the Directorate in specific HR policies.

Communication

- Facilitates good communication with medical staff, formally through meetings and informally through other opportunities.

- Liaises with other clinical managers in support of good multidisciplinary team working.

- Acts as a primary communication point within the Division for management and medical colleagues.

This job description is subject to review in light of changing circumstances. It is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the Clinical Director will work.

Southern Health and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

Job Plan Dates		
This job plan is effective from:	1st September 2011	1.10.11 as per timetable.
Next Job Plan Review Due on/before:	1st September 2012	

Personal details:		
Name of doctor: Mr	Personal Information redacted by USI	Contract: Type:
Directorate/Division & Location:	Urology/ Surgery and Elective Care Division	Whole Time

On-call rotas only - On-call availability supplement:			
Rota Frequency – i.e. Number of doctors on rota:	1 : 3		
Rota Category:	Category A		
For info: More frequent than or equal to 1 in 4	= Category A: 8%	Category B: 3% of basic salary	
Less frequent than 1 in 4 or equal to 1 in 8	= Category A: 5%	Category B: 2% of basic salary	
1 in 9 or Less frequent	= Category A: 3%	Category B: 1% of basic salary	

Summary of Programmed Activities:		
Direct Patient Care excluding on-call:	8.91 PA's	
Supporting Professional Activities:	1.75 PA's	Specific Roles: 0.25 for Lead Clinician work
On-Call Allocation:	*Predictable* PA's	*Unpredictable* 1.57 PA's
Any Annualised Activity & Reason	PA's	Reason:
Any Additional HCS Responsibilities:	PA's	Reason:
Any External Duties:	PA's	Reason:
TOTAL PA's:	12.25 PA's	

Southern Health and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

1. OBJECTIVES: Refer to Section 3 in Regional Job Planning Guidance.
Objectives should be specific, measurable, achievable, reasonable and time bound. They may refer to protocols, policies, procedures and work patterns to be followed. Where objectives are set in terms of output and outcome measures, these should be reasonable and agreement should be sought.

Service Developments & Objectives
- Service developments and key targets which will impact on PAs

Personal Objectives
- Objectives against which PA's will be allocated [both DCC and all SPA's]
- E.g. Activity targets specifying an indicative activity for outpatient clinics, theatre lists.
- E.g. Quality objectives incorporating attainment of standards of quality of care.

Team Objectives
- As appropriate to the team job plan e.g. to guarantee to provide a fixed number of clinics or operating lists for the whole team over a year when achievable.

SUPPORTING RESOURCES

Facilities and resources required for delivery of duties and objectives	
1. Staffing support	
2. Accommodation	
3. Equipment	
4. Any other identified resources	

Southern Health and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

2. DIRECT CLINICAL CARE (Section 8 in Regional Job Planning Guidance.)
Emergency duties, including work during or arising from on-call, Operating Sessions including preoperative and postoperative care, Ward Rounds, Outpatient activities, Clinical diagnostic work, Other patient treatment, Public health duties, Multidisciplinary meeting about direct patient care, Any administration related to any of the above, including referrals & notes.

3. JOB PLAN TEMPLATE
This job plan is subject to review at least once per year by you and your Clinical manager. In the case of a new employee a review of the job plan will take place 3 months after commencement and annually thereafter.

(If appropriate cut and paste your job plan into this space set out in the following format.)

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS				Total Hours	Prem
				DCC	SPA	APA	EPA		
Mon	8.30 – 9.00	Clinical Lead meeting **(weeks 2 & 4)**	CAH	0.25				11.125	
	8.00 - 1.30	**Week 1** - Day surgery (incl 1 hr return travel)	STH	1.375					
	9.00 – 1.30	**Week 2** - SPA (incl 30 mins Admin)	CAH	0.125	1.0				
	8.30 – 1.30	**Week 3** – B'bridge OPC (+1 hr return travel)	BPC	1.25					
	9.00 – 1.30	**Week 4** – Admin	CAH	1.125					
	1.30 – 2.00	Ward round	CAH	0.5					
	2.00 – 5.00	Stone treatment OPC 3/4 Admin 1/4	CAH	3.0					
	5.00 – 7.30	SPA	CAH		2.5				
Tues	8.30 – 9.00	Pre op Ward Round	CAH	0.5				9.00	
	9.00 – 5.00	Theatre	CAH	8.0					
	~~5.00 – 5.30~~ 6.00	~~Theatre~~ Pre op Ward Round	CAH	~~0.5~~ 1.0					
Wed	8.30 - 9.00	Ward round	CAH	0.5				5.00	
	~~9.00 – 1.30~~ 1.00	Stone treatment Daycases + Admin	CAH	~~4.5~~ 4.0					
	1.30	OFF							
Thurs	8.30 – 9.30	Radiology meeting	CAH	1.0				9.00	
	9.30 – 12.00	Ward Round + SPA	CAH	1.0	1.5				
	12.00 – 1.30	Departmental Meeting	CAH	1.5					
	1.30 – 2.15	Admin	CAH	0.75					

Southern Health and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

	2.15 – 5.00	MDT	CAH	2.75						
	5.00 – 5.30	Admin	CAH	0.5						
Fri	8.30 – 9.00	Ward round	CAH	0.5					7.00	
	9.00 – 12.00	Thorndale Specialist clinic (3 out of 4)	CAH	2.25						
	12.00 – 1.00	Lead clinician work	CAH		1.0					
	1.00 – 2.00	SPA	CAH		1.0					
	2.00 – 5.00	Outpatient Clinic	CAH	3.0						
	5.00-6.00	Lead Clinician (3 out of 4)	CAH	0.75						
			TOTAL HOURS:	35.62	7				42.62	
			TOTAL PROGRAMMED ACTIVITIES:	8.91	1.75				10.65	

4. EMERGENCY WORKLOAD

Type	Day/Time	Location	Allocated PAs
Predictable Emergency on-call Work*			
Unpredictable Emergency on-call Work*	11.4 hours per week		1.57
TOTAL PA's for ON-CALL:		1.57	

*Please refer to Medical Staffing / Trust Guidance for method for calculating on-call so that prospective cover is included – this means cover will need to be provided for absent colleagues on annual leave and study leave.

On-call availability Supplement	
On-call Category	A
Agreed on-call Rota Frequency	1:3 Prospective
On-Call Supplement	8%

5. SUPPORTING PROFESSIONAL ACTIVITIES (Section 9 in Regional Guidance)

- It is expected that PA's including SPA's will normally take place at a consultant's principal place of work if space, equipment and protected time are provided. Alternatives arrangements can be agreed with the Clinical Director.
- The Trust would expect that all consultants have a minimum allocation of 1.5 for supporting professional activities for maintaining a professional career. Where additional SPA's are undertaken to varying degrees by consultants these should be programmed into the Job Plan and agreed with the Clinical Manager.

Southern Health and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

Please provide full details on SPA responsibilities

6. **EXTERNAL DUTIES** – Please refer to Trust Guidance on approval for External Duties. An External Duties approval form must be completed on an annual basis.

Please provide full details on External Duties, time frames, funding arrangements etc

7. **Additional HPSS Responsibilities** – Please refer to Trust Guidance on approval of these duties. An HPSS Additional Responsibilities approval from must be completed on an annual basis.

Please provide full details on these duties, time frames, funding etc

8. **PRIVATE PRACTICE & FEE PAYING SERVICES**

Type	Please Tick:
You are not currently undertaking regular private practice however if this changes during the year your have agreed to inform the clinical director before any changes are made to your work-plan.	☐
You are currently undertaking regular private practice as outlined in your job plan and will undertake an additional PA if offered, up to a maximum of 11 PA's per week, as detailed in the terms and conditions of service.	☑
You are currently undertaking ad hoc private practice with the Trust and it is agreed that this practice will continue, provided it does not affect the efficiency of multidisciplinary team working. You have agreed to ensure that if any of your agreed NHS activity is displaced due to private practice you will carry out in NHS activity at an agreed later stage.	☐

9. **AGREEMENT:**

Signed: Doctor	Personal Information redacted by the USI	**Signed: Clinical Manager**	Personal Information redacted by the USI
Date:	22.7.11	Date:	22/8/11

Southern Health and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

Signed: Associate Medical Director & Director of Service		
Date:		

To be completed and forwarded to:

- **The Medical Staffing Manager, Medical HR, Ground Floor, Trust HQ, CAH**

73209161

Southern Health and Social Care Trust

JOB DESCRIPTION

JOB TITLE Head of Urology and ENT

BAND 8B

DIRECTORATE Acute

INITIAL LOCATION To Be Confirmed

REPORTS TO Assistant Director of Surgery & Elective Care

ACCOUNTABLE TO

JOB SUMMARY

- To be responsible for the operational management and strategic development of Urology and ENT services across the Southern Trust.
- To be responsible for leadership, service provision and service development of Urology and ENT services and ensuring high quality patient centred services.
- To be responsible for achieving service objectives through the implementation of national, regional and local strategies and access targets.
- To work in partnership with the Assistant Director, Associate Medical and Clinical Director to define a service strategy, which support the Trust's and Division's overall strategic direction and ensures the provision of a high quality responsive service to patients within resources.
- As a head of service, the jobholder will be a member of the division's senior management team and will therefore contribute to policy development in the division and the achievement of its overall objectives.

KEY DUTIES / RESPONSIBILITIES

1. Quality & Governance

1.1 Promote a culture which focuses on the provision of high quality safe and effective care, promotes continuous improvement, empowers staff to maximise their potential.

1.2 Be committed to supporting honest, open communication and effective multi-disciplinary working.

1.3 Develop appropriate mechanism/forums for accessing the views of and engaging with staff, service users and their carers and use this information to inform the development, planning and delivery of services.

1.4 Support the Assistant Director with the implementation of quality initiatives such as Investors in People and Charter Standards.

2. Leading & People Management

2.1 Lead, manage, motivate and develop staff so as to maintain the highest level of staff morale and to create a climate within the Division characterised by high standards and openness.

2.2 Ensure the contributions and perspectives of staff are heard, valued and considered when management decisions are taken within the division.

2.3 Ensure that the division has in place effective arrangements for staff appraisal, training and development, using the KSF framework.

2.4 Continually review the workforce to ensure that it reflects the division's service plans and priorities. The manager will implement skill mix review, role redesign and changes to working practices as required.

2.5 Ensure the division implements and adheres to Trust HR policies and procedures.

2.6 Work in partnership with Trade Unions and staff representatives

in developing the workforce, managing employee relations and changing working practices.

3. Service Delivery

3.1 Manage and co-ordinate the delivery of services to achieve safe and effective outcomes for patients who come into contact with the Trust.

3.2 Support the Assistant Director in achieving key access and performance targets for each service through robust planning and service improvement.

3.3 Make sure that services are delivered to the standard and quality expected by the DHSSPS, Regional Authority and by the Trust Board.

3.4 Facilitate multi-disciplinary and inter-agency working to make sure that services are co-ordinated to best effect.

3.5 Identify and contribute to local and national development initiatives e.g. clinical networks and national programmes.

3.6 Make sure that all recommendations arising from RQIA inspections are implemented in a timely manner.

3.7 Act as a member of the division's senior management team and contribute to its policy development processes.

3.8 Make sure that services are maintained at safe and effective levels, that performance is monitored in accordance with the Trust's policies and procedures and that corrective action is taken, where necessary, to address deficiencies.

3.9 Make sure that serious adverse incidents, accidents, incidents and near misses are brought to the attention of the Assistant Director at the earliest opportunity and are appropriately managed.

4. Strategic Planning and Development

4.1 Assist with the development of the strategic plan for the delivery

of operational services on behalf of the Assistant Director in line with regional strategies, Ministerial and HSSA priorities.

4.2 Work closely with the Assistant Director to secure the commitment and involvement of commissioners and relevant internal and external stakeholders in the implementation of strategic planning initiatives and targets.

4.3 Work with members of relevant teams on the innovative development of new and existing services.

5. Financial & Resource Management

5.1 Be responsible and accountable for a delegated budget ensuring the optimum use of resources through establishing and maintaining effective management/financial processes.

5.2 Identify, negotiate and implement cost improvement and revenue generation opportunities when they arise.

5.3 Participate in contract and service level negotiations with commissioners.

5.4 Ensure that working arrangements are in place to enable the division to comply with the Trust's complaints procedure. To investigate complaints as appropriate under the procedure and ensure action is taken to address issues of concern and prevent reoccurrence of similar events.

5.5 Update and monitor the operational policies of the Division and take account of risk management needs.

5.6 Ensure procedures are in place to report, investigate and monitor clinical incidents putting action in place to address areas of concern.

5.7 Ensure that environmental standards are appropriate for safe & clean care delivery.

6. Information Management

6.1 Ensure the effective implementation of all Trust information management policies and procedures within the Division.

6.2 Ensure systems and procedures for the management and storage of information meet internal and external reporting requirements.

7. Corporate & Divisional Responsibilities

7.1 Contribute to the Trust's corporate planning, policy and decision making processes including the implementation of the Trust Performance Management Framework, in line with annual schedule, by contributing to the development of a Divisional Plan for Elective Services.

7.2 Attend meetings of the Trust Board, its' committees or SMT as required to provide appropriate, high quality, information to the Assistant Director/ Director, Chief Executive and Trust Board concerning those areas for which he/she is responsible.

7.3 Develop and maintain working relationships with senior managers and staff to ensure the achievement of the Trust's objectives and the effective functioning of the directorate's management team.

7.4 Support the Assistant Director in establishing and maintaining effective collaborative relationships and networks with external stakeholders in the public, private voluntary and community sectors.

7.5 Participate in and comply with requirements in the production of performance reports.

7.6 Contribute to the Trust's overall corporate governance processes to ensure the development of an integrated governance framework for the Trust that assures safe and effective care for patients and clients and complies with public sector values, and codes of conduct, operations and accountability.

7.7 Lead by example in practising the highest standards of conduct in

accordance with the Code of Conduct for HPSS Managers.

HUMAN RESOURCE MANAGEMENT RESPONSIBILTIES

1. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.

2. Maintain staff relationships and morale amongst the staff reporting to him/her.

3. Review the organisation plan and establishment level of the service for which he/she is responsible to ensure that each is consistent with achieving objectives, and recommend change where appropriate.

4. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

5. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

6. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered

and safe environment for patients/clients, members of the public and staff.

3. Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

4. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

5. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

6. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

7. Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the Band may be assigned from time to time.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the Band may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

Southern Health and Social Care Trust

PERSONNEL SPECIFICATION

JOB TITLE	Head of Urology and ENT Band 8B
DIRECTORATE	Acute Services
SALARY	£44,258 – £54,714 per annum pro rata
HOURS	37.5 per week (Job share may be considered)
Ref No:	73209161

June 2009

Notes to applicants:

1. *You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

***ESSENTIAL CRITERIA** – these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;*

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

QUALIFICATIONS / EXPERIENCE / SKILLS

1. Hold a relevant[1], University Degree or recognised Professional Qualification or equivalent qualification **AND** 2 years experience in a Senior Role[2] **OR** have at least 5 years experience in a Senior Role[2].

[1] *'relevant' will be defined as a business or health related field*
[2] *'Senior Role' is defined as Band 7 or equivalent or above.*

2. Have a minimum of 1 years experience in a lead role delivering objectives which have led to a significant[3] improvement in service.

3. Have a minimum of 1 years experience working with a diverse range of internal and external stakeholders in a role which has contributed to the successful implementation of a significant[3] change initiative.

4. Have a minimum of 2 years experience in staff management.

5. Hold a full current driving licence valid for use in the UK and have access to a car on appointment[4].

The following are essential criteria which will be measured during the interview stage.

KNOWLDEGE / SKILLS / ABILITIES

6. Have an ability to effectively manage a delegated budget to maximise utilisation of available resources.

8. Have an ability to provide effective leadership.

9. Demonstrate evidence of highly effective planning and organisational skills.

10. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.

INTERVIEW ARRANGEMENTS – FOR NOTING BY ALL CANDIDATES

[3] *'Significant' is defined as contributing directly to key Directorate objectives*
[4] *This criterion will be waived in the case of a suitable applicant who has a disability which prohibits them from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.*

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this leadership role. The competencies concerned are given in the NHS Leadership Qualities Framework, details of which can be accessed at www.nhsleadershipqualities.nhs.uk Particular attention will be given to the following competencies:

- *Self Belief*
- *Self Management*
- *Drive for results*
- *Holding to account*
- *Seizing the future*
- *Leading change through people*
- *Effective and strategic influencing*

Informal enquiries to: Email: Personal Information redacted by the USI

Tel: Personal Information redacted by the USI

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trusts Smoke Free Policy

Urology Review Project Implementation Board Meeting
30th November 2010 at 2.00pm in Room A11, Castle Buildings

Attendees - Present
Beth Malloy
Diane Corrigan
Bronagh McCann
Karen McClenaghan
Brian Best
Diane Keown
Chris Hagan
Patrick Keane
Gillian Rankin
Michael Young
Margaret O'Hagan
Sarah Groogan
Geraldine Hillick
Louise McMahon
Joanne Kelly
Hubert Curren

1. Apologies
David McCormick
Stephen Hall
Brian Armstrong
Seamus McGoran
Dermot Hughes
Paula Clarke

2. Notes of the previous meeting

Sara Groogan requested that the Northern Team be reported as CAN – due to sickness and attendance at a Trust Performance Meeting

3. Matters Arising - Referral Arrangements and Processes for the Management of Radical Pelvic Surgery Patients

There was further discussion around the pathway for radical pelvic surgery for patients with benign conditions. It was noted that Mark Fordham has advised – "the IOGs do not comments on surgery for benign disease. I added that it would be reasonable for a patient requiring such as cystectomy should have it performed by someone who is performing them regularly".

However following further discussion, it was agreed that these patients should also be sent to Belfast Trust given that the incidence of this condition is relatively uncommon. Beth Malloy and Diane Corrigan confirmed this will be the Commissioning decision of the Board/PHA.

Action: Each Trust to ensure these patients are referred to Belfast for surgery

It was suggested that the clinicians will review the referral arrangements and management process for the reconstructive surgery element and come back with a decision in two weeks.

Action: Patrick Keane

4. Urology Project Board Terms of Reference

Beth Malloy reminded members of the ToR for the Project Board

5. Feedback on revised Team Plans

- Team East – Beth Malloy confirmed that the Board was in a position to confirm the progression of the Team East plan. A formal letter will be issued.
- Team South – Beth Malloy confirmed that there will be meeting with the Trust in the next couple of weeks to resolve some outstanding issues.
- Team North – Sara Groogan advised they are meeting with consultants next week and will submit their revised plan before Christmas.

Action: Each Trust to action as required

6. Development of Key Performance Indicators

There was further discussion on quality indicators. Beth Malloy made it clear that the intention of the development of the KPI was to improve quality of the urology service. It was agreed that the Board should identify the service quality indicators and the Consultants would identify the clinical quality indicators to review the long term outcomes for the patients.

Patrick Keane informed the group that he is a member of a group reviewing an online patient questionnaire/ satisfaction survey. He said he would review a draft copy on 2 December, he agreed to share the details with the group.

Action: Patrick Keane

It was agreed in principle that a bid would be submitted to GAIN to carry out a Radical Pelvic Surgery audit making use of the BAUS Complex Surgery database. A bid would also be submitted to carry out PROM's on prostatectomy. It was discussed TURP's is a procedure which is carried out across the region and is ideal for audit.

Action: Bronagh McCann to review the timetable and opportunities for a GAIN audit submission

7. Feedback on Regional Patient Pathways

The draft Regional Patient Pathways were discussed.

- The Haematuria Single Visit Pathway is to be discussed/ratified at the NICAN meeting on the 26th January.

- The testicular cancer pathway was discussed; it became clear during the discussion that there was a need to clarify the pathway for testicular swelling. It was recognised that currently two pathways operated, one with GP direct access to Ultrasound, with the second referral via Urologist. It was agreed that a consistent and standardised pathway would be required across the region.
- PSA testing guidance has not yet been accepted and is to be discussed and signed off at the NICAN Board on the 9th December.

Action: Pathway Group – John McKnight and Brian Duggan

It is agreed that the input of interventional radiology is crucial and it has been decided that Beth Malloy will link with Stephen Hall and the Radiology Clinical Reference Group regarding radiology issues.

Action: Stephen Hall/Beth Malloy

It was agreed that the new regional pathways would be finalised at the urology meeting in February ready for circulation to general practice for comment. It was agreed that Hubert Curran would act as the GP link regarding this issue.

Action: Pathway Group / Hubert Curran

8. Confirm Membership for Implementation

Team North West will nominate a Clinical Nurse Specialist to attend this group. The nominated person will set-up an informal network and feed back/take comments from their Clinical Nurse Specialist colleagues.

Action: Margaret O'Hagan

Sara Groogan confirmed that Colin Mulholland is the clinical representative for Team North West. It was agreed that the circulation list will be amended accordingly.

Action: Beth Malloy

9. Any Other Business

The group would welcome regional guidance on the future provision of reversal of vasectomy.

8. Date of Next Meeting

The next meeting is to be held on Friday 11th February at 2pm in Room A11, Annex 7, Castle Buildings.

Urology Review Project Implementation Board Meeting
24th June 2011 at 1.00pm
Conference Room 3, 1st Floor, HSCB Linenhall Street, Belfast

Present
Beth Malloy
Brian Armstrong
Brian Best
Christine Allam
Eddie O'Neill
Geraldine Hillick
Heather Trouton
Hubert Curran
Bronagh McCann
Margaret O'Hagan
Michael Young
Sara Groogan
Caroline Mason
Seamus McGoran

1. Apologies

Brian Duggan
Catherine McNicholl
Chris Hagan
Colin Mulholland
David McCormick
Dermot Hughes
Diane Corrigan
Joe O'Sullivan
John McKnight
John Simpson
Martin Sloan
Patricia Donnelly
Patrick Keane
Paula Clarke
Stephen Hall
Valerie Jackson

2. **Notes of the previous meeting: 25 March 2011 – approved**

3. **Matter arising**

- Scrotal Swelling; US Audit

Dr. Stephen Hall was not able to attend the meeting. This would be deferred to a future meeting.
ACTION: Dr. Stephen Hall

- GP Education

Dr Curran outlined the on-going discussion concerning GP Education and Training. He circulated a paper and explained that has offered to support the GP awareness sessions concerning the patient pathways.

- Acute Kidney Obstruction

Michael Young explained that the Southern Trust has complete d2 acute kidney obstruction patients at the weekend. None of the other Trust have information available of the number of patients which may require transfer. It was agreed that each Team scope out the potential number of patients required for transfer. Bronagh McCann agreed the Team East needed to identify the potential issues regarding the transfer of these patients into Team East.
ACTION: All Trusts
ACTION: Bronagh McCann

- Radical Pelvic Surgery Audit Update in Chris Hagan's absence

Brian Best confirmed that the inaugural meeting of the regional audit group was held and the next meeting is planned for September.
Bronagh McCann agreed to liaise with the nominate of Audit Lead and confirm the audit requirements and timescales.
Bronagh McCann agreed to complete the application for the GAIN audit if this would support the establishment of the regional audit.
ACTION: Bronagh McCann

Beth Malloy in response to an enquiry from Urology colleagues explained that she expected the audit results to be shared openly and reviewed both locally and nationally with both Urology colleagues but also with PHA clinical colleagues to ensure the Board was advised of the both the good progress to implement the Urology Review recommendations but to also highlight areas of concern for potential additional investment.

- KPI

Bronagh McCann explained the KPI included in the Team East Plan. These were agreed.

Beth Malloy accepted that the Urology BADS Rates were challenging in some instances and would welcome regional advice from the Teams regarding proposed Day Case Rates and proposed the length of stay.
ACTION: Teams

- Use of 23HR Category for Urology

Brian Armstrong explained the need to consider the use of a 23 hour category. It was agreed this would be <1 to 0 day stay analysis by procedures.

4. Patient Pathways

Hubert Curran confirmed the Lower Urinary Tract Symptoms (LUTS) – Male, Raised PSA, Haemoturia, Renal Colic, Acute Urinary Retention have been circulated with Primary Care and have received a positive response. He confirmed these would be used to develop referral criteria/protocols to assist GP's and this would then be utilized for electric referral.

Scrotal/Testicular Swelling Pathway
Brian Duggan explained the pathway is still in draft with urology colleagues for comments. He agreed to send a final draft to Beth Malloy when agreed. He explained that a Queen's DVD has been developed.
ACTION: Brian Duggan

5. Adjustment to Request From for PSA Test

Beth Malloy explained that some recent examples had highlighted laboratory request form for a PSA test may lead to a reduction in the number of PSA tests completed. It was suggested that the "potential excessive" request for a PSA test was also associated with internal hospital requests for PSA tests.
Dr. O'Neill highlighted a recent paper discussed by the Urology NICAN team, which was discussed at length. It appeared from the discussion that not all urologists were content to triage direct to the biopsy and the Pathway was potentially applicable to a small number of patients. Beth Malloy explained the proposed pathway would need to be a standardised process and would be considered by the Cancer Commissioning Group before further implementation. Trusts agreed to review the laboratory request form for a PSA test and discuss the amendments to the request form. An update would be provided at the next meeting.
ACTION: All trusts

6. Update on team plans and progress

Team East – Bronagh McCann explained that the emergency rota across Team East would be established from 1st September. She confirmed the new consultant was appointed and would be in post from November 2011.

Team North – A meeting was planned for 28th June 2011 to discuss the implementation of the team.
Team South – Final team volumes to be agreed.

7. Service Improvement

Following the previous discussion concerning PSA, it was agreed that the PSA patient pathway for service improvement was the area for focused service improvement. It was agreed this should also include the use of existing or current PSA tests and the information contained within lab systems prior to requesting a further test. It was agreed Teams review the Raised PSA patient pathway and implement improvements.
ACTION: Trusts

8. Transforming Cancer Patient follow-up Remote PSA tracking

Liz Henderson attended to update the group on the current work to transform the cancer patient follow-up. It was agreed that a further meeting would be established to discuss the specific improvements in "Effective follow-up: Testing risk Stratified Pathways" document was highlighted.
ACTION: Liz Henderson

9. HSC Regional Clinical Engagement Process

Beth Malloy explained the HSC/PHA was review the process of clinical engagement and would be considering the consolidation of existing groups.

10. Any other business

None

11. Date of Next Meeting

The next meeting is to be held on Friday 21st October 2011 in Conference Room 2, HSCB, Linenhall Street, Belfast.

Southern Health and Social Care Trust

Acute Services Division – Urology Implementation Planning Group Meeting – Tuesday 6th September 2011 – Meeting Room, Admin Floor, CAH at 10.30am

Present: Alexis Davidson, Mary McGeough, Heather Trouton, Martina Corrigan, Kate Courley, Connie Connolly and Pauline Matier.

Apologies: Anita Carroll, Sandra Waddell

Topic	Issue for Discussion	Action	Lead
Implementation Funding - Mrs Trouton outlined that the purpose of the meeting was to get key stakeholders together to plan the implementation of the Urology project. She read the contents of the Departmental letter confirming funding and shared copies of the Department's indicative calculations for allocation of funding.			
Theatre Sessions and Equipment – Mrs Trouton advised that as part of implementation it was proposed that two addition consultant urologists would be recruited each	Mrs Davidson advised that the current compliment of image intensifiers for the Trust was as follows: 1 in CAH - for Urology Service		

requiring theatre sessions and an image intensifier at each session. Mrs Trouton outlined the services identified for funding allocation and requested the group to scope what would be required in their individual areas. She further advised that the service needed to achieve end of year targets with existing resources and that work was in progress to achieve this.	1 in STH - not for Urology Service 0 in DHH She further advised that funding would be required for any additional equipment including MRI scanning requirements.	Mrs Davidson to scope requirements and impact.	Mrs A Davidson
Business Case for Implementation – Mrs Trouton advised that a business case needed to be developed for implementation and that Sandra Waddell would take the lead on this. She further advised that she would hope that a full years activity would be delivered by April 2013.	Time scale for recruitment – depended on business case being completed by end of September 2011, allowing for a six month recruitment period. Mrs Davidson did not think this achievable in respect of Consultant Radiologists Mrs Connolly advised that she needed to identify nursing requirements for 4 x OP clinics per week	Mrs Sandra Waddell to progress with Mrs Corrigan and Mrs Matier Consultant Radiologist job plan to be developed Consultant Anaesthetist job plan to be developed	Mrs Sandra Waddell/Mrs Martina Corrigan/Mrs P Matier Mrs Davidson/Dr Hall Mrs Mary McGeough/Dr McAllister Mrs Connie Connolly

		Nursing requirements to be identified	
Theatre Accommodation – Mrs Trouton queried availability of additional theatre space to facilitate additional sessions and the feasibility of extended theatre hours of 8am – 2pm and 2-m – 8pm. OPD Accommodation – Mrs Trouton advised that it would be preferable to have C&B and ACH OPD activity centralised to CAH. Mrs Trouton queried whether or not the provision of a radiographer for ureteric stones impacted on the radiology service.	Mrs McGeough advised that availability was limited and recovery support and scheduling of lists was a consideration also. Mrs Trouton suggested the 5th consultant backfilling as a proposal. Mrs Davidson advised that any HR issues around extended theatre hours for anaesthetists should be resolved by April 2012. Accommodation required : Office accommodation for x 2 Consultants, 1 secretary and a Specialist Nurse. ? Anaesthetist Mrs Davidson advised that no accommodation was required for the Consultant Radiologist. Mrs Connolly advised that pre-op facilities need to be provided and that pre-op services could assist with this aspect of the business plan.	Feasibility of options to be scoped with Dr McAllister Mrs Kate Corley to scope Mrs Mary McGeough to scope Mrs Davidson to scope Mrs Davidson to liaise with Radiological Consultants to identify best fit pathway for development	Mrs Mary McGeough Mrs Kate Corley Mrs Mary McGeough Mrs Alexis Davidson Mrs Alexis Davidson Martina Corrigan

	Mrs Davidson queried the diagnostic pathway for Erne Hospital patients. Mrs Corrigan confirmed that sessions are 1 day per month at the Erne but patients may go to STH for diagnostics.		
Support Services – medical records, portering, CSSD, domestic services, etc. Theatre Nursing Staff – Mrs Trouton advised that as funding had been confirmed that recruitment of permanent theatre nursing staff could proceed and that said staff could be utilised in the interim to provide support for additionality until April 2012.	Mrs Corley advised that there would be a big impact on these services with the proposed increase in volume of turnover.	Mrs Corley to liaise with Mrs Helen Forde re medical records implications and scope all other support service requirements. Mrs McGeough to discuss with Mr Ronan Carroll to progress.	Mrs Kate Corley Mrs Mary McGeough
For Next Meeting – Mrs Trouton advised that everyone should identify any gaps/issues/requirements(including equipment requests) and forward these to Martina Corrigan for meeting with Sandra Waddell on 14th September 2011.		All members.	All members.

Team South Urology Steering Group/Project Board

Dr Gillian Rankin	Interim Director of Acute Services (Chair)
Dr Eamon Mackle	Associate Medical Director – Surgery & Elective Care
Mr Michael Young	Clinical Lead Urologist
Mr Robin Brown	Clinical Director – Surgery & Elective Care
Mrs Heather Trouton	Acting Assistant Director of Acute Services – Surgery & Elective Care
Mrs Paula Clarke	Acting Assistant Director of Performance & Reform
Mr Ronan Carroll	Assistant Director of Acute Services – Cancer & Clinical Services
Mr Joe Lusby	Deputy Chief Executive, Director of Acute Services, Western Trust
GP Representative	Western Trust
Mrs Helen Walker	Assistant Director – Human Resources
Mrs Carol Cassells	Senior Financial Management Accountant - Acute Services
Ms Beth Malloy	Assistant Director Scheduled Services, PMSID, H&SCB

Project Team

Mrs Heather Trouton	Acting Assistant Director of Acute Services – Surgery & Elective Care (Chair)
Mrs Martina Corrigan	Head of Urology & ENT
Sandra Waddell	Head of Planning – Acute
Project Manager	To be appointed
Heads of Service	As needed
Finance Representative	
HR Representative	

Clinical Assurance Group

Mr Young
Mr O'Brien
Mr Akhtar
Mrs Martina Corrigan
Mrs Shirley Tedford
GP Representative

Regional Review of Urology Services

Team South Implementation Plan

Document History	
Document Name:	Team South Implementation Plan
Status:	Draft v0.1
Version and Date:	V0.1 14 Jun 10
Origin:	Acute Planning SHSCT

Contents

Tables

Appendices

1. Background

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. It was completed in March 2009. The purpose of the regional review was to:

'Develop a modern, fit for purpose in 21century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.'

One of the outputs of the review was a modernisation and investment plan which included 26 recommendations to be implemented across the region. Three urology centres are recommended for the region. Team South will be based at the Southern Trust and will treat patients from the southern area and also the lower third of the western area (Fermanagh). The total catchment population will be approximately 410,000. An increase of two consultant urologists, giving a total of five, and two specialist nurses is recommended.

The Minister has endorsed the recommendations and Trusts have been asked to develop implementation plans to take forward the recommended team model.

2. Current Service Model

The current service model is an integrated consultant led and ICATS model. The service's base is Craigavon Area Hospital where the inpatient beds (19) and main theatre sessions are located. There are general surgery inpatient beds at Daisy Hill Hospital (and at the Erne Hospital).

The ICATS services are delivered from a purpose built unit, the Thorndale Unit, and a lithotripsy service is also provided from the Stone Treatment Centre on the Craigavon Area Hospital site.

Outpatient clinics are held at Craigavon Area Hospital, South Tyrone Hospital, Banbridge Polyclinic and Armagh Community Hospital.

Day surgery is carried out at Craigavon and South Tyrone Hospitals. A Consultant Surgeon at Daisy Hill Hospital who maintains close links with the urology team also undertakes some urology outpatient and day case work.

The Urology Team

The integrated urology team comprises:

- 3 Consultant Urologists,
- 2 Registrars (1 of the Registrar posts will revert to a Trust Grade Doctor from August 2010),
- 2 Trust Grade Doctors (1 post is currently vacant)
- 1 GP with Special Interest (7 sessions per week)
- 1 Lecturer Practitioner in Urological Nursing (2 sessions per week)
- 2 Urology Specialist Nurses (Band 7)

The clinical sessions which are currently being undertaken by medical and specialist nursing staff are given as Appendix 1.

The ICATS Service

Referrals to urology are triaged by the Consultant Urologists and are booked directly to either an ICATS or consultant led clinic by the outpatient booking centre. Consultant to consultant referrals go through the central referral and booking office and are booked within the same timescales as GP referrals.

The following services are provided within ICATS:

- Male Lower Urinary Tract Services (LUTS)
- Prostate Assessment and Diagnostics

- Andrology
- Uro-oncology
- GPwSI (general urology clinic)
- Haematuria Assessment and Diagnostics
- Histology Clinics

Current Sessions

Outpatient, day surgery and inpatient theatre sessions are given in Table 1.

Table 1: Current Urology Sessions

	Craigavon	South Tyrone	Banbridge	Armagh	Total
Consultant Led OPs					
General	2.75 per week[1]	1 per month	2 per month	2 per month	4 per week
Stone Treatment	1 weekly				1 week

ICATS	Weekly
Prostate Assessment	1.5
Prostate Biopsy	1
Prostate Histology	1
LUTS	3
Haematuria	2
Andrology	2.5
General Urology	2.5
	13.5

Main Theatres (CAH)	Weekly	
	6	3 all day lists

	Craigavon	South Tyrone
Day Surgery		
GA	1 weekly[2]	1 monthly
Flexible Cystoscopy	1.5 weekly[3]	
Lithotripsy	1 weekly	

1) 1 consultant led outpatient clinic at CAH is every week except the 3rd week in the month
2) Numbers treated on the weekly GA list at Craigavon are restricted by anaesthetic cover
3) 2 lists/1 list on alternate weeks

Current Activity

In 2009/10 the integrated urology service delivered the core service shown in Table 2. In house additionality and independent sector activity has also been included in the table. It should be noted that in 2009/10 new outpatient attendances at the Stone Treatment Centre were erroneously recorded as review attendances. The new outpatient attendances are therefore understated by approximately 240.

Table 2: 2009/10 Actual Activity for the Urology Service

		Core Activity	IHA	IS	Totals
2009/10	Cons Led New OP	610	474	0	**1084**
	ICATS/Nurse Led New OP	1233	30		**1263**
	Total New OP	1843	504	0	**2347**
	Cons Led Review OP	2391	70	0	**2461**
	ICATS/Nurse Led Rev OP	1594	0	0	**1594**
	Total Review	3985	70	0	**4055**
	Day Case	1502	3	383	**1888**
	Elective FCE	1199	29	140	**1368**
	Non Elective FCE	629	0	0	**629**

Activity by consultant for 2009/10 is provided in Table 3.

Table 3: Activity by Consultant for 2009/10

		Mr Young[2]	Mr O'Brien	Mr Akhtar[3]	All Core Activity
2009/10	New OP	242	174	193	**609**
	Review OP	964	903	327	**2194**
	Total OP	1206	1077	520	**2803**
	Day Case	696	452	354	**1502**
	Elective FCE	380	512	307	**1199**
	Non Elective FCE	233	210	186	**629**
	FCEs + DCs	**1309**	**1174**	**847**	**3330**
	Day Case Rates [1]	65%	47%	54%	56%

[1] INCLUDES flexible cystocopies (M45) and DCs/FCEs with no primary procedure recorded.
[2] Mr Young's new outpatients are understated by an estimated 240, as Stone Treatment new attendances were recorded as reviews.
[3] Mr Akhtar undertakes an alternative weekly biopsy list at Thorndale. These patients are recorded under ICATS.

Notes:
1) Source is Business Objects
2) Day case and elective FCEs exclude in house additionality (3 DCs & 29 FCEs) and also independent sector activity (383 DCs and 140 FCEs)
3) Outpatient Activity is consultant led only & has been counted on specialty of clinic. It excludes in house additionality (474 new, 70 review).

4) There were an **additional 1 new and 197 review** attendances which have not been allocated to a particular consultant as they were recorded under 'General Urologist'.

There is a substantial backlog of patients awaiting review at consultant led clinics. The total number of patients is 4,037. The Trust's plan to deal with this backlog has been included as Appendix 2.

Pre-operative Assessment

Pre operative assessment is already well established. All elective patients are sent a pre-assessment questionnaire and those patients who require a face to face assessment are identified from these. For urology the percentage is high due to the complexity of the surgery and also the nature of the patient group who tend to be older patients with high levels of co-morbidity. It is not possible to provide the number of urology patients who come to hospital for a pre-assessment appointment as all patients are recorded under a single speciality.

Between 1 Apr 09 and 31 Dec 09 692 of 853 elective episodes had a primary procedure recorded. Of the 692, 404 (**58.4%**) were admitted on the day their procedure was carried out. A surgical admission ward was established in July 2009. It closes at 9pm each evening (so beds are not 'blocked'). This has enabled significant improvements to be made in the numbers of patients being admitted on the day of surgery, in part because consultants have confidence that a bed will be available for their patient. Figures have improved further since December 2009 and across all surgical specialties between 85% and 100% of patients are now admitted on the day of their surgery.

Suspected Urological Cancers

It is not feasible to extract the numbers of suspected urological cancers. However, the figure can be estimated using the numbers of patients attending for prostate and haematuria assessment in 2009/10 – 434.

The urology team multi disciplinary meetings (MDMs) are already established. A weekly MDT meeting is held and it is attended by consultant urologists, consultant radiologist, consultant pathologist, specialist nurses, and cancer tracker. The only outstanding issue is that of oncology input to the meeting. Confirmation of when this will be available is awaited from Belfast Trust and it is expected that a date for commencement will be available in the near future.

The Southern Trust provides chemotherapy only for prostate cancer patients (at Craigavon Hospital). Chemotherapy for all other cancers and radiotherapy for all cancers is provided by Belfast Trust. When oncology support is

available for the MDM then referral will take place during the meetings. An interim arrangement is in place with referral taking place outside the meetings.

The Trust accepts that all radical pelvic operations will be undertaken at Belfast City Hospital. The Trust asks for clarification with regard to:

- At what point in the pathway patients should be referred;
- Arrangements for review of the patients.

3. Benchmarking of Current Service

It is the Trust's intention to use the opportunity of additional investment in the urology service to enhance the service provided to patients and to improve performance as demonstrated by Key Performance Indicators such as length of spell, new to review ratios and day case rates.

The Regional Health and Social Care Board (HSCB) has provided comparative data for the Trusts in Northern Ireland. Table 4 below provides a summary of the Trust's performance compared to the regional position with further detail being provided in Appendix 3.

Table 4: Regional Benchmarking

		2006/07	2007/08	2008/09	2009/10
New : Review Ratio	All Trusts	1.96	2.03	1.79	1.68
	SHSCT	**4.04**	**3.27**	**3.28**	**2.09**
Day Case Rates	All Trusts	50.1	48.5	49.8	48.5
	SHSCT	**43.8**	**45.5**	**48.8**	**40.0**
Average LOS (elective)	All Trusts	3.7	3.5	3.4	2.9
	SHSCT	**3.7**	**4.3**	**3.9**	**2.7**
Average LOS (non elective)	All Trusts	4.8	4.7	4.6	4.4
	SHSCT	**4.5**	**4.8**	**4.6**	**4.7**

1) Data for 2009/10 is up to the end of February 2010

2) Day cases exclude flexible cystoscopies and uncoded day cases (Prim Op M70.3 and Sec Op 1 Y53.2 also excluded)

Table 5 compares the Southern Trust's average length of spell for specific Healthcare Resource Groups (HRGs) with the Northern Ireland peer group for the period 1st January – 31st December 2009. The Trust's length of spell compares very favourably with the peer group average.

Check if these were just elective procedures.

Table 5: Peer Group Comparison for Length of Spell (Northern Ireland Peer Jan 09 – Dec 09)

HRG v3.5	Spells	SHSCT LOS	Peer LOS
L55 - Urinary Tract Findings <70 without complications & comorbidities	11	3.5	0.3
L32 - Non-Malignant Prostate Disorders	16	3.6	2
L21 - Bladder Minor Endoscopic Procedure without complications & comorbidities	670	0.3	0.1
L14 - Bladder Major Open Procedures or Reconstruction	4	11	6.7
L98 - Chemotherapy with a Urinary Tract or Male Reproductive System Primary Diagnosis	3	4.3	0.5
P21 - Renal Disease	13	1.8	0.7
L28 - Prostate Transurethral Resection Procedure <70 without complications & comorbidities	21	4.4	3.1
L52 - Renal General Disorders >69 or with complications & comorbidities	9	5.9	3.7
L69 - Urinary Tract Stone Disease	37	2.3	1.9
L22 - Bladder or Urinary Mechanical Problems >69 or with complications & comorbidities	28	6.7	3.2
L02 - Kidney Major Open Procedure >49 or with complications & comorbidities	34	9.5	7.8
L25 - Bladder Neck Open Procedures Male	11	6.4	4.8
L08 - Non OR Admission for Kidney or Urinary Tract Neoplasms <70 without complications & comorbidities	5	2	1.3
L07 - Non OR Admission for Kidney or Urinary Tract Neoplasms >69 or with complications & comorbidities	20	9.1	8.4
L27 - Prostate Transurethral Resection Procedure >69 or with complications & comorbidities	78	5.3	4.2
L17 - Bladder Major Endoscopic Procedure	77	4.7	3.8
L03 - Kidney Major Open Procedure <50 without complications & comorbidities	9	5.7	4.8
L13 - Ureter Intermediate Endoscopic Procedure	91	2.3	1.6
L10 - Kidney or Urinary Tract Infections <70 without complications & comorbidities	61	4.2	3
L43 - Scrotum Testis or Vas Deferens Open Procedures <70 without complications & comorbidities	45	1.4	1.2
L23 - Bladder or Urinary Mechanical Problems <70 without complications & comorbidities	16	2.2	1.9

The British Association of Day Surgery (BADS) produces targets for short stay and day case surgery for the various surgical specialties. The Trust has compared its performance to the BADS targets for 2008/09 (clinical coding is complete) and 2009/10 (clinical coding is incomplete). The analysis is provided as Appendix 4. The Trust will use the BADS recommendations to determine appropriate day case rates for the new service model for urology.

