Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
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Colm Donaghy
C/O
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

28 April 2022

Dear Sir,

Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

Provision of a Section 21 Notice requiring the provision of evidence in the form of a written statement

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry has commenced its investigations into the matters set out in its Terms of Reference. The Inquiry is continuing with the process of gathering all of the relevant documentation from relevant departments, organisations and individuals. In addition, the Inquiry has also now begun the process of requiring individuals who have been, or may have been, involved in the range of matters which come within the Inquiry's Terms of Reference to provide written evidence to the Inquiry panel.

The Urology Services Inquiry is now issuing to you a Statutory Notice (known as a Section 21 Notice) pursuant to its powers to compel the provision of evidence in the form of a written statement in relation to the matters falling within its Terms of Reference.

This Notice is issued to you due to your held posts, within the Southern Health and Social Care Trust, relevant to the Inquiry's Terms of Reference.

The Inquiry is of the view that in your roles you will have an in-depth knowledge of matters that fall within our Terms of Reference. The Inquiry understands that you will have access to all of the relevant information required to provide the witness statement required now, or at any stage throughout the duration of this Inquiry. Should you consider that is not the case, please advise us of that as soon as possible.

The Schedule to the enclosed Section 21 Notice provides full detail as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. As you may be aware the Trust has responded to our earlier Section 21 Notice requesting documentation from the Trust as an organisation. However if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the Trust and has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you and/or your legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In particular, you are asked to provide your evidence in the form of the template witness statement which is also enclosed with this correspondence. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

If there is any difficulty in complying with this time limit you must make an application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty.

Finally, I would be grateful if you could acknowledge receipt of this correspondence and the enclosed Notice by email to Personal Information redacted by the USI.

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

Issued by the Urology Services Inquiry on 28 April 2022. Annotated by the Urology Services Inquiry.

THE INDEPENDENT PUBLIC INQUIRY INTO
UROLOGY SERVICES IN THE
SOUTHERN HEALTH AND SOCIAL CARE TRUST

Chair's Notice

[No 12 of 2022]

pursuant to Section 21(2) of the Inquiries Act 2005

WARNING

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

TO: **Colm Donaghy**
C/O
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by noon **on 10th June 2022.**

APPLICATION TO VARY OR REVOKE THE NOTICE

AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by noon **on 3rd June 2022**.

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 28th April 2022

Signed: Personal Information redacted by the USI

Christine Smith QC

Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE

[No 12 of 2022]

General

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the Inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors or, if you prefer, you may contact the Inquiry.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person.

The Inquiry understands that you are no longer employed by the SHSCT. All questions asked in this Notice refer to the period of your tenure as Chief Executive. The Inquiry has named certain personnel in this Notice, which it understands as holding certain posts during your tenure. Please either confirm those are the correct post holders when answering those questions or, if not, please identify who held the posts referred to and name any additional personnel which you are aware of as being relevant to the Inquiry's Terms of Reference.

Your position(s) within the SHSCT

4. Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.

5. Please set out all posts you held during your period of employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly reported and those departments, services, systems, roles and individuals whom you managed or had responsibility for.

7. With specific reference to *the operation and governance of urology services*, please set out your roles and responsibility and lines of management.

8. It would be helpful for the Inquiry for you to explain how those aspects of your roles and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, other roles, including the roles of the Directors and Assistant Directors, the Medical Director, Clinical Director, Associate Medical Director and Head of Urology Service or with any other role which had governance responsibility.

Engagement with Staff and the Trust Board, Governance and Risk Issues

9. Describe how you usually engaged with your Senior Management Team on a day-to-day basis, including the Medical Director.

10. Describe how you usually engaged with your clinical staff on a day-to-day basis.

11. Please also set out the details of any weekly and monthly scheduled meetings with those staff members (referred to by you at 6, 7 and 8), and how long those meetings typically lasted. If a minute was taken of such meetings, please provide all minutes of any meeting which referenced urology services during your tenure from 2007 until 2009.

12. Please explain how you, as Chief Executive, assured both yourself and the Board that the clinical governance systems in place during your tenure were adequate. How did you ensure that the Board was appraised of both serious concerns and current performance given the applicable standards of clinical care and safety? What is your view of the efficacy of these systems in place, if any?

13. During your tenure, was the Board appraised of those departments within the Trust which were performing exceptionally well or unsatisfactorily and, if so, how was this done? Was there a committee which was responsible for overseeing performance? If so, where did it sit in the managerial structure and hierarchy and how did the Trust Board gain sight of these matters?

14. Please provide details of any specific training you received in respect of any aspects of clinical governance, patient care and safety or any other risk factors relevant to the Trust's operational functioning.

15. How, as the accountable officer, did you ensure that all Board members were kept up to date on clinical governance best practice?

16. How did you ensure that learning from clinical governance failures which may have been identified as a result of investigations were raised during Board discussions? Please illustrate your answer with examples, if applicable. Were any such issues concerning urology services raised with the Board?

17. Was it a requirement of your role that you undertook annual continuing professional development? If not, did you undertake such training anyway? In any event, please provide details of any training undertaken by you in your role as the CEO when you took up your post?

18. Were you aware of any avenues for sharing best/worst practice between Chief Executives of health care Trusts in NI, health care providers in the Republic of Ireland and NHS Trusts throughout the UK? If not, do you consider that the sharing of information in this way would assist in maintaining and enhancing clinical governance and overall patient care? Whether you agree or not, please explain your answer.

19. What is your view of the adequacy of the risk management arrangements in the Trust during your time in post?

20. Did you consider that the training and development for staff at all levels, including at senior management and Board level, encouraged a culture of reporting and learning from incidents? Please explain your answer. During your time, was the Board made aware of any problems in this area and, if so, what was done about it?

21. How was the Board assured, if at all, that there was a continued focus on reflective learning from the things that go wrong and celebration of the things that go well?

22. As former CEO, what is your view of the efficacy of the quality and safety monitoring systems that were in place in the Trust and executed through your operational teams during your tenure? Are there specific aspects of these systems that you found particularly helpful and are there parts of these systems

that required improvement? If yes, please explain. What changes did you either put in place, or attempt to put in place, to augment the assurance that was in place, and what direct observations and conversations did you have with clinical staff on the ground to see for yourself what the issues and problems were and what services were providing excellence?

23. How much time did you spend talking to your Senior Management Team and the Trust Board about clinical governance issues generally? This might helpfully be expressed as a percentage of daily/weekly hours.

24. How did staff generally inform you about or engage you in conversations regarding clinical governance issues? Was it your usual experience that they generally do so informally, or in writing, or both?

25. How would you describe the methods which you deployed to ensure that you got to know that what is expected of people in terms of compliance with clinical governance standards and arrangements was actually being carried out? Did you consider these methods successful? It would assist if you could illustrate your answer with examples.

26. Please provide examples of a number of issues that were escalated through to the Trust Board or Trust Board Committees where there were patient quality and safety concerns. The examples can come from any department, but we would be particularly interested to hear about any issues from urology. You should describe the route by which those concerns passed through the clinical governance structures and the route by which the Board then agreed a plan to improve matters and then sought assurance that the issues had been resolved. Did you as CEO have any concerns about these processes? If so, what changes, if any, did you make to improve assurance and ownership at all levels in the Trust?

27. In respect of your role, please detail your lines of engagement with the Trust Board, to include all formal and informal avenues.

28. Who on the Trust Board had responsibility for clinical governance and patient safety during your time in post? Please explain the Board oversight of clinical governance and patient safety generally, including the name(s) of and duties of any *Board Assurance Manager* during your tenure.

29. How did you let the Board know if problems regarding clinical governance arose? Did you utilise both formal and informal methods of contact and, if so, who was your point of contact and why? Did you think the mechanisms for doing this were good enough and, if not, what would have improved them?

30. Describe the most significant clinical governance/clinical risk challenges which you faced during your tenure as Chief Executive, and explain how you addressed them.

31. Did you engage in any program with a view to improving any aspect of clinical governance or clinical risk management during your tenure as Chief Executive? If so, fully explain the steps which you took as part of this program and outline any changes which resulted.

32. What percentage of the time at Trust Board was taken up with care quality and patient safety concerns and what emphasis was placed on receiving assurance that any such issues were resolved?

33. Was it your experience while in post that the Board had taken appropriate actions in relation to quality and safety concerns and sought to prioritise resources appropriately for these actions to be effective?

34. Do you have any knowledge of, or personal experience of, matters regarding clinical governance and patient safety not having been dealt with properly by the Trust and/ or the Trust Board during your tenure? If so, please provide full details, including setting out whether any failure to properly act has been admitted to and addressed, and any subsequent lessons identified and implemented – and if not, why do you think that did not happen?

35. Please set out what you considered to be the challenges in terms of learning the lessons from clinical governance and safety issues, and how staff were appraised of these and encouraged to reflect and learn? Are there any examples of this where minutes and presentations, if any, can be provided and where improvements have been put into place and embedded as demonstrated by audit?

36. Did you and the Trust Board identify and share lessons learned from adverse incidents, complaints, litigation and public inquiries, etc., concerning clinical governance and patient care and safety, both regionally and nationally? Whether your answer is yes or no, please explain. Do you consider it practicable that such lessons learned are shared and, if not, what needs to change to allow that to happen in a meaningful way?

37. How would you describe the "*risk appetite*" of the Trust and the Trust Board while you were Chief Executive? Was there, as part of the risk management strategy and process within the Trust, an annual Board appraisal of risk appetite in relation to quality and safety, operational performance and finance?

38. Were you, as CEO, able to assure the Board that high standards of professional practice were maintained? How did you seek to gain this assurance? Did this involve nurses, allied health professionals, doctors, technicians, and managers?

39. How were you assured as to how clinical appraisal was managed in the Trust? What assurance does the Board receive in this regard? Did you have any concerns about this during your tenure?

40. Did the Trust Board ever raise the issue of budget allocation and the prioritisation of risk, or seek to establish whether you, and they, were content that an acceptable risk prioritisation/budget allocation balance had been struck?

41. Please provide all notes and minutes of any meetings with the Trust Board, Trust Committees, any Trust or Departmental Staff or any third party or health body in which the problems with Urology Services were discussed during your time in post.

42. Do you consider that the Board operated efficiently and effectively during your tenure? If not, please describe your experiences.

43. Was it your view that the Board was, individually and collectively, motivated to address concerns regarding governance and clinical and patient safety as they arose within Urology Services or more generally? Did they always follow up on concerns raised? Were meetings conducted in an open and transparent manner? What was your experience of the Boards appetite for identifying concerns and implementing lessons learned?

44. Explain how your performance was appraised, to include how often and by whom, and how this was recorded. How were your performance targets evaluated?

45. Please explain how, if at all, the consideration of clinical risk within an area/specialty influenced how you allocated annual budgets for Departments? If you did prioritise clinical risk, what methodology did you use and what criteria did you apply? In other words, how, if at all, did you reflect clinical risk in budget allocation?

46. During your tenure, was it your experience that Departments or specialities sought an increased budget allocation to reflect their specific risk and, if so, what was your response? Please provide specific examples to explain your answer.

47. Did you have any personal knowledge whether such a system, which permitted budgetary requests specific to risk management, existed before your time in post?

48. Are you aware of other Trusts or health care providers who take or apply this risk/budget allocation approach or model?

49. How, if at all, did you satisfy yourself that the approach taken to risk in allocating budgets was acceptable?

Urology services/Urology unit: Staffing

50. The Inquiry understands that a regional review of urology service 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. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out your involvement, if any, in the establishment of the urology unit in the Southern Trust area.

51. What, if any, performance indicators were used within the urology unit at its inception?

52. Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, or any previous or subsequent protocol (please specify) provided to or disseminated in any way to you or by you, or anyone else, to urology consultants and staff in the SHSCT? If yes, how and by whom was this done? If not, why not?

53. How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits within it) impact on the management, oversight and governance of urology services? How, if at all, were the time limits for urology services monitored as against the requirements of that protocol or any previous subsequent protocol? What action, if any, was taken (and by whom) if time limits were not met?

54. Do you think the urology service/department was adequately staffed and properly resourced during your tenure? If that is not your view, can you please expand noting the deficiencies as you saw them?

55. Were you aware of any staffing problems within urology during your tenure? If so, please set out the times when you were made aware of such problems, how and by whom.

56. Were there periods of time when any posts within urology remained vacant for a period of time? If yes, please identify the post(s) and provide your opinion of how this impacted. How were staffing challenges and vacancies within urology managed and remedied?

57. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?

58. Did staffing posts, roles, duties and responsibilities change in urology during your tenure? If so, how and why?

59. Did your role change in terms of governance during your tenure? If so, explain how and why it changed with particular reference to urology services, as relevant?

60. Explain your understanding as to how the urology services were supported by non-medical staff during your tenure. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff.

61. Do you know if there was an expectation that administration staff would work collectively within urology or were particular administration staff allocated to particular consultants? How was the administrative workload monitored

62. Were any concerns raised with you about the adequacy and/or availability of administrative staff for urology clinicians? Are you aware of such concerns having been raised with any other staff? If so, please explain and provide any

documentation. If you do not have sufficient understanding to address this question, please identify those individuals you say would know.

63. Did administrative staff within urology services ever raise any concerns directly with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.

64. Who was in overall charge of the day to day running of the urology during your tenure? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of urology services and to whom that person/those persons answered.

65. What, if any role did you have in staff performance reviews?

66. Was your role subject to a performance review or appraisal? If so, please explain how and by whom and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

Engagement with urology staff

67. Describe how you engaged with all staff within urology. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

68. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

69. Were there any informal meetings between you and urology staff and management? If so, were any of these informal meetings about patient care and safety and/or governance concerns? If yes, please provide full details and any minute or notes of such meetings?

70. During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

Complaints

71. Please describe your role, and the role of members of the management team, should a complaint about clinical governance and/or patient safety be made by (i) member of staff, (ii) a patient, or (iii) anyone else, and provide an overview of how any such complaint was handled and your role in the process. It would be helpful if your answer referred to a specific example/s, preferably from urology, if any.

72. Please explain your understanding of how the management of clinical governance operated between clinical, nursing and other Directors and Departments, and detail your involvement in any of those processes.

73. During your tenure, did you think the relative responsibility for different aspects of clinical governance was clearly allocated between the relevant clinical and/or operational/managerial members of your senior team? Did you have cause to question or improve this? Was there a clear demarcation of particular responsibilities and, if so, how was this communicated within the senior team? Was it clearly set out or did it cause issues?

74. What is your view of how the complaints and whistle-blowing procedures, etc. operated and did you make any improvements in those areas? Have there been incidences where a member or members of staff, a patient or anyone else raised concerns about how effective those procedures were and what was your response to that?

Governance – generally

75. What was your role in relation to the Directors of Directors Human Resources and Organisational Development, the Assistant and Associate Directors, the Head of Service for Urology, the Medical and Clinical Directors, consultants and

other clinicians in urology, including in matters of clinical governance? You should explain all lines of management and accountability for matters of patient risk and safety and governance in your answer. Please name the post-holders you refer to in your answer.

76. Who oversaw the clinical governance arrangements of the urology department and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately? Please explain and provide documents relating to any procedures, processes or systems in place on which you rely on in your answer.

77. How did you oversee the quality of services in urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of services?

78. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for overseeing performance metrics?

79. How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

80. How could issues of concern relating to urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside urology services, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

81. Did those systems or processes change over time? If so, how, by whom and why?

82. How did you ensure that you were appraised of any concerns generally within urology?

83. How did you ensure that governance systems, including clinical governance, within urology were adequate? Did you have any concerns that governance

issues were not being identified, addressed and escalated as necessary? If yes, please explain.

84. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.

85. What systems were in place for collecting patient data on urology? How did those systems help identify concerns, if at all?

86. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

87. During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation.

88. How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?

89. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns, having the potential to impact on patient care and safety, arose. Please provide an explanation of that process during your time in post, including the name(s) and roles of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

90. Did you feel supported in your role by the Trust Board and general management and medical line management? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

Concerns regarding urology

91. The Inquiry is keen to understand how, if at all, during your tenure you liaised with and had both formal and informal meetings with:

(i) The Trust Board
(ii) The Chair of Trust Board – the Inquiry understands this to have been Anne Balmer
(iii) The Medical Director - the Inquiry understand this to have been Patrick Loughran;
(iv) The Director of Acute Services – the inquiry understands this to have been Jim McCall/Joy Youart;
(v) The Director of Human Resources and relevant Human Resources personnel – please name;
(vi) The Assistant Directors - the inquiry understands this to have been Simon Gibson; please name any others.
(vii) The Associate Medical Director - the inquiry understands these to have been Eamon Mackle (Surgery) and Stephen Hall (Anaesthetics)
(viii) The Clinical Director - please name any other post holders during your tenure;
(ix) The Head of Service, please name any other post holders during your tenure;
(x) The consultant urologists in post.
(xi) The Nurse Managers.

The Inquiry is interested to understand how you liaised with these individuals in matters of concern regarding urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (ii) specifically with reference to urology services concerns. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc. Your answer should also include any individuals not named

in (i) – (xi) above but with whom you interacted on matters falling with the Inquiry's Terms of Reference.

92. Can you explain from your perspective how you understood Urology Services was supposed to operate, from a clinical governance and patient care and safety perspective, during your time in post compared to how it did in fact operate?

93. Can you identify in what aspects you considered Urology Services to be operating adequately and in what respects it was failing to do so? If your understanding changed over time, please explain this within your answer.

94. During your tenure, please describe the main problems you encountered or that were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters:

    (a) What were the concerns raised with you, when were they raised and who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and detail what was discussed and what was planned as a result of these concerns.

    (b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

    (c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not?

    (d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements and how was this done? Please provide all relevant documents.

(e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?

(f) If you were given assurances by others, please name those individuals and set out the assurances they provided to you. How did you test those assurances?

(g) Were the systems and agreements put in place to rectify the problems within urology services successful?

(h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

95. Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were -

(a) properly identified,
(b) their extent and impact assessed,
(c) the potential risk to patients properly considered?

96. What, if any, support was provided to urology staff (other than Mr. O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q111 will ask about any support provided to Mr. O'Brien).

97. Was the urology department offered any support for quality improvement initiatives during your tenure?

Mr. O'Brien

98. Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

99. What was your role and involvement, if any, in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

100. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention?

101. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

102. What actions did you or others take or direct to be taken as a result of these concerns? If actions were taken, please provide the rationale for them. You should include details of any discussions with named others regarding concerns and proposed actions. Please provide dates and details of any discussions, including details of any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

103. Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so:

(i) what risk assessment did you undertake, and

(ii) what steps did you take to mitigate against this? If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person and if known, any steps taken

104. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr. O'Brien and others, given the concerns identified.

105. Did you ever speak to or contact Mr. O'Brien, either formally or informally, regarding the concerns raised, or any proposed actions or plans, or about any matter falling within the Inquiry's Terms of Reference? If so, please provide full details.

106. What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?

107. How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed?

108. Did any such agreements and systems which were put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?

109. Did Mr O'Brien raise any concerns regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise and

with whom, and when and in what context did he raise them? How, if at all, were those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?

110. Did you raise any concerns about the conduct/performance of Mr O'Brien. If yes:
(a) outline the nature of concerns you raised, and why it was raised
(b) who did you raise it with and when?
(c) what action was taken by you and others, if any, after the issue was raised
(d) what was the outcome of raising the issue?

If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not?

111. What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss support option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

112. How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raised were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

113. Did you communicate in any way, either formally or informally, with your successor Chief Executive, Mairead McAlinden, in relation to any issues of concern regarding urology services, such as patient safety, clinical risk or governance issues? If so, please provide all details and any relevant documentation.

Learning

114. What was the position regarding the concerns raised regarding urology by the end of your tenure? Had concerns of which you were made aware been addressed to your satisfaction? If so, please explain. If not, why not?

115. Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why, and why you consider it did not come to your attention.

116. Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?

117. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and the unit, and the concerns involving Mr. O'Brien in particular?

118. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

119. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

120. Do you think, overall, the governance arrangements were fit for purpose? Did you have concerns about the governance arrangements and did

you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?

121. Given the Inquiry's Terms of Reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 12 of 2022
Date of Notice: 28th April 2022

Witness Statement of: Colm Donaghy

I, Colm Donaghy, will say as follows:-

1. ***Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the Inquiry if you would provide this narrative in numbered paragraphs and in chronological order.***

1.1 I was appointed Chief Executive of the Southern Health and Social Care Trust on 1/4/2007. I was the most senior executive member of the Trust Board and responsible for leading the development of the vision for the strategic direction of the Trust in line with the overall policies and priorities of the Health and Personal Social Services. As Accountable Officer for the Trust I was accountable to the Trust Board, the Health and Social Services Strategic Authority and ultimately the Minister for the performance and governance of the Trust and the delivery of high quality care responsive to the needs of the population in line with performance targets established by the Health and Social Services Strategic Authority. I was responsible for leading reform within the Trust including the implementation of the Health and Personal Social Services Review of Public Administration decisions.

Urology Services Inquiry

1.2 A review of Urology services was undertaken by the Department of Health and Social Services in 2008 (I'm not sure of exact dates). This review impacted on our local Urology service as complex Urological procedures were not to be undertaken in Craigavon Hospital but rather transferred to the Regional Centre at Belfast City Hospital. The review also indicated that the Department were considering the future configuration of Urology Services in N. Ireland. The two options under consideration by the Department were a 2-site option (Belfast City/ Altnagelvin) or a 3-site option (Belfast City/ Altnagelvin and Craigavon). The Trust was keen to ensure that the 3-site option was the preferred option taken forward by the Department. As a result in January 2009 the Trust decided to carry out a review of its Urology service to ensure it was in the best position to support the 3-site option (**email and *terms of reference attached as appendix A1 and A2, located in Section 21 12 of 2022, Attachments***). In January I met with the Director of Acute Services and the Director of Performance and Reform to discuss the best way forward and the process for the review (I am unable to give specific dates and times of meetings). The terms of reference for the Urology Review were agreed at the Senior Management Team meeting on 21 January 2009 ***(attached as appendix B1 and B2, located in Section 21 12 of 2022, Attachments)***

1.3 As a result of undertaking the Review of Urology Services the Medical Director, Dr Loughran, became aware of an issue with Mr O'Brien's clinical practice. In short the issue was that Mr O'Brien was admitting patients previously under his care for inpatient treatment with IV fluids including anti-biotics. Dr Loughran informed me (I cannot recall the date) verbally and agreed to meet with Mr O'Brien to discuss the issue. My recollection is that it was Dr Loughran's view that the treatment was not harmful to the patients but was potentially ineffective. I informed the Chairman Mrs Anne Balmer verbally at our weekly meeting (I am unable to give specific dates). As Mr O'Brien was not prepared to change his practice Dr Loughran decided to get advice from experts in Urology outside the Trust to advise if Mr O'Brien's practice was efficacious. I received a copy of Dr Loughran's letters to Mr O'Brien (***attached as appendix C1, C2, C3, C4, located in Section 21 12 of 2022, Attachments***). I received two complaints from patients

Urology Services Inquiry

Personal Information redacted by the USI and Personal Information redacted by the USI complaining about the potential closure of ward two south for Urology patients as a result of the Trust's review of Urology (***attached as appendix D1, D2, D3, D4, located in Section 21 12 of 2022, Attachments***). This issue was still being dealt with when I left the Trust on 31/8/09.

2. ***Please also provide any and all documents within your custody or under your control relating to the terms of reference of the Urology Services Inquiry ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors or, if you prefer, you may contact the Inquiry.***

2.1 I have attached the relevant documents referenced as appendices. I received these documents from the Southern Trust to assist the completion of my witness statement.

3. ***Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person.***

The Inquiry understands that you are no longer employed by the SHSCT. All questions asked in this Notice refer to the period of your tenure as Chief Executive. The Inquiry has named certain personnel in this Notice, which it

understands as holding certain posts during your tenure. Please either confirm those are the correct post holders when answering those questions or, if not, please identify who held the posts referred to and name any additional personnel which you are aware of as being relevant to the Inquiry's Terms of Reference.

Your position(s) within the SHSCT

4. Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.

4.1 Qualifications:

- BA degree in Sociology 1980 Queen's University Belfast
- MA degree in Business Strategy 2002 University of Ulster

4.2 Occupational History:

- 1/3/1980 – 1/3/1992: Various roles at Northern Ireland Housing Executive
- 01/03/1992 - 01/08/1994: Planning Manager at Southern Health and Social Services Board ('SHSSB')
- 01/08/1994 until 01/06/1995: Assistant Director of Planning at SHSSB
- 01/06/1995 until 01/06/2000: Director of Planning and Performance in Craigavon Community Trust (n.b. this did not include Craigavon Area Hospital)
- 01/06/2000 to 01/11/2002: Director of Planning at SHSSB
- 01/11/2002 to 01/09/2006: Chief Executive at SHSSB

5. Please set out all posts you held during your period of employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

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5.1 I held the post of Chief Executive Designate of the Southern Health and Social Care Trust (SHSCT) from 01/09/2006 until 01/04/2007. My main duty was to amalgamate the four Trusts within the Southern area at that time (viz. Newry and Mourne HSCT, Craigavon Area HSCT, Craigavon and Banbridge HSCT and Armagh and Dungannon HSCT) into the Southern Health and Social Care Trust. The trust was established on 1 April 2007. I was appointed as Chief Executive of SHSCT and I held this position from 01/04/2007 to 31/08/2009. My main duties were as outlined in the Job Description attached entitled Chief Executive JD **attached as appendix E1 & E2, located in Section 21 12 of 2022, Attachments**. The job description was an accurate reflection of my duties and responsibilities.

6. ***Please provide a description of your line management in each role, naming those roles/individuals to whom you directly reported and those departments, services, systems, roles and individuals whom you managed or had responsibility for.***

6.1 I was responsible for line managing the Directors in the Trust and the Head of Communications. The Directors were as follows: Mr. Brian Dornan Director of Children's Services (Executive Director of Social Work); Mr. Martin Dillon Director of Finance; Mr. Kieran Donaghy Director of Human Resources; Mrs. Mairead McAlinden Director of Performance and Reform; Dr Patrick Loughran Medical Director; Mrs. Joy Youart Director of Acute Services; Dr Gillian Rankin Director of Older People and Primary Care; Mr. Francis Rice Director of Mental Health and Disability Services (Executive Director of Nursing). The Head of Communications was Mrs. Ruth Rogers.

6.2 I was responsible to the Trust Board. In my capacity as Accountable Officer for the Trust, I reported to Dr Andrew McCormick who was the Permanent Secretary in the Department of Health and Social Services.

7. ***With specific reference to the operation and governance of urology services, please set out your roles and responsibility and lines of management.***

7.1 I was responsible for directly managing the Director of Acute Services and the Medical Director, both of whom had direct responsibility for managing services and maintaining safe quality care in acute hospital services including urology.

8. ***It would be helpful for the Inquiry for you to explain how those aspects of your roles and responsibilities which were relevant to the operation and governance of urology services, differed from and/or overlapped with, for example, other roles, including the roles of the Directors and Assistant Directors, the Medical Director, Clinical Director, Associate Medical Director and Head of Urology Service or with any other role which had governance responsibility.***

8.1 My roles and responsibilities did not overlap with others. They differed in so far as the Director of Acute Services and the Medical Director were directly managed by me as set out in my answer to Question 7.

Engagement with Staff and the Trust Board, Governance and Risk Issues

9. ***Describe how you usually engaged with your Senior Management Team on a day-to-day basis, including the Medical Director.***

9.1 The Senior Management Team, including the Medical Director, were all situated at the Craigavon Area Hospital site where I was based. I engaged regularly with the team, both informally (during the course of daily duties) and formally (e.g., meetings). At all times during my tenure I operated an “open door” policy; directors were able to speak with me without having to make an appointment.

10. ***Describe how you usually engaged with your clinical staff on a day-to-day basis.***

10.1 As stated in my answer to Question 9, I operated an “open door” policy with all staff including senior clinical staff. I also met with senior clinical staff through a new forum named the Associate Medical Director’s (AMD) forum which was established in

2007. The AMD was set up to enable senior medical staff to share ideas, practice and experiences in their roles and areas of responsibility. I also met with other staff, including nurses and Allied Health Professionals during regular walk arounds (I ensured to visit wards/services at least once per week alone and approximately once per month with the Chairman).

11. Please also set out the details of any weekly and monthly scheduled meetings with those staff members (referred to by you at 6, 7 and 8), and how long those meetings typically lasted. If a minute was taken of such meetings, please provide all minutes of any meeting which referenced urology services during your tenure from 2007 until 2009.

11.1 I chaired the weekly Executive Team meetings. These meetings involved all of the Directors and the Head of Communications. These meetings lasted approximately 2 hours and 30 minutes. They had an agenda and minutes were taken, both of which are available. I also attended the monthly Trust Board meetings that involved all Directors and Non-Executive Directors. The Trust Board meetings lasted approximately 2 hours 30 minutes. Minutes of these meetings were also taken and are available (as the Senior Management Team SMT meetings).

12. Please explain how you, as Chief Executive, assured both yourself and the Board that the clinical governance systems in place during your tenure were adequate. How did you ensure that the Board was appraised of both serious concerns and current performance given the applicable standards of clinical care and safety? What is your view of the efficacy of these systems in place, if any?

12.1 The Trust Board was engaged in setting up the governance arrangements for the new Southern Trust in 2007. This included arrangements such as the Trust Board and all of the Directors attending a workshop taken by John Bullivant of the Good Governance Institute in 2007.The Trust developed an assurance framework which was designed to highlight patient safety and performance issues. The assurance framework was designed to provide an integrated approach to patient and client safety and give assurance to the Trust Board and individual Directorates. The

Framework was a document that was intended to assist the Board to identify, manage and minimize the principal risks to achieving its objectives. The Assurance framework describes the organisation's objectives, identifies principal risks to their achievement, the key controls through which these risks will be managed and the sources of assurance about the effectiveness of these controls. The Trust Board received formal updates on safety issues and performance at Board meetings that were rated using a RAG scale. The scale was broken down into red, amber and green; Red where performance was not delivering against expectation, amber where performance was partially delivering or not complete and green where performance was in line with expectation. I set up a clinical forum which included the Medical Director and Associate Medical Directors. The purpose of this forum was to allow managerial and clinical issues to be shared and discussed. As part of the governance arrangements the Trust established a Governance Committee of the Trust Board that was attended by all Directors with the purpose of reviewing clinical information and quality indicators. The systems in my view were effective and kept under review (Corporate Risk Register September 2009 **attached as appendix F, located in Section 21 12 of 2022, Attachments**). The Corporate Risk Register set out the main risks to the Trust achieving its objectives and included clinical, financial and managerial risks.

13. ***During your tenure, was the Board appraised of those departments within the Trust which were performing exceptionally well or unsatisfactorily and, if so, how was this done? Was there a committee which was responsible for overseeing performance? If so, where did it sit in the managerial structure and hierarchy and how did the Trust Board gain sight of these matters?***

13.1 During my tenure the Board was appraised of performance across a range of performance and quality standards by a monthly report, (**Example attached as appendix G, located in Section 21 12 of 2022, Attachments as Appendix G**), that highlighted good and poor performance against those standards. There was no Committee responsible for overseeing performance. There was a Director of Planning and Performance whose responsibility was to liaise with the different Departments and collate the report for the Trust Board.

Urology Services Inquiry

14. Please provide details of any specific training you received in respect of any aspects of clinical governance, patient care and safety or any other risk factors relevant to the Trust's operational functioning.

14.1 I did not receive any specific training on clinical governance, patient care, safety or any other risk factors relevant to the Trust's operational functioning.

15. How, as the accountable officer, did you ensure that all Board members were kept up to date on clinical governance best practice?

15.1 I ensured that any learnings from national reviews of failing Trusts were made available to and discussed by Board members. On foot of this I ensured that appropriate actions were agreed and developed, including implications for governance arrangements. Developments in best practice or new guidance from the Department would have been discussed at the Governance Committee.

16. How did you ensure that learning from clinical governance failures which may have been identified as a result of investigations were raised during Board discussions? Please illustrate your answer with examples, if applicable. Were any such issues concerning urology services raised with the Board?

16.1 Please see the answer to Question 15. For example, the Trust had to deal with an outbreak of Clostridium Difficile (C Diff) during 2008. This was discussed at Trust Board and an action plan was agreed and put into place by the Trust Board. To the best of my recollection the issues raised regarding Urology services, during my tenure as Chief Executive, were the Regional Review of Urology services in 2008-2009 and Mr. O'Brien's clinical practice in relation to a cohort of patients receiving inpatient IV treatment in 2009 (See response to question 1). The Regional review was carried out by the Department of Health and Social Services with the objectives of improving access to Urology services for patients and delivering a more efficient and effective service overall. This led to the Trust's internal review of Urology services with the purpose of ensuring a coordinated, efficient and effective service to allow it to be in a position to

respond positively to the regional review. To the best of my recollection, during this review the Director of Acute Services, the Director of Performance and Reform and the Medical Director became aware of Mr. O'Brien's practice of using beds and resources to deliver care to a cohort of patients that was not necessarily efficacious. Dr Loughran, Medical Director, made me aware of the issue and I informally briefed Anne Balmer who was the Chairman at the time during our weekly meeting. Dr Loughran felt that, while the practice probably did not pose safety issues for the patients concerned, it was questionable in relation to its efficacy. Following a number of unsuccessful attempts by Dr Loughran to persuade Mr. O'Brien to consider alternative treatments other than hospital admission, we agreed to involve independent medical expertise to assess Mr. O'Brien's practice in this instance and provide advice to the Trust and Mr. O'Brien with regards to the most appropriate way forward. I am aware that the Medical Director did seek independent advice. I left the Trust on 31/8/2009 prior to the process concluding.

