Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
T: 02890 251005 | E: info@usi.org.uk | W: www.urologyservicesinquiry.org.uk

Stephen McNally
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

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

Chair's Notice

[No 14 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: **Stephen McNally**
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 14 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 2017 until 2018.

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. The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a

substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog.

I. What is your knowledge of and what was your involvement, if any, with this plan?
II. How was it implemented, reviewed and its effectiveness assessed?
III. What was your role, if any, in that process?
IV. Did the plan achieve its aims in your view? If so, please expand stating in what way you consider these aims were achieved. If not, why do you think that was?

55. As far as you are aware, were the issues raised by the *Implementation Plan* reflected in any Trust governance documents, minutes of meetings, and/or the Risk Register? Whose role was it to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.

56. To your knowledge, were the issues noted in the *Regional Review of Urology Services, Team South Implementation Plan* resolved satisfactorily or did problems persist following the setting up of the urology unit?

57. Do you think the urology unit 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?

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

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

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

61. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?

62. 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?

63. Explain your understanding as to how the urology unit and 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.

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

65. 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.

66. 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.

67. Who was in overall charge of the day to day running of the urology unit 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 the unit and to whom that person/those persons answered.

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

69. 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 unit staff

70. Describe how you engaged with all staff within the unit. 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.

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

72. 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?

73. 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

74. 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.

75. 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.

76. 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?

77. 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

78. 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 the urology unit, 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.

79. 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.

80. 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?

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

82. 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?

83. 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 the unit, 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?

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

85. How did you ensure that you were appraised of any concerns generally within the unit?

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

87. 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.

88. What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?

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

90. 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.

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

92. 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.

93. 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 the urology unit

94. 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 Roberta Brownlee
    (iii) The Medical Director - the Inquiry understand this to have been Richard Wright;
    (iv) The Director of Acute Services – the inquiry understands this to have been Esther Gishkori;

(v) The Director of Human Resources and relevant Human Resources personnel – the inquiry understands these to have been Vivienne Toal and Siobhan Hynds

(vi) The Assistant Directors - the inquiry understands these to have been Heather Trouton and Ronan Carroll;

(vii) The Associate Medical Director - the inquiry understands these to have been Mark Haynes (Surgery) and Damian Scullion (Anaesthetics)

(viii) The Clinical Director, the inquiry understands this to have been Colin Weir, however please name any other post holders during your tenure;

(ix) The Head of Service, namely Martina Corrigan,

(x) The consultant urologists in post.

(xi) The Nurse Managers –please name any post holders during your tenure.

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.

95. 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?

96. 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.

97. 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.

98. 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?

99. 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. (Q114 will ask about any support provided to Mr. O'Brien).

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

Mr. O'Brien

101. 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)?

102. 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.

103. 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?

104. 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.

105. 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.

106. 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

107. 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.

108. 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.

109. 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?

110. 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?

111. 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?

112. 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?

113. 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?

114. 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.

115. 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.

116. Did you communicate in any way, either formally or informally, with your predecessor Chief Executive, Francis Rice, or your successor, Shane Devlin, 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

117. 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?

118. 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.

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

120. 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?

121. 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.

122. 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?

123. 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?

124. 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

USI Ref: Section 21 Notice No.14 of 2022
Date of Notice: 28 April 2022

Witness Statement of: Stephen McNally, Retired Accountant

I, Stephen McNally, 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 This statement covers my role as:

- Director of Finance from 01 March 2011 to 22 January 2017;
- Acting Chief Executive from 23 January to 9 July 2017;
- Director of Finance role between 10 July and 14 November 2017;
- Acting Chief Executive between 15 November 2017 and 17 March 2018; and
- Director of Finance to 31 March 2018;

but principally concerns my 2 short periods as Acting Chief Executive.

1.2 I retired from the Trust on 31 March 2018 and remain retired.

1.3 [redacted] Personal Information redacted by the USI .

1.4 In January of February 2016, Trust Board members had been told that there had been a problem with a consultant concerning patient records which he/ she had kept at home.

1.5 I am aware that, in December 2016, a 'Maintaining High Professional Standards' process had commenced. I was not involved at this point. I was told subsequently, and prior to taking the acting Chief Executive role, that I may have a role to play. I do not recall who told me, it was either the Interim Chief Executive, Mr Rice, or the Medical Director, Dr Wright. My impression was that my role was to be in respect of administration, signing off on process and that I would be walked through anything I was required to do.