4. Demand for Team South Urology Service

The Trust has utilised the methodology recommended by the Board to calculate the demand for the service. It has been assumed that the population of Fermanagh will be similar to the Southern area. As inclusion of Fermanagh will increase the population catchment area for urology by 18%, an uplift of 18% has been applied. Table 6 overleaf shows the calculation of the estimated demand for the service. It should be noted that this does not factor in any future growth in demand.

Table 6: Projected Activity for Team South

		2009/10 Actual Activity					
		Core Activity	**IHA**	**IS**	**Growth in WL**	**SHSCT Activity to be Provided**	**Tean Sout Capa Requ**
2009/10	Cons Led New OP	610	474	0	87	1171	1
	ICATS/Nurse Led New OP	1233	30		100	1363	1
	Total New OP	1843	504	0	187	2534	**2**
	Cons Led Review OP	2391	70	0		2461	2
	ICATS/Nurse Led Rev OP	1594	0	0		1594	1
	Total Review	3985	70	0		4055	**4**
	Day Case	1502	3	383	47	1935	**2**
	Elective FCE	1199	29	140	28	1396	**1**
	Non Elective FCE	629	0	0		629	

1) Source is Business Objects
2) Activity has been counted on specialty of clinic
3) Review activity is actual activity and N:R ratio will be skewed because of the significant review backlog . As shown 1:2
4) OP WL between end Mar 09 & end Mar 10 had increased by 187 (Information Dept).
5) 2009/10 breaches have been used to estimate growth in waiting list for day cases and FCEs
6) 18% added for Fermanagh, based on population size relative to SHSCT population

The projected demand from Table 6 was used to calculate the numbers of session which will be required to provide the service. These are summarised in Table 7 below with the detail of the calculations provided as Appendix 5.

Table 7: Weekly Sessions for New Service Model

	Weekly Sessions
Consultant Led OPs	
General	5
Stone Treatment	1
ICATS	
Prostate Assessment	1.5
Prostate Biopsy [1]	1
Prostate Histology [2]	1
LUTS	3
Haematuria	1
Andrology/General Urology	5
Urodynamics	1.5
	14
Main Theatres	9
Day Surgery	
GA	3
Flexible Cystoscopy	3
Lithotripsy	1/2

1) Prostate Assessment and Biopsy will run side by side
2) Consultants will see their own patients, so whilst this has been noted as a single session, it is unlikely to be a single session in practice.
3) All sessions with the exception of ICATS andrology & general urology, will run over 48 weeks. ICATS andrology & general urology will run over 42 weeks.
4) Lithotripsy day case sessions have been calculated over 42 and 48 weeks. A second consultant with special interest in stone treatment will be required if sessions are to run over 48 weeks.

5. Proposed Service Model

The proposed service model will be an integrated consultant led and ICATS model. The ICATS service is currently being reviewed. Some changes which will improve the service provided to patients have already been agreed by clinical staff. These include:

- The prostate pathway has been reviewed (a draft revised pathway is included in Appendix 6). Patients requiring a biopsy will be given the opportunity to have this done on the same day as their initial assessment (where this is clinically appropriate).
- Patients triaged to the haematuria service will have flexible cystoscopy carried out on the same day as their initial assessment. In the current service model these patients have to come back to the hospital to have this done in the Day Surgery Unit.
- Urodynamics will move from the inpatient ward to the Thorndale Unit and sufficient staff will be trained to avoid backlogs of patients awaiting investigation.

The Andrology and General Urology elements of the ICATS service will be reviewed over the coming months.

The main acute elective and non elective inpatient unit for Team South will be at Craigavon Area Hospital with day surgery being undertaken at Craigavon, South Tyrone, and the Erne Hospitals. Day surgery will also continue to be provided at Daisy Hill by a Consultant Surgeon. It is planned that staff travelling to the Erne will undertake an outpatient clinic and day surgery/flexible cystoscopy session in the same day, to make best use of time. The frequency of sessions is to be agreed with the Western Trust.

Outpatient clinics will be held at Craigavon, South Tyrone, the Erne and Armagh Community Hospital. Outpatient clinics will also continue to be provided at Daisy Hill by a Consultant Surgeon. All outpatient referrals will be directed to Craigavon Area Hospital and they will be triaged on a daily basis. Suspected cancer referrals will be appropriately marked and recorded. For patients being seen at the Erne Hospital it is anticipated that Erne casenotes will be used with a copy of the relevant notes being sent to Craigavon Area Hospital when elective admission is booked. The details of this process have to be agreed with the Western Trust.

Consultant and Nurse led sessions will be provided over 48 weeks. The detail of job plans is to be agreed with clinical staff but they will be based around the sessions identified in the previous section. Due to available theatre capacity, particularly in main theatres, a 3 session operating day is currently being discussed.

Work is ongoing to develop patient flow and clinical pathways for the service. Draft pathways are included as Appendix 6. The on call urologist at Craigavon Area Hospital will be available to provide advice at any time to medical staff at the Erne or Daisy Hill Hospitals on the management or transfer of emergency cases.

6. Timetable for Implementation

Task	**Timescale**
Submission of Team South Implementation Plan	22 June 10
Approval to Proceed with Implementation from HSCB	July 10
Completion of Job Plans/Descriptions for Consultant Posts	End July 10
Completion of Job Plans/Descriptions for Specialist Nurses	End July 10
Consultant Job Plans to Specialty Advisor	End July 10
Advertisement of Consultant Posts	September 10
Advertisement of Specialist Nurse Posts	September 10
New Consultants and Specialist Nurses in post	February 11

APPENDICES

Southern Health and Social Care Trust

Quality Care - for you, with you

Regional Review of Urology Services

Team South Implementation Plan

V0.3 revised 09 Nov 10

Contents

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1. Background

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. It was completed in March 2009. The purpose of the regional review was to:

'Develop a modern, fit for purpose in 21century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.'

One of the outputs of the review was a modernisation and investment plan which included 26 recommendations to be implemented across the region. Three urology centres are recommended for the region. Team South will be based at the Southern Trust and will treat patients from the southern area and also the lower third of the western area (Fermanagh). The total catchment population will be approximately 410,000. An increase of two consultant urologists, giving a total of five, and two specialist nurses is recommended.

The Minister has endorsed the recommendations and Trusts have been asked to develop implementation plans to take forward the recommended team model.

The Trust submitted an Implementation Plan for Team South in June 2010 (draft v0.2). Further work was undertaken on the patient pathways and these were revised and submitted under separate cover. They have not been replicated in this document.

2. Current Service Model

The current service model is an integrated consultant led and ICATS model. The service's base is Craigavon Area Hospital where the inpatient beds (19) and main theatre sessions are located. There are general surgery inpatient beds at Daisy Hill Hospital (and at the Erne Hospital).

The ICATS services are delivered from a purpose built unit, the Thorndale Unit, and a lithotripsy service is also provided from the Stone Treatment Centre on the Craigavon Area Hospital site.

Outpatient clinics are currently held at Craigavon Area Hospital, South Tyrone Hospital, Banbridge Polyclinic and Armagh Community Hospital.

Day surgery is carried out at Craigavon and South Tyrone Hospitals. A Consultant Surgeon at Daisy Hill Hospital who maintains close links with the urology team also undertakes urology outpatient and day case work. It is important that capacity to deal with the demand from the Newry and Mourne area is built into the new service model as it will need to be absorbed by the Urology Consultants following Mr Brown's retirement.

The Urology Team

The integrated urology team comprises:

- 3 Consultant Urologists,
- 2 Registrars (1 of the Registrar posts will revert to a SHO Doctor from August 2011),
- 2 Trust Grade Doctors (1 post is currently vacant)
- 1 GP with Special Interest (7 sessions per week)
- 1 Lecturer Practitioner in Urological Nursing (2 sessions per week)
- 2 Urology Specialist Nurses (Band 7)

The ICATS Service

Referrals to urology are triaged by the Consultant Urologists and are booked directly to either an ICATS or consultant led clinic by the outpatient booking centre. Red Flag referrals are managed within the Cancer Services Team. Consultant to consultant referrals go through the central referral and booking office and are booked within the same timescales as GP referrals.

The following services are provided within ICATS:

- Male Lower Urinary Tract Services (LUTS)
- Prostate Assessment and Diagnostics

- Andrology
- Uro-oncology
- GPwSI (general urology clinic)
- Haematuria Assessment and Diagnostics
- Histology Clinics
- Urodynamics

Current Sessions

Outpatient, day surgery and inpatient theatre sessions are given in Table 1.

Table 1: Current Urology Sessions

	Craigavon	South Tyrone	Banbridge	Armagh	Total
Consultant Led OPs					
General	2.75 per week[1]	1 per month	2 per month	2 per month	4 per week
Stone Treatment	1 weekly				1 week

ICATS	Weekly	Personnel
Prostate Assessment	1.5	Specialist Nurse & Registrar
Prostate Biopsy	1	Consultant Urologist/Radiologist & Specialist Nurse
Prostate Histology	1.5	Specialist Nurse & Consultant/Registrar
LUTS	3	Specialist Nurse & Registrar
Haematuria	2	Specialist Nurse & Registrar
Andrology	2.5	GPwSI & Nurse Lecturer
General Urology/Stable Prostate Cancer	2.5	GPwSI
	14	

Main Theatres (CAH)	Weekly	
	6	3 all day lists

	Craigavon	South Tyrone
Day Surgery		
GA	1 weekly[2]	1 monthly
Flexible Cystoscopy	1.5 weekly[3]	
Lithotripsy	2 weekly	

1) 1 consultant led outpatient clinic at CAH is every week except the 3rd week in the month
2) Numbers treated on the weekly GA list at Craigavon are restricted by anaesthetic cover
3) 2 lists/1 list on alternate weeks

Current Activity

In 2009/10 the integrated urology service delivered the core service shown in Table 2. In house additionality and independent sector activity has also been included in the table. It should be noted that in 2009/10 240 new outpatient attendances at the Stone Treatment Centre were erroneously recorded as review attendances. This mistake has been corrected in the figures in Tables 2 and 3 below.

Table 2: 2009/10 Actual Activity for the Urology Service

		Core Activity	IHA	IS	Totals
2009/10	Cons Led New OP	850	474	0	**1324**
	ICATS/Nurse Led New OP	1220	30		**1250**
	Total New OP	2070	504	0	**2574**
	Cons Led Review OP	2151	70	0	**2221**
	ICATS/Nurse Led Rev OP	1509	0	0	**1509**
	Total Review	3660	70	0	**3730**
	Day Case	1502	3	383	**1888**
	Elective FCE	1199	29	140	**1368**
	Non Elective FCE	629	0	0	**629**

Activity by consultant for 2009/10 is provided in Table 3.

Table 3: Activity by Consultant for 2009/10

		Mr Young	Mr O'Brien	Mr Akhtar[2]	All Core Activity
2009/10	New OP	482	174	193	**849**
	Review OP	724	903	327	**1954**
	Total OP	1206	1077	520	**2803**
	Day Case	696	452	354	**1502**
	Elective FCE	380	512	307	**1199**
	Non Elective FCE	233	210	186	**629**
	FCEs + DCs	**1309**	**1174**	**847**	**3330**
	Day Case Rates [1]	65%	47%	54%	56%

[1] INCLUDES flexible cystocopies (M45) and DCs/FCEs with no primary procedure recorded.
[2]Mr Akhtar undertakes an alternative weekly biopsy list at Thorndale. These patients are recorded under ICATS.

Notes:
1) Source is Business Objects
2) Day case and elective FCEs exclude in house additionality (3 DCs & 29 FCEs) and also independent sector activity (383 DCs and 140 FCEs)
3) Outpatient Activity is consultant led only & has been counted on specialty of clinic. It excludes in house additionality (474 new, 70 review).
4) There were an **additional 1 new and 197 review** attendances which have not been allocated to a particular consultant as they were recorded under 'General Urologist'.

There is a substantial backlog of patients awaiting review at consultant led clinics. The Trust has submitted a plan to deal with this backlog and implementation of this plan is in progress.

Pre-operative Assessment

Pre operative assessment is already well established. All elective patients are sent a pre-assessment questionnaire and those patients who require a face to face assessment are identified from these. For urology the percentage is high due to the complexity of the surgery and also the nature of the patient group who tend to be older patients with high levels of co-morbidity. It is not possible to provide the number of urology patients who come to hospital for a pre-assessment appointment as all patients are recorded under a single speciality.

Between 1 Apr 09 and 31 Dec 09 692 of 853 elective episodes had a primary procedure recorded. Of the 692, 404 (**58.4%**) were admitted on the day their procedure was carried out. A surgical admission ward was established in July 2009. It closes at 9pm each evening (so beds are not 'blocked'). This has enabled significant improvements to be made in the numbers of patients being admitted on the day of surgery, in part because consultants have confidence that a bed will be available for their patient. Figures have improved further since December 2009 and across all surgical specialties between 85% and 100% of patients are now admitted on the day of their surgery.

Suspected Urological Cancers

It is not feasible to extract the numbers of suspected urological cancers. However, the figure can be estimated using the numbers of patients attending for prostate and haematuria assessment in 2009/10 – 434.

The urology team multi disciplinary meetings (MDMs) are already established. A weekly MDT meeting is held and it is attended by consultant urologists, consultant radiologist, consultant pathologist, specialist nurses, and cancer tracker. The first part of the meeting is the local MDT meeting and the local team then link in with the regional MDT meeting.

The Southern Trust provides chemotherapy only for prostate and bladder cancer patients (at Craigavon Hospital). Chemotherapy for all other cancers and radiotherapy for all cancers is provided by Belfast Trust. The Trust is transferring all radical pelvic operations to Belfast Trust.

3. Benchmarking of Current Service

It is the Trust's intention to use the opportunity of additional investment in the urology service to enhance the service provided to patients and to improve performance as demonstrated by Key Performance Indicators such as length of spell, new to review ratios and day case rates.

The Regional Health and Social Care Board (HSCB) has provided comparative data for the Trusts in Northern Ireland. Table 4 below provides a summary of the Trust's performance compared to the regional position.

Table 4: Regional Benchmarking

		2006/07	2007/08	2008/09	2009/10
New : Review Ratio	All Trusts	1.96	2.03	1.79	1.68
	SHSCT	**4.04**	**3.27**	**3.28**	**2.09**
Day Case Rates	All Trusts	50.1	48.5	49.8	48.5
	SHSCT	**43.8**	**45.5**	**48.8**	**40.0**
Average LOS (elective)	All Trusts	3.7	3.5	3.4	2.9
	SHSCT	**3.7**	**4.3**	**3.9**	**2.7**
Average LOS (non elective)	All Trusts	4.8	4.7	4.6	4.4
	SHSCT	**4.5**	**4.8**	**4.6**	**4.7**

1) Data for 2009/10 is up to the end of February 2010

2) Day cases exclude flexible cystoscopies and uncoded day cases (Prim Op M70.3 and Sec Op 1 Y53.2 also excluded)

Table 5 compares the Southern Trust's average length of spell for specific Healthcare Resource Groups (HRGs) with the Northern Ireland peer group for the period 1st January – 31st December 2009 for elective and non elective admissions.

Table 5: Peer Group Comparison for Length of Spell (Northern Ireland Peer Jan 09 – Dec 09)

HRG v3.5	Spells	SHSCT LOS	Peer LOS
L55 - Urinary Tract Findings <70 without complications & comorbidities	11	3.5	0.3
L32 - Non-Malignant Prostate Disorders	16	3.6	2
L21 - Bladder Minor Endoscopic Procedure without complications & comorbidities	670	0.3	0.1
L14 - Bladder Major Open Procedures or Reconstruction	4	11	6.7
L98 - Chemotherapy with a Urinary Tract or Male Reproductive System Primary Diagnosis	3	4.3	0.5
P21 - Renal Disease	13	1.8	0.7
L28 - Prostate Transurethral Resection Procedure <70 without complications & comorbidities	21	4.4	3.1
L52 - Renal General Disorders >69 or with complications & comorbidities	9	5.9	3.7
L69 - Urinary Tract Stone Disease	37	2.3	1.9
L22 - Bladder or Urinary Mechanical Problems >69 or with complications & comorbidities	28	6.7	3.2
L02 - Kidney Major Open Procedure >49 or with complications & comorbidities	34	9.5	7.8
L25 - Bladder Neck Open Procedures Male	11	6.4	4.8
L08 - Non OR Admission for Kidney or Urinary Tract Neoplasms <70 without complications & comorbidities	5	2	1.3
L07 - Non OR Admission for Kidney or Urinary Tract Neoplasms >69 or with complications & comorbidities	20	9.1	8.4
L27 - Prostate Transurethral Resection Procedure >69 or with complications & comorbidities	78	5.3	4.2
L17 - Bladder Major Endoscopic Procedure	77	4.7	3.8
L03 - Kidney Major Open Procedure <50 without complications & comorbidities	9	5.7	4.8
L13 - Ureter Intermediate Endoscopic Procedure	91	2.3	1.6
L10 - Kidney or Urinary Tract Infections <70 without complications & comorbidities	61	4.2	3
L43 - Scrotum Testis or Vas Deferens Open Procedures <70 without complications & comorbidities	45	1.4	1.2
L23 - Bladder or Urinary Mechanical Problems <70 without complications & comorbidities	16	2.2	1.9

The British Association of Day Surgery (BADS) produces targets for short stay and day case surgery for the various surgical specialties. The Trust compared its performance to the BADS targets for 2008/09 (clinical coding is complete) and 2009/10 (clinical coding is incomplete) and submitted an analysis of its performance in version 0.2 of the Implementation Plan.

The Trust recognises that there is the potential to improve the performance of the urology service and will take this forward through the development of the new service model.

4. Demand for Team South Urology Service

The Trust has agreed the methodology for calculating the outpatient demand for the service with the Performance Management and Service Improvement Directorate, based on the actual activity for 2009/10. It is important that when the demand and the capacity of the current and future services are being calculated, that the **whole service** is considered. A significant amount of both new and review activity is undertaken within the ICATS service. However the service is not an independent ICATS service. Consultants triage all urology referrals and decide which are suitable to be treated at ICATS clinics. They also supervise the clinics. Table 6 presents the projected demand for **outpatient slots** for the overall service.

It has been assumed that the Trust's proposal to manage the review backlog will be funded separately and the capacity required to eradicate the backlog has not been included in the demand analysis.

Using actual activity for 2009/10 as a proxy for demand:

Table 6: Projected Outpatient Activity for Team South

	New Attendances	Notes
2009/10 Actual Consultant Led	1084	1
2009/10 Actual Stone Treatment Centre	240	2
2009/10 Actual ICATS	1250	3
2009/10 Fermanagh referrals	318	4
DNA rate @ 3%	87	5
Growth @ 12%	357	6
Total **SLOTS**	**3336**	
2009/10 Actual Newry & Mourne	610	7
DNA rate @ 3%	18	
Growth @ 12%	75	
	704	

Notes:

1) Actual attendances at consultant led clinics, as shown in Table 6 of the Trust's Implementation Plan. In house additionality is included.

2) In 2009/10 240 Stone Treatment Clinic new attendances were recorded as review.

3) Actual attendances at ICATS clinics.

4) Fermanagh referral figure was taken from the Board's model (it is lower than the SHSCT original estimate).

5) The same DNA rate was used as in the Board's model. The actual DNA rate in 2009/10 was 5.5%.

6) The same growth rate was used as in the Board's model.

7) A General Surgeon based at Daisy Hill Hospital also sees urology patients. It is estimated that 610 new attendances at his clinics in 2009/10 were urology patients. **Capacity for the future needs to be built into the service model for these referrals although this work will continue to be undertaken by the General Surgeon.**

For the purposes of calculating the required outpatient sessions 3336 new attendance slots has been used (ie excluding Newry and Mourne demand).

Projected inpatient and daycase activity has not been changed since the submission of version 0.2 of the Trust's Implementation Plan. It is summarised in Table 7 overleaf.

Table 7: Projected Activity for Team South

		2009/10 Actual Activity					
		Core Activity	**IHA**	**IS**	**Growth in WL**	**SHSCT Activity to be Provided**	**Team South Capacity Required [3]**
2009/10	Day Case	1502	3	383	47	1935	**2283**
	Elective FCE	1199	29	140	28	1396	**1647**
	Non Elective FCE	629	0	0		629	**742**

1) Source is Business Objects
2) 2009/10 breaches have been used to estimate growth in waiting list for day cases and FCEs
3) 18% added for Fermanagh, based on population size relative to SHSCT population

5. Proposed Service Model

The proposed service model will be an integrated consultant led and ICATS model. The Trust has submitted the proposed pathways, as requested to the Performance Management and Service Improvement Directorate.

The main acute elective and non elective inpatient unit for Team South will be at Craigavon Area Hospital with day surgery being undertaken at Craigavon, South Tyrone, and the Erne Hospitals (availability of sessions to be confirmed). Day surgery will also continue to be provided at Daisy Hill by a Consultant Surgeon. It is planned that staff travelling to the Erne will undertake an outpatient clinic and day surgery/flexible cystoscopy session in the same day, to make best use of time.

There is potential to have outpatient clinics held at Craigavon, South Tyrone, Armagh Community Hospital, Banbridge Polyclinic and the Erne Hospital. Outpatient clinics will also continue to be provided at Daisy Hill by a Consultant Surgeon. All outpatient referrals will be directed to Craigavon Area Hospital and they will be triaged on a daily basis. Suspected cancer referrals will be appropriately marked and recorded. For patients being seen at the Erne Hospital it is anticipated that Erne casenotes will be used with a copy of the relevant notes being sent to Craigavon Area Hospital when elective admission is booked. The details of this process have to be agreed with the Western Trust.

The majority of nurse led/ICATS sessions will be provided over 48 weeks with consultant led sessions being provided over 42 weeks. Due to the limited availability of theatre capacity, particularly in main theatres, a 3 session operating day is currently being discussed.

The projected demand from Tables 6 and 7 was used to calculate the number of sessions which will be required to provide the service. These are summarised in Table 8 below with the detail of the calculations provided as Appendix 1. **Note –** as previously stated, demand from Newry and Mourne has not been included in the calculations.

Table 8: Weekly Sessions for New Service Model

	Weekly Sessions	Weeks	Personnel
Consultant Led OPs			
General	5.5	42	
Stone Treatment	1.5	42	
ICATS			
Prostate Assessment	1.5	48	Registrar & Specialist Nurse
Prostate Biopsy [1]	2	48	Consultant Urologist/ Radiologist & Specialist Nurse
Prostate Histology [2]	1	48	Specialist Nurse & Consultant/Registrar
LUTS	3	48	Specialist Nurse & Registrar
Haematuria	1.5	**42**	Specialist Nurse & Registrar
Andrology/General Urology/Stable Prostate Cancer	5	42	GPwSI & Nurse Lecturer
Urodynamics	1.5	48	Specialist Nurse
	15.5		
Main Theatres	9	42	
Day Surgery			
GA	4	42	
Flexible Cystoscopy	3	42	
Lithotripsy	2	42	

The detail of job plans is to be agreed with the existing Consultants but they will be based around the sessions identified in Table 8. The expected weekly consultant led sessions, which are subject to confirmation and agreement with consultants, are given in Table 9 overleaf.

Table 9: Proposed Consultant Led Sessions

	Weekly Sessions
Outpatients (including Stone Treatment)	
Craigavon	4.5
South Tyrone	1
Armagh	0.5
Banbridge Polyclinic	0.5
Erne	0.5
Total OPD	**7**
Prostate Biopsy	**2**
Day Surgery	
CAH	1
STH	2.5
Erne	0.5
Lithotripsy	2
Total Day Surgery	**6**
Main Theatre	**9**

The Trust accepts the need to move towards delivering activity volumes at outpatient clinics which comply with BAUS guidelines and has made good progress in this regard. The original consultant templates enabled the Trust to deliver the outpatient volumes in 2009/10 which are shown in Table 10.

Table 10: Draft Outpatient Volumes at Consultant Clinics in 2009/10

		Core Activity
2009/10	Consultant Led New OP	850
	Consultant Led Review OP	2151
	Total Activity	3001

Revised templates which provide significantly more new outpatient capacity have been agreed with the consultant urologists and these have been implemented. They are shown in Table 11 overleaf.

Table 11: Current Consultant Templates (Recently Revised and Extended)

Consultant	Location	Day	Frequency	Sessions/ Annum	Travel Time	New	Review	New/ Annum	Review/ Annum
Mr Young	BBP	Mon am	Monthly	10	45	6	6	60	60
	ACH	Mon am	Monthly	10	50	6	6	60	60
	CAH (STC)	Mon am	Weekly	42	0	5	11	210	462
	CAH	Fri pm	1,2,4 & 5	32	0	5	7	160	224
Mr O'Brien	BBP	Mon am	Monthly	10	45	5	7	50	70
	ACH	Mon am	Monthly	10	50	5	7	50	70
	CAH	Tues pm	Weekly	42	0	5	7	210	294
Mr Akhtar	CAH	Mon pm	Weekly	42	0	4	7	168	294
	STH	Tues pm	Monthly	10	60	6	3	60	30
Total Annual Slots								**1028**	**1564**

These templates will be used initially as the basis of the new (5 consultant) service model giving a projected capacity of 1533 new and 2310 review appointments at consultant clinics, subject to the agreement of consultant job plans (Table 12 overleaf). It is anticipated that an overall new to review ratio across the service (consultant led and ICATS) of 1:2 will be achieved initially.

Following the appointment and commencement of all new staff, within 12 – 18 months the Trust anticipates aligning all consultant templates with the BAUS guidelines. Draft templates which are subject to agreement with the consultants, are shown in Table 13 overleaf. Travelling time has been accommodated within the templates. The new to review ratio across the service (consultant led and ICATS) will be reduced to the recommended 1:1.5.

Table 12: Draft Initial Consultant Outpatient Templates for 5 Consultant Model (for first 12 – 18 months)

Consultant	Location	Day	Frequency	Sessions/ Annum	Travel Time	New	Review	New/ Annum	Review/ Annum
Consultant 1	CAH	Fri am	2/Month	21	0	6	8	126	168
	STH	Thurs pm	2/Month	21	60	5	8	105	168
	Stone Centre	Mon am	2/Month	21	0	6	11	126	231
Consultant 2	CAH	Tues pm	Weekly	42	0	6	8	252	336
	ACH	Mon am	Monthly	10.5	50	5	8	52.5	84
	Erne	Mon pm	Monthly	10.5	60	5	8	52.5	84
Consultant 3	CAH	Mon pm	2/Month	21	0	6	8	126	168
	STH	Tues pm	2/Month	21	60	5	8	105	168
Consultant 4	CAH	Fri am	2/Month	21	0	6	8	126	168
	ACH	Mon am	Monthly	10.5	50	5	8	52.5	84
	Erne	Mon pm	Monthly	10.5	60	5	8	52.5	84
Consultant 5	CAH	Mon pm	2/Month	21	0	6	8	126	168
	STH	Thurs pm	2/Month	21	60	5	8	105	168
	Stone Centre	Mon am	2/month	21	0	6	11	126	231
Total Annual Slots								**1533**	**2310**

* Please note that templates are draft at present. An additional 0.5 weekly Stone Treatment OP session will be required which still has to be worked in to the job plans.

Table 13: Draft Final Consultant Outpatient Templates for 5 Consultant Model

Consultant	Location	Day	Frequency	Sessions/ Annum	Travel Time	New	Review	New/ Annum	Review/ Annum
Consultant 1	CAH	Fri am	2/Month	21	0	6	9	126	189
	STH	Thurs pm	2/Month	21	60	5	8	105	168
	Stone Centre	Mon am	2/Month	21	0	6	11	126	231
Consultant 2	CAH	Tues pm	Weekly	42	0	6	9	252	378
	ACH	Mon am	Monthly	10.5	50	5	8	52.5	84
	Erne	Mon pm	Monthly	10.5	60	5	8	52.5	84
Consultant 3	CAH	Mon pm	2/Month	21	0	6	9	126	189
	STH	Tues pm	2/Month	21	60	5	8	105	168
Consultant 4	CAH	Fri am	2/Month	21	0	6	9	126	189
	ACH	Mon am	Monthly	10.5	50	5	8	52.5	84
	Erne	Mon pm	Monthly	10.5	60	5	8	52.5	84
Consultant 5	CAH	Mon pm	2/Month	21	0	6	9	126	189
	STH	Thurs pm	2/Month	21	60	5	8	105	168
	Stone Centre	Mon am	2/month	21	0	6	11	126	231
Total Annual Slots								**1533**	**2436**

* Please note that templates are draft at present. An additional 0.5 weekly Stone Treatment OP session will be required which still has to be worked in to the job plans.

6. Timetable for Implementation

Task	Timescale
Submission of Team South Implementation Plan	23 June 10
Re-submission of Team South Implementation Plan	09 Nov 10
Approval to Proceed with Implementation from HSCB	17 Nov 10
Completion of Job Plans/Descriptions for Consultant Posts	Nov 10
Completion of Job Plans/Descriptions for Specialist Nurses	Nov 10
Consultant Job Plans to Specialty Advisor	Dec 10
Advertisement of Consultant Posts	January 11
Advertisement of Specialist Nurse Posts	January 11
New Consultants and Specialist Nurses in post	July 11

APPENDIX 1

Calculation of Sessions Required for Team South

Calculation of Sessions Required for Team South

Prostate Pathway (Revised)

A reduction from the current 4 appointments to 3 appointments is planned in the current service model with the assessment and prostate biopsy taking place on the same day (for appropriate patients).

1st appointment – the patient will be assessed by the specialist nurse (patient will have ultrasound, flow rate, U&E, PSA etc). A registrar needs to be available for at least part of the session eg to do DRE, take patient off warfarin etc. 5-6 patients can be seen at an assessment clinic (limited to a maximum of 6 by ultrasound). In the afternoon appropriate patients from the morning assessment would have a biopsy. 4-6 patients can be biopsied in a session (though additional biopsy probes will need to be purchased). Not all patients will need a biopsy and the session will be filled with those patients from previous weeks who did not have a biopsy on the same day as their assessment (because they needed to come off medication, wanted time to consider biopsy etc). Based on 2009/10 figures it is estimated that 434 patients will require biopsy.

321 patients for assessment @ 5 per session = 64 sessions per annum = 1.4 assessment sessions per week.

378 patients had prostate biopsy in 2009/10 (Note some patients will come directly for biopsy from the ward or OPD). Uplifting this for Fermanagh region gives a requirement for 434 slots @ 5 per session = 87 sessions per annum. 2 biopsy sessions per week (over 48 weeks).

The majority of patients with benign pathology will be given their results by telephone (Specialist Nurse time needs to be built in to job plans for this).

2nd appointment will be to discuss the test results – patients with positive pathology and those patients with benign pathology who are not suitable to receive results by telephone. 180 patients had positive pathology. Uplifting this for Fermanagh region gives a requirement for 215 patients needing a second appointment. These patients will be seen by a consultant or registrar.

3rd appointment will be discussion of treatment with the estimated 215 patients per annum, following MDT. The consultants would prefer to see their own patients and feel that the appropriate model is for each to have a weekly 'Thorndale session' to do:

- 2nd and 3rd prostate appointments,
- Check urodynamic results/patients
- Other urgent cases.

LUTS

419 new patients. The new to review ratio is 1:0.8, therefore there will be approximately 336 reviews.

419 new patients @ 4 per session = 105 sessions

336 reviews @ 8 per session = 42 sessions

103 + 42 = 147 sessions per annum = **3 sessions per week** (over 48 weeks)

Registrar input is required.

Haematuria (Revised)

Currently ultrasound, history, bloods, urines etc done by the Specialist Nurse/Radiographer. Patients come back to DSU to have flexi carried out by a Registrar.

This will move to a 'one stop' service with the flexi being done on the same day in Thorndale (by a Registrar). 5 patients per session (may be a slightly longer session than normal) have been agreed.

241 new patients @ 5 per session = 48.2 sessions = **1.5 per week** (over 42 weeks)

Note – some patients will require IVP. The view of the clinical staff is that it may be rather onerous for the older patient to have this along with the other investigations done on the same day. However this will be considered further and the potential for protected slots discussed with Radiology.

Andrology/General Urology ICATS

For planning purposes it has been agreed to use a new to review ratio of 1:1.5 with 3 new and 5 review at a clinic. It is assumed that sessions will only run over 42 weeks.

639 @ 3 news per session = 213 sessions = **5 per week** (over 42 weeks)

Urodynamics

These will be located alongside consultant clinics.

306 cases at 5 per all day session = 61 all day sessions. 1.5 per week will be built in to the service model.

Time will also need to be built into the Specialist Nurses' job plans to pre assess the patients (this may not need to be face to face) as there otherwise would be a high DNA rate for this service.

Consultant Clinics

1405 new patient slots are required at consultant clinics, including the capacity to review urodynamics results/patients. The table below provides the draft outpatient clinic templates for the 5 consultant model. These templates will provide a capacity for 1533 new and 2310 review outpatient slots initially as shown below. Following the appointment and commencement of all new staff, within 12 – 18 months the Trust anticipates increasing the templates to provide 1533 new and 2436 review slots.

Stone Treatment

311 attendances @ 6 news = 52 sessions. 1.3 session per week will be required.

Day Cases

Flexible Cystoscopy

Based on the current day case rates 2283 day cases (including flexible cystoscopies) would be undertaken.

2008/09 activity has been used to apportion flexible cystoscopies etc, as coding is incomplete for 2009/10.

1243 flexible cystoscopies were carried out as day cases (primary procedure code = M45) and this was 56% of the total daycases (2203), in 2008/09.

It has therefore been assumed that 56% of 2283 cystoscopies will be required = 1279. 237 of these will be done in Thorndale (Haematuria service), leaving1042.

Numbers on lists vary between 6 -10, depending on where the list is undertaken, and whether any patients who have MRSA are included on the list. An average of 8 per list has been used for planning purposes.

1042 @ 8 per list = 131 lists = **3 flexi list per week** (over 48 weeks)

Lithotripsy

268 day cases were carried out in 2008/09. This was 12.2% of the total day cases. Assuming 12.2% of 2283 will be lithotripsy gives a requirement for 279.

279 @ 4 per session = 70 sessions. This equates to 1.5 per week if delivered over 48 weeks (will required a second consultant with SI in stone treatment) and 2 per week if delivered over 42 weeks.

Other Day Cases

The day case rate for specific procedures will be increased (assuming suitable sessions and appropriate equipment can be secured).

In 2008/09 2203 day cases and 1273 elective FCEs were carried out (3476 in total and a day case rate of 63.4%). If the British Association of Day Surgery recommended day case rates had been achieved for the basket of procedures for urology in 2008/09 then an additional 215 day cases would have been carried out increasing the total day case rate from 63.4% to 69.6%

For Team South we have projected 2283 day cases and 1647 FCEs (Day case rate of 58%). If a day case rate of 69.6% is applied to the total elective activity of 3930 then this changes the mix to 2735 day cases and 1195 elective FCEs.

Of the 2735 day cases:

- 1279 are flexible cystoscopies;
- 279 are lithotripsy
- 103 had no procedure (add 18% to account for Fermanagh region) = 121
- 279 are introduction of therapeutic substance in to bladder + 18% = 329

This leaves 727 day cases to be carried out. Some will be done in dedicated day surgery sessions and some will be more suited to main theatre via the elective admissions ward (in case an overnight stay is required). 4 patients are normally done in dedicated day surgery sessions at present but consultants feel that this could be increased to 5.

727 @ 5 per list = 146 lists = 3.5 lists (over 42 weeks). To maximise the potential to treat patients on a day case basis, 4 weekly lists are planned .

Inpatients

1195 elective FCEs are projected. A limited number of patients may not have a procedure carried out. However some non elective cases are added to elective theatre lists. The numbers of procedures carried out on a list also varies significantly and on occasions a single complex case can utilise a whole theatre list. For the purposes of planning, 3 cases per list has been taken as an average.

1195 @ 3 per list = 399 lists = 9 lists (over 48 weeks).

UROLOGY REVIEW SUMMARY OF RECOMMENDATIONS
(Southern Trust)

Section 2 – Introduction and Context

	Recommendation	Update	Update – August 2013
1 P8	Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.	Completed.	Completed
2 P9	Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.	The Trusts and the associated urology teams will need to assess the implications of any pending retirements, particularly with the regard to the transfer of 'N' code work.	Completed
3 P10	A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.	The Trusts have been advised to review their own urinary continence services to ensure they are integrated across the urology team. A separate review of urinary continence services is to be undertaken by the Board through the LCGs.	This work has commenced and is being taken forward by OPCC

Section 3 – Current Service Profile

	Recommendation	Update	Update – August 2013
4 P15	Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.	The Trusts have been advised to review their internal processes for Consultant to Consultant referrals and streamlined as appropriate.	This work is complete. After each outpatient attendance and outcome sheet is completed and this allows for an immediate consultant to consultant referral to be made
5 P15	Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.	The NICaN Standard Working Policy for Urological Cancer MDTs was formally signed off at the NICaN Urology Group on 8 October 2009. The Referral Guidelines were completed in May 2007 and have not been revised. The Board is currently working with NICaN to agree referral guidance for suspected urological cancer.	The Trust has representatives sitting on the NICaN group to take this recommendation forward
6 P17	Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.	The teams will take into account the demand for both core and special interest urology, in the recruitment of new urology consultants.	Completed and an additional interview took place on 8 August for a replacement for Consultant who went to Belfast.
7 P17	Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.	The Board has developed Regional Pathways for the following conditions: o Diagnosis and Management of an acutely obstructed kidney with sepsis	Trust representatives attended the group set up to discuss and take this forward with the Board.

		○ Diagnosis and Management of Acute Urinary Retention ○ Diagnosis and Management of Suspected Renal Colic ○ Haematuria ○ Lower Urinary Tract System (LUTS) male only ○ Prostate ○ Testicular Cancer	
8 P17	Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.	The teams have been advised to develop pathways with A&E colleagues, including the details of the expected standards for the urological input and the timely transfer and admission to an acute Urology Unit.	This is still work in process and is currently in draft for sign off by Emergency Department colleagues.
9 P18	Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.	The teams have been advised to established appropriate arrangements to manage urology patients admitted under general surgery without urology units. notify the appropriate urology unit of the patient, how the urology advice will be provided and within what agree timescale. This has included – the 7 day notification of admission be arranged, the 7 day access to advice, either electronically or via telephone, including, as required, weekend ward rounds or transfer of the patient.	This is currently in place between Daisy Hill and South West Acute Hospitals

10 P20	In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.	The teams have outlined their current arrangements for Urology ICATS. The Board continues to work with the Trusts to ensure the effective use of ICATS services across the overall patient pathway. This should include the consideration of the following options: o direct to diagnostics o to direct treatment on an inpatient/daycase list o for return to primary care with advice on further management o to hospital Consultant outpatients	Due to the shortage of Middle-grade doctors and the retirement of the General Practitioner with Specialist Interest (GPwSI) the Urology Team have commenced a review of the ICATS service provided within the Trust.

Section 4 – Capacity, Demand and Activity

	Recommendation	Update	Updated August 2013
11 P23	Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.	The team Implementation Plans included the key elements of the Elective Reform Programme including; Pre Operative Assessment Admission on the day of surgery Day surgery rates by Consultant Average LOS by procedure Number and % of cancelled operations for both clinical and non clinical reasons The Board is continuing to monitor these areas of improvement.	This is a continuous monitoring process within the Directorate/Division and Urology Team.

Section 5 – Performance Measures

	Recommendation	Update	Updated August 2013
12 P27	Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.	The team should outline the expected number of suspected cancer patients referred per week and what location it is proposed these should be sent to. The teams are recommended to triaged referrals on a daily basis, provided sufficient capacity for suspected urological cancers and introduce one stop clinics.	The Team have introduced one-stop clinics for Prostate Red Flags and Haematuria Red Flags and both these clinics are working well. A new process has been put in place to triage red-flag letters in that these are brought on a daily-basis to the consultant on call
13 P13	Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.	The Trusts continue to take steps to implement the key elements or the elective reform programme and highlight any potential constraints to achievement, and what steps will be taken to overcome these. These include improvements in the Admission on the day of surgery, default to day surgery and effective POA for all urology patients. The BADS directory identifies 28 urology operations (M and N codes) which could be done as day surgery. The Board continues to work with Trusts to improve the levels.	All patients are now admitted on day of surgery except if they have been identified by the Consultant or Anaesthetist of needing to be admitted the day before. All patients that can be done as a daycase are identified at the outpatient clinic and recorded as being able to be done as a daycase. We are continuing to work at increasing our daycase rates
14 P29	Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.	The Trusts urology teams will participate in the Boards benchmarking processes.	The Trust are happy to participate with the Board regarding benchmarking processes.

15 P30	Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.	The average Consultant Urological Surgeon and team should be performing between 1000 – 1250 inpatient and day patient FCEs per annum. (page 41 Review).	This is ongoing work
16 P31	Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.	A urologist working on their own should see 7 new and 7 review patients up to a maximum of 20 per clinic. (page 40/41 of Review). The national new to review ratio is 1:2.1. It is accepted their will be some variation due to case mix/complexity. The teams are continuing to take actions to deal with those teams who are an outlier from this level, and to achieve a performance in the upper quartile, at 1:1.5 The teams are continuing to implement new models for review and patient initiated review for some groups of patients.	Clinic templates have been changed to reflect the agreed SBA levels and all consultants that are in post are working to these levels
17 P32	Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.	The team implementation plan should explain the booking processes for patients and how these will be change to reflect the new team model. This should include the following information; where should the referrals be sent to, how will these be triaged on a daily basis, how will both new and review patients be partially booked, how will patient notes be generated and transferred across the team locality,	This is work in progress particularly between the Craigavon and SWAH and is almost complete.