17. ***Was it a requirement of your role that you undertook annual continuing professional development? If not, did you undertake such training anyway? In any event, please provide details of any training undertaken by you in your role as the CEO when you took up your post?***

17.1 It was not part of my role to undertake annual continuing professional development. I was a member of two national learning sets. The first included myself and the Medical Director and the second included myself and the Chairman. Both learning sets included Chief Executives, Medical Directors and Chairmen from others Trusts in the United Kingdom. The purpose of the learning sets was to share best practice and innovation across our respective organisations. I also attended workshops and seminars however I am unfortunately unable to recall when and what these were specifically.

18. ***Were you aware of any avenues for sharing best/worst practice between Chief Executives of health care Trusts in NI, health care providers in the Republic of Ireland and NHS Trusts throughout the UK? If not, do you consider that the sharing of information in this way would assist in***

maintaining and enhancing clinical governance and overall patient care? Whether you agree or not, please explain your answer.

18.1 The Trust Chief Executives in Northern Ireland met once per month and discussed a wide range of issues, including best practice across organisations. At national level, across the United Kingdom, information was shared on a range of issues including clinicians, faulty equipment and the outcome of independent or public inquiries. To the best of my knowledge information was not formally shared with the Republic of Ireland. In my view sharing information and the outcome of reviews between organisations does assist with improving clinical safety and patient care. Sharing information or lessons learnt enables other organisations to assess whether or not they need to improve their own governance systems.

19. ***What is your view of the adequacy of the risk management arrangements in the Trust during your time in post?***

19.1 The Trust had an adequate risk management process in place. The Trust maintained a Corporate Risk Register (see response to question 12) with corporate risks highlighted that were drawn from the high-level risks identified by the risk assessment processes within each Directorate and at corporate level. Each Directorate assessed clinical and resource risks and rated them on their risk register as red (High Level) amber (Medium) or green (Low). High level (red) risks have been endorsed by each Director and forwarded for consideration of the SMT for inclusion onto the corporate risk register. Each risk identified was underpinned by a full risk assessment. In addition Directorates maintained their own risk registers which were actively managed by governance staff in each Directorate.

20. ***Did you consider that the training and development for staff at all levels, including at senior management and Board level, encouraged a culture of reporting and learning from incidents? Please explain your answer. During your time, was the Board made aware of any problems in this area and, if so, what was done about it?***

20.1 The promotion of a culture of openness and transparency, and encouraging the reporting of incidents, was an ongoing process. I do not consider that the Trust fully achieved this culture. Additional training was put in place as a result. For example, following the C diff outbreak ward-based staff were encouraged to identify and report incidents. Training on completing incident reports and identifying serious adverse incidents was provided to clinical staff. To the best of my knowledge the Board was not made aware of specific problems in this area.

21. ***How was the Board assured, if at all, that there was a continued focus on reflective learning from the things that go wrong and celebration of the things that go well?***

21.1 The Trust Board was aware of processes that promoted reflective learning such as Root Cause Analysis methodology which was introduced as part of the process to reduce health care acquired infections. The Board was also aware of the introduction of new ways of working that included reflective practice such as the Productive Ward. The Productive Ward series was introduced to the Trust in 2009 (**See Trust Board Agenda and Minutes 30th April 2009 attached as appendix H1 & H2, located in Section 21 12 of 2022, Attachments**). Its main purpose was to release time for nurses to provide care to their patients and improve the patient experience and care. Part of the process to achieve this entailed staff reflection. The Trust also held an annual celebration and recognition award conference for staff to which Board members were invited. Additionally the Trust Board invited staff to present to the Board on successful projects (see Trust Board minutes of 30th April 2009 as above).

22. ***As former CEO, what is your view of the efficacy of the quality and safety monitoring systems that were in place in the Trust and executed through your operational teams during your tenure? Are there specific aspects of these systems that you found particularly helpful and are there parts of these systems that required improvement? If yes, please explain. What changes did you either put in place, or attempt to put in place, to augment the assurance that was in place, and what direct observations and conversations***

did you have with clinical staff on the ground to see for yourself what the issues and problems were and what services were providing excellence?

22.1 The quality and safety monitoring systems during my tenure were effective and were kept under continuous review. The engagement of clinicians in the governance process worked well in particular the AMD Forum and direct involvement of clinical staff in problem solving, for example, C Diff. At the formation of the Trust, I introduced a number of assurance measures that were new to the Trust environment including a new post of Board Secretary, the AMD Forum, the Assurance Committee and governance staff embedded in the Directorates directly providing care. I met with both managerial and clinical staff during my walkabouts both with the Chairman and on my own. I asked staff what was working well and what senior management could do to support them to do their job better. During one of my walkabouts in 2008 nursing staff on one of the wards in Craigavon Hospital indicated that they were increasingly having to complete administrative tasks at the cost of direct patient care. I discussed the issue with the Director of Acute Services Ms. Joy Youart and we decided to pilot The Productive Ward series with the support of the Beeches Management Centre in Belfast. The Beeches Management Centre was funded by all 6 Trusts in Northern Ireland and had expertise in delivering management development and improvement programmes for health and social care Trusts. The Productive Ward series was being promoted by the Beeches at that time. It was a process of assisting ward staff to reflect on daily activity and prioritise tasks with the aim of releasing time to care for patients. The Productive Ward was piloted successfully and received very positive feedback from staff. I attended the feedback from staff who had gone through the process and they confirmed as an outcome it released more time for patient and they felt improved the level of care they could give to patients.

23. How much time did you spend talking to your Senior Management Team and the Trust Board about clinical governance issues generally? This might helpfully be expressed as a percentage of daily/weekly hours.

23.1 I find it difficult to properly estimate but think it may have been approximately 20% of my time.

24. How did staff generally inform you about or engage you in conversations regarding clinical governance issues? Was it your usual experience that they generally do so informally, or in writing, or both?

24.1 Senior staff would engage with me both on an informal and formal basis. Initially senior staff would speak to me to voice their concerns or any issues they encountered. They would then follow up their concerns in writing if the issue required further investigation and follow up.

25. How would you describe the methods which you deployed to ensure that you got to know that what is expected of people in terms of compliance with clinical governance standards and arrangements was actually being carried out? Did you consider these methods successful? It would assist if you could illustrate your answer with examples.

25.1 I would describe the methods as multi-faceted. One of the indicators of compliance was the number and nature of complaints. Another was the information I gleaned from walkabouts. Formally I relied on the assurance framework and performance reports on compliance with standards. One example would be the Trust's compliance with access to cancer services set out as standards in the monthly report to the Executive Team and Trust Board. Another example would be when I visited the surgical theatres on the Craigavon Area Hospital site as part of my walkabout and surgeons highlighted to me that they were unhappy with the quality of one of the theatres and felt they required indemnity to use the theatre. I raised this with the AMD for surgery and the Executive Team and Trust Board. As a result we temporarily improved the theatre and replaced it with a brand new theatre within one year. I also relied on external audit and inspection carried out by the external auditors or the Regulation Quality and Improvement Authority. At the time I felt they were adequate, but they were always subject to review and potential improvement.

Urology Services Inquiry

26. Please provide examples of a number of issues that were escalated through to the Trust Board or Trust Board Committees where there were patient quality and safety concerns. The examples can come from any department, but we would be particularly interested to hear about any issues from urology. You should describe the route by which those concerns passed through the clinical governance structures and the route by which the Board then agreed a plan to improve matters and then sought assurance that the issues had been resolved. Did you as CEO have any concerns about these processes? If so, what changes, if any, did you make to improve assurance and ownership at all levels in the Trust?

26.1 In 2008 a review of Gynecology patients had to be completed due to concerns over the work of a temporary employee. Initially concerns were raised by the employee's colleagues with the Clinical Director. These concerns were escalated to the Medical Director who in turn escalated same the Chairman and me. The Trust Board was informed and an action plan was put in place to complete a precautionary review of 300 patients. Another example is the C Diff outbreak that happened in 2008. At the time the trust were monitoring the level of C Diff infections in our hospitals and the Clinical Director for Micro-Biology highlighted to the Medical Director and myself that there was an increase in infections beyond expected levels. I informed the Chairman and requested that a report on these concerns be compiled for the Trust Board. I took personal responsibility for putting in place measures to contain and reduce the outbreak. I worked closely with the Medical Director and Micro-Biologist and his team to develop a plan that was agreed by the Trust Board. We increased resources for training, cleaning and staffing. In particular we achieved engagement and ownership from medical staff to review anti-biotic prescribing and we introduced a training module on anti-biotic prescribing for the intake of new junior doctors each year. As a result our C Diff cases reduced and exceeded the standard expected.

27. In respect of your role, please detail your lines of engagement with the Trust Board, to include all formal and informal avenues.

27.1 I engaged with the Trust Board formally through the monthly Board meetings and Trust Board Workshops. Informally I met with the Chairman once per week and undertook walkabout visits with her once per month.

28. Who on the Trust Board had responsibility for clinical governance and patient safety during your time in post? Please explain the Board oversight of clinical governance and patient safety generally, including the name(s) of and duties of any Board Assurance Manager during your tenure.

28.1 The Trust Board was corporately responsible for clinical governance. The Medical Director had direct responsibility for clinical governance and patient safety on the Trust Board while other Directors had a responsibility for ensuring good governance in their areas of service and managerial responsibility. The Trust also had a system whereby each Directorate team had access to professional nursing or AHP advice. There was a Board Secretary Mrs. Jennifer Holmes who would have had Board assurance as part of her responsibility. Responsibilities included ensuring the Trust operated in accordance with agreed standards of integrated governance, to ethical standards appropriate to a public service organization and with due regard to wider societal obligations and to develop and maintain a strategic awareness of developments in integrated governance and advise the Chief Executive on their potential implication for the Trust.

29. How did you let the Board know if problems regarding clinical governance arose? Did you utilise both formal and informal methods of contact and, if so, who was your point of contact and why? Did you think the mechanisms for doing this were good enough and, if not, what would have improved them?

29.1 I would contact the Chairman initially and agree how the Board should be informed. My direct point of contact was the Chairman. I communicated with the Chairman both formally and informally. The Chairman was my point of contact as she was in the Trust on a weekly basis. The mechanism was effective and I wouldn't suggest any changes.

30. Describe the most significant clinical governance/clinical risk challenges which you faced during your tenure as Chief Executive, and explain how you addressed them.

30.1 Please see answer to Question 26. The Gynae Review and the C Diff outbreak were the most significant clinical challenges I faced during my tenure.

31. Did you engage in any program with a view to improving any aspect of clinical governance or clinical risk management during your tenure as Chief Executive? If so, fully explain the steps which you took as part of this program and outline any changes which resulted.

31.1 I was the first Chief Executive of the Southern Health and Social Care Trust and I set up the initial governance arrangements in collaboration with the Chairman and Trust Board. As such the Trust engaged with the Institute of Good Governance and developed the governance framework that included a Governance Committee responsible for reviewing referred to in my answer to Question 12. It also resulted in the appointment of the new post of Board Secretary (Response to question 28) **(job description attached as appendix I, located in Section 21 12 of 2022, Attachments**).

32. What percentage of the time at Trust Board was taken up with care quality and patient safety concerns and what emphasis was placed on receiving assurance that any such issues were resolved?

32.1 A large percentage of time was taken up by reporting on performance which included a focus on quality and patient care standards. The Board also considered the Assurance Committee's reports and any issues arising from same. It is difficult to pinpoint a precise percentage however I would estimate approximately 50% of Trust Board time was taken up on these responsibilities. Non-Executive Directors were encouraged to exercise their "challenge function," which included seeking assurance on unresolved issues. Executive Directors also provided a challenge function at Executive Team meetings and at Trust Board.

33. Was it your experience while in post that the Board had taken appropriate actions in relation to quality and safety concerns and sought to prioritise resources appropriately for these actions to be effective?

33.1 It was my experience that the Board took effective action and at times prioritised resources. Please see my answers to questions 16 and 26. In addition in 2009 the Trust identified a shortfall in midwifery staffing for maternity services in Craigavon Hospital and Daisyhill hospital. The Senior Management Team (SMT) approved the appointment of additional staff to cope with the volume of births and ensure safe care was being provided and the issue was discussed at the Trust Board in June 2009.

34. Do you have any knowledge of, or personal experience of, matters regarding clinical governance and patient safety not having been dealt with properly by the Trust and/ or the Trust Board during your tenure? If so, please provide full details, including setting out whether any failure to properly act has been admitted to and addressed, and any subsequent lessons identified and implemented – and if not, why do you think that did not happen?

34.1 I have no recollection of matters regarding clinical governance and patient safety not having been dealt with properly. A number of clinical issues arose such as the C Diff outbreak, the Gynae review and clinically managing patients between A&E and potential admission to acute wards. The fact that these issues arose was an indication of the need for improvement or change in clinical behaviours. I have outlined the C Diff and Gynae issues and how they resolved in previous answers. The A&E issue manifested as long waits by patients in A&E due to lack of clinical decision making in the Clinical Admissions ward adjacent to A&E. The issue was addressed by appointing a General Physician to review all patients in the Clinical Admissions ward and give them authority to discharge or admit patients. This worked well and the Trust appointed a second physician to provide additional support and split the workload. In all of these cases the Trust accepted that its clinical systems were not working properly and that appropriate action needed to be taken to improve them.

35. Please set out what you considered to be the challenges in terms of learning the lessons from clinical governance and safety issues, and how staff were appraised of these and encouraged to reflect and learn? Are there any examples of this where minutes and presentations, if any, can be provided and where improvements have been put into place and embedded as demonstrated by audit?

35.1 The challenge for learning lessons from clinical governance and safety issues was a cultural/behavioural one. The example that illustrates this best is infection control. From 2007-2008 the Department of Health and Social Services introduced standards in relation to health care acquired infections. Initially this was expressed as a numerical target for each Trust depending on the size and rate of infections of MRSA and C Diff at that time. While the Trust had an infection control team, which was led by a microbiologist and made up of nurses, they were mainly reactive to spikes in infection rather than proactive. This led to a culture where infection was not considered important until it manifested as a problem. To change this culture it was important to engage with clinicians and gain clinical ownership over the issue. To achieve this the Trust introduced the care bundle concept and engaged with clinicians to design an effective response. In relation to C Diff the areas that were identified as important were cleanliness (both hand washing and throughout ward areas), anti-microbial prescribing and ensuring clinicians were bare below their elbows when dealing directly with patients. The Trust also embarked on a publicity campaign to inform the public of the need to wash their hands which included a large poster being erected at the entrance to the Craigavon Area Hospital site. Clinicians also contributed ideas such as training the new intake of junior doctors on prescribing anti-biotics. The Trust introduced “Root Cause Analysis” which is a methodology that analyses the causes of an issue which promoted reflective learning. The Trust provided training to staff in this methodology. This led to behavioural changes being made whereby hand washing became the norm, wearing bare arms below the elbow (i.e., short sleeves and no white coats) was the accepted practice and appropriate rates of anti-microbial prescribing was regarded as crucial by medical staff. The changes were embedded and auditing was used as a tool to ensure compliance. Regular hand washing audits were conducted at ward level and senior medics carried out spot audits on anti-microbial prescribing to ensure proper levels of prescribing.

36. Did you and the Trust Board identify and share lessons learned from adverse incidents, complaints, litigation and public inquiries, etc., concerning clinical governance and patient care and safety, both regionally and nationally? Whether your answer is yes or no, please explain. Do you consider

it practicable that such lessons learned are shared and, if not, what needs to change to allow that to happen in a meaningful way?

36.1 Serious Adverse Incidents (SAI) were shared with our commissioner the Southern Health and Social Care Board. When an SAI was identified it was notified to the commissioner. The Trust carried out an investigation and sent a report to the commissioner within a specified timescale. The commissioner would consider if lessons applied to other Trusts in Northern Ireland. In relation to complaints the system was not as sophisticated regarding lessons learned. While the Trust and individual Directorates did learn lessons they were not necessarily shared either across organisations nor across Directorates in the Trust. The emphasis at the time was to meet complaints response timescales and this is what was monitored at Board and SMT level. The Trust did consider the outcome of public inquires, for example the Mid Staffordshire NHS Foundation Trust public inquiry led by Robert Francis QC, and assessed the impact on our own services. Clinical Litigation was managed centrally by the Central Services Agency and I cannot recollect significant changes taking place as a result of litigation. Child care litigation did result in lessons being learned as it was more closely managed by the Trust with direct involvement of Trust staff in the process. I do consider that lessons learned should be shared and it would be practicable. This requires cultural change and a recognition that to err is human. The removal of a blame culture is very important. When something goes wrong then the emphasis needs to be on learning and making improvements rather than blaming and punishment.

37. How would you describe the "risk appetite" of the Trust and the Trust Board while you were Chief Executive? Was there, as part of the risk management strategy and process within the Trust, an annual Board appraisal of risk appetite in relation to quality and safety, operational performance and finance?

37.1 The risk appetite of the Trust Board was low in my opinion. There was no annual Board appraisal of risk appetite. The risk appetite would have been unknown at that time. The Board did have a process for managing risks which was recommended by the Department of Health and Social Services and based on the New Zealand health systems model. This methodology identified and risk stratified the major risks to

achieving its objectives but this was not expressed as risk appetite (See response to question 12).

38. Were you, as CEO, able to assure the Board that high standards of professional practice were maintained? How did you seek to gain this assurance? Did this involve nurses, allied health professionals, doctors, technicians, and managers?

38.1 I was able to assure the Board that high professional standards were maintained. To ensure that care professional standards (between nurses, social workers and AHPs) were properly considered, senior professionals from these groups were seconded on to Directorate teams where their profession was not represented adequately or at all. This allowed them to be represented at Directorate team meetings. Doctors were subject to revalidation and appraisal and the outcome of this process was considered by the Trust Board. In addition the Trust Board had professionals as Executive members of the Board from social work, nursing and medicine. None of these processes involved technicians or managers. I sought to gain assurance from the Executive Directors of Nursing (included AHPs), Social Work and Medicine. I met individually with each Director once per month to review performance of their Directorate to and discuss clinical, patient and client care issues.

39. How were you assured as to how clinical appraisal was managed in the Trust? What assurance does the Board receive in this regard? Did you have any concerns about this during your tenure?

39.1 It was the responsibility of the Executive Directors of Nursing, Social Work and Medical to ensure clinical appraisal and supervision was completed. It is my understanding that this was undertaken through their professional lines of accountability and the compilation of Social Care Statutory functions reports, provision of the Medical Directors' update on revalidation and appraisal, the Nursing Directors governance lead and via professional advisors. I was confident that each of the Directors were exercising their responsibility and at the time I had no concerns.

40. Did the Trust Board ever raise the issue of budget allocation and the prioritisation of risk, or seek to establish whether you, and they, were content

that an acceptable risk prioritisation/budget allocation balance had been struck?

40.1 In the example of infection control the Trust Board did seek to establish that the Executives, including myself, had sufficient resources to meet our action plan. The Trust Board did not, as a separate exercise, give due consideration to balancing an acceptable risk prioritisation to budget allocation ratio. It tended to be considered as risks arose. Another example would be the identification in 2008 of staff shortages in maternity services. The Trust SMT identified resources to employ additional midwives and help mitigate the risk and deliver better quality care.

41. Please provide all notes and minutes of any meetings with the Trust Board, Trust Committees, any Trust or Departmental Staff or any third party or health body in which the problems with Urology Services were discussed during your time in post.

41.1 I have requested these notes and minutes and meetings from the Southern Trust but they have not been provided yet. When I do receive the documents I will review them and inform the Inquiry if there is anything that causes me to alter my views.

42. Do you consider that the Board operated efficiently and effectively during your tenure? If not, please describe your experiences.

42.1 I consider that the Trust Board did act efficiently and effectively during my tenure.

43. Was it your view that the Board was, individually and collectively, motivated to address concerns regarding governance and clinical and patient safety as they arose within Urology Services or more generally? Did they always follow up on concerns raised? Were meetings conducted in an open and transparent manner? What was your experience of the Boards appetite for identifying concerns and implementing lessons learned?

43.1 It was my view that the Board was individually and collectively motivated to address concerns as they arose generally. They followed up on concerns and acted in

an open and transparent manner. The Board had a strong appetite for identifying concerns and implementing lessons. With regard to infection control, gynae, maternity and A&E the Trust Board and SMT considered the issues and implemented changes/improvements as a result. In my recollection concerns regarding urology services were not discussed at Trust Board.

44. Explain how your performance was appraised, to include how often and by whom, and how this was recorded. How were your performance targets evaluated?

44.1 I had to produce my performance objectives for the year in a specifically designed pro forma (**attached as appendix J, located in Section 21 12 of 2022, Attachments).** These were then discussed with the Chairman and agreed with the Terms and Remuneration Committee. The Chairman made an assessment of my performance formally once per year and presented this to the Terms and Remuneration Committee at year end. I made an initial assessment of my performance which the Chairman reviewed and discussed and an outcome was agreed. In addition to this, there was a Departmental Accountability Review once per year in which the Chairman and Executives reviewed the Organisation's performance against Departmental objectives and targets.

45. Please explain how, if at all, the consideration of clinical risk within an area/specialty influenced how you allocated annual budgets for Departments? If you did prioritise clinical risk, what methodology did you use and what criteria did you apply? In other words, how, if at all, did you reflect clinical risk in budget allocation?

45.1 The risk assessment process for the Trust at that time was based on the New Zealand Health Service's model. The Department recommended that the Trust follow this model. This involved each Directorate maintaining a risk register and escalating corporate risks to the Trust's corporate risk register. Each register highlighted the risk and the mitigation in place to manage the risk. The corporate risk register was discussed at Assurance Committee and Trust Board levels. Directorate risk registers were considered at Directorate team meetings. Risks highlighted included clinical,

managerial and financial concerns. The mitigation would have included managing resources to reduce or eliminate the risk.

46. During your tenure, was it your experience that Departments or specialities sought an increased budget allocation to reflect their specific risk and, if so, what was your response? Please provide specific examples to explain your answer.

46.1 Directorates sought to mitigate risk by reallocating resources under their control or making a business case in support of additional resources. Operational decisions were taken by the Executive Team and were based on the strength of the case made and the availability of resources at the material time. One example was the additional resources requested by the Acute Directorate to manage patients between A&E and the Clinical Decision Unit (see my answer to question 34). A business case was presented to the Executive Team who approved the additional resource. Another example was the increase in resources required to manage cleanliness in hospital wards to reduce health care acquired infections. A case was presented to the Executive Team which was approved.

47. Did you have any personal knowledge whether such a system, which permitted budgetary requests specific to risk management, existed before your time in post?

47.1 I am aware that risk management systems were in place however I am not familiar with the detail of what they entailed.

48. Are you aware of other Trusts or health care providers who take or apply this risk/budget allocation approach or model?

48.1 To the best of my knowledge all of the Trusts in Northern Ireland applied this approach/model.

49. How, if at all, did you satisfy yourself that the approach taken to risk in allocating budgets was acceptable?

49.1 Through the overall management of risk process. Through this process I was able to identify the main risks that required additional resources to be managed. The Corporate Risk Register brought together all the major clinical and financial risks to the achievement of Trust objectives. This enabled the Trust to identify how the risks could be mitigated including allocation of resources.

Urology services/Urology unit: Staffing

50. The Inquiry understands that a regional review of urology service 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. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out your involvement, if any, in the establishment of the urology unit in the Southern Trust area.

50.1 My involvement in establishing the urology unit was as part of the corporate decision-making process. I had no direct involvement.

51. What, if any, performance indicators were used within the urology unit at its inception?

51.1 As I had no direct involvement, I am unaware of the specific performance indicators for the urology unit.

52. Was the 'Integrated Elective Access Protocol' published by DOH in April 2008, or any previous or subsequent protocol (please specify) provided to or disseminated in any way to you or by you, or anyone else, to urology consultants and staff in the SHSCT? If yes, how and by whom was this done? If not, why not?

52.1 The protocol would have been shared with all relevant personnel. I have no memory of how this specific protocol was shared but it would have been practice to

share it with the Directorate Team and AMDs who in turn would've disseminated it further.

53. How, if at all, did the 'Integrated Elective Access Protocol' (and time limits within it) impact on the management, oversight and governance of urology services? How, if at all, were the time limits for urology services monitored as against the requirements of that protocol or any previous subsequent protocol? What action, if any, was taken (and by whom) if time limits were not met?

53.1 From the best of my recollection the protocol entailed a re-organisation of the beds available to urology. The time limits would have been monitored within the Acute Services Directorate and action taken within the Directorate to ensure time limits were met. I am unable to recall any further details.

54. Do you think the urology service/department was adequately staffed and properly resourced during your tenure? If that is not your view, can you please expand noting the deficiencies as you saw them?

54.1 I became aware of staffing and other challenges as a result of undertaking the review in 2009. These included insufficient capacity to meet the patient demands on the service leading to patients being transferred to the private sector for care, the need to complete job planning for the 3 existing consultants in order to recruit an additional consultant and a need to reorganize the service to meet the standards set out regionally.

55. Were you aware of any staffing problems within urology during your tenure? If so, please set out the times when you were made aware of such problems, how and by whom.

55.1 I am unable to recall any further details in relation to staffing problems within urology during my tenure (See response to question 54).

56. Were there periods of time when any posts within urology remained vacant for a period of time? If yes, please identify the post(s) and provide your

opinion of how this impacted. How were staffing challenges and vacancies within urology managed and remedied?

56.1 I am unable to recall if any posts within urology remained vacant for a period of time during my tenure.

57. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?

57.1 I am unable to recall any details in relation to staffing problems within urology during my tenure.

58. Did staffing posts, roles, duties and responsibilities change in urology during your tenure? If so, how and why?

58.1 I am unable to recall any details in relation to staffing changes within urology during my tenure.

59. Did your role change in terms of governance during your tenure? If so, explain how and why it changed with particular reference to urology services, as relevant?

59.1 My role did not change.

60. Explain your understanding as to how the urology services were supported by non-medical staff during your tenure. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff.

60.1 I am not familiar with the detail required to respond to this question.

61. Do you know if there was an expectation that administration staff would work collectively within urology or were particular administration staff allocated to particular consultants? How was the administrative workload monitored?

61.1 I am not familiar with the detail required to respond to this question.

62. Were any concerns raised with you about the adequacy and/or availability of administrative staff for urology clinicians? Are you aware of such concerns having been raised with any other staff? If so, please explain and provide any documentation. If you do not have sufficient understanding to address this question, please identify those individuals you say would know.

62.1 In my recollection there were no concerns raised with me directly about the availability of administrative staff for urology clinicians. I am aware that the Review of Urology services set out a number of staff challenges including the potential recruitment of a 4th consultant **(terms of reference attached as appendix A2, located in Section 21 12 of 2022, Attachments).**

63. Did administrative staff within urology services ever raise any concerns directly with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.

63.1 None of the administrative staff raised concerns with me during my tenure.

64. Who was in overall charge of the day to day running of the urology during your tenure? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of urology services and to whom that person/those persons answered.

64.1 It is my understanding that the overall running of the Urology service was the responsibility of the service manager Simon Gibson and the Clinical Director who from recollection at that time may have been Mr. M. Young.

65. What, if any role did you have in staff performance reviews?

65.1 I reviewed the performance of the Director of Acute Services Ms. Joy Youart once per year formally using Individual Performance Review documentation and informally by meeting on a monthly basis.

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66. Was your role subject to a performance review or appraisal? If so, please explain how and by whom and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

66.1 Yes my role was subject to performance appraisal by the Chairman and the Term and Remuneration Committee of the Board and approval by the Trust Board. I completed an Individual Performance Review (**IPR attached as appendix L, located in Section 21 12 of 2022, Attachments**) at the beginning of the year. The performance year ran from April to April. I would usually complete the documentation in February and agree objectives for the year with the Chairman. At year end I would give an initial assessment of my performance and discuss this with the Chairman. The documentation would then be considered by the Terms and Remuneration Committee and my performance assessed.

Engagement with urology staff

67. Describe how you engaged with all staff within urology. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

67.1 I was not directly involved with urology staff.

68. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

68.1 I had no scheduled meetings with urology staff.

69. Were there any informal meetings between you and urology staff and management? If so, were any of these informal meetings about patient care

and safety and/or governance concerns? If yes, please provide full details and any minute or notes of such meetings?

69.1 I had no informal meetings with urology staff.

70. During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

70.1 I have no recollection of the relationships between medical and managerial staff. I know there would have been tension between the Medical Director and Mr. O'Brien regarding treatment of some patients. See answer to question 16.

Complaints

71. Please describe your role, and the role of members of the management team, should a complaint about clinical governance and/or patient safety be made by (i) member of staff, (ii) a patient, or (iii) anyone else, and provide an overview of how any such complaint was handled and your role in the process. It would be helpful if your answer referred to a specific example/s, preferably from urology, if any.

71.1 Complaints from patients, their relatives or representatives were managed by individual Directorates and initially, for about 6 months from April 2007, I signed every letter of response to a complaint. This process entailed an investigation of the complaint by staff following receipt of the letter. There were timescales for response that were monitored at Directorate, Executive Team and Trust Board levels. From late 2007 Directors signed all their Directorate complaint responses on my behalf. Complaints from staff were handled within Directorates by their line manager.

72. Please explain your understanding of how the management of clinical governance operated between clinical, nursing and other Directors and Departments, and detail your involvement in any of those processes.

72.1 The management of clinical governance operated between medical, nursing, social work and other Directors through the operation of the Corporate Risk Register, the Trust

Board and the Executive Team meetings. At the Executive Team and Board meetings, which involved all Directors, governance and risks were discussed. In addition the Directors of Nursing and Social Work ensured that Directorates had access to senior professional social work, nursing or AHP advice at their Directorate team meetings if those professions were not already represented. I also attended the Executive Team and Trust Board meetings.

73. During your tenure, did you think the relative responsibility for different aspects of clinical governance was clearly allocated between the relevant clinical and/or operational/managerial members of your senior team? Did you have cause to question or improve this? Was there a clear demarcation of particular responsibilities and, if so, how was this communicated within the senior team? Was it clearly set out or did it cause issues?

73.1 As the Southern Trust was a new organization in 2007, the governance arrangements were also new and required some time to get used to. Initially there was some confusion regarding responsibilities at Directorate level. The senior management team debated the issues at our weekly team meetings and improvements were introduced, for example professional advice to Directorate Teams from co-opted professionals. Following debate and discussion responsibilities were clarified with the senior team.

74. What is your view of how the complaints and whistle-blowing procedures, etc. operated and did you make any improvements in those areas? Have there been incidences where a member or members of staff, a patient or anyone else raised concerns about how effective those procedures were and what was your response to that?

74.1 Complaints were administered well, however, learning from complaints was less apparent (See response to question 36. The Trust Board was aware of this and implemented a system whereby complainants would be consulted prior to Trust Board meetings. Whistle blowing procedures were introduced however my memory of their effectiveness is not clear.

Governance – generally

75. What was your role in relation to the Directors of Directors Human Resources and Organisational Development, the Assistant and Associate Directors, the Head of Service for Urology, the Medical and Clinical Directors, consultants and other clinicians in urology, including in matters of clinical governance? You should explain all lines of management and accountability for matters of patient risk and safety and governance in your answer. Please name the post-holders you refer to in your answer.

75.1 I was the line manager for Kieran Donaghy who was the Director of Human Resources and Organisational Development. Kieran had a direct responsibility for governance in his Directorate and a corporate responsibility for governance including clinical governance as a member of the Executive Team. I directly managed the Medical Director who had responsibility for managing the clinical governance arrangements in the Trust. I had no direct relationship with the Assistant Directors, Associate Directors, the Head of Urology Services, Clinical Directors or consultants in urology. Notwithstanding this, I am aware that the Assistant Directors were managed by their Director and the Associate Directors were managed within their Directorate.

76. Who oversaw the clinical governance arrangements of the urology department and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately? Please explain and provide documents relating to any procedures, processes or systems in place on which you rely on in your answer.

76.1 Clinical governance arrangements of the Urology Department were overseen by the Clinical Director who was supported by the service manager. The Clinical Director was responsible for liaising with the urology staff and ensuring clinical safety and governance. The service manager was responsible for ensuring the service model worked efficiently and support staff were in place. The service manager would ensure any case for additional resources was properly developed and that changes and/or improvements in service were being appropriately implemented. Clinical Directors job description is attached. I depended on the Director of Acute Services and her managerial and clinical staff to provide assurance. If there were serious issues then

these would have been escalated through clinical and managerial lines of accountability.

77. How did you oversee the quality of services in urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of services?

77.1 I did not directly oversee the quality of services in the urology department as this was the responsibility of the service manager (don't know who this was at the time) (who reported to their assistant director (Mr. Gibson) and the Clinical Director who reported to their Associate Medical Director (Mr. Mackle). I was, however, provided with assurance by the Director of Acute Services (Ms. Joy Youart) and Medical Director (Dr Loughran) as well as the operation of the risk management processes and the Assurance Framework.

78. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for overseeing performance metrics?

78.1 The performance metrics in urology were overseen by the Service Manager.

79. How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

79.1 In general I received assurance through the operation of the governance, risk management frameworks and performance reports. I relied on the risk management and governance arrangements in the Acute Directorate to assure me that appropriate standards were being met and maintained.