1.6 I did not have any sense that I would be required to interview the consultant or any of his/her colleagues. I do recall the director of HR, Mrs Toal, brought me through the MHPS framework and related Trust Guidelines. I did not have any prior experience of this type of investigation.

1.7 The matter was reported to a confidential meeting of the Trust Board on 27 January 2017. Members were told that a consultant urologist had been excluded from the workplace in December 2016, had now returned and was working under supervision and control and an investigation was underway.

1.8 I had been told that there was a possibility that patient harm (possibly in the form of them not being seen as early as ought to have been the case) may have resulted from the consultant's handling of patient records. I had been told that a risk assessment had been carried out and this had identified a range of controls to prevent any further difficulty.

1.9 I do recall that the case investigator role had passed to a different consultant at some point during the investigation.

1.10 I knew that there was an ongoing look back exercise and a number of serious adverse incident reviews. I knew that the investigation was still open during my second period of cover as Acting Chief Executive. This is the full extent of my actual memory of this investigation.

1.11 I do not have any memory of undertaking any part of the investigation or asking others to do this on my behalf. It may be that I should have been more proactive and made enquiries about progress and outcomes. I have no memory that I did. I accept that, as Acting Chief Executive, ultimate responsibility for the matter rested with me whilst I held that role.

1.12 By way of background to my role as Acting Chief Executive, I was aware that the role of Chief Executive had been covered by three individuals, each on an interim basis, that it had been advertised but not filled, and that it was to go back to advert. Mr Rice, the then Interim Chief, did say he would apply but had to take sick leave. The Chair of the Trust agreed with the Department of Health (DOH) that the advert would be held until his return. The Chair put out a trawl for applications for an Acting Chief Executive role. I did not apply but was subsequently asked to take on the role. I understood this to be caretaking while a valued colleague was ill. I was advised that the period of cover was expected to be 16 weeks.

1.13 I had no expectation that I would be required to carry out any critical appraisal of systems, policies and procedures of clinical governance, board assurance, incident handling, complaints management and/or lesson review. I expect that the time required to do a review of this magnitude would be greatly in excess of the 16 week period during which I was expected to act as Chief Executive.

1.14 Unfortunately Mr Rice required a longer period of leave than had been anticipated and I actually ended up covering 22 weeks.

1.15 I was again asked to cover the role for a period of 6 weeks while the newly appointed Chief Executive, Mr Devlin, worked a reduced period of notice with the Ambulance Service. This was extended several times. I ceased providing cover on 19 March 2017.

1.16 The Trust has provided me with the following:-

a. 17 emails which mention Mr O'Brien or other non-connected governance matters and the minutes of each Trust Board and Governance Committee between January 2017 and March 2018, the

minutes of a Trust Board meeting on 30 September 2010 and another Trust Board meeting on 24 November 2010.

b. The minutes of Senior Management Team meetings for all of 2017 and the first three months of 2018.
c. The minutes of in-year monitoring meetings with the Acute Services senior team in 2017.
d. The minutes of Medical Staff meetings between 15 November 2017 and 19 March 2018.
e. The Maintaining High Professional Standards Formal Investigation, Case Manager Determination. This was produced by Dr Khan in 2018 after the date of my retirement.
f. Investigation Report Under the High Professional Standards Framework, Mr Aidan O'Brien Consultant Urologist. This was produced by Dr Khan subsequent to the date of my retirement.

1.17 These documents are the only records that indicate, or might have indicated, my knowledge or involvement in the investigation.