Section 7 – Urological Cancers

	Recommendation	Update	Progress August 2013
18 P37	The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.	The teams have continued to implement Urology team MDMs. The teams are continuing to ensure IOG compliance, including oncology input to the MDM, and the pathway for oncology and radiotherapy treatments.	This is working well as MDM's are held every Thursday with a link into Belfast Trust
19 P38	By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.	NICaN has formally issued the Urology MDM Working Policy, October 2009. All radical pelvic operations have now transferred to the Belfast City Hospital.	Complete
20 P38	Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).	All radical pelvic operations are now transferred to the Belfast City Hospital.	Complete

Section 8 – Clinical Workforce Requirements

	Recommendation	Update	Progress August 2013
21 P41	To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.	The Trusts have outlined the details of the expected activity per team. The Board has agreed the volumes of activity associated with 23 wte consultants across the region.	2 New Consultants had been appointed and were in post, however one has since left to take up post in Belfast and the Trust have advertised and are interviewing on 8 August

22 P41	Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.	The Board has agreed volumes of activity per team consistent with the BAUS recommendations. The teams have implemented changes to the consultant job plans to implement the team model.	Once the fifth consultant has been appointed and taken up post the team will move to the 5-team job plan
23 P43	At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.	The teams have appointed additional CNS posts. The teams have provided the detailed job plans for each of the existing Urology CNS both cancer and non cancer. The Board continues to work to standardise how this activity is recorded. The Board and PHA are undertaking a review of cancer CNS posts across the region.	The Trust are considering this as part of the review of ICATS and will take into consideration any recommendations form the Board and PHA review

Section 9 – Service Configuration Model

	Recommendation	**Update**	**Progress August 2013**
24 P44	Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.	The elements of the team model were included on Page 45 of the Review. The Board continues to work with each of the Trusts to reconfigure the services into a 3 team model to achieve long term stability. This will include the redirection of referrals across LCGs to utilisation of capacity and support the delivery of waiting times targets.	Complete
25	Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should	The teams have agreed arrangements for out of hours and	Complete

P46	ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.	Consultant on call. These are linked to recommendations 7 and 8.	
26 P46	Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.	The teams have agreed new team arrangements and structures across the relevant Trusts. The Board continues to work with the Trusts to support the team structures and new arrangements. .	Ongoing in conjunction with Board

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Action List

Project Name	Urology Review Backlog Action Plan	Organisation	SHSCT	Project Owner	Martina Corrigan	Date Written:	06/05/2011

Item No.	Action / Issue	Person Responsible	Due Date	Progress report so far	% Complete	Progress Tracker	Exception report/ Issues/ help required
1	Update project Plan	HOS	06/05/2011	complete	100%		
2	Triage Patient Centre Letters 2008 backlog review patients will be triaged utilising administrative triage, nurse triage and consultant triage	HOS/Lead Nurse/ Specialist Nurses	31/03/2011	complete	100%		
3	Triage Patient Centre Letters 2009 backlog review patients will be triaged utilising administrative triage, nurse triage and consultant triage	HOS/Lead Nurse/ Specialist Nurses	31/03/2011	nurse triage complete- consultant triage ongoing	50%		on a weekly basis to ensure that momentum is maintained in triaging these letters. However it should be noted that through nurse/admin triage any patients that were deemed urgent have been given an urgent appointment with consultant
4	Triage Patient Centre Letters 2010 backlog review patients will be triaged utilising administrative triage, nurse triage and consultant triage	HOS/Lead Nurse/ Specialist Nurses	30/06/2011	nurse triage complete- consultant triage ongoing	50%		HOS working and meeting with consultants on a weekly basis to ensure that momentum is maintained in triaging these letters. However it should be noted that through nurse/admin triage any patients that were deemed urgent have been given an urgent appointment with consultant
5	Triage Patient Centre Letters 2011 backlog review patients will be triaged utilising administrative triage, nurse triage and consultant triage	HOS/Lead Nurse/ Specialist Nurses	ongoing from 1 July	ongoing not to commence until 1 July	0%		
6	Calculation of clinic requirements to undertake review backlog - 2008 review backlog	HOS	30/04/2011	complete	100%		18 additional clinics required to clear this backlog

Received from Mrs Heather Trouton on 15/04/22. Annotated by the Urology Services Inquiry.

7	Calculation of clinic requirements to undertake review backlog - 2009 review backlog	HOS	30/04/2011	complete	100%					67 additional clinics required to clear this back
8	Calculation of clinic requirements to undertake review backlog - 2010 review backlog	HOS	30/04/2011	complete	100%					93 additional clinics required to clear this backlog
9	Timetable of additional clinics to be undertaken	HOS	30/04/2011	complete	100%					To clear 2008 will take until October 2011 (approximately) To clear 2009 will take until November 2012 To clear 2010 will take until approximately July 2013 However HOS working with all consultants to see who has the most capacity to see if this specialty can pool in order to bring this date forward
10	Establish current capacity per site and identify any operational considerations	RBC Manager / HOS	31/03/2011	ongoing	50%					
11	Discharge Review Practices	Ward Sister overseen by Lead nurse	ongoing	ongoing	25%					This work is ongoing and it was agreed to be reviewed after one month, that is week commencing 9 May

12	Referral and booking centre interactions - development of an escalation plan which will allow the referral and booking centre to highlight capacity gaps in relation to urgent reviews	Head of Health records/ HOS	30/04/2011	ongoing	25%		
13	Referral and booking centre interactions - development of clear protocols for the referral and booking centre regarding the allocation of patients to review slots	AD/AMD	30/04/2011	ongoing	25%		
14	referral and booking centre interactions - development of clear protocols for the addition of patients to the urgent review lists	AD/AMD	30/04/2011	ongoing	25%		
15	referral and booking centre interactions - guidance to be developed and agreed with clinicians in respect of what patients are added to the urgent waiting list	HOS	30/04/2011	ongoing	25%		this is an agenda item on departmental meeting on 26 May 2011
16	referral and booking centre interactions - 'top of list' patients validated and actioned	OSL	ongoing	ongoing	25%		
17	Communication - ensure clear communication between clinical and administrative staff in respect of review requirements supported through the Ward Sister scrutiny of review appointment requests	Ward Sister overseen by Lead nurse	ongoing	ongoing	25%		this work is ongoing and it was agreed that this would be reviewed week beginning 9 May 2011
18	Administrative Processes - Undertake baseline assessment of compliance with the IEAP per consultant	OSL	30/04/2011	ongoing	75%		

19	Administrative Processes - Clinical guidelines to be agreed around application of IEAP i.e. robust criteria for re-appointments of DNAs etc	AD/AMD	31/05/2011	ongoing	25%					
20	Administrative Processes - Establish quarterly report to identify the number of patients who fall out of line with the IEAP	OSL	01/06/2011	ongoing	25%					

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Action List

Project Name	Urology Review Backlog	Organisation	SHSCT	Project Owner	Martina Corrigan	Date Written:	06/05/2011

Item	Action / Issue	Person	Due Date	Progress report so	% Complete	Progress	Exception report/ Issues/
21	Administrative processes - Develop clear administrative and clerical protocols for the management of review patients ie compliance with IEAP, DARO functionality, addition of patients for review appointment at same time as listing for surgery and avoidance of duplication	OSL	30/04/2011	ongoing	50%		

Received from Mrs Heather Trouton on 15/04/22. Annotated by the Urology Services Inquiry.

UROLOGY REVIEW BACKLOG
4 May 2011

Overall total patients waiting end April 2011

2008 = 264
2009 =1194
2010 = 1333

After triage

2008 = 234
2009 = 803
2010 = 1105

Per consultant (2008-2009)

Mr Young is on average discharging 41% after triage
Mr O'Brien is on average discharging 43% after triage
Mr Akhtar is on average discharging 40% after triage

Note that with change of practice the consultants did not put as many patients on review list during 2010 so therefore are only discharging around 20% after triage.

Total additional review only clinics required to clear backlog = 179 (12 patients on each clinic)

Per consultant

Mr Young (total 78 clinics required)

2008 = 18 clinics at 3 additional clinics per month will take 6 months to clear = September 2011

2009 = 27 clinics at 3 additional clinics per month will take 9 months to clear = July 2012

2010 = 33 clinics at 3 additional clinics per month will take 11 months to clear = June 2013

So by June 2013 Mr Young's current backlog will be cleared

Mr O'Brien (total 59 clinics required)

2008 – cleared

2009 = 24 clinics at 3 additional clinics per month will take 8 months to clear = November 2011

2010 = 35 clinics at 3 additional clinics per month will take 12 months to clear = November 2012

So by November 2012 Mr O'Brien's current backlog will be cleared

Mr Akhtar (total 41 clinics required)

2008 – cleared

2009 – 16 clinics at 3 per month for April – June 2011 and then 8 per month from June onwards means 2009 will be cleared by July 2011.

2010 – 25 clinics at 8 additional per month will take 4 months to clear = October 2011.

So by October 2011 Mr Akhtar's current backlog will be cleared.

Urology review backlog will take until June 2013 to be cleared.

For SDP bid there were:

30 additional consultant new patient clinics (to hold 9 weeks) – Mr Akhtar is willing to do these at 3 per week which is why he can only do 1 additional review backlog clinic per week during these months

24 additional consultant review backlog clinics – this has been agreed as:
12 for Mr Young
3 for Mr O'Brien
9 for Mr Akhtar

See below urology review backlog position as at 16/02/2022 compared to January 2022.

Review outpatient backlog update (as at for 16th February 2022)

	Jan-22		Feb-22	
	Total	**Longest Date**	**Total**	**Longest Date**
Glackin	73	May-20	95	May-19
O' Donoghue	405	Mar-17	394	Mar-17
Young	500	Dec-16	475	Dec-16
Haynes	121	Feb-19	123	Feb-19
Omer	69	Mar-18		
Khan	15	May-21	149	Jul-17
O' Brien	288	Jul-13	234	Jul-13
Tyson	43	May-19		
Jacob	4	Jul-17		
Solt	10	Oct-19	10	Oct-19
Fel	4	Dec-20	3	Jan-21
Mr Brown			2	Apr-17

OUT-PATIENT WAITING LIST - UROLOGY

Date	Total	>9-Weeks	>52-Weeks	Longest Wait
@ 31/1/2022	**5530**	**4869**	**3763**	**313**
@ 31/3/2021	4819	4280	3461	269
@ 31/3/2020	4041	3390	2063	217
@ 31/3/2019	3754	2964	1969	167
@ 31/3/2018	2988	2253	1079	114
@ 31/3/2017	2562	1872	195	76
@ 31/3/2016	2714	2040	4	74
@ 31/3/2015	1880	1252	0	46
@ 31/3/2014	1335	822	0	26
@ 31/3/2013	416	0	0	9

OUT-PATIENT REVIEW BACKLOG - UROLOGY

Date	Total	Urgent	Routine
@ 31/1/2022	1503	743	760
@ 31/3/2021	2295	945	1350
@ 31/3/2020	2832	1182	1650
@ 31/3/2019	2711	1175	1536
@ 31/3/2018	2228	846	1382
@ 31/3/2017	1636	462	1174
@ 31/3/2016	2021	607	1414
@ 31/3/2015	2739	418	2321
@ 31/3/2014	3541	393	3148
@ 31/3/2013	3025	157	2868
@ 31/3/2012	2572	200	2372
@ 31/3/2011	3293	N/A	N/A

Southern Health &
Social Care Trust

Corporate Risk Register

December 2009

Final Version 9th Dec 2009

SOUTHERN HEALTH AND SOCIAL CARE TRUST CORPORATE RISK REGISTER DECEMBER 2009

Contents

SOUTHERN HEALTH AND SOCIAL CARE TRUST CORPORATE RISK REGISTER DECEMBER 2009

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Corporate/Cross Programme			
Rating High	**Preparedness for Pandemic Flu, specifically a H1N1 current pandemic**	1. Provide Safe, High Quality and Effective Care	• SHSCT H1N1 Plans in final draft • Weekly SMT/Silver Team meetings • Bronze command and control meetings ongoing at Directorate level • Daily monitoring in place – hospitalized patients, attendances at A&E, GP OOHs, MIUs • Representation at regional Trust Liaison Group meetings • Representation at regional professional fora • Vaccination plan submitted for HPA approval • Business cases for funding submitted to various workstreams • Ward 3 (Isolation Ward) operationally ready

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Strong	Planning on going as directives from DHSSPS issues/change. Trust synchronisation workshop being arranged	Medical Director	Weekly review by SMT/Silver Control Team	Ongoing

SOUTHERN HEALTH AND SOCIAL CARE TRUST CORPORATE RISK REGISTER DECEMBER 2009

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Corporate/Cross Programme			
Rating High	**Maintenance and development of Trust estate (facilities, equipment, ICT, etc) to support service delivery and improvement**	1. Provide Safe, High Quality and Effective Care	• Maintaining Existing Service capital priorities submitted to DHSSPS and some funding secured to address critical risks • Capital priorities funded where possible from CRL and business cases prepared for major schemes awaiting funding • HCAI risks funded in 08/09 and ongoing • Bi monthly meetings with DHSSPS (Strategic Investment Group) at which capital investment issues are discussed. • CRL report to SMT bi-monthly.

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Strong	• Ongoing prioritization and bidding process in place • CRL management process in place	Director of Performance and Reform	Bi monthly	CRL Monitoring group SIG meeting bi-monthly with DHSSPS

SOUTHERN HEALTH AND SOCIAL CARE TRUST CORPORATE RISK REGISTER DECEMBER 2009

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Corporate/Cross Programme			
Rating High	**Sufficient funding to fully close baseline gaps** **Achieving the year two BCBV plans (including productivity line)**	Making best use of resources.	• Contingency Plans to address the potential gaps have been drawn up and are being implemented • Efforts to identify recurring savings are being given new momentum and additional capacity to identify and drive forward schemes has been created with the appointment of Best Care Best Value (BCBV) senior posts in operational directorates. BCBV Programme Board and project structure is in place including Directorate specific BCBV performance management meetings. • Trust Board report (finance paper) • Weekly review by SMT • BCBV Programme Board and project structure in place

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Strong	• Ongoing review of controls • BCBV Project Plan • Trust contingency plan	Directors of Finance and Performance and Reform	Ongoing Review within specified timescales	Ongoing

SOUTHERN HEALTH AND SOCIAL CARE TRUST CORPORATE RISK REGISTER DECEMBER 2009

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Corporate/Cross Programme			
Rating High	**Funding constraints on domiciliary care services**	Making best use of resources	• Criteria and sub criteria for provision of specific services (eg meals services and night sit services) • Part of financial contingency plan • Multi-disciplinary training package produced • Staff supervision and review of caseloads • Domiciliary Care Review Group has been established (OPPC) • Reported as part of financial reporting • Access to domiciliary care monitored at Directorate level

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Strong	Actions as above – service reform programme underway and ongoing discussions with commissioner regarding sustainable funding.	Directors of Older People and Primary Cares and Mental Health and Disability.	Monthly review of contingency plans	Ongoing

SOUTHERN HEALTH AND SOCIAL CARE TRUST CORPORATE RISK REGISTER DECEMBER 2009

Risk ID	Title / Description	Link to Corporate Objective / Value	Potential for Harm	Control Measures
Children and Young Peoples Directorate				
1866 **Rating High**	**Protection of Vulnerable Adults**	1 provide safe, high quality care.	There are inconsistencies in practice and limited specialist expertise available for the protection of vulnerable adults. Systems and processes need to be reviewed.	Lead director and lead professional reviewing arrangements.

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Moderate	Proposal for change to arrangements and appointment of co-ordinator. Awaiting funding from HWIP. DHSSPSNI identified additional monies for protection arrangements. Increased targeted training.	Directors CYP (Ex Dir SW) & OPPC Trust Vulnerable Adults Forum.	1st December, 2009	(I) Reports to Director, SHSSB and Trust Board of Directors. (I) Trust reporting arrangements via vulnerable adults forum. (I) Audit programme. (E) RQIA reviews. (E) HSCB monitoring of statutory functions.

SOUTHERN HEALTH AND SOCIAL CARE TRUST CORPORATE RISK REGISTER DECEMBER 2009

Risk ID	Title / Description	Link to Corporate Objective / Value	Potential for Harm	Control Measures
Children and Young Peoples Directorate				
1909 **Rating High** **Ref No 1909**	**Level of unallocated child care cases in FSS teams.**	1 provide safe, high quality care.	There has been insufficient capacity in family support teams to allow allocation of all cases transferred from Gateway. Retention of social work staff in FST has been difficult resulting in significant numbers of relatively inexperienced AYEs in these teams.	Weekly monitoring of numbers of unallocated cases. Workforce strategy group for family support and safeguarding teams. Social work supervision and line management arrangements.

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Strong	Independent child care consultant commissioned to review unallocated child care referrals April – June 2009. RQIA Action plans. Case management review report action plans. Further development of workforce strategy paper.	Colm McCafferty	1st December, 2009	Weekly HSCB reports. Monthly DHSSPSNI reports. Performance report to Trust Governance Committee. Annual Delegated Statutory Functions Report.

SOUTHERN HEALTH AND SOCIAL CARE TRUST CORPORATE RISK REGISTER DECEMBER 2009

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Learning Disability & Mental Health Directorate			
Forensic Services **Rating High**	**Issues relating to release from prison of LD /Mental Health clients into the community including those on probation. Communications between PBNI and HSC. Person Specific.**	Provide Safe, High Quality and Effective Care	• Encourage client engagement with services. • Provisions of the Criminal Justice (N.Ireland) Order 2008. • Individual client specific control measures. • Mental Health Order(where applicable). • Ongoing liaison with PBNI and PPS • Issued raised with DHSSPS and NIO (letter from CX 10/9/09)

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Moderate	Issues to be taken forward at Regional Forensics Steering Group which includes representatives from Court & Probation services.	Director of Mental Health and Disability	Monthly SMT Governance item	Ongoing

SOUTHERN HEALTH AND SOCIAL CARE TRUST CORPORATE RISK REGISTER DECEMBER 2009

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Corporate/Cross Programme			
Rating Moderate	**Risk of non compliance with European Working Time Directive (EWTD).**	Making best use of resources and providing safe, high quality care.	EWTD steering group has ensured compliance in the majority of medical specialties. HR leading work to identify and address EWTD issues for other service areas and staff groups.

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Moderate	• Actions plans being developed to address residual areas of non-compliance. • Regular meetings between HR and medical management to explore alternative solutions for compliance. • Derrogation for some specialties.	Director of HR	Bi-monthly	Ongoing

SOUTHERN HEALTH AND SOCIAL CARE TRUST CORPORATE RISK REGISTER DECEMBER 2009

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Medical Directorate/Cross Directorates			
Compliance with Standards and Guidelines **Rating High**	**Assessment of Implementation of national and regional clinical and social care guidelines. Resulting in failure to provide clinical and social care to a recognised standard**	*Provide Safe, High Quality and Effective Care*	1. *Information on Standards and Guidelines disseminated via chief executives office.* 2. *SABS system in place for the issue and response to Safety Action Bulletins* 3. *Business case submitted to SHSSB in 2008 (business case declined)* 4. *Effectiveness and Evaluation Dept monitoring progress with a small number of clinical guidelines in line with national and regional projects.*

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Some weaknesses	*Pursue appointment of a standards and guidelines post to ensure cataloguing of standards, progress with implementation and to provide assurances that these are being acted upon as appropriate.*	*Medical Director*	*January 2010*	*At each SMT Governance meeting*

Risk ID	*Title / Description*	*Link to Corporate Objective / Value*	*Control Measures*
Performance & Reform			
Informatics - Clinical Coding Performance & Contracts Performance & Reform *Rating High*	**Delays in the timeliness and quality of Clinical Coding**		• *Coding Action Plan in place* • *Corporate recognition of significance of improving position demonstrated via Mid staffs action plan process* • *CHKS benchmarking project established to identify clinical indicators* • *Clinical indicators reported at corporate level against peer for mortality, re-admission and length of stay* • *Initial clinical indicators report commissioned to identify clinical outcomes associated individual performance for consultant medical staff with acute and community activity for inpatients, daycases and outpatients* • *Clinical interface group established by Medical Director 's Office to engage clinicians in clinical outcome measures and consider options for engagement, validation and integration of this work into current clinical outcome review processes(Dec 09)* • *Clinical interface group to consider how clinical outcomes measures for consultant medical staff not involved in OP, IP/DC work* *Data quality improvement group has been set up and detailed action plan produced.*

Control Strength	*Action Plan*	*Nominated Lead for Actions*	*Review Date*	*Monitoring*
	Coding audit to be undertaken annually£5K cost prohibitive. Negotiations ongoing.	*Assistant Director Information*	*March 2010*	
	Backlog of £14,000 episodes needs to be addressed, without compromising current FCEs. 2 coders to work on backlog. Further 2 coders to be appointed to backfill this gap.	*Assistant Director Information*	*Dec 09*	*June 2010*
	New coding process to be implemented to improve efficiency Consultation Paper drafted.	*Assistant Director Information*	*Consultation Oct 09*	*Implement Dec 09*
	Mid Staffordshire action plan to be developed further to diagnostics assessment of position against recommendations underway	*Project managers Mid Staffs Review*		
	Process to be agreed and established to integrate clinical outcome measures into current clinical outcome review processes	*Medical Director*	*Pending meeting Dec 09*	
	Standing clinical indicators reports to be agreed and produced to support clinical outcome review processes. *Resources to be identified to support above processes*	*Medical Director* *(Lesley Leeman)(*	*Pending meeting Dec 09*	

SOUTHERN HEALTH AND SOCIAL CARE TRUST CORPORATE RISK REGISTER DECEMBER 2009

There are a number of corporate risks which the Trust is currently managing successfully, however these risks need to remain in focus due to their potential impact. Examples of these are:

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Corporate/Cross Programme			
Rating Low	**Prevention and management of HCAI within the Trust**	1. Provide Safe, High Quality and Effective Care	• Project structure in place, Strategic, Operational and Clinical Teams • HCAI Improvement plan in place and being implemented • Regular monitoring and reporting to SMT, Trust Board and key staff throughout organization • RCAs completed for all HCAIs(C Diff, MRSA bacteraemia and MSSA bacteraemia) and process for identifying and addressing root cause. • Hand hygiene campaign underway

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Strong	HCAI Improvement Plan	Medical Director/Operational Directors	Ongoing Review within specified timescales	Ongoing

SOUTHERN HEALTH AND SOCIAL CARE TRUST CORPORATE RISK REGISTER DECEMBER 2009

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Acute Directorate			
Rating Moderate	**RQIA recommendations on maternity services**	1. Provide Safe, High Quality and Effective Care	• Additional staff have been recruited to address the recommendations of the RQIA review of maternity services • Temporary medical staff have been recruited to provide increased labour ward cover in DHH • Ongoing discussions with commissioners • Weekly reporting to SMT • Regular update to Trust Board

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Strong	Action plan developed and under discussion with commissioner	Director of Acute Services	Weekly update to SMT	Ongoing

SOUTHERN HEALTH AND SOCIAL CARE TRUST CORPORATE RISK REGISTER DECEMBER 2009

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Acute Directorate			
Rating Moderate	**Ongoing achievement of Access Targets**	1. Provide Safe, High Quality and Effective Care	• Weekly report to SMT • Monthly Trust Board report • Reporting of access breaches to SMT and RHSCB

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Strong	• Action plan provided to RHSCB and interim funding secured • Internal analysis as to sufficiency of funding and impact	Directors of Acute Services, Performance and Reform, Older People and Primary Care, Children and Young People, Finance, Mental Health and Learning Disability	Weekly	Weekly

SOUTHERN HEALTH AND SOCIAL CARE TRUST CORPORATE RISK REGISTER DECEMBER 2009

Risk ID	Title / Description	Link to Corporate Objective / Value	Potential for Harm	Control Measures
Children and Young Peoples Directorate				
1467 **Rating Moderate**	**Decontamination of dental instruments**	1 provide safe, high quality care	Because of revised guidelines the Trust is not permitted to replace dental autoclaves. When an autoclave breaks down clinics have to be cancelled which impacts on capacity to meet targets.	Vigilance by clinicians regarding equipment efficiency and use of instruments prior to treatment.

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Strong	Order for new autoclave stopped by DHSSPSNI. Estates have a case developed to bring servicing in house up to the required standard.	Michelle Oliver	1st December, 2009	Decontamination Committee

SOUTHERN HEALTH AND SOCIAL CARE TRUST CORPORATE RISK REGISTER DECEMBER 2009

Risk ID	Title / Description	Link to Corporate Objective / Value	Potential for Harm	Control Measures
Children and Young Peoples Directorate				
2201 **Rating Moderate**	**Unaccredited and unregulated accommodation for 16&17 years.**	1 provide safe, high quality care	Young people aged 16 and 17 from a care and non care background may be placed in accredited accommodation or other facilities which are not registered as children's homes. The inconsistency between legislation and policy needs to be resolved as well as increasing the range of suitable provision.	Individual risk assessment on each young person placed Placement needs determined by thorough assessment Placement agreed at HOS & AD level Director of Social Services and HSCB notified in writing HSCB, RQIA, DLS and DHSSPS are aware that this is an issue in all Trusts

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Strong	Work with young people at risk of homelessness who are from a non care background. HOS to reinforce to teams that all such young people are subject to robust assessment and that such placements are to be notified to Director and HSCB in accordance with procedures. Individual young people to be included in teams risk register.	Carmel Rooney	1st December, 2009	Child Protection, LAC procedures and Family Group Conferencing At least weekly social work visits – young person spoken to on own Regular telephone contact with young Active contact maintained with parents/carers Young person to remain subject to formal reviews LAC/Case planning, agenda to include the appropriateness of the placement and identification of alternative placements. Monthly monitoring by HOS LAC and HSCB

Southern Health &
Social Care Trust

Corporate Risk Register

June 2010

Version with new updates 21 June 2010

Next review of Corporate risk Register tabled for September 2010 SMT Governance Meeting

Contents

Issues downgraded for removal from Corporate Risk Register

Placement of 16 and 17 year olds in unaccredited facilities (B Doran request to remove) No longer a Corporate Risk Issue will be managed as Directorate risk issue.

Section One High level Corporate Risks

There are a number of corporate risks which the Trust is currently seeking to managing successfully, these risk areas are of high concern to the Senior Management Team due to their potential impact and the current restraints on the Trust in seeking to reduce the level of risk in these areas.

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Corporate/Cross Programme			
Rating High	**Maintenance and development of Trust estate (facilities, equipment, ICT, etc) to support service delivery and improvement**	1. Provide Safe, High Quality and Effective Care	• Maintaining Existing Service capital priorities submitted to DHSSPS and some funding secured to address critical risks • Capital priorities funded where possible from CRL and business cases prepared for major schemes awaiting funding • HCAI risks funded in 08/09 and ongoing • Bi monthly meetings with DHSSPS (Strategic Investment Group) at which capital investment issues are discussed. • CRL report to SMT bi-monthly.

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Strong	• Ongoing prioritization and bidding process in place • CRL management process in place	Director of Performance and Reform	Bi monthly	CRL Monitoring group SIG meeting bi-monthly with DHSSPS

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Corporate/Cross Programme			
Rating High	**Achieving the year two BCBV plans (including productivity line)** **Sufficient funding to fully close baseline gaps**	Making best use of resources.	• Contingency Plans to address the potential gaps have been drawn up and are being implemented • Efforts to identify recurring savings are being given new momentum and additional capacity to identify and drive forward schemes has been created with the appointment of Best Care Best Value (BCBV) senior posts in operational directorates. BCBV Programme Board and project structure is in place including Directorate specific BCBV performance management meetings. • Trust Board report (finance paper) • Weekly review by SMT • BCBV Programme Board and project structure in place

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Strong	• Ongoing review of controls • BCBV Project Plan • Trust contingency plan	Directors of Finance and Performance and Reform	Ongoing Review within specified timescales	Ongoing

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Corporate/Cross Programme			
Rating Moderate	**Impact of demand patterns on Trust Domiciliary Care Expenditure**	Provide safe, high quality and effective care.	1. Services and staff made aware of SH&SSB Access to Domiciliary Care Criteria. 2. Development of OPPC Access to Domiciliary Care sub eligibility Criteria (ie. access criteria and sub criteria agreed for provision of specific services (meals services, personal care, toileting, back to bed and night sit services). 3. Raising of authority for Dom Care Package approval to Heads of Services. 4. Financial contingency plan in place since Nov '08 and revised in April 2010. 5. Agreed content of a training package and the training package has been produced, along with delivery of multi-disciplinary training for staff who assess for services, to ensure consistent roll-out and application of the various access criteria and sub eligibility criteria. and 6. Ongoing development of Domiciliary Care access criteria and control measures in discussion with Commissioner

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Some Weaknesses	Domiciliary Help Group established to consider issues, develop and implement an action plan.	Director of OPPC in conjunction with Assistant Director	Quarterly	Ongoing
	Care Management RPE Group established to consider issues, develop and implement an action plan.	Director of OPPC in conjunction with Assistant Director	Quarterly	Ongoing

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
	Development of Directorate Financial Contingency Plans to address over expenditure 2010/11 Plan now agreed in April '10	Director of OPPC	Feb '11	Ongoing via BCBV
	Defining level of access criteria which can be met within budget available: last reviewed April '10	Director and Assistant Director	June '10	Ongoing
	Working towards devolving budget responsibility and accountability to HOS and Team Levels	Director and Assistant Director and Finance Officers	April '10	Ongoing

Risk ID	Title / Description	Link to Corporate Objective / Value	Potential for Harm	Control Measures
Children and Young Peoples Directorate				
1866 **Rating High**	**Protection of Vulnerable Adults**	1 provide safe, high quality care.	There are inconsistencies in practice and limited specialist expertise available for the protection of vulnerable adults. Systems and processes need to be reviewed.	Lead director and lead professional reviewing arrangements.

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Moderate	Proposal for change to arrangements and appointment of co-ordinator. Awaiting funding from HWIP. DHSSPSNI identified additional monies for protection arrangements. Increased targeted training.	Directors CYP (Ex Dir SW) & OPPC Trust Vulnerable Adults Forum.	June 2010 Commissioning Plan to clarify development funding and priorities 2010/11	(I) Reports to Director, SHSSB and Trust Board of Directors. (I) Trust reporting arrangements via vulnerable adults forum. (I) Audit programme. (E) RQIA reviews. (E) HSCB monitoring of statutory functions.

Risk ID	Title / Description	Link to Corporate Objective / Value	Potential for Harm	Control Measures
Children and Young Peoples Directorate				
1909 **Rating High** **Ref No 1909**	**Level of unallocated child care cases in FSS teams.**	1 provide safe, high quality care.	There has been insufficient capacity in family support teams to allow allocation of all cases transferred from Gateway. Retention of social work staff in FST has been difficult resulting in significant numbers of relatively inexperienced AYEs in these teams.	Weekly monitoring of numbers of unallocated cases. Workforce strategy group for family support and safeguarding teams. Social work supervision and line management arrangements.

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Strong	Independent child care consultant commissioned to review unallocated child care referrals April – June 2009. RQIA Action plans in place and being implemented Case management review report action plans. Further development of workforce strategy paper.	Director of C&YP	Monthly	Weekly HSCB reports. Monthly DHSSPSNI reports. Performance report to Trust Board and reporting to Governance Committee Annual Delegated Statutory Functions Report.

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Learning Disability & Mental Health Directorate			
Forensic Services **Rating High**	**Issues relating to release from prison of LD /Mental Health clients into the community including those on probation. Communications between PBNI and HSC. Person Specific.**	Provide Safe, High Quality and Effective Care	• Encourage client engagement with services. • Provisions of the Criminal Justice (N.Ireland) Order 2008. • Individual client specific control measures. • Mental Health Order(where applicable). • Ongoing liaison with PBNI and PPS • Issued raised with DHSSPS and NIO (letter from CX 10/9/09)

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Moderate	Issues to be taken forward by SHSCT Forensics services and also ongoing liaison between Trust and HSC Board, DHSSPSNI and NIO.	Director of Mental Health and Disability	Monthly	Ongoing

Risk ID	*Title / Description*	*Link to Corporate Objective / Value*	*Control Measures*
Corporate/Cross Directorates			
Medical Directorate ***Rating High***	**Compliance with Standards and Guidelines** Lack of assessment of Trust performance against national and regional clinical and social care guidelines endorsed and issued by DHSSPS and commissioner, resulting in lack of assurance and potential failure to identify where the Trust is not providing clinical and social care to endorsed standards	Provide Safe, High Quality and Effective Care	1. Information on Standards and Guidelines disseminated via chief executives office to Medical Director and Lead Director. 2. SABS system in place for the issue and response to Safety Action Bulletins 3. Effectiveness and Evaluation Unit monitoring progress with a small number of clinical guidelines in line with national and regional projects 4. Review of C&SC Governance operation systems and processes underway to report in July 2010

Control Strength	*Action Plan*	*Nominated Lead for Actions*	*Review Date*	*Monitoring*
Some weaknesses	Reallocation of resources within the medical directorate to ensure work is taken forward to ensure cataloguing of standards, monitoring of progress with implementation and provision of assurances to SMT and Trust Board that the Trust is compliant with these standards.	Medical Director	July 2010	At each SMT Governance meeting

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Corporate/Cross Directorates			
Medical Directorate **Rating High**	Lack of comprehensive systems of assessment and assurance in relation to safety and quality of Trust services, including morbidity and mortality and other indicators of safety and quality	**Provision of Safe Effective Care**	▪ Governance Committee and SMT Governance Group in place ▪ Directorate and Division-specific governance groups in place with regular review of information emerging from SAIs, AIs, complaints, etc. ▪ System of Root Cause Analysis in place for SAIs and HCAIs. ▪ Limited range of quality and safety indicators in place and reported monthly to Trust Board ▪ Staff training in reporting of incidents ongoing ▪ The Patient Safety imitative suite of interventions as per the Regional Patient Safety Forum is well established. ▪ Effectiveness and evaluation unit have a defined programme of activity. ▪ Reallocation of resources in medical directorate to ensure standards and guidelines workload is taken forward. ▪ Rolling programme of specialty-specific information to Trust Board from April 2010

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
	Review of C&SC Governance operational systems and processes underway, including assessment against recommendations of Mid Staffordshire	Chief Executive	July 2010	Monthly progress report to SMT Governance
	Development of benchmarked clinical indicators via CHKS.	DP&R/Medical Director	June 2010	Monthly progress update to SMT Governance and bimonthly to Governance Committee
	Review of Specialty M&M system underway to ensure assurance in relation to service quality and safety	Medical Director	June 2010	Recommendations for SMT approval by June 2010
	Improvement Plan for clinical coding underway	DP&R	May 2010	Monthly performance reported to Trust Board

Section Two Moderate level Corporate Risks

There are a number of corporate risks which the Trust is currently managing successfully, however these risks need to remain in focus due to their potential impact. Examples of these are:

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Corporate/Cross Programme			
Human Resources **Rating Moderate**	Risk of non compliance with European Working Time Directive (EWTD).	Making best use of resources and providing safe, high quality care.	EWTD steering group has ensured compliance in the majority of medical specialties. HR leading work to identify and address EWTD issues for other service areas and staff groups.

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Moderate	• Actions plans being developed to address residual areas of non-compliance. • Regular meetings between HR and medical management to explore alternative solutions for compliance. • Derrogation for some specialties.	Director of HR	Bi-monthly	Ongoing

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Acute Directorate			
IMWH **Rating Moderate**	Capacity to deliver high quality standards of maternity care as defined by RQIA report.	Provide safe, high quality and effective care.	1. Action plan for final RQIA report in progress. 2. Temporary medical staff have been recruited to provide increased labour ward cover in DHH. 3. Continuing discussions with commissioners, NIMDTA regarding anaesthetic cover and other matters. 4. Monthly report to SMT. 5. Regular update to Trust Board

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Strong	Action Plan developed and under discussion with commissioner.	Director of Acute	Monthly update to SMT Governance	Ongoing

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Acute Directorate			
All Divisions **Rating Moderate**	Ongoing achievement of Access Targets and review appointments	1. Provide Safe, High Quality and Effective Care	• RVBL team established to 'cleanse' the lists of patients waiting, ensuring no duplication or incorrect recording of activity. • Specialist Nurses working in Consultation with relevant Consultants to screen urgent, and patients waiting the longest length of time. • Patients waiting since 2007 have had their Patient Centre letter on PAS downloaded, and appointment given if appropriate. • Vacant Outpatient sessions have been backfilled with Review Backlog patients, when Consultant available. • Heads of Service are meeting with Relevant Consultants and conveying current provision on a monthly basis

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Some Weaknesses	• Arranging additional clinics to target primarily Review Backlog patients- not feasible in current financial situation • Reduce the current number of new patients within Outpatient template, to increase the capacity of review patients- not feasible, as performance targets will then be breached. • Recruit additional Medical staff to address shortfall in capacity- not feasible in current financial situation.	Directors of Acute Services, Performance and Reform, Older People and Primary Care, Children and Young People, Finance, Mental Health and Learning Disability	Weekly	Weekly

OPPC Podiatry issues added 28 April 2010

Risk ID	Title / Description	Link to Corporate Objective / Value	Potential for Harm	Control Measures
Children and Young Peoples Directorate OPPC Directorate				
1467 **Rating Moderate**	Decontamination of dental instruments Decontamination of Podiatry instruments	1 provide safe, high quality care	Because of revised guidelines the Trust is not permitted to replace dental autoclaves. When an autoclave breaks down clinics have to be cancelled which impacts on capacity to meet targets. Exposure of patients accessing the service and staff working within the service to infection.	Vigilance by clinicians regarding equipment efficiency and use of instruments prior to treatment.

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Strong	Order for new autoclave stopped by DHSSPSNI. Estates have a case developed to bring servicing in house up to the required standard. **Use of a Central Decontamination Service for all Podiatry Re-usable Instruments -** This is the preferred option of choice and currently the only option that would enable the service to eliminate all decontamination and other potential risks. It is not possible to implement a change from local to central decontamination due to funding shortfalls and CSSD capacity constraints at this time.	Michelle Oliver Head of Podiatry Services	1st December 2009	Decontamination Committee

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Corporate/Cross Programme			
Rating Moderate	Carrying out of annual reviews of care plans (Statutory Requirement) for domiciliary placements and care home placements.	Provide safe, high quality and effective care.	