80. How could issues of concern relating to urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside urology services, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

80.1 Issues were brought to my attention either by the Director of Acute Services, the Director of Performance and Reform, the Medical Director, other staff or patient complaints. The systems in place to deal with concerns included complaints handling, internal Directorate arrangements, risk management processes, performance monitoring and whistle blowing. The risk management and performance monitoring processes were in my view effective and did identify concerns and enable corrective action. The complaints process and whistle-blowing processes were less effective and few organization wide changes were made as a result of these processes.

81. Did those systems or processes change over time? If so, how, by whom and why?

81.1 Some systems did change over time responding to best practice and lessons from reviews. In relation to governance the Trust initiated a review in 2009 to improve the level of integrated clinical governance across Directorates. The review was not completed before I left the Trust. In urology the service changed due to the 2008 review. Changes were the overall responsibility of the Director and implemented by the Clinical Director and Service Manager supported by the AMD.

82. How did you ensure that you were appraised of any concerns generally within urology?

82.1 I would have been informed of concerns through the established line management arrangements.

83. How did you ensure that governance systems, including clinical governance, within urology were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary? If yes, please explain.

83.1 I relied upon individual Directors to ensure appropriate governance arrangements in their Directorates, as set out in the risk management and governance frameworks, were adequate. This was evident by the management and clinical arrangements in place. These arrangements included the risk assessment processes at corporate and Directorate level, the provision of governance staff within each Directorate and the

involvement of clinical staff in managerial positions such as Clinical Directors and Associate Medical Directors. In urology these arrangements were set out in the review of 2008. At the time I had no concerns that governance issues were not being properly addressed.

84. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.

84.1 Concerns raised and/or identified by me or others were reflected in individual Directorate Risk registers or the Corporate Risk Register if appropriate.

85. What systems were in place for collecting patient data on urology? How did those systems help identify concerns, if at all?

85.1 The main system in place was the Patient Administration System (PAS). It was utilized for both clinical and management purposes. The PAS did assist with identifying concerns e.g. readmission rates for patients which is a quality indicator. Clinicians would also have used the information from PAS to manage their outpatient and inpatient services.

86. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

86.1 In my opinion the system was limited in the information it provided as it only had patient information on hospital treatment and did not link with the systems used community and primary care. Over time the Health and Social Care System developed the electronic Health and Care Number that enabled a record for each citizen including all care provided in hospital, primary and community care to be accessed by clinicians that revolutionised the availability of clinical information.

87. During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during

your time, providing documentation or sign-posting the Inquiry to any relevant documentation.

87.1 During my tenure the Trust was developing performance systems for the organisation. Performance objectives for individual consultant medical staff were set as a part of the job planning process which was aligned to the Trust's overall objectives and performance requirements. Initially in 2007 performance objectives for medical staff were not linked to overall Trust objectives but this improved over time. Specialty teams objectives therefore were the sum of their job plans together with other objectives such as improving the environment or adopting technology. The process improved during 2008 as it was better aligned to Trust objectives. I am not aware of the documentation or performance objectives of the urology service at that time.

88. How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?

88.1 The national change to the Consultant' Contract in 2006 meant job planning became an important means of managing the medical manpower available to deliver care. In my opinion the annual cycle of appraisal job planning worked well by matching manpower and plans to service requirements. This had to be managed over time as, at the introduction of job planning, there was a mismatch between service requirements and Consultant plans. By 2007-2008 this had evolved effectively. Appraisal and revalidation initially concentrated on completing the process and therefore its effectiveness was not really measured. I was unsure of its effectiveness at the time however I was aware that introducing cultural or behavioral change would take time.

89. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns, having the potential to impact on patient care and safety, arose. Please provide an explanation of that process during your time in post, including the name(s) and roles of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

89.1 The process I will explain is in relation to infection control. During 2008 the Trust had an outbreak of C Diff. The personnel involved were Dr Nizam Damani (Consultant microbiologist), Nurse Reid (the lead nurse in infection control), Ms. Joy Youart (Director of Acute Services) Mrs. McAlinden (Director of Performance and Reform), Dr Patrick Loughran (Medical Director) and hospital medical staff. The Trust Board and Executive Team also became involved. The process began with identifying an increase in C Diff infections over and above what was expected. This was identified by the infection control team. Dr Damani contacted Dr Loughran regarding his concerns. Dr Loughran spoke to me and we then met with Dr Damani. I informed the Chairman and we agreed to inform the Trust Board at our next meeting. The regional infectious diseases lead contacted the Trust about the increase in infection. I put in place a taskforce chaired by me that included the Medical Director, Director of Acute Services, Director of Performance and Reform, Dr Damani, the lead infection control nurse and the AMDs. I led meetings with senior nursing and medical staff across the Trust. The taskforce identified the issues and devised a plan for tackling them. The plan was agreed by the Executive Team and Trust Board and achieved ownership of medical and nursing staff. The plan was implemented and resulted over a two month period of a very substantial reduction in C Diff infections and, over time, the Trust reduced infections well below expectations and well within regional standards.

89.2 The documentation that will reflect this is Senior Management Team meeting, Trust Board meetings and email correspondence.

90. Did you feel supported in your role by the Trust Board and general management and medical line management? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

90.1 Yes, I felt supported generally by the Trust Board, general and medical managers. In regard to infection control for example medical staff initially resisted changes suggested about managing C diff as they interpreted the plan as extra work, however, they took ownership when the impacts of infection on clinical care were outlined by Dr Damani. The Trust Board and Executive Team were very supportive in other areas

such as the Gynae review and the need to provide additional support to maternity services.

Concerns regarding urology

91. The Inquiry is keen to understand how, if at all, during your tenure you liaised with and had both formal and informal meetings with:

1. ***(i) The Trust Board***

   91.1 I met with the Trust Board once per month at Trust Board meetings and informally at Trust Board workshops that were held every two months. Governance issues were discussed at Trust Board. The workshops were usually organised around specific themes.

2. ***(ii) The Chair of Trust Board – the Inquiry understands this to have been Anne Balmer.***

   91.2 I met with the Chairman at least once per week informally and we discussed Trust performance and governance and in particular if there were any issues.

3. ***(iii) The Medical Director – the Inquiry understand this to have been Patrick Loughran;***

   91.3 I had contact with Dr Loughran on an almost daily basis as our offices were on the same floor in Trust HQ. We met informally and formally. Formal meetings included the Trust Board, SMT and individual performance review meetings. Dr Loughran could raise governance issues with me during any of these meetings. I met with Dr Loughran regarding Mr O'Brien's clinical practice in 2009.

4. ***(iv) The Director of Acute Services – the inquiry understands this to have been Jim McCall/Joy Youart;***

91.4 I met with Mr McCall and Ms Youart mostly on a formal basis at Trust Board, SMT meetings and individual performance review meetings. Mr McCall and Ms Youart could raise governance issues with me during these meetings. I spoke to and met Joy in 2009 regarding the Trust's review of urology services. I cannot recollect speaking to her about Mr O'Brien's clinical practice in 2009, but I may have.

5. ***(v) The Director of Human Resources and relevant Human Resources personnel – Kieran Donaghy;***

91.5 I met with Mr Donaghy on an almost daily basis informally. I also met with him formally in Trust Board, Executive Team and individual performance review meetings. Mr Donaghy could raise any issues with me at these meetings. I have no recollection of speaking to Mr Donaghy about urology services.

6. ***(vi) The Assistant Directors - the inquiry understands this to have been Simon Gibson; please name any others.***

91.6 I didn't meet formally with assistant directors. I would have met them informally when on Trust walkabouts or staff gatherings. Should Mr Gibson have concerns his first point of contact was his Director. I have no recollection of speaking to Mr Gibson about urology services.

7. ***(vii) The Associate Medical Director - the inquiry understands these to have been Eamon Mackle (Surgery) and Stephen Hall (Anaesthetics)***

91.7 I met informally occasionally when on walkabouts in the Trust and formally when I attended the AMD Forum. The AMDs were most likely to raise concerns either with Dr Loughran or the Director of Acute Services. Although they did have the opportunity to raise issues at the AMD Forum when I attended or informally. I have no recollection of speaking to Mr Mackle or Dr Hall about urology services.

Urology Services Inquiry

8. ***(viii) The Clinical Director - please name any other post holders during your tenure;***

91.8 Mr Michael Young was the Clinical Director but I am unsure of the time period. The Clinical Director would most likely raise concerns with his AMD or Assistant Director. I have no recollection of speaking to Mr Young about urology services.

9. ***(ix) The Head of Service, please name any other post holders during your Tenure***

91.9 I am not aware of any other post holders. The Head of Service would not have contacted me directly. I cannot recollect their name.

10. ***(x) The consultant urologists in post.***

91.9 I didn't meet with the consultant urologists. They would have raised concerns with their AMD or the Medical Director. I have no recollection of speaking to the urology consultants about issues with their service.

11. ***(xi) The Nurse Managers.***

91.10 I met with nurse managers infrequently during Trust walkabouts.

The Inquiry is interested to understand how you liaised with these individuals in matters of concern regarding urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (ii) specifically with reference to urology services concerns. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc. Your answer should also include any individuals not named in (i) – (xi) above but with whom you interacted on matters falling with the Inquiry's Terms of Reference.

91.11 I have no recollection of speaking to anyone else about urology issues during my tenure as Chief Executive of the Southern Trust.

91.12 I met formally once per week with the Executive Team that included the Medical Director, Director of Performance and Reform, Director of Finance, Director of Human Resources and Organisational Development, Director of Acute Services, Director of Children's Services (Executive Social Work Director), Director of Mental Health and Disability Services (Executive Nurse Director), Director of Older People Services and Head of Communications. I also spoke to Directors informally most days as we had offices on the same site. I met with the Trust Board once per month and also at Trust Board workshops that were held every second month. I met informally with the Chairman Anne Balmer a couple of times per week. I also met formally to discuss the Executive Directors meeting agenda that was shared with the Chairman. The Director of Human Resources and Organisational Development was Kieran Donaghy. I met occasionally with Associate Medical Directors in relation to specific issues. I didn't meet with the Assistant Director, Clinical Director, Head of Service, consultants or nurse managers unless as part of a walkaround visit. I engaged with the Director of Acute Services, Director of Performance and Reform and the Medical Director regarding urology governance generally in relation to the Trust's review of urology services. This engagement was both by conversation and email. In addition the Executive Team considered the Term of Reference for the review. I spoke to the Chairman regarding the urology review and Mr. O'Brien's practice.

92. Can you explain from your perspective how you understood Urology Services was supposed to operate, from a clinical governance and patient care and safety perspective, during your time in post compared to how it did in fact operate?

92.1 In my opinion Urology services should operate similar to other hospital specialties. I was not aware it was operating differently at that time. Patients are referred into the service either through their GP or from other internal hospital services (elective/planned care). Additionally, patients would access the service through A&E (non-elective/emergency care). The service would consider referrals and treat patients according to their clinical priority. This could include outpatient appointments, day

procedures, inpatient medical care and inpatient surgery. It was for medical staff to determine the appropriate care to be provided usually as a result of an outpatient appointment for elective care patients and a consultation with the patient in relation to emergency patients. From a clinical governance perspective urology services were managed using the Trust's risk management and assurance processes.

93. Can you identify in what aspects you considered Urology Services to be operating adequately and in what respects it was failing to do so? If your understanding changed over time, please explain this within your answer.

93.1 I had no information prior to 2009 to suggest that the urology service wasn't operating satisfactorily within the resources it had. I had no detailed knowledge of its operation until 2009. In 2009 the Trust decided to carry out a review of the urology service. I became aware that this was in an effort to increase the capacity it had to deal with patient through put. This was primarily as a result of the regional review. Prior to carrying out the review I became aware that consultant job planning was incomplete and demand for the service outstripped resources. These issues were included in the review terms of reference.

94. During your tenure, please describe the main problems you encountered or that were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters:

> ***(a) What were the concerns raised with you, when were they raised and who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and detail what was discussed and what was planned as a result of these concerns.***
>
> 94.1 Please see my response to question 16.
>
> ***(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?***

94.2 Dr Loughran involved independent urology experts to advise on efficacy and safety issues with regard to Mr. O'Brien's clinical practice. My understanding is that the independent experts confirmed that the treatment was not efficacious. Following the outcome of a Regional Review the Trust carried out a review of Trust urology services in 2009 to ensure the service was best placed to provide quality patient care and become one of 3 centres in N. Ireland providing urology services.

(c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not?

94.3 I considered that the challenge of excess demand over available resources faced by the urology service in 2009 could impact on the effective and efficient delivery of patient care. If the service and individuals are under pressure then there is more likelihood of errors. I agreed to the Trust review of urology services to support the service to improve and lead to the investment of additional resources. I also considered Mr O'Brien's practice of treating patients in hospital with IV fluids was not effective and should not continue.

(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements and how was this done? Please provide all relevant documents.

94.4 I am unaware of the detail of the arrangements put in place. I am aware that the Trust provided more day surgery and less inpatient care. The Director of Acute Services and her clinical and managerial staff would have implemented and monitored the new systems. My recollection is that the implementation happened after I left the Trust. In relation to Mr O' Brien's practice I was satisfied that Dr Loughran would take the proper action to cease his practice of treating patients with IV fluids in hospital. This had not concluded prior to my departure from the Trust.

(e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?

94.5 See answer to 4 above. The new systems and processes were put in place after I left the Trust.

(f) If you were given assurances by others, please name those individuals and set out the assurances they provided to you. How did you test those assurances?

94.6 I was assured by Dr Loughran that the best way to persuade Mr O'Brien to change his practice was to get independent expert advice. Ms Youart Director of Acute Services and Mrs McAlinden Director of Performance and Reform assured me that the Trust's review of urology services would deliver the improvements required to improve patient care and meet the standards set out the regional review.

(g) Were the systems and agreements put in place to rectify the problems within urology services successful?

94.7 See response to 4 above.

(h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

94.8 See response to 4 above.

94.9 During my tenure the capacity of the urology service to meet demand was raised with me by the Director of Performance and Reform and the Director of Acute Services and as a result the Trust completed a review of the urology service. I met with the Director of Performance and Reform and spoke to the Director of Acute Services. The Trust's review of Urology Services resulted from these conversations. The terms of reference were discussed and agreed at an Executive Team meeting. Dr Loughran also raised Mr. O'Brien's practice of admitting a cohort of patients for IV treatment. Dr

Loughran arranged to get independent advice on the treatments efficacy and safety. I briefed the Chairman. My understanding from conversations with Dr Loughran was that the treatment may not have been unsafe but was not evidenced based and therefore ineffective. I left the Trust prior to completion of the process.

95.Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were -

(a) properly identified,
(b) their extent and impact assessed,
(c) the potential risk to patients properly considered?

95.1 I believe the issues of the challenges facing the urology service in 2009 and Mr. O'Brien's clinical practice in 2009 were properly identified and their impact assessed.

95.2 The terms of reference for Trust's urology review identified the challenges facing the service and the process for dealing with those challenges. The potential risk to patients was also properly considered as a part of the review with regard to better meeting patient demand and the available capacity and therefore reducing waiting times and improving care.

95.3 With regard to Mr. O'Brien's clinical practice the issue was identified and Dr Loughran involved independent experts to assess both efficacy and safety to patients.

96. What, if any, support was provided to urology staff (other than Mr. O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q111 will ask about any support provided to Mr. O'Brien).

96.1 I am unable to recall this information or whether I was aware of this information at the material time. Interaction with Human Resources would have been directly with the Director of Acute Services.

97. Was the urology department offered any support for quality improvement initiatives during your tenure?

97.2 In my opinion the review of urology services would have resulted in quality improvement. I am unable to recall any further information about support or whether I was aware of this information at the material time.

Mr. O'Brien

98. Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

98.1 I had no direct line management responsibility for Mr. O'Brien. He would have been managed within the Directorate of Acute Services. From memory I did not meet with Mr. O'Brien and had little or no contact with him during my tenure.

99. What was your role and involvement, if any, in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

99.1 I did not engage with Mr. O'Brien in relation to job planning.

100. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention?

100.1 Please see para 16. I was made aware of issues regarding Mr. O'Brien's clinical practice in April/May 2009 by Dr Loughran. I am not aware how long the issue of his practice was in existence. The only documents available to me are the Trust emails and letters sent to Mr. O'Brien at that time (**attached as appendix M1, M2, M3, M4, located in Section 21 12 of 2022, Attachments**).

Urology Services Inquiry

101. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

101.1 I recall discussing Mr. O'Brien with Dr Loughran on a few occasions but I am unable to provide specific dates and times, as minutes were not taken of these discussions. I also briefed the Chairman in relation to Mr. O' Brien's clinical practice but cannot provide specific dates as no minutes were taken. I am unable to set out in detail the content of the discussions but I have outlined in previous paragraphs the nature of the discussions.

102. What actions did you or others take or direct to be taken as a result of these concerns? If actions were taken, please provide the rationale for them. You should include details of any discussions with named others regarding concerns and proposed actions. Please provide dates and details of any discussions, including details of any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

102.1 The actions taken are already set out in response to questions 16, 54, 94 and 95. The relevant documents are the terms of reference for the urology review, the SMT minutes of January 2009 and Dr Loughran's emails and letters regarding Mr. O'Brien's clinical practice.

103. Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so:

1. ***(i) what risk assessment did you undertake, and***
2. ***(ii) what steps did you take to mitigate against this? If none, please explain.***

If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person and if known, any steps taken

103.1 I did not undertake a risk assessment. I considered that the concerns raised about Mr. O'Brien's clinical practice as set out in my response to question 16 and 94 did potentially constitute ineffective care. I was not unaware that there were patient safety issues. I met with the Medical Director Dr Loughran and briefed the Chairman on the issue. Dr Loughran was responsible for taking the necessary actions to deal with Mr. O'Brien's practice. Dr Loughran as the medical Director was more familiar with the clinical issues and I was satisfied that he was taking appropriate action to resolve them.

104. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr. O'Brien and others, given the concerns identified.

104.1 I did not agree anything directly with Mr. O'Brien. I agreed with Dr Loughran that an independent review should be sought on his practice of admitting patients for IV treatment.

105. Did you ever speak to or contact Mr. O'Brien, either formally or informally, regarding the concerns raised, or any proposed actions or plans, or about any matter falling within the Inquiry's Terms of Reference? If so, please provide full details.

105.1 I did not contact Mr. O'Brien at any time.

106. What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?

106.1 I am unable to recall this information or whether I was aware of this information at the material time. Dr Loughran may be able to answer this question.

107. How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed?

107.1 As the processes and systems were completed after I left the Trust in August 2009 I am unable to answer this question. I was satisfied at the time that Dr Loughran was taking the appropriate course of action to resolve the concerns.

108. Did any such agreements and systems which were put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?

108.1 In my opinion the review of urology services was completed and would have assisted in improving access to urology services. However it was not fully implemented during my tenure. See response to question 107.

109. Did Mr O'Brien raise any concerns regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise and with whom, and when and in what context did he raise them? How, if at all, were those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?

109.1 I am unaware of issues he may have raised.

110. Did you raise any concerns about the conduct/performance of Mr O'Brien. If yes:
(a) outline the nature of concerns you raised, and why it was raised
(b) who did you raise it with and when?

(c) what action was taken by you and others, if any, after the issue was raised
(d) what was the outcome of raising the issue?

If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not?

109.1 I did not raise any concerns with the exception of briefing the Chairman as detailed above.

111. What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss support option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

111.1 I am unable to recall this information or whether I was aware of this information at the material time. The Head of Service, Assistant Director Simon Gibson, Associate Medical Director Mr. Mackle or Director of Acute Services Ms. Youart should be able to answer these questions.

112. How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raised were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

112.1 I am unable to recall this information or whether I was aware of this information at the material time. The Director of Acute Services Ms. Youart. Should be able to answer this question

113. Did you communicate in any way, either formally or informally, with your successor Chief Executive, Mairead McAlinden, in relation to any issues of concern regarding urology services, such as patient safety, clinical risk or governance issues? If so, please provide all details and any relevant documentation.

113.1 I don't remember communicating with Mrs. McAlinden either formally or informally about the stated issues.

Learning

114. What was the position regarding the concerns raised regarding urology by the end of your tenure? Had concerns of which you were made aware been addressed to your satisfaction? If so, please explain. If not, why not?

114.1 The position regarding the demand and capacity of the service was ongoing and a plan to organise inpatient beds, increase day procedures across Craigavon and Daisyhill Hospital sites was in place but not fully implemented. The plan was a result of the Trust's review of urology services and included a reorganization of inpatient beds, day procedures and an increase in staff resources. The issue of Mr. O'Brien's practice of admitting patients for IV treatment was ongoing when I left the Trust at the end of August 2009.

115. Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why, and why you consider it did not come to your attention.

115.1 I have subsequently become aware that there were issues with urology services specifically related to Mr. O'Brien because of the Inquiry but I am not aware of the detail of those issues. I don't know if these issues existed during my tenure.

116. Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?

116.1 I am not aware of the issues which led to the public inquiry and therefore any response would be conjecture.

117. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and the unit, and the concerns involving Mr. O'Brien in particular?

117.1 Mr. O'Brien's practice of admitting patients for IV treatment may have been an indication of other issues that were not obvious at that time. With the benefit of hindsight, a wider review of his practice at that time may have been appropriate.

118. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

118.1 No. I am of the view that the problem of Mr. O'Brien's practice and the challenges that led to the Trust's review of urology services during my tenure were properly addressed prior to my departure.

119. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

119.1 I do not have enough information or knowledge to be able to answer this question save for what I have stated already in my answer to Question 117.

120. Do you think, overall, the governance arrangements were fit for purpose? Did you have concerns about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?

120.1 The governance arrangements at that time were under continuous review and there was always the potential to improve the processes. The issue of Mr. O'Brien's clinical practice was not highlighted through the governance processes but rather as a result of initiating a review of the Trust's urology service. Once the issue was identified I was satisfied with the actions taken by Dr Loughran Medical Director. I do think that

overall the governance arrangements were fir for purpose. The trust had in place an integrated governance framework that included appropriate risk assessment processes. The Medical Directors office was resourced to provide support and advice on clinical governance to the Directorates within the Trust. This included staff in each Directorate dedicated to governance in order to provide support to Directorate teams and staff. This was further strengthened by ensuring the appropriate Directorates had senior care professional advice where that was not already available. In addition the Trust created a Governance Committee reporting directly to the Trust Board. In 2009 the Trust Board agreed to review these arrangement with a view to strengthening them. In August 2009 the Trust considered proposals to strengthen those arrangements (**paper attached as appendix N, located in Section 21 12 of 2022, Attachments**). This process continued after I left the Trust at the end of August 2009. I did not raise governance concerns with anyone.

121. Given the Inquiry's Terms of Reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

121.1 I have nothing further to add.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: _____Colm Donaghy_____

Date: ___10th June 2022_____

S21 12 of 2022

Witness statement of: Colm Donaghy

Table of Attachments

Appendix	Document Name	Q Number
A1& A2	Appendix A1 20090120 E and ToR re Review of Urology Services.pdf Appendix A2 20090121 SHSCT Review of Urology Services - tabled at SMT on 21 January 2009.pdf	*1b*
B1 & B2	Appendix B1 20090121 SHSCT Review of Urology Services - SMT Notes 21 January 2009 Appendix B2 20090121 SHSCT Review of Urology Services - Agenda 21 January 2009 A.pdf	*1b*
C1, C2, C3, C4	Appendix C1 20090518 E and Ltr from Dr Loughran to Mr A O'Brien Appendix C2 20090518 E and Ltr from Dr Loughran to Mr A O'Brien A. Appendix C3 20090602 E Ltr and Diary from Dr Loughran to Mr A O'Brien Appendix C4 20090602 E Ltr and Diary from Dr Loughran to Mr A O'Brien A	*1c*
D1, D2, D3, D4	Appendix D1 20090506 E and Ltr from Personal Information redacted by the USI re Urology Services Appendix D2 20090506 E and Ltr from Personal Information redacted by the USI re Urology Services A Appendix D3 20090513 E and Ltr from Personal Information redacted by the USI re Urology Ward Appendix D4 20090513 E and Ltr from Personal Information redacted by the USI re Urology	*1c*

	Ward A	
E1 & E2	Appendix E1 CHIEF EXECUTIVE Colm Donaghy JD Appendix E2 General Surgery CD JD	*5*
F	Appendix F 20090924 CRR	*12*
G	Appendix G 20090528 Performance Report to TB	*13*
H1& H2	Appendix H1 20090430 TB Public Agenda Appendix H2 20090430 TB Public Minutes	*21*
I	Appendix I Board Secretary JENNIFER HOLMES	*31*
J	Appendix J 200809 IPR - Colm Donaghy	*44.*
K	Appendix K 2009 10 IPR Chief Executive Final	*66.*
L	Appendix L1 20090717 E and Ltr to Mr A O'Brien re Urology Patients Appendix L2 20090717 E and Ltr to Mr A O'Brien re Urology Patients A Appendix L3 20090717 E and Ltr to Mr A O'Brien re Urology Patients Appendix L4 20090717 E and Ltr to Mr A O'Brien re Urology Patients	*100.*
M	Appendix M 20090528 Board Assurance Framework	*120.*

Wright, Elaine

From:	McAlinden, Mairead [redacted] >
Sent:	20 January 2009 08:31
To:	Donaghy, Colm; Youart, Joy; Loughran, Patrick
Cc:	Wright, Elaine; McAlinden, Mairead; Radcliffe, Sharon
Subject:	URGENT: ToR REVIEW OF UROLOGY SERVICES v0.1
Attachments:	REVIEW OF UROLOGY SERVICES v0.1.doc

<<REVIEW OF UROLOGY SERVICES v0.1.doc>> Colm/Joy/Paddy - as requested at last week's SMT, please see attached draft Terms of Reference for the Review of Urology Services commissioned by SMT.

Given the pressures and timescale, it would be helpful to agree/sign off at this week's SMT, so please advise urgently if any changes required as ideally needs to be circulated by Elaine Tuesday pm.

Mairead

SHSCT REVIEW OF UROLOGY SERVICES

Draft Terms of Reference

Context

The Urology Service within the Southern Trust faces a number of challenges, namely:

- Capacity is not sufficient to meet current demand, and patients are regularly transferred to Independent Sector providers to meet access targets, incurring financial risk to the Trust.
- Agreement has been reached in principle that a 4th consultant is required to sustain services and meet demand, however the Job Plan for this consultant and associated revision of Job Plans for the current three consultants have not been progressed, so the permanent post cannot be interviewed.
- There is potential to provide the urology service across CAH and DHH sites, better exploiting day case potential and theatre capacity at DHH.
- The Urology ICATs service needs to be reviewed to ensure it is operating as originally planned.
- The Regional Review of Urology Services has resulted in a recommendation that complex urology cancers will in future be treated only in the Regional Centre. This will result in a limited transfer of current demand for these treatments to BHSCT.
- The Regional Review is also considering the future configuration of urology services, and is currently exploring options for a 2-site (Belfast and Altnagelvin) and a 3-site (Belfast, Altnagelvin and Craigavon) model.
- If the option which would favour the 3-site model and maintenance of a Craigavon/SHSCT service, then the current service needs to prove it is/can meet the standards which will be set for this service model including the 'Action On' Urology and IOG Guidance standards. An assessment of the current service against these standards is therefore urgently required.
- Under the auspices of CAWT, HSE have expressed an interest in exploring the commissioning of urology services from the Trust.

Given current capacity and other issues detailed above, the Trust is currently not in a position to exploit this potential market.

As a consequence of the above challenges, the Trust's Senior Management Team have commissioned an urgent review of the Trust's urology services, to be completed by end of March 2009.

Terms of Reference for Urology Review

The Urology Review will be led by the Director of Acute Services, and will deliver the following project objectives:

- An agreed analysis of the capacity gap in relation to urology services, recognising the impact of the Regional Review.
- Assess the current service against the standards set out in 'Action On' Urology and IOG Guidance and, where standards are not currently met, bring forward agreed plans to address same
- Develop an agreed cross site service model including ICATs to deliver assessed future demand, including potential future business which could be generated from other commissioners, through either:
    - The new model of urology services for NI as recommended by the Regional Urology Review Group
    - Demand from HSE

  and service standards as set out in 'Action On' and IOG guidance.
- The development of agreed team job plans to deliver this model.
- The development of a business case to commissioners to deliver the agreed model of care.
- Developing the sustainability of the service and reducing costs through the urgent progression to recruit funded consultant and other posts on a permanent basis.

Review Project Sponsor

The Project Sponsor is the Chief Executive, and reporting on the progress of the review will be through weekly reports to the Senior Management Team.

Review Structure

The Review Group will be chaired by the Director of Acute Services and will include membership from:

- Medical Director
- Director of Finance
- Director of Performance and Reform
- Associate Medical Director with responsibility for Urology Assistant Director with responsibility for Urology (Project Management Lead)
- Clinical Director for Urology (Project Clinical Lead)

Resources for project support will be quantified and secured by the Chair.

Review Timetable

The Review Group will deliver against the project objectives as set out in the following timetable:

- Establish Review Group and hold first meeting — by 31 January 09
- Analysis of the service capacity gap — by 13 February
- Assess the current service against standards — by 13 February
- Develop an agreed cross site service model that will deliver standards and access targets — by 6 March
- Report to SMT for approval of Service Model — by 11 March
- Finalise agreed team job plans in line with Service Model — by 20 March
- Commence recruitment of funded posts in line with agreed service model — by 23 March
- Completion of a business case for new Service Model — by end April

Southern Health and Social Care Trust

DRAFT

Notes of SMT Meeting held on Wednesday 21 January 2009 @ 2pm in the Boardroom, Trust Headquarters

Present: Colm Donaghy
Martin Dillon
Kieran Donaghy
Brian Dornan
Dr Loughran
Mairead McAlinden
Dr Rankin
Francis Rice
Joy Youart
Ruth Rogers
Elaine Wright

Apologies: Jennifer Holmes

ITEM	NOTE	*ACTION*
1	APOLOGIES Apologies were received from Jennifer Holmes.	
2	NOTES OF MEETING HELD ON 14 JANUARY 2009 The notes of the meeting held on 14 January 2009 were agreed by members.	
3	MATTERS ARISING 3.1 5th Tier Structures Nothing further to report. 3.2 Best Care: Best Value – Update Members noted that a draft agenda had been prepared for the forthcoming workshop. Further discussions to take place. 3.3 IMPACT – A New Programme for Senior Leaders in H&SC Mr K Donaghy advised that he had invited Ms Myra Weir to come to give a brief presentation on the IMPACT programme.	

	3.4 Escalation Processes for Theatre Cancellations/Ward Closures Members noted that plans were in place with regard to the escalation processes for Theatre cancellations and Ward closures and that Ms Youart would be re-enforcing at team meetings.	
4	PERFORMANCE UPDATE Mrs McAlinden provided a weekly performance update to members and highlighted progress and areas of concern following the Performance meeting with DHSSPS that morning. Mr Rice referred to the Mental Health Service and the transition to the new model. The Chief Executive said it would be beneficial for Mr Rice to share information on the process with members. Weekly Update on Fractures Performance Performance with fractures continues to progress satisfactorily.	
5	INFECTION CONTROL UPDATE – PROGRESS REPORT The Chief Executive outlined the systems and process put in place for the Infection Control structure within the Trust. Members noted the audit process and the need to ensure proof of actions. Dr Loughran advised that there has been a period of 9 clear days of reported C-Difficile cases and members seen this as a turning point for the Trust. The Chief Executive stressed however, that the interim arrangements which have been put in place with remain and the Trust will continue to strive to combat Infection Control.	
6	CSR UPDATE - Acute Quality Care Project PID Ms Heather Troughton attended the meeting to discuss the Acute Quality Care Project PID.	

	Ms Troughton explained the background to the PID advising that the Acute Directorate has developed a number of RPE Projects and a Directorate wide approach to improving productivity through continuous improvement methods. Members noted that the project aim is to improve the quality of services delivered by the Trust across the acute hospital system, and Ms Troughton went on to outlined the various stages, timescales and milestones involved. Members acknowledged and commended the project.	
7	CAPITAL PRIORITIES - Portadown CCTC Mr Martin Kelly attended the meeting to update members on the project delays pertaining to Portadown CCTC. Mr Kelly explained that the report provides an update for SMT on the issues surrounding the impact of flooding on the programme and budget for the Portadown CCTC. Mr Kelly drew member's attention to the background for the 5 week delay to the project's programme. Following discussion, members noted the programme update and associated costs and timeframe. In concluding, members noted that the impact of the delays on the programme pushes the handover from December 2009 to January 2010. The cost of the delay has yet to be fully bottomed out by the design team, but is estimated to be approximately £200k.	
8	MATERNITY SERVICES Ms Youart referred to the paper regarding Integrated Maternity & Women's Health Division. She explained that the paper sets out the background to the recent Midwifery Staffing pressures and describes the steps and measures that have been taken to date to address same. The paper focus on the following key areas – activity, staffing, patient safety, communication and equipment.	