1.18 The following summarises the references to urology in these documents. They are in date order.

- 30 September 2010 - Trust Board - Dr Rankin outlined the clinical issues in urology services as detailed in her briefing note and the actions being taken in relation to IV fluids and Antibiotics, Cystectomies and the Regional Urology Review. *Relevant document can be located at Relevant to CX Chair's Office/Evidence after 4 Nov 21 CX Chair/ref no 35/20100930 Confidential TBoard Clinical Issues in Urology Service 09.2010*
-

- 25 November 2010 - Trust Board - Clinical Issues in Urology Briefing note updating on IV fluids and Antibiotics, Cystectomies and the Regional Review of Urology. *Relevant document can be located at*

Relevant to CX Chair's Office/Evidence after 4 Nov 21 CX Chair/ref no 35/20101125 Confidential TBoard Update on Urology issues

-

- 29 January 2015 - Trust Board - Mrs McAlinden (chief executive) provided the context around the NHSCT Urology service and the recent media coverage. She informed members of a commissioner led discussion which had taken place at a regional level to agree what the other urology networks could undertake to address the NHSCT gap. She advised that there was a proposal that the Southern Trust would accept referrals from Cookstown, which Mrs Burns had not accepted and set out reasons for this. She advised that Mrs Clarke and Mrs Burns subsequently met with the HSCB and it was agreed that the Trust would provide limited support, but only on a temporary basis to March 2015.
- The emails concern an enquiry by a MLA about waiting times.
- 27 January 2017 - Trust Board - Mrs Toal (HR Director) advised that, under the Maintaining High Professional Standards framework, there is a requirement to report to Trust Board any medical staff who have been excluded from practice. She reported that one consultant urologist was immediately excluded from practice from 30th December 2016 for a 4 week period. Mrs Toal reported that the immediate exclusion had now been lifted and the consultant is able to return to work with a number of controls in place.

  Dr Wright explained the investigation process. He stated that Dr Khan has been appointed s the case manager and Mr Weir, case investigator. Mr J Wilkinson is the nominated Non-executive Director. Dr Wright confirmed that an early alert had been forwarded to the Department and the GMC and NCAS have also been advised.'

1.19 At this point, my understanding was that the difficulty was in urology, an unnamed consultant had been excluded but was now back in the workplace and working under supervision; external bodies had been

informed; and an investigation was to be carried out by clinical colleagues. I understood that I might be asked to consider and sign documents at some stage in the process.

1.20 There was no further mention of this matter in any meeting of the Trust Board or the Governance Committee during my tenure.

1.21 Clearly, as the investigation had commenced it would be expected to have reached a conclusion over this amount of time. It is also clear that the staff conducting the investigation would have reported their findings to a range of officers including the Chief Executive.

1.22 I am reasonably certain that I never received correspondence sent to me or given into my office regarding the investigation. On reflection, I acknowledge that I should maybe have made enquiries as to the progress of this matter and asked whether my input was necessary. As mentioned already, I did know that there was an ongoing look-back exercise and preparations were being made for serious adverse incident reviews and I think I also knew that the case investigator role had passed to a different colleague. I believe that I thought that these factors explained why the investigation and MHPS process were likely to take quite a long time.

1.23 At the time of Mr Rice's return in July 2017, I did not think it odd that the process had not been completed. As indicated in the previous paragraph, I had thought that these matters could well take a long time and I knew that it was difficult to free up clinical colleague time to review each patient's position. I accept that this was quite a passive position on my part and I acknowledge that I could have taken a more proactive approach to understand the position fully before returning to my Director of Finance role.

1.24 At the end of my first period of cover for Mr Rice on 9 July 2017 I had no expectation that I would ever hold the Chief Executive role again, particularly given that I was due to retire 8 months after that. Upon returning to my normal role, the detail of this MHPS matter quickly left my mind as I became reacquainted with the many issues concerning my substantive post as Director of Finance.

1.25 I do not remember any discussion about it with Mr Rice on his return in July 2017 or at the point of his retirement in November 2017. I am only aware that the matter had not been resolved thereafter because I had not seen any report to the Governance Committee or the Trust Board about it. I believe that I assumed, again without question, that this was a complex process which dated back to 2010 or earlier. I thought that it could well take a long time to conclude.

1.26 In March 2018 I did not list this issue in my handover paper to Mr Devlin, I believe, because I had not been involved with it at any time during my second period covering the role of Chief Executive. I anticipated that Mr Devlin would receive a report about it in due course.

[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 do not have any documents relating to my employment with the Trust. I retired on 31 March 2018 and handed in any papers I had for disposal.

[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.

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

4.1 I am a retired member of the Chartered Institute of Public Finance and Accountancy. I trained as an accountant in local government in England prior to taking up a post of Director of Finance in the Armagh and Dungannon Trust in 1996.