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Some Weaknesses	Group constituted to examine operational management of the annual review process. Group has met and given attention to those longest outstanding reviews in the first instance.	Assistant Director & Heads of Services	April 09	June 09
	Consideration being given to the establishment of a Permanent Placement Team.	Assistant Director & HOS	May '10	Sept '10

Section Three Low Level Corporate risks

There are a number of corporate risks which the Trust is currently managing successfully, these risks are categorised as low with a plan to reallocate to Directorate risk registers. Examples of these are:

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Corporate/Cross Programme			
Rating Low	Prevention and management of HCAI within the Trust	1. Provide Safe, High Quality and Effective Care	• Project structure in place, Strategic, Operational and Clinical Teams • HCAI Improvement plan in place and being implemented • Regular monitoring and reporting to SMT, Trust Board and key staff throughout organization • RCAs completed for all HCAIs(C Diff, MRSA bacteraemia and MSSA bacteraemia) and process for identifying and addressing root cause. • Hand hygiene campaign underway

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Strong	HCAI Improvement Plan	Medical Director/Operational Directors	Ongoing Review within specified timescales	Ongoing

Incorporates changes agreed by SMT Governance on 23rd November

Southern Health & Social Care Trust: Summary of Corporate Risks as at November 2011

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
No	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update (November 2011)**	**Lead Director**	**Status**
1	Achievement of PfA Access targets and review appointments to secure timely assessment and treatment • A number of inpatient/DC/OP waiting times significantly beyond access standards • Outreach specialties (oral surgery, ophthalmology, etc) not within control of Trust • Outpatient Reviews in a number of specialties significantly beyond clinical review timescales • Plain film X Ray reporting only maintained at current level of IRMER with unfunded additional capacity and no regional standard for areas appropriate for IRMER	• Bi-weekly reporting to SMT • Monthly reporting to Trust Board • Action plans in place for reductions in waiting times with associated business cases submitted for capacity gaps where defined/agreed. • Bids submitted for non-recurring funding on a quarterly basis • Performance meetings with RHSCB • Review backlog plan submitted to RHSCB • OP Review backlog action plan in place and being incrementally implemented. • Bids for additional capacity submitted and secured on a specialty basis • Bi-weekly reporting to SMT	• On-going work with RHSCB to agree capacity gaps and associated funding requirements • Qtr 3 and 4 non-recurring bid for additional resources submitted to HSCB • Business case for Team South Urology now approved (July 2011) • Consultant recruitment proceeding for establishment of local Ophthalmology service • Identification of IS support with HSCB for approval where no IH capacity exists and access times are now extending to almost 52 weeks. IS contracts placed for Orthopaedics, Ophthalmology, Oral Surgery and Scopes. • In house additional capacity utilised where possible within funding allocated Plain Film X Ray • IS and IHA utilised (but unfunded) to maintain reading of non-IRMER plain film X Rays at 28 days • RQIA draft Report Phase 1 Action Plan in progress. Phase 2 visit on 23 August 2011. No report received as yet. OP Review Backlog • RVBL Team established to cleanse lists • Specialist Nurses working with relevant consultants to screen urgent reviews and longest waiters	P&R/ Operational Directors	HIGH

Incorporates changes agreed by SMT Governance on 23rd November

			• Cutting plans being formalised to monitor steady reduction of review backlog waits in association with non-recurrent funding of in-house additional capacity		
2	Achievement of statutory functions/duties: Level of Unallocated Child Care Cases	• Weekly monitoring and review of numbers of unallocated cases and reports to AD • Monthly Priority 5 Report to DHSSPS and HSCB • Monthly reporting to Trust Board • Social work supervision and line management arrangements in place • Fortnightly reporting to the Chief Executive commenced September 2011 • RQIA Review action plans in place and being implemented • Workforce Strategy Group in place	• Participation in regional demand and capacity work (RHSCB leading) • Working regionally with RHSCB and other Trusts to develop 'threshold' standards • The Trust has received recurrent funding from HSCB to address unallocated cases. The Trust has started the recruitment process to establish a Court LAC Team that will deal with interim care proceedings cases, thus increasing the capacity within FIT to allocate Family Support Cases. • Template being developed by HSCB to monitor Trust reductions in unallocated cases.	CYP	HIGH
3	Achievement of statutory functions/duties: Level of OPPC Domiciliary clients Annual Reviews not completed	• Monthly monitoring of reviews undertaken by Head of Service/ADs.	• Domiciliary Care Reviews – exercise underway to scope the number of reviews carried out and those outstanding • An excel spreadsheet is in development that will provide staff with a live register of expected review dates for Residential and Nursing Home clients, as well as for domiciliary care reviews • Social work capacity and demand work underway to identify the long term requirements to manage the review process in a timely fashion	OPPC	MODERATE

Incorporates changes agreed by SMT Governance on 23rd November

			• Recruitment of additional temporary social work staff underway to provide additional resources to ensure the Trust reaches compliance with the expected annual review process		
4	Systems of assessment and assurance in relation to quality of Trust services Learning from Adverse Incidents, complaints and user feedback - lack of formal, embedded system of learning	• C&SC Governance Review completed and new structures and assurance reports being implemented • Update on implementation to Governance Committee on a quarterly basis • Governance Committee, SMT Governance Group and Governance Working Body in place and operating to agreed remit • Directorate, Division and Professional Governance Fora in place and reporting to SMT/ Governance Committee • CHKS comparative mortality benchmarking tool - contract in place and information extracted for governance information • Mortality Reports to Governance Committee • Chair/Chief Executive/Director/NED programme of visits in place and feedback to Chief Executive • For SAIs and appropriate level of AIs, investigation/RCA process embedded with reports	• Embedding of new Governance Structures/processes underway • Web-based incident reporting (on Datix) being rolled out – target date for full roll out 1.4.2012 • Review of Specialty M&M system completed. Implementation taking place • Management of Change process in place to minimise risk of this organisational change • Reviewing and revising Incident Policy and SAI Management Policy • Risk Management Policy to be reviewed by 2012 • Clinical and Quality indicator programme of work across Directorates • Director of Nursing report being developed • Medical Director developing proposals for establishment of Patient Safety Forum • Internal Audit of complaints and incidents planned for November 2011	CX	MODERATE

Incorporates changes agreed by SMT Governance on 23rd November

		to Director/SMT Governance to approve recommendations/ actions and ensure shared learning • Governance Committee SMT Governance, Governance Working Body, Divisional and Directorate Governance For a Professional Governance Fora Patient Experience Committee for shared learning			
5	Compliance with Standards and Guidelines • Need for full assessment of Trust position in relation to ALL guidelines issues and endorsed by DHSSPS and RHSCB • Identification where financial and service implications affect compliance and escalation of same to DHSSPS/RHSCB	• Following Governance Review, new system now in place for Clinical Guidelines • SMT Governance (monthly) and Governance Committee • Drugs and Therapeutics Committee (quarterly) • System of logging and monitoring standards and guidelines • SABS system in place for Safety Action Bulletins	• Need to ensure that all standards and guidelines are assessed in relation to compliance • Any received from 1 April 2010 system of assessment of compliance and reporting in place • All NICE guidelines and NPSA guidelines received from 1 January 2009 have been reviewed and any actions required are being taken forward. Any received prior to this date have not yet been reviewed as to level of compliance due to capacity and on-going demand – action underway to scope risk • Compliance report completed for Standards and Guidelines from 2010 • Review of SABS process map to ensure effective dissemination and management of Safety Action Bulletins	CX	**MODERATE**

Incorporates changes agreed by SMT Governance on 23rd November

6	Lack of compliance with RQIA recommendations in relation to the management of medicines management in domiciliary care	Risk management includes • Training programme for domiciliary care staff in place • Trust Medicines Management policy • Review of operational procedures • Induction training for new Dom Care Supervisors	• Issues with achievability of compliance have been raised with HSCB • Working Group in place • Operational guidance for domiciliary care staff to be finalised • Workshop arranged with IS providers to share best practice • Trust representatives on regional group	OPPC/DoN	HIGH
7	Insufficient capital to maintain and develop Trust estate to support service delivery and improvement	• MES prioritised investment plan agreed by Trust Board and shared with DHSSPS • Recent capital allocations have addressed highest priority risks and this process is on-going CRL also utilised where possible to address highest risk • Strategic development plans in place for major projects and business cases submitted for highest risk areas • Fire Safety Action Plan in place (see below) • High Voltage capacity limit on supply to Craigavon Area Hospital Identified (see below)	• On-going prioritisation and bidding process for capital in place • Fire Safety Action Plan in place and agreed to inform MES investment • Recommendations from RQIA hygiene inspection reports prioritised for CRL/Minor works where no other funding source available • £3,753k MES funding secured for 11/12 • Business case approved and 11/12 phased funding for CAH T1-4 secured • Business cases in development to address significant MES infrastructure issues requiring investment > £500k • Structural engineer reports commissioned for sites at higher risk to inform action plan	P&R	HIGH
8	Fire Safety and compliance with Fire Safety Regulations (NI) 2010	• Fire Safety Action Plan in place • Local Fire Safety Management Arrangements in place • Funding to resolve deficiencies – prioritised within MES - £600K allocated for 2010/11 & £1.3m for 2011/12	• Additional staff being recruited (at risk) to implement highest priorities on action plan including Fire risk assessments and fire audits • Staff training on-going • Fire Safety Action Plan in place and to be monitored quarterly • New methods for delivering mandatory fire training agreed and to be implemented and tested 2011/12	P&R	MODERATE

Incorporates changes agreed by SMT Governance on 23rd November

			• Programme of fire risk assessments and fire drill exercises in the hospitals are being carried out		
9	High Voltage capacity limit on electrical supply to CAH • Identified under MES scheme • Possible limit to expansion of service provision on the CAH site • Increased electrical demand on existing limited supply may exceed capability of supply	• All future development/ expansion of the estates is to be notified to Estate Services • Generator backup • Load shedding • Monitoring current demand	• Developing schemes with NIE on options for provision of increased supply capacity • Investigating funding streams with SOC to be submitted to HEIG November 2011	P&R	HIGH
10	HCAI	• Increased level of C.difficile April/May 11 picked up through monitoring systems • Action Plan in place • Dedicated ward opened • Action Plan for C Diff Public Inquiry Recommendations agreed and being implemented • Tailored package of actions to deal with Norovirus outbreak • Major focus on staff training • IV Peripheral Line project rolled out in August 2011	• Action plan being implemented and reported to SMT • Monitoring indicating that levels back to normal	Medical Director	MODERATE
11	Protection of Vulnerable Adults – inconsistencies in practice and issues with interagency working	• Lead Director and lead professional for Adult Safeguarding in place and Safeguarding Partnership Board/Forum/structures in place • Specialist Safeguarding Team to provide advice and support • Procedural guidance completed • Training to all managers	• Development of key interfaces underway • Intensive training programme for Investigation and Designated officers is underway • Workshops scheduled for the Autumn to roll out the Procedural Guidance • Taking forward the implementation of the Soscare Vulnerable Adults module to address our information	CYP	MODERATE

Incorporates changes agreed by SMT Governance on 23rd November

		• Report to Trust Board as part of Statutory Functions Reporting	requirements • Application to research department to examine decision making and thresholds within Adult Safeguarding has been successful. This research will now commence • Work ongoing with Community Information Department to agree a safeguarding dashboard report for presentation at directorate and SMT Governance meetings		
12	ID1971 Potential for harm to patients/clients/staff/visitors as LD/MH clients released from prison into the community including those on probation	• On-going liaison with PBNI and PPS • CX wrote to DHSSPSNI and NIO 10/9/09 to outline concern • Monthly review at MH/LD Governance meeting • Individual client specific control measures	• Meeting with Director Prison Health on 7/1/11 and a range of actions agreed • Trust currently reviewing recommendations from MoD case to identify any actions required • Risk summary being updated for sharing with NI courts & tribunals service with covering letter	MH&D	MODERATE
13	Implementation of new regional on-call arrangements. Risks in relation to disruption to services in the 'out of hours' period as a result of staff withdrawing from on-call rotas from 1.10.2011 due to the reduction in on-call payments. The following services are provided by staff who will experience the biggest reductions in on-call payments: • Social Work out of hours service • Pharmacy emergency duty • Radiography out of hours service	• Meetings with Directorates and HR are currently taking place to consider alternative ways of working for example, partial / full shifts, extended days, recruitment of staff to waiting lists where this is possible and appropriate in order to ensure cover can be provided during the out of hours period from October onwards. • JNCF standing agenda item for discussion with Trade Union colleagues • Director of Social Work & HR collated OOH Social Work information.	• Contingency arrangements are currently being explored. • SMT approved Project Structure for delivery of on-call implementation with Trade Union representation. • Involvement in regional discussions across Trusts to share experience / learning	CYP/ HR&OD	**MODERATE**

Incorporates changes agreed by SMT Governance on 23rd November

	• Laboratory out of hours service	• Director of Social Work & HR have issued letter to all co-ordinators. • Out Of Hours Project Team established in the Trust • Director involved in regional group chaired by Director of HSCB to review developments • Current Arrangements to remain in place until 2012			
14	Development of robust Business Continuity Planning arrangements	• Business Continuity Plans were developed in most Directorates in preparation for pandemic in 2009. • Performance management arrangements in place between PHA/HSCB and SH&SCT • Further development of plans for severe weather • Stock take undertaken • Engagement of Consultant	• Project Manager to be recruited to embed business continuity planning within the organization. • Business impact analysis and review of existing plans to be undertaken • To be reviewed monthly by Medical Director • To be reviewed monthly by SMT		**MODERATE**
15	Day of Industrial Action – 30th November 2011: - Failure to have in place contingency staffing arrangements - Delayed urgent appointments/procedures as a result of appointments having to be cancelled	• Ongoing discussions with Trade Union representatives locally • Ongoing regional discussions and principles agreed for strike action on 30.11.11	• Joint Management/Trade Union communiqué issued requesting that all Trade Union members notify their line manager as to whether they intend to take strike action • Impact on services following discussions with Trade Unions agreed re minimum staffing levels • For all services, where possible, appointments are not booked for 30.11.11 • Meetings with Management and Trade Union representatives scheduled to monitor ongoing impact of industrial action		**MODERATE**

Incorporates changes agreed by SMT Governance on 23rd November

CORPORATE OBJECTIVE 4: BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
16	Fully embedded appraisal system – lack of evidence of compliance	• Succession Planning - established and on-going • Evaluation • Governance – new arrangements in place and ongoing • KSF policy and monitoring system in place • Consultant appraisal policy and monitoring system in place	• KSF – Currently implementing • Supervision – combining staff supervision/KSF and PDP by September 2011 • Mandatory Training		**MODERATE**
CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES					
17	Achievement of financial balance in 2011/12 • In year • Recurring	• Financial Plan in place and agreed by Trust Board • BCBV Project structure • Contingency Plan for 2011/12 in place • Financial monitoring systems in place • Monthly report to SMT and Trust Board	• Month 6 position analysed and on target for year end break even (N/R) • Month 6 monitoring of recurrent plan showing satisfactory progress	DoF/ All	MODERATE
18	Management and monitoring of procurement and contracts – not compliant with best practice guidance	• Clarification required with respect to CoPE coverage and capacity. Issue raised with A McCormick July 2011 seeking regional way forward • Request for review of role/terms of reference of newly formed Social Care Procurement Unit to Regional Social Care Procurement Group and Regional Procurement Board	• Action plans in place to address weaknesses identified in IA reports with updates to SMT and Audit Committee • interim arrangements for improved support to monitoring and workplan for review of contracts documentation agreed to improve robustness of social care contract management &	DoPI/DoF/All	MODERATE

Incorporates changes agreed by SMT Governance on 23rd November

		• Interim approach for social care procurement agreed by SMT in absence of CoPE support including awareness training for Community Contracts Team and 'light touch' support/advice to ongoing procurements by COPE • Contracts management improvement group established and key actions formed • Bimonthly reporting to SMT	monitoring • Scoping exercise to commence to establish central database for all Trust contracts and recommend best way forward for contracts management arrangements. Recruitment of temporary staff to complete scoping exercise underway with appointments to be in place by December 2011. • Project Manager appointed October 2011 and due to commence in December 2011 • Trust has responded to draft recommendations of J. Allen Review of Procurement and awaits final recommendations of Procurement Policy		
19	Implementation of Business Systems Transformation Programme • Maintenance of existing services over the 12-18 month implementation period in light of the potential retention and morale impact on those staff to be displaced • Disruption to ongoing business resulting from the secondment of 26-30 staff to oversee the implementation	• The Trust has established an implementation structure • Engagement in regional process	• The Trust requires a clearly documented and communicated HR strategy outlining the options for those staff potentially displaced • Secure backfill staff with the appropriate skills and experience on a timely basis • The Trust may need to reschedule corporate priorities as the workload associated with the implementation increases		HIGH

Incorporates changes agreed by SMT Governance on 23rd November

Changes to Corporate Risk Register since September 2011 - date

Date	Decision taken at	Changes to Corporate Risk Register
28th September 2011	**SMT Governance**	Remove Corporate Risk 14 '**Decontamination of dental instruments and podiatry instruments'** from Corporate Risk Register Agreed addition of '**Implementation of Business Systems Transformation Programme'** to Corporate Risk Register. Risk assessments in relation to i) 'Lack of Business Continuity Plans' and ii) 'Industrial Action' to be considered at next SMT Governance meeting.
2nd November 2011	**SMT Governance**	Remove Corporate Risk 2 '**Alternative provision for clients placed in Southern Cross Care Homes'** from Corporate Risk Register Agreed addition of '**Business Continuity Plans' and 'High Voltage Infrastructure**' to Corporate Risk Register. Risk assessment in relation to Industrial Action to be considered at next SMT Governance meeting
9th November 2011	**SMT**	Agreed addition of '**Proposed Industrial Action on 30th November 2011**' to Corporate Risk Register
23rd November 2011	**SMT Governance**	Downgrade Corporate Risk 4 '**Systems of assessment and assurance in relation to quality of Trust services'** from high to moderate risk Remove Corporate Risk 13 '**Full compliance with RQIA Maternity Review recommendations'** and Corporate Risk 14 '**Implementation of RQIA recommendations from 'Independent Review of Reporting Arrangements for Radiological Investigations Phase 1'** from Corporate Risk Register

Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

to Governance Committee

4th December 2012

Summary of Corporate Risks as at November 2012

There are 18 Corporate Risks (6 high level and 12 moderate level) as agreed by the Senior Management Team on 28th November 2012

HIGH RISKS	* Corporate Objective	Risk Rating	Change to Status since April 2012
1. Ongoing achievement of PfA access targets and review appointments	1	HIGH	Unchanged
2. Achievement of statutory duties/functions - Level of Residential Home/Nursing Home/ Domiciliary Annual Reviews not completed	1	HIGH	⇧
- Care Management processes	1	HIGH	New risk added on 31.10.12
3. Insufficient capital to maintain and develop Trust estate (facilities, equipment etc) to support service delivery and improvement	1	HIGH	Unchanged
4. RQIA recommendations in relation to the supervision and administration of medication by Trust/independent agency domiciliary care workers, day care workers and Trust staff in Supported Living Accommodation and Residential Homes	1	HIGH	Unchanged
5. High Voltage capacity limit on electrical supply to Craigavon Area Hospital	1	HIGH	Unchanged
6. Implementation of Business Systems Transformation Programme	5	HIGH	Unchanged

MODERATE RISKS	* Corporate Objective	Risk Rating	Change to Status Since April 2012
7. Systems of assessment and assurance in relation to quality of Trust services	1	MODERATE	Unchanged
8. Compliance with Standards and Guidelines	1	MODERATE	Unchanged
9. Fire Safety	1	MODERATE	Unchanged
10. Asbestos – legal compliance with legislation	1	MODERATE	New risk added on 4.7.12
11. HCAI – risk to achievement of PfA target	1	MODERATE	Unchanged
12. Risk of harm to patients from water borne pathogens	1	MODERATE	New risk added on 2.5.12
13. Protection of Vulnerable Adults – inconsistencies in practice and Issues with interagency working	1	MODERATE	Unchanged

MODERATE RISKS	* Corporate Objective	Risk Rating	Change to Status Since April 2012
14. Implementation of new regional on-call arrangements	**1**	**MODERATE**	Unchanged
15. Robust Business Continuity Planning	**1**	**MODERATE**	Unchanged
16. Fully Embedded Appraisal system	**4**	**MODERATE**	Unchanged
17. Financial Balance – risk in 2012/13 that the Trust will not achieve financial balance in year and not meet requirement for £11m cash release	**5**	**MODERATE**	Unchanged
18. Management and monitoring of procurement and contracts	**5**	**MODERATE**	Unchanged

Note – Red font indicates the changes that have been made to the Register since September 2012

Corporate Objectives

1: Provide safe, high quality care.

2: Maximise independence and choice for our patients and clients.

3: Support people and communities to live healthy lives and improve their health and wellbeing.

4: Be a great place to work, valuing our people.

5: Make the best use of resources.

6: Be a good social partner within our local communities.

Southern Health & Social Care Trust: Summary of Corporate Risks as at October 2012

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
No	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update (November 2012)**	**Lead Director**	**Status**
1	Achievement of Priority for Action access targets and review appointments to secure timely assessment and treatment • A number of inpatient/day case/outpatient waiting times significantly beyond access standards (Acute and Mental Health areas) • Outreach specialties (oral surgery, ophthalmology, etc) not within control of Trust • Outpatient Reviews in a number of specialties significantly beyond clinical review timescales • Plain film X Ray reporting only maintained at current level of Ionizing Radiation Medical Exposure Regulations with unfunded additional capacity and no regional standard for areas appropriate for Ionizing Radiation Medical Exposure Regulations • A number of patients waiting beyond Allied Health Professions access target	• Bi-weekly reporting to Senior Management Team • Monthly reporting to Trust Board • Action plans in place for reductions in waiting times with associated business cases submitted for capacity gaps where defined/agreed. • Bids submitted for non-recurring funding on a quarterly basis • Performance meetings with Health and Social Care Board • Review backlog plan submitted to Health and Social Care Board • Outpatients Review backlog action plan in place and being incrementally implemented. • Bids for additional capacity submitted and secured on a specialty basis	• On-going work with Health and Social Care Board to agree capacity gaps and associated recurrent funding requirements. A number of Investment Proposal Templates (IPTs) submitted and others to be developed after notification of Commissioner intent to proceed. Offers now made by Health and Social Care Board for General Surgery, Gynaecology and AHP investment. • Quarter 3 and Quarter 4 bids for non recurrent funding submitted to Health and Social Care Board for all specialties with gaps with requirement to maintain access at March 2012 position by March 2013. Capacity increased both in-house and in Independent Sector. • Independent Sector contracts re-let for 2012/13 include mobile MRI capacity, Ophthalmology, Oral Surgery, Orthopaedics and Urology • Business case for Team South Urology approved (July 2011). 3 Urologists will be in post from November 2012. • Consultant recruitment for local Ophthalmology service successful with the lead post appointed. Out to recruitment for second Consultant post. In discussion with Co-operation and Working Together (CAWT) and Dublin North East. Future potential for small volume of long waits to flow to Dublin North East.	Performance and Reform/ Operational Directors	HIGH

			• In house additional capacity utilised where possible within funding allocated • Risks to maintaining March 2012 access position, including agreed backstops, highlighted at fortnightly Elective Performance meetings with Health and Social Care Board. Plain Film X Ray • Independent Sector and In-house additionality utilised (but unfunded) to maintain reading of non-Ionizing Radiation Medical Exposure Regulations plain film X Rays at 28 days • Phase 1 Action Plan in progress. Phase 2 report received and Action Plan developed. Action Plan sent by Chief Executive to Chief Medical Officer and Health and Social Care Board to seek clarification on timescales and process for regional actions. Response received, but no regional action yet. Outpatient Review Backlog • Whilst significant reduction in volume of review backlog achieved initially, the number of routine waits has shown an increasing trend in 2012 as the system continues to bring in significant volumes of in-house additional new patients to meet access targets. • Of the total waits, 66% of those waiting have only been waiting from 1 April 2012. • The longest waits remain in Urology and Ophthalmology • Work continues to cleanse lists and Specialist Nurses are working with		

			relevant consultants to screen urgent reviews and longest waiters • Cutting plans formalised to monitor steady reduction of review backlog waits in association with non-recurrent funding of in-house additional capacity • Trust anticipates a rolling backlog in reviews until recurrent demand /capacity gaps have been addressed.		
2	Achievement of statutory functions/duties: Care Management Processes. Risk includes: • Level of Older People and Primary Care Residential Home/Nursing Home/Domiciliary clients Annual Reviews not completed. • The Trust should have robust care management communication processes in place and an assurance through audit that staff are appropriately undertaking these functions, including a clear understanding of the relative roles and responsibilities of the Trust's professional staff, contracts and finance functions, and clarity about the roles and responsibilities of RQIA and the Office and Care and Protection within the Care Management process.	• Monthly monitoring of reviews undertaken by Head of Service/Assistant Directors • Group established to examine operational management of the annual review process • Audit of Care Management on-going within Mental Health & Disability Services. Stage 1 re reviews completed. Stages 2 and 3 re processes and quality of reviews ongoing	• Domiciliary Care Reviews – exercise underway to scope the number of reviews carried out and those outstanding. 67% of all reviews completed at end of September 2012. 33% have been waiting longer than a year to have their reviews carried out • A Cutting Plan is being agreed to recover the backlog in Annual Reviews. • Development of an excel workbook in place for 100% of clients to provide staff with a live register of review dates for Residential and Nursing Home clients, as well as for domiciliary care reviews. • Social work capacity and demand work paper has been presented and additional capacity has been identified and all staff have commencement dates. Further capacity and demand work has been undertaken in the Memory Services and is in final draft. • Additional temporary social work staff remain in post to ensure the Trust reaches compliance with the expected annual review process. The outcome of the capacity and demand work will inform future staffing levels.	Older People and Primary Care	**HIGH**

			• Permanent Placement Team in process of establishment. This team will be established during the 2012/13 period. The service model will be developed to carry out reviews for all clients in Nursing/Residential Homes and contract reviews etc. • Older People & Primary Care Services/Mental Health and Disability Services/ /Contracts and Finance are to conduct a Review of Care Management processes which will include roles & responsibilities (internally & externally) . Membership from RQIA has been requested for this working group. • A letter will be issued to all care management staff reminding them of the requirements relating to care management including assessments, monitoring and taking action proportionate to assessed levels of risk. The letter will request that staff ensure that they continue vigilance in monitoring residents' expenditure in Residential /Nursing Home and Supported Living, pending the outcome of the cross Directorate review and implementation of recommendations. • Adult Safeguarding Team to consider further targeted vulnerable adults training for those staff in care management and involved in annual reviews.		

3	Systems of assessment and assurance in relation to quality of Trust services	• Clinical and Social Care Governance Review completed and new structures and assurance reports being implemented • Update on implementation to Governance Committee on a quarterly basis • Governance Committee, Senior Management Team and Governance Working Body in place and operating to agreed remit • Directorate, Division and Professional Governance Fora in place and reporting to Senior Management Team/ Governance Committee • Caspe Healthcare Knowledge Systems (CHKS) comparative mortality benchmarking tool - contract in place and information extracted for governance information • Review of Specialty Mortality and Morbidity system completed. • Mortality Reports to Governance Committee • Chair/Chief Executive/Director/Non Executive Director programme of visits in place and feedback to Chief Executive • Serious Adverse Incident/Adverse Incident reporting system in place	• New Governance structures/processes embedded • Web-based incident reporting (on Datix) rolled out across the Trust • Reviewing and revising Incident Policy and Serious Adverse Incidents Management Policy • Risk Management Policy to be reviewed by October 2012 • Clinical and Quality indicator programme of work across Directorates • Executive Director of Nursing report to Trust Board in November 2012 showing performance against Nursing Quality Indicators (NFIs) • Executive Director of Nursing report on Allied Health Professions Quality Indicators to Governance Committee in December 2012 • Internal Audit of complaints completed and a satisfactory level of assurance achieved • Internal Audit of incidents completed and a satisfactory level of assurance achieved • Governance Working Body in place and meeting regularly. Priority strategic areas agreed and work underway	Chief Executive	MODERATE

	Learning from Adverse Incidents, complaints and user feedback - lack of formal, embedded system of learning	• For Serious Adverse Incidents and appropriate level of Adverse Incidents, investigation/Root Cause Analysis process embedded with reports to Director/Senior Management Team Governance to approve recommendations/actions and ensure shared learning • Governance Committee Senior Management Team, Governance Working Body, Divisional and Directorate Governance Fora, Professional Governance Fora, Patient and Client Experience Committee for shared learning	• 4 issues arising from Serious Adverse Incidents brought to Governance Working Body on 20th January 2012 and being taken forward for organisational learning. Governance Committee updated on progress in September 2012. • National Early Warning System (NEWS) implemented on 1st August 2012 in adult in-patient settings within Acute and Older People and Primary Care. Progress report on implementation to Trust Board on 30th August 2012 • Reviewing and revising Incident Policy and Serious Adverse Incidents Management Policy		
4	Compliance with Standards and Guidelines (S&G) • Due to the volume/ complexity of new S&G being issued to the Trust by external agencies, it is a challenge for the Trust to also monitor and review the compliance status of those S&G that have already met full compliance in order to ensure that this is maintained. Since 1st January 2012, a total of 172 new standards and guidelines have been regionally endorsed from a range of different external agencies. . The Trust register now indicates a total of 350 standards have been issued since 01/04/2012.	• Establishment of six monthly performance/accountability reports for standards and guidelines. • Standard item for discussion at SMT (monthly) and Governance Committee with submission of relevant reports / assurance statements • Standard item for discussion at the Directorate Governance meetings with submission of relevant reports • For those that are 'pharmacy' related a compliance report is also presented by the Trust's Medicines Governance Pharmacist to the Operational Directors and members of the Drug and Therapeutics Committee on a quarterly basis.	• The SABS process map to ensure effective dissemination and management of Safety Action Bulletins was presented and agreed at SMT on 10/10/12. These new processes will be implemented with effect from 01/11/2012. • Following the establishment of Standards and Guidelines Risk Assessment and Prioritisation Group in April 2012 a total of 137 newly issued S&G have been reviewed and managed through the new corporate process. • A BSO graduate intern has been appointed to the Patient Safety & Quality service from 08/10/2012 on an initial 6 month placement. The primary function of this post is to identify all standards that have been issued prior to April 2010 and determine a risk	Chief Executive	**MODERATE**

	• There is often a time lag between when the external agencies require the Trust to achieve full compliance and when this is actually achieved • Standards and guidelines that have been regionally endorsed prior to January 2009 have not been reviewed / managed in line within the Trust's new assurance processes and as a consequence the level of compliance / required action has not been identified for each. • Since 5th April 2012, the Patient Safety and Quality Service has continued to carry a Band 5 vacancy and this has significantly impacted on service capacity. This post has been approved in October 2012 and will now be advertised.	Last report presented on 27/09/2012. • Database has been established and there is system of logging and monitoring standards and guidelines • SABS system in place for Safety Action Bulletins	based approach for ensuring that these are effectively implemented within the organisation and that an assurance framework is in place. • As part of the 2012/13 Internal Audit programme the effectiveness of the corporate process for managing Standards and Guidelines is to be audited and reported on • Meetings have been held with the Trust's ITS Programme Management Team to determine how best to integrate the existing standards and guidelines database into the Trust's *Datix* safety module. A work plan has been established to take this work forward over the next 6 months.		

5	Lack of compliance with RQIA recommendations in relation to the supervision and administration of medication by Trust/independent agency domiciliary care workers, day care workers and Trust staff in Supported Living Accommodation and Residential Homes	Risk management includes • Training programme for domiciliary care staff in place – all staff have received medicines management training by November 2010 • Refresher training underway by Sept 2012 (without competency assessment - OSCE) • Trust Medicines Management policy • Medicines Management Steering Group • Review of operational procedures • Induction training for new Domiciliary Care Supervisors all of whom have now received medicines management training • SH&SCT and RQIA Incident reporting systems in place • Workshop held with Independent Sector Providers • Draft educational and competency framework rolled out to support the delivery and management of training of all Trust domiciliary care workers, day centre and social education centre staff • Risk assessment for transcribing completed • Transcribing procedure developed and implemented • Transcribing training carried out in Day Care, Supported Living and Residential Care	• Issues with achievability of compliance have been raised with the Health and Social Care Board • Trust draft Operational Procedures regarding medicines management for domiciliary care workers to be reviewed following meeting with Director of Older People and Primary Care and Director of Mental Health and Disability Services • Implement interim guidelines for commissioners of domiciliary care services until Trust operational procedures are agreed. Guidance developed, but not yet fully implemented due to Commissioners continuing to work to local/legacy arrangements and a delay in regional workstreams in relation to the production of a pharmacy produced medication administration record. • Trust representatives on regional group. No meeting since 2011. Trust staff to contribute to Health and Social Care Board regional workstreams when they are re-established. • Transcribing competency assessments to be carried out by trained nominated staff for day care, supported living and residential care.	Older People and Primary Care/ Executive Director of Nursing	HIGH

6	Insufficient capital to maintain and develop Trust estate to support service delivery and improvement	• Maintaining Existing Services prioritised investment plan agreed by Trust Board and shared with Department • Recent capital allocations have addressed highest priority risks. This process is on-going. Capital Resource Limit also utilised where possible to address highest risk • Strategic development plans in place for major projects and business cases submitted for highest risk areas • Fire Safety Action Plan in place (see below) • High Voltage capacity limit on supply to Craigavon Area Hospital Identified (see below)	• On-going prioritisation and bidding process for capital in place • Fire Safety Action Plan in place and agreed to inform Maintaining Existing Services investment • Recommendations from RQIA hygiene inspection reports prioritised for Capital Resource Limit/Minor works where no other funding source available • £2.1m Maintaining Existing Services funding secured for 2012/13 • Craigavon Hospital Theatres1-4 in progress and to be completed by November 2012 • Business cases in development to address significant Maintaining Existing Services infrastructure issues requiring investment > £500k including c.£2.2m for structural works to tower block at South Tyrone Hospital • Structural engineer reports commissioned for sites at higher risk to inform action plan	Performance and Reform	HIGH
7	Fire Safety and compliance with Fire Safety Regulations (NI) 2010	• Fire Safety Action Plan in place and to be monitored quarterly • Local Fire Safety Management Arrangements in place • Funding to resolve deficiencies – prioritised within Maintaining Existing Services • Approximately £1.2 million was invested in 2011/12 to improve fire safety by upgrading the fire alarm systems in Craigavon Area Hospital, Rathfriland and Warrenpoint Health Centres, construction of escape bed lifts in Craigavon and Lurgan Hospitals, upgrading fire hydrants at Daisy Hill and	• Additional staff have been recruited to implement highest priorities on action plan including Fire risk assessments and fire audits • Staff training on-going • New methods for delivering mandatory fire training agreed and to be implemented and tested 2012/13 • Programme of fire risk assessments and fire drill exercises in the hospitals are being carried out • Initial Firecode funding allocation from Maintaining Existing Services for 2012/13 c. £500k to be directed to next highest priority risks and further funding continues to be sought	Performance and Reform	MODERATE

		Craigavon Hospitals and the construction of a bin store at Craigavon Area Hospital to remove fire loading from the basement	• Update on Fire Safety Action plan to Trust Board in November 2012 as part of Estates Annual Report		
8	High Voltage capacity limit on electrical supply to Craigavon Area Hospital • Identified under Maintaining Existing Services scheme • Possible limit to expansion of service provision on the Craigavon Area Hospital site • Increased electrical demand on existing limited supply may exceed capability of supply	• All future development/ expansion of the estates is to be notified to Estate Services • Generator backup • Load shedding • Monitoring current demand • Business Continuity Plans for restabilising electrical service in the event of unplanned interruption	• Developing schemes with Northern Ireland Electricity on options for provision of increased supply capacity. • Independent experts appointed to provide Infrastructure condition report and inform plans for new High Voltage/Low Voltage infrastructure • Mechanical Infrastructure and Electrical Infrastructure Business Cases are being progressed in parallel as both Combined Heat and Power (within Mechanical) and new High Voltage intake (within electrical) Strategic Outline Case are required to manage the onsite risk. • Peak Lopping is progressing following agreement with Northern Ireland Electricity • Phase 1 business case for Low Voltage works to provide short-term mitigation for risks approved in June 12 for £2.5m spend in year.	Performance and Reform	HIGH
9	Asbestos and compliance with Control of Asbestos (N.I.) 2007 • Risk of exposure to asbestos by being unable to identify existing asbestos across all Trust property and from lack of a unified/single asbestos management plan.	• Estates Services Asbestos Management Group • Asbestos Policy in place • Revised Asbestos Management Procedures in place • Refurbishment and Demolition Surveys performed when significant work is required on any facility older than 2000 • Asbestos Registers in two legacy systems plus one on-line system	• Re-survey Armagh and Dungannon and Craigavon and Banbridge Estate and develop an integrated Trust Asbestos Management Plan for complete Trust Estate. • One year's management inspections integrated into the Trust's existing Asbestos Register.	Performance and Reform	**MODERATE**

10	HCAI • Risk to achievement of Priorities for Action target identified	• Dedicated isolation ward on Craigavon Area Hospital site • Comprehensive isolation policy in place and strictly adhered to • Ongoing mandatory and tailored training • Comprehensive governance structure in place, including bi-monthly Strategic Forum and fortnightly Clinical Forum • Outbreak /incident management plan in place • Independent and self-audit programme in place • Extensive action plans in place to deal with trends/prevalent HAIs • Antibiotic stewardship • Root Cause Analysis process in place	• Compliance with DHSSPS Board to Ward assurance • Further development of independent audit functions • Ongoing measurement of compliance against DHSSPS Communiqués including Independent Review of Pseudomonas • Measurement of compliance against NICE - Prevention & Control of HCAI - Quality Improvement Guide on-going. • Revision and re-launch of Trust Root Cause Analysis process for HCAI's	Medical Director	MODERATE
11	Risk of harm to patients from water borne pathogens (i.e. legionella, pseudomonas)	• Water Safety Group in place • Revised Legionella policy and procedures in place • Compliance with PHA and HEIG guidance: HSS(MD)6/12 - Water sources and potential for pseudomonas aeruginosa infection from taps and water systems • Legionella risk assessments, sampling and monitoring regime in place (as per L8, PHA & HEIG), results analysed, appropriate action taken as required • Pseudomonas sampling and monitoring regime in place in Neonatal Unit and Special Care Baby Unit; in progress in augmented care	• Water safety plan approved by Trust Board • Installing a trial system for copper sliver ionisation of Ramone Building water system • Extension of legionella testing areas • Consideration of opportunities to increase automated water temperature and flow monitoring • Review resources needed to manage water quality systems (Microbiology, IPC and Estate Services) and identify to Department of Health, Social Services and Public Safety as part of an overall organisational assessment of the unfunded impact of meeting standards and guidelines.	Director of Performance & Reform/ Medical Director	MODERATE

		• IPC guidance on environmental cleaning developed and rolled out (sinks, equipment, etc.) • Infection prevention and control guidance and procedures are continuously reviewed, modified and issued to address emerging risks • Infection prevention and control audit programme and implementation of appropriate actions based on findings • On-going staff education programme highlighting risks of water borne pathogens • Design of water systems within care facility/environment; attention is given to designing system that will reduce the likelihood of propagation of water borne pathogens			
12	Protection of Vulnerable Adults – inconsistencies in practice and issues with interagency working	• Lead Director and lead professional for Adult Safeguarding in place and Safeguarding Partnership Board/Forum/structures in place • Specialist Safeguarding Team to provide advice and support • Procedural guidance completed • Training to all managers • Report to Trust Board as part of Statutory Functions Reporting • Director of Social Work Report to Trust Board	• Development of key interfaces underway • The majority of staff across directorates now trained in the Soscare Vulnerable Adults module. • All Vulnerable Adults referrals now captured on Soscare with the referrals within the first 4 months of the year to be backdated on the system by 31.3.13. • Adult Safeguarding Dashboard Report became operational in July 2012. Trust wide summary report is sent to the Executive Director of SW and specific divisional/directorate reports sent to HOS and governance leads.	Children and Young People's Services	MODERATE

			• Adult safeguarding research commenced in July 2012. On target for completion date of 31st December 2012. Learning from the research will then be disseminated throughout the Trust. • Trust Adult Safeguarding Policy to Policy and Records Committee in September 2012 for approval. • Delegated Statutory Functions Action Plan to Trust Board in November 2012.		
13	Implementation of new regional on-call arrangements. Risks in relation to disruption to services in the 'out of hours' period as a result of staff withdrawing from on-call rotas from 1.10.2011 due to the reduction in on-call payments. The following services are provided by staff who will experience the biggest reductions in on-call payments: • Social Work out of hours service • Pharmacy emergency duty • Radiography out of hours service • Laboratory out of hours service	• Meetings with Directorates and Human Resources are currently ongoing to consider alternative ways of working for example, partial / full shifts, extended days, recruitment of staff to waiting lists where this is possible and appropriate in order to ensure cover can be provided during the out of hours period. • Joint Negotiating and Consultation Forum (JNCF) standing agenda item for discussion with Trade Union colleagues • Director of Social Work & Human Resources collated Out of Hours Social Work information. • Director of Social Work & Human Resources issued letter to all co-ordinators with regular update meetings with the Co-ordinators. • The Regional Out of Hours Review Group has been established of which Trust	• The Trust has been participating in the Regional group to plan for the new service model. Timelines for action are being met and the DHSSPS have agreed an extension of the current on-call rates until 30.9.12. • Regional Group has met on a number of occasions since January 2012. A regional contingency plan for a period of four months (October 2012 to January 2013) will be required until the new regional service commences on 1st February 2013. • Discussions are currently ongoing with NIPSA and the staff affected regarding the contingency arrangements • Options have been explored for shift systems in Radiography and Laboratory. A shift system is now operational in Radiography in DHH and CAH from 1st October 2012. In relation to Laboratory, discussions are ongoing in relation to seeking agreement in relation to shift system to be introduced once there are sufficient new staff trained, however, in the interim, the on-call circular has been applied to this service from 1st	Children and Young Peoples' Services/ Human Resources	**MODERATE**

		Directors are members. The Project Initiation Document (PID) has been developed and agreed by the Project Board (comprising Executive Directors of Social Work and the Director of HSCB • Collectively Trusts are seeking an extension to the implementation of the proposed new service arrangements • Social Work staff who are willing to continue on the Out of Hours rota beyond 31.03.2012 will receive current on-call payments • Out of Hours Project Team established in the Trust .	October 2012. • Agreement has been reached in Pharmacy in relation to the implementation of the on-call circular and implemented from October 2012. • Previous difficulties in relation to the hyperbaric chamber on-call have been worked through and arrangements are being finalised during September in relation to the implementation of the on-call circular to both nursing and technical staff.		
14	Development of robust Business Continuity Planning arrangements	• Business Continuity Plans were developed in most Directorates in preparation for pandemic in 2009. • Performance management arrangements in place between Public Health Agency/ Health and Social Care Board and Trust • Further development of plans for severe weather • Stock take undertaken • Engagement of Consultant • Business Continuity Management Policy • Progress reports provided on a monthly basis by the Business Continuity Manager to the Medical Director • Updates provided to Senior Management Team via Medical Director's report and Governance Committee	• Temporary Business Continuity Project Manager has been working with Directors and their staff to identify key time critical services • Business Continuity Manager currently working with Directorate staff to undertake departmental level business impact analyses which will assist with the review/update of the existing suite of continuity/contingency plans for each service in line with the BS25999	Medical Director/ Operational Directors	**MODERATE**

CORPORATE OBJECTIVE 4: BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
15	Fully embedded appraisal system – lack of evidence of compliance	• Succession Planning - established and on-going. Band 7 Programme 'Breaking Through'being finalised • Evaluation • Governance – new arrangements in place and ongoing • Knowledge and Skills Framework (KSF) policy and monitoring system in place • Consultant appraisal policy and monitoring system in place • Mandatory Training	• Personal Development Plans received from over 44% of staff. Directorate aligned Support Staff (from HR)have been meeting with teams and demonstrating the documentation as well as encouraging team leaders to apply the policy fully in their area of responsibility and send the completed PDPs to HR for the record. • Supervision – combining staff supervision/KSF and PDP • E-learning Policy approved by SMT in September 2012 • E-Learning packages for Moving and Handling, Safeguarding, Infection Prevention & Control, Food Safety and COSHH completed. Fire Safety and Waste Management packages almost completed • Basic ICT Skills training roll-out September-December 2012	Human Resources	**MODERATE**
CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES					
16	Achievement of financial balance in 2012/13 to include requirement for £11m cash release • In year • Recurring	• Contingency Plan for 2012/13 in place • Best Care Best Value (BCBV) Project structure • Financial monitoring systems in place • Monthly report to SMT and Trust Board	• Trust Delivery Plan, including 2012/13 financial plan, approved by Health and Social Care Board in June 2012.	Finance and Procurement/ All	MODERATE

	Financial impact of Transforming Your Care	• Transforming Your Care (TYC) project leads in place in all Directorates to take forward implementation of priority projects in key workstreams. • Trust BCBV project structure supported by shared Trust/ Local Commissioning Group accountability arrangements through Southern Health Economy Population Plan (SHEPP) Programme Board.	• Initial Draft population plan including indicative financial plans for the period to March 2015 submitted on 22nd June 2012. • Financial Plan for 2013/14 and 2014/15 submitted to HSCB on 23rd November 2012.		
17	Management and monitoring of procurement and contracts – not compliant with best practice guidance	• Clarification required with respect to Centre of Procurement Excellence coverage and capacity. Issue raised with A McCormick July 2011 seeking regional way forward • Interim approach for social care procurement agreed by Senior Management Team in absence of Centre of Procurement Excellence support including awareness training for Community Contracts Team and 'light touch' support/advice to ongoing procurements by Centre of Procurement Excellence • Contracts management improvement group established and key actions formed • Bimonthly reporting to SMT	• Action plans in place to address weaknesses identified in Internal Audit reports with updates to Senior Management Team and Audit Committee • Interim arrangements for improved support to monitoring and workplan for review of contracts documentation agreed to improve robustness of social care contract management and monitoring • Project Team in place to undertake scoping exercise to establish central database for all Trust contracts and assess risks associated with current contract management arrangements • Initial reports providing a summary position on procurement status/risk at Directorate level have been issued by scoping team • New guidance on Single Tender Action (STA) processes issued and implemented • Trust has responded to draft recommendations of J. Allen Review of Procurement. Final recommendations of Procurement Policy awaited	Performance and Reform/ Finance/All	MODERATE

			• Trust to bring forward proposals to Regional Social Care Procurement Group to address procurement deficiencies in social care		
18	Implementation of Business Systems Transformation Programme • Maintenance of existing services over the 12-18 month implementation period in light of the potential retention and morale impact on those staff to be displaced • Disruption to ongoing business resulting from the secondment of 26-30 staff to oversee the implementation • Disruption to transaction processing/quality of management information/financial forecasting and achievement of financial duties Shared Services	• The Trust has established an implementation structure • Engagement in regional process	• Human Resources strategy outlining the options for those staff potentially displaced • Secure backfill staff with the appropriate skills and experience on a timely basis • The Trust may need to reschedule corporate priorities as the workload associated with the implementation increases • The Trust continues to prepare itself for FPL implementation on December 17, and has not experienced any local or regional difficulties which would result in a project abort or postponement • The Human Resources Payroll, Travel and Subsistence (HRPTS) side continues to face delays and contractual difficulties. It is expected that this side of the implementation will be delayed for up to six months. There will be a knock-on effect on shared service implementation. • Efforts being renewed to secure suitable employment opportunities within the Trust for displaced staff and to maximize the potential for staff to stay with their current function until replacement systems are tried, tested and in place • Assurance to be sought from BSO that all functions will be maintained throughout the period of transition	Human Resources/ Finance	HIGH

Changes to Corporate Risk Register since April 2012 to date

Date	Decision taken at	Changes to Corporate Risk Register
2nd May 2012	**SMT**	Agreed to separate out risk of harm to patients from water borne pathogens from HCAI risk and include on Corporate Risk Register as moderate risk.
4th July 2012	**SMT**	Agreed addition of risk of exposure to asbestos fibres from work activities on or near asbestos containing materials within Trust facilities to Corporate Risk Register as moderate risk. Risk assessment on 'Lack of compliance with RQIA recommendations in relation to the management of medicines management in domiciliary care' discussed. Risk assessment to be reviewed by Trust Medicines Management by Non Nursing Staff in the Community Steering Group on 23rd July 2012 and update to be provided to next SMT.
5th September 2012	**SMT**	Review of risks and updates received for a number of risks. Agreed removal of Corporate Risk No. 2 '**Level of unallocated child care cases'** – will be managed as Directorate risk issue. Agreed to escalate 'Level of Residential Home/Nursing Home/Domiciliary Annual Reviews not completed' from moderate to high risk.
31st October 2012	**SMT**	Under Corporate Risk No. 2 '**Achievement of statutory duties/functions,** agreed to include additional risk on the robustness of care management processes.
28th November 2012	**SMT**	Review of risks and updates received for a number of risks.

Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

to Governance Committee

3rd December 2013

Reviewed by SMT on 27th November 2013 1

Summary of Corporate Risks as at November 2013

There are 17 Corporate Risks (8 high level and 9 moderate level) as agreed by the Senior Management Team

Note – Red font indicates the changes that have been made to the Register since September 2013

Risk No.	HIGH RISKS	* Corporate Objective	Risk Rating	Change to Status since January 2013
1.	Ongoing achievement of PfA access targets and review appointments	**1**	**HIGH**	Unchanged
2.	Achievement of statutory duties/functions - Level of Residential Home/Nursing Home/ Domiciliary Annual Reviews not completed	**1**	**HIGH**	Unchanged
6.	Insufficient capital to maintain and develop Trust estate (facilities, equipment etc) to support service delivery and improvement	**1**	**HIGH**	Unchanged
8.	High Voltage capacity limit on electrical supply to Craigavon Hospital	**1**	**HIGH**	Unchanged
10.	High Pressure Hot Water System	**1**	**HIGH**	New risk added on 27.03.13
13	Accreditation status of Laboratory, Craigavon Area Hospital	**1**	**HIGH**	New risk added on 26.06.13
15	Financial Balance – risk in 2013/14 that the Trust will not achieve financial balance in year	**5**	**HIGH**	⇧
17.	Implementation of Business Systems Transformation Programme	**5**	**HIGH**	Unchanged

Risk No.	MODERATE RISKS	* Corporate Objective	Risk Rating	Change to Status Since January 2013
3.	Achievement of statutory duties/functions: Care Management processes	1	MODERATE	⇩
4.	Systems of assessment and assurance in relation to quality of Trust services	1	MODERATE	Unchanged
5.	Compliance with Standards and Guidelines	1	MODERATE	Unchanged
7.	Fire Safety	1	MODERATE	Unchanged
9.	Asbestos – legal compliance with legislation	1	MODERATE	Unchanged
11.	HCAI	1	MODERATE	Unchanged
12.	Risk of harm to patients from water borne pathogens	1	MODERATE	Unchanged

Risk No.	MODERATE RISKS	* Corporate Objective	Risk Rating	Change to Status Since January 2013
14	Fully Embedded Appraisal system	**4**	**MODERATE**	Unchanged
16	Management and monitoring of procurement and contracts	**5**	**MODERATE**	Unchanged

Corporate Objectives

1: Provide safe, high quality care.

2: Maximise independence and choice for our patients and clients.

3: Support people and communities to live healthy lives and improve their health and wellbeing.

4: Be a great place to work, valuing our people.

5: Make the best use of resources.

6: Be a good social partner within our local communities.

Southern Health & Social Care Trust: Summary of Corporate Risks as at November 2013

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
No	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update (November 2013)**	**Lead Director**	**Status**
1	Achievement of Priority for Action access targets and review appointments to secure timely assessment and treatment • A number of inpatient/day case/outpatient waiting times beyond access standards/targets (Acute,OPPC and Mental Health areas) • Outreach specialties (oral surgery, ophthalmology, etc) not within control of Trust • Outpatient Reviews in a number of specialties significantly beyond clinical review timescales • Plain film X Ray reporting only maintained at current level of Ionizing Radiation Medical Exposure Regulations with unfunded additional capacity and no regional standard for areas appropriate for Ionizing Radiation Medical Exposure Regulations	• Bi-weekly reporting to Senior Management Team • Monthly reporting to Trust Board • Action plans in place for reductions in waiting times with associated business cases submitted for capacity gaps where defined/agreed. • Fortnightly Elective Performance meetings with Health and Social Care Board • Outpatients Review backlog action plan in place and being incrementally implemented. • Identification of capacity gaps to HSCB for non recurrent funding for additional capacity on a specialty basis	• On-going work with Health and Social Care Board to agree capacity gaps and associated recurrent funding requirements. A number of Investment Proposal Templates (IPTs) submitted and others to be developed after notification of Commissioner intent to proceed. Offers now made by Health and Social Care Board for General Surgery, Gynaecology and ENT investment. Ongoing discussion regarding level of funding proposed. • Engagement with Health and Social Care Board on Quarter 3 and Quarter 4 bids for non recurrent funding for all specialties with gaps with requirement to maintain access at March 2013 and improve in accordance with Commissioning Plan targets for 2013/14 position by September 2013. Capacity increased both in-house and in Independent Sector (IS). • Independent Sector contracts rolled over into 2013/14 for Ophthalmology, Orthopaedics, Gynaecology and new contracts being procured for Ophthalmology, Orthopaedics, General Surgery, Pain Management, Urodynamics, Mobile MRI and Mobile Catherisational Laboratory capacity • Business case for Team South Urology approved (July 2011). 3 Urologists are now in post. • Consultant recruitment for local Ophthalmology service successful with the lead post appointed.	Performance and Reform/ Operational Directors	HIGH

			• In house additional capacity utilised where possible within funding allocated • Non-recurrent Recovery plans developed for AHP services – with Commissioner support secured Plain Film X Ray • Independent Sector and In-house additionality utilised (but unfunded) to maintain reading of non-Ionizing Radiation Medical Exposure Regulations plain film X Rays at 28 days • Phase 1 Action Plan in progress. Phase 2 report received and Action Plan developed. Action Plan sent by Chief Executive to Chief Medical Officer and Health and Social Care Board to seek clarification on timescales and process for regional actions. Response received and regional group now convened. • Proposal developed to extend range of x-rays read by Radiographers to be submitted to Commissioner with repeated request for recurring funding for Independent Sector additionality (see above). Current costs of £14K per month Outpatient Review Backlog • Whilst significant reduction in volume of review backlog achieved initially in the number of routine waits in Q3 and 4 of 2011/12, there has been an increasing trend in 2012/13 as the system continues to bring in significant volumes of in-house additional new patients to meet access targets.		

			• Trust anticipates a rolling backlog in reviews until recurrent demand/ capacity gaps have been addressed. • Of the total waits, <5% have been waiting from before 1 April 2012 with the longest waits, dated from the 2010/11 year, relating to urology. • Work continues to cleanse lists and Specialist Nurses are working with relevant consultants to screen urgent reviews and longest waiters • Whilst some funding has been provided in 2012/13 to address review backlog, capacity to put in the place the additional capacity required is limited by availability in specialties that have capacity gaps and require to utilise capacity to maintain access times for new referrals also. • Health and Social Care Board has agreed funding to address review consequences of new in-house additional capacity being delivered in 2013/14 for Quarters 1 and 2 of 2013/14. No decisions have been made in relation to Quarters 3 and 4		
2	Achievement of statutory functions/duties: • Level of Older People and Primary Care Residential Home/Nursing Home/Domiciliary clients Annual Reviews not completed.	• Monthly monitoring of reviews undertaken by Head of Service/Assistant Directors • Group established to examine operational management of the annual review process • Delegated Statutory Functions Report • Monthly reporting to Trust Board (from August 2013) • Annual meeting with Heath & Social Care Board Director of Social Care/Children's Services and follow up of action plan	• Domiciliary Care Reviews – monthly reporting exercise underway to identify the number of reviews carried out and those outstanding. • Reviews completed by 31/10/2013: Domiciliary Care: 83% Nursing Homes –84% Residential Homes –89% Overall completion rate –83% 17% have been waiting longer than a year to have their reviews carried out • Primary Target List process in place to monitor completion of reviews. Designated management focus on reviews and utilisation of staff across all localities	Older People and Primary Care	**HIGH**

			• Care Home Support Team (Permanent Placement Team) in process of establishment. This team will commence in January 2014. The service model will be developed to carry out reviews for all clients in Nursing/Residential Homes and contract reviews etc. • Adult Safeguarding Team to consider further targeted vulnerable adults training for those staff in care management and involved in annual reviews.		
3	Achievement of statutory functions/duties: • Care Management processes. The Trust should have robust care management communication processes in place and an assurance through audit that staff are appropriately undertaking these functions, including a clear understanding of the relative roles and responsibilities of the Trust's professional staff, contracts and finance functions, and clarity about the roles and responsibilities of RQIA and the Office and Care and Protection within the Care Management process.		• The review of care management processes has been completed. Draft operational guidance and recommendations from the review approved by the Senior Management Team on 26.6.2013. Implementation Plan drafted and agreed by the Senior Management Team.		**MODERATE**

4	Systems of assessment and assurance in relation to quality of Trust services	• Clinical and Social Care Governance Review completed and new structures/processes embedded • Update on progress to Governance Committee on a quarterly basis • Governance Committee, Senior Management Team and Governance Working Body in place and operating to agreed remit • Directorate, Division and Professional Governance Fora in place and reporting to Senior Management Team/ Governance Committee • Caspe Healthcare Knowledge Systems (CHKS) comparative mortality benchmarking tool - contract in place and information extracted for governance information • Review of Specialty Mortality and Morbidity system completed. • Mortality Reports to Governance Committee • Chair/Chief Executive/Director/Non Executive Director programme of visits in place and feedback to Chief Executive • Executive Director of Nursing report to Trust Board showing performance against Nursing Quality Indicators (NFIs) • Serious Adverse Incident/Adverse Incident reporting system in place • Executive Director social work has established an internal	• Web-based incident reporting (on Datix) rolled out across the Trust • Work has commenced on review of Risk Management Policy • Clinical and Quality indicator programme of work across Directorates • Internal Audit Review of Clinical and Social Care Governance achieved satisfactory assurance. Action Plan to Governance Committee – December 2013. • Review of Mortality and Morbidity process underway to be completed by December 2013, ensuring that all aspects of care considered (via nursing input) and outcomes fed into Governance systems	Chief Executive Medical Director	**MODERATE**

		group to progress implementation of the quality indicators contained in the Social Work Strategy • Director CYP provides Roles and Responsibilities reports on all Looked After Children and Child Protection services • Priority 5 Returns provide assurance on activity and monitoring arrangements for all children's social work services			
	Learning from Adverse Incidents, complaints and user feedback - lack of formal, embedded system of learning	• For Serious Adverse Incidents and appropriate level of Adverse Incidents, investigation/Root Cause Analysis process embedded with reports to Director/Senior Management Team Governance to approve recommendations/actions and ensure shared learning • Governance Committee Senior Management Team, Governance Working Body, Divisional and Directorate Governance Fora, Professional Governance Fora, Patient and Client Experience Committee for shared learning	• 4 issues arising from Serious Adverse Incidents brought to Governance Working Body and being taken forward for organisational learning. Implementation of NEWS has now been completed across Acute, Older People and Primary Care and Mental Health and Disability Directorates. Audit in place to monitor compliance. Falls Working Group ongoing Progress on the other 2 issues remain to be reported to Governance Committee on a rotational basis. • Governance Working Body in the process of reviewing their workstreams		

5	Compliance with Standards and Guidelines (S&G) • From 1st April 2007, a total of 736 standards and guidelines have been externally endorsed to the SH&SCT by a range of external agencies and placed on the Trust register. Due to the volume/ complexity of new S&G being issued to the Trust by external agencies, it is a challenge for the Trust to monitor and review the compliance status of all of these S&G • From 1st April 2012 to 30th September 2013, a total of 393 new standards and guidelines have been regionally endorsed from a range of different external agencies.. • There is often a time lag between when the external agencies require the Trust to achieve full compliance and when this is actually achieved • From 1/9/2013, the Patient Safety and Quality Manager's post will be vacant for 1 year	• Standards and Guidelines Risk Assessment and Prioritisation Group established in April 2011. All newly issued S&G have been reviewed and managed through the new corporate process prior to sending to the nominated Lead Director and Change Lead for action • AMD for Standards and Guidelines (Acute Services) in post • Establishment of six monthly performance/accountability reports for standards and guidelines. • Standard item for discussion at SMT (monthly) and Governance Committee with submission of relevant reports / assurance statements • Standard item for discussion at the Directorate Governance meetings with submission of relevant reports • For those that are 'pharmacy' related a compliance report is also presented by the Trust's Medicines Governance Pharmacist to the Operational Directors and members of the Drug and Therapeutics Committee on a quarterly basis. • Database established and system in place for logging and monitoring	• Since 4/10/2012 a BSO graduate intern has undertaken a comprehensive look back exercise to identify all standards and guidelines that have been issued from 1/04/2007 to 31/03/2010. A total of 281 standards and guidelines have been identified and added to the Trust S&G register. The systemic review of these identified circulars is currently being finalised by the relevant Operational Directorates for prioritisation and action planning (where required) and provision of a statement of assurance to confirm that the required recommendations have been embedded within clinical practice. The outcomes from this look back exercise will be captured within the Trust S&G Accountability Report. • There is a need to establish a more effective information system for the logging and project management of these standards and guidelines in order to ensure all actions are being progressed within the specified timescales by the nominated change lead. Given the volume of standards and guidelines within the system, this is now urgently required in order to effectively manage the risk and ensure that work is being progressed and monitored on an ongoing basis. • Additional Band 2 appointed for one year to support Standards & Guidelines.	Chief Executive	**MODERATE**

		• SABS system in place for Safety Action Bulletins • Process map to ensure effective dissemination and management of Safety Action Bulletins			
6	Insufficient capital to maintain and develop Trust estate to support service delivery and improvement	• Maintaining Existing Services prioritised investment plan agreed by Trust Board and shared with Department • Recent capital allocations have addressed highest priority risks. This process is on-going. Capital Resource Limit also utilised where possible to address highest risk • Strategic development plans in place for major projects and business cases submitted for highest risk areas Specific examples: • Fire Safety Action Plan in place (see below) • High Voltage capacity limit on supply to Craigavon Area Hospital Identified (see below) • High pressure hot water system (HPHW) at Craigavon Area Hospital (see below) • £2.9m secured to complete structural works to tower block at South Tyrone Hospital	• On-going prioritisation and bidding process for capital in place • Fire Safety Action Plan in place and agreed to inform Maintaining Existing Services investment • Recommendations from RQIA hygiene inspection reports prioritised for Capital Resource Limit/Minor works where no other funding source available • £1.99m Maintaining Existing Services funding secured for 2013/14. • Craigavon Area Hospital Main Theatres Refurbishment Project - the 4 theatres and recovery ward have been completed and are in use. • Business cases in development to address significant Maintaining Existing Services infrastructure issues requiring investment > £500k Business cases for High Voltage/Electrical works and Mechanical Infrastructure have been approved by DHSSPS enabling works to progress during 2013/14. • Structural repairs and replacement of external envelope to STH are progressing well.	Performance and Reform	HIGH

7	Fire Safety and compliance with Fire Safety Regulations (NI) 2010	• Fire Safety Action Plan in place and to be monitored quarterly • Local Fire Safety Management Arrangements in place • Funding to resolve deficiencies – prioritised within Maintaining Existing Services • Approximately £1.1 million was invested in 2012/13 to improve fire safety by upgrading the fire alarm system in Daisy Hill Hospital, fire compartmentation works throughout the Trust and installation of the bed escape lifts at Craigavon Area Hospital	• Staff training on-going • New methods for delivering mandatory fire training agreed and to be implemented and tested 2013/14 • Programme of fire risk assessments and fire drill exercises in the hospitals are being carried out • Firecode funding allocation from Maintaining Existing Services for 2013/14 c. £450k is for fire alarm systems which is to be directed to next highest priority risks and further funding continues to be sought • 2013/14 MES funding bid for bed escape lifts in Daisy Hill Hospital and new stair – funding not provided in initial allocation • Minor alterations to be carried out to escape stair in Daisy Hill Hospital to more easily accommodate ski sheet evacuations • Internal Audit Report – limited assurance. Priority 1 issues relate to completion of the Fire Risk Assessment Programme; attendance at training and recording of housekeeping.	Performance and Reform	MODERATE
8	High Voltage capacity limit on electrical supply to Craigavon Area Hospital • Identified under Maintaining Existing Services scheme • Possible limit to expansion of service provision on the Craigavon Area Hospital site • Increased electrical demand on existing limited supply may exceed capability of supply	• All future development/ expansion of the estates is to be notified to Estate Services • Generator backup • Load shedding • Monitoring current demand • Business Continuity Plans for restabilising electrical service in the event of unplanned interruption	• Schemes to provide a new supply for the site are ongoing with Northern Ireland Electricity. A new 6MVA supply has been agreed. Site wide installation of High Voltage supply now ongoing. (our current position is this project is not sufficient to significantly impact the overall risk rating). • Independent experts appointed to provide Infrastructure condition report and inform plans for new High Voltage/Low Voltage infrastructure • Mechanical Infrastructure and Electrical Infrastructure Business Cases have been approved and these	Performance and Reform	HIGH

			projects are being progressed in parallel as both Combined Heat and Power (within Mechanical) and new High Voltage intake (within electrical) Strategic Outline Case are required to manage the onsite risk. • Peak Lopping is installed and completed following agreement with Northern Ireland Electricity • Phase 1 business case for Low Voltage works to provide short-term mitigation for risks approved in June 2012 for £2.5m works now completed.		
9	Asbestos and compliance with Control of Asbestos (N.I.) 2007 • Risk of exposure to asbestos by being unable to identify existing asbestos across all Trust property and from lack of a unified/single asbestos management plan.	• Estates Services Asbestos Management Group • Asbestos Policy in place • Revised Asbestos Management Procedures in place • Refurbishment and Demolition Surveys performed when significant work is required on any facility older than 2000 • Asbestos Registers in two legacy systems plus one on-line system	• Re-survey of the Estate completed. Where the presence of asbestos has been identified, plans are in place to monitor and maintain and/or remove the asbestos – this is in accordance with legislation. • One year's management inspections integrated into the Trust's existing Asbestos Register. Update of Asbestos Register almost complete – target date mid December 2013	Performance and Reform	**MODERATE**
10	Upgrade of High Pressure Hot water System (HPHW) at Craigavon Area Hospital required • Reliance on a single set of heating pipes for heating and hot water into all hospital areas in the main hospital block and for conditioned air for critical air handling plant into theatres etc. • Pipeline and expansion bellows beyond recommended lifespan	• Independent expert inspection carried out at end of March 2013 • Full business case for replacement of the HPHW system/mechanical infrastructure (£8.1m) approved July 2013. • Mitigating measures (Priority Risk Mitigation and Enabling Works) have been designed to provide resilience to the system as an interim measure with the following now in place (as at 29.3.2013) - Replacement bellows	• Service Contingency plans reviewed and in place due to works programme extending into winter. • Continued implementation of of mitigating measures (Priority Risk Mitigation and Enabling Works) • Permanent solution will go live, in parallel with mitigating measures, at the end of January 2014 (substantially removing the risk at that point) with completion scheduled for the end of March 2014	Performance and Reform	**HIGH**

	and failure would have major impact on provision of hospital services/lead to temporary closure	ordered to facilitate urgent repairs if required - Hot air blowers on site • Emergency Plans/Business Continuity plan controls in place (see corporate risk 13)			
11	HCAI • Risk to achievement of Priorities for Action target identified • Risk to patient safety • Lack of automated HCAI surveillance system linked to Trust laboratory system • Lack of appropriate isolation facilities (including negative pressure facilities) within the Trust hospital network	• Comprehensive isolation policy in place and strictly adhered to • On-going mandatory and tailored training • Manual surveillance systems in place • Comprehensive governance structure in place, including bi-monthly Strategic Forum and fortnightly Clinical Forum • New negative pressure room opened in Medical Admissions Unit, CAH • Patient Flow Managers are prioritising single room with ensuite facilities accommodation for patients with infection/suspected infection • Daily Infection Prevention Control (IPC) HCAI report of inpatients with C.difficile and MRSA histories circulated to bed managers and patient flow staff • Outbreak /incident management plan in place • Independent and self-audit programme in place • Extensive action plans in place to deal with trends/prevalent HAIs • Antibiotic stewardship including antibiotic ward rounds • Root Cause Analysis process in place	• On-going measurement of compliance against DHSSPS Communiqués • Ongoing self auditing using the RQIA Audit tools. Compliance statement completed August 2013 and action plan developed. Re-audit planned for December 2013 • Learning outcomes from RCAs being shared with senior and junior medical staff. Shared learning calendar for 2014 now agreed. • Engagement meeting with HSCB regarding GP involvement in c.difficile RCA cases. Communication issued to GPs • Further development of Urinary Catheter project to target E-coli infections. Snap shot audit undertaken. Major staff awareness audit questionnaire agreed – to be issued in December 2013 • Engagement with PHA and HSCB on funding streams for Ramone facility (August 2013) • Engagement with PHA on Regional Surveillance system funding and procurement to recommence • IPCT continue ongoing monitoring and reporting against the 'time to isolation' standard of 2 hours • IPC revising and updating Trust Outbreak Plan in line with Regional Outbreak Guidance • Director of Acute Services and ICT Clinical Lead to undertake a series of	Medical Director	MODERATE

		• Compliance monitoring against key DHSSPS standards and guidelines relating to HCAI • Following step down of Ramone Ward (November 2013), further enhancement of Risk Management Plan	engagements with Ward Managers to reinforce the need for effective IPC and identify any further training/support needed • Director of Performance and Reform and Medical Director to explore options on how to enhance isolation capacity through modular build.		
12	Risk of harm to patients from water borne pathogens (i.e. legionella, pseudomonas)	• Water Safety Group in place • Water Safety Plan • Revised Legionella policy and procedures in place • Compliance with PHA and HEIG guidance: HSS(MD)6/12 - Water sources and potential for pseudomonas aeruginosa infection from taps and water systems • Legionella risk assessments, sampling and monitoring regime in place (as per L8, PHA & HEIG), results analysed, appropriate action taken as required • Pseudomonas sampling and monitoring regime in place in Neonatal Unit and Special Care Baby Unit; in progress in augmented care • IPC guidance on environmental cleaning developed and rolled out (sinks, equipment, etc.) • Infection prevention and control guidance and procedures are continuously reviewed, modified and issued to address emerging risks • Infection prevention and control audit programme and implementation of appropriate	• A water dosing system for copper sliver ionisation of Ramone Building is currently under trial • Consideration of opportunities to increase automated water temperature and flow monitoring • Review of resources needed to manage water quality systems (Microbiology, IPC and Estate Services) completed and identified to Health and Social Care Board/Public Health Agency as part of an overall organisational assessment of the unfunded impact of meeting standards and guidelines (July 2013) • Independent review of water safety plans completed and draft report received – assurance and recommendations agreed at Water Safety Group (July 2013) • £450K MES funding secured for priority works identified through risk assessments • Sampling process under review to take account of improvements to infrastructure and strengthened control measures	Director of Performance & Reform/ Medical Director	MODERATE

		actions based on findings • On-going staff education programme highlighting risks of water borne pathogens • Design of water systems within care facility/environment; attention is given to designing system that will reduce the likelihood of propagation of water borne pathogens			
13	Inability of Laboratory at Craigavon Area Hospital to maintain its Biochemistry Accreditation Status	• Action Plan in place to address non-conformances • External Quality Assurance and Internal Quality controls	• Action plan updated as progress is made. Progress update to Governance Committee in February 2014 • Application for re-accreditation to be made in January 2014		**HIGH**

<table>
<tr><td colspan="6">CORPORATE OBJECTIVE 4: BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE</td></tr>
<tr>
<td>14</td>
<td>Fully embedded appraisal system – lack of evidence of compliance</td>
<td>There are a variety of mechanisms in place to ensure appraisal takes place:-

• Consultant Appraisal</td>
<td>The 2012 appraisal round started in January 2013 and the current status of those completed is outlined in the table below.

It is anticipated that all 2012 appraisals will be completed by the end of 2013. The Medical Director and Revalidation Support Team have written to those whose appraisals are outstanding and reminded them of their obligation to complete them in a timely manner. Associate Medical Directors have also been advised.

<table>
<tr><th>Division/Directorate</th><th>No. of Eligible Doctors</th><th>% of 2012 Appraisals Completed/In Progress</th></tr>
<tr><td>Children & Young People's Services Directorate</td><td>39</td><td>92% complete</td></tr>
<tr><td>Anaesthetics, Theatre & ICU Division</td><td>25</td><td>92% complete</td></tr>
<tr><td>Mental Health & Learning Disability Directorate</td><td>26</td><td>81% complete</td></tr>
<tr><td>Integrated Maternity & Women's Health</td><td>22</td><td>77%complete</td></tr>
<tr><td>Medicine & Unscheduled Care</td><td>64</td><td>81% complete</td></tr>
<tr><td>Surgery & Elective Care</td><td>37</td><td>62% complete</td></tr>
<tr><td>Cancer & Clinical Services</td><td>35</td><td>80% complete</td></tr>
<tr><td>Emergency Medicine</td><td>19</td><td>53% complete</td></tr>
<tr><td>TOTAL</td><td>267</td><td>62% complete</td></tr>
</table>
</td>
<td>Director of Human Resources</td>
<td>MODERATE</td>
</tr>
</table>

		• Professional Supervision • Knowledge and Skills Framework (KSF) policy and monitoring system in place • KSF	• KSF / PDPs are operational in the Trust. It is recognised that the majority of professional staff groups avail of the Supervision process, therefore the current focus is to ensure the unregulated workforce has the opportunity to have a Personal Development Review meeting with their Line Manager and develop a Personal Development Plan. • KSF is a standing item on the agenda of the ETWD (Education, Training and Workforce Development Committee) and SMT. • VWAC (Vocational Workforce Assessment Centre) have established a working group to further embed KSF throughout the organisation. • Directorate aligned staff from the Vocational Workforce Assessment Centre meet with teams, managers or staff on a one to one demonstrating the documentation, giving support and encourage team leaders to complete Personal Development Plans (PDP's) with their staff. • From January 2013 to October 2013, 1,250 staff have attended KSF update sessions which have been delivered in different locations throughout the Trust. These sessions are on-going.		

		Staff Attitude Survey results provide staff view	• Following consultation in November 2013, the KSF form has been condensed and amended in response to feedback from staff and managers, in order to make it more user friendly. 2012 HSC Staff Survey results for the Trust provided evidence that 60% of respondents to the survey had a Development Review/Appraisal in the last 12 months. This had increased from 48% in 2009.		

CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES					
15	• Achievement of financial balance in 2013/14 2013/14 to include requirement for cash release • In year • Recurring	• Contingency Plan for 2013/14 in place • Best Care Best Value (BCBV) Project structure • Financial monitoring systems in place • Monthly report to SMT and Trust Board	Trust Delivery Plan revised and resubmitted at the request of the Health and Social Care Board in August 2013. A number of meetings have taken place with the commissioner – this work is ongoing. HSCB has confirmed £1.6m of non recurrent funding and initial confirmation re use of slippage which reduces potential deficit to £9.6m. However, it is imperative that the Trust fully delivers all existing and new TYC contingency plans. Trust has put in place directorate monitoring meetings to review progress against all TYC plans both in terms of deliverability in year and recurrently. Older People and Primary Care Directorate has a continued focus on community care expenditure which includes Domiciliary Care and Care Home bed expenditure with a view to reducing current over expenditure and identifying opportunities for cash releasing. In respect of the financial pressure arising through nursing paybill, the Acute Directorate has undertaken a workforce review using 4 different tools for comparative purposes and is currently engaged with the Public Health Agency/ Health & Social Care Board re these tools which demonstrate a usage that is compatible with the tools, but in excess of funded staffing levels	Finance and Procurement/ All	**HIGH**

16	Management and monitoring of procurement and contracts – not compliant with best practice guidance	• Clarification required with respect to Centre of Procurement Excellence coverage and capacity. Issue raised with A McCormick July 2011 seeking regional way forward • Interim approach for social care procurement agreed by Senior Management Team in absence of Centre of Procurement Excellence support including awareness training for Community Contracts Team and 'light touch' support/advice to ongoing procurements by Centre of Procurement Excellence • Contracts management improvement group established and key actions formed • Bimonthly reporting to SMT • Project Team established and central database for all identified local Trust contracts in place. (Ceased October 2013) • New guidance on Single Tender Action (STA) processes issued and implemented. Follow up training provided in March 2013. • Training on Contract Management with focus on responsibilities of Contract Owners rolled-out in November with follow up sessions delivered in January 2013	• Action plans in place to address weaknesses identified in Internal Audit reports with updates to Senior Management Team and Audit Committee • Monitoring reporting in place providing a summary position on procurement status/risk at Directorate level and follow up actions with Directorates ongoing • Interface meeting established with BSO/PaLS and process agreed for prioritization of e procurement requirements within available capacity. • Additional capacity for procurement sourced via third party provider contracted by BSO/PaLS. Further small amount of in-house capacity has been established to support low risk procurements in Estates • Capacity sought via IPT for social care procurement of key projects including(Domiciliary Care and Meals) under influence of CoPE • Trust has responded to draft recommendations of J. Allen Review of Procurement. Final recommendations of Procurement Policy awaited • Proposals brought forward by Trusts on regional basis to address procurement deficit for Estates services not agreed regionally. Regional Social Care Procurement Group developing strategy for social care procurements. No agreed regional way forward for procurement capacity gaps. Issues continue to be raised with DHSSPS and Regional Procurement Board	Performance and Reform/ Finance/All	MODERATE

			• New Structures for contract & procurement management being developed. Contracts Management Improvement Group stood down		
17	Implementation of Business Systems Transformation Programme • Maintenance of existing services over the 6-9 month implementation period in light of the potential retention and morale impact on those staff to be displaced • Disruption to ongoing business resulting from the secondment of staff to oversee the implementation • Disruption to transaction processing/quality of management information/financial forecasting and achievement of financial duties • Staff preparedness required within challenging timescales (See below for HRPTS specific risks) • Transfer to Shared Services and maintenance of service delivery	• The Trust has established an implementation structure • Engagement in regional process • Chief Executive letter to Ms Julie Thompson, on behalf of Trust Board, requesting assurance that lessons have been learned from FPL and will be applied to HRPTS • Risks documented and shared with BSO HRPTS Central Team	• Human Resources strategy outlining the options for those staff potentially displaced • Secure backfill staff with the appropriate skills and experience on a timely basis • The Trust may need to reschedule corporate priorities as the workload associated with the implementation increases • The Human Resources Payroll, Travel and Subsistence (HRPTS) implementation is scheduled for 16/12/2013 (go/no-go decision meeting scheduled for 3/12/2013) . • The Trust has agreed with BSO the establishment of pathfinder with effect from 1 October 2013 within recruitment. This will mean that 14 staff will move to the employment of BSO.	Human Resources/ Finance	HIGH

	HRPTS Specific Risks Identified: 1. Funding for project resources - significant cut in regional funding has increased project risks and impacts on all readiness areas ie data, processes, user readiness, ICT etc. This also increases the difficulty, and risk, in trying to maintain quality of non-HRPTS Trust business. 2. E-roster interfaces - non-availability of update functionality for Commcare and Allocate (under) - 4 uploads were to be available (Master Data, Time & Enhancements, Absences & Work Patterns). Currently only one of these will be delivered by the supplier - Time & Enhancements - however the Trusts HRPTS Payroll Lead / Regional Payroll Functional Specialist Group has raised concerns regarding the level of this functionality. Direction was then given BSO HRPTS Central Team that alternative option of working with suppliers of Comcare and Allocate re possibility of them supplying upload functionality should be		HRPTS Risk 1: The Trust wrote to the Programme Director, Michael Crawford, on 4th June 2013, regarding a number of issues including funding for project staff. Internal resources have been redeployed to HRPTS work and overtime working has been, and continues to be, required HRPTS Risk 2: Internal HRPTS E-Roster Work Group continues to progress work directly with system suppliers to ensure a workable interim solution is in place for HRPTS go-live. Contingency plans are being urgently progressed.		

	explored by Trusts. Non-availability of the uploads has potential resource implications (eg for Domiciliary Care Supervisors and/or Payroll Team) 3. Early Life Support - concern that at go-live stage for SHSCT, central resources and HCL Axon will be stretched, potentially still providing support to stabilisation issues in BHSCT, while supporting go-live in SEHSCT at the same time. 4. Go-live and stabilisation resource requirements in terms of training resources, floorwalkers, help desk staff and control room resources to support deployment plans for core users, MSS and ESS 5. ICT Readiness - concern regarding the inability to fully roll out ESS to the whole Trust, due to limitations of ICT infrastructure, system access issues etc.		HRPTS Risk 3: A letter was sent to Michael Crawford (BSTP Programme Director) raising a number of concerns/risks, including early life support resources. SHSCT Case for HCL Axon support was then submitted and approved, however HCL Axon can only resource part of the Trusts support requirement. HRPTS Risk 4: Deployment Plan is being reviewed with input from Directorate Change Leads. Support and stabilisation model to be progressed HRPTS Risk 5: This is being managed by the BSO HRPTS Central Team via a regional working group, with Trust participation, to scope and address ICT issues impeding full deployment of ESS/MSS, including the investigation of a 'home access' model.		

	6. Solution functionality - full functionality of the solution is still not available, and has not all be tested eg e-recruitment functionality will not be available until sometime in 2014. A number of defects have been raised by HSC organisations already live with HRPTS, a number of which have yet to be resolved 7. Reporting functionality – ongoing concerns regarding reporting functionality eg ability of managers to see a 'dashboard' relating only to their area of responsibility 8. Staff Engagement - potential lack of 'buy in'/commitment from managers and staff across the organisation - which is critical for successful implementation as the new system is underpinned by manager and employee self service 9. Benefits realisation - risk that all anticipated benefits will not be achievable, including: ➢ Data Inputting - was to reduce, however non availability of uploads for Comcare, Allocate and Timeware means this		HRPTS Risk 6: BSO HRPTS Central Team project manages solution functionality. Trust staff are endeavoring to learn from go-live experiences from other HSC organisations (BSO, WHSCT & BHSCT) HRPTS Risk 7: Trust staff availing of learning opportunities from other HSC organisations already live with HRPTS HRPTS Risk 8: SHSCT BSTP Change Network and HRPTS Directorate LITs have been established. Awareness Sessions are being provided for staff. Training will also be rolled out for Managers Self Service & Employee Self Service in 2014		

	may not happen. ➢ MSS - non-availability of Team Support Role may increase work for some managers, where there is currently admin support to complete documentation. Also raises a risk of potential for password sharing which would breach Trust security policy. ➢ Reporting - Elements of improved management information are unlikely to be achievable at point of go-live. Also, benefit was to include reduction in reporting resources which is now unlikely ➢ New/additional work - which may not have been considered as part of overall benefits realisation, in terms of new OM work and increased systems management work (moving from systems managing HR/Finance users to systems managing all staff as users).				

	10. Password Reset - increased resource requirement if automated functionality is not provided 11. Cutover/Go llve plan - proposed go-live date for Core Users in mid-December carries a risk in terms of timescales/ resources for completion of necessary readiness work, user training etc. Plus risk of two Trusts going live at the same time. Risk to payroll service for payments from 16th December onwards (including some December 2014 weekly and fortnightly paid staff payments) Delays experienced in PPT due to HCL Axon resources being diverted to WHSCT and BHSCT data activities. Payroll resources will not permit the absorption of these delays when other concurrent activities come on-line (e.g. training, roll-out of timesheets etc.) and this puts at risk the Trust's ability to complete essential readiness work in preparation for go-live.		HRPTS Risk 10: HSC organisations have continued to ask for password reset functionality, which will be a cost to the service. This is now being progressed at a regional level. No definite timescale yet for availability HRPTS Risk 11: Risks have been documented and provided to the BSO HRPTS Central Team		

Changes to Corporate Risk Register since January 2013 to date

Date	Decision taken at	Changes to Corporate Risk Register
30th January 2013	**SMT**	Agreed removal of Corporate Risk No. 13 'Implementation of new regional on-call arrangements – will be managed as Directorate risk issue. Consideration to be given to escalation of Risk No. 15 'Financial impact of Transforming Your Care' from moderate to high risk in light of unresolved gap.
27th February 2013	**SMT**	Agreed to escalate 'Financial impact of Transforming Your Care' from moderate to high risk. Although Financial Plan in place, there are a number of risks aligned to this and the Trust will also require a contingency in each of the years of the CSR period. Agreed to downgrade Risk No. 5 'Lack of compliance with RQIA recommendations in relation to the supervision and administration of medication by Trust/independent agency domiciliary care workers, day care workers and Trust staff in Supported Living and Residential Homes' from high to moderate risk on the basis that the Trust has taken all possible actions within its control and is now escalating to regional level. Risk No. 9 'Asbestos and compliance with legislation' to be reviewed at end of March 2013 when surveys have been completed. Agreed additional element to 'Implementation of BSTP' Risk No. 19.
27th March 2013	**SMT**	Agreed additional risk relating to High Pressure Hot Water System at Craigavon Area Hospital
15th May 2013	**SMT**	Combine Risk No 16 'Achievement of financial balance with Risk No. 17 'Financial Impact of Transforming Your Care'
26th June 2013	**SMT**	Agreed removal of Risk No 5 'RQIA recommendations in relation to the supervision and administration of medication by Trust/independent agency domiciliary care workers, day care workers and Trust staff in Supported Living Accommodation and Residential Homes' on the basis that the Trust has taken all possible actions within its control and has now escalated to regional level.

		Agreed additional risk (NO. 14) that Laboratory at Craigavon Area Hospital will not maintain its Biochemistry Accreditation status
28th August 2013	**SMT**	Review of risks and agreed no changes to status of current risks at this point in time. Discussed the risk that current levels of activity within Acute and OPPC Directorates are not funded by the Commissioner and agreed to include this under Risk No. 16 (financial risk). The following areas were highlighted for review at next SMT as regards downgrade/removal from the Corporate Risk Register:- Care Management processes Implementation of Business Systems Transformation Programme Asbestos Protection of Vulnerable Adults Business Continuity Planning
10th September 2013	**Governance Committee**	Review of risks
23rd October 2013	**SMT**	Agreed removal of Risk No 12 'Protection of Vulnerable Adults' – will be managed on all Adult Directorate Registers as a risk issue. Agreed removal of Risk No 13 'Development of Robust Business Continuity Planning arrangements' – will be managed on Medical Directorate/Operational Directorate Risk Registers
27th November 2013	**SMT**	Review of risks and agreed no changes to status of current risks at this point in time.

Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

to Trust Board

27th November 2014

BRIEFING NOTE FOR TRUST BOARD, 27th NOVEMBER 2014

There are currently **22** Corporate Risks, (12 high level 10 moderate level) as agreed by the Senior Management Team on 19th November 2014.

Review of Risk Ratings

Risk ratings have been reviewed and decision taken to downgrade 'Achievement of Financial Balance in 2014/15 from high to moderate risk. As a result of additional HSCB allocations and DHSSPS approval of a number of additional contingency proposals, the Trust would now expect to breakeven in 2014/15.

Removal of Risks

None

New Risks

None

Summary of Corporate Risks as at November 2014

Note – Red font indicates the changes that have been made to the Register since October 2014

Risk No.	HIGH RISKS	* Corporate Objective	Risk Rating	Change to Status since May 2014
1.	Ongoing achievement of Commissioning Plan Standards/Targets	**1**	**HIGH**	Unchanged
2.	Outpatient Reviews in a number of specialties significantly beyond clinical review timescales	**1**	**HIGH**	Unchanged
3.	Achievement of statutory duties/functions - Level of Residential Home/Nursing Home/ Domiciliary Annual Reviews not completed	**1**	**HIGH**	Unchanged
6.	Medicines Management compliance in domiciliary care	**1**	**HIGH**	New risk added on 9.7.14
7.	Inability to recruit/retain Consultant medical staff for specific specialties	**1**	**HIGH**	New risk added on 9.7.14
9.	Insufficient capital to maintain and develop Trust estate (facilities, equipment etc) to support service delivery and improvement	**1**	**HIGH**	Unchanged
11.	High Voltage capacity limit on electrical supply to Craigavon Hospital	**1**	**HIGH**	Unchanged
12.	The lack of capability, due to staff shortages within Estate services, to provide and maintain a safe and efficient healthcare environment.	**1**	**HIGH**	New risk added on 1st October 2014
13.	Pharmacy Aseptic Suite, CAH	**1**	**HIGH**	Unchanged
16.	Accreditation status of Laboratory, Craigavon Area Hospital	**1**	**HIGH**	Unchanged

21.	GP Out of Hours Service - inability to attract adequate cover for GP shifts	1	HIGH	Unchanged
22.	Health Visiting Service – impact on families due to decreased staffing levels	1	HIGH	Unchanged
Risk No.	**MODERATE RISKS**		**Risk Rating**	
4.	Achievement of statutory duties/functions: Robust Care Management processes	1	MODERATE	Unchanged
5.	Systems of assessment and assurance in relation to quality of Trust services	1	MODERATE	Unchanged
10.	Fire Safety	1	MODERATE	Unchanged
8.	Long term placements for clients with challenging behaviour resulting in delayed discharge from hospital – specifically Dementia and Mental Health	1	MODERATE	New risk added on 9.7.14
14.	HCAI	1	MODERATE	Unchanged
15.	Risk of harm to patients from water borne pathogens	1	MODERATE	Unchanged

17.	Fully embedded Appraisal system	4	MODERATE	Unchanged
18.	Financial Balance – risk in 2014/15 that the Trust will not achieve Financial balance in year	5	MODERATE	Downgraded from high risk 19.11.14
19.	Management and monitoring of procurement and contracts	5	MODERATE	Unchanged
20.	HRPTS Payroll and Travel Payments	5	MODERATE	Separated out from BSTP risk on 15.10.14

Corporate Objectives

1: Provide safe, high quality care.

2: Maximise independence and choice for our patients and clients.

3: Support people and communities to live healthy lives and improve their health and wellbeing.

4: Be a great place to work, valuing our people.

5: Make the best use of resources.

6: Be a good social partner within our local communities.