	Ms Youart provided an outline of a number of provisions which have been put in place. Mrs McAlinden advised members that a Business Case had been written which included the impact of the shift that would come from the closure of Lagan Valley Maternity. Following some discussion and consideration of the paper, SMT recognise the pressures that maternity services are under and at any time would support access to agency and bank staff if managers felt that is what is required in order to maintain safe services.	
9	CHANGING FOR THE BETTER – 5 YEAR STRATEGIC PLAN Mr Kelly distributed copies of a log of all responses received to the proposed closures of Slieve Roe House, Kilkeel and Skeagh House, Dromore. Discussion took place with regard to the process for the logging and analysis of all responses received, and this was taking place within the Equality Unit and Planning.	*M McAlinden / K Donaghy*
10	TERMS OF REFERENCE – REVIEW OF UROLOGY SERVICES Members noted the Terms of Reference for the Review of Urology Services, which had been previously commissioned by SMT. Member signed-off the Terms of Reference.	
11	TERMS OF REFERENCE – REVIEW OF GYNAECOLOGY SERVICES Following consideration of the above, and the need to include some new members to the review team, SMT signed-off the Terms of Reference for the Review of Gynaecology Services.	
12	PLANS TO CONSULT ON SERVICE DEVELOPMENTS & **CSR PROPOSALS IN OLDER PEOPLE'S SERVICES** Dr Rankin referred to the briefing paper on the plans to consult on service developments and CSR Proposals in Older People's Services.	

	Dr Rankin outlined the consultation proposals, advising that an invitation will be offered to a small number of voluntary and community organised in each locality area to meet to present and discuss the proposals. Members noted that a meeting with the Armagh District GP's had been arranged for Wednesday 11 February 2009 @ 2.30pm.	
13	VISIT TO TAYSIDE & HEALTH COMMITTEE MEETING – 12 FEBRUARY 2009 Following discussion, members agreed to convey their apologies to the Tayside Visits and E Wright will liaise with the Tayside Link and request copies of overheads etc from the visit. Discussion took place regarding the forthcoming Health Committee Meeting planned for Thursday 12 February 2009 and agreed the attendance of members at same. Further discussion to place nearer the time.	*E Wright to forward apologies and obtain copies of presentations*
14	STEEEP RECOGNITION EVENT – 3 APRIL 2009 Ms Youart sought member's views on holding a recognition event for the STEEEP Workshop attendees. She advised that the final STEEEP Workshop was being held on 3 April 2009. Discussion took place on the scheduling of special recognition events, ie STEEEP, Excellence Awards and the BCBV Senior Managers Forum.	
15	TRUST/SDU MEETINGS Mrs McAlinden advised members that the Trust/SDU meeting scheduled for March, August and November would be held in a Trust venue. The March meeting will also include a visit to a Trust service and Mrs McAlinden agreed to take forward.	*M McAlinden to take forward*

16	CHANGES TO THE DAY UNIT IN CHERRYVILLA INTO A WARD AREA Mr Rice referred to the paper regarding the Changes to the Day Unit in Cherryvilla into a Ward Area. Members noted the required works and estimate of costs to carry this out. Mr Rice outlined the interim position as the resettlement process continues.	
17	EXCELLENCE AWARDS CEREMONEY 2009 Members noted the Excellence Awards Ceremony 2009 paper which was tabled for discussion. Members agreed to submit comments to K Donaghy for consideration.	*All – comments to K Donaghy*
18	PROPOSAL FOR ADDITIONAL STAFF RESOURCES TO SUPPORT THE BREAST SCREENING PROGRAMME TO EXTEND COVERAGE TO WOMEN AGED 65-70 Ms Youart referred to the proposal for additional staff resources to support the Breast Screening Programme to extend coverage to women aged 65-70. Following consideration of the paper, members 'signed off' the proposal to proceed.	
19	TRUST WORKFORCE PRODUCTIVITY MONITORING REPORTS, APRIL – SEPTEMBER 2008 Mr K Donaghy referred to the Trust Workforce Productivity Monitoring Reports for the period April – September 2008. Mr Donaghy advised that the report had been developed to help monitor workforce productivity within the new Trusts and will assist in benchmarking performance across Trusts in order that areas for improvement can be identified.	
20	TRUST BOARD AGENDA & MINUTES – GUIDANCE & RELEASE Members noted the Trust Board Agenda & Minutes – Guidance & Release paper which was tabled for approval prior to submission to the Trust Board Workshop on 29 January 2009.	*To Trust Board Workshop – 29 Jan 09*

21	STRESS DOWN DAY WITH SAMARITANS – 6 FEBRUARY 2009 Mr K Donaghy referred to information regarding a 'Stress Down Day with the Samaritans' on 6 February 2009. This was tabled for noting/information.	
22	TDP PROGRESS UPDATE AS AT 20 JANUARY 2009 Members noted the TDP Progress Update as at 20 January 2009.	
23	ANY OTHER BUSINESS 23.1 Audit of Target & Implementation of MEWS Mr Rice updated members on the progress of Audits with regarding to MEWS. He advised that following completion of the first audit, improvement plans were being developed in order to move forward and learn lessons. 23.2 Regional Suicide Helpline Mr Rice informed members of the current position with regard to the Regional Suicide Helpline and the involvement of Contact Youth. He assured members that all evidence was documented in writing to the DHSSPS. 23.3 HPB Immunisation Programme Mr Dornan advised members that a number of schools may be showing signs of withdrawing from the HPB Immunisation Programme and he expressed concern at this possible course of action. Following discussion, members agreed the need to inform and involve the Southern Board. Mr Dornan will follow up. 23.4 Health Committee Meeting: 12 February 2009 Members discussed the attendance required at the forthcoming Health Committee Meeting planned for 12 February 2009. It was agreed that the service Directors would attend and they were asked to put into their diaries. Apologies were recorded from Francis and Brian, who will arrange to send deputies as required.	*F Rice* *F Rice* *B Dornan to follow up*

24	DATE OF NEXT MEETING The next SMT is scheduled for Wednesday 28 January 2009, in the Boardroom, Trust Headquarters. This meeting would be an SMT Governance Meeting.	

Southern Health and Social Care Trust

SENIOR MANAGEMENT TEAM MEETING

Date: Wednesday 21 January 2009
Time: 2.00pm
Venue: Boardroom, Trust Headquarters

Agenda

1 Apologies

2 Notes of meeting held on 17 January 2009

3 Matters Arising from the Notes
- 3.1 5th Tier Structures
- 3.2 Best Care: Best Value
- 3.3 IMPACT – A New Programme for Senior Leaders in H&SC
- 3.4 Escalation Processes for Theatre Cancellations/Ward Closures

4 SI Performance Update – *M McAlinden/M Dillon*
- Weekly Update on Fractures Performance – *J Youart*

5 SI Infection Control Update - Progress Report - *Dr Loughran*

6 SI CSR Update
- Acute Quality Care Project PID – *J Youart*

7 SI Capital Priorities
- Portadown CCTC – *M McAlinden*

8 SI Maternity Services – *J Youart*

9 SI Changing for the Better – 5 Year Strategic Plan

10 Terms of Reference – Review of Urology Services – *M McAlinden*

11 Terms of Reference – Review of Gynaecology Services – *M McAlinden*

12 Plans to Consult on Service Developments & CSR Proposals in Older People's Services – *Dr Rankin*

13 Visit to Tayside & Health Committee Meeting – 12 February 2009 - *All*

14 STEEEP Recognition Event – 3 April 2009 – *J Youart*

15 Trust/SDU Meetings – *M McAlinden*

16 Changes to the Day Unit in Cherryvilla into a Ward Area – *F Rice*

17 Excellence Awards Ceremony 2009 – *K Donaghy*

18 Proposal for Additional Staff Resources to Support the Breast Screening Programme to Extend coverage to Women aged 65-70 – *J Youart*

19 Trust Workforce Productivity Monitoring Reports, April – September 2008 – *K Donaghy*

20 Trust Board Agenda & Minutes: Guidance & Release – *E Kilpatrick*

21 Stress Down Day with Samaritans – 6 February 2009 – *K Donaghy*

22 TDP Progress Update as at 20 January 2009 – *M McAlinden*

23 Any other Business

24 Date of Next Meeting – Wednesday 28 January 2009

Wright, Elaine

From: White, Laura [redacted]
Sent: 18 May 2009 12:57
To: O'Brien, Aidan
Cc: 'Donaghy, Colm'; 'Wright, Elaine'; Young, Michael Mr; 'paulette.dignam [redacted] 'teresa.cunningham [redacted]
Subject: Further Ltr from Dr Loughran re meeting of 21st April
Attachments: 20090518_Ltr_AO'Brien_PLtc.doc

Mr O'Brien
Please find attached letter from Dr Loughran in relation to the above.
Regards,Laura

Ms Laura White
Personal Assistant to
Dr Patrick Loughran
Medical Director
Southern Health & Social Care Trust
College of Nursing
Craigavon Area Hospital
68 Lurgan Road
PORTADOWN
BT63 5QQ

Tel: [redacted]
Fax: [redacted]
E-mail: laura.white [redacted]

P Please consider the environment before printing this e-mail.

Southern Health and Social Care Trust

Medical Directorate

18 May 2009 Our Ref: PL/TC/lw

Mr Aiden O'Brien
Urology Department
CAH

Dear Aiden

I have now contacted and spoken to Mr Mark Fordham at length. I explained to him that we have patients who are being admitted for IV fluids and antibiotics. I gave him your viewpoint as best I could. He said that while he understood that you are doing your best for this group of patients, he did not know of any evidence base which would support these therapies.

We went on to a more detailed discussion about his practice and a widely accepted approach to recurrent urinary infections. He felt that once such patients had the initial standard investigations carried out, that they should be managed in primary care with no further hospital interventions. He talked about voiding techniques, advice to patients about oral hydration and the use of night time oral antibiotics. He also talked about the specifics in relation to females, and local oestrogen therapy and advising patients in relation to personal care. He also felt that if patients needed particular advice and reassurance that a once weekly MSSU provided at the hospital for 6 successive weeks would indicate that 90% of these patients did not have urinary infections and had what he described as "abacterial "cystitis.

I explained that we have a very strong antibiotic guideline in place. He supported the use of such a guideline and went on to say that he believes that such circumstances need bacteriological evidence before antibiotics should be commenced.

Summary

Over the last 6 weeks, I have spoken and written to you about a cohort of about 30 patients who are admitted for IV antibiotics and IV fluids as a prophylaxis for recurrent UTI's.

We have had a letter from a politician asking for the treatment to be provided at home. Our CX is taking this forward with Mrs C Hanna, MLA.

Cont'd. ……

I have discussed the situation with a senior microbiologist from Stoke Mandeville who believes there is no evidence base to support the treatments.

In the above paragraphs I have described the reaction of a senior urological surgeon from Manchester who also believes there is no evidence to support the treatment.

Our commissioner has expressed concern and asked me to seek independent advice so that an evidence based discussion could take place around the continuation or discontinuation of such therapies.

I would now like to meet with you immediately to take this forward. In advance of the meeting perhaps you could reflect on the possibility of changing these patients to oral therapy with an MSSU taken at the hospital at a regular interval. As on previous occasions, I have copied this to Michael Young, whose opinion on the way forward might also be valuable.

Dr Patrick Loughran
Medical Director

cc Mr Michael Young, Consultant
Mr Colm Donaghy, Chief Execurive

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by the USI / Fax: Personal Information redacted by the USI / Email: Patrick.loughran Personal Information redacted by the USI

Wright, Elaine

From: White, Laura [redacted]
Sent: 02 June 2009 14:30
To: OBrien, Aidan; McCorry, Monica
Cc: Young, Michael; Donaghy, Colm; Wright, Elaine; Dignam, Paulette
Subject: Meeting today - Tue 2nd June
Attachments: 20090602_Ltr_AO'Brien_PLtc.doc

Dear Mr O'Brien

Please find attached letter from Dr Loughran in relation to today's meeting.

Laura

Ms Laura White

Personal Assistant to

Dr Patrick Loughran

Medical Director

Southern Health & Social Care Trust

College of Nursing

Craigavon Area Hospital

68 Lurgan Road

PORTADOWN

BT63 5QQ

Tel: [redacted]

Fax: [redacted]

E-mail: laura.white@[redacted]

P Please consider the environment before printing this e-mail.

Southern Health and Social Care Trust

Medical Directorate

2 June 2009 Our Ref: PL/lw

Mr Aiden O'Brien
Urology Department
CAH

Dear Aiden

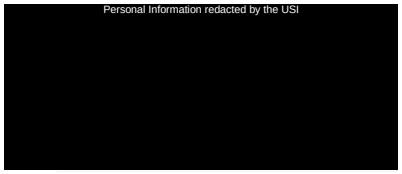
Thank you very much for meeting with me today. We agreed that you:

- would provide me with a complete list of the patients who are currently on the IV programme.
- will accept an independent assessment of this IV therapy.

I will arrange terms of reference with Mr Mark Fordham and speak to Jean O'Driscoll the Micro-biologist again.

I will also speak to Michael Young in due course.

Regards



Dr Patrick Loughran
Medical Director

cc Mr Michael Young, Consultant
Mr Colm Donaghy, Chief Executive

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by the USI / Fax: Personal Information redacted by the USI / Email: Patrick.loughran Personal Information redacted by the USI

Wright, Elaine

From: Wright, Elaine <[redacted]
Sent: 06 May 2009 16:46
To: Donaghy, Colm
Subject: FW: LETTER FOR ACTION PLEASE
Attachments: [redacted] re Urology Services 240309.pdf

With Joy who is following up.
e

-----Original Message-----
From: Wright, Elaine [redacted]
Sent: 02 April 2009 15:41
To: Youart, Joy
Cc: Hayes, Nicola
Subject: LETTER FOR ACTION PLEASE

<<[redacted] re Urology Services 240309.pdf>>

Mrs Elaine Wright
PA to Mr Colm Donaghy, Chief Executive
Southern Health & Social Care Trust
Tele: [redacted]

This email is confidential and intended solely for the use of the individual(s) to whom it is addressed. Any views or opinions presented are solely those of the author and do not necessarily represent those of Southern Health and Social Care Trust. If you are not the intended recipient, be advised that you have received this email in error and that any use, dissemination, forwarding, printing, or copying of this email is

strictly prohibited. If you have received this email in error please notify the sender.

Hand delivered
To: Joy D
cdon
1/4/09

Mr. Colm Donaghy,
Chief Executive
Southern Health and Social
Care Trust.
Craigavon.

24th March, 2009.

Dear Mr. Donaghy,

I am very disappointed to hear and to read that the Urology Ward in 2 South, Craigavon Area Hospital is to close. It has annoyed and hurt me, as I am a user of care on a weekly basis (as I have a Chronic bladder condition) and I attend 2 South Urology. I believe it has been proposed that Urology Patients are to be dispersed into other wards, as well as the Urology Staff.

I have been a patient under the care of Mr. Aidan O'Brien for 17-18 years (since he was first appointed to Craigavon Area Hospital as Urology Consultant.)

I have always received excellent care and attention from him and all the Nursing Staff in ward 2 South. I want to Praise, and I am very thankful for the Urology Ward and the staff during these years of Surgery and various treatments.

During these years, I have seen the adaptation of the Urology Ward for Patients and staff eg - The Urodynamics Room. The introduction and initiation of Nurse Led Care for Clinics for:-

(A) Urology Patients with cancer coming from theatre.

(B) Renal Care patients

(C) Intravesical Sodium Hyaluronate Sol. treatments.

(d) Chemotherapy treatments for Cancer

Patients.

I have been, and indeed currently attend for intravesical Sodium Hyaluronate SOL. treatment in week 2 South Urology every week. The main nurse for my care and a relief Sister (for annual leave etc.) provide very Professional and Specialist Urology care. The continuity of one nurse Staff Member is very important to me, as She knows my medical condition, and provides excellence in Urology Nursing Care, and indeed it makes my visits for treatments alot easier.

Therefore, I am devasted to hear this news regarding the closure of week 2 South Urology, as I have developed a friendship and confidence for 17 years plus with Staff. Over the years and Currently I can contact the Nursing Staff

by telephone to the ward to discuss eg. pain, infection etc. Also, I am able to contact the staff for laboratory reports. The care I have received and continue to receive from the staff is exemplary.

Mr. O'Brien has spent the last 17-18 years setting up and establishing an excellent Urological Service within the S.H.S.C.T., on the ward 2 South, and Outpatient Clinics. This has involved dedication, working very hard and long hours. Most days Mr. O'Brien could, and is still seen on the ward at 10pm. at night. I KNOW, because I was one of his first patients in Craigavon Area Hospital, where he was the only Urology Consultant for many, many years. This Consultant, Mr. O'Brien has been very visionary for

Urology Services and provision of care, what must he feel now? Has the current information been discussed with him and the other Urology Consultant, before the decision to make these changes, as I can only imagine this as devastation for them?

What does the future hold for Urology patients requiring Surgery and Specialist Urological Care within Craigavon Area Hospital now?

What happens with my weekly treatment? Where do I go now? Will I have an Urological trained nurse to carry out my treatments? These are great concerns for me at this time.

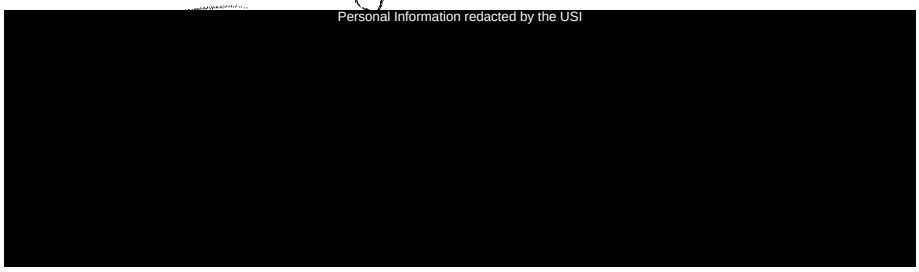
I am also very concerned for this very anxious time for all the staff, as it is very unsettling and causes great stress, and yet, they have to continue working and providing excellent care.

I look forward to hearing from you, and answering these questions and concerns.

Please, please, re, consider the valuable Service and care that the Urology Consultants and the Nursing Staff provide.

Urology Services Should be provided in one unit to provide continuity and specialist urology care and job satisfaction for staff.

Yours Sincerely,



Wright, Elaine

From: Donaghy, Colm [redacted]
Sent: 13 May 2009 10:19
To: [redacted]
Cc: Wright, Elaine
Subject: RE: Letter sent on 3rd April ref Urology Ward (2s)

[redacted] - Thank you for your letter. I have asked my PA to check our email and post system and I can assure you that this is the first time I have received your letter. I have forwarded your letter to our Director of Acute Services Mrs Joy Youart and you will receive a reply within the next 2 weeks.

Colm Donaghy

From: [redacted]
Sent: 13 May 2009 09:28
To: colm.donaghy [redacted]
Cc: anne.balmer [redacted]
Subject: Letter sent on 3rd April ref Urology Ward (2s)
Importance: High

Dear Sir/Madam

Please find attached a copy of the letter I sent to you on the

3rd April 2009. To date I have received no acknowledgement

of any description regarding this.

I respectfully request a response within the next 24 hrs.

Personal Information redacted by the USI

P Consider the environment. Please don't print this e-mail unless you really need to.

Received from Colm Donaghy on 13/06/22. Annotated by the Urology Services Inquiry.

Personal Information redacted by the USI
Personal Information
Personal Information
Personal Information

12th May 2009

Dear Sir

It has recently been brought to my attention that you and the Southern Health Board, plan to close 2s (Urology Ward) from the beginning of June – to me this has come as a major shock and concern.

Almost 20 years ago I developed cancer, with numerous complications, including having both my hips and shoulders replaced at 34 years of age, due to complications possibly attributed to the Chemotherapy treatment I received in CAH at that time. Along with this I also developed other major problems including serious Urological issues, which are still very prevalent and continue to affect my life on a daily basis.

Under the care of your exceptional Consultant Urologist, Mr A O'Brien and his team, they have spent a lot of time and effort in finding an appropriate form of treatment, that permits me to live as normal a life as possible, outside my bi-monthly admissions to 2s Urology for treatment. Perhaps you have never experienced this type of medical problem (if not, count yourself lucky), but let me assure you it is not easy to live with, both personally and for those around me. However over the past few years and my regular admissions to 2s Urology, this has allowed me to receive appropriate treatment, which without my life would be intolerable.
As with any condition and regular admission to hospital (particularly the same ward), the relationship you build with your Consultant, the team of nurses and doctors etc, is paramount in helping one feel comfortable, relaxed and ultimately benefit from this care. These individuals have got to know me, come to understand my specific needs and are also able to deal with such personal issues, with the utmost courtesy and dignity.

I wonder if this aspect of the work your committed staff undertakes is even considered or enters your decision making equation when making such radical decisions. I am aware (from working for the board for nearly 20 years, prior to being medically retired), finance for you and your colleagues is probably very high on your agenda – BUT what about me and the rest of the patients?

I was also appalled that, to my knowledge, I was never consulted (as a regular inpatient) as to how I would feel about this. Indeed I would be obliged to know who was consulted.

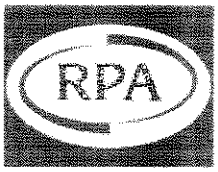
As it stands to date, I am in a very stressed and concerned state, as the possibility of me being able to continue to receive this vital in patient treatment I have over the years (in a conducive ward) cannot be guaranteed.

I respectfully request that you consider making the opportunity available to me to discuss this matter with you, in person, prior to the planned changes occurring.

Very concerned and anxious

Personal Information redacted by the USI

C.C. - Mr A O'Brien (Consultant Urologist)



Information Pack
TRUST CHIEF EXECUTIVE

Chief Executive (Designate) (5 POSTS) HSS TRUSTS

The Chief Executives (Designate) will be responsible for establishing and, by April 2007, for leading and managing the new Health and Social Services Trust to which they are appointed, in line with Departmental direction.

Job Description:

JOB SUMMARY

The Chief Executive is the most senior executive member of the Trust Board and leads the development of the vision for the strategic direction of the Trust in line with the overall policies and priorities of the HPSS. As the *Accountable Officer* for the Trust, the Chief Executive is accountable to the Trust Board, the HSSA and ultimately the Minister for the performance and governance of the Trust in the delivery of high quality care, responsive to the needs of the population in line with performance targets established by the HSSA.

The Chief Executive has overall responsibility for the management and performance of the Trust, including meeting Ministerial priorities as defined by the HSSA, statutory requirements, achieving performance targets, securing continuous improvement and for providing high quality and effective services within a clear financial framework.

The Chief Executive will lead reform within the Trust including the implementation of the HPSS RPA decisions, ensuring that appropriate, robust systems are in place and necessary changes are achieved.

KEY RESULT AREAS

DELIVERY

- Lead the development of the annual business plan for the provision of services in partnership with key stakeholders. In particular, work with the HSSA to ensure that the business plan fully reflects the priorities of the Authority and its expectations in terms of delivery.

- Deliver against Ministerial priorities as established in Departmental strategies and policies and translated into HSSA targets. In particular, the Chief Executive will be expected to deliver against all targets which are identified as critical and mandatory by the Department and HSSA.

- Ensure that the needs of patients, clients and their carers are at the core of the way that the Trust delivers services and that human, physical, capital and financial resources are effectively deployed to meet those needs, in line with HSSA targets, and achieve the best outcomes possible.

- Manage an effective process to ensure the continuing, objective and systematic evaluation of clinical and social care services offered by the Trust and ensure rapid and effective implementation of indicated improvements.

- Lead the Trust in making an effective contribution to education, teaching and research.

- Ensure that systems to provide high standards of care are based on good practice, research evidence, national standards and in accordance with guidelines, and to audit compliance to those standards and the statutory duty of care.

- Achieve high levels of performance and excellence against Controls Assurance standards

- Achieve and sustain high level of public confidence in the appropriateness. priority, safety and effectiveness of services provided by the Trust

- Ensure that effective systems are in place to take learning from complaints and other actions against the Trust and translate these into action for improvement

STRATEGIC LEADERSHIP

- Provide clear leadership for the Trust in the development of business plans, ensuring these reflect and contribute to meeting targets set by the HSSA.

- Development of a common understanding of the vision and strategic aims of the Trust.

- Provision of clear and positive leadership, motivation and development to all staff throughout the Trust to ensure their engagement with and commitment to achieving the business plan.

- Work with the Trust Board, staff and partners in the local health economy to ensure delivery against the agreed business plan.

CORPORATE MANAGEMENT

- With the Chair, be responsible for the organisational structure of the Trust, its probity and effectiveness.

- Manage the Trust through the senior management team, ensuring and maintaining effective operational management processes.

- Ensure that the work of the Trust is clearly and effectively communicated to employees throughout the organisation and that members of the Board are aware of issues and opinions of key staff groups.

- Continually evaluate and review all services in order to deliver user centred treatment and care. Change systems and practices as necessary to improve services and establish a culture of continuous improvement.

- Ensure that systems and process are in place to enable the Trust Board and the HSSA to evaluate the effectiveness of the Trust's use of human, capital and financial resources and that people perform to the best of their ability and addressed under-performance quickly and effectively.

GOVERNANCE

- Work with the Chair to ensure that the Board works effectively in fulfilling its role in ensuring the delivery of HSSA targets to deliver effective governance in accordance with public sector values and the relevant code of practice.

- Work with the Chair and Trust Board to deliver effective governance in accordance with public sector values and the codes of operation and Accountability.

- Work with the senior management team to ensure that reports on statutory functions are completed as necessary ensuring that any action needed internally in the Trust is taken promptly

- Ensure that robust arrangements are in place to meet the statutory clinical and integrated governance requirements

- Ensure that arrangements are in place to assure all quality standards

- Monitor and report on performance against HSSA delivery targets and ensure corrective action is taken when there is unacceptable deviation from the Trust's agreed business plan

EXTERNAL RELATIONSHIPS

- Establish collaborative relationships with external partners in the public, private and voluntary sectors to develop initiatives which will improve services and inter-agency communication.

- Develop linkages with other Trusts, the HSSA and as necessary the DHSSPS to promote best practice and innovation in the provision of services.

- Work with the Department, the HSSA and other Trusts in developing a strategy for dealing with the media which reflects Ministerial views and which secures the confidence of public representatives.

- Develop a strategy to maximise effective engagement of the local population with the Trust.

FINANCES

- Work through the senior management team to ensure that budgets are managed appropriately and give the best outcomes for resources available.

- Ensure that robust financial systems and controls are in place to achieve "break-even" on budgets and that immediate action is taken to control over-spends.

- Develop, through the Finance Director, management information on financial spend and inter-linkages such as overtime, absence and agency costs, which inform management and control of budgets.

STAFF RESOURCES

- Ensure that people management practices support continuous improvement in staff capability and quality of services provided including encouragement of and widening participation in learning opportunities.

- Lead the development of systems to promote the health and well-being of staff.

- Develop and maintain systems to support development and performance appraisal for all staff to ensure that poor performance is dealt with quickly and remedial action taken.

- Develop, through the HR Director, management information on staff utilization, development and return on investment, which improve management and a rigorous continuous improvement culture.

- Ensure that the Trust has a diverse and representative workforce, and that the right skills are in the right place to deliver its objectives.

DEVELOPMENT OF SELF

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

- Lead by example in practicing the highest standards of conduct in accordance with the Code of Conduct for HPSS managers

- Continuously strive to develop self and improve capability in the leadership of the Trust and its staff

Note: This job description is an indication of the responsibilities of the Chief Executive. It is not a definitive description and may change in light of changing circumstances.

TRANSITIONAL RESPONSIBILITIES

During the transitional period the Chief Executive (designate) will be responsible for ensuring that measures are in place, in line with Departmental direction, to enable the new Trust to be prepared for establishment in April 2007. Immediate responsibilities on appointment will focus on:

- Developing and implementing new organisational and managerial structures for the Trust, within the guidance and framework established by the Department.
- Identifying a location for the new Trust's headquarters, which meets criteria established by the Department.
- Developing a strategy to ensure effective implementation of RPA in line with the framework established by the Department.
- Recruiting and developing a senior management team and take forward the establishment of organisational structures below Director level.
- Establishing systems to ensure that HSSA and Departmental targets will be acted on as a priority once the Trust becomes operational.
- Identifying areas of work where transitional arrangements will be required to ensure effective implementation of RPA.
- Developing financial, governance and workforce strategies for the Trust.
- Establishing processes to ensure statutory requirements are reported and acted on appropriately.

GENERAL RESPONSIBILITIES

Employees of the Trusts 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 No Smoking Policies.
- 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.
- as the accountable officer comply with the code of business conduct.

RECORDS MANAGEMENT

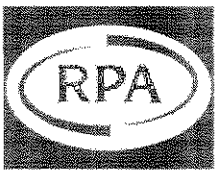
Chief Executives are responsible for all records held, created or used as part of their business including patient/client, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000, the Environment Information Regulations 2004 and the Data Protection Act 1998.

Information Pack
TRUST CHIEF EXECUTIVE

Terms and Conditions

Salary will be £95,189 - £126,917 per annum for the Belfast Trust and £83,290 - £111,052 per annum for the Northern, Western, Southern and South Eastern Trust. (Salary scales are currently under review)
In addition to the 10 public holidays the annual leave allowance will be 33days. He/she may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere. The successful candidates should therefore have access to a form of transport that will permit them to meet the requirements of the post in full and be prepared to travel as required.

An applicant wishing to speak to someone about the process for appointment to the above position should contact Vivienne Walker (Mrs) at the DHSSPS – RPA Unit – Beeches Management Centre (telephone Personal Information redacted by the USI) or by email to vwalker Personal Information redacted by the USI



Chief Executive (Designate) (5posts)

Personnel Specification:

Knowledge, skills and experience required:

Applicants must provide evidence by the closing date for application that they are working in the HPSS or an organisation affected by RPA and have:

- Successfully discharged, for a period of at least 5 years, within the last 8 years, senior management responsibilities in a major complex organisation.
- At least 3 years' experience within the last 6 years of managing major change programmes addressing significant organisational, managerial or service change.
- Delivered against challenging performance management programmes meeting a full range of key targets and making significant improvements.
- Worked with a diverse range of stakeholders, external to the organisation, to achieve successful outcomes.
- Had personal accountability for a significant budget for 3 years, within the last 6 years, in a major complex organisation, securing value for money by effective prioritisation and driving efficiencies.
- Successfully demonstrated high level governance and organisational skills (including strategic planning, risk management, financial and people management skills).

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.
The following additional desirable criteria may be introduced dependant upon the number of applications received.
-Experience of leadership in health or social care.

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. The competencies concerned are given in the HPSS Leadership Qualities Framework. Particular attention will be give to the following:

- Setting direction
- Effective and strategic influencing
- Leading change through people
- Delivering the Service
- Drive for improvement
- Drive for results

The following additional clarification is provided:

"senior management" is defined as experience gained at the top management levels of an organisation, i.e. Chief Executive or as a permanent member of the senior management team;

"major complex organisation" is defined as one with at least 200staff 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 concerned.

Southern Health and Social Care Trust

Quality Care - for you, with you

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

Corporate Risk Register

September 2009

"Risk Management is Everybody's Responsibility"

CONTENTS

SUMMARY

The Southern Health and Social Care Trust (the Trust) Corporate Risk register is drawn from the high level risks identified by the Risk Assessment processes within each directorate and at corporate level. High level (Red) risks have been endorsed by each Director and forwarded for consideration of the Senior Management Team for inclusion onto the corporate risk register.

All other levels of risk (moderate and low) are managed within operational directorates at the relevant level.

Each risk identified is underpinned with a full risk assessment and is set in the context of:

1. A link to a corporate objective or value
2. The potential for serious harm to the organisations strategic business
3. The control measures in place to mitigate against the risk and their strength (Strong, Moderate or Weak)

An action plan to manage the risk has been devised with a nominated lead, review date and monitoring frequency detailed

CONTEXT

Risk management is a process of continual improvement which requires the identification, assessment, analysis, evaluation, treatment, monitoring and communication of risk.

The Trust Board is responsible for ensuring that the organisation consistently follows the principles of good governance applicable to HPSS organisations. This includes the development of systems and processes for financial control, organisational control, clinical and social care governance and risk management.

Within the context of this strategy the Trust Board has a specific role in reviewing principal risks and significant gaps in control and assurance via the Assurance Framework, and ensuring that where gaps have been identified corrective actions are taken.

The Governance Committee will receive assurances from the Trust Senior Management Team (SMT) Governance Steering Group that risks are being effectively managed.

STRUCTURES AND RESPONSIBILITIES

1.1 Trust SMT Governance Steering Group

The terms of reference of the SMT Governance Steering Group are to:

- Ensure that the Trust has an effective corporate risk register.
- Review the corporate Risk Register and ensure and that all significant risks are escalated to the Board Assurance Framework.