[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.

5.1 My posts with the Trust were as follows:

- Assistant Director of Finance-Costing 01 April 2008 to 28 February 2011. *Relevant document can be located at S21 No 14 of 2022/ S.McNally – JD PS – AD Finance.*
- Director of Finance and Procurement 10 July 2011 to 22 January 2017. *Relevant document can be located at S21 No 14 of 2022, Director of FP 2010.Stephen McNally*
- Acting Chief Executive 23 January 2017 to 09 July 2017. I am unable to locate the exact job description for this post but would accept this

similar version sets out my understanding of the Chief Executive's role and responsibilities. *Relevant document can be located at S21 14 of 2022 Attachments, Chief Executive JD September 2017.*

- Director of Finance and Procurement 10 July to November 2017. *Relevant document can be located at S21 No 14 of 2022, Director of FP 2010.Stephen McNally(A1)*
- Acting Chief Executive 15 November 2017 to 17 March 2018. I am unable to locate the exact job description for this post but would accept this similar version sets out my understanding of the Chief Executive's role and responsibilities. *Relevant document can be located at S21 14 of 2022 Attachments, Chief Executive JD September 2017 (A1).*
- Director of Finance and Procurement March 2018. *Relevant document can be located at S21 No 14 of 2022, Director of FP 2010.Stephen McNally(A2)*

5.2 My job descriptions are attached. They are an accurate outline of my duties.

[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 The Assistant Director of Finance reported to the Director. The Director reported to the Chief Executive. The Chief Executive reported to the Chair, Trust Board and Permanent Secretary. The finance posts had line management responsibility for finance staff. The Chief Executive post managed the Directors.

[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 As Acting Chief Executive I had an overall responsibility for the operation and governance of all services. I exercised this general responsibility through delegation to service directors as supported by the Director of Finance, the Director of Human Resources and the Director of Planning.

[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 The director of acute services along with the appropriate assistant director and head of service was responsible for the operation of effective systems of governance within urology services. The medical director, the assistant medical director, the assistant director of clinical governance and clinical director were responsible for ensuring that such systems supported clinical staff in exercising their professional obligations to their patients. The service director and the medical director reported to the chief executive.

8.2 The chief executive did not manage staff other than the directors and his office staff, the board assurance manager and the communications team. Management relied on clear lines of reporting as supported by standing orders, the scheme of delegation and a range of governance systems which were regularly audited or reviewed. My understanding was that governance was a personal responsibility falling on each doctor, nurse or other health professional. The role of the chief executive/ organisation was to provide them with the framework and support to carry out all of the activities that they needed to ensure that their practice was safe, up to date and in line with professional and other regulations. That support included the assistance with

peer review, clinical audit, mentoring, training and education and a mechanism for appraisal and revalidation.

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 Some of the Directors and Chief Executive were accommodated on the same floor and operated a full and complete open door approach in order to support each other and run the organisation. Other Directors were a short distance away.

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

I would only have engaged with individual clinical staff on an issue by issue basis.

For example, I met with Dr Khan and Mr Hayes individually and together in 2018 on an issue involving accommodation within the newly completed paediatric unit at Craigavon Area Hospital. This was still in discussion at the date of my retirement. I also met with a consultant and her union representative in relation to a concern she had resulting from being scheduled to cover two sites at the same time. This was resolved within her clinical team.

[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 2017 until 2018.

11.1 The senior management team, including the chief executive and all directors, had a weekly meeting which usually lasted for two hours. There were also in-year monitoring meetings with each directorate team which also lasted one hour. I have

examined the minutes of these meetings held during my tenure. The only reference to urology services is during the in-year monitoring meeting with the acute directorate; reference is made to the waiting list position across all specialties including urology. Reference is also made to the on-going look-back exercise and the preparations for serious adverse incident reviews. I would have met all directors on numerous occasions for informal conversation; minutes were not taken but I do not have any memory of discussing urology in general or the investigation into Mr O'Brien during any of these conversations

[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 operated an extensive and multi strand approach to all aspects of governance. A board assurance report was provided twice a year. The basics of the governance arrangements included:-

-Standing orders, a scheme of delegation and standing financial instructions;
-A register of interests;
-The DOH governance self assessment process;
-Audit report to those charged with governance;
-Audit committee;
-Governance committee;
-Endowment and gifts committee;
-Patient and client experience committee;
-Remuneration committee.