Southern Health & Social Care Trust: Summary of Corporate Risks as at November 2014

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
No	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update (November 2014)**	**Lead Director**	**Status**
1	Achievement of Commissioning Plan Standards and Targets and review appointments to secure timely assessment and treatment • A number of inpatient/day case/outpatient waiting times beyond access standards/targets (Acute,OPPC and Mental Health areas) • AHP services across all programmes • Outreach specialties (oral surgery, ophthalmology, etc) not within control of Trust • Plain film X Ray reporting only maintained at current level of Ionizing Radiation Medical Exposure Regulations with unfunded additional capacity and no regional standard for areas appropriate for Ionizing Radiation Medical Exposure Regulations	• Bi-weekly reporting to Senior Management Team • Monthly reporting to Trust Board • Action plans in place for reductions in waiting times with associated business cases submitted for capacity gaps where defined/agreed. • Fortnightly Elective Performance meetings with Health and Social Care Board • Identification of capacity gaps to HSCB for non recurrent funding for additional capacity on a specialty basis	• On-going work with Health and Social Care Board to agree capacity gaps and associated recurrent funding requirements. Agreement reached on Gynae; ENT General Surgery, Cardiology and Trauma and Orthopaedics with implementation progressing. Agreement remains outstanding on rheumatology and endoscopy and discussions are being undertaken between Health and Social Care Board and the Trust. • Initial Quarter 1 and 2 non-recurrent allocations provided by Health and Social Care Board to maintain end of March 2014 access positions in Quarter 1 and 2 did not allow access position to be held. • HSCB direction to pause sending new patients to the independent sector(IS) in July followed by no allocations for additional in-house or IS capacity from 1/10/14 is significantly impacting on performance • The Trust is working with the Health and Social Care Board to identify what additional capacity could be provided to diagnostic imaging and scopes should additional resource become available for Quarter 3&4	Performance and Reform/ Operational Directors	HIGH

			• While access position deteriorating across a wide range of specialities with capacity gaps key areas of risk within the clinical pathway include:- - Symptomatic Breast Clinic where SBA capacity currently only covers Red Flag demand. Routine referrals are presenting risk associated with the significantly increasing access time and potential for cancer diagnosis within these referrals. - CT Diagnostic where SBA capacity will not cover the majority of urgent and all routine and GP referrals - Endoscopy Diagnostic where SBA capacity will not cover the majority of urgent and all routine referrals - US diagnostic where SBA capacity will not cover the majority of routine referrals - Orthopaedic In-Patients, Day Cases and Outpatients presenting as risk due to the significantly increasing access times which has been further significantly compounded by the cancellation of elective surgery to facilitate an increase in the clinically urgent additional trauma theatre sessions/ additional fracture clinics. These combined factors are leading to an increase in complaints from elective orthopaedic patients.		

			• The Trust has agreed for a limited volume of additional activity to be undertaken to address these key risks within clinical pathways for scopes, MRI, CT and symptomatic breast clinics in advance of funding being confirmed by Health & Social Care Board for these areas. • SLCG continue in discussion with WHSCT re opthalmology to undertake 'SHSCT service' element. Visiting service continues from BHSCT with BHSCT managing transfer of patients to the Independent Sector from 1/4/2014. • No non-recurrent resources were provided AHP in Quarter 1/2 by HSCB (until the outcome of the PHA demand / capacity exercise). The Trust has been retaining a number of staff at financial risk as approved by Trust Board in April 2014. However, these staff will be released at the end of August 2014, resulting in reduced access performance. • Focus on SBA was well maintained in 2013/2014 with only a small number of specialties in Amber or Red within the HSCB RAG Status assessment. Focus remains on delivery of SBA as first priority with delivery of access standards following this. Position at end September demonstrates areas of underperformance following impact of annual leave in Q2. Action		

			underway to ensure pull back of SBA by end of Q3 Plain Film X Ray • In 2013/2014, IS and IHA were utilised through recurrent funding from HSCB; use of Radiology MCN monies; and through a small element of non-recurrent funding. However, the level of plain film reporting was in excess of that projected through the funding so this additionality will have been unfunded. No funding has been agreed yet for 2014/2015 from HSCB for plain film reporting. This level of reporting remains within the Non-IR(MER)'d plain films. • All recommendations from the RQIA Phase 2 Action plans are in place. • Allocation letter has been received in response to proposal submitted to SLCG for plain film reporting by Radiographers of ED films. Staff trained awaiting backfill for full implementation. • The reporting capacity within radiology to report plain films is unchanged in that all inpatient and ED plain films, with the exception of Chest x-rays, are unreported ie IRMERISED.		

	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (November 2014)	Lead Director	Status
2	Outpatient Reviews in a number of specialties significantly beyond clinical review timescales (Consultant led Outpatient Clinic Review s and AHP Review/Interventions)	• Bi-weekly reporting to Senior Management Team • Monthly reporting to Trust Board • Outpatients Review backlog action plan • Review of administrative process and development of associated Standard Operating Procedure to ensure maintenance of validated 'clean' waiting list and removal of patients off the review backlog waiting list at appropriate times	Outpatient Review Backlog • Whilst significant reduction in volume of review backlog achieved initially in the number of routine waits in Q3 and 4 of 2011/12, there has been an increasing trend in 2012/13 and 2013/14 as the system continues to bring in significant volumes of in-house additional new patients to meet access targets. • Consultant Led Backlog at 3/11/2014, 23,479 patients were past their clinically indicated review. 5% relate to mental health services and 11% of these patients were Ophthalmology patients which is a visiting service. • Of the total patients on the review backlog list, 1.6% of these date back to before 1/4/2012. The volume of patients backlogged before 1/4/14 equates to 38% of the total waiting list which is an improving position. • From Q3/4 in 2013/14, the Trust has only accepted non recurrent allocations for new outpatients that include sufficient capacity for the associated review appointments to assist in not adding to the backlog • A small resource has been provided to undertake data validation on the longest waits.		

			• The Trust has submitted review backlog discussion plan to HSCB (July) and has sought regional discussion on best practice and options to address in the absence of specific funding to create additional capacity to see additional review patients. Options include renewed interface with primary care around this issue and SLCG have been asked to facilitate this approach • Review backlog discussion plan highlights emergent backlog in review/interventions in AHP services, specifically Podiatry and Speech & Language services. Options are being developed to address the governance risk created by these backlogs for discussion with commissioner. • The Trust has engaged with the Commissioner and is preparing plan to undertake data, patients and clinical validation of longest waits subject to funding (November 2014)		

	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (November 2014)	Lead Director	Status
3	Achievement of statutory functions/duties: • Level of Older People and Primary Care Residential Home/Nursing Home/Domiciliary clients Annual Reviews not completed.	• Monthly monitoring of reviews undertaken by Head of Service/Assistant Directors • Group established to examine operational management of the annual review process • Delegated Statutory Functions Report • Monthly reporting to Trust Board (from August 2013) • Annual meeting with Heath & Social Care Board Director of Social Care/Children's Services and follow up of action plan	Older People and Primary Care Directorate has undertaken a Domiciliary Care review and has a project in place to implement the recommendations with focus on: **1. Case note review** **–** enhancing the level of scrutiny applied to reviewing case notes, to assist practitioners in focusing on specific aspects of care during face to face reviews **2. Decision Support Tools** **–** updating and enhancing the tools available to staff for use during the assessment and review process. **3. PTLs/ Domiciliary Care Reviews** **–** introducing an enhanced level of performance management inclusive of monthly reporting in respect of the compliance with review targets in terms of both the frequency of reviews as well as the outcomes of reviews in terms of controlling overall expenditure. **4. Staff Job Planning** – to improve staff efficiency **5. Report Development** – to improve availability of reports to enhance caseload management for staff **4. Information Review** - Validation and Quality Assurance exercise of patient/client information. -	Older People and Primary Care	**HIGH**

			5. Trust Home Care Consultation - Review of staff deployment and future requirements **6. Mixed Economy of Provision** – Controlled shift of work to IS Providers. **Compliance with Review Target** 12 month annual review by 31/10/2014:- – Domiciliary Care: - 82% – Nursing Homes – 88% – Residential Homes –85.6% Overall completion rate –83.8% Therefore,16.2 % have been waiting longer than 12 months to have their reviews carried out. NB: Those clients whose reviews are outstanding are subject to a desktop risk assessment to ensure that the delay in having their review carried out is not detrimental to their care. **Care Home Support Team** - Commenced on 20th January 2014 with a phased approach. The service model developed will carry out reviews for all clients in Nursing/Residential Homes **Adult Safeguarding Team** - Further targeted vulnerable adults training for those staff in care management and involved in annual reviews.		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (November 2014)	Lead Director	Status
4	Achievement of statutory functions/duties: The Trust should have robust care management communication processes in place and an assurance through audit that staff are appropriately undertaking these functions, including a clear understanding of the relative roles and responsibilities of the Trust's professional staff, contracts and finance functions, and clarity about the roles and responsibilities of RQIA and the Office and Care and Protection within the Care Management process.		Mental Health Training completed. Learning/Physical Disability - one session remaining. All disability keyworker staff will be trained prior to implementation. OPPC are currently 50% trained or registered and this presents a significant risk to the Project's completion and implementation by February 2015. Situation has been brought to attention of Director of OPPC, Assistant Director Lead for the project and OPPC representatives on the project monitoring group. At present a significant number of OPPC will remain untrained post February 2015 at this stage. Project targets for e-learning and communication are on schedule and standardising information has been forwarded for Community Information System (Paris) rollout. Other departments (Finance and Contracts) in the Trust are all aware of implementation and in agreement with same. Restructuring process by Heads of Service is in progress within the Disability Directorate.		**MODERATE**

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (November 2014)	Lead Director	Status
5	Systems of assessment and assurance in relation to quality of Trust services Specific risks include:- 4.1 Lack of compliance with Standards and Guidelines (DHSSPS/HSCB/other) 4.2 Lack of agreed indicators/measures of quality to provide assurance across some Trust services 4.3 Effectiveness of systemic process to review all intelligence from incidents, complaints, litigation and user feedback to identify and address service safety and quality issues 4.4 Effectiveness of process for learning from Adverse Incidents, complaints and user feedback - lack of formal, embedded system of learning	• Standards and Guidelines report on compliance to Governance Committee and DHSSPS Accountability Review meetings • Standards and Guidelines Risk Assessment and Prioritisation Group • Clinical and Social Care Governance Review completed and new structures/processes embedded • Governance Committee, Senior Management Team and Governance Working Body in place and operating to agreed remit • Directorate, Division and Professional Governance Fora in place and reporting to Senior Management Team/ Governance Committee • Quality Sub Group • Caspe Healthcare Knowledge Systems (CHKS) comparative mortality benchmarking tool - contract in place and information extracted for governance information • Review of Specialty Mortality and Morbidity system completed. • Mortality Reports to Governance Committee • Chair/Chief Executive/Director/Non Executive Director programme of visits in place and feedback	• New I.T. system to capture Standards and Guidelines now agreed and implementation planned for March 2015 • Web-based incident reporting (on Datix) rolled out across the Trust • Morbidity and Mortality Group have standardised M&M processes in the SHSCT, providing assurance that all deaths are being reviewed in the same way and to coordinate a standard approach to learning from M&M meetings which has a patient safety focus. • Q2020 Strategy Regional Workstreams continue to develop regional quality indicators for reporting via Trust Quality Report • Trust Quality Report to Trust Board in October 2014	Chief Executive Medical Director	**MODERATE**

		to Chair and Chief Executive • Executive Director of Nursing report to Trust Board showing performance against Nursing Quality Indicators (NFIs) • Medical Director Report to Trust Board and Governance Committee includes Quality and Safety Indicators • Serious Adverse Incident/Adverse Incident reporting system in place • Executive Director Social Work has established an internal group to progress implementation of the quality indicators contained in the Social Work Strategy • Director, Children and Young People's Services, reports to Trust Board and Governance Committee including Roles and Responsibilities on all Looked After Children and Child Protection services • For Serious Adverse Incidents and appropriate level of Adverse Incidents, investigation/Root Cause Analysis process embedded with reports to Director/Senior Management Team Governance to approve recommendations/actions and ensure shared learning • Governance Committee Senior Management Team,	• 4 issues arising from Serious Adverse Incidents brought to Governance Working Body and being taken forward for organisational learning. Implementation of NEWS has now been completed across Acute, Older People and Primary Care and Mental Health and Disability Directorates. Audit in place to		

		Governance Working Body, Divisional and Directorate Governance Fora, Professional Governance Fora, Patient and Client Experience Committee for shared learning • Complaints assessed/screened for adverse incident review • Litigation process now embedded to ensure early alert to operational Directors	monitor compliance. Falls Working Group ongoing Progress on the other 2 issues remain to be reported to Governance Committee on a rotational basis. • Governance Working Body in the process of reviewing its Terms of Reference and workstreams to ensure that outputs are in line with the SHSCT Quality Improvement Framework		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update (November 2014)**	**Lead Director**	**Status**
6	Lack of compliance with RQIA Standards in relation to medicines management in domiciliary care	• Trust Medicines Management policy • Review of operational procedures • Incident reporting system in place • Interim procedure on prescribing • Trust Medicines Steering Group • Trust representatives on regional group • Themed Domiciliary Care Forum (IS) focused on safe administration of medication	• Trust response letter on medicines compliance/adherence sent to Mr Joe Brogan in June 2014 • Competency based training re medicines management for domiciliary care workers completed for 939 staff. Three 'mop up' sessions scheduled for October/November 2014. • A registered nurse has been seconded in the Newry and Mourne area for a pilot of one year dedicated to progressing review regarding safer systems • Interim transcribing arrangements have been agreed by the Executive Nurse Director	Older People and Primary Care/Mental Health and Disability	HIGH

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (November 2014)	Lead Director	Status
7	Inability to recruit/retain Consultant medical staff for specific specialties • Consultant Medical Staff in Dermatology, Emergency Medicine, Orthodontics, T&O, Haematology and Psychiatry Old Age • SAS Medical Staff in Anaesthetics, GP Out of Hours, Urology, Dermatology, Emergency Medicine and Paediatrics	• Recruitment campaigns • Use of Locum agencies • Risk Assessment • Detailed Action Plan is held within the HROD Directorate.	**Dermatology:** There is a recognised UK shortage of consultant posts and therefore a new model to attract GPs was introduced. A number GPs were appointed and are due to take up post within the next few weeks. This will provide additional service cover. **T&O:** Two consultant posts have been appointed and are due to take up post in January 2015 and August 2015. A re-advertisement in conjunction with the specialty doctor vacancies is planned. **Emergency Medicine:** It is still proving difficult to recruit Consultant positions within ED. The Trust introduced a Clinical fellowship programme for ED and two applicants are due to be interviewed at the end of the month. **Anaesthetics:** It is planned to develop a training programme with the aim of "growing our own" specialty doctors. A proposal has been drafted and is currently under consideration by the service.	Human Resources & Organisational Development/ Medical Director	**HIGH**
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update (November 2014)**	**Lead Director**	**Status**
8	Long term placements for clients with challenging behaviour resulting in delayed discharge from hospital – specifically Dementia and Mental Health	• Multidisciplinary Team Assessments • Monthly Delayed Discharge meeting for all Mental Health Wards including Gillis	• Continue to explore the potential for existing homes to manage cases with an individualised bespoke package • Potential to procure a specialist home for people with dementia and challenging behaviour discussed with Commissioners	Mental Health and Disability/Older People and Primary Care	**MODERATE**

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (November 2014)	Lead Director	Status
9	Insufficient capital to maintain and develop Trust estate to support service delivery and improvement	• Maintaining Existing Services prioritised investment plan agreed by Trust Board and shared with Department • Recent capital allocations have addressed highest priority risks. This process is on-going. Capital Resource Limit also utilised where possible to address highest risk • Strategic development plans in place for major projects and business cases submitted for highest risk areas Specific examples: • Fire Safety Action Plan in place (see below) • High Voltage capacity limit on supply to Craigavon Area Hospital Identified (see below) • High pressure hot water system (HPHW) at Craigavon Area Hospital (see below) • £2.9m secured to complete structural works to tower block at South Tyrone Hospital	• On-going prioritisation and bidding process for capital in place • Fire Safety Action Plan in place and agreed to inform Maintaining Existing Services investment • Recommendations from RQIA hygiene inspection reports prioritised for Capital Resource Limit/Minor works where no other funding source available • Craigavon Area Hospital Main Theatres Refurbishment Project - the 4 theatres and recovery ward have been completed and are in use. • Business cases in development to address significant Maintaining Existing Services infrastructure issues requiring investment > £500k Business cases for High Voltage/Electrical works and Mechanical Infrastructure have been approved by DHSSPS enabling works to progress during 2014/15. • Structural repairs and replacement of external envelope to STH are progressing well. • Strategic Outline Case completed for Major Redevelopment at CAH site and Outline Business Case to be progressed.	Performance and Reform	HIGH

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (November 2014)	Lead Director	Status
10	Fire Safety and compliance with Fire Safety Regulations (NI) 2010	• Fire Safety Action Plan in place • Local Fire Safety Management Arrangements in place • Funding to resolve deficiencies – prioritised within Maintaining Existing Services • Approximately £450k was invested in upgrade of fire alarm systems in 2013/14 which consisted of upgrading fire alarm systems to Hill Building, Trasna House, partial upgrade to South Tyrone Hospital and providing/upgrading fire alarm zone maps throughout the Trust	• Staff training on-going • New methods for delivering mandatory fire training agreed and to be implemented and tested 2014/15 • Programme of fire risk assessments and fire drill exercises in the hospitals are being carried out • Firecode funding allocation from Maintaining Existing Services for 2014/15 c. £110k is for swing arm door closers in residential homes and alterations to fire alarm programme in Lurgan Hospital. • Internal Audit Report in 2013/14 – limited assurance. Priority 1 issues relate to completion of the Fire Risk Assessment Programme; attendance at training and recording of housekeeping. Action Plan in place with majority of issues to be addressed by December 2014 • Fire Training attendance has increased to 70%. The new Fire Prevention Officer posts have now been filled and fire risk assessments have been given a high priority with 33 assessments carried out in the last quarter. • One Fire Prevention Officer on Long Term sick leave which will reduce capacity for completion of Fire Risk Assessments as work is prioritised • Update on Action Plan to come to Governance Committee in December 2014	Performance and Reform	MODERATE

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (November 2014)	Lead Director	Status
11	High Voltage capacity limit on electrical supply to Craigavon Area Hospital • Identified under Maintaining Existing Services scheme • Possible limit to expansion of service provision on the Craigavon Area Hospital site • Increased electrical demand on existing limited supply may exceed capability of supply	• All future development/ expansion of the estates is to be notified to Estate Services • Generator backup • Load shedding • Monitoring current demand • Business Continuity Plans for restabilising electrical service in the event of unplanned interruption • Peak Lopping installed and completed following agreement with Northern Ireland Electricity • Phase 1 business case for Low Voltage works to provide short-term mitigation for risks approved in June 2012 for £2.5m works now completed.	• Schemes to provide a new supply for the site are ongoing with Northern Ireland Electricity. A new 6MVA supply has been agreed. Site wide installation of High Voltage supply now ongoing. (our current position is this project is not sufficient to significantly impact the overall risk rating). • Independent experts appointed to provide Infrastructure condition report and inform plans for new High Voltage/Low Voltage infrastructure • Mechanical Infrastructure and Electrical Infrastructure Business Cases have been approved and these projects are being progressed in parallel as both Combined Heat and Power (within Mechanical) and new High Voltage intake (within electrical) Strategic Outline Case are required to manage the onsite risk. • Contract for new Combined Heat and Power plant is due for completion November 2015 which will provide additional source of supply for the site. At this point, this risk will be re-assessed and may reduce to moderate risk. • CAH site High Voltage infrastructure works, together with the new NIE High Voltage supply, anticipated completion April 2016	Performance and Reform	HIGH

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (November 2014)	Lead Director	Status
12	The lack of capability, due to staff shortages, to provide and maintain a safe and efficient healthcare environment. Specific risks include:- • Failure to deliver capital works programme to quality, cost and/or time • Limited ability to develop and implement processes to meet Internal Audit requirements • Limited ability to comply with procurement regulations • Failure to meet departmental requirements for PPEs, Peer Review processes etc. • Risk to long term Estates service due to absence of resilience/succession • Limited ability to deliver effective operational service • Failure to manage property effectively	• Extensive reorganisation/ restructuring of Estates Services. However, failure to fully implement restructuring through non replacement of posts removed resilience and hampered ability to effectively carry out the Estates function. • Reduction in Capital projects from c 60pa to 24pa based on priority • Heads of Service covering for vacancies within their areas • Staff redirected to higher priority areas	• Review of proposals to appoint to Funded Staffing levels (by March 2015) • Composite Estates Works Improvement Plan developed and monitored fortnightly by Assistant Director Estate Services • SMT approval given to commence recruitment of key posts (12/11/14) – it is anticipated the process will take from 3-6 months to complete (training required thereafter). Risk to be keep under review as this recruitment progresses	Director of Performance and Reform	**HIGH**

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (November 2014)	Lead Director	Status
13	The external audit of the pharmacy Aseptic Suite, which prepares all the total parenteral nutrition and the chemotherapy for oncology and haematology patients, has identified several issues: • The design and fabric of the aseptic building does not meet the modern building standards for pharmacy aseptic dispensing units (critical audit finding). • Application of the newly introduced capacity plan has identified the chemotherapy pharmacists' activity is exceeding 100% on a regular basis (Major audit finding) • The two isolators used in the cytotoxic reconstitution section of the aseptic suite both require urgent replacement.(Major audit finding)	• Increased environmental monitoring to check for failures of sterility in the unit • Expiry dates of all products prepared has been reduced to a maximum of 24 hours. • A daily report on the chemotherapy pharmacists activity level in relation to the capacity plan has been developed and implemented • Additional activity will not be accepted by the aseptic unit until the staffing issue is resolved • Additional environmental and function testing is being performed on both isolators to identify any sterility failures.	• Health Estates has completed its section of the business case for a new build aseptic suite co-located with the Mandeville Unit. The business case is now with the Trust Finance Team. • The Capita Model for chemotherapy/cytotoxic dispensing has been applied to the current workload in the unit. This has identified a staffing deficit of 3.6wte pharmacists. A meeting to discuss recurrent funding with HSCB is set for 19/11/14. • The first replacement isolator is now fully operational. The second isolator is being installed on 11th November 2014.	Director of Acute Services	**HIGH**

	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (October 2014)	Lead Director	Status
14	HCAI • Risk to achievement of Priorities for Action target identified • Risk to patient safety • Lack of automated HCAI surveillance system linked to Trust laboratory system • Lack of appropriate isolation facilities (including negative pressure facilities) within the Trust hospital network • Emerging infections (CPE/VHF/ebola) • HCAI outbreaks in tertiary services (BHSCT)	• Comprehensive isolation policy in place and strictly adhered to • On-going mandatory and tailored IPC training • Manual surveillance systems in place. Independent and self-audit programme • Comprehensive governance structure in place, including bi-monthly Strategic Forum and monthly Clinical Forum meetings • Outbreak /incident management plan in place • Establishment of antimicrobial management team to oversee antimicrobial stewardship • HCAI Root Cause Analysis process in place • Compliance monitoring against key DHSSPS standards and guidelines relating to HCAI	• On-going measurement of compliance against DHSSPS Communiqués • Ongoing self-auditing using the RQIA Audit tools. • Learning outcomes from RCAs being shared with senior and junior medical staff. Shared learning calendar for 2014 now agreed. • Engagement meeting with HSCB regarding GP and Primary Care involvement in C.difficile RCA cases. Communication has been issued to GPs and will be supported by a Newsletter. • Further development of Urinary Catheter project to target E-coli infections and promote safer clinical practice when dealing with urinary catheters. • Engagement with PHA on Regional Surveillance system funding and procurement to recommence • New weekly E-Alert issued to staff to provide a digest of current IPC threats and issues locally, nationally and internationally. E-Alert is mailed directly to Doctors, GP Out of Hours, Clinical Forum members and Operational Directors • Management Plans for emerging infections CPE and VHF/ebola in progress • Emergency planning exercise for VHF/ebola carried out October 2014. • Enhanced HCAI RCA form developed to further improve meta-	Medical Director	MODERATE

			analysis of C Difficile cases • Ongoing staff training taking place for VHF/ebola precautions • Renewed focus on isolation and screening of transferred patients.		
No.	**Risk Area and Principal Risks**	Key Controls	**Action Planned/Progress update (November 2014)**	**Lead Director**	**Status**
15	Risk of harm to patients from water borne pathogens (i.e. legionella, pseudomonas)	• Water Safety Group in place • Water Safety Plan • Revised Legionella policy and procedures in place • Compliance with PHA and HEIG guidance: HSS(MD)6/12 - Water sources and potential for pseudomonas aeruginosa infection from taps and water systems • Legionella risk assessments, sampling and monitoring regime in place (as per L8, PHA & HEIG), results analysed, appropriate action taken as required • Pseudomonas sampling and monitoring regime in place in Neonatal Unit and Special Care Baby Unit; in progress in augmented care • IPC guidance on environmental cleaning developed and rolled out (sinks, equipment, etc.) • Infection prevention and control guidance and procedures are continuously reviewed, modified and issued to address	• A water dosing system for copper sliver ionisation of Ramone Building is currently under trial • Consideration of opportunities to increase automated water temperature and flow monitoring • Review of resources needed to manage water quality systems (Microbiology, IPC and Estate Services) completed and identified to Health and Social Care Board/Public Health Agency as part of an overall organisational assessment of the unfunded impact of meeting standards and guidelines (July 2013) • Independent review of water safety plans completed and draft report received – assurance and recommendations agreed at Water Safety Group (July 2013) • £200k MES General Capital funding secured for priority works identified through risk assessments • New sampling regime approved by Trust Board and new monitoring regime now in place with bi-monthly monitoring. This will continue until September 2014 at which point	Director of Performance & Reform/ Medical Director	MODERATE

		emerging risks • Infection prevention and control audit programme and implementation of appropriate actions based on findings • On-going staff education programme highlighting risks of water borne pathogens • Design of water systems within care facility/environment; attention is given to designing system that will reduce the likelihood of propagation of water borne pathogens	testing will go to quarterly (subject to satisfactory reduction in legionella positives. As at November 2014 this has not happened due to a number of positive Legionella counts being detected as part of the sampling regime. • Second Independent Review of Water Management arrangements expected end November 2014. • New Trust wide contract for the control of water systems to be tendered by PALs (estimated start date of contract – March 2015)		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update (November 2014)**	**Lead Director**	**Status**
16	Inability of Laboratory at Craigavon Area Hospital to maintain its Biochemistry Accreditation Status	• Action Plan in place to address non-conformances • External Quality Assurance and Internal Quality controls	• Action plan updated as progress is made. • Application for re-accreditation under the new ISO15189 standards submitted end April 2014.		**HIGH**

<table>
<tr><th colspan="6">CORPORATE OBJECTIVE 4: BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE</th></tr>
<tr><th>No.</th><th>Risk Area and Principal Risks</th><th>Key Controls</th><th>Action Planned/Progress update (November 2014)</th><th>Lead Director</th><th>Status</th></tr>
<tr><td>17</td><td>Fully embedded appraisal system – lack of evidence of compliance</td><td>There are a variety of mechanisms in place to ensure appraisal takes place:-
Consultant Appraisal
Professional Supervision
Knowledge and Skills Framework (KSF) policy and monitoring system in place
KSF is a standing item on the agenda of the Education, Training and Workforce Development Committee and SMT meetings
Action Plan in place
Staff Attitude Survey results provide staff view
Working Group established by Vocational Workforce Assessment Centre to further embed KSF throughout the organisation.</td><td><u>Consultant Appraisal</u>

The 2013 appraisal round commenced in March 2014 and currently 84% (of 296) are completed/in progress. It is anticipated that all 2013 appraisals will be completed by end of December 2014. In the meantime, the Medical Director and Revalidation Support Team have issued reminders to those 48 whose appraisals are outstanding. Work will commence on the 2014 appraisal round in early 2015.

<table><tr><th>Division/Directorate</th><th>No. of Eligible Doctors</th><th>% of 2013 Appraisals Completed/In Progress</th></tr><tr><td>Children & Young People's Services Directorate</td><td>43</td><td>88% complete (38)</td></tr><tr><td>Mental Health & Learning Disability Directorate</td><td>27</td><td>74% complete (20)</td></tr><tr><td>Anaesthetics, Theatre & ICU Division</td><td>24</td><td>96% complete (23)</td></tr><tr><td>Surgery & Elective Care</td><td>46</td><td>83% complete (38)</td></tr><tr><td>Cancer & Clinical Services</td><td>46</td><td>85% complete (39)</td></tr><tr><td>Medicine & Unscheduled Care</td><td>64</td><td>91% complete (58)</td></tr><tr><td>Integrated Maternity & Women's Health</td><td>27</td><td>74%complete (20)</td></tr><tr><td>Emergency Medicine</td><td>19</td><td>63% complete (12)</td></tr><tr><td>TOTAL</td><td>296</td><td>84% complete (248)</td></tr></table>
The 2012 appraisal round is 100%</td><td>Medical Director

Director of HROD</td><td>MODERATE</td></tr>
</table>

			complete. The 2013 appraisal round commenced in March 2014. It is anticipated that all 2013 appraisals will be completed by November 2014. In the meantime, the Medical Director and Revalidation Support Team have issued reminders to those whose appraisals are outstanding. **Knowledge and Skills Framework** Work is ongoing with individual Directorates to help to promote KSF and increase uptake within each Directorate As a result of all of the above, there has been a significant increase in completed PDPs being returned to HR Department.		

CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update (November 2014)**	**Lead Director**	**Status**
18	• Achievement of financial balance in 2014/145	• Contingency Plan for 2014/15 in place • Best Care Best Value (BCBV) Project structure • Financial monitoring systems in place • Monthly report to SMT and Trust Board	As a result of additional Health and Social Care Board allocations and Departmental approval to a number of additional contingency proposals, the Trust would now expect to breakeven in 2014/15. Position to be confirmed post implementation of additional contingency measures.	Finance and Procurement/ All	**MODERATE**
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update (November 2014)**	**Lead Director**	**Status**
19	Management and monitoring of procurement and contracts – not compliant with best practice guidance	• Clarification required with respect to Centre of Procurement Excellence coverage and capacity. Issue raised with A McCormick July 2011 seeking regional way forward • Interim approach for social care procurement agreed by Senior Management Team in absence of Centre of Procurement Excellence support including awareness training for Community Contracts Team and 'light touch' support/advice to ongoing procurements by Centre of Procurement Excellence • Contracts management improvement group established and key actions formed • New guidance on Single Tender Action (STA) processes issued	• Action plans in place to address weaknesses identified in Internal Audit reports with updates to Senior Management Team and Audit Committee • Monitoring reporting in place providing a summary position on procurement status/risk at Directorate level and follow up actions with Directorates ongoing (Central monitoring ceased in October 2013) • Interface meeting established with BSO/PaLS and process agreed for prioritization of e procurement requirements within available capacity. • Additional capacity for procurement sourced via third party provider contracted by BSO/PaLS. Further small amount of in-house capacity has been established to support low risk	Director of Performance and Reform/ Director of Finance and Procurement/ All Directors	MODERATE

		and implemented. Follow up training provided in March 2013. • Training on Contract Management with focus on responsibilities of Contract Owners rolled-out in November with follow up sessions delivered in January 2013	procurements in Estates • Capacity sought via IPT for social care procurement of key projects including (Learning disability Day Opportunities/Respite and Domiciliary Care) under influence of CoPE. Bid approved, however recruitment has been suspended due to financial pressures. Alternative options being considered to progress these procurements. • Trust has responded to draft recommendations of J. Allen Review of Procurement. Final recommendations of Procurement Policy awaited • Proposals brought forward by Trusts on regional basis to address procurement deficit for Estates services not agreed regionally. Regional Social Care Procurement Group developing strategy for social care procurements. No agreed regional way forward for procurement capacity gaps. Issues continue to be raised with DHSSPS and Regional Procurement Board • New Structures for contract & procurement management being developed as part of Management Review • New Regional Task and Finish Group established to determine impact of new EU Directives for Social Care Procurement and provide guidance for social care. Work is ongoing on this process with input from Trust.		

			• Measured Term Contract (MTC) in place for 2014/15 which mitigates risks to procurement for schemes <£30k • Internal Audit Report on Estates Procurement and Contract Management 2013/14 provided an unacceptable level of assurance. Improvement action plan in place and discussed at Audit Committee in June 2014. Improvement Plan in part contingent on increase in Estates team resources within current funded levels. (Refer to Risk No. 12)		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update (November 2014)**	**Lead Director**	**Status**
20	HRPTS: • Payroll & Travel Payments - potential for inaccurate and/or late payments. Negative media publicity and impact on Trust's reputation as a good employer. • Transfer to Shared Services and maintenance of service delivery	• The Trust has established an HRPTS implementation structure, including a BSTP Project Board, BSTP Change Network and HRPTS Directorate LITs. • Progress updates to Audit Committee	• E-recruitment functionality to commence implementation in November 2014 with full deployment by April 2015. • Ongoing communication/engagement with Managers as regards timely completion of paperwork • 3-weekly meetings continue to be held with the Trust's Head of Resourcing and the BSO Head of Recruitment & Selection to monitor quality and address any issues arising. All issues are logged and tracked for completion. • Income and Payments have both transferred to Shared Services	Finance	MODERATE

			Centres in July and October respectively. • Weekly and Fortnightly staff are transferring to the Payroll Shared Service Centre in November 2014 with monthly staff following in January 2015. Payroll staff will be released at the end of January 2015 with some being retaining for a further few weeks to close down any outstanding work. • Customer Forums are in place for monitoring the performance of services in Shared Services Centres. .		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update (November 2014)**	**Lead Director**	**Status**
21	GP Out of Hours Service – Reduced ability to maintain adequate service provision and patient safety due to vacant GP shifts	• Recruitment process for vacant posts • Business Continuity Plan • Medical Managers with medical responsibility for the service • Call Centre Co-ordinator • Call Manager system • Late availability payment • Flexibility re shift patterns offered • Daily monitoring of rotas and appropriate contingency plans deployed based on resources available	• Advertisement on HSC recruit for sessional GPs closed with 11 applicants. 9 have been interviewed and 2 pending interviews. • Regular updates to HSCB/Integrated Care Department regarding vacant shifts. • Daily text messages and phone calls to GPs in attempts to cover shifts. • Small team of nurses in GP Out of Hours Service working extra hours, where possible to assist in covering gaps • IPT submitted to appoint 50 Nurse Triage staff. Trust proceeded at risk to commence the recruitment process. Shortlisting currently underway with plans to interview in December 2014.	Older People and Primary Care	

			• As and when bank Advanced Nurse Practitioner posts have been shortlisted and interviews scheduled for end of November 2014 • Nurse Leads have been appointed and commenced end of September 2014 • Review of workload of clinicians ongoing by Clinical Lead • KPIs continue to be monitored hourly. Weekly triage KPIs sent to HSCB • Working with Integrated Care Dept to address capacity issues and use of locum GPs. Locum agencies had been contacted and no doctors available. • Locally Enhanced Service pilot commissioned by the Health and Social Care Board commenced on 6th October 2014 • Working with other OoH providers to secure additional capacity • Working ongoing with HSCB to progress Pharmacy Pilot and enable Pharmacist to undertake triage at weekends for medication related calls. Currently recruiting a Pharmacist. Plan to commence pilot in January 2015. Currently planning for Christmas/New Year holiday period and winter period		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (November 2014)	Lead Director	Status
22	Health Visiting Service – Impact on children/families due to reduced ability to deliver services as a result of decreased staffing levels in the service	• Control measures in place include step down i.e. universal contacts to non-vulnerable families have been reduced; • Utilisation of bank (limited supply) and additional hours of existing health visiting staff; • Drop in clinics available to ensure rapid access to HV if parent worried or concerned about an infant / child; • Rota system is in place to equitably allocate clinic cover, new births, movement in visits and new safeguarding cases; • Team managers to notify HoS and Named Nurse for Safeguarding Children is they are unable to allocate a child protection case. .	• The Health Visiting workforce position at September 2014 demonstrates that Staff in Post equate to the Funded Staffing Levels. However, the reality is that there are 8.43wte unavailable to deliver the service (due to planned and unplanned absence). This equates to 7% of the workforce not available at a given time. This is an improved position from that of May 2014 when the % of the HV workforce unavailable was 16%. Eleven caseloads are still affected. • Due to the regional shortage of Health Visitors, the amount of temporary staff the SH&SCT is able to secure through the bank is insufficient to meet the deficit. • This staffing deficit means that: **Armagh** currently has a 10% step down to core service in place; **Dungannon** currently has a 10% step down to core service in place; **Portadown** currently has a 20% step down to core service in place; **N&M** (Team 2) currently has a 10% step down to core service in place. This is also an improved position from May 2014 when parts of the Trust Health Visiting service had a reduction	Executive Director of Nursing/ Director of Children & Young People	

			of 40% to core services. • Although there are improved staffing levels in some of the teams i.e. Lurgan/Brownlow and Banbridge, these teams have a significant backlog of preschool children to see due to the universal contacts having been reduced during the period of step down. There is continued pressure within the service to address this backlog. • In communications with the Health & Social Care Board and Public Health Agency regarding the Health Visiting workforce, SHSCT has confirmed that vacancies have been filled, as well as articulating the need for additional funding to meet the particular needs of the population within the Southern Trust area. • Eight Health Visiting students have now completed the regional programme and have registered with the Nursing and Midwifery Council (NMC). Six of these students have successfully secured permanent positions within the Health Visiting workforce, and posts are within the current Funded Staffing Levels. • Sixty-one Health Visiting places were approved for 14/15 and SHSCT is facilitating 12 students.		

Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

to Governance Committee on
8th December 2015

INTRODUCTION

The SH&SCT Corporate Risk Register identifies corporate risks, all of which have been assessed using the HSC grading matrix, in line with DHSSPS guidance. This ensures a consistent and uniform approach is taken in categorizing risk in terms of their level of priority so that proportionate action can be taken at the appropriate level in the organization. The process for escalating and de-escalating risk at Team, Divisional and Directorate level, is set out in the Trust's Risk Management Strategy.

Each risk on the Register has been linked to the Trust's Corporate Objectives as detailed below:-

1: Provide safe, high quality care.

2: Maximise independence and choice for our patients and clients.

3: Support people and communities to live healthy lives and improve their health and wellbeing.

4: Be a great place to work, valuing our people.

5: Make the best use of resources.

6: Be a good social partner within our local communities.

OVERVIEW OF CORPORATE RISK REVIEW AS AT 30th NOVEMBER 2015

LOW	MEDIUM	HIGH	EXTREME	TOTAL
0	10	12		22

New risks identified by SMT or escalated from Directorate Risk Registers	New Risk No.8 Inability to secure senior medical staff to provide 24/7 senior cover for Emergency Department in Daisy Hill Hospital.
Risks removed from the Register	• Risk No. 9 Long term placements for clients with challenging behaviour resulting in delayed discharge from hospital – specifically Dementia and Mental Health' and retain on MHD Directorate Risk Register. • Risk No.10 Fire Safety – effective management measures are now in place and risk assessments have been substantially progressed. To be managed on Directorate Risk Register • Risk No. 15 Water Safety –effective management measures are now in place and the instances of Legionella detections have been significantly reduced with the installation of the CuAg water treatment system at Craigavon Area Hospital. To be managed on Directorate Risk Register

	• Risk No. 12 The lack of capacity, due to staff shortages within Estate services, to provide and maintain a safe and efficient healthcare environment – Whilst there are still critical vacancies in the Estates structure, their replacement has been approved corporately and resolution rests within Estates.
Merged risks	None
Risks where overall rating has been reduced	Risk No. 12 'High Voltage capacity limit on electrical supply to Craigavon Area Hospital' – downgraded from high to medium risk Risk No.3 'Achievement of Statutory Duties/Functions – 'Level of Residential Home/Nursing Home/Domiciliary Annual Reviews not completed' – downgraded from high to medium risk Risk No. 6 'Medicines Management compliance in Domiciliary Care' – downgraded from high to medium risk
Risks where overall rating has been increased	None

Summary of Corporate Risks as at November 2015

Risk No.	HIGH RISKS	* Corporate Objective	Risk Rating	Change to Status since November 2014
1.	Achievement of Elective Commissioning Plan Standards and Targets	1	HIGH	Unchanged
2.	Out-Patient Reviews and Planned Treatment Backlogs	1	HIGH	Unchanged
7.	Inability to recruit/retain Consultant medical staff for specific specialties	1	HIGH	Unchanged
8.	Inability to secure senior medical staff to provide 24/7 senior cover for Emergency Department in Daisy Hill Hospital	1	HIGH	New risk added on 30.9.2015
9.	Inability to Increasing inability to recruit registered nursing staff	1	HIGH	Unchanged
10.	Insufficient capital to maintain and develop Trust estate (facilities, equipment etc) to support service delivery and improvement	1	HIGH	Unchanged
12.	Pharmacy Aseptic Suite, CAH	1	HIGH	Unchanged
14.	Accreditation status of Laboratory, Craigavon Area Hospital	1	HIGH	Unchanged
16.	Implementation of NMC's revised revalidation arrangements for Registered Nurses, Midwives and Specialist Community Public Health Nurses	1	HIGH	Unchanged

20.	GP Out of Hours Service - inability to attract adequate cover for GP shifts	1	HIGH	Unchanged
21.	Health Visiting Service – impact on families due to decreased staffing levels	1	HIGH	Unchanged
22.	Safeguarding of Residents within HH/BC	1	HIGH	Unchanged

Risk No.	MODERATE RISKS	* Corporate Objective	Risk Rating	Change to Status Since November 2014
3.	Achievement of statutory duties/functions - Level of Residential Home/Nursing Home/ Domiciliary Annual Reviews not completed	1	MEDIUM	Downgraded from high risk 25.11.2015
4.	Achievement of statutory duties/functions: Robust Case Management processes	1	MEDIUM	Unchanged
5.	Systems of assessment and assurance in relation to quality of Trust services	1	MEDIUM	Unchanged
6.	Medicines Management compliance in domiciliary care	1	MEDIUM	Downgraded from high risk 25.11.2015

11.	High Voltage capacity limit on electrical supply to Craigavon Hospital	**1**	**MEDIUM**	Downgraded from high risk 30.9.2015
13.	HCAI	**1**	**MEDIUM**	Unchanged
15.	Fully embedded Appraisal system	**1**	**MEDIUM**	Unchanged
17.	Financial Balance – risk in 2015/16 that the Trust will not achieve Financial balance in year	**4**	**MEDIUM**	Downgraded from high risk 19.11.14
18.	Management and monitoring of procurement and contracts	**5**	**MEDIUM**	Unchanged
19.	HRPTS Payroll,Travel Payments and Shared Services Recruitment	**5**	**MEDIUM**	Separated out from BSTP risk on 15.10.14

Southern Health & Social Care Trust: Summary of Corporate Risks as at November 2015

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
No	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
1	**Achievement of Elective Commissioning Plan Standards and Targets** ***a) Waiting times in excess of Commissioning Plan Standards / Targets across***: • Out-Patients; • Diagnostics (including Endoscopy); • In-Patients; and • Day Cases (Acute; CYPS; Mental Health; and OPPC areas) • AHP professions	INTERNALMONITORING: 1. ***Fortnightly Operational Performance meetings:*** • Acute Directorate, and • Children & Young Peoples Services Directorate 2. ***Monthly Operational Performance meetings***: • Mental Health & Disability Directorate 3. ***Quarterly Operational Performance meetings:*** • Older Persons and Primary Care Directorate 4. ***Monthly Operational AHP Performance*** - Cross- directorate ***5. Monthly reporting to Senior Management Team and Trust Board*** ***6. Monthly exception reporting to Operational Directorates In-Year Assurance meetings with Chief Executive.***	**Access Times** a) Focus on Service and Budget Agreement (SBA) remains as first priority within Operational Directorates, where robust SBA volumes exist into 2015/16. Delivery of access times will follow SBA delivery on the priority list. Recurrent capacity gaps prioritised with SLCG, in line with early indication of available recurrent funding in 2015/2016 as: - Symptomatic Breast Clinic and - Haematology. IPT was submitted and formal allocation received for recurrent funding for symptomatic breast services (July 2015) b) Non-recurrent allocation received for Diagnostics (including Endoscopy) in 2015/16 • The totality of diagnostic volumes allocated cannot be secured via in-house capacity alone and challenges have been faced securing Independent Sector capacity • No allocations received for Out-Patients; In-Patients; or Day Cases.	Performance and Reform and Operational Directors	**HIGH**

		EXTERNAL MONITORING: 7. **Monthly** Elective and Unscheduled Performance meetings with Health and Social Care Board ACTION PLANNING: 8. Implementation plans in place to reduce access times, where demand remains static, and additional ***recurrent*** capacity has been invested/ approved via IPT 9. Periodic plans developed aligned to ***non-recurrent*** allocations of available funding for elective access via HSCB 10. Operational plans under development to maintain red flag waiting time standards and reduce urgent waiting times to the acceptable clinical timescale. However, routine waiting times will increase as a consequence of the management of the red flag and urgent waiting times.	• IS Providers have been given permission to undertake the treatment of the paused patients from 2014/15 in Quarter 1 of 2015/16. • SMT permission granted for additionality in April 2015 to continue to address previously identified risk areas that were funded via non-recurrent allocations in 2014/15. Spend from April to be re-couped from 2015/16 non-recurrent allocations. Further non-recurrent funding made available in November for Independent Sector capacity. The Trust will work to identify what Independent Sector capacity can be put in place to increase capacity for Quarter 4 2015/16. c) Key areas of risk identified within the Acute Services Directorate have been **partially addressed** with non-recurrent funding and part year effect recurrent investments in : • Symptomatic Breast Clinic • CT and • Endoscopy . d) Remaining areas of risk highlighted to Health and Social Care Board formally include:- a. Haematology (New OP) b. Urology (OP Review Backlog) c. General Surgery (OP Review Backlog) d. Cardiology (OP Review		

	b) Plain film reporting only maintained at current level, which excludes films that have been categorised as IRMER'ised (Ionizing Radiation Medical Exposure Regulations) with unfunded additional capacity and no regional standard for areas appropriate for Ionizing Radiation Medical Exposure Regulations		Backlog) e. Dermatology (OP Review Backlog) f. Trauma (New OP and IP) The Trust will continue to re-direct internally resources to areas of greatest risk as funding becomes available or as operationally feasible. **Plain Film X Ray** e) A non-recurrent allocation for plain film reporting has been received for Quarter 3 & 4 (2015/2016). This non-recurrent funding is being utilised for Independent Sector (IS) provision. • The original IS provider is now working to full capacity with no further options for additional plain film reporting to be undertaken. • With the lack of internal reporting capacity, the Trust is facing further pressure for plain film reporting. • A further IS contract has been procured and awarded (September 2015) and additional capacity is anticipated in Quarter 4. • An operational plan is being developed, in the first instance, to return chest x-ray plain film reporting to within the 28-day standard.		

			f) HSCB has provided recurrent funding for the implementation of plain film reporting by radiographers for ED films. g) HSCB has provided recurrent funding for plain film reporting of the remaining in-patient IRMER'ised patients. h) A training programme is in place to increase the scope of Plain Film reporting that is carried out by Radiographers. **AHP Access Times** No non-recurrent funding to address access times has been allocated in 2015/16 as the outcome of the PHA demand and capacity exercise remains outstanding No non-recurrent resources from HSCB were provided in 2014/15 either. The Trust has agreed to retain a level of additionality until the end of August 2015. The Trust, In parallel with the PHA/HSCB review, is undertaking a capacity and demand exercise to calculate available capacity within the AHP professions which will inform future capacity gaps and investment priorities. It is anticipated that this work should be completed in Q3 2015/16. .		