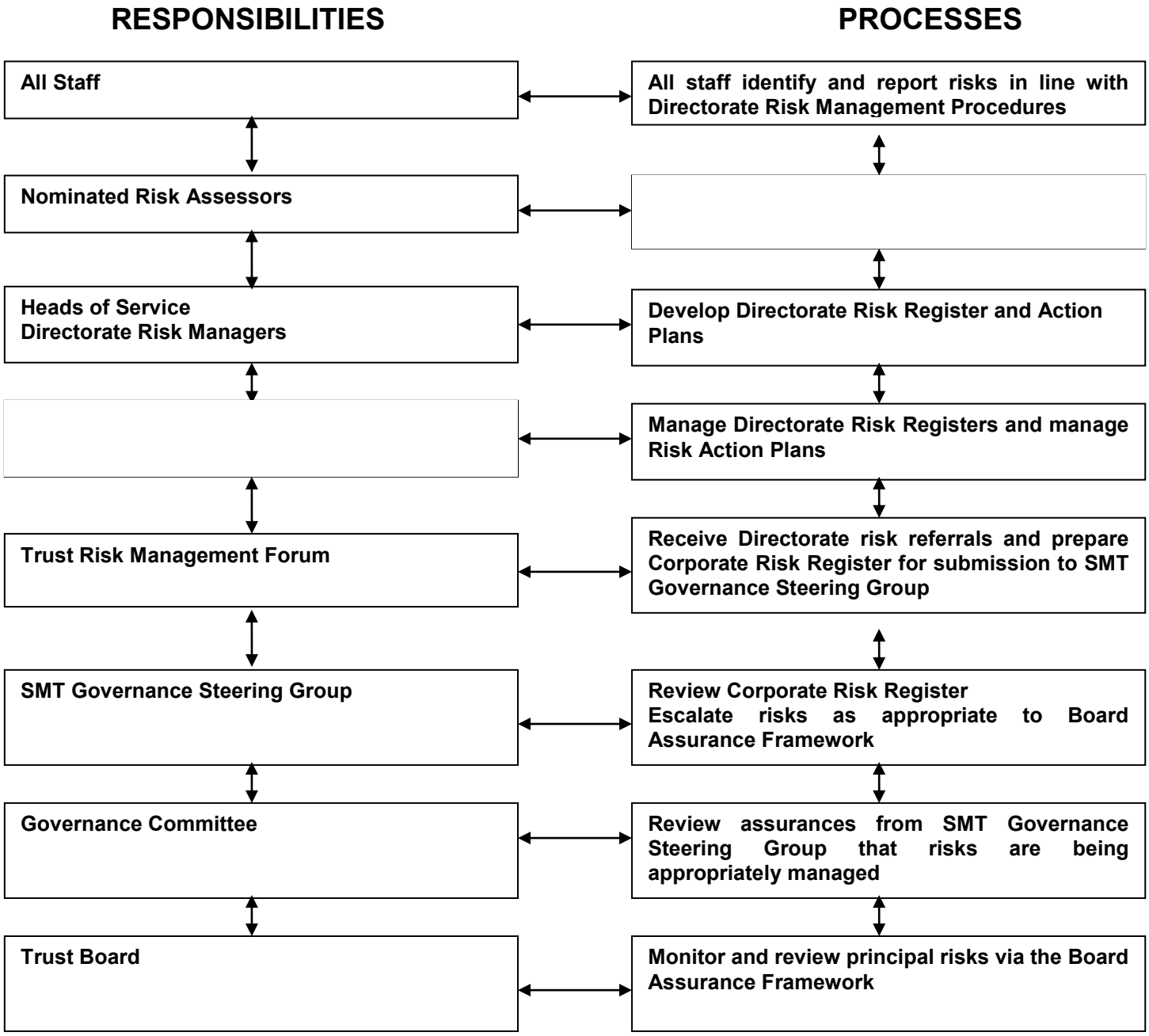
1.2 Trust Risk Management Forum

The terms of reference of the Risk Management Forum are to:

- Receive written risk referrals from Directorate Risk Management Committees.
- Review risk referrals with a view to appropriateness for inclusion in the Corporate Risk Register.
- Develop and manage the Corporate Risk Register.
- Submit the Corporate Risk Register to the SMT Governance Steering Group.
- Provide advice and support as appropriate to Directorate Risk Management Committees with regard to risk ratings and development of risk action plans.

1.3 Directorate Risk Management Committees

Directorate Risk Management Committees are responsible for reviewing and managing Directorate Risk Registers. Directorates will be supported in this function by the Risk Manager, Acute Services and the Patient Client Liaison, Safety and Risk Managers, Directorates of Children & Young People, Older People & Primary Care and Mental Health & Disability, as appropriate.



RISK IDENTIFICATION

Adverse incident reporting, legal claims, complaints and user views provide robust data but by definition are retrospective. Internal and external assessment are less quantifiable than adverse incident information but are critical in identifying key risks which have the potential to impact on the Trust.

Key Elements of Risk Identification

External Scrutiny and Inspection	Occurrences	Internal Assessments
Prospective	Retrospective	Prospective
• Internal Audit Reports • Accreditation Bodies Report • RQIA reports • Reports from Professional Bodies • Health and Safety Executive Reports/Visits • Environmental Health Reports • Mental Health Commission Reports • Independent Reviews • Coroner's Reports	• Adverse Incident Reporting • User Views • Complaints • Locally resolved expressions of dissatisfaction • Legal Claims • Patient and Client Satisfaction Measures • Employee Satisfaction Measures • Sickness and Absence Records • Staff Turnover • Levels of Agency Utilisation	• Controls Assurance – Self Assessments • Performance reporting • Specialist Committees e.g. Infection Control Health & Safety etc. • Risk Assessments (including H&S; business/project planning e.g., new activities, services; referrals) • Management of relationship risk – i.e., service partners/key suppliers taking into account the behaviour and risk priorities of those partners • Networking – use of media reports and

External Scrutiny and Inspection	Occurrences	Internal Assessments
	• Medical Device and Equipment Alerts • Introduction of new guidelines/ standards	information from other Trusts • Other self-assessment tools - Health and Social Care Quality Standards Audit Commission.

Directorates are required to develop appropriate systems and mechanisms to support the identification of risk.

A risk assessment form should be applied to this risk assessment process.

RISK ANALYSIS and EVALUATION

For each risk identified an assessment will be made of the **likelihood** of the risk occurring and the consequence or **impact** if this were to happen. The assessment will be made taking into account the effectiveness of controls that are already in place to mitigate the risk.

Once identified, risks will be analysed and actioned following the steps below:

i) Step 1 - Determining Risk Likelihood

In assessing **likelihood** it is important to consider the nature of the risk being assessed. On the one hand risk may be scored in relation to probability of future occurrence. However, in using likelihood scores reactively, for example, when reviewing adverse incidents a more appropriate perspective might be '*How likely is this to occur again? / How frequently has this occurred?*'

Table A should be used to assign a descriptor for this perceived risk. This should be determined by **either** frequency **or** probability.

TABLE A

Frequency/Probability of Risk

	DESCRIPTOR				
	Rare	**Unlikely**	**Possible**	**Likely**	**Very Likely / Almost Certain**
FREQUENCY (Reactive)	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
PROBABILITY (Proactive)	Could only occur in exceptional circumstances	Don't expect it to happen but it is possible	May occur occasionally	Will probably occur. Likely to occur imminently	Will occur or does occur regularly

ii) Step 2 – Determining the Risk Impact/Consequence

The risk impact/consequence, Table B (known as the 5x5 matrix) provides guidance on applying the impact criteria. In determining the risk impact/consequence the following question should be asked:

If harm occurred, what are the likely consequences to the Trust achieving its objectives?

All risks should be assessed **across each** of the 5 consequence / impact categories. The highest value attained against any one of the categories will be the impact / consequence grade e.g. an incident that affects a small number of persons (moderate) but results in a full public enquiry (catastrophic) will be scored with an impact/consequence rating of 'catastrophic'. If in doubt, grade **UP** not down.

TABLE B - Risk Impact/Consequence Table (5x5 Matrix) **CATEGORY**

CONSEQUENCE / IMPACT

	PEOPLE (Any person affected by an Incident:Patient/ Client, Staff, User, Visitor or Contractor)	**RESOURCES** (Premises, money, equipment, Business interruption, problems with service provision)	**ENVIRONMENT** (Air, Land, Water, Waste management)	**REPUTATION** (Adverse publicity, Complaints, Legal/Statutory Requirements, Litigation)	**QUALITY AND PROFESSIONAL STANDARDS** (including Government priorities, targets and organisational objectives)
CATASTROPHIC	Incident that leads to one or more deaths	Severe organisation wide damage / loss of services /unmet need	Toxic release affecting off-site area with detrimental effect requiring outside assistance	National adverse publicity. DHSSPS executive investigation following an incident or complaint. Criminal prosecution.	Gross failure to meet external standards, priorities.
MAJOR	Permanent physical / emotional injuries / trauma / harm.	Major damage, loss of property / service / unmet need.	Release affecting minimal off-site area requiring outside assistance (fire brigade, radiation, protection service etc)	Local adverse publicity. External investigation or Independent Review into an incident / complaint. Criminal prosecution / prohibition notice.	Repeated failure to meet external standards.

TABLE B - Risk Impact/Consequence Table (5x5 Matrix) **CATEGORY**

CONSEQUENCE / IMPACT

	PEOPLE (Any person affected by an Incident:Patient/ Client, Staff, User, Visitor or Contractor)	**RESOURCES** (Premises, money, equipment, Business interruption, problems with service provision)	**ENVIRONMENT** (Air, Land, Water, Waste management)	**REPUTATION** (Adverse publicity, Complaints, Legal/Statutory Requirements, Litigation)	**QUALITY AND PROFESSIONAL STANDARDS** (including Government priorities, targets and organisational objectives)
MODERATE	Semi permanent physical / emotional injuries / trauma / harm (recovery expected within 1 year). Includes RIDDOR reportable incidents.	Moderate damage, loss of property / service / unmet need.	On site release contained by organisation.	Damage to public relations. Internal investigation (high level), into an incident / complaint. Civil action.	Repeated failure to meet internal standards or follow protocols.
MINOR	Short-term injury / harm. Emotional distress. (Recovery expected within days / weeks.)	Minor damage, loss of property / service / unmet need.	On site release contained by organisation.	Minimal risk to organisation. Local level internal investigation into an incident / complaint. Legal challenge.	Single failure to meet internal standards or follow protocol.

TABLE B - Risk Impact/Consequence Table (5x5 Matrix) **CATEGORY**

CONSEQUENCE / IMPACT

	PEOPLE (Any person affected by an Incident:Patient/ Client, Staff, User, Visitor or Contractor)	**RESOURCES** (Premises, money, equipment, Business interruption, problems with service provision)	**ENVIRONMENT** (Air, Land, Water, Waste management)	**REPUTATION** (Adverse publicity, Complaints, Legal/Statutory Requirements, Litigation)	**QUALITY AND PROFESSIONAL STANDARDS** (including Government priorities, targets and organisational objectives)
INSIGNIFICANT	No injury / harm or no intervention required	No damage or loss, no impact on service. Insignificant unmet need.	Nuisance release.	Minimal risk to organisation, Informal complaint	Minor non compliance.

DETERMINING THE RISK RATING

Following the identification of the level of **likelihood** and **impact/consequence** of the identified risk, a risk rating will be calculated using the matrix. This rating will prioritise and inform the further management of the risk identified.

Risk Matrix

	CONSEQUENCE (POTENTIAL IMPACT)				
LIKELIHOOD	**Insignificant (1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5) (will undoubtedly recur, a persistent issue)					
Likely (4) (will probably recur, not a persistent issue)					
Possible (3) (may recur occasionally)					
Unlikely (2) (do not expect it to happen again)					
Rare (1) (can't believe it will ever happen again)					

VERY LOW (1 – 5)	LOW (6-11)	MODERATE (12-19)	HIGH (20 – 25)

An example of a risk rating using the risk matrix is:

Likelihood x Consequence (Potential Impact) = Risk Rating e.g. Possible x Moderate = Yellow (9)

RISK ACCEPTANCE FRAMEWORK

The Trust recognises that it is impossible, and not always desirable, to eliminate all risks especially in the delivery of care to patients/clients. A mark of good risk management is the innovative and imaginative use of resources in finding ways to avoid or reduce risks whenever possible.

Fine and balanced judgements will be necessary regarding the health and welfare of individuals especially within a person centred approach to patient/client care. It is sometimes the case that a higher level of risk may be accepted to facilitate a new and innovative service, which increases the quality of life for patients/clients.

The risk management process should identify the hazard and apply appropriate risk assessment and management action plans. Regardless of the level of risk assessed, all risk assessments must be recorded in the risk register, monitored and reviewed when necessary, determined by the risk rating, to ensure desirable outcomes.

RISK ACCEPTANCE FRAMEWORK CATEGORISATION

The Risk Acceptance Framework for the Southern Trust applies a 'traffic light' system with regard to the categorisation of risks against the scale of very low, low, moderate and high. The categorisation of risk against these scales determines if a risk is acceptable or not, and the level and urgency of intervention required. The Risk Acceptance categorisation process should be applied as a guide. Individual managers are encouraged to consider the acceptance of risk on an individual case by case basis. This judgement should be used to inform the level and urgency of action required. The 'traffic light' system applied to the Risk Acceptance Framework is as follows:

Green Risks (Very Low)

Identified risks which fall in the green area are deemed as very low (acceptable) risks and may require no immediate action, but must be monitored regularly to assess if and when action is required. These risks must be entered onto the local Risk Register.

Yellow Risks (Low)

Identified risks which fall in the yellow area are deemed low risk to the Trust but require action to reduce the risk. Responsibility for taking action would normally remain at a local level within the appropriate Directorates / Service Areas and be entered on the Team / Service Risk Register.

Where these risks cannot be managed locally they should be forwarded to the appropriate Directorate Risk Team for consideration for further local action, resourcing or acceptance by the Directorate Risk Team for the Directorate Risk Register.

These risks must be entered on the local risk register and where appropriate the Directorate Risk Register for information and monitoring purposes.

Amber Risks (Moderate)

Identified risks which fall in the amber area are deemed moderate risk to the Trust and require prompt action to reduce the risk to an acceptable level.

When risks cannot be reduced locally they should be submitted to the Directorate Risk Team for consideration for recommended action, i.e. further local action, resourcing or acceptance.

Where these risks cannot be managed within the Directorate they should be referred to the Trust Risk Management Forum for consideration and/or addition to the Corporate Risk Register.

These risks must be entered on the local risk register and where appropriate the Directorate Risk Register.

Red Risks (High)

Identified risks which fall in the red area are deemed high risk to the Trust and must be reported to the appropriate Director and Chief Executive. Immediate action is required to reduce the level of risks to an acceptable level. The appropriate Director will ensure the implementation of a time monitored action plan with regular reports to the Chief Executive and Governance Committee.

These risks will be entered onto the Directorate, and if appropriate the Corporate Risk Register(s) for monitoring by the SMT Governance Steering Group.

Where the identified risks represent significant gaps in controls/assurances they will be escalated by the SMT Governance Steering Group to the Board Assurance Framework.

Any definition of risk must be pragmatic and time dependent as the passage of time will reduce the tolerance of risk once deemed acceptable. In an attempt to help prioritise all risks the following definitions should be applied as a guide to the management of risks by the Southern Trust:

Southern Health &
Social Care Trust

Corporate Risk Register

September 2009

SOUTHERN HEALTH AND SOCIAL CARE TRUST CORPORATE RISK REGISTER SEPTEMBER 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 SEPTEMBER 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 SEPTEMBER 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 SEPTEMBER 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 SEPTEMBER 2009

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Generic Across all Directorates			
Protection of Children and Vulnerable Adults **Rating High**	Protection of children and vulnerable adults due to delays in POCVA checking procedures.	Provide Safe, High Quality and Effective Care.	• Adherence to procedures by Trust staff. • All staff screened pre employment, all existing employees' status also updated. • Regular reporting on POCVA waiting times to SMT • Access to services monitored by SMT and Trust Board via performance report on CYP statutory reports.

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Moderate	As above	Director of Children and Young People's Services	Ongoing	Ongoing

SOUTHERN HEALTH AND SOCIAL CARE TRUST CORPORATE RISK REGISTER SEPTEMBER 2009

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Corporate/Cross Programme			
Rating High	Risk of non compliance with European Working Time Directive (EWTD).	Making best use of resources and providing safe, high quality care.	Bimonthly EWTD steering group meetings chaired by the Chief Executive to monitor compliance.

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 SEPTEMBER 2009

Children and Young Peoples Directorate			
Rating High	Unallocated cases in all FSS SW teams	Provide Safe, High Quality and Effective Care	• Reporting to SMT, Trust Board and Commissioner/DHSSPS

Control Strength	**Action Plan**	**Nominated Lead for Actions**	**Review Date**	**Monitoring**
Strong	• Monitor unallocated cases • Monitor standard of existing Work • Liaise with HR to ensure the timely recruitment of new staff • Unallocated cases are managed consistent with the agreed southern Board protocol. • Head of Family Support meets with the Team Leaders on a weekly basis to review/risk manage. • Further discussion re non-recurring funds from DHSSPSNI • Further discussion re SHSSB capitation proposals • Part time staff are working full time/overtime • Residential staff and LAC staff are assisting with referrals • Further discussion re capacity analysis.	Director of Children and Young People	Ongoing	Ongoing

SOUTHERN HEALTH AND SOCIAL CARE TRUST CORPORATE RISK REGISTER SEPTEMBER 2009

Risk ID	Title / Description	Link to Corporate Objective / Value	Control Measures
Children and Young Peoples Directorate			
Woodside Adolescent Centre **Rating High**	Protection of staff and other clients against violent and aggressive clients.	Being a great place to work, valuing our people	• Reporting of incidents • Staff Training programme

Control Strength	Action Plan	Nominated Lead for Actions	Review Date	Monitoring
Strong	• Updated risk assessment on all young Peoples' files. • Staff trained in TCI & restorative practice. • Arrangements for staff supervision/support in place. • Occupational Health and Staff counselling in place • Use of sanctions and positive reinforcement with clients • risk management strategy meetings for clients in place .	Director of Children and Young People		Ongoing

SOUTHERN HEALTH AND SOCIAL CARE TRUST CORPORATE RISK REGISTER SEPTEMBER 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 SEPTEMBER 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 SEPTEMBER 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 SEPTEMBER 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

Performance Report April 2009

Priority for Action
Standards and Targets

And

Key Corporate Performance Indicators

26 May 09

CONTENTS

1.0 Introduction

This report forms part of the Trusts performance management framework and sets out a summary of Trust performance against:

- Priority for Action (PfA) 2009/10 Standards and Targets and
- Key Performance Indicators (KPIs) of corporate performance

In respect of the 2009/10 PfA targets the Service Delivery Unit (SDU) has commenced a process to agree data definitions, in liaison with Trusts, for all key PfA targets to ensure consistency in measurement and reporting. This process should be completed in early June and thereafter baselines will be established and monitoring arrangements put in place. Performance reporting in Quarter 1 will therefore focus on the 2008/09 targets which have rolled over into 2009/10 as standards or where the target has been uplifted.

During this time the Performance report will also be reviewed to develop and co-ordinate reporting reflecting a greater range of clinical and social care indicators including for example;

- reporting on risk adjusted mortality and
- stability of placements of Looked After Children

The PfA standards and targets and KPIs of corporate performance are presented in this performance report within the key domains defined within the performance management framework.

- Efficiency of Care Delivery
- Access & Targets
- Clinical and Social Care Quality
- Workforce – detailed reporting via HR & OD Directorate Report
- Finance – will be reported through the Monthly Finance Report

The level of performance will be assessed against each target/KPI as follows:

Assessed Level of Performance	
Target achieved/achievable or on track for achievement - No current risk	
Target partially achieved/achievable - Minimal Risk, management actions required to minimise risk	
Target not achieved/achievable - Risk, management actions required	
Performance not yet assessed	

Variation in performance from the previous month's position is indicated by the arrows: ⇔⇩⇧

Improvement towards the target indicated by:	⇧
Worsening performance from the target indicated by:	⇩
No significant change in performance indicated by:	⇔

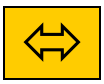
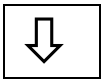
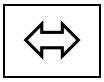
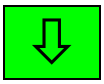
To date, the SDU has not indicated which PfA targets may be monitored less intensively and form part of the supplementary framework however a summary of those areas for which the Trust is identified as responsible and which lend themselves to supplementary monitoring is included in appendix I for information.

2.0 **Executive summary – Key Domains**

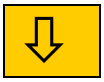
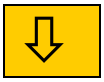
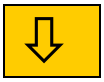
2.1 EFFICIENCY

Target/Indicator	Baseline	Target	Actual		Comments
PFA Diagnostic Reporting From April 2009 -all urgent tests reported within 2 days -75% of routine within 2 weeks -100% of routine within 4 weeks (Target rolled over from 2008/09)	**Sept 08** **26%** **77.9%** **89.3%**	**Apr 09** **100%** **75%** **100%**	**Apr 09** **80.9%** **70.8%** **81.8%**	⇩ ⇔ ⇔	Although significant progress has been made in respect of performance against this target since monitoring began in Sept 09 some risk is identified with the ability to achieve and sustain this target recurrently. Management actions will be targeted to support this area.
PFA 4.4 Timely Hospital Discharge From April 2009, -90% complex discharges within 48 hours -no. complex discharge will take longer than seven days -all other patients should be discharged within six hours Target rolled over from 2008/09	**Mar 08** **98.6%** **0** **96.3%**	**Mar 10** **90%** **0** **100%**	**April 09** **98%** **(95/97)** **NI Ave: 84.9%** **0** **98%** **(2517/2569)** **NI Ave: 97%**	⇩ ⇔ ⇧	The Trust continues to sustain the target for complex discharges and perform well against the regional average. In respect of 'simple' discharges the Trust is performing above the regional average. The ability to achieve a 100% is continues to be constrained often associated with patient/ relative choice.

PFA 4.1 Unplanned Admissions By March 2010 50% of unplanned hospital admissions related to exacerbation of severe chronic conditions are reduced New target	**Mar 09** **Baseline to be established**	**Mar 10** **50% reduction (-)**	**April 09** **Monitoring not in place**	⇔	This work stream is being taken forward regionally with representation from the Southern Trust. Data definitions to be agreed and baseline to be established for monitoring
PFA Priority Area 6 Mental Health Hospital Discharge By March 2009, - 75% of admissions discharged < 7days -all other patients discharges being discharged within max 90 days. (Number shown is in excess of 90 days) Target rolled over from 2008/09	**Sept 08** **96%** **0**	**Mar 09** **75%** **0**	**April 09** **99%** **(122/123)** **0**	⇧ ⇔	One current inpatient is waiting in excess of 90 days for discharge (162 days at end of April)
PSA 6.1 Mental Health Unplanned Admissions -By March 2010; reduce the number of admissions to mental health hospitals by 5% Target rolled over from 2008/09	**Mar 08** **1697** **Annual Admissions**	**Mar 10** **1612** **Ave Monthly admissions should not exceed 134**	**April 09** **118**	⇧	A new working target has been established from the March 08 position to bring the total reduction to 5%. This target is subject to finalisation of relevant data definitions which are currently out for consultation.

PFA Priority Area 7 Learning Disability Hospital Discharge By March 2010, - 75% of admissions discharged < 7days -all other patients discharged being discharged within max 90 days. (Number shown is in excess of 90 days) Target rolled over from 2008/09 - all patients discharged to receive continuing care plan to receive visit within 7 days	**Nov 07 – Mar 08** **cumulative** **66%** **0** **Baseline to be established**	**Mar 10** **75%** **0**	**April 09** **60%** **(3/5)** **0** **Monitoring not in place**	 	At the end of April there were 3 current inpatients who were waiting over 90 days for discharge. These patients waits range from 185 days – 322 days
KPI ALOS Episodic Average Length of Stay for Elective and Non Elective Admissions to Hospital	**Process Average 2008/09** **5.5 Non-elective** **1.16 Elective**	**To be agreed**	**April 09** **6.24 Non-elective** **1.19 Elective**	 	The average LoS for elective episodes in March is consistent with the process average, whilst non-elective is slightly above the process average but within then normal variation.
KPI OP DNA % patients who 'Did not attend' an OP appointment and did not advise the hospital in advance.	**Process Average 2008/09** **7.5%** **5.6%** **7.5%**	**Bench mark** **8.6%** **(English National Average)**	**April 09** **7.1% Total** **4.9% New patients** **8.1% Review patients**		The total DNA rate increased slightly in April, predominantly related to an increase in review patients who did not attend. The new patient DNA rate decreased

KPI Day Case Rate Daycase rate as a percentage of elective admissions	**Process Average SHSCT 2008/09** **45.6%**	**Bench mark** **70.6%** **(English National Average)**	**April 09** **44 %** **(2008/09 Average 45.7%)**	⇩	This indicator represents all daycases as a percentage of elective admissions. Annual analysis of the daycase rate for those procedures identified in the Audit Commissions 'Basket of 25' shows an improvement from 55.4% in 07/08 to 59.5% in 08/09. Action plan for 09/10 targets to be submitted to SDU by end of May.
KPI % Discharges Coded -cumulative coding position 08/09 -95% of discharges to have clinical coding applied within 31 days by Dec 08 and - 100% within 62 days	**March 08** **- 97%** - -	**Target** **100%** **95%** **100%**	**April - Mar 09** **83%** - -	⇧	Performance monitoring against 31 and 62 day targets have not yet been established. The Trust has received an external clinical coding review/audit and is considering actions associated with the findings to consolidate improvement work initiated.

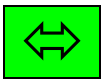
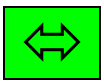
KPI Freedom of Information (FOI) % requests responded to within 20 days	**2007/08** **79%** **(Regional Position based on April – Dec published data 81%)**	**Target** **100%**	**Mar 09** **81.3%** **(16 requests – 13 responded to within 20 day limit)**		To allow for the 20 day time lag this position is being report a month in arrears.
KPI Partial Booking of OP Appointments **%** Consultant led New and Review Appointments partially booked **%** Community led New and Review Appointments partially booked	**March 08** **94.1% (New)** **72% (Review)** **54.8% (New)** **4% (Review)**	**Target Sept 08** **100%**	**April 09** **96% (New)** **88% (Review)** **86/3% (New)** **15% (Review)**		The Trusts new centralized booking centre opened in March 2009 initially centralizing Craigavon Area Hospital and Banbridge Polyclinic with phased implementation for other sites planned.
KPI – Complaints 72% of complaints responded to within 20 working days	**March 08** **65.6%**	**Target** **72%**	**Mar 09** **64%** **(30/47)**		To allow for the 20 day time lag this position is being report a month in arrears.

2.2 ACCESS & TARGETS

Target/Indicator	Baseline	Target	Actual		Comments
PFA 3.1: Waiting time Arthritis Drug Therapies - By March 2010, no patients should wait longer than 9 months to commence specialist drug therapies for treatment of severe arthritis, reducing to 21 weeks by March 11. Target increased from 2008/09	**Mar 08 for 21 week position** **Mar 08** 18	**Mar 11** **Mar 10** **0**	**April 09** **Mar 09** 28 (Actual waiters)	⇧	Monitoring arrangements require to be established to monitor the 9 month target requirement. Monitoring against the 21 week target (March 11) is available and provided for information.
PFA 3.2 IP/DC, OP & Diagnostic Access Targets By March 2010, no patient will wait longer than -9 weeks for a first OP appointment, -9 weeks for a diagnostic test, and -13 weeks for IP/DC treatment Standard rolled over from 2008/09 The 9/9/13 week 08/09 target must be sustained month on month in 209/10.	**Mar 08** **OP: 1624** **Diag: 188** **IP/DC: 1614**	**Mar 10** **OP: 0** **Diag: 0** **IP/DC: 0**	**30 Apr 09** **OP: 35 breaches** **Diag: 5 breaches** **IP/DC: 4 breaches**	⇩ ⇩ ⇩	In April there were 35 OP breaches;19 ENT and 17 orthopaedic ICATs. 5 urodynamic (diagnostic test) breaches reported at the end of March rolled over into May until these patients were treated. 4 IP/DC general surgery patients breached due predominantly due to cancellation issues. An analysis of all April breaches has been

					completed and recommendations made.
PFA AHP Access By March 2010 -no patients should waiter longer than 9 weeks from referral to commencement of AHP treatment. -the 13 week target achieved in March 09 should be sustained Target increased from 2008/09	**Mar 09** **322** **0**	**Mar 10** **0** **0**	**1 May 09** **485** **3 breaches**	⇔ ⇔	In April there were 3 breaches of the13 week target in learning disability occupational therapy. These breaches were associated with capacity issues. This service provision is currently being reviewed
PFA Fractures -By March 2010, 95% of patients will wait no longer than 48 hours for inpatient fracture treatment. Target rolled over from 2008/09	**Mar 09** **75.6%**	**Mar 09** **95%**	**April 09** **91.3%** **NI Ave 79%**	⇧	Trust performance improved in April with 42 out of 46 patients treated within the target time.

PFA Cancer By March 2009, - 98% of cancer patients will commence treatment within 31 days and -95% of patients urgently referred with suspected cancer will begin treatment within 62 days -all urgent GP referrals for breast cancer are seen in 14 days and Target rolled over from 2008/09	**Mar 08** **99%** **96%** **100%**	**Mar 09** **98%** **95%** **100%**	**Mar 09** **Position @ 4 May 09** **100% (81/81)** **96.7% (29/30)** **100%**	⇧ ⇧ ⇔	Due to the 31 and 62 day time lag these targets are reported retrospectively. The final position for March in respect of the 62 day pathway will not be formalised until June.
PFA A&E Access From April 2009, 95% of patients treated & discharged or admitted within 4 hrs Standard rolled over from 2008/09	**Mar 08** **SHSCT 95.2%** **CAH 92.9%** **DHH 97.1%**	**Mar 09** **SHSCT 95%** **CAH 95%** **DHH 95%**	**Apr 09** **SHSCT 92.5%** **CAH 90.8%** **DHH 90.9%**	⇩ ⇩ ⇩	April performance falling below 95% on the DHH site for the first time since Jan 2008 due to staffing issues. In April there was 1 breach of the 12 hour position which has been reported to SDU and management actions reviewed.

PFA 4.2 Care of Older People From April 2009, -no older person with continuing care needs will wait more than eight weeks for a completed assessment, -with the main components of care met within a further 12 weeks Standard rolled over from 2008/09	**Mar 08** **99.2%** **100%**	**Mar 09** **100%** **100%**	**April 09** **100%** **100%**	 	The Trust continues to sustain this target.

PSA 5.3 Care leavers By March 2010, ensure that at least 70% of care leavers aged 19 are in education, training or employment Revised target	**Mar 09** **36** **Care leavers** **33 (92%)** **In education, training or employment**	**Mar 10** **-** **47**	**April 09** **36** **Care leavers** **26 (72%)** **In education, training or employment**	⇩	
PSA 5.4: Care leavers By March 2010 increase to 175 the number of care leavers aged 18-20 living with their former foster carers or supported family Revised target	**Mar 09** **27** **(End of Month position)**	**Mar 10** **33**	**April 09** **26**	⇩	The number of care leavers living with former foster carers dropped by 1 in April from the March position.

PSA 6.3 M Health Assessment and Treatment By March 2010 -ensure no patient waits longer than 9 weeks from referral to assessment and commencement of treatment for mental health, excluding psychological therapies, Target increased from 2008/09 -pyschological therapies to sustain 13 week maximum wait Target rolled over from 2008/09	**Mar 08** **Baseline to be established** **94**	**Mar 10** **0** **0**	**April 09** **Monitoring arrangements to be put in place** **0**	⇔	Baseline to be established and monitoring arrangements put in place. This target position is being sustained.

New targets for which monitoring arrangements have yet been established

PSA 7.3 Specialised Wheelchairs
By March 2010
- ensure an 18 week maximum waiting time for 90% of all wheelchairs
New target

PFA –Housing Adaptations
By March 2010
-all lifts/ceiling track hoists to be installed within 22 week of OT assessment/ option appraisal
- all minor urgent works to be completed within 10 days
New target

PFA – Autism
By March 2010
-ensure that all children wait no longer than 13 weeks for assessment, and
- a further 13 weeks for commencement of specialist treatment
New target

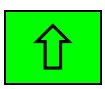
PFA – Acquired Brain Injury
By March 2010,
-ensure a 13 week maximum waiting time from referral to assessment and commencement of specialised treatment
New target

2.3 CLINICAL AND SOCIAL CARE QUALITY

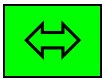
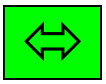
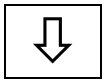
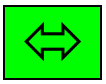
Target/Indicator	Base-line	Target	Actual		Comments
PFA - HCAI In the year to, by March 2010, ensure a -35% reduction in the number of hospital patients with staphylococcus aureus (MSSA) bloodstream infections (including MRSA), and a -35% reduction in cases of clostridium difficile infections compared to 2007/08 Target increased	**2007/08** **MRSA ?14** Episodes **MSSA ?38** Episodes **C Diff 134** Episodes	**Mar 10** **MRSA 9** Episodes (Ave <1 per month) **MSSA 25** Episodes (Ave 2 per month) **C Diff 87** Episodes Ave 7 per month	**April 09** **MRSA/ 1** Episode **MSSA 3** Episode **C Diff 4**	⇧ ⇧	The baselines for MRSA and MSSA are currently being defined and may be subject to final change. In 09/10 these organisms will be monitored separately. The C Diff baseline and target have been defined and monitoring is in place. Additional reporting on Healthcare Associated Infection is included and will be developed.
PSA 3.6 Renal By March 2010, -at least 60% of patients should receive dialysis via a fistula Target increased	**Mar 09** **36.8%**	**Mar 10** **60%**	**Apr 09** **38.5%** **(37/101)**	⇧	This target continues to be challenging as in-house staff are trained to undertake this work.