12.2 Each committee reviewed, scrutinised and challenged the information they received in order that it could assure the Board that processes were delivering outcomes to the required standards.

12.3 The governance committee was the overarching committee responsible for providing assurance to the Board on all aspects of governance. The remit of the committee was to ensure that:-

-there are effective and regularly reviewed structures in place to support the effective implementation and continued development of integrated governance across the Trust;
-there is an assessment of assurance systems for effective risk management which identify, evaluate and respond to risks and that responses are effective;
-any significant gaps in controls and assurances and major risks are escalated to the Trust Board;
- any recommendations, remedial actions and system failings are reported to Trust Board;
- independent and objective assurance is sought.

12.4 The committee covered:-

-Clinical and social care governance systems with regular reports on incidents, complaints and patient safety issues;
-Risk assessment and risk management systems;
-Health and safety;
-Medicines management with regular reports from the Director of Pharmacy;
-Information and governance systems;
-Litigation systems;
-National Audit outcomes;
-Whistle-blowing process.

12.5 The committee also reviewed the findings of other significant assurance functions. This included reviews by the Department of Health, the Health and Social

Care Board, the Regulation and Quality Improvement Authority, and professional bodies such as the Royal Colleges. The Regional Morbidity and Mortality System had been updated to encourage group learning. The Trust carried out the first internal audit of clinical audit in NI during 2017.

12.6 While there were always recommendations for improvement I do not recall any significant concern about clinical governance systems or that any aspect of control could not be relied upon.

12.7 The Trust adopted a risk management strategy in 2014, *Relevant document can be located at Ongoing Discovery May 2022/Document Number 2 iii a/201809 Risk Management Strategy* to ensure that the Trust uses a systematic and consistent approach to risk management. Risk registers are developed at departmental, divisional, directorate and corporate level and seek to capture all clinical, operational and financial risk. Risks are identified through reports from external bodies such as RQIA, Accreditation bodies, independent reviews, complaints, incidents, litigation, staff turnover, self assessments and monitoring reports. All risks are graded in accordance with a risk matrix and entered on the appropriate register. The senior management team review the corporate risk register every 6 weeks. All staff are responsible for managing risks within the scope of their roles. There are structured processes in place for incident reporting and investigation. There is an organisational forum which shares learning throughout the organisation. The register was revised in 2017 in the light of good practice from other organisations and comments from the non-executive directors.

12.8 The Board Assurance Framework is integral to governance arrangements. It sets out the relationship between objectives, potential risks to achievement, and the key controls through which these risks are managed and controlled. It sits alongside the corporate risk register, the 22 control assurance standards and performance reporting to provide an assurance about how effectively risks are managed. Independent assurance comes from Internal Audit, RQIA, Benchmarking, GMC, NIMDTA, Royal Colleges and other professional sources. In 2017/18 the Trust participated in a number of work streams with the DOH, HSCB and RQIA to

strengthen and improve investigation and reporting of incidents with a view to maximise learning, highlight risk and improve patient safety.

12.9 I never received a report which indicated that any aspect of this assurance framework could not be relied upon to give adequate assurance.

[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 The Director of Planning, Performance and Reform provided a benchmarking report to Trust Board setting out comparisons of performance and some patient safety data. The Trust received a presentation at each meeting from staff working across the service setting out their experiences of managing their area of service including improvements and challenges. The Director of Planning and Medical Director reports were the main source of information in respect of unsatisfactory performance or outcomes. There was no performance management committee. The reports to Trust Board were extensive and they were, in my experience, subjected to significant challenge on the information provided and recommendations made. All board members participated actively in all such discussions and when necessary these challenges were then followed up at subsequent meetings. The minutes of Trust Board meetings throughout 2017 demonstrate significant challenge on the issues of emergency department overnight cover and breast cancer services.

[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 was taken through the Maintaining High Professional Standards Framework in January 2017 by the HR director, Mrs Toal. I do not recall receiving any other

training in clinical governance or patient care while acting chief executive or at time as director of finance.

[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 relied on the Medical and other care providing Directors, as well as the systems of tracking the receipt and dissemination of such information, to ensure that the governance committee and Trust Board were aware of all new or amended advice and had received assurance that this was appropriately distributed.