	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
2	**Out-Patient Review and Planned Treatment Backlogs** ***Out-Patient Review Waiting List Backlogs in:*** • Acute; • CYPS; • MHD; and • OPPC ***Planned Treatment Backlogs:*** • Acute only On-going risk with a significant volume of patients waiting ***past their clinically indicated review timescale*** in Outpatient and AHP services.	Internal and External monitoring controls included as in Corporate Risk 1 above. <u>ACTION PLANNING</u>: • Short-term validation exercise undertaken in Quarter 4 2014/15 within a limited number of Acute Services Directorate specialties • Operational workshop undertaken to review the ability to identify red flag and urgent reviews on the out-patient review waiting list and the processes for monitoring; escalation; and actioning of these reviews, that have been clinically agreed and communicated with the Consultants.	a) Outpatient Backlog At 1 November 2015, there were a total of 20,627 patients waiting in excess of their clinically indicated timescale for review out-patient appointment (Dr-led services only, including Visiting Specialties) as follows: • 44% (9155 people) waiting in excess of 6-months past their clinically indicated timescale; • 15% (3,073) waiting between 3 – 6-months past their clinically indicated timescale; and • 41% (8,398) waiting less than 3-months past their clinically indicated timescale. • The longest waits for Trust services are for Urology and extend back to 2011/12; all patients for 2011/12 and 2012/13 have been validated and those waiting from 2011/12 have all been offered an appointment date. • The longest waits are in the visiting service of Ophthalmology and the Trust is working with the Local Commissioning Group to resolve this. No non-recurrent funding has been received from HSCB in 2015/16 for the out-patient review backlog.		**HIGH**

			The Acute Services Directorate has identified a number of areas of clinical risk within their review backlog and these were contained within the clinical risk paper to SMT on 29 April 2015. This paper details potential contingency options for discussion and approval in order to minimise the clinical risk associated with this backlog. <u>b) Planned Patient Backlog</u> • As at 2nd November 2015, there are a total of 1,356 patients on the planned treatment backlog. The longest waiting patient dates back to February 2014. • 71% (962) of the planned treatment backlog relates to Endoscopy. The non-recurrent allocation for Endoscopy in Quarter 1 & 2 will only facilitate the maintenance of planned scopes at 8-months past their clinically indicated timescale. Endoscopy, in totality, has been identified as a clinical risk within the clinical risk paper escalated to HSCB in May 15(as referenced in Risk 1 above) and through monthly elective access meetings with HSCB. • In line with JAG accreditation requirements the planned treatment backlog should not exceed 6-months.		

			c) AHP review backlogs AHP backlogs for review are not as readily quantifiable. However, available information indicates significant review backlog volumes within Podiatry; Speech & Language Therapy; Dietetics; and Occupational Therapy. The Trust will continue to re-direct internally resources to areas of greatest risk as funding becomes available.		
	Risk Area and Principal Risks	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
3	Achievement of statutory functions/duties: • Level of Older People and Primary Care Residential Home/Nursing Home/Domiciliary clients Annual Reviews not completed.	• Monthly monitoring of reviews undertaken by Head of Service/Assistant Directors • Group established to examine operational management of the annual review process • Delegated Statutory Functions Report • Quarterly reporting to Trust Board (from October 2015) • Annual meeting with Heath & Social Care Board Director of Social Care/Children's Services and follow up of action plan	Older People and Primary Care Directorate has undertaken a Domiciliary Care review and has a process in place to implement the recommendations to achieve compliance. Substantial validation is on-going with teams regarding the recording of OPPC reviews as currently two systems are being used. Those clients whose reviews are outstanding are subject to a desktop risk assessment to ensure that the delay in having their review carried out is not detrimental to their care. **Care Home Support Team (CHST)** The CHST now has responsibility for the majority of clients, with a remaining 8 clients due to transfer on completion of their reviews.	Older People and Primary Care	**MEDIUM**

			An assurance process is embedded to ensure all residents in a Care Home with a Failure to Comply Notice in place or Vulnerable Adult investigation ongoing has an up to date review in place. Currently there are no Failure to Comply notices in Care Homes in the SHSCT area **Adult Safeguarding Team** Further targeted vulnerable adults training for those staff in care management and involved in annual reviews. September 2015 Caseload Analysis being led by Social Work Governance Team and supported by the Executive Director of Social Work, has now reported and findings will support changes within teams in respect of how caseloads are allocated and managed.		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
4	Achievement of statutory functions/duties: The Trust should have robust case management communication processes in place and an assurance through audit that staff are appropriately undertaking these functions, including a clear understanding of the relative roles and responsibilities of the Trust's professional staff, contracts and finance functions, and clarity about the roles and responsibilities of RQIA and the Office and Care and Protection within the Case Management process.	• New Trust Case Management Guidance	• Mental Health, Learning/Physical Disability and Older People and Primary Care training completed. • Internal Audit of Case Management being planned. • Restructuring process by Heads of Service is in progress within the Disability Division of the Mental Health & Learning Disability Directorate. • Process to be completed within Mental Health and Learning Disability Directorate by December 2015	Mental Health and Disability/Older People and Primary Care	**MEDIUM**

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
5	Systems of assessment and assurance in relation to quality of Trust services Specific risks include:- 1. Lack of compliance with Standards and Guidelines (DHSSPS/HSCB/other) 2 Lack of agreed indicators/measures of quality to provide assurance across some Trust services 3. Effectiveness of systemic process to review all intelligence from incidents, complaints, litigation and user feedback to identify and address service safety and quality issues 4 Effectiveness of process for learning from Adverse Incidents, complaints and user feedback - lack of formal, embedded system of learning	• Standards and Guidelines report on compliance to Governance Committee and DHSSPS Accountability Review meetings • Web-based incident reporting (on Datix) rolled out across the Trust • Clinical and Social Care Governance Review completed and new structures/processes embedded • Governance Committee and Senior Management Team • Directorate, Division and Professional Governance Fora in place and reporting to Senior Management Team/ Governance Committee • Quality Sub Group • Morbidity and Mortality Group • Caspe Healthcare Knowledge Systems (CHKS) comparative mortality benchmarking tool - contract in place and information extracted for governance information • Review of Specialty Mortality and Morbidity system completed. • Mortality Reports to Governance Committee • Chair/Chief Executive/Director/Non Executive Director programme of visits in place and feedback to Chair and Chief Executive	• New I.T. system to capture Standards and Guidelines has not been progressed. The Quality 2020 workstream focusing on Standards & Guidelines has proposed a regional approach to developing an IT system to the Quality 2020 Steering Group. • Q2020 Strategy Regional Workstreams continue to develop and strengthen regional quality indicators for reporting via Trust Quality Report • The Trust has commenced the development and implementation of a Quality Framework. The role and remit of the Clinical and Social Care Governance Working Body will be reviewed within this work • The revisit of Clinical and Social Care Governance has completed with a pilot of the new approach of dashboard assurance reports to Governance Committee on 8.12.2015	Chief Executive	**MEDIUM**

		• Executive Director of Nursing report to Trust Board showing performance against Nursing Quality Indicators (NFIs) • Medical Director Report to Trust Board and Governance Committee includes Quality and Safety Indicators • Serious Adverse Incident/Adverse Incident reporting system in place • Trust Annual Quality Report • Executive Director Social Work has established an internal group to progress implementation of the quality indicators contained in the Social Work Strategy • Director, Children and Young People's Services, reports to Trust Board and Governance Committee including Roles and Responsibilities on all Looked After Children and Child Protection services • For Serious Adverse Incidents and appropriate level of Adverse Incidents, investigation/Root Cause Analysis process embedded with reports to Director/Senior Management Team Governance to approve recommendations/actions and ensure shared learning • Governance Committee Senior Management Team, Governance Working Body, Divisional and Directorate Governance Fora,		

		Professional Governance Fora, Patient and Client Experience Committee for shared learning • Complaints assessed/screened for adverse incident review • Litigation process now embedded to ensure early alert to operational Directors			
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
6	Lack of compliance with RQIA Standards in relation to medicines management in domiciliary care	• Trust Medicines Management policy • Review of operational procedures • Incident reporting system in place • Interim procedure on prescribing • Trust Medicines Steering Group • Trust representatives on regional group • Themed Domiciliary Care Forum (IS) focused on safe administration of medication	• Annual Competency based training re medicines management for domiciliary care workers completed for all staff. • A registered nurse has been seconded in the Newry and Mourne area for a pilot of one year since August 2014, dedicated to progressing medicines review and safer systems. A report has been shared on progress / issues to date. This pilot has now been extended to the Armagh and Dungannon areas with core teams supporting the work in Newry/Mourne areas. • As part of this, single patient medication files are being tested across providers to minimise risk of error. • Following a Regional Medication workshop held by the HSCB, a business case is being developed to secure funding to deliver an interim system which includes a specialist medicines assessment and provision of appropriate solutions for service users who are identified as potentially requiring	Older People and Primary Care/Mental Health and Disability	**MEDIUM**

			domiciliary care support in the area of medicines management. • Interim funding is required to allow time to fully evaluate and determine the impact of the assessment process on service delivery in the redesigned Medicines Management Pathway. • Project Nurse to review existing service users in other two localities (Armagh & Dungannon and Craigavon & Banbridge) commencing in November 2015 • Audit risk assessments for new service users to ensure compliance with guidelines commencing November 2015		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
7	Inability to recruit/retain Consultant medical staff for specific specialties • Consultant Medical Staff in Dermatology, Emergency Medicine, Orthodontics, T&O, Haematology, Psychiatry Old Age and Radiology • SAS Medical Staff in Anaesthetics, General Surgery, GP Out of Hours, Urology, Dermatology, Emergency Medicine and Paediatrics	• Recruitment campaigns • Use of Locum agencies • Risk Assessment highlighting controls/action in place • Detailed Action Plan is held within the HROD Directorate.	**Dermatology:** There is a recognised UK shortage of consultant posts in Dermatology and therefore a new model to attract GPs has been introduced. From late November 2014, 4 part-time GPs have started in post so this has proved successful. Two retired consultants were engaged to undertake some WLI clinics however this arrangement ceased at the end of June 2015. An application was submitted to the Royal College of Physicians in 2014 for International Medical Graduates (IMGs) under the Medical Training Initiative (MTI) scheme, but was unsuccessful.	Human Resources & Organisational Development/ Medical Director	**HIGH**

			One local doctor reached her CCT date in July 2015, so would be eligible to apply for a consultant post in the Trust. An IPT is currently being developed. As no funding currently available, the Trust is considering going at risk to recruit another Consultant Dermatologist **T&O:** Two consultants have been appointed to T&O during 2015. One commenced in post at the start of January, however the other was not able to take up post until August. In addition 2 Temporary Specialty Doctors have also been appointed. One transferred from a Clinical fellow post within the Southern Trust and the other started on 3 June 2015. One has since left the Trust, however the other has been appointed to a permanent Specialty Doctor post. This means there are now 9 Consultants and 4 Specialty Doctors in T&O. There are plans to advertise for another permanent Consultant, 2 Clinical Fellows and 3 Temporary Specialty Doctors in T&O. **Emergency Medicine:** A permanent Consultant commenced in Craigavon Area Hospital on 1st May 2015. Two Specialty Doctors were recently interviewed and appointed to ED in DHH, however despite these appointments it still proves very difficult to recruit to Consultant and Specialty Doctor positions within ED The Trust has recently advertised for Consultant and Specialty Doctor posts in DHH. The adverts also featured in the		

			ROI and stated that enhanced rates of pay and a full relocation package would be considered, however these campaigns were unsuccessful. The situation in Daisy Hill Hospital has worsened considerably following the recent resignation of the Lead Consultant and a full time Specialty Doctor. At consultant level, this will leave one Temporary F/T consultant and one permanent P/T consultant. At SAS (middle grade) level there is one Associate Specialist and two Specialty Doctors – all are full time. The Trust regularly raises the requirement for ED locums with all contracted agencies and other known non-contracted agencies. Apart for occasional ad-hoc cover, it has been very difficult to secure any 'longer term' cover. The Trust also embarked on a recruitment campaign for middle grade doctors in ED with M3 Creating Connections. This company undertakes medical recruitment project work with Trusts and Health Boards on behalf of doctors.net.uk. There was only one application received, however the candidate subsequently withdrew. The Trust has also met with 'A Team Recruitment regarding a proposal to recruit medical staff from the EU, however it is expected to take at least 6 months to recruit and train suitably qualified doctors via this route.		

			The Trust has also introduced a Clinical fellowship programme for ED. One appointment has been made – starting in August 2015. **Anaesthetics:** It is planned to develop a training programme with the aim of "growing our own" specialty doctors. A proposal has been drafted and is currently under consideration by the service. **Radiology:** There is a recognized gap in Consultant Radiologist numbers and Clinical Radiology has recently been included in the Government approved shortage occupation list. The Trust has successfully appointed a number of Consultant Radiologists over the past few years; however some of these have left to take up other posts. The position remains unstable. In February 2015, the Trust successfully appointed 4 permanent Consultant Radiologists. One person has since withdrawn, however the other 3 took up post in August 2015.		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	
8	Inability to secure senior medical staff to provide 24/7 senior cover for Emergency Department in Daisy Hill Hospital	• Trust Senior Oversight Group • Escalation procedures in place to alert senior management of any changes in rota • In-house training programme • Daily review by Senior Management of night reports and follow up on issues • Daily audit of notes	• Ongoing recruitment of Consultants and Middle Grade Doctors for Emergency Department • Use of locums • Ongoing review of medical rota to ensure senior doctors on duty until midnight • Opening of observation area from 22.00 – 08.00 for patients who have no definite diagnosis and have not been assessed or discussed with a		**HIGH**

			Registrar • Support provided as required by Paediatric Registrar and Anaesthetic Registrar in the out of hours period. Medical and Surgical Registrar will provide additional support if on duty overnight • Recruitment of senior nursing staff to be on duty 24/7 • Additional ENPs currently being recruited • Associate Medical Director exploring a 16 Consultant model for both Emergency Departments • Resignation of a Consultant effective from 1.2.2016. Action plans in development to seek to address this. • Regular updates to Commissioner and DHSSPS		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
9	Increasing inability to recruit registered nursing staff	• Ward Sister/Charge Nurse management of available staff on a shift by shift basis • Assistant Director/Head of Service (Operational) oversight regarding availability with possible redeployment of staff to respond to prioritised need • Escalation to Operational Director as required • Open registration for Nurse Bank • E-rostering roll out	• All opportunities to secure permanent staff continue to be progressed • Regular recruitment drives ongoing with the most recent drive for Adult Nursing including Year 2 and Year 3 students. This resulted in 153 job offers on the day with many of the pre-employment checks undertaken. Follow up work is now underway to maintain a relationship with all appointees until their start dates. The most recent drive for MH Nursing is also aimed at including	**Acute Director and Medical Director**	**HIGH**

			Year 2 and Year 3 students and is ongoing at the time of this update • Introduction of Rotational Programmes within and across Directorates. • Targeted recruitment of current nursing students for bank Band 3 roles ongoing with a view to introducing them to the Southern Trust for their Band 5 career. • Six staff have secured places on the funded Open University Pre-registration Nursing Programme commencing September 2015. A further ten staff were successful at interview. SHSCT has offered these ten deferred places for the OU PRNP commencing September 2016. • A Trust Nursing Workforce Planning Group has been established to seek to address current and future anticipated challenges regarding the demand for and supply of Registered Nurses across all programmes of care. Consideration is now being given to International Recruitment. • A regional Nursing Workforce Planning Group, chaired by Mr F Rice, Executive Director of Nursing, has now completed a scoping exercise at a high level to collate the statistics on vacant posts compared to Funding Staffing and the numbers of staff unavailable for work due to various types of leave.		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
10	Insufficient capital to maintain and develop Trust estate to support service delivery and improvement	• Maintaining Existing Services prioritised investment plan agreed by Trust Board and shared with Department • Recent capital allocations have addressed highest priority risks. This process is on-going. Capital Resource Limit also utilised where possible to address highest risk • Strategic development plans in place for major projects and business cases submitted for highest risk areas Specific examples: • Fire Safety Action Plan in place High Voltage capacity limit on supply to Craigavon Area Hospital Identified (see below) • Aging High Pressure Hot Water system (HPHW) at Craigavon Area Hospital has now been replaced with new Low Pressure Hot Water system. • £2.9m secured to complete structural works to tower block at South Tyrone Hospital • Completion of Theatre development CAH	• On-going prioritisation and bidding process for capital in place • Fire Safety Action Plan in place and agreed to inform Maintaining Existing Services investment • Recommendations from RQIA hygiene inspection reports prioritised for Capital Resource Limit/Minor works where no other funding source available • Business cases in development to address significant Maintaining Existing Services infrastructure issues requiring investment > £500k Business cases for High Voltage/Electrical works and Mechanical Infrastructure have been approved by DHSSPS enabling works to progress during 2015/16. Phase 1 of Mechanical Infrastructure complete. • Strategic Outline Case submitted for major redevelopment at CAH site. Work is now being progressed on the main business case for submission in 2015/16. • New negative pressure isolation room at CAH to be completed by November 2015. • Provision of new negative pressure isolation room at DHH awaiting decision on preferred option from Acute Services. Thereafter proposals to be incorporated in Business Case for consideration by SMT/Trust Board.	Director of Human Resources and Organisational Development	**HIGH**

			The sewage system serving the wards at CAH has reached a critical point with frequent blockages leading to bursts and subsequent contamination of patient and support areas. This presents a serious infection control risk; causes disruption to services; and has been reported in the press potentially damaging service user confidence. An extensive replacement programme commenced in August 2015 through a carefully co-ordinated and phased programme of ward decants. Works will be carried out to the most critical areas over the next few months (subject to the availability of decant space v winter pressures). Further works may be necessary after the winter period to complete the programme. A review of maintaining existing services (for the next 5 years) has been carried out. This review has identified that funding in the region of £119 million is required to address risk areas including: Critical Telecommunications infrastructure; Infection control and Health & Safety issues in patient areas; Medical Gas infrastructure and ventilation system risks; Structural repairs to DHH. This requirement could be significantly reduced should the replacement of CAH proceed.		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
11	High Voltage capacity limit on electrical supply to Craigavon Area Hospital • Identified under Maintaining Existing Services scheme • Possible limit to expansion of service provision on the Craigavon Area Hospital site • Increased electrical demand on existing limited supply may exceed capability of supply	• All future development/ expansion of the estates is to be notified to Estate Services • Generator backup • Load shedding • Monitoring current demand • Business Continuity Plans for restabilising electrical service in the event of unplanned interruption • Peak Lopping installed and completed following agreement with Northern Ireland Electricity • Phase 1 business case for Low Voltage works to provide short-term mitigation for risks approved in June 2012 for £2.5m works now completed.	• Schemes to provide a new supply for the site are ongoing with Northern Ireland Electricity. A new 6MVA supply has been agreed. Site wide installation of High Voltage supply now ongoing. • Independent experts appointed to provide Infrastructure condition report and inform plans for new High Voltage/Low Voltage infrastructure • Mechanical Infrastructure and Electrical Infrastructure Business Cases have been approved and these projects are being progressed in parallel as both Combined Heat and Power (within Mechanical) and new High Voltage intake (within electrical) Strategic Outline Case are required to manage the risk. • Installation of new Combined Heat and Power plant is completed and G59 approval from NIE (to permit parallel generation) in place. Contract for operation and maintenance of plant being finalised with PALS. This will provide additional source of supply for the site. At this point, this risk will be re-assessed and may reduce to moderate risk. • CAH site High Voltage infrastructure works, together with the new NIE High Voltage supply, anticipated completion September 2016	Human Resources & Organisational Development	**MEDIUM**

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
12	The external audit of the pharmacy Aseptic Suite, which prepares all the total parenteral nutrition and the chemotherapy for oncology and haematology patients, has identified several issues: • The design and fabric of the aseptic building does not meet the modern building standards for pharmacy aseptic dispensing units (critical audit finding). • Application of the newly introduced capacity plan has identified the chemotherapy pharmacists' activity is exceeding 100% on a regular basis (Major audit finding)	• Increased environmental monitoring to check for failures of sterility in the unit • Expiry dates of all products prepared has been reduced to a maximum of 24 hours. • A daily report on the chemotherapy pharmacists activity level in relation to the capacity plan has been developed and implemented • Additional activity will not be accepted by the aseptic unit until the staffing issue is resolved	• The queries received in relation to the business case for a new build aseptic suite co-located with the Mandeville Unit have been addressed and the OBC was submitted to the Department on 1.7. 2015. A letter of Commissioner Support received from the HSCB has been submitted. The Trust has identified this as its top priority for capital funding. • Recent deterioration in the fabric of the building is being addressed through an interim plan involving urgent minor works to the aseptic suite. • The Capita Model for chemotherapy/cytotoxic dispensing was applied to the current workload in the unit. This identified a staffing deficit of 3.6wte pharmacists. Using the capacity plan as a model the unit is short 2 pharmacists for the current workload. HSCB agreed to fund	Director of Acute Services	**HIGH**

	• The two isolators used in the cytotoxic reconstitution section of the aseptic suite both require urgent replacement.(Major audit finding)	• Additional environmental and function testing is being performed on both isolators to identify any sterility failures.	the 2 additional band 7 pharmacists required. The IPT was received in May 2015 and the recruitment process is complete. The pharmacists will start in January 2016. • complete		
	Risk Area and Principal Risks	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
13	HCAI • Risk to achievement of Priorities for Action target identified • Risk to patient safety • Lack of automated HCAI surveillance system linked to Trust laboratory system • Lack of appropriate isolation facilities (including negative pressure facilities) within the Trust hospital network • Emerging infections (CPE/VHF/ebola) • HCAI outbreaks in tertiary services (BHSCT)	• Comprehensive isolation policy in place and strictly adhered to • On-going mandatory and tailored IPC training • Manual surveillance systems in place. Independent and self-audit programme • Comprehensive governance structure in place, including bi-monthly HCAI Strategic Forum and monthly HCAI Clinical Forum meetings • Outbreak /incident management plan in place • Establishment of antimicrobial management team to oversee antimicrobial stewardship • HCAI Root Cause Analysis process in place • Compliance monitoring against key DHSSPS standards and	• On-going measurement of compliance against DHSSPS Communiqués • Ongoing self and independent audit using the RQIA Augmented Care Audit tools. • Learning outcomes from RCAs being shared with senior and junior medical staff. • Engagement meeting with HSCB regarding GP and Primary Care involvement in C.difficile RCA cases • Embedding Urinary Catheter project to target E-coli infections and promote safer clinical practice when dealing with urinary catheters across community and acute sites. • Engagement with PHA on Regional Surveillance system funding and procurement to recommence	Medical Director	**MEDIUM**

	• Increasing emergence of CPE infections	guidelines relating to HCAI	• Enhancement communication to front line clinical staff via HCAI e-Alert • Suite of procedures and guidelines to support the prevention, management and control of CPE. • Completed Ebola Management Plan • CPE Outbreak/Incident Management • Enhanced HCAI RCA information management system and system developed to further improve meta-analysis of C Difficile cases • Renewed focus on isolation and screening of transferred patients, including planning of negative pressure isolation facilities on CAH site • Joint letter from Medical Director, Executive Director of Nursing and Director of Acute Services issued to staff re Infection Control practice • Re-launch of IV Programme in Acute sites to address increasing MRSA/MSSA bacteraemia • Development of a Business Plan to consider Infection Prevention Control (IPC) Nursing Workforce within the Trust		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
14	Inability of Laboratory at Craigavon Area Hospital to maintain its Biochemistry Accreditation Status	• Action Plan in place to address non-conformances • External Quality Assurance and Internal Quality controls	• The Trust has submitted its application for re-accreditation and is awaiting a new date. A pre-assessment visit is planned for 8th October 2015. This visit will assess the Laboratory's state of readiness for a full UKAS 151189 inspection. • Action Plan updated as progress is made. • Full inspection advised for April 2016		**HIGH**

CORPORATE OBJECTIVE 4: BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
15	Fully embedded appraisal system – lack of evidence of compliance	There are a variety of mechanisms in place to ensure appraisal takes place:- • Medical Appraisal • Professional Supervision • Knowledge and Skills Framework (KSF) policy and monitoring system in place • KSF is a standing item on the agenda of the Education, Training and Workforce Development Committee and SMT meetings • Action Plan in place and reviewed quarterly • Staff Attitude Survey results provide staff view • Working Group established by Vocational Workforce Assessment Centre to further embed KSF throughout the organisation.	**Consultant / Medical Appraisal** As at 16/11/15, 93% of 300 eligible doctors have completed their 2014 appraisal. **Knowledge and Skills Framework** A KSF steering group continues to meet quarterly. Work is ongoing with individual Directors and Heads of Services to support staff and managers when completing their KSF Documentation, and therefore to increase uptake within each Directorate KSF reports continue to be collated monthly and forwarded to Directors. Regular reports regarding uptake levels across the Trust continue to be presented to SMT PDP's are now being recorded on HRPTS as a qualification. As a result of all of the above, there has been an increase in the extent to which KSF is being implemented across the Trust. Work underway to improve mandatory training levels within the Trust	Medical Director Director of HR and Organisational Development	**MEDIUM**

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
16	Implementation of the Nursing Midwifery Council's (NMC) revised revalidation arrangements in April 2016	• NI Revalidation Programme Board, attended by the Executive Director of Nursing, meets bi-monthly • NI Revalidation Working Group attended by the Trust's Assistant Director Nursing Governance, meets monthly • In October 2015 the NMC has agreed its arrangements for the revalidation of nurses and midwives to commence in April 2016	The Trust's Medical Revalidation Team has been extended to support the implementation and progression of Nursing and Midwifery revalidation which is due to commence in April 2016. Extensive work has been undertaken to establish a Nursing and Midwifery Revalidation information management system which holds all (3,023) Trust NMC registrants' PIN, Annual Fee Expiry and Revalidation dates. This information management system is now live and will provide assurance to the Executive Director of Nursing, SMT and Trust Board in relation to the progression of Nursing and Midwifery revalidation. Monthly revalidation reports will be issued to individual nursing / midwifery managers to support local arrangements on the timely revalidation of nurses and midwives for whom they have responsibility. Standard Operating Procedures have been developed to provide timely reports to nursing and midwifery managers and heads of service. Assistant Director Nursing Governance, with Directorate Champions are developing tools and proformas to support nurses and midwives in evidencing compliance with the core revalidation elements and to prepare nurses/midwives for their professional development discussion with their NMC colleague. Assistant Director Nursing Governance has linked with the AD Nursing Workforce Development and Training and Clinical Education Centre to scope out planned support programmes.	Executive Director of Nursing	**HIGH**

CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
17	• Achievement of financial balance in 2015/16	• Contingency Plan for 2015/16 in place • Best Care Best Value (BCBV) Project structure • Financial monitoring systems in place • Monthly report to SMT and Trust Board	As a result of additional Health and Social Care Board allocations and Departmental approval to a number of additional contingency proposals, the Trust would now expect to breakeven in 2015/16.	Finance and Procurement/ All	**MEDIUM**
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
18	Management and monitoring of procurement and contracts – not compliant with best practice guidance	• Contracts management improvement group established and key actions formed • New guidance on Single Tender Action (STA) processes issued and implemented. Follow up training provided . • Training on Contract Management with focus on responsibilities of Contract Owners rolled-out with follow up sessions also delivered	**GENERAL** • Action plans in place to address weaknesses identified in Internal Audit reports with updates to Senior Management Team and Audit Committee • Monitoring reporting in place providing a summary position on procurement status/risk at Directorate level and follow up actions with Directorates ongoing	Director of Performance and Reform/ Director of Finance and Procurement/ All Directors	**MEDIUM**

			(Central monitoring ceased in October 2013) • Interface meeting established with BSO/PaLS and process agreed for prioritization of e procurement requirements within available capacity. • Capacity sought via IPT for social care procurement of key projects including (Learning disability Day Opportunities/Respite and Domiciliary Care) under influence of CoPE. Bid approved, however recruitment has been suspended due to financial pressures. Alternative options being considered to progress these procurements. • Trust has responded to draft recommendations of J. Allen Review of Procurement. Final recommendations of Procurement Policy awaited • New Structures for contract & procurement management being developed as part of Management Review **ESTATES** • Proposed models brought forward by PALS and Trusts on regional basis to address procurement deficit for Estates services agreed by Directors of Finance. Regional Steering and Working Groups established. Recruitment of PALS team underway.		

			Recruitment of Trust Team being taken forward under newly appointed Head of Service. • Measured Term Contract (MTC) in place for 2015/16 which mitigates risks to procurement for schemes <£45k • Estates Works Management Improvement Action Plan (incorporating all IA recommendations) established and 95% implemented during 14/15. Internal Audit undertook a follow-up audit (reported March 2015) and verified that the majority of recommendations had been either partially or fully implemented. Further IA work to be undertaken third quarter of 2015/16. • Two replacement Estates Officers appointed and volume of works being undertaken balanced against resources to facilitate compliance. **SOCIAL CARE PROCUREMENT** • Regional Procurement Board via Social Care Procurement Group have agreed approach to social care procurement. Internal plan to be developed to secure necessary resources, skill and capacity to take forward a limited number of social care procurements		

			• Capacity sought via HSCB transitional funding in 2014/15 for social care procurement of key projects including (Learning Disability Day Opportunities/Respite and Domiciliary Care) under influence of CoPE. Bid approved, however recruitment has been suspended due to financial pressures. • Internal resource diverted to provide procurement support to key mental health directorate projects in 2014/15 enabling change. This capacity has been extended into 2015/16. • Further capacity established in October 2015 to support domiciliary care procurement from redirected internal resources. • Impact of 2015 Public Contract Regulations on social care procurement assessed and key actions agreed to scope demand and capacity requirements		

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
19	Payroll & Travel - HRPTS System & Shared Services • Payroll & Travel Payments - potential for inaccurate and/or late payments. Negative media publicity and impact on Trust's reputation as a good employer. • Transfer to Payroll Shared Services and maintenance of service delivery • Recruitment – considerable delays currently being experienced in the recruitment of posts which is impacting on operational services	• Customer Forums are in place for monitoring the performance of services in Shared Services Centres • Progress updates to Audit Committee • Regular meetings with BSO • Escalation procedure in place by Trust's Head of Resourcing • Weekly monitoring	• Ongoing communication/engagement with Managers as regards timely completion of paperwork • Weekly, Fortnightly and Monthly staff transferred to the Payroll Shared Service Centre. • Additional resources identified to support BSO in the delivery of services	Finance Director	**MEDIUM**

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
20	GP Out of Hours Service – Reduced ability to maintain adequate service provision and patient safety due to vacant GP shifts	• Recruitment process for vacant posts • Business Continuity Plan • Medical Managers with medical responsibility for the service • Call Centre Co-ordinator • Call Manager system • Late availability payment • Flexibility re shift patterns offered • Daily monitoring of rotas and appropriate contingency plans deployed based on resources available	• Regular updates to HSCB/Integrated Care Department regarding vacant shifts. Escalation to HSCB when GP cover is significantly reduced. • When clinical cover reduced to less than 50% or 1 red eye doctor, early alert sent to HSCB by 3.00 p.m. • A weekly email of vacant shifts is being sent on a Monday to all clinicians. Daily text messages and phone calls to GPs and Nurses in attempts to cover shifts. • Small team of nurses in GP Out of Hours Service working extra hours, where possible to assist in covering gaps • IPT submitted to appoint 50 Nurse Triage staff. Trust proceeded at risk to commence the recruitment process. Interviews have been completed. Nurse Advisors – 25 are competent and able to work. A further 9 have received telephone triage training and are being shadowed to be deemed competent • As and when bank Nurse Practitioners have been recruited and are working within the service. • Recruitment of 8A service improvement role to the end of April 2015 to review the service model. Report will be presented by end July2015. • Review of workload of clinicians ongoing by Clinical Lead	Older People and Primary Care	**HIGH**

			• KPIs continue to be monitored hourly. Weekly triage KPIs sent to HSCB • Working with Integrated Care Dept to address capacity issues and use of locum GPs. Locum agencies had been contacted and no doctors available. • Working with other OoH providers to secure additional capacity • Twice daily operational meetings to review cover and actions required. • Pharmacy pilot has been extended to end of March 2016 using winter pressures money and covering hours 10.00 a.m. – 8.00 p.m. • Winter pressures plan is being implemented, with enhanced rates and increased capacity • Locally Enhanced Service (LES) implemented on 7th November 2015 until end of March 2016 • Contingency and escalation plan agreed and now being implemented		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
21	Health Visiting Service – Impact on children/families due to reduced ability to deliver services as a result of decreased staffing levels in the service	• Control measures in place include step down i.e. universal contacts to non-vulnerable families have been reduced; • Utilisation of bank (limited supply) and additional hours of existing health visiting staff; • Drop in clinics available to ensure rapid access to HV if parent worried or concerned	• The Health Visiting workforce position demonstrates that Staff in Post equate to the Funded Staffing Levels. The reality is that there are 16.54 wte unavailable to deliver the service (due to planned and unplanned absence), which equates to 20% of this workforce not available at a given time. This demonstrates a worsening position	Executive Director of Nursing/ Director of C&YPS	**HIGH**

		about an infant / child; • Rota system is in place to equitably allocate clinic cover, new births, movement in visits and new safeguarding cases; • Team managers to notify HoS and Named Nurse for Safeguarding Children if they are unable to allocate a child protection case. • Provision of universal contacts is being monitored across service/teams on a quarterly basis through IoP report and this information is sent to Director/DHSSPS/HSCB/PHA .	from that of May 2015 when 14% of the HV workforce was unavailable. This staffing deficit means that all 7 Health Visiting Teams are in step down: • There are currently 8 permanent vacancies, 7 maternity leaves and 8 staff on long-term sick leave. • Due to the regional shortage of Health Visitors, the amount of temporary staff the SH&SCT is able to secure through the bank is insufficient to meet the deficit. • Eleven Health Visiting students are currently completing their management placements which releases some of the Practice Teachers time to work into some of the vacant caseloads. • In communications with the HSCB and PHA regarding the Health Visiting workforce, assurance has been given that SHSCT are proactively processing vacancies in order to appoint staff as soon as possible. SHSCT has also articulated the need for additional funding to meet the particular needs of the population within this area. • Sixty-one Health Visiting places were approved regionally for 14/15 and SHSCT is facilitating 11 students. These students will finish in September 2015. 5 of the permanent vacancies have been		

			offered and accepted by the students, with e-requisitions in progress for the remaining vacancies. We continue to await additional investment agreed with the PHA. This situation is exacerbated by the reduced capacity of the Family Nurse Partnership team (detailed on the CYP Directorate Risk Register).		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
22	Safeguarding of residents within HH/BC - Historical and ongoing risk to residents of potential financial abuse.	• Review of Residents within the Care Management process. Residents' reviews are held more frequently if required. • Families were given choice regarding continuing with placement or seeking an alternative following the outcome of the initial investigation – 4 out of 5 moved • Liaison with the residents, relatives/families where appropriate. • Weekly Trust meetings to review status & regular updates provided to Trust Board / SMT. • Regular updates from Trust HHBC group provided to DHSS/HSCB/RQIA/Other Trusts	• Ongoing liaison with the residents, relatives/families where appropriate. • Suspension of new admissions/respite beds remains in place. Current controls to remain as agreed by SMT and Trust Board. • Public Prosecution Service has determined no prosecution of the Home Owners regarding one client • RQIA is currently pursuing a prosecution of the Home Owners under Article 42 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. • Formal Court Order regarding disclosure received by Trust. Information requested was provided to DLS for	Mental Health & Disability	**HIGH**

		• Within Disability Services potential placements are discussed and prioritised at Trust Accommodation Panel. • Regular advice/support/ direction by Trust Legal Advisers • Contract Review Meetings with HHBC and quarterly operational meetings with HHBC as part of the contract compliance process. • Trust addresses in writing any identified concerns/queries as they arise with the Home Owners and their Legal representatives. • Trust addresses any identified concerns/queries raised by resident/relatives and Trust staff. • Trust addresses any identified concerns/queries raised by DHSSPSNI/RQIA. • Adult Safeguarding Process. Remaining residents have care and protection plans which have been put in place and updated as required. • Contacts with RQIA • Trust "Procedure for Responding to RQIA Alerts & Other Performance Management issues within Social Care Contracts".	presentation to the Court on 16.9.2015. • Scoping exercise has been completed should alternative placements be required and will • be revisited • Update Report to Trust Board on 26th November 2015		

		• Ongoing processes with OCP / RQIA / NMC / HSCB re SAI, Disclosure & Barring Service (DBS) • Trust assumed responsibility for mobility monies which are now held in PPP accounts and payment is only made on receipt of verified invoices. • New Trust Case Management Guidance and Training Programme completed.			

Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

November 2016

to Governance Committee
on 8th December 2016

INTRODUCTION

The SH&SCT Corporate Risk Register identifies corporate risks, all of which have been assessed using the HSC grading matrix, in line with Departmental guidance. This ensures a consistent and uniform approach is taken in categorizing risk in terms of their level of priority so that proportionate action can be taken at the appropriate level in the organization. The process for escalating and de-escalating risk at Team, Divisional and Directorate level, is set out in the Trust's Risk Management Strategy.

Each risk on the Register has been linked to one of the four domains contained within the Board Assurance Framework and to the relevant Trust Corporate Objectives as detailed below:-

Four Accountability domains contained within the Board Assurance Framework

- Domain 1 Corporate Control
- Domain 2 Safety and Quality
- Domain 3 Finance
- Domain 4 Operational Performance and Service Improvement

Corporate Objectives

1: Provide safe, high quality care.
2: Maximise independence and choice for our patients and clients.
3: Support people and communities to live healthy lives and improve their health and wellbeing.
4: Be a great place to work, valuing our people.
5: Make the best use of resources.
6: Be a good social partner within our local communities.