PFA 4.1 Community Care By March 2010 -45% of people in care management have their assessed care needs met in a domiciliary setting. Target increased	**Mar 08** **43.7%**	**Mar 10** **45%**	**April 09** **44.9%** **(1682 people)**	⇧	This target has been increased from 44 to 45%. Pre-existing data definitions for this target and monitoring are being reviewed and will be finalised in the next few weeks.
PFA 4 – Direct Payments By March 2010, -number of direct payment cases increases to 1,250 Target increased	**Mar 09** **361**	**Mar 10** **240 (SHSCT target)**	**Apr 09** **379**	⇧	The number of direct payments continues to increase month on month.
PFA Family Group Conferences During 2009/10 -ensure that at least 500 children and young people whose assessed need is on levels 1,2 or 3 of the Hardiker model have participated in a FGC. Target rolled over from 2008/09	**2008/09** **58**	**Mar 10** **96** **(Ave 8 per month)**	**April 09** **7**	⇧	New emphasis has been placed on FGC in 2009/10 and management actions put in place. See additional information
PSA 5.1 - Children in Care By March 10 90% of children admitted to residential care prior to admission should -have had formal assessment	**Baseline to be established**	**Target**	**Monitoring arrangements to be established**		The Children in Care target has been revised, moving from the number of children in care to encompass a bundle of best practice for children prior to

-have had placement matched through Children's Resources Panel -Every child taken into care should have a plan for permanence and timescale agreed within six months New target					admission to care. Definitional issues and monitoring arrangements require to be put in place for this target The number of children in care has increased and at end of April 364 children in SHSCT were in care.
PSA 5.2 Family support interventions <u>By March 2010</u> -provide family support interventions to 2000 children in vulnerable families each year New Target	**Oct 08 – March 09** **153** **306** **Extrapolated for full year**	**Mar 10** **384** **(Ave 32 per month)**	**Apr 09** **19**		Baseline and monitoring arrangements subject to ongoing data definitional agreement and may be subject to change.
PFA 5.3 - Foster Carers <u>By March 2010</u>, - increase foster carers by 300 (NI target) from the March 2006 total	**Mar 06** **217**	**Mar 10** **275**	**Apr 09** **291**		Performance against this target continues to improve and currently exceeds the target position

PFA – Assessment of Children at Risk From April 2009 -all Child protection referrals should be allocated within 24 hours of receipt By March 2010, -90% of family support referrals should be allocated to a social worker within 20 days for initial assessment -post assessment 90% of cases requiring family support pathway assessment allocated within further 20 days with :initial assessment completed within 10 days & :pathway assessment completed within 20 days New target	**Baseline to be established**	**Target**	**Monitoring arrangements to be established**		This new PFA target will monitor the timelines of referral allocation and post assessment allocations. Monitoring arrangements will be put in place The Trust continues to monitor unallocated cases and the number of unallocated cases continues to decrease. See additional information.
PSA 6.2 M Health Resettlement By March 2010, - resettle 60 patients from hospital to appropriate community places	**2006/07** **0** **2007/08** **6** **2008/09**	**Mar 10** **13**	**Apr 09** **15** **(14 completed and 1 commenced)**		The Trust has achieved this target however the target and current definitions are being reviewed and this may be subject to future

from March 2006 position. Target Rolled over from 2008/09	**14** **Cumulative position**				change.
PSA 7.1 Learning Disability Resettlement By March 2010 - resettle 90 learning disability patients from hospital to appropriate places in community for March 2006 position. Target rolled over from 2008/09	**Mar 07** **0**	**Mar 10** **18**	**Apr 09** **17** **(11 resettled & 7 commenced)** **(17 SHSCT, 1 NHSCT excluded)**	⇧	
Surgical Site infections(SSI Bundle compliance rate -orthopaedics (all elective hips & knees -Caesarean Section (audit of 20 cases per month Monitoring rolled over from 2008/09	**Oct 08** **15%** **CAH 5%** **DHH 5.26%**	**Mar 09** **95%** **95%** **95%**	**Apr 09** **100%** **79.4%** **70%**	⇔ ⇧ ⇧	The trust set internal targets for Surgical Site infection compliance with bundle of care rates in May 2008 as part of the quality improvement programme. Performance is monitored via casenote audit.

Central Line Infections -Rate per 1000 line days -Compliance with bundle Monitoring rolled over from 2008/09	**Oct 08** **CAH** **0** **DHH** **0** **CAH** **30%** **DHH** **0%**	 **3%** **3%** **95%** **95%**	**Apr 09** **0** **0** **40%** **(10 patients)** **0%** **(2 patient only)**	   	This quality improvement target measures the number of central line catheter-related bloodstream infections Measurement reflects all Central Lines at CAH & DHH and compliance with the care bundle elements.
Ventilator Acquired Pneumonia (VAP) - Ventilator days between infections - Compliance with bundle Monitoring rolled over from 2008/09	**Oct 08** **517** **100%**	**Mar 09** **-** **95%**	**Apr 09** **196** **100%**	 	This QIP aims to achieve 95% compliance with all bundle elements in ICU in CAH by March 2009. The Trust also measures days free of infections. The Trust had 1188 days free of VAP from May 2008 until the last suspected case in March 2009

Crash Call Rate -Rate per 1000 calls Monitoring rolled over from 2008/09	**Oct 08** **CAH** **3.7** **DHH** **0.9**	**Mar 09** **-**	**April 09** **CAH** **2.97** **DHH** **1.84**	⇩ ⇩	This quality improvement target is focused on crash calls in A&E, ICU and coronary care.
Mental Health Indicators -%compliance with multi-disciplinary review -%compliance with risk assessment -%compliance with patient/carer involvement in TP (Audited via 30 case records per month) Monitoring rolled over from 2008/09	**Oct 08** **CAH** **79%** **SLH** **67%** **CAH** **63%** **SLH** **17%** **CAH** **88%** **SLH** **100%**	**Mar 09** **100%** **100%** **100%**	**April 09** **CAH** **100%** **SLH** **100%** **CAH** **71%** **SLH** **67%** **CAH** **100%** **SLH** **100%**	⇧ ⇔ ⇔	These QIP focus on inpatient review, assessment and compliance with patient/carer involvement in treatment planning All are sampled by random audit of 30 active casenotes each month

KPI - Crude Mortality Rate Deaths as a percentage of total hospital deaths and discharges	**Peer Average** **2007/08 1.98%** **2008/09 1.88%**	**Target**	**SHSCT** **2007/08 1.22%** **2008/09 1.18%**	⇧	The mortality rate provided shows the Trust average against a peer group of District General Hospitals. This has been extract from the 'CHKS' comparative benchmarking tool. See additional information
KPI – Re-admission rate Discharges from the Trust that are re-admitted to the Trust again within 28 days as a percentage of total discharges	**Peer Average 2007/08 6.5%** **2008/09 6.1%**	**Target**	**SHSCT** **2007/08 5.6%** **2008/09 5.2%**	⇧ ⇧	The re-admission rate provided shows the Trust average against a peer group of District General Hospitals. This has been extracted from the'CHKS 'benchmarking tool. See additional information
KPI Environmental Cleanliness Cleanliness Maters Strategy indicates that 85% or above is an acceptable level of cleanliness.	**KPMG baseline** **DHH 90%** **STH 88%** **CAH 84%**	**Target** **85%**	**April 09** **DHH 93%** **STH 89%** **CAH 92%**	⇔	Trust Average 93%, ranging from 89% in STH to 96% in Lurgan
KPI – Looked After children Number who received no visit	**Mar 08** **6**	**Target** **0**	**April 09** **0**	⇧	All LAC received a statutory visit in month.

KPI – Health & Care Number % of potential H+C matches that are achieved each month for acute system transactions	**Dec 08 Baseline** **96%**	**Internal Target** **100%**	**Mar 09** **94%**	⇔	Regional comparators are not yet available.

New targets for which monitoring arrangements have yet been established

PFA Respite – dementia

By March 2010

-provide an additional 1200 dementia respite places compared to March 2008 total

New target monitoring

PSA 7.2 – Respite Physical and sensory disability

By March 2010

- improve access to Physical/sensory disability by providing an additional 100 respite packages per year compared to March 2008 position

New target monitoring

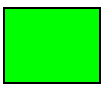
PSA 7.4 – Respite Learning Disability

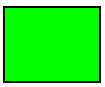
By March 2010

-improve access to learning disability by providing an additional 100 respite packages a year compared to March 2008 position

New target monitoring

2.4 WORKFORCE – No update until year end target finalised.

Target/Indicator	Baseline	Target	Actual		Comments
PFA 9.1 Each Trust should ensure that, during 2008-09, **levels of absenteeism** are reduced to 10% below average 2007-08 levels, working towards a regional target of 5.2% in 2010-11	**Mar 08** **5.58%**	**Mar 09** **5.02%**	**Mar 09** **4.94%**		The 2008/9 target figure of 5.02% is based on the 10% reduction requirement however this is below the target of 5.2% to be achieved by 2010/11. 4.94% is the Trust's cumulative sick leave rate for 2008/9.
PFA 9.1 Each Trust should ensure that, by March 2009, they meet their individual target set by the Department to achieve an overall **reduction in the number of admin and clerical staff,** as a proportion of all Trust staff, to 19.5%	**Mar 08** **19.12%**	**Mar 09** **19.5%**	**Mar 09** **19.39%**		This excludes As & When staff.
PFA 9.1 Each Trust should ensure that, by March 2009, they achieve a **reduction of one point in the ratio of qualified to unqualified nurses**	**Mar 08** **75.5:24.5**	**Mar 09** **74.5:25.5**	**Mar 09** **76.5:23.5**		The achievement of a reduction in the ratio of qualified to unqualified nurses is dependent upon Departmental funding, specific initiatives for skill mix being identified and capacity created for the effective implementation of these initiatives.
PSA 9.1 Each Trust should ensure that, by March 2009, they achieve a **reduction of one point in the ratio of qualified to unqualified AHPs**	**Mar 08** **86:14**	**Mar 09** **85:15**	**Mar 09** **85:15**		The Trust's ratio of qualified to unqualified AHPs as at the end of March 2009 meets this years PFA Target. The ratio of qualified to

					unqualified staff will however continue to be monitored on a quarterly basis.
PSA 9.1 Each Trust should ensure that, during 2008-09, **staff turnover (excluding admin and clerical staff)** is reduced by 5% compared to the position in 2007-08.	**Mar 08** **12.5%**	**Mar 09** **11.9%**	**Mar 09** **9.7%**		The PFA target to reduce staff turnover by 5% is a contradiction to the requirement for the Trust to reduce staffing levels to achieve CSR savings targets. Some staff reductions need to be achieved through turnover.

3.0 Analysis, Additional information and Exception reporting by Domain

Efficiency

-

Access & Targets

-

Clinical and Social Care Quality

- Healthcare Associated Infection
- Quality Improvement Targets (Patient Care Indicators)
- Family Group Conferences
- Unallocated Child Care Cases
- Re-admission Rates with Peer comparison
- Mortality Rates with Peer comparison

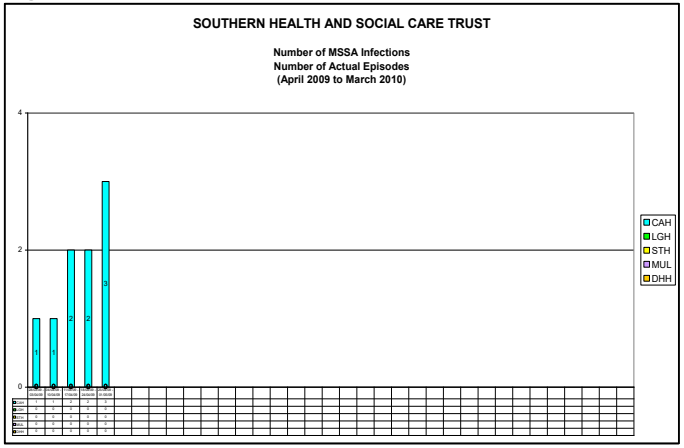
Clinical and Social Care Quality

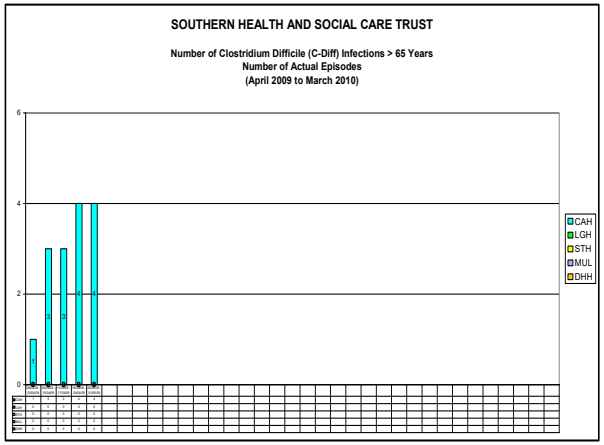
Healthcare Associated Infection

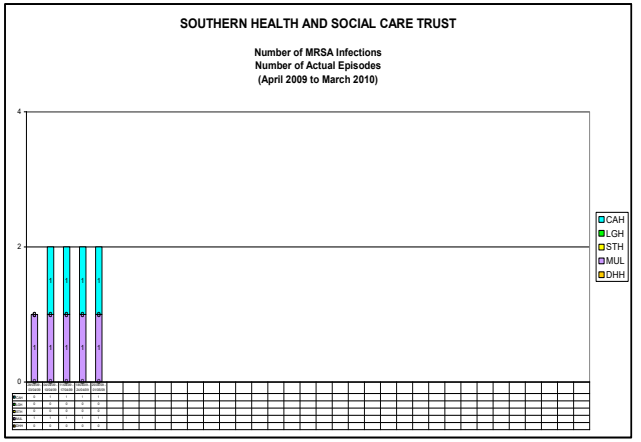
It is anticipated that performance information on a range of health care associated infection will be routinely provided to inform the Board monthly on performance against the PfA targets for C difficile and MRSA and MSSA bacteraemias in the Trust but also to include a range of information on infection prevention and control measures including

- Trust Data on C Diff, MRSA, MSSA episodes, including comparable data as available
- Hand hygiene Compliance audits
- Environmental Cleanliness Audits
- Antibiotic Compliance Audits and
- HCAI related death information

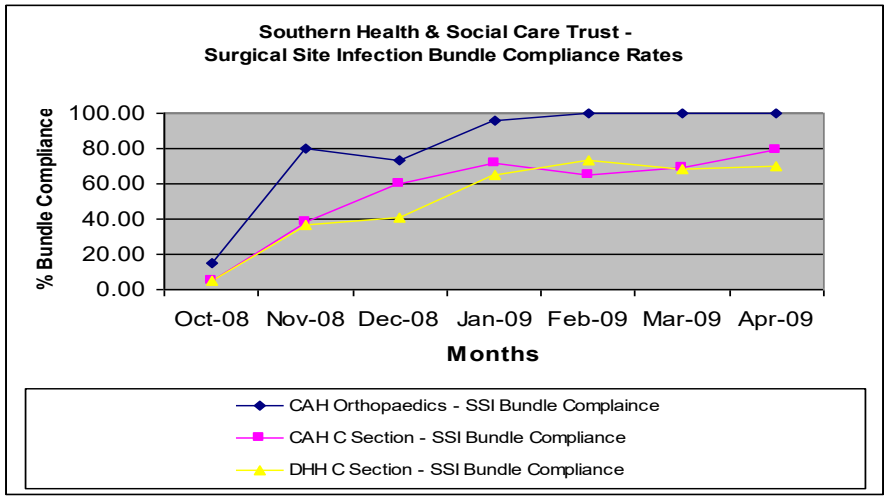
Current cumulative weekly information on MRSA, C Diff and MSSA; target profile will be added when baselines agreed with SDU.

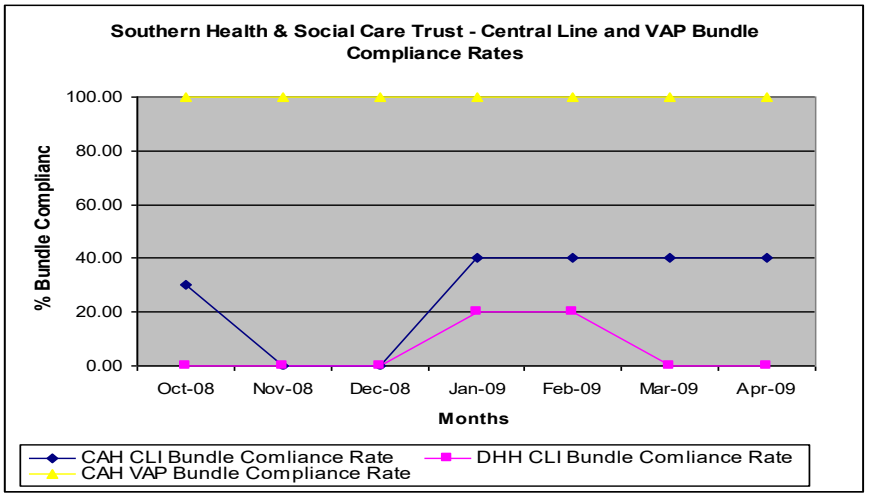


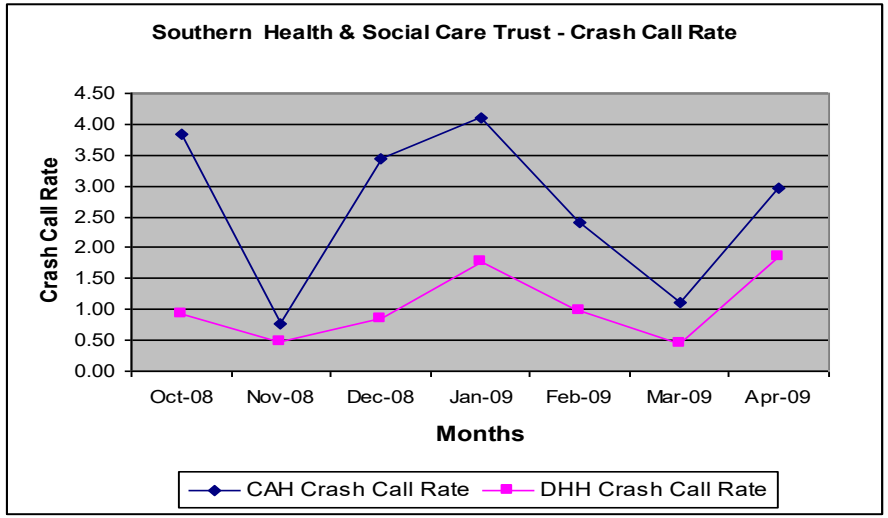


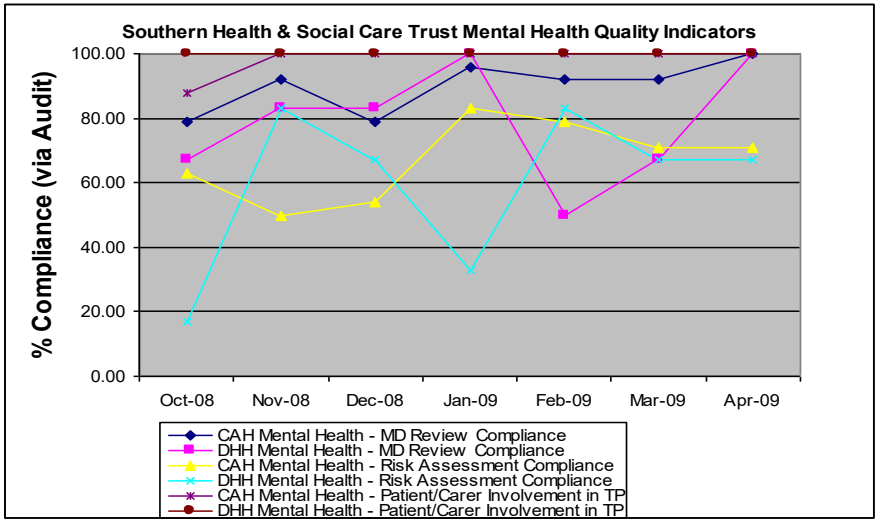


Quality Improvement Targets (Patient Safety Indicators)







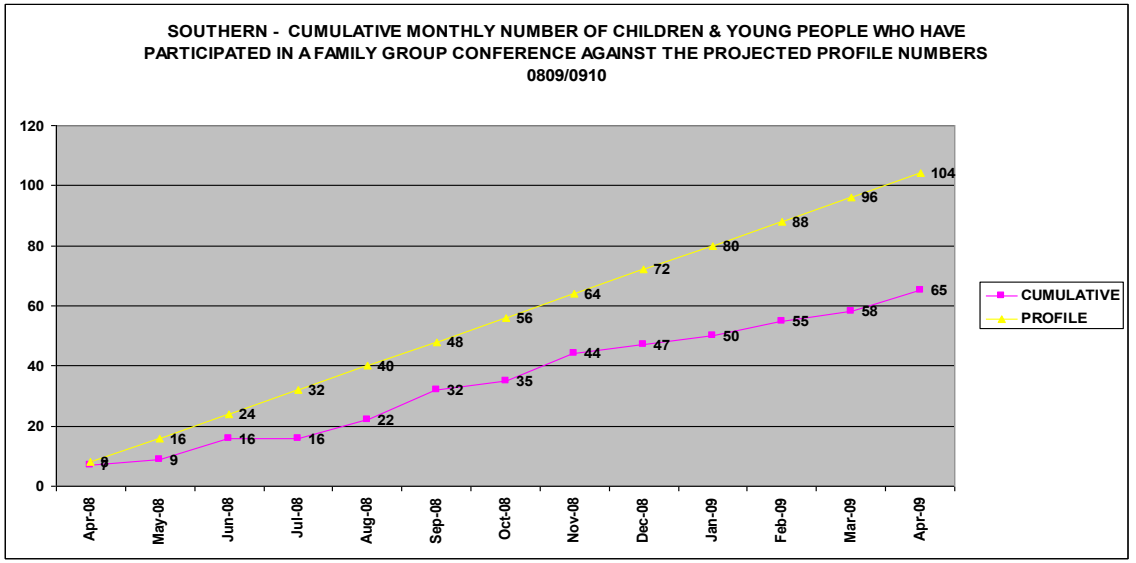


Children & Young People

Family Group Conferences

A number of management actions have been taken to improve the performance in 2009/10 of FGCs.

- A FGC Co-Ordinator is available to support and promote this service with SWs and TLs.
- There will be short seminars in each locality in April/May, highlighting the positives for children and families of FGC.
- An audit of the UNOCINI proforma references FGC will be undertaken and outcomes will be explored with a Focus Group of staff to explore issues more fully.
- FGC will be considered more proactively and certainly in the following circumstances:-
  - Where UNOCINI is completed.
  - At Transition Points eg child moving to secondary school / young person moving to 16+ Service.
  - For LAC placed with parents to promote discharge of Care Order.
  - Extended Foster care – young person 18 years +.
  - Relatives / Friends placement.
  - Potential Placement breakdown.
  - When legal proceedings are considered.
  - Promoting family support in contact arrangements.

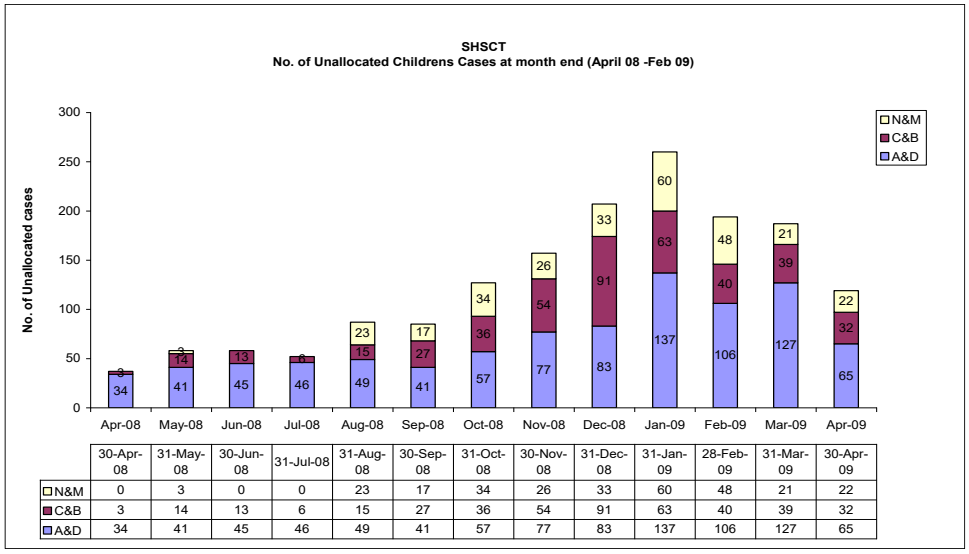


Unallocated Child Care Cases

The overall position has seen a significant reduction in the number of unallocated cases with the reported April position at 119 from the March position of 187. In month monitoring however shows an increase over the first three weeks in may due to staff absence, a high level of incoming referrals and limited capacity within the family support team due to child protection and LAC cases.

Trust Action taken to mitigate risks and strengthen our system include

- Out of Hours initiative continues through social work staff in the Family Support Teams.
- Interviews for Senior Practitioner, Team manager and Social work staff for new Gateway Team in May
- Recruiting social work staff for Family Support Teams (permanent, temporary, part time). Have received 85 applicants. Interviews to take place in June 2009.

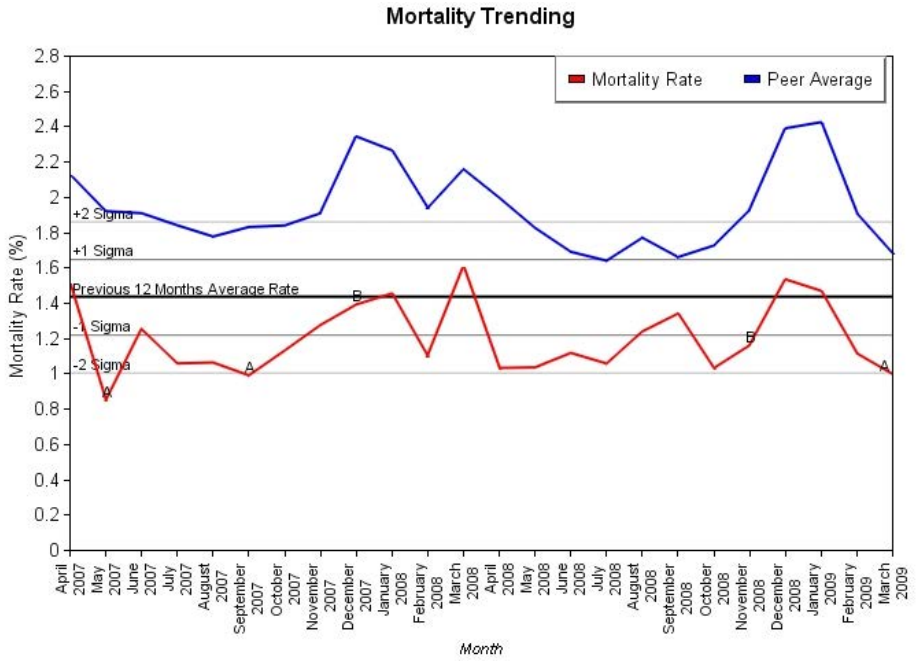


	30-Apr-08	31-May-08	30-Jun-08	31-Jul-08	31-Aug-08	30-Sep-08	31-Oct-08	30-Nov-08	31-Dec-08	31-Jan-09	28-Feb-09	31-Mar-09	30-Apr-09
N&M	0	3	0	0	23	17	34	26	33	60	48	21	22
C&B	3	14	13	6	15	27	36	54	91	63	40	39	32
A&D	34	41	45	46	49	41	57	77	83	137	106	127	65

Clinical and Quality Indicators

The mortality and re-admission trending positions above have been extracted from CHKS benchmarking tool. This shows high level performance against crude mortality (which is not risk adjusted) and re-admissions within 28 days. These rates will be analysed further in order to identify any significant variation at Directorate level.

Red Line - represent the SHSCT performance over the last two years (April 07 – March 09).
Solid Black Line - represents the Trusts own average performance in the previous 12 months and the standard variations on the positive and negative sides of this average (Sigma +/-1 and +/- 2)
Blue line – represents the peer performance over the last two years (April 07 – March 09)



Appendix 1 - Summary of 'Supplementary' PfA targets

Priority Area 1 – Improving Health and Well-Being	
Births to teenage mothers	By March 2010, Commissioners and Trusts should achieve a 40% reduction in births to mothers under 17
Bowel cancer screening	By December 2009, Commissioners and Trusts should establish a comprehensive bowel screening programme for those aged 60 – 69
Priority Area 2 – Ensuring Safer, Better Quality Services	
Trust Quality Initiatives	By June 2009, Trusts should submit to the Department for approval and monitoring quality improvement plans to prevent venous thrombo-embolism (VTE) through risk assessment and adherence to local policies of CTE prophylaxis
Patient Experience	By September 2009, Trusts should adopt Patient and Client Experience Standards in relation to Respect, Attitude, Behaviour, Communication and Privacy and Dignity, and have put in place arrangements to monitor and report performance against these standards on a quarterly basis
Service Frameworks	By March 2010 ensure implementation of agreed standards from (i)cardiovascular service framework and (ii)respiratory service framework
Priority Area 3 – Improving Acute Services	
Stroke Services	By March 2011 ensure that 50% of patients attending hospital within one hour of onset of stroke symptoms receive a CT scan and report within a maximum of two hours to information appropriate use of thrombolysis
Priority Area 4 – Ensuring fully integrated care and support in the community	
Unplanned admissions	Early intervention approaches should be further developed to support identified patients with severe chronic diseases so that exacerbations of their disease which would otherwise lead to unplanned hospital admissions are reduced by 50% by March 2010
Palliative Care	By March 2011, Trusts should establish multi-disciplinary palliative care teams and supporting service improvement programmes to provide appropriate palliative care in the community to adult patients requiring such services

Priority 5 – Improving Children's Services	
Children on Child Protection Registrar	By June 2008, Commissioners and Trusts should agree regional policies, procedures and thresholds for the management of cases onto and off the CPR
Priority 6 – Improving Mental Health Services	
Assessment and treatment	From April 2009, implement a stepped care model.
Domestic Violence	A Local Domestic Violence Partnership should be established in each Trust area which should by September 2009, have produced and begun the implementation of a local DV action plan. By March 2010 each Trust should ensure that appropriate social services staff have participated in at least 95% of the Multi-Agency Risk Assessment Conference held in their areas during the year.
Priority Area 8 – Ensuring Effective financial Control and Improved Efficiency	
Finance	The Department and all HSC organisations should live within the resources allocated and achieve financial balance
Timely Implementation of Service Developments	Commissioners and Trusts should ensure that not less than 90% of the monies allocated for service developments in 2009-10 are expended during the course of the year in accordance with agreed plans
Efficiency Targets	Commissioners and Trust should during 2009-10 achieve the efficiency targets specifically by the Department. Commissioners and Trusts should ensure that all initiatives within the Regional Pharmaceutical Clinical Effectiveness Programme are implemented to meet the targets set by the Department.

Southern Health and Social Care Trust

BOARD OF DIRECTORS MEETING

DATE: Thursday, 30th April 2009
TIME: 10.00 a.m.
VENUE: Boardroom, Daisy Hill Hospital, Newry

AGENDA

	ITEM	DIRECTOR	BOARD ACTION REQUIRED
1.	Chairman's welcome and apologies	Mrs A. Balmer	
2.	'Care in the System' DVD	Mr B. Dornan	
3.	Minutes of Board meeting held on 26th March 2009	Mrs A. Balmer	approval
4.	Matters arising from previous meeting		
5.	Strategic issues • Acute Services Reform and Development at Craigavon and Daisy Hill Hospitals - Presentation Speaking Rights: Councillor John McArdle, Newry and Mourne District Council	Mr C. Donaghy/ Mrs J. Youart	

	ITEM	DIRECTOR	BOARD ACTION REQUIRED
6.	Patient/Client Safety and Quality of Care		
	i) Progress Report on the Regional Crisis Response Helpline – 'Lifeline'	Mr F. Rice	information
	ii) Infection Prevention and Control • Report for the period 1 April 2008 – 31 March 2009	Dr P. Loughran/ Mrs J. Holmes	information
	iii) RQIA Unannounced Inspection at Craigavon Hospital - Action Plan (verbal update)	Mrs J. Youart	information
	iv) The Productive Ward	Mrs J. Youart	information
7.	Operational Performance		
	i) Performance Report (ST151/09) ii) Finance Report (ST152/09) iii) Human Resources Report (ST153/09)	Mrs M. McAlinden Mr M. Dillon Mr K. Donaghy	approval approval approval
8.	Board Committees • Endowments and Gifts Committee – Minutes of meeting held on 6th October 2008 (ST154/09)	Dr R. Mullan	approval
9.	Sealed documents • Lease of new premises for ARKE Early Years Sure Start Project, Unit 6, 1st Floor, Armagh Shopping Centre • Agreement between SH&SCT and M.P. Coleman Ltd for proposed car park, Hospital Road, Newry • Lease of premises at Suite A, 2nd Floor, Lennox House, 17-21 Market Street, Armagh	Mrs A. Balmer	information

	• Lease of sub station at Windsor Hill, 'A', Newry		
10.	Chairman's and Non-Executive Directors' Business	Mrs A. Balmer	information
11.	Any other business		
Date of next Board of Directors meeting: Thursday, 28th May 2009 in the Boardroom, SH&SSB, Armagh			

Southern Health and Social Care Trust

Minutes of a meeting of the Board of Directors held on Thursday, 30th April 2009 at 10.00 a.m. in the Boardroom, Daisy Hill Hospital, Newry

PRESENT:

Mrs A Balmer, Chairman
Mrs R Brownlee, Non Executive Director
Mr M Dillon, Director of Finance
Mrs D Blakely, Non Executive Director
Mr B Dornan, Director of Children and Young People's Services/Executive Director of Social Work
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Mr E Graham, Non Executive Director
Mrs H Kelly, Non Executive Director
Mrs E Mahood, Non Executive Director
Dr P Loughran, Medical Director

IN ATTENDANCE:

Mrs M McAlinden, Director of Planning and Reform
Dr G Rankin, Director of Older People and Primary Care Services
Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs J Youart, Acting Director of Acute Services
Mrs S Cunningham, Chief Executive, Southern Health and Social Services Council
Mrs J Holmes, Board Secretary
Mrs L Cartmill, Communications Manager
Mrs S Judt, Committee Secretary (Minutes)

1. CHAIRMAN'S WELCOME AND APOLOGIES

The Chairman welcomed everyone to the meeting, in particular members of the public and elected representatives. Apologies were recorded from Mr C Donaghy, Chief Executive, Mr A Joynes, Non Executive Director and Dr R Mullan, Non Executive Director.