[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 The governance committee was the appropriate place for detailed discussion on such matters. The committee chair subsequently advised Trust Board. I did not change any system or procedure during my periods of tenure. I relied on the systems already in existence and the Board Assurance Framework outlined in my response to question 12 to ensure that all systems, including those charged with learning, operated as intended.

16.2 The only reference to urology was at the confidential meeting of the Trust Board on 27 January 2017.

16.3 At its meeting on 11 October 2017 (at which time Mr Rice was interim chief executive) the senior management team approved a proposal to establish a Trust Lessons Learned Forum in order to ensure that there was a

robust system in place to respond appropriately when things go wrong and ensure that the Trust can continually improve the safety of services.

[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 No; it was not a requirement that I undertook professional development. It was initially anticipated that I would hold the Chief Executive role for around 16 weeks only.

[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 Yes; chief executives met on a regular basis and the sharing of information and experiences was encouraged.

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

19.1 I considered the risk management process to be working as intended and cannot recall any report which suggested that it could not be relied upon.

19.2 The corporate risk register, *Relevant document can be located at* Relevant to CX Chair's Office/reference no 2c/20170907 Integrated Governance Framework 2017_21 was discussed at the governance committee meeting on 07 September 2017 (when Mr Rice was interim chief executive). The report contained information on:-

- Corporate Control;
- Safety and Quality;
- Finance;
- Operational Performance.

19.3 All risks were assessed in terms of the probability that the risk would arise and the potential impact on the provision of service.

[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 Board was proud of the Trust's approach to learning and improvement. I would doubt that any staff felt that they would not be supported in reporting and investigating incidents.

[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 Board encouraged reflective learning and had many events to celebrate improvement including an annual quality and service improvement award event when staff teams were praised for their work in transforming and improving services. There was a Safety, Quality and Experience celebration event held on 13 June 2017. As set out in my response to question 12, all systems of assurance were subject to periodic review. I did not change any of these assurance systems. I relied on these systems to give the Board assurance that reflective learning was used to inform all aspects of Trust business. I did not receive any indication, while in post, that these systems could not be relied upon.

[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 My response to question 12 sets out the processes used by the Trust to obtain assurance on the efficacy of systems and their operation. Every system was subject to ongoing improvement and any shortcomings in execution were identified through audit and review. Trust Board continually sought out and applauded excellence. The Director of Planning, Performance and Reform had a team of staff dedicated to continuous improvement. I was in the CEO post for only two short periods of time and had no ambition to alter systems and procedures that were subject to testing and review that had not identified any significant shortcoming during my tenure. The Trust employed some 11,000 staff. Each member of staff had a role in quality and safety monitoring. I did not have any conversation with any clinical staff on these matters outside of the Trust Board processes outlined earlier.

[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 In relation to my periods as acting Chief Executive, this would have been a very small percentage if talking about general issues. The senior management team and Trust Board always had information and reports which encompassed aspects of clinical governance and the management of these took up significant periods of time.

The most frequent were matters of waiting lists and waiting times and cancelled operations arising from the need to
secure bed capacity for emergency admissions. I cannot put a figure on the time spent and, while it was significant, it was probably not more than a small percentage of weekly hours (in a 55-60 hour working week). All specialties were discussed at these meetings including urology. None of these meetings considered issues arising from the investigation of Mr O'Brien with the exception of the confidential Trust Board meeting on 27 January 2017 advising members that an investigation had commenced.

[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 My most significant conversation on a clinical governance issue was with the medical director concerning emergency service overnight cover at Daisy Hill Hospital. Dr Wright spoke to me about these matters and then confirmed his advice in writing.

24.2 At a senior management team meeting on 17 May 2017 I reminded colleagues that any correspondence received from staff raising concerns in respect to safety issues must be set in context and brought to the chief executive's attention.

24.3 I do not recall any discussion with any colleague, formal or otherwise, about the concerns subject to the investigation with the exception of the look-back exercise referenced above.

[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 relied upon the process outlined in my response to question 12 to provide assurance that staff were aware of what was expected of them and that they used the appropriate procedures in their day to day work. As with all other systems our periodic reviews identified deficiencies and made recommendations for remedial action and improvement. During my two brief periods as Acting Chief Executive I had no information to suggest that any system could not be relied upon.