OVERVIEW OF CORPORATE RISK REVIEW AS AT NOVEMBER 2016

LOW	MEDIUM	HIGH	EXTREME	TOTAL
0	9	4	0	13

The Corporate Risk Register has been reviewed by SMT on two occasions since the last Governance Committee meeting, most recently on 30th November 2016. Changes include:-

New risks identified by SMT or escalated from Directorate Risk Registers	None
Risks removed from the Register	Risk No. 6 Workforce Resourcing – Workforce shortages SMT agreed on 30.11.2016 to remove the **'Health visiting'** risk and manage this under the CYP Directorate risk register. This is due to the fact that Health visiting staffing levels have stabilised and are at the highest level seen in the last five years. The service has received significant investment and all investment posts have been filled.
Merged risks	None
Risks where overall rating has been reduced	Risk No. 1 Revalidation Arrangements – downgraded from high to medium risk by SMT on 26.10.2016 given that arrangements are now in place to provide assurance on timely revalidation and that monitoring procedures will identify those registrants at risk of failing to revalidate.
Risks where overall rating has been increased	None

Updates in blue font for ease of reference

SUMMARY OF CORPORATE RISKS AS AT NOVEMBER 2016

DOMAIN 1: CORPORATE CONTROL				
Risk No.	**Risk Area/Description**	**Corporate Objective**	**Risk Rating**	**Page**
1	**Revalidation Arrangements –** Implementation of Nursing Midwifery Council's (NMC) revised revalidation arrangements in April 2016	1 & 4	**MEDIUM**	**7**
2	**Appraisal –** lack of evidence of compliance with a fully embedded appraisal (KSF) system	1 & 4	**MEDIUM**	**8**
3	**BSO Shared Services:** Payroll/Travel and Recruitment	4&5	**MEDIUM**	**9**
4	**Data Processing –** lack of contract with BSO	1&5	**MEDIUM**	**11**
5	**Infrastructure** – Insufficient capital to maintain and develop Trust Estate (facilities, equipment, ICT Estate etc.) to support service delivery and improvement	1	**HIGH**	**12**

DOMAIN 2: SAFETY AND QUALITY				
Risk No.	**Risk Area/Description**	**Corporate Objective**	**Risk Rating**	**Page**
6	**Workforce Resourcing – Workforce Shortages**	1	**HIGH**	**18**
7	**Achievement of Statutory Duties/Functions –** robust case management processes	1	**MEDIUM**	**27**
8	**Capability of Trust systems of assessment and assurance in relation to quality of Trust services**	1	**MEDIUM**	**28**
9	**Healthcare Acquired Infections (HCAI)**	1	**MEDIUM**	**30**
10	**Safeguarding of residents from risk of potential financial abuse**	1	**HIGH**	**32**

DOMAIN 3: FINANCE				
Risk No.	**Risk Area/Description**	**Corporate Objective**	**Risk Rating**	**Page**
11	**Achievement of recurrent financial balance**	5	**MEDIUM**	**34**
12	**Management and monitoring of procurement and contracts –** lack of compliance with best practice guidance	5	**MEDIUM**	**35**
DOMAIN 4: OPERATIONAL PERFORMANCE AND SERVICE IMPROVEMENT				
13	**Achievement of Commissioning Plan Standards and Targets**	1	**HIGH**	**38**

DOMAIN 1: CORPORATE CONTROL					
CORPORATE OBJECTIVES: 1 & 4 – PROVIDING SAFE, HIGH QUALITY CARE & BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
RISK AREA/CONTEXT: REVALIDATION ARRANGEMENTS					
Risk No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
1	Implementation of the Nursing Midwifery Council's (NMC) revised revalidation arrangements in April 2016	• SMT agreement that 50% of Nursing Governance Co-Ordinators (NGCOs) hours would be allocated to supporting organisational and registrant readiness for revalidation. • Professional Revalidation Support Team • Nursing and Midwifery Revalidation information management • NMC Revalidation Implementation Group, chaired by the Executive Director of Nursing, to support and direct registrants and managers.	Arrangements to support organizational and registrant readiness for the revised NMC revalidation have been very successful. Standard Operating Procedures for checking Annual Fees and Revalidations are in place and are monitored. Monthly revalidation reports are issued to individual nursing / midwifery managers to support local arrangements on the timely reflective discussion and confirmation meetings for those they have responsibility for. Bi-monthly reports to SMT from the Revalidation Support Team provide assurance that all NMC registrants meet the requirements for continued practice.	**Executive Director of Nursing**	**MEDIUM**

DOMAIN 1: CORPORATE CONTROL					
LINK TO CORPORATE OBJECTIVES: 1 & 4 - PROVIDING SAFE, HIGH QUALITY CARE & BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
RISK AREA/CONTEXT: FULLY EMBEDDED APPRAISAL SYSTEM					
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
2	Lack of evidence re compliance of a fully embedded appraisal (KSF) system	There are a variety of mechanisms in place to ensure appraisal takes place:- • Professional Supervision • Knowledge and Skills Framework (KSF) policy and monitoring system in place • Action Plan in place and reviewed quarterly • Staff Attitude Survey results provide staff view • Working Group established by Vocational Workforce Assessment Centre to support Directors to further embed KSF. • PDPs recorded on HRPTS as a qualification	Knowledge and Skills Framework Work ongoing with Directors and Heads of Services to support staff and managers when completing their KSF documentation to increase uptake within each Directorate KSF reports continue to be collated monthly and forwarded to Directors. Regular reports regarding uptake levels across the Trust continue to be presented to SMT There has been a slight increase in the extent to which KSF is being implemented across the Trust – 56% as at 30th September 2016, although this is still short of the Internal Audit target of 60% by September 2016. Work is continuing to improve mandatory training levels within the Trust.	**Director of HR and Organisational Development**	**MEDIUM**

DOMAIN 1: CORPORATE CONTROL					
LINK TO CORPORATE OBJECTIVES 4 & 5 - BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE & 5 – MAKING BEST USE OF RESOURCES					
RISK AREA/CONTEXT: Shared Services Centres – Payroll / Travel & Recruitment					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
3	**Shared Services** • **Payroll & Travel SSC** – risk to accuracy of payroll as control environment not yet stabilized. Negative media publicity and impact on Trust's reputation as a good employer.	• Customer Forums are in place for monitoring the performance of services in Shared Services Centres • Monthly KPI data shared with the Trust • Progress updates to Audit Committee with attendance by BSO, as required • Regional audit of BSO Payroll Shared Services, currently six monthly • Trust participation in a number of groups to provide assistance on progressing improvements in Payroll Shared Services Centre	• Ongoing communication/engagement with Managers as regards timely completion of paperwork • Internal Audit Report – Payroll Shared Services, September 2016 – limited assurance • Internal Audit re-audit February 2017 • Quarterly BSO Assurance Reports circulated to Audit Committee members regarding progress on Internal Audit recommendations • Trust participation in new governance arrangements post BSTP to monitor shared services performance and achievement of benefits realisation	**Finance Director**	**MEDIUM**

	• **Recruitment Shared Services Centre (RSSC):** The speed of response / time to fill urgent posts poses a risk for front line services. This risk has the potential to increase as Recruitment Shared Services continues to be rolled out to all Trusts – there is a risk that standards will drop and the urgency of Trust services will be lost.	• Continued involvement in regional work / RSSC issues. Assurances to be sought from RSSC Head of Service regarding maintenance of standards and improvement on time to fill urgent positions. Monitoring reports on performance against standards also be provided by RSSC. • Monitoring and ongoing review of all aspects of the pre-employment checks including Occupational Health checks. • Identification of any internal issues, which may be contributing to the timeliness of recruitment exercises. • Local action plan in place to address issues/delays within the control of the Trust	Regular engagement with RSSC managers to monitor activity and review particular operational issues of concern/shortfalls in service delivery. An issues log is maintained by the Head of Resourcing. There are also regular meetings with RSSSC and Occupational Health to specifically address any blockages and share planning information. Internal Audit Report – Recruitment Shared Services, September 2016 – limited assurance Internal Audit re-audit February 2017 A Recruitment and Selection Liaison Officer has been appointed to monitor and take action in relation to any delays in the recruitment process in conjunction with BSO. A programme of refresher training is being rolled out across the Trust during October to December 2016. This will not only provide users with training in the E-Recruitment system, but will also incorporate details of managers' roles and responsibilities in relation to the recruitment and selection of staff, as well as associated Key Performance Indicators.	**Director of Human Resources and Organisational Development**	

DOMAIN 1: CORPORATE CONTROL					
CORPORATE OBJECTIVES: 1 & 5 – PROVIDING SAFE, HIGH QUALITY CARE & MAKING BEST USE OF RESOURCES					
RISK AREA/CONTEXT: Lack of Data Processing Contract with BSO					
Risk No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
4	Lack of 'Data Processing' Contract with BSO as per Information Commissioner (ICO) guidelines. Risk of financial penalties/ fines and adverse publicity in the event of a data loss or breach.	• Trust ICT Security policy • Trust performance in application/ use of HCN re anonymized data	• This Risk requires ongoing monitoring in line with development of electronic and shared systems approaches in HSC. • The Trust has engaged Department of Legal Services (DLS) to assist with development of an appropriate contract. • Risk escalated and shared on regional basis via NI Electronic Care Record Information Governance Workstream • Meeting scheduled for 17th November 2016 with BSO and other Trusts to discuss and agree action	**Director of Performance & Reform**	**MEDIUM**

DOMAIN 1: CORPORATE CONTROL (also linked to Domain 3 Finance and Domain 4: Operational Performance and Service Improvement)					
CORPORATE OBJECTIVE: 1 – PROVIDING SAFE, HIGH QUALITY CARE					
RISK AREA/CONTEXT: INFRASTRUCTURE – Maintenance and development of Trust Estate (facilities, equipment, ICT etc.) to support service delivery and improvement					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
5	Insufficient capital (and associated revenue) funding to maintain and develop Trust Estate (including I.T. Estate) to support service delivery and improvement Specific risks include:- • Critical Telecommunications infrastructure; • Design and fabric of Aseptic suite, Craigavon Area Hospital • High Voltage capacity limit at Craigavon Area Hospital • Increased risk of significant service disruption due to high degree of construction activity on Trust sites • Maintenance and development of existing ICT Estate	• Maintaining Existing Services prioritised investment plan agreed by Trust Board and shared with Department • Recent capital allocations have addressed highest priority risks. This process is on-going. • Capital Resource Limit also utilised where possible to address highest risk • Strategic development plans in place for major projects and business cases submitted for highest risk areas:-	• On-going prioritisation and bidding process for capital throughout the year • Recommendations from RQIA hygiene inspection reports prioritised for Capital Resource Limit/Minor works where no other funding source available • Business cases continue to be developed for all schemes as per Capital Resource Limit allocation • The outline business case for Craigavon Area Hospital Redevelopment was submitted to the Department of Health, Social Services & Public Safety on 15th June 2016. A phased build is proposed. Assuming approval by March 2017 of the masterplan concept and to phase 1 funding, phase 1 (including enabling works) could be completed by October 2026.	**Director of Human Resources and Organisational Development/ Director of Acute Services/ Director of Performance and Reform**	**HIGH**

	Critical Telecommunications infrastructure **System Support:** Increased risk of in-cohesive maintenance, system support, due to gaps in out-of-hours provision of cover. Construction of the new Paediatric unit at Craigavon Area Hospital has highlighted an additional resilience risk relating to critical cable routes for telecoms and IT infrastructure	• The Trust has entered into a comprehensive contract (VDCP) with BT to manage the existing network and support the structured replacement of individual legacy systems. The existing Siemens DX switches, which serve telecoms users for approximately 60% of the Trust, reach end of supported life in November 2017.At present, in the event of a failure, BT VDCP through Siemens guarantee a repair within 4/8 hours depending on service level agreement.	• A review of maintaining existing services (for the next 5 years) has been carried out. This review has identified that funding in the region of £119 million is required to address risk areas including: Critical Telecommunications infrastructure; Infection control and Health & Safety issues in patient areas; Medical Gas infrastructure and ventilation system risks; Structural repairs to DHH. This requirement could be significantly reduced should the replacement of CAH proceed. • Prioritisation of highest Estates risks undertaken to inform allocation of available capital and revenue funding for 2016/17. • SMT approved Capital Funding of £342,000 (2015/16) for the provision of a Core Telephony Platform to provide the centralised telephony foundation and continuity for the existing Avaya Telephony infrastructure deployment. Planned completion end March 2016. • Requirement for additional funding to replace 5 systems on core DX sites including St Lukes, Tower Hill, Craigavon Hospital and Daisy Hill Hospital. [5 systems c£450k each] • Requirement for additional funding to replace 4 systems serving		

		• After November 2017, BT will no longer provide a guaranteed service agreement and it will be "best endeavours" i.e. only if parts can be sourced (used stock of whatever) etc. they will try and fix it. If the fault is software related there is unlikely to be a fix. A fault will leave the Trust without internal/external communications for a considerable period. These phone systems are well beyond their expected life and desperately need to be replaced.	Medium and Small sites (62). [4 systems c£425k each] • Replacement of Core System and roll-out of Handsets being progressed on a phased basis – £950k revenue funding has been approved to progress this during 2016/17 • Proposals being developed for independent secure cable route to improve resilience • Programme in place to address critical infrastructure risks by November 2017 at which point this risk can be reviewed		
	Design and fabric of the Aseptic building does not meet the modern building standards for pharmacy aseptic dispensing units (critical audit finding)	Increased environmental monitoring to check for failures of sterility in the unit • Expiry dates of all products prepared has been reduced to a maximum of 24 hours.	• Confirmation of the funding for the business case for a new build aseptic suite co-located with the Mandeville Unit was received at the end of July. The design team have met with the aim of commencing the build in March/April 2017. • Recent deterioration in the fabric of the building has been addressed through an interim plan involving urgent minor works to the aseptic suite which was completed in mid-May 2016. • The external auditor revisited the suite on 26th July 2016 and	**Director of Acute Services**	

	High Voltage capacity limit on electrical supply to Craigavon Area Hospital • Identified under Maintaining Existing Services scheme • Possible limit to expansion of service provision on the Craigavon Area Hospital site • Increased electrical demand on existing limited supply may exceed capability of supply	• All future development/ expansion of the estates is to be notified to Estate Services • Generator backup • Load shedding • Monitoring current demand • Business Continuity Plans for restabilising electrical service in the event of unplanned interruption • Peak Lopping installed and completed following agreement with Northern Ireland Electricity • Phase 1 business case for Low Voltage works to provide short-term mitigation for risks approved in June 2012 for £2.5m works now completed. • Installation of new Combined Heat and Power plant is complete and G59 approval from NIE (to permit parallel generation) is in place. This will provide increased resilience through an additional source of supply for the site.	their report was received on the 30/10/16. The report will still classing the unit as high risk due to the critical finding re the fabric and design of the unit, however, it recognizes the work that has been done to manage this risk whilst the new unit is awaited. • Schemes to provide a new supply for the site are ongoing with Northern Ireland Electricity. A new 6MVA supply has been agreed. Site wide installation of High Voltage supply now ongoing. • Independent experts appointed to provide Infrastructure condition report and inform plans for new High Voltage/Low Voltage infrastructure • Mechanical Infrastructure and Electrical Infrastructure Business Cases have been approved and these projects are being progressed in parallel as both Combined Heat and Power (within Mechanical) and new High Voltage intake (within electrical) Strategic Outline Case are required to manage the risk. • Planned completion date for High Voltage works on Craigavon Area Hospital site is 11.12.2016 at which point this risk can be reviewed.	**Director of Human Resources & Organisational Development**	

	Increased risk of significant service disruption due to high degree of construction activity on Trust sites	• Use of competent 3rd parties- Professional Design Teams & Contractors- competency is part of procurement assessment • Competent staff and comprehensive procedures • Wide stakeholder engagement on all projects • Project specific information- pre-construction information, construction phase plan and Health & Safety File • Use of in-house rules 'Requirements for contractors' in work schemes • Use of work permits for higher risk work processes • Communications team & global email used for wider general & public communications • Annual plan of works	• Recruitment of 'project compliance officer' type of role who would provide a constant presence on work schemes to review Health and Safety, permit compliance, quality, etc. to be progressed in 2016/17 • Longer term planning of work schemes and allocation of funding to spread (on-site) work schemes over the entire year rather than in the 4th quarter which is generally the case. • c£500k funding approved for the creation of additional car parking spaces on the Craigavon Area Hospital site during 2016/17 • On Craigavon Area Hospital site provide an additional site entrance/ exit – design proposals to be developed 2016/17 • Updates to 'Requirements for contractors' document underway • Job Description for 'Project Compliance' post under review as part of re-structuring . To be taken forward in Quarter 4 2016/17. Once post is appointed, this risk can be reviewed.	**Director of Human Resources & Organisational Development**	

	Maintain and develop existing ICT estate, including server infrastructure, data storage, etc and support to ICT service modernization Specific risks relate to:- Ability to implement planned upgrades / infrastructure as foundation to support developments in ICT innovation and limits these developments within the Trust Capacity to expedite/support mobile working roll out which subsequently (impacts on front line service capacity workforce risks below)	• ICT infrastructure requirements in terms of maintaining existing services have been prioritized in the IT Business plan approved by Trust Board and shared with HSCB. • Retention and disposal protocols in place • E-mail Archiving policy and procedure approved by SMT March 16.. • Bids for funding continue to be made to Capital Allocations Group and e-health division of HSCB for access to slippage. IS Technology partners utilised to provide support in line with available NR resources. • Prioritisation is being given to maintaining existing services and replacement of existing devices to upgrade them and minimize support requirements. • Service requests for more laptops and mobile devices are currently being declined.	• On-going prioritisation and bidding process for capital in place • Policies and procedures in place to manage ICT storage capacity. • A business case is underway to outline the full costs (including staff support) associated with further IT users. • All internal business cases for IT innovation include the recurrent support costs for both infrastructure requirements, licensing and service desk. • A number of vacancies previously held as part of corporate contingency have been released in 16/17, however recruitment processes are delaying commencement date of staff offered posts • The Trusts technology partner Hewlett Packard is providing temporary non-recruitment staffing to support Trust operational management in 16/17 • Processes in place to ensure all internal business cases for IT innovation include the recurrent support costs for both infrastructure requirements, licensing and service desk.	**Director of Performance and Reform**	

DOMAIN 2: SAFETY AND QUALITY

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE

RISK AREA/CONTEXT: WORKFORCE RESOURCING – WORKFORCE SHORTAGES

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
6	**Workforce Resourcing Risk – Workforce shortages** The Trust is facing a number of workforce resourcing risks, including the following key risks: **Medical shortages** • Consultant Medical Staff in Dermatology, Emergency Medicine, Breast Surgery and Radiology • SAS Medical Staff in Anaesthetics, General Surgery, GP Out of Hours, Urology, Dermatology, Emergency Medicine and Paediatrics	**Key controls to include:** • Ongoing recruitment (including overseas) campaigns • Use of Locum agencies • Risk Assessment highlighting controls/action in place • Trust Senior Oversight Group for ED DHH • Escalation procedures in place to alert senior management of any changes in rota for ED DHH • Daily review by Senior Management of night reports and follow up on issues on ED DHH • Daily audit of notes for ED DHH • Close monitoring of all Breast referral waiting times • Submission of HSCB Unscheduled Care Escalation plan (6th May 2016)	**Dermatology Medical:** A Dermatology trainee is now required to rotate to Craigavon one day per week. This should encourage trainees to apply for Consultant posts in Craigavon. Two retired Consultants continue to undertake some Waiting List Initiatives (WLI) clinics for Dermatology. There has also been an increase in expanding nurse led clinics. However there is still a requirement for a new (3rd) Consultant post which will be difficult to fill. **Emergency Medicine:** The Trust continues to advertise regularly for Consultants in Emergency Medicine. A Consultant will commence in ED on 3rd January 2017. This Consultant will be required to provide a sessional commitment to Daisy Hill Hospital each week.	**Human Resources & Organisational Development/ Medical Director/Director of Acute Services**	**HIGH**

			The most recent advertising campaign which closed on 9th November 2016 has attracted a further applicant. This applicant will be interviewed on 14th February 2017. The Trust regularly raises requirements for ED locums with all contracted agencies and other known non-contracted agencies. A number of 'longer term' locums have been engaged at Consultant and Middle Grade level. Ongoing review of ED DHH medical rota to ensure senior doctors are on duty until midnight. Opening of observation area from 22.00 – 08.00 for patients who have no definite diagnosis and have not been assessed or discussed with a Registrar. Recruitment of senior nursing staff to be on duty 24/7. **Breast Service** The Trust has secured the services of a part time Breast radiologist until 31st December in the first instance to support service provision. The Trust will seek to extend this post after December. As an interim measure, the Northern, South Eastern and Belfast Trusts are offering additional clinics to see a proportion of Southern Trust red flag referrals to reduce the waiting time for the triple assessment appointment to clinically acceptable levels. Transfers of patients have occurred over recent weeks and we are seeing waiting times falling.		

			A Breast surgeon was interviewed on 21st November 2016 and was subsequently offered the post. While this surgeon has accepted the job, a start date has yet to be agreed. A number of our own surgical Breast medics have increased their job plan capacity which now enables them to undertake additional sessions in house , again to increase capacity and reduce waiting times. The Breast service has met with Dr Gerry Millar to explore options for further GP training on the management of Breast Pain to enable these patients to be appropriately assessed and treated in their own GP surgery and further that we would train a small number of GP's with specialist interest in Breast pain who could assist with specific breast pain clinics working in conjunction with secondary care colleagues to manage this group of patients outside of the triple assessment clinics so increasing capacity for suspect cancer patients. There are further discussions planned and underway with other Trusts regarding the potential for a more sustainable network, providing cross Trust working to enable the provision the required capacity in Symptomatic breast services to meet Southern Trust demand.		

			There are plans by the HSCB to review Breast services from a regional perspective with a view to supporting a sustainable service design to meet the needs of the whole population. **Radiology:** The position remains unstable. Four consultant posts were advertised in April 2016 with only one applicant who has since been appointed. The remaining posts were re-advertised in September 2016. One applicant will be interviewed on 28th November 2016 for the Breast Imaging post. There was one applicant for a Gastro/Urology post. However, the applicant has not been shortlisted. **European Recruitment** The Trust engaged with A Team Recruitment regarding the recruitment of medical staff at SHO level from the EU. A total of 9 doctors have now accepted offers – 1 paediatrics, 7 surgery, and 1 ED DHH. Two doctors have already commenced in surgery in DHH. The remaining doctors will be required to pass the IELTS test before they can gain a license to practice with the GMC.		

		• Business Continuity Plan and Escalation in place • On Call Manager system • Pharmacy Service in place until March 2017 • Any concerns raised by GPs on the safety of the service will be escalated and addressed by Trust and HSCB. • Contract with Dalriada Out of Hours for additional Nurse Triage 6pm-8am from December 2015. • Daily contingency plan in place	**GP Out of Hours:** • Action Plan agreed with HSCB being progressed including initiatives to attract GPs to work in the service • Further skill mix planned in response to capacity and demand review including triage nurses and nurse practitioners • Minimal response to overseas recruitment drive for GPs • Monitoring of KPIs and performance on daily basis	**Director of Older People and Primary Care**	
	Nursing shortages • Inability to recruit Registered Nurses across all areas, including Health Visiting Service	• Ward Sister/Charge Nurse management of available staff • Escalation process agreed • Open registration for Nurse Bank • Open Recruitment campaigns • International Recruitment Plan	**Registered Nurses:** • International recruitment is progressing on a regional basis. • EU and non-EU recruitment drives commenced in May 2016 and recruitment exercises have taken place in the Philippines, Italy and Romania during the last 7 months. 92 posts have been offered for SHSCT from the Philippines to date and candidates are currently progressing through a range of pre-employment requirements before they can commence in the Trust. 17 posts	**Executive Director of Nursing/ Human Resources and Organisational Development**	

			were offered from the campaign in Italy and 11 nurses commenced employment in September 2016; a further 3 will commence in December 2016 as pre-Registration Nurses, pending completion of all requirements for full NMC registration. • Rotational Programmes continue to be a unique attraction to working in the SHSCT. Further roll out continues to be explored with programmes being actively planned for upcoming intakes of newly qualified nurses. • Department of Health announced increase to adult pre-registration training places by 100 commencing September 2016. Associated work has commenced to further access student placements across the Trust • SH&SCT have worked with OU and Department of Health to maximise funding and been successful to increase significantly the number of places on the OU PRNP commencing September 2016. SH&SCT have 23 staff commencing in September 2016, 7 of these staff are entering stage 2 of the programme with a further 16 commencing stage 1 of the programme. In addition 5 staff have been given a deferred place for stage 2 of the programme in 2017 • Collaborative approaches to local recruitment by the 5 HSC Trusts are		

			being taken forward through the Regional Recruitment Working Group • A 'one stop shop' recruitment day for Adult Nurses was held on 25.11.2016 with 73 candidates due to attend for interview • A range of measures have been presented and agreed at SMT aimed at releasing the capacity of nurses at ward level (e.g. increase in admin support and other non-nursing support at ward level).		

	Failure to attract/appoint required staff and delays in recruitment processes in mental health/disability inpatient wards, community teams, supported living and day care facilities	• Use of Agency • Cyclical recruitment monitored and reviewed to ensure waiting lists are updated • Creation of the training role with specific interest in disability and mental health	• Additional hours for existing workforce has improved the situation temporarily • Transfer of staff to meet need is becoming increasingly difficult as many services are also stretched due to staffing pressures Introduction of a local transfer policy to assist this process • Undertake recruitment drives for adult practitioners with advertising specific to Mental Health and Disability Directorate – currently ongoing. 17 new registrants recruited to Bluestone Mental Health wards, bringing nurse staffing to funded level. Over recruitment attempted to offset Bank hours • Undertake recruitment drives initially within CAMHS, then CAMHS & Adult Mental Health and if no success then externally for specific training posts. • Creation of local banks • Improve linkages with Southern Regional College to facilitate career advice on Health and Social Care related roles and visible presence at open days	**Director of Mental Health and Learning Disability**	

	Reduced ability to provide 24/7 laboratory service at Daisy Hill Hospital due to insufficient Biomedical Scientists New Regional IT implementations such as NIECR, BSTP and HRPTS have not included recurrent funding for local IT support	• Shadow rota in place from 1st July 2016 • Ongoing training in blood transfusion • Procedures in place in absence of Biomedical Scientist support on site	• The laboratory service is currently training as many Biomedical Scientists as is possible to function on the Daisy Hill Hospital rota. However, training in all aspects of Blood sciences and Blood transfusion takes a significant period of time. • Recruitment process resulted in 3 applicants – selection November 2016. N.B. Two resignations anticipated from the Haematology/Blood Transfusion service in January 2017 and March 2017. . The issue has been raised at the Regional Pathology Network Board. .	**Director of Acute Services**	

DOMAIN 2: SAFETY AND QUALITY					
CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
RISK AREA/CONTEXT: Achievement of Statutory Functions/Duties					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
7	The Trust should have robust case management communication processes in place and an assurance through audit that staff are appropriately undertaking these functions, including a clear understanding of the relative roles and responsibilities of the Trust's professional staff, contracts and finance functions, and clarity about the roles and responsibilities of RQIA and the Office and Care and Protection within the Case Management process.	• New Trust Case Management Guidance	• Mental Health, Learning/Physical Disability and Older People and Primary Care training completed. • Internal Audit of Case Management completed. Heads of Services tasked with taking forward required actions. • Restructuring process by Heads of Service completed within the Mental Health and Learning Disability Directorate.	**Director of Mental Health and Disability/ Director of Older People and Primary Care**	**MEDIUM**

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
8	Capability of Trust systems of assessment and assurance in relation to quality of Trust services Specific risks include:- 1. Monitoring and assurance of implementation/ compliance with Standards and Guidelines 2. Effectiveness of processes in place to review all intelligence from incidents, complaints, litigation and user feedback to highlight areas of risk and safety to drive improvement 3. Effectiveness of processes in place to disseminate and share learning from incidents, complaints and user feedback across the organisation	• Standardised process in place for the dissemination of Standards and Guidelines across the Trust • Web-based incident reporting Screening and investigation procedures in place in operational directorates with regards to incidents and complaints • Clinical and Social Care Governance information presented in dashboard format to SMT Governance and Governance Committee using trends over time to highlight risk • Guidelines in place for Directors setting out triggers for presentation of SAIs to SMTand Trust Board • Directorate, Division and Professional Governance Fora in place with reporting arrangements to SMT Governance, Governance Committee and Trust Board • Mortality and Morbidity structure in place across all clinical specialties • Mortality Reports to Governance Committee • Chair/Chief Executive/Director/Non Executive Director programme	• Project ongoing to improve on the dissemination of learning across the Trust. Linked to regional Q2020 improvement work. • Standards and Guidelines database to be updated to improve tracking of compliance and reporting functionality – December 2016 • Ongoing improvement of processes to disseminate learning across the Trust via - Learning Letters - Safety Alerts - Professional Forums - Mortality and Morbidity meetings - Incident screening processes • Develop corporate system to track compliance and report on RQIA reviews action plans – December 2016 • Develop the use of Clinical and Social Care Governance Audit to provide assurance of compliance and identify risk • Implementation of the Trust's Quality Improvement Framework.	**Medical Director**	**MEDIUM**

		of visits in place and feedback to Chair and Chief Executive • Executive Director Reports to Trust Board • Continuous Improvement support function to front line staff – capability and capacity building for service improvement • Trust Annual Quality Report • Executive Director Social Work has established an internal group to progress implementation of the quality indicators contained in the Social Work Strategy .			

DOMAIN 2: SAFETY AND QUALITY					
CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
RISK AREA/CONTEXT: HCAI					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
9	• Risk to achievement of HCAI Priorities for Action targets • Risk to patient safety • Lack of automated HCAI surveillance system linked to Trust laboratory system • Lack of appropriate isolation facilities (including negative pressure facilities in Daisy Hill Hospital) within the Trust hospital network • Increasing emergence of infections (CPE/VHF) • HCAI outbreaks in tertiary services • Depletion in IPC Nurse staffing	• Comprehensive isolation policy in place and strictly adhered to • On-going mandatory and tailored IPC training • Manual surveillance systems in place. Independent and self-audit programme • Comprehensive governance structure in place, including bi-monthly HCAI Strategic Forum and monthly HCAI Clinical Forum meetings • Outbreak /incident management plan in place • Establishment of antimicrobial management team to oversee antimicrobial stewardship • HCAI Root Cause Analysis process in place • CDI 'trigger' system in place • Compliance monitoring against key DHSSPS standards and guidelines relating to HCAI	• On-going measurement of compliance against DHSSPS Communiqués • Ongoing self and independent audit using the RQIA Augmented Care Audit tools. • Learning outcomes from RCAs being shared with senior and junior medical staff. • Engagement opportunities to be created with HSCB regarding GP and Primary Care involvement in C.difficile RCA cases • Embedding Urinary Catheter project to target E-coli infections and promote safer clinical practice when dealing with urinary catheters across community and acute sites – this requires resource. • Engagement with PHA on Regional Surveillance system funding and procurement to recommence • Enhanced communication to front line clinical staff via HCAI e-Alert • Suite of procedures and guidelines to support the prevention, management and control of CPE. • Enhanced HCAI RCA information management system and system developed to further improve meta-	**Medical Director**	**MEDIUM**

	• Reduction of Microbiological medical workforce from four to two Doctors through loss of a Staff Grade and Special Registrar attachment • High bed occupancy rate and limited isolation resource • Increased Estates new builds and refurbishment reduce number of facilities available	• Close liaison between IPC Team and Patient Flow Team • Close liaison between IPC Team and Estates colleagues	analysis of C Difficile cases • Re-launch of IV Programme in Acute sites to address increasing MRSA/MSSA bacteraemia • Electronic C Difficile database is under significant review and a new model is being created in this regard. • Implementation of a CDI 'trigger' system that will act as new early warning criteria to identify potential CDI outbreaks earlier • Development of Clinical Antibiotic Stewardship champions to implement new Antibiotic Stewardship Policy • Seeking funding that will support continuous drive to recruit suitable IPC staff • Appointment of locum Staff Grade and seek funding to secure this as a permanent post		

DOMAIN 2: SAFETY AND QUALITY					
CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
RISK AREA/CONTEXT: Safeguarding of residents from risk of potential financial abuse					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
10	Safeguarding of residents within HH/BC - Historical and ongoing risk to residents of potential financial abuse.	• Review of Residents within the Care Management process. Residents' reviews are held more frequently if required. • Families were given choice regarding continuing with placement or seeking an alternative following the outcome of the initial investigation – 4 out of 5 moved • Liaison with the residents, relatives/families where appropriate. • Weekly Trust meetings to review status & regular updates provided to Trust Board / SMT. • Regular updates from Trust HHBC group provided to DHSS/HSCB/RQIA/Other Trusts • Within Disability Services potential placements are discussed and prioritised at Trust Accommodation Panel.	• Ongoing liaison with the residents, relatives/families where appropriate. • Suspension of new admissions/respite beds remains in place. Current controls to remain as agreed by SMT and Trust Board and QA by independent "critical friend" review (January 2016) • Updates routinely provided to Trust Board • The Trusts Legal Adviser received a pre action letter for judicial review from Arthur Cox dated 29th September 2016. The Trust legal adviser responded on 18th October 2016. • On 9th November 2016 the Trust Legal Adviser informed the Trust that Judicial Review proceedings have been served. The leave application is listed for 6 February 2017. A responding Affidavit will be filed. The Trust has instructed Senior and Junior counsel.	**Director of Mental Health and Disability Services**	**HIGH**

		• Regular advice/support/ direction by Trust Legal Advisers • Contract Review Meetings with HHBC and quarterly operational meetings with HHBC as part of the contract compliance process. • Trust addresses in writing any identified concerns/queries as they arise with the Home Owners and their Legal representatives. • Trust addresses any identified concerns/queries raised by resident/relatives and Trust staff. • Trust addresses any identified concerns/queries raised by DHSSPSNI/RQIA. • Adult Safeguarding Process. Remaining residents have care and protection plans which have been put in place and updated as required. • Contacts with RQIA • Trust "Procedure for Responding to RQIA Alerts & Other Performance Management issues within Social Care Contracts". • Ongoing processes with OCP / RQIA / NMC / HSCB			

		re SAI, Disclosure & Barring Service (DBS) • Trust assumed responsibility for mobility monies which are now held in PPP accounts and payment is only made on receipt of verified invoices. • New Trust Case Management Guidance and Training Programme completed.			

DOMAIN 3: FINANCE					
LINK TO CORPORATE OBJECTIVE 5: MAKING THE BEST USE OF RESOURCES					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
11	Achievement of recurrent financial balance	• Contingency Plan in place • Best Care Best Value (BCBV) Project structure • Financial monitoring systems in place • Monthly report to SMT and Trust Board	• Outturn at month 7 would indicate in-year breakeven. It is hoped this can be maintained through a range of non-recurrent measures, including natural slippage on allocations.	**Director of Finance and Procurement and Operational Directors**	**MEDIUM**

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
12	Management and monitoring of procurement and contracts – not compliant with best practice guidance	**GENERAL** • Guidance and training on Direct Contract Award processes available. Follow up training and advice available as required from Head of Purchasing and Supply • Training on Contract Management with focus on responsibilities of Contract Owners rolled-out with follow up sessions also delivered • Action plans in place to address weaknesses identified in Internal Audit reports with updates to Senior Management Team and Audit Committee • Interface meeting established with BSO/PaLS and process agreed for prioritization of e procurement requirements within available capacity. • COPEs for significant element of spend • Measured Term Contract which mitigates risks to procurement schemes <£45k.	**GENERAL** Trust continues to highlight in Governance Statement the lack of central resource in Trust for contract monitoring BSO PALs undertake contract monitoring for those regional contracts awarded through them Reminder global emails continue to be issued on Direct Contract Award processes	**Director of Finance and Procurement**	**MEDIUM**

		ESTATES New regional arrangements re Estates procurement between Trusts and PALS being established and developed. Trust Procurement Board operational chaired by DOFP with membership from PALS and CPD HP as required.	**ESTATES** • Regional way forward for procurement capacity gaps at CoPE level for Estates being addressed but will take some 5 years to embed. • Recruitment of Phase 1 PALS team complete. Recruitment of Trust Team underway – anticipated completion March 2017 • Volume of works being undertaken balanced against resources to facilitate compliance • Actions arising from Internal Audit report either complete or in progress. • Recruitment process for Procurement Officers and Replacement Estate Development Officers underway	**Director of HROD**	

	Lack of regional formalised guidance/agreed approach for management of social care procurements under threshold value of £589k	**SOCIAL CARE PROCUREMENT** All Social care procurements undertaken by Trust are under influence of Social Care Procurement Unit (CoPE) Range of standard process and procedures in place agreed by regional social care procurement network	**SOCIAL CARE PROCUREMENT** Internal resource diverted to provide procurement support to key mental health directorate projects in 2015/16 enabling change. Trust proceeding to recruitment of two substantive posts further to agreement with BSO/PALs on job roles to support both regional over threshold procurements and under threshold local procurements when process agreed Trust participating in regional group to bring forward proposals for management of under threshold 'procurement' which provide a proportionate responses to testing of VFM and openness/transparency	**Director of Performance and Reform; All Directors**	

DOMAIN 4: OPERATIONAL PERFORMANCE AND SERVICE IMPROVEMENT					
CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
RISK AREA/CONTEXT: Achievement of Commissioning Plan Objectives and Goals for Improvement (OGI)					
No	**Description of Risk**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
13	Ongoing achievement of Commissioning Plan Objectives and Goals for Improvement (OGIs) ***a) Waiting times in excess of OGIs for Elective areas***: • Out-Patients; • Diagnostics (including Endoscopy); • In-Patients and Day Cases • Allied Health Professions	INTERNAL MONITORING: 1. ***Fortnightly Operational Performance meetings:*** • Acute Directorate 2. ***Monthly Operational Performance meetings***: • Mental Health & Disability Directorate • Children and Young People's Services Directorate • Older People and Primary Care Directorate 3. ***Monthly Operational AHP Performance*** - Cross- directorate ***4. Monthly reporting to Senior Management Team and Trust Board*** 5. ***Monthly exception reporting to Operational Directorates In-Year Assurance meetings with Chief Executive.***	**a) Access Times** **Outpatients** - Delivery of Service and Budget Agreement (SBA) volumes (where agreed) remains first priority within Operational Directorates. Recovery plans in place to optimise delivery of core commissioned levels of activity. Prioritisation of Red Flag and urgent assessment/treatment. Delivery of routine patients will follow, based on chronological order. Recurrent capacity 'gaps', which have been agreed with Southern Local Commissioning Group remain in a range of specialty areas affecting routine access times across diagnostics, inpatients/daycases and outpatients. **Diagnostics** - Non-recurrent allocation received for additional Diagnostics imaging and reporting capacity (including Endoscopy) in 2015/16 and 2016/17. The volumes allocated does not address the gaps in all areas but assists with stemming the growth of long waits	**Performance and Reform and Operational Directors**	**HIGH**

		EXTERNAL MONITORING: 6. **Monthly** Elective and Unscheduled Performance meetings with Health and Social Care Board **ACTION PLANNING:** 7. Implementation plans in place to reduce access times, where demand remains static, and additional ***recurrent*** capacity has been invested/ approved via IPT 8. Periodic plans developed aligned to ***non-recurrent*** allocations of available funding for elective access via HSCB 9. Operational plans under development to maintain red flag waiting time standards and reduce urgent waiting times to the acceptable clinical timescale. However, routine waiting times will increase as a consequence of the management of the red flag and urgent waiting times.	The additional diagnostic volumes allocated cannot be secured via in-house capacity alone . Whilst challenges have been faced securing Independent Sector capacity, additional capacity has been secured in-year for endoscopy. Investment was received in 2015/16 to increase capacity in MRI and proposals have been submitted for a 2nd CT mobile (capital & revenue) with expect additional capacity on site in early 2017. An interim mobile solution will come on site in December 2106 to provide contingency and additional capacity. **Inpatients/Daycases and Outpatients** - £700k of non-recurrent funding was made available by Health and Social Care Board (HSCB) for elective areas in Q1/2 in 2016/17. Further funding has been made available (October 2016) to increase in-house capacity in Quarter 3/4, however, it is challenging to increase capacity in-house in the Winter period. The Trust will continue to re-direct any available internal resources to areas of greatest risk as funding becomes available or as operationally feasible (re Workforce capacity) throughout 2016/17		

	b) Plain film reporting only maintained at current level, which excludes films that have been categorised as IRMER'ised (Ionizing Radiation Medical Exposure Regulations) with unfunded additional capacity and no regional standard for areas appropriate for Ionizing Radiation Medical Exposure Regulations		**AHP Access Times-** Additional capacity has been provided in AHP areas (from the £700k) funding where temporary staff can be secured. However, due to the short-term nature, the Trust has faced challenged in securing temporary resource to increase capacity. A regional demand and capacity analysis undertaken by PHA/HSCB concluded with formal gaps in capacity recognized by the commissioner. No specific funding has been provided. The Trust has prioritized demographic funding to address these gaps and recruitment is ongoing. Due to accrued backlogs, waits for routine patients will still be in excess of agreed position. Focus remains on urgent cases. **b) Diagnostic Imaging Reporting** Non-recurrent allocation for plain film reporting was received from HSCB in 2015/16 and 201617 for the recognised capacity gap in this area. Increasing demand coupled with manpower issues, is creating a more significant gap. An operational plan is in place to focus capacity on urgent and prioritised areas, including plain film chest x-ray The Trust has sourced additional capacity via two independent sector contracts which are predominantly utilised to support the gap in plain film reporting.		

			Internal additional reporting capacity has been focused on scanning and reporting CT, non-obstetric ultrasound and MRI examinations. HSCB has provided early recurrent funding for the implementation of plain film reporting by radiographers for ED films to partially address the gap. Trust has submitted proposal for training of radiographers to increase reporting capacity in plain film and non-obstetric ultrasounds. Whilst this has not been funded yet the Trust has agreed to prioritise a number of posts into training to reduce the lag time for implementation.		
	Risk Area and Principal Risks	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
	a) Out-Patient Review and Planned Treatment Backlogs ***Out-Patient Review Waiting List Backlogs in:*** • Acute; • CYPS; • MHD; and • OPPC	Internal and External monitoring controls included as in Corporate Risk 1 above. <u>ACTION PLANNING</u>: • Short-term validation exercise undertaken in Quarter 4 2014/15 within a limited number of Acute Services Directorate specialties • Operational workshop undertaken to review the ability to identify red flag and urgent reviews on the out-patient review waiting list and the processes for	**a) Outpatient Backlog** At the September position, there were a total of 17,260 patients waiting in excess of their clinically indicated timescale for review out-patient appointment (for doctor-led Acute, Children's and Older People's services) and 1504 for Mental Health services. (Visiting Specialties managed by other Trusts are excluded). Longest routine waits extend back to 2013/14. In 2016/17 some additional review patients were prioritized for additional capacity from the £700k non recurrent allocation; however total volume of those waiting beyond clinically indicated dates has started to increase again.		**HIGH**

	b*) Planned Patient Backlogs** • Acute only On-going risk with a significant volume of patients waiting ***past their clinically indicated review timescale in Outpatient and AHP services.	monitoring; escalation; and actioning of these reviews, that have been clinically agreed and communicated with the Consultants.	The Trust will continue to re-direct internal resources to areas of greatest risk as funding becomes available or as operationally feasible throughout 2016/17. Operational process are in place to ensure patients requiring clinically urgent review are prioritised. **b) Planned Patient Backlog** As at 1st November 2016, there were a total of 1450 patients on the planned treatment backlog. The longest waiting patient dates back to October 2014 and relates to Urology. 69% (1003) of the planned treatment backlog relates to Endoscopy with the longest substantial wait from May 2015. Non recurrent funding received in 2015/16 and 2016/17 is insufficient to meet the demand for new and planned repeat endoscopy. Priority is given to red flag, urgent and planned patients initially, then routine waits. Operational processes have been established to prioritise those planned patients that require urgent review. In line with JAG accreditation requirements, the planned treatment backlog should not exceed 6-months.		

			c) AHP review backlogs AHP backlogs for review are not as readily quantifiable. However, available information indicates significant review backlog volumes within Podiatry; Speech & Language Therapy; Dietetics; and Occupational Therapy**.** The Trust will continue to re-direct internally resources to areas of greatest risk as funding becomes available however, ability to access staff on short term contracts remains challenging. Short term AHP capacity is prioritized from the £700k of non-recurrent funding made available in Q1/2.		