2. ‘CARE IN THE SYSTEM’ DVD

The Chairman welcomed two young adults, Personal Information redacted by the USI and Personal Information redacted by the USI and Mrs Kate Mooney, Training and Development Consultant, to the meeting. Mrs Mooney introduced a DVD in which a group of young people, who have experienced the care system, share their experiences, views and thoughts to help others highlight and understand the importance of various issues. This DVD will be used as a training tool for future and current social workers. The two young adults then highlighted the key messages, emphasising the importance of listening to young people.

Board members congratulated and thanked the group of young adults for their contribution and participation in this important project and commended the DVD as a useful training resource for the Trust.

3. MINUTES OF MEETING HELD ON 26TH MARCH 2009

The minutes of the meeting held on 26th March 2009 were agreed as an accurate record and duly signed by the Chairman.

4. MATTERS ARISING

There were no matters arising.

5. STRATEGIC ISSUES

i) Acute Services Reform and Development at Craigavon and Daisy Hill Hospitals – Presentation

Mrs McAlinden spoke of the vision for acute care that the Trust has committed to in its 5-year strategy. She stated that whilst the Trust wished to maintain its profile of services, it recognised the need to reform to develop the range and accessibility of care and in expanding services, to provide more locally based services.

Mrs Youart assured members of the Trust’s commitment to ongoing service development and capital investment in Daisy Hill Hospital. She stated that in the first phase, the Trust has spent £5 million on maintaining current services at Daisy Hill Hospital in 2008/09 which resulted in refurbishment of the Maternity Unit, replacement of the Generator Plant, an upgrade of the Theatre Ventilation, improvements in decontamination and infection control, Firecode investment, Renal Service development and

additional car parking. Mrs Youart outlined a range of interim developments (Phase 2) planned for the next 12-18 months. She then outlined the longer term Strategic Development Plan for Daisy Hill Hospital which has been submitted as a capital priority for Departmental funding, which includes a redevelopment of Theatres, the development of a Day Procedure Unit, refurbishment of Outpatients to include an Ambulatory Care Centre, upgrade of Maternity Unit, the refurbishment of the Radiology Department, provide additional clinical accommodation and undertake remedial works to the external façade.

The Chairman invited those who people who had speaking rights to address the Board.

Councillor John McArdle, Newry and Mourne District Council

Councillor McArdle welcomed the Board of Directors to Daisy Hill Hospital. He thanked them for the provision of funding for the Social Education Centre, the Rehabilitation Home for problem children on the Rathfriland Road, Newry and for the retention of Slieve Roe House, Kilkeel. He raised a number of issues in relation to Level 4, Daisy Hill Hospital, a replacement CT scanner, car parking, community care, the rumour that ENT services will move to Daisy Hill Hospital, recent appointments to the Patient Client Council, plans for the removal of paediatrics at Daisy Hill Hospital and withdrawal of physiotherapy services at Millbrook Resource Centre, Bessbrook. He referred to the lack of Ministerial recognition of the Trust's performance against the 12 hour A&E target and the high performance of Daisy Hill Hospital in environmental cleanliness and infection control.

The Chairman responded by advising Councillor McArdle that the Board would endeavour to answer some of his questions today, but assured him that these would be answered in full when he met with the Chairman.

Level 4, Daisy Hill Hospital

Councillor McArdle asked about the Trust's plans for the future of Level 4 and the staff and where the patients would be facilitated? Mrs McAlinden advised that there is ongoing discussion with clinicians in terms of future planning and assured Councillor McArdle that future plans would not be to the detriment of patients. She stated that the Trust had no plans for any job

losses in the Newry and Mourne area and reiterated the Trust's commitment to expanding services at the hospital.

Replacement CT Scanner

Councillor McArdle stated that the present scanner is nearly eight years old and the promise of a replacement has not materialised. Mrs McAlinden acknowledged that this is an issue for Daisy Hill Hospital and is being considered alongside the need for replacement of other diagnostic equipment across the Trust. She confirmed that it is on the list of priorities and a business case is currently being developed, although funding was limited.

Car Parking

Councillor McArdle referred to car parking at Daisy Hill Hospital as 'an increasing nightmare' which must be resolved immediately. Mrs McAlinden responded by referring to the recent investment by the Trust to provide approximately 100 additional car parking spaces in a new car park on the site and that staff are being strongly encouraged to use this parking facility to free up the parking more adjacent to the hospital for patients and visitors. She advised that the Trust is awaiting Ministerial approval to its proposals to introduce car parking charges as part of its Traffic Management Strategy and intends to introduce a mix of free and fee paid parking. Councillor McArdle commented that he believed the only long term solution would be the creation of a multi-storey car park at Daisy Hill Hospital.

Patient Client Council

Councillor McArdle made reference to the fact that in recent appointments to this new body, Newry and Mourne, South Armagh, Armagh City and Craigavon have been left without representation. Mrs S Cunningham stated that it is very unfortunate that only one person living in the Southern Area is on the Patient Client Council Board. She added that the Patient Client Council intends to establish local advisory committees and through that mechanism it will provide an opportunity for local people to get involved in local issues.

Physiotherapy Services at Millbrook Resource Centre, Bessbrook

Mr Rice explained that these physiotherapy sessions were previously funded by the Big Lottery Fund, but unfortunately that funding has come to an end. The Trust is in the process of recruiting an additional Physiotherapist and whilst physiotherapy will be accessed on an individualised assessed basis at this facility, it will not be possible to provide the service at the current level. Mr Rice agreed to provide a formal written response to Councillor McArdle on this matter. The Chairman advised that Mr Dominic Bradley MLA had also requested speaking rights on this matter, but as he was an apology at today's meeting, she would arrange for the Chief Executive to discuss this with Mr Bradley when they next meet.

Councillor Frank Feely

Councillor Feely began by requesting amendments to the minutes of the meeting held on 26th March 2009 to reflect his remarks. The Chairman invited Councillor Feely to put his concerns in writing to herself.

Councillor Feely expressed the view that Daisy Hill Hospital has not been receiving the same funding as Craigavon Hospital. He quoted from Outline Health Estates Business Plans for Craigavon and Daisy Hill Hospitals and queried the significant expenditure at Craigavon Hospital against the low level of expenditure at Daisy Hill Hospital over the two year period 2006-08. He stated that Newry and Mourne is shown as fourth on the deprivation list table and condemned the Board for allocating the least resources to the area.

Mrs McAlinden advised Councillor Feely that decisions on the Trust's capital allocation are not taken by the Trust Board, but at Ministerial and Departmental level. She acknowledged that the Southern Area has not attracted its fair share of capital resources, but emphasised that this was in no way due to a lack of effort by the Trust. Mr Dillon stated that the Trust is now a single Trust with a hospital network and that each hospital has an individual role to play. Decisions on capital expenditure are based on need. The Chairman reiterated that the Trust has been strongly lobbying and will continue to do so for a fair share of the capital investment budget.

Mr Peter Murray, Newry and Mourne Health Committee

Mr Murray welcomed the opportunity to address the Board and thanked the Trust for the openness and transparency with regard to plans for Daisy Hill Hospital and its commitment to ongoing service developments at the hospital. He highlighted the recent positive developments at Daisy Hill Hospital in relation to Renal Services and ENT. He expressed concern that a number of the independent sector homes do not have adequate single rooms. Dr Rankin acknowledged people's wishes for single rooms, but stated that the physical nature of the buildings as they currently exist, means that whilst the majority of rooms will be single, there will be a number of double rooms. She went on to say that there is a standard set by the RQIA as to the number of single and double rooms and this applies to both the public and private sector. Mr Murray concluded by expressing his thanks to Mrs S Cunningham for the work she has done on behalf of the Southern Health and Social Services Council and hoped that she will have a meaningful role in the new body. The Chairman endorsed Mr Murray's comment.

Referring to the £81m investment in Daisy Hill Hospital, Councillor McArdle sought reassurance that this development would happen in the next 1-2 years, but voiced his concern that if the Minister does not approve this very soon, the danger is that the opportunity will be missed and the Trust will fall victim to spending cuts. Mrs McAlinden clarified that this investment was longer term, not in the next 1-2 years, but the majority was within the 10 year capital plan and will be subject to approval from the Minister both in terms of the amount and the timescale.

6. PATIENT/CLIENT SAFETY AND QUALITY OF CARE

i) Progress Report on the Regional Crisis Response Helpline – 'Lifeline'

Mr Rice presented a progress report for the period May 2008 – March 2009 which details the activities of the Trust as lead commissioner for Lifeline, the performance of the Lifeline service and key issues for the future. He stated that significant resources have been invested by the Trust to support the development of the Lifeline Project by Contact Youth. Referring to the challenges faced in the first contract period, Mr Rice advised that the Trust,

together with the DHSSPSNI and Contact Youth have renegotiated the contract to convert resources from unrealised wraparound activity into outgoing interventional/assessment telephone calls. Key performance indicators have been developed and monitored and these are reviewed monthly by the Contracts and Performance Management and Clinical Governance Sub Groups. An evaluation of the impact of the service is being undertaken on behalf of the Regional Steering Group by the Health Promotion Agency and the outcome of this will be shared with Board members.

Mr Rice reported that the Trust has achieved its PfA Supplementary target in respect of ensuring operationalisation and smooth integration of the helpline into its service model. Mrs McAlinden congratulated Mr Rice and his team on the achievements so far. The Chairman endorsed Mrs McAlinden's comments and asked Mr Rice to pass on the Board's appreciation to staff.

ii) **Infection Prevention and Control – Report for the period 1 April 2008 – 31 March 2009**

Mrs Holmes presented a report which provides an overview of performance in relation to infection rates for C. difficile, MRSA and MSSA, together with the results of audits of prevention and control measures in place within the Trust for the period April 2008 – March 2009.

Dr Loughran stated that the number of C. difficile episodes had peaked in November and December 2008 and, due to the actions taken by the Trust and the robust arrangements put in place, there was a significant reduction in the first quarter of 2009. The Chairman referred to the fact that the Trust's episodes of C.difficile had fallen to below 5 over the past 3 months and emphasised the importance of sustaining this. Dr Loughran reported a slight upward trend in the rates for MRSA and MSSA, but members were assured that the work undertaken for C.difficile is being replicated for MRSA and MSSA and this should achieve a reduction in these rates.

Referring to the hand hygiene audits, Dr Loughran reported a 90% level of compliance across the Trust. He stated that it was pleasing to note that staff were responding to the Trust's

Antiobiotic Guidelines and a reduction in the Trust's usage of broad spectrum antibiotics has been achieved.

The Chairman asked that performance in relation to Healthcare Associated Infection is incorporated into the Performance Report and reported on a monthly basis to the Board of Directors.

At the invitation of the Chairman, Mrs McAlinden updated members on the Trust's actions to date in response to Swine Flu. She began by advising that the hospital and primary care response action plan has now been put in place and Dr Rankin and Mr Dornan are co-ordinating a community response plan. Personal protective equipment for dealing with influenza is being made available to staff who may need them. A Swine Flu Planning Team meets on a daily basis.

ii) **RQIA Unannounced Inspection at Craigavon Hospital – Action Plan**

Mrs Youart gave a verbal update on progress against the action plan. She provided assurance that the majority of actions have now been completed and an ongoing report is provided to the Senior Management Team in respect of this.

iii) **The Productive Ward – Presentation**

Mrs Youart gave a presentation on the Productive Ward – Releasing Time to Care programme which is being piloted at three sites – Ward 1 South, Craigavon Hospital; Ward 6 in Lurgan Hospital and Silverwood Ward in the Bluestone Unit. She stated that the aim of the programme is to:-

- Increase the proportion of time staff spend on direct patient care;
- Improve productivity resulting in reduced costs and all forms of waste;
- Improve safety;
- Engage and empower staff to redesign ward processes and environment.

Mrs Youart provided members with examples of work undertaken to date which have resulted in positive changes on the wards.

The Chairman asked about plans to roll out the programme across the Trust. Mrs Youart advised that a paper has been prepared for consideration by the Senior Management Team and Trust wide implementation will be discussed at the Ward Managers Forum the following week. Mrs Cunningham commended the programme and stated that she was looking forward to seeing it extended to other wards. She asked about patient input into the process. Mrs Youart advised that the programme comprises a number of modules that will address patient care, respect, dignity etc. and added that Dr Rankin is taking a lead in a Trust wide initiative on the Patient/Client experience. Dr Rankin advised that informal feedback from staff, patients and visitors in one of the pilot sites, (Ward 6, Lurgan Hospital) has indicated that their experience is of a much calmer environment.

7. OPERATIONAL PERFORMANCE

i) Performance Report (ST151/09)

Mrs McAlinden introduced the Performance Report for March 2009 and spoke of the high and sustained level of performance across the Trust. She paid tribute to staff for the achievement of both Ministerial and the Trust's own targets this year. In response to a question from the Chairman on the Trust's performance against other Trusts, Mrs McAlinden stated that the position would be known in May 2009, but indications at Departmental level is that the Trust has performed well against the range of Ministerial targets.

ii) Finance Report (ST152/09)

Mr Dillon presented a short report outlining the provisional outturn position for 2008/09. He stated that this report is based on a draft Income and Expenditure and Balance Sheet and indicates a modest surplus of circa £82k and that financial breakeven has been achieved. He went on to say that the figures should be treated with some degree of caution and are at this stage unaudited.

The Final Accounts are due to be submitted by 9.00 a.m. on 5th May 2009 and are then subject to External Audit. These will be presented to the Audit Committee on 27th May, prior to approval at the Trust Board meeting on 28th May 2009.

Mr Dillon said that the achievement of break-even owed significantly to the one-off windfall write-back of £1.9m Agenda for Change creditor funding. He stated that the Trust would ensure that there are sufficient funds to pay arrears to those staff who have left the organisation. In addition, a considerable number of staff have requested a review of their Agenda for Change banding and some provision to cover any further arrears also needed to be made.

iii) **Human Resources Report (ST153/09)**

Mr Donaghy highlighted the key areas of this report. He advised that RPA activity is ongoing across the Directorates. Referring to Access NI, he reported that they had been marginally underperforming against their published standards over the last few months, but checks were now being returned in a timely manner. Mr Donaghy stated that it was pleasing to note that the vacancy rates have been declining and the staff turnover figure is favourable. The Trust's level of sickness absence is currently at 4.94%, well below the regional target of 5.2% by 2010/11. In response to a question from Mrs Brownlee about Selection and Recruitment training, Mr Donaghy advised that ongoing training is now being organised on a monthly basis.

8. **BOARD COMMITTEES**

i) **Minutes of meeting of Endowments and Gifts Committee held on 6th October 2008**

In the absence of Dr Mullan, this item was deferred to the next meeting.

9. **SEALED DOCUMENTS**

The Chairman advised that the following had been sealed in the name of the Trust:-

- Lease of new premises for ARKE Early Years Sure Start Project, Unit 6, 1st Floor, Armagh Shopping Centre

- Agreement between SH&SCT and M.P. Coleman Ltd for proposed car park, Hospital Road, Newry

- Lease of premises at Suite A, 2nd Floor, Lennox House, 17-21 Market Street, Armagh

- Lease of sub station at Windsor Hill, 'A', Newry

10. **CHAIRMAN'S AND NON-EXECUTIVE DIRECTORS' BUSINESS**

A list of the Chairman's and Non Executive Directors' business was noted.

11. **ANY OTHER BUSINESS**

The Chairman asked that the Non Executive Directors notify her if they wish to visit those wards piloting the Productive Ward programme.

The next Board of Directors meeting will be held on Thursday, 28th May 2009 at 10.00 a.m. in the Boardroom, SH&SSB, Armagh

Board Secretary

Band 8b - £41,038 - £50,733

Southern HSS Trust

Job Description

The Board Secretary will be responsible through the Chief Executive for servicing the Trust Board and Senior Executive Team of the Southern HSS Trust. The postholder will work proactively with the Chair and Chief Executive to ensure a planned approach to matters of strategic intent and issues requiring Board and Senior Executive team action. He/She will manage the process of agenda setting, provision and dissemination of information to support the effective functioning of the Trust Board, its committees and Senior Executive Team. The role will require liaison across the Trust and the establishment and maintenance of effective networks both internal and external to the organisation.

Principal duties:

- Provide high quality support to the Chief Executive in his role as principal advisor to the Chair and Trust Board.
- Provide a secretariat to the Board of Directors, its committees and Senior Executive Team.
- Analyse all relevant information and propose an agenda to the Board and Senior Executive Team and supervise the logistics of the organisation of meetings ensuring Board Members are provided with all the information needed for the meetings.
- Supervise the taking and approval of minutes, taking appropriate follow up action and ensure all those tasked with action follow up and report at subsequent meetings.
- Monitor and review the rhythm and pattern of meetings to ensure Trust objectives and the development of the organisation and delivery of its key objectives are met.
- Ensure the Trust operates in accordance with agreed standards of integrated governance, to ethical standards appropriate to a public service organisation and with due regard to wider societal obligations.

- Develop and maintain a strategic awareness of developments in integrated governance and advise the Chief Executive on their potential implications for the Trust.

- Take an active role in the strategic management of the Trust through membership of the Senior Executive Team and to represent the Chief Executive at specific events, functions and meeting with key stakeholders.

People and Financial Management

- Provide clear leadership to staff within the Chief Executive's Office in order to support a culture of effective team working, continuous improvement and innovation.

- Manage the department's budget ensuring efficient and effective use of public funds.

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 Board Secretary works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Chief Executive.

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.

RECORDS MANAGEMENT

The jobholder will be responsible to the Chief Executive for all records held, created or used as part of their business including 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 exceptions, under the Freedom of Information Act 2000, the Environment Information Regulations 2004 and the Data Protection Act 1998.

December 2006

Information Pack

Board Secretary

Terms and Conditions

The NHS terms and conditions (Agenda for Change) will apply to this post.

Salary will be £41,038 - £50,733 per annum.

In addition to 10 public holidays, the annual leave allowance will be as follows:-

- On appointment – 27 days
- After 5 years service – 29 days
- After 10 years service – 33 days

He/she may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere. The successful candidate should therefore have access to a form of transport that will permit them to meet the requirements of the post in full and be prepared to travel as required.

An applicant wishing to have an informal discussion about the process for appointment should contact Mr C Donaghy, Chief Executive (telephone Personal Information redacted by the USI

Board Secretary

Southern HSS Trust

Personnel Specification:

ESSENTIAL CRITERIA

Applicants must provide evidence by the closing date for application that they are working in a substantive post in the HPSS or an organisation affected by RPA[1] and have:

University Degree or a recognised professional qualification and at least 2 years' experience at senior management level.

Or

At least 5 years' experience at senior management level; and

Knowledge and experience of Corporate Governance.

The ability to prioritise and perform under pressure and under public scrutiny.

High level interpersonal, communication and writing skills.

Proven record of being able to meet tight deadlines and deliver outcomes.

Be able to demonstrate a good understanding of HPSS and/or public sector policy and management issues.

SHORTLISTING

[1] Details of RPA affected organizations are given on pages 23 – 28.

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form and a shortlisting interview. 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. The following additional desirable criteria may be introduced dependant upon the number of applications received:-

- Experience of working at Management Board level

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

Southern Health and Social Care Trust

INDIVIDUAL PERFORMANCE REVIEW

Mr Colm Donaghy, Chief Executive

IPR 2008/09

SOUTHERN HEALTH AND SOCIAL SERVICES BOARD - INDIVIDUAL PERFORMANCE REVIEW

PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

1. Key objectives for the coming period	**3. Action required** (Who needs to do what, by when for each key objective)	**5. Notes on attainment** (for completion by manager prior to major review)	**6. Rating 1-5** (if applicable - see guide notes)
DEVELOP A 5 YEAR STRATEGIC PLAN FOR THE TRUST 31 MARCH 2009	Develop Directorate Plans by Sept 2008 Prepare Plan for consultation by November 2008 Consult on plans to March 2009 Make final decision in March 2009	Plan completed Consultation launched in December 2009 Decisions made at 26 March 2009 meeting	

PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

1. Key objectives for the coming period	**3. Action required** (Who needs to do what, by when for each key objective)	**5. Notes on attainment** (for completion by manager prior to major review)	**6. Rating 1-5** (if applicable - see guide notes)
ENSURE THE PROVISION OF SAFE, HIGH QUALITY & EFFECTIVE CARE	Deliver the PfA targets associated with the Ministerial target on Safe, Better Quality Services, i.e. a reduction in health care associated infection. Ensure the introduction of an evaluation process to assess the effective delivery of services – by better engagement with users and staff. Work with RQIA and other external reviewers to improve patient quality and safety. Work with the Patient Safety Forum (NI) to further enhance patient safety initiatives in the Trust. Continue to ensure delivery of the Trust's statutory functions.	See 2008/09 Performance Report	

PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

1. Key objectives for the coming period	**3. Action required** (Who needs to do what, by when for each key objective)	**5. Notes on attainment** (for completion by manager prior to major review)	**6. Rating 1-5** (if applicable - see guide notes)
MAXIMISE INDEPENDENCE AND CHOICE FOR OUR PATEINTS & CLIENTS BY ENSURING THE DELIVERY OF ACCESSIBLE AND RESPONSIVE CARE	Deliver the PfA targets associated with the Ministerial priorities 3, 4 and 5 e.g. reductions in hospital waiting times, improvements in emergency care and integrated care and support in the community etc. Deliver the supplementary PfA targets associated with the Ministerial priorities 6 and 7 re Breast Cancer referral, increased capacity of pediatric and neo-natal intensive care, reduction in waiting lists and time for MS and Arthritis patients, etc. In the context of a 5 year strategic plan, develop a reform and productivity plan to redesign services to delivery improved choice and access to care.	See 2008/09 Performance Report	

PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

1. Key objectives for the coming period	**3. Action required** (Who needs to do what, by when for each key objective)	**5. Notes on attainment** (for completion by manager prior to major review)	**6. Rating 1-5** (if applicable - see guide notes)
RESPOND TO THE OUTCOME OF THE GOVERNMENT'S COMPREHENSIVCE SPENDING REVIEW BY APRIL 2008, WITH A PLAN TO ACHIEVE FINANCIAL BALANCE OVER 3 YEAR PIEORD 2008/09 – 2010/11	Put in place a project infrastructure by April 2008. Engage with staff and staff side. Identify projects as part of the plan and monitor closely during the year.	Best Care Best Value launched Project Structure put in place including Project Board and Project Assurance Group	

PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

1. Key objectives for the coming period	**2. Rank order** (Importance to overall success)	**3. Action required** (Who needs to do what, by when for each key objective)	**4. Development Need? Yes/No?** (If yes, detail in PDP)	**5. Notes on attainment** (for completion by manager prior to major review)	**6. Rating 1-5** (if applicable - see guide notes)

PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

1. Key objectives for the coming period	**2. Rank order** (Importance to overall success)	**3. Action required** (Who needs to do what, by when for each key objective)	**4. Development Need? Yes/No?** (If yes, detail in PDP)	**5. Notes on attainment** (for completion by manager prior to major review)	**6. Rating 1-5** (if applicable - see guide notes)

PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

1. Key objectives for the coming period	**2. Rank order** (Importance to overall success)	**3. Action required** (Who needs to do what, by when for each key objective)	**4. Development Need? Yes/No?** (If yes, detail in PDP)	**5. Notes on attainment** (for completion by manager prior to major review)	**6. Rating 1-5** (if applicable - see guide notes)
		(i)			

PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

1. Key objectives for the coming period	**2. Rank order** (Importance to overall success)	**3. Action required** (Who needs to do what, by when for each key objective)	**4. Development Need? Yes/No?** (If yes, detail in PDP)	**5. Notes on attainment** (for completion by manager prior to major review)	**6. Rating 1-5** (if applicable - see guide notes)

We agree that the above objectives are a fair basis on which this work will be planned and reviewed

7. Individual's signature	**8. Manager's signature**	**Date**	**9. Grandparent's signature**	**Date**

Date(s) agreed For interim review

10. Manager's overall rating	**11. 'Grandparent's comments & signature**

Southern Health and Social Care Trust

INDIVIDUAL PERFORMANCE REVIEW

Mr Colm Donaghy, Chief Executive (April – August '09)
Mairead McAlinden Acting CX (September – March '10)

IPR 2009/10

SOUTHERN HEALTH AND SOCIAL SERVICES BOARD - INDIVIDUAL PERFORMANCE REVIEW

PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

1. Key objectives for the coming period	**3. Action required** (Who needs to do what, by when for each key objective)	**5. Notes on attainment** (for completion by manager prior to major review)	**6. Rating 1-5** (if applicable - see guide notes)
Corporate Objective 1: Providing safe, high quality care ▪ Ongoing implementation of the Trust's 5 Year Strategic Plan	Key Service Changes to be delivered in 09/10: ▪ New model of non-acute hospital care ▪ New model of Statutory Residential Care ▪ Ongoing implementation of 'Change in Mind' mental health strategy ▪ Development of strategy for paediatric and neonatal services 'Changing for Children' Secure improvements to Trust estate to support the delivery of safe, high quality care	Service changes delivered within planned timescales, including capital investment Capital investment of £35m secured, funding major projects (maternity improvement, Portadown HCC, T&O Unit) as well as a range of estate improvements to support safe care (HCAI, DHH Neonatal Unit, Fire Safety, etc)	

PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

1. Key objectives for the coming period	3. Action required (Who needs to do what, by when for each key objective)	5. Notes on attainment (for completion by manager prior to major review)	6. Rating 1-5 (if applicable - see guide notes)
▪ Delivery of Ministerial PfA Standards and Targets	Develop services, with robust review and performance management arrangements, to ensure delivery of PfA Secure investment for key areas of undercapacity Manage risk in relation to ministerial standards and statutory duties	See 2009/10 Performance Report Key recurring investment secured in key hospital specialties to improve capacity. Community investment also secured for mental health, child care, etc. Capital business cases developed to increase capacity (NNU, SCBU, Maternity) Corporate Risk Register in place and reviewed monthly by SMT and quarterly by Governance Committee reflects effective risk management. Board Assurance Framework in place	
▪ Ensure effective response to regulatory reviews	Ensure recommendations arising from RQIA and other regulatory reviews of services and facilities are effectively addressed within the Trust	Key actions addressed in respect of: ▪ Environmental cleanliness ▪ Infection Control ▪ Child Care ▪ Intrapartum Care ▪ Hyponatremia ▪ Domiciliary care provision ▪ Stat. Residential Care and Day Care provision Process in place to monitor and report actions against RQIA recommendations to SMT, Governance Committee and Trust Board	

▪ Implement 'Safeguarding Vulnerable Groups' legislation	Develop policies, procedures, implementation plan and communication strategy, and negotiate funding base/staff contribution	Trust fully prepared for implementation of legislation and to apply to new starts wef July '10 and existing workforce wef 2013.	

PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

1. Key objectives for the coming period	**3. Action required** (Who needs to do what, by when for each key objective)	**5. Notes on attainment** (for completion by manager prior to major review)	**6. Rating 1-5** (if applicable - see guide notes)
Corporate Objective 2: Maximise independence and choice for our patients and clients	▪ Ongoing development of Direct Payments and achievement of related PfA target	Achieved	
	▪ Development of 'In Control' initiative	Progress in line with approved project plan, resources secured for project management	
	▪ Development of PPI Strategy	Development in line with project timescales	
	▪ Achievement of resettlement targets for mental health and disability	Achieved	

PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

1. Key objectives for the coming period	3. Action required (Who needs to do what, by when for each key objective)	5. Notes on attainment (for completion by manager prior to major review)	6. Rating 1-5 (if applicable - see guide notes)
Corporate Objective 3: Supporting People and communities to live healthy lives and improve their health and wellbeing	▪ Completion of Trust Health and Wellbeing Strategy and Action Plan ▪ Successful delivery of local Suicide Prevention Strategy framework, engagement process and action plan. ▪ Commission and performance manage Suicide Helpline on behalf of NI ▪ Ongoing implementation of Stepped Care model in Mental Health to improve access to early intervention and primary care based services ▪ Effective planning for pandemic flu threat, preparation of the workforce and deployment plans. ▪ Established Southern Area Domestic Violence Partnership ▪ Ongoing leadership of and Trust engagement with CAWT to secure funding for cross-border health and wellbeing improvement initiatives	Achieved, approved by Trust Board Achieved 2009/10 objectives, model of good practice for engagement and process, key actions delivered. Performance management systems, processes and improvements delivered, successfully transferred to PHA on 1 April 2010. Steps 1 to 3 now fully implemented and service restructuring significantly progressed. Additional staffing implemented, Centralised booking centre in place. Achieved, regional recognition of best practice. Workforce trained, prepared and deployment plans in place. Action plan and training completed Partnership in place and developing Ongoing and significant funding secured for a range of projects on obesity, etc.	

PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

1. Key objectives for the coming period	**2. Rank order** (Importance to overall success)	**3. Action required** (Who needs to do what, by when for each key objective)	**4. Development Need? Yes/No?** (If yes, detail in PDP)	**5. Notes on attainment** (for completion by manager prior to major review)	**6. Rating 1-5** (if applicable - see guide notes)
Corporate Objective 4: **Being a great place to work, valuing our people**		▪ Ensure a stable, well skilled workforce ▪ Minimise turnover through effective HR policies ▪ Be creative in terms of valuing staff ▪ Meet Equality requirements and promote diversity within the workforce ▪ Ensure workforce is compliance with legislation ▪ Ensure effective staffside engagement		Stable workforce achieved in 09/10 Celebration event developed and delivered to recognize staff achievements Ongoing implementation of policies, procedures and employment practice and EQIA impact assessment of service changes Range includes ▪ Vetting and Barring ▪ Staff induction programme ▪ Mandatory training matrix under development 'Working in Partnership' policy implemented and agreed, Management of Change policy agreed and implemented to support service changes.	

				Staffside engagement mechanisms in place across all Directorates and corporately	

PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

1. Key objectives for the coming period	**2. Rank order** (Importance to overall success)	**3. Action required** (Who needs to do what, by when for each key objective)	**4. Development Need? Yes/No?** (If yes, detail in PDP)	**5. Notes on attainment** (for completion by manager prior to major review)	**6. Rating 1-5** (if applicable - see guide notes)
Corporate Objective 5: **Making best use of resources**		Ongoing delivery of BCBV plans to secure CSR efficiency savings Achievement of financial balance in 2009/10 Improving the efficiency of the workforce		£18m of CSR efficiency savings delivered and contingency plan for remainder delivered to ensure financial balance achieved at end of 2009/10. Provisional out-turn is modest surplus (c£4k) Consultant Job Planning process in place, policies and guidance agreed, AMD/CD roles defined and agreed, SPA time and HPSS additional duties agreed, capacity/demand analysis underway to inform job planning. Major leadership challenges from September in relation to managing under achievement of efficiency targets	

				requiring in-year additional efficiency plans and negotiation with DHSSPS and RHSCB to secure additional funding, and ensuring Trust Board informed and engaged with financial risk management process.	

PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

1. Key objectives for the coming period	2. Rank order (Importance to overall success)	3. Action required (Who needs to do what, by when for each key objective)	4. Development Need? Yes/No? (If yes, detail in PDP)	5. Notes on attainment (for completion by manager prior to major review)	6. Rating 1-5 (if applicable - see guide notes)
Corporate Objective 6: **Being a good social partner within our local communities**		▪ Stabilise funding for key community and voluntary sector partners ▪ Ensure delivery of Environmental Strategy and associated action plan. ▪ Ongoing partnership working to improve quality of life of local population ▪ Ongoing development of volunteering within the Trust		Commissioning and financial strategy agreed to revise contractual relationships, shared objectives and improved VFM See Environmental Strategy Annual Report, achievements included improved energy efficiency and improved ARENA audit outcomes Additional Supported Living schemes in partnership with NIHE and other partners. ▪ Volunteering policy in place ▪ New initiatives developed including 'Here to Help' scheme in CAH	

PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives for 2010/11

1. Key objectives for the coming period	**2. Rank order** (Importance to overall success)	**3. Action required** (Who needs to do what, by when for each key objective)	**4. Development Need? Yes/No?** (If yes, detail in PDP)	**5. Notes on attainment** (for completion by manager prior to major review)	**6. Rating 1-5** (if applicable - see guide notes)
1. Financial challenge of increased efficiency levy potentially driving service reconfiguration or reductions 2. Continue to implement Strategic Plan and service reform priorities, in face of financial challenges 3. Improve governance systems and processes to ensure delivery of safe, high quality care and ensure this is given priority		▪ Development/agreement of Financial Plan and implications of same ▪ Ensure Trust secures income for increased activity and capacity gaps ▪ Reduce dependence on IS ▪ Ongoing implementation of key strategies in 'Changing for the Better' 5 year strategy, focusing on Acute, Paediatrics and Care of Older People ▪ Commission and deliver review of governance, aligning with recommendations of Mid Staffordshire QCC report	Yes – further leadership and personal development, would wish to explore potential for CX Development Programme in UK		

We agree that the above objectives are a fair basis on which this work will be planned and reviewed

7. Individual's signature	8. Manager's signature	Date	9. Grandparent's signature	Date

Date(s) agreed For interim review

10. Manager's overall rating	11. 'Grandparent's comments & signature

Wright, Elaine

From: White, Laura [redacted]
Sent: 17 July 2009 13:22
To: 'Wilson, Roberta2'; 'Donaghy, Colm'
Cc: 'Wright, Elaine'
Subject: Ltr to Mr Aiden O'Brien
Attachments: 20090717_Ltr_AO'Brien_UrologyPatients_PLlw.doc

Roberta and Colm
Please find attached copy of letter re Urology Patients sent to Mr Aiden O'Brien in internal post today as he doesn't open e-mails.
Laura

Ms Laura White
Personal Assistant to
Dr Patrick Loughran
Medical Director
Southern Health & Social Care Trust
College of Nursing
Craigavon Area Hospital
68 Lurgan Road
PORTADOWN
BT63 5QQ

Tel: [redacted]
Fax: [redacted]
E-mail: laura.white[redacted]

P Please consider the environment before printing this e-mail.

Southern Health and Social Care Trust

Medical Directorate

17 July 2009 Ref: PL/lw

Mr Aiden O'Brien, Consultant Urologist
SHSCT, Urology Department
Level 2 South, CAH

Dear Aiden

I refer to our previous conversations and correspondence, and my expectation that you would provide me with the list/cohort of patients who were in the programme for repeated IV fluids and antibiotics. I have now obtained the list from the Director of Acute services.

I have advised the Chief Executive that I have considered:

- The contents of correspondence and the meetings with you,
- The informal phone calls between me and Dr O Driscoll and Mr Mark Fordam
- Your belief that these therapies are evidence based
- The commissioner's uncertainty of the evidence base of the therapies
- Your reluctance to consider alternative non IV therapies

I am now bound to take an independent assessment of the whole situation to allow me to advise the Chief Executive of the safety and efficacy of the treatment.

I have written to Dr O Driscoll and Mr Mark Fordam to ask them to provide a formal assessment.

I expect to agree terms of reference for the investigation in the immediate future.

I would ask you to take this final opportunity to consider if there is an alternative way to treat these patients.

I would be very happy to speak with you and Mr Young to discuss this cohort of patients. I am on leave at present returning on Monday 3rd August, and I will make myself available at any time that week.

Yours sincerely

[redacted]

Dr Patrick Loughran
Medical Director
c.c. Michael Young, Colm Donaghy, Roberta Wilson

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: (028) Personal Information / Fax: (028) Personal Information / Email: patrick.loughran Personal Information redacted by the USI

Wright, Elaine

From: Hayes, Nicola [redacted] >
Sent: 01 June 2009 12:38
To: OBrien, Aidan
Cc: Donaghy, Colm; Wright, Elaine; McAlinden, Mairead; Radcliffe, Sharon; Gibson, Simon; Mackle, Eamon; Brown, Robin; Tedford, Shirley; Martin, Clare
Subject: Urology Services
Attachments: Mr O'Brien re Services 1.6.09 signed.pdf

Importance: High

Hello Mr O'Brien

Please find attached correspondence from Joy Youart in response to your letter of 29.5.09.

Kind regards.

Nicky

Nicky Hayes

Personal Assistant to Mrs Joy Youart, Acting Director of Acute Services

Southern Health & Social Care Trust

Craigavon Area Hospital

[redacted] (Direct Line)

Southern Health and Social Care Trust

Acting Director of Acute Services
Administration Floor
Craigavon Area Hospital

Mr Aidan O'Brien
Consultant Urological Surgeon
Southern Health & Social Care Trust
Craigavon Area Hospital

1 June 2009 **Our Ref:** JY/njh **Your Ref:**

Dear Aidan

Urology Services

Many thanks for your letter dated 29 May 2009 regarding the recent response to the consultation on the surgical reconfiguration of beds and making the time to come and see me directly on Friday.

The eight points presented in your paper on Wednesday were very helpful in reaching consensus and agreement. As requested in your letter, I am more than happy to respond to each point and outline the role of the Urology Ward Manager.

Can I at the outset, thank you and your colleagues for all the time and commitment you have personally given to move us forward to a consensus position. I very much appreciate how difficult this has been, but now feel we can all move forward with an agreed position. I will take the points in order as presented in your paper.

Point 1
Both Mairead McAlinden and myself are committed to the transfer of flexible cystoscopies and the expanded use of both the Thorndale Unit and other Trust facilities. I know already the options regarding a link corridor are being explored as a matter of priority and see no barriers presently to this occurring in the short term.

Point 2
I feel we have all been striving to achieve this point and work is currently underway with all specialties, to maximise day surgical facilities. This is now part of an action plan.

Point 3
I am delighted that there is agreement to utilise Ward 3 South for elective day surgical patients. This I believe will be further facilitated by the development of care pathways in Urology. I have asked Heather Trouton and Robin Brown to support and assist your team in developing those care pathways.

Point 4
I acknowledge the commitment to admit all patients to Ward 3 South and could I suggest that the team liaise with Connie Connolly and Heather Trouton to facilitate this.

/cont.2..

Point 5
I acknowledge there is a degree of flexibility required in utilising the elective short stay ward. I am hopeful that by developing care pathways as outlined above, this will assist in determining the best area for post-operative management.

I would like to suggest that the procedures that could utilise this facility are identified and we work through the implementation of these over the next month with the team.

Point 6
The Urology Unit will provide care for long stay and non-elective patients as appropriate, I am sure that the work to develop care pathways will assist with this. I am happy to provide support for this to be taken forward.

Point 7
I can only reiterate my thanks to the team in accepting this proposal that the Urology Unit will be located in the ward area, to which all general surgical non-elective patients will be admitted.

Point 8
I would like to outline for you the role I have discussed with Shirley Tedford. Firstly, I recognise the role she has played in co-ordinating the numerous activities in Urology, which are much wider than a Ward Manager's role. This has been a wide span of responsibility and I feel we need to recognise and give her the time to undertake the diverse role required.

With this in mind, I feel the role needs to expand to one of Nurse Clinical Lead/Co-ordinator for Urology Services. The role will encompass providing nursing leadership/co-ordination to both the Urology Unit and the patients who are being admitted to both the day case and short stay areas.

The role will also cover the services in Urodynamics and the Thorndale Unit, establishing and supporting the areas outlined alone in Point 1.

I have also discussed with Shirley the development with yourselves of care pathways with the assistance of Mr Robin Brown.

The Ward will be managed by Sheila Mulligan with nursing and clinical leadership input from Shirley.

I know they have both discussed this and are in agreement. They feel they can manage this on a day-to-day basis. I believe this will have a number of benefits to Shirley in her new role:-

- Dedicated time to develop the Urology Service without the day-to-day demands of running a 36 bedded ward ensuring clinical quality in the Urology area

- Time to develop care pathways with the clinical team

/cont..3..

Craigavon Area Hospital, 68 Lurgan Road, Portadown, County Armagh, BT63 5QQ Tel No 028 3861 2510
Fax No 028 3839 4935 Email Address joy.youart@southerntrust.hscni.net

- Providing clinical support to Urology nurses in both the Urology Unit, Day Case & Short Stay areas
- Development of the services that can be provided in the Thorndale Unit and Urodynamics
- Time to liaise with community colleagues in the development of protocols for aspects of care that can be delivered in a community setting.

I know when we spoke on Friday, you felt this was a role that had been suggested a while ago and you indicated your support for such a role. I really appreciate that this has been a challenging time for you and the team and I hope this letter provides the reassurance and commitment from the Senior Management Team you require.

I look forward to taking forward these developments with you and your team in a spirit of openness and partnership working.

Finally, may I thank you personally for all the time and commitment you have given to enable us to move forward on all of these points.

With best wishes.

Yours sincerely

Personal Information redacted by the USI

Mrs Joy Youart
Acting Director of Acute Services

cc Mr C Donaghy, Chief Executive
Mrs M McAlinden, Director of Performance & Reform
Mr S Gibson, Assistant Director of Acute Services (Surgery & Elective Care)
Mr E Mackle, Associate Medical Director (Surgery & Elective Care)
Mr R Brown, Clinical Director (Surgery & Elective Care – DHH Site)
Sr S Tedford, Ward 2 South (Urology)

Craigavon Area Hospital, 68 Lurgan Road, Portadown, County Armagh, BT63 5QQ Tel No Personal Information redacted by the USI
Fax No Personal Information redacted by the USI Email Address joy.youart Personal Information redacted by the USI

Southern Health and Social Care Trust

BOARD ASSURANCE FRAMEWORK

MAY 2009

1. Introduction

The Board of Directors of the Southern Trust (The Board) has a responsibility to provide high quality care, which is safe for patients, clients, young people, visitors and staff and which is underpinned by the public service values of accountability, probity and openness.

The Board is responsible for ensuring it has effective systems in place for governance, essential for the achievements of its organisational objectives. The purpose and design of the Board's Assurance Framework is to ensure that the Board can be effective in driving the delivery of its objectives. This document will assist the Board to identify, manage and minimise the principal risks to achieving the objectives in 2009/10.

The Board of Directors of the Southern Trust defined the corporate objectives for 2009/10 in the Trust 'Vision Values and Objectives[1]'; these are to

Objective 1: Provide safe, high quality care

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

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

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

Objective 5: Make the best use of resources

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

[1] Southern HSC Trust Visions Values and Objectives, November 2008

The Assurance framework is an integral part of the governance arrangements for the Southern Trust and should be read in conjunction with the Trust Delivery Plan 2009/10, the 5-year strategic plan – 'Changing for the Better and the Integrated Governance Strategy.

The Assurance Framework describes the organisational objectives, identifies principal risks to their achievement, the key controls through which these risks will be managed and the sources of assurance about the effectiveness of these controls. It lays out the sources of evidence which the Board will use to be assured of the soundness and effectiveness of the systems and processes in place to meet objectives and deliver appropriate outcomes.

This framework should provide the Board with confidence that the systems, policies, and people are operating effectively, are subject to appropriate scrutiny and also that they have been informed about the principal risks affecting the organisation.

Abbreviations used in Framework

BCBV – Best Care Best Value
CAWT – Co operation and Working Together
CRL – Capital Resource Limits
DHSSPS – Department of Health Social Services and Public Safety
HCAI – Healthcare Associated Infection
HSCB – Health and Social Care Board
PfA – Priorities for Action
PHA – Public Health Agency
PSA – Public Service agenda
RQIA – Regulation and Quality Improvement Authority
SHSSB – Southern Health and Social Services Board
SMT – Senior Management Team
SRF – Strategic Resources Framework (details how the HPSS organisations are planning to spend the public money they have been allocated).
TFR – Trust Financial Returns (covering unit costs for Acute and Community services).

Objective 1 - Provide safe, high quality care.

Risk Area and principal risks.	Existing Controls	Assurances – Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
1.PSA & Ministerial Targets **Risk:** Non achievement of targets for 09/10 for Fractures and Healthcare associated infections.	Performance Monitoring arrangements.	Performance Management Framework and Performance reporting (I) SDU performance monitoring (weekly) (E)			Performance Management Reports to Trust Board (Monthly) Performance reports to SMT (Weekly)
	Healthcare Associated Infection project structure, Improvement plan and associated work streams.	J O' Driscoll review of HCAI prevention and control arrangements (E) Performance monitoring - infection rates, compliance with care bundles and HCAI related audits (I)			Performance Report to Trust Board (Monthly)
	Trauma and Orthopaedics steering group.	Performance management framework			Fracture performance report to SMT (weekly) and included in Performance report to Trust Board (monthly)
	Trust delivery plan 2009/10	Performance reporting			Performance report to Trust Board (quarterly) and report to Commissioner (quarterly)

	Patient Safety Programme.	Patient safety reports monthly to Patient Safety Forum.	Patient safety work programmes associated with reduction in Infection rates not linked to HCAI reporting.	Include compliance with relevant care bundles and infection rates in Performance report to Trust Board. (Ref. HCAI Improvement plan work streams)	Patient Safety Report to Governance Committee (Quarterly). Performance reporting to Trust Board. (monthly)
	Trust Discharge steering group and delayed discharge sub group.				Performance reports to SMT (weekly) and Trust Board (monthly).

Objective 1 - Provide safe, high quality care.

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
2. Statutory Functions **Risk:** Unacceptable level of unallocated child care cases.	Performance monitoring arrangements.	Performance Management Reports (I)			Performance reports to Trust Board (monthly)
	Weekly monitoring of numbers of unallocated child care cases. Workforce strategy group for family support and safeguarding teams.	Reports to Director of CYPS, SHSSB, and Board of Directors.	No ongoing process for independent assurance re. Unallocated child care referrals.	Commission independent child care consultant to review unallocated child care referrals during Apr-June 09	Reports to Trust Board: - Corporate parenting; - Delegated Statutory Functions; - Looked After Children - Adoption Report - Child Protection Panel - Social Care Governance report to Governance committee (twice a year)
	Social Care Governance structures (*Social Care governance forum and Social work professional forum in each Programme of Care*), systems, processes.	Trust reporting: -Corporate parenting - Delegated statutory functions -Looked After Children - Adoption - Child Protection Social Care Governance reporting. Audit programme (I)			

2. Statutory Functions (contd)		RQIA Review of Child Protection services. (E)	-Level of unallocated child care referrals -Shortcomings in information to enable risk assessment of individual cases. - No source of independent assurance. (as above) - Capacity gap.	Action plan to address RQIA recommendations.	RQIA Action plan progress report to Governance committee (Quarterly)
	Statutory Functions monitoring meetings with SHSSB for children's services and adult services.	SHSSB monitoring of discharge of statutory functions (E) SHSCT monitoring.(I)			Statutory Functions report to Trust Board.
	Action plans to address recommendations of Case Management Reviews.	Case Management Reviews (E)			Case Management Review reports and action plans Governance Committee – Confidential Agenda (Quarterly)

Objective 1 - Provide safe, high quality care.

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
2. Statutory Functions (contd) **Risk:** Shortcomings in current practice arrangements in approved social workers.	Annual audit of approved social work.		- Inadequate system of supervision of approved social workers. - Shortcomings in training - Level of practice experience of some approved social workers.	Agreement with SHSSB on appointment of approved social work lead who will take forward a review of practice, training and supervision.	
	Action plan to address RQIA Mental Health and Disability service Review Recommendations.	RQIA Review of Mental Health and Learning Disability services (E)			Action plan – progress report to Governance Committee (Quarterly).

Objective 1 - Provide safe, high quality care.

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
3. HPSS Quality Standard – 'Safe and Effective Care'	Action plans to address Recommendations from Independent Reviews e.g. RQIA, SHSSB, Ombudsman	Independent Reviews by RQIA, SHSSB (E)			Action plans and progress reports to Governance committee. (Quarterly)
	MEWS Governance group				Professional Governance report to Governance committee.
Risk: Shortcomings in arrangements for Protection of Vulnerable adults.	Lead director and Lead professional for 'Protection of Vulnerable adults'.		Inadequate practice leadership in respect of protection arrangements for vulnerable adults.	Proposal for change to protection arrangements and appointment of a Coordinator. DHSSPS identified additional monies for protection arrangements. Increased targeted training.	
Risk: Capacity to deliver Quality Maternity Services.	Draft Action plan to address risks in Maternity service provision.	RQIA Review of Intrapartum Care Services. (E)		Final action plan based on final recommendations from RQIA Review of Intrapartum care services.	Action plan progress to Governance Committee.

Corporate Objective 1 - Provide safe, high quality care.

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
3 (i) Ensuring safe practice and appropriate management of risk	Clinical and Social Care Governance structures, systems and processes. SHSCT Risk Management strategy. Risk Management forum. Incident reporting process. Datix recording of incidents and reporting to Governance forums. SHSCT Trust policy committee. Use of Root Cause analysis to investigate Serious Adverse Incidents.	Incident reports (I) Internal Audit reports (I) Reports of reviews by Royal Colleges and Regulatory Bodies inc RQIA (E) Independent review reports/Case Management Reviews – SHSSB, RQIA, Ombudsman (E) Medicine Inspectorate annual inspection (E) and Aseptic services inspection – Regional Pharmaceutical laboratory service (E)		Action plan for Management of Hyponatraemia	Reports from RQIA. (Trust Board) Independent review reports. (Governance Committee) Internal Audit reports. (Audit committee)
Risk: Organisational risks not identified in a timely way and appropriately managed.			Corporate Risk Register not finalised and reviewed on regular basis.	Review of Trust Risk Management Arrangements.	

Corporate Objective 1 - Provide safe, high quality care.

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
Risk : Insufficient capital to maintain existing services.	Capital allocation process for Capital Resource Limit (CRL) funding. CRL group - manage/monitor these funds. Business case approval process.	CRL proposals in TDP and brought to SMT for approval. Business case approval for approved schemes.		Capital priorities paper (2008) submitted to DHSSPS for major capital priorities/schemes. Annual bidding for Maintaining existing services capital funds.	Trust Delivery plan. (Trust Board approved)
Risk: Insufficient capacity in respect of neonatal care.	Monitoring status of neonatal cots. Increased supply of trained staff and increased staffing levels to neonatology.	Daily Reporting neonatal cot position to SHSSB		'Changing for Children' neonatology working group – developing proposals to increase capacity.	
Risk: Commissioning care that could expose patients/clients to unnecessary/ avoidable risks.	Contract compliance monitoring, annual review and regulation of services by RQIA. 'Contact Youth' Performance monitoring		'Contact Youth is not a regulated service provider.	Service level agreement identifies Key performance indicators - finance, contractual, performance and clinical & social care governance.	Reports to SMT, Regional Lifeline steering group and the DHSSPS.

Corporate Objective 1 - Provide safe, high quality care.

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
3 (ii) Preventing, detecting, communicating and learning from adverse incidents and near misses. **Risk:** Culture of under-reporting of incidents and near misses.	Monitoring, Reporting and analysing adverse incidents/complaints/ clinical negligence claims. Clinical and social care governance forums and reports. Integrated Governance strategy and associated committees and sub committees.	Incident Reports (I) Governance reporting framework (I)	Model for learning lessons from adverse incidents, complaints etc.	Further develop systems, processes and culture for sharing learning.	Governance Reports – Governance Committee (Quarterly)
	Monitoring maternal and child mortality rates with recommendations implemented through Effectiveness and Evaluation work programme/Directorate performance management systems.	National confidential enquiries (E).	Lack of assurance that recommendations have been actionned and lessons learned. Lack of Trust wide 'model for learning lessons.'	Directorate Governance Arrangements to incorporate recommendations from National Confidential Enquiries.	

Corporate Objective 1 - Provide safe, high quality care.

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
3 (iii) Promoting Effective Care	Policies, procedures, protocols and guidelines.	Clinical and Multi-professional audit reports (I).	No Trust – wide process for the receipt, assessment, prioritisation and implementation of evidence based standards and guidelines and lack of integration with audit function.	Senior appointment to be made within medical directorate for standards and guidelines.	Report of Clinical and Multi-professional Audit – Governance Committee (Annuaal)
			Limited clinical outcome indicators. Not sufficient benchmarking to ensure optimum performance being achieved.	CHKS benchmarking project.	
	Improvement plan for MEWS and PEWS and MEWS Governance group	Audit of MEWS and PEWS.			Report to Governance committee.
	Directorate Clinical and Social Care Governance structures and processes.	Directorate governance meetings and Mortality and Morbidity meetings in Acute.(I)	Lack of assurance to SMT and Governance committee of Lessons learned and improvements in treatment and care provided.	Development of Model for Learning Lessons.	
	Effectiveness and Evaluation Unit annual work programme of Clinical and multi-professional audits.	Report of Effectiveness and Evaluation Unit (I)			Patient Safety Report to Governance committee (Quarterly)

	Patient safety Programme: - Team working - Record keeping - Patient/client safety interventions.	Monitoring of Patient Safety programme reports to Governance Committee.			Patient Safety Report to Governance Committee (Quarterly)

Corporate Objective 1 - Provide safe, high quality care.

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
4. Controls Assurance Standards i)Decontamination of Medical Devices ii) Environmental cleanliness iii) Fleet and Transport Management iv) Food Hygiene Infection Control v) Medical Devices and Equipment Management vi) Medicines Management vii)Research Governance viii) Risk Management **Risk:** No risks identified at April 09.	Southern Trust process for management of self assessment and verification of compliance with controls assurance standards.	Self assessment against CAS (II) Internal Audit assessment and verification of level of compliance with controls assurance standards (I)	Lack of external assessment for all controls assurance standards.	External assessment process being developed for a range of Controls Assurance standards in 09/10	Controls Assurance report to Governance & Audit committees and Trust Board – annually. Internal Audit verification reports to Audit committee - annually

Corporate Objective 2 - Maximising independence and choice for our patients and clients

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
1.PSA & Ministerial Targets	Performance monitoring arrangements.	Performance Reports – weekly to SMT and monthly to Board (I) DHSSPS (SDU) performance monitoring (E) Performance review meetings with Commissioner (E) Reform, Productivity and Efficiency Project Board (I)			Performance Management Reports (Trust Board) Performance reports weekly to SMT.
Risk: Re - settlement delayed as Supporting People money not available to provide housing with care in older people and mental health and learning disability programmes.	Southern Area Supporting People Partnership. Best Care Best Value Project Board monitoring and reporting. 'Supporting People' proposals to SMT for approval.			Ongoing discussion with N I Housing Executive and exploration of alternative funding mechanisms and options for provision of supported housing schemes.	Best Care Best Value report (Trust Board)

Corporate Objective 2 - Maximising independence and choice for our patients and clients

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
1.PSA & Ministerial Targets (contd) **Risk:** Non achievement of target for number of family group conferences,	Contract with Barnardos. Regular meetings between Barnardos and Trust senior staff. Training Trust staff in Family Group conferencing to increase capacity.	Performance Monitoring – monthly to SMT (I) to DHSSPS (E)		Monitoring of existing controls.	Performance Reports to Trust Board.
2. Trust Strategic Priorities - Maximising self directed support. **Risk:** Capacity to Implement In control project.	5 - Year Strategic Plan consultation and approved 5-year plan. Changing for the Better Project Board. In Control project steering group and targets identified for In Control pilot.	Ministerial, DHSSPS and Commissioner approval processes and public consultation.		See existing controls.	

Corporate Objective 2 - Maximising independence and choice for our patients and clients

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
3. HPSS Quality standard: Accessible, Flexible and Responsive Services (i) Service Planning processes	5- Year strategic plan Changing for the Better Project Board	Ministerial, DHSSPS and Commissioner approval processes and public consultation.			Reports to Trust Board (monthly)
Risk: Personal and Public Involvement not embedded in service planning processes.	Personal and Public Involvement (PPI) Strategy and action plan.			Implementation of Personal and Public involvement strategy and action plan.	PPI reports to SMT (2 per annum) Report to Trust Board (annually)

Corporate Objective 2 - Maximising independence and choice for our patients and clients

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
3 (ii) Service Delivery for individuals, carers and relatives.	Professional codes of practice.	Professional Regulation (I & E)		.	Governance Reporting Framework – quarterly (Governance Committee)
	Corporate Vision and values	Users views and complaints reporting.(I)			
Risk: Lack of performance indicators and lack of assurance re. quality of services provided.	Policies and procedures for assessment, planning and provision of services			Development of performance indicators.	
	Equality Scheme and associated policies.	Section 75 Annual progress report and 5-year review of progress to the Equality Commission (I) & (E)			Section 75 Annual Progress report. (Trust Board) 5 - year review Equality Scheme Report. (Trust Board)

Corporate Objective 3 - Supporting people and communities to live healthy lives and improve their health and wellbeing.

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
1.PSA & Ministerial Targets **No Principal risks at Apr '09**	Performance monitoring arrangements and weekly reports to SMT.	Performance Management Framework (I)			Performance Management Reports toTrust Board (monthly) and SMT (weekly)
	Steering Groups for Service Frameworks – Cardiovascular, Respiratory.				
	Project Team – Bowel Cancer screening.				
	Protecting Lives Project Structure	Multi - agency Project Board and Progress Report (I) and (E)			Protecting Lives report to Trust Board (two per annum)
2. Trust – Strategic priorities. **No principal risks identified at Apr '09**	Existing arrangements in Legacy Trusts for involving users in service planning. User and community engagement action plan. User involvement structures. Personal and Public involvement strategy. Southern Investing for Health partnership. CAWT.	Performance Management Framework. Southern Area wraparound stakeholder forum.(E) Southern Council (E) Local politicians (E) Media (E)			Performance Management Reports (Trust Board) Performance reports weekly to SMT

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
3. HPSS Quality Standard – 'Promoting, Protecting and Improving Health and Social Wellbeing' **No principal risks identified at April '09**	Trust wide lead and structures for Health, Wellbeing and Improvement. RQIA Action plan for implementing recommendations following 07-08 review of compliance with standard.	Self assessment against quality standard. (I) RQIA Clinical and Social Care Governance Review Report 2007-08 (E)			Governance reporting framework – Governance committee. RQIA progress report on Clinical and Social Care Governance action plan 07/08

Corporate Objective 4- Be a great place to work, valuing our people.

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
1. PSA and Ministerial Targets **Risk:** Ability to achieve skill mix for nursing.	Performance monitoring arrangements. In Childcare – Family support and gateway workforce group. Directorate workforce groups. Group supervision of Assessed Year in Employment by principal practitioners.	Performance Management Framework – weekly reports to SMT and monthly to Board (I) DHSSPS (SDU) performance monitoring (E) Performance review meetings with Commissioner (E)		Ongoing review and monitoring of outcomes of STEEP, BCBV and workforce initiatives.	Performance Management Reports (Trust Board) Performance reports weekly to SMT. HR report to Board of Directors (monthly)
	STEEP work programme.			As above	
	Best Care Best Value.			As above	
2.Trust Strategic Priorities	- HR Policies and Procedures. - Health and Wellbeing Policy - Occupational health service. - Staff Care - Induction of Staff Workforce Strategy	Internal Audit Reports (E)			Internal Audit reports to Audit committee.(Quarterly)
	SHSCT Vision, Values and Objectives.	Staff Survey (I)			Staff Survey Report (Board of Directors)

Risk: Staff disaffected and de-motivated as result of Agenda for Change outcomes.	Trust Agenda for Change Assimilation group.	Assimilation report to SMT (I) Regional Consistency check Joint Working Group of Agenda for Change (E)			Human Resources Report (Board of Directors)

Corporate Objective 4- Be a great place to work, valuing our people.

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
3. Controls Assurance Standards : **- Human Resources** **- Health and Safety** **Risks:** None at April '09	Southern Trust process for management of self assessment and verification of compliance with controls assurance standards.	Self assessment against CAS and action plan(II) Internal Audit work programme (I)			Controls Assurance report to Governance & Audit committees and Trust Board – annually. Internal Audit reports to Audit committee - annually

Corporate Objetive 5 - Make the best use of resources

(a) Financial Viability, Reform and Control of Costs

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
1. Target – To achieve financial balance on a recurrent basis. **Risks:** Failure to fully achieve Best Care Best Value (BCBV) plans. Not being able to fully close the baseline deficits. Unforeseen cost pressures arising. Predicted levels of income not achieved. Lack of performance/efficiency benchmarks to identify areas for reform.	Monitoring of the delivery of BCBV Plan. Annual financial plan. Income agreed with commissioners and ongoing dialogue with Commissioners Detailed policy and procedure in place for budget setting. Robust system in place for budget profiling. System for budget setting involves all relevant parties. Training budget holders. Process for identification of emerging pressures. Process for budget monitoring & formulation of corrective action plans. Robust monitoring and forecasting. Increased vigilance. Realistic assumption re slippage.	BCBV project board. (E) BCBV project assurance group. Financial Performance Report to Budget holders and Trust Board(I) Internal Audit reports (I) External Audit reports (E)	.	CHKS Benchmarking project.	Financial Performance Report - Bi-monthly to Trust Board Final Accounts to Audit Committee & Trust Board (annually)

Corporate Objective 5 - Make the best use of resources

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
Target – To achieve CRL, Capital Cost Absorption Duty and EFL.	Monitoring of annual capital plan. Seeking new cover, switching cover. Applying agreed methodology. SouthernTrust protocol for approval of spend.	Internal Audit (E) External Audit (E) Reports to budget holders.			Financial Performance Report – Bi –monthly to Trust Board.
Target – to prevent fraud. **No principal risks identified at Aug'08**	SHSCT Fraud Policy and Response plan. Fraud awareness training included in Corporate induction programme. Internal monitoring.	Internal Audit (E) External Audit (E)			Losses Report to Audit Committee. Quarterly returns to Audit Committee.

Corporate Objective 5 - Make the best use of resources

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
Target – to benchmark and understand costs.	Preparation of SRF, TFRs Staff well versed in preparation of SRF and TFRs.				
2 Trust-Specific Priority - To prepare for the Review of Finance Regime and potential Activity Based Funding system. **Risk:** Capacity to deliver timely and quality coding.	Experience in unit cost preparation. Weekly coding report. Performance reporting on levels of coding.	CHKS Clinical coding Audit report (E)		Action plan to address CHKS recommendations.	
3. HPSS Quality Standard compliance with 'Corporate Leadership and Accountability' (f) Ensure financial management achieves economy, effectiveness, efficiency, probity & accountability in use of resources. **No principal risks at April '08**	Financial management systems, policies and procedures include: Standing orders; Standing financial instructions; Authorisation framework; Budgetary framework; Fraud and Corruption plan; Code of Conduct for managers; Gifts and Hospitality policy; Procurement.	Internal Audit reports (I) External Auditors (E)			Financial Performance reports. - Trust Board Performance Management reports. - Trust Board. Internal Audit reports - Audit Committee

Corporate Objective 5 - Make the best use of resources

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
4. Controls Assurance Standards – achieve substantive compliance for standards: - **Financial Management** - **Purchasing and Supply** - **Risk:** No risk to achieving substantive compliance.	Southern Trust process for management of self assessment and verification of compliance with standards. Internal Audit assessment and verification of level of compliance with controls assurance.	Self assessment against controls standards.(I) Internal Audit assessment and verification of level of compliance with standards (I)			Controls Assurance report to Governance Committee & Trust Board (annually). Internal Audit verification reports to Audit Committee (annually)
5. Standing Financial instructions.	Standing orders. Standing Financial Instructions and scheme of delegation. Authorisation framework for expenditure. Budgetary controls processes. Instances of non compliance or waiving brought to the attention of Audit committee.	Internal Audit Reports (E) External Audit reports (E) Review of annual accounts. (E)			Internal Audit Reports on financial processes to Audit Committee. External Auditors Management Letter to Audit committee and Trust Board Final Accounts - to Audit Committee and Trust Board annually.

Corporate Objective 5 - Make the best use of resources

(b) Stewardship and Value for Money

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
Risk: Investment decisions not informed by proper business cases and robust approval mechanisms.	Proportionate business cases are required for approval by SMT and where appropriate by Trust Board.	Trust Board (I) DHSSPS (E) HSCB (E)			
Risk: Insufficient scrutiny of existing spend to ensure that expected activity/outputs/ outcomes are delivered.	Internal performance indicators. Commissioner scrutiny. Internal and External inspections.	HSCB (E) PHA (E)			
Risk: Insufficient productivity and other performance indicators.	Reference unit costs produced annually and benchmarked against others. CHKS benchmarking data.	DHSSPS (E) HSCB (E) PHA (E)			
Risk: Expenditure not spent on the purposes for which it was committed.	System of internal control. Production of annual audited accounts.	Internal Audit (E) External Audit (E) DHSSPS (E)			

Corporate Objective 6 - Be a good social partner within our local communities.

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
1. PSA and Ministerial Targets **Risk:** None at April 09		Performance Management Framework(I)			Performance Management Reports (Trust Board) Performance reports weekly to SMT
2. Trust Strategic Priorities.	Action plan to enhance user and public involvement within the Trust.	Report of Consultation on the Draft Action Plan Framework to enhance Personal and Public Involvement within Southern HSC Trust. (I)	Variability across Trust in the level of involvement of service users, carers and public in planning and development of local solutions to improve health and social wellbeing. Variability in arrangements for communication with service users and local communities with regard to changes in service provision.	Development of Southern Trust Strategy for user and community engagement. Development of capacity for user and community engagement. Communication strategy – service users and community engagement.	
Risk: None at April 09	Performance Monitoring arrangements. Picker Survey	Southern Area wraparound stakeholder forum.(E) Southern Council (E) Local politicians (E) Media (E) Picker survey report. (E)	Patient and Client Experience Committee	Patient and Client experience committee to be established June 09.	

Corporate Objective 6 - Be a good social partner within our local communities.

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
2. Trust Strategic Priorities (contd) **Risk:** Inadequate funding to implement Environmental Strategy.	Environmental strategy and action plan 2009-11	ARENA environmental review and benchmark survey (E)		Action plan with limited funding allocation from CRL for 2009/10	

Corporate Objective 6 - Be a good social partner within our local communities.

Risk Area and principal risks.	Existing Controls	Assurances - Internal (I) and External (E)	Gaps in controls and Assurances	Action	Reporting Arrangements
2. Controls Assurance Standards: **-** Buildings, Land, Plant and Non medical equipment. - Emergency planning - Environmental Cleanliness - Environmental Management - Fleet and Transport Management - Health and Safety -Security Management - Waste Management	Southern Trust process for management of self assessment and verification of compliance with controls assurance standards.				