[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 I did not escalate issues about the urology service. This happened prior to my tenure.

The issue which I did escalate was the concern about the on-going provision of overnight emergency services at Daisy Hill Hospital. As outlined above, the medical director advised me of his concerns in a face to face conversation and then confirmed his concern in writing. I immediately alerted the chair and the chair alerted board members. An extraordinary Trust Board meeting was called and the Board asked me to escalate the matter to the DOH and HSCB. Work began immediately to secure contingency arrangements at Craigavon Area Hospital and The HSCB commenced a process of seeking to secure consultant and other medical cover. A

summit was hosted by the DOH in April 2017 and a pathfinder project established to find an enduring solution. A way forward had been agreed at the date of my retirement.

26.2 I was satisfied that this matter had been appropriately escalated through the organisation. I did not take any steps to change the established procedures.

[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 reported to Trust Board and would have regular formal and informal meetings with the Chair and other non-executive Board members. The Trust did not distinguish between Board Directors and Service Directors and engagement with officers involved the full team unless a matter was specific to one Directorate.

[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 It was my understanding that each doctor, nurse and any other health professional was responsible for the patients he/ she treated. The trust through its operational directors had a responsibility to put in place systems and procedures to monitor and test that services were achieving standards and quality of care outcomes. The medical director, the executive director of nursing, and the executive director for social work were responsible for the mechanisms which supported staff to test and prove that their practice was safe, up to date and achieving desired outcomes in line with peers. The Medical Director had overall responsibility for medical staff governance. The executive director of nursing had responsibility for nurses, midwives and allied health professional governance. The executive director for social work had responsibility for social worker governance.

28.2 The Board Assurance Manager was Mrs Sandra Judt. She was primarily responsible for the production of the mid-year and year-end Board Assurance Report and the coordination of evidence to support the 22 control assurance standards mentioned in my response to Question 1.

28.3 The Governance Committee of the Board had overarching responsibility for providing assurance to the Board on all aspects of governance and it regularly considered the effectiveness of the Trust's governance arrangements. It was comprised of Non-Executive Directors who were independent of Trust management. It met 4 times in 2017/18. The Committee Chair reported to the Trust Board meeting following the governance meeting.

[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 alerted the Chair who then alerted Board members. I had reminded colleagues that all concerns of patient safety had to be set in context and brought to the Chief Executive's attention. The process was that issues be confirmed in writing. I thought the process was good enough and I did not seek to change any system during my period of tenure.

[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 The biggest area of clinical concern was the ongoing provision of emergency services. This issue was beyond the Trust's ability to effectively manage and was immediately notified to the DOH and HSCB in March 2017. The issue was the significant and persistent shortage of consultant cover for overnight services at Daisy Hill Hospital. The Trust had exhausted all avenues of recruitment. The matter was beyond the Trust's ability to secure an enduring solution. A pathfinder project was established and a solution secured at the point of my retirement.

30.2 Another significant issue was the provision of breast cancer services, again a problem in recruiting consultants. The matter was also escalated to the HSCB and DOH and a regional support system put in place.

[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 did not engage in any program with a view to improve any aspect of clinical governance or clinical risk management during my tenure as acting chief executive. As mentioned above, I expected to hold this post for 16 weeks only.

31.2 However, I do recall one potentially relevant issue under this broad heading: a consultant colleague, Dr Donal Duffin, raised a concern with the chair of the Governance Committee that he and some colleagues felt that their assessment of any risk that they entered on the risk register was being down-graded by administrative staff. I asked the HSC Leadership Centre to carry out an independent review of Dr Duffin's concerns. Their report was not considered to be sufficiently probing and the Governance Committee commissioned a second investigation which completed after the date of my retirement. I do not believe that the matter was connected to urology.

[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 The Board spent a high percentage of its time on care and patient safety issues and always followed up the implementation of actions until complete. There was a specific section on each agenda for this. There was also a section of the agenda set aside for service improvement and learning. Concerns from any report were always carried forward to subsequent meetings and remained on the agenda until resolved. The Governance Committee was responsible for assuring the Board on all aspects of governance. It met 4 times during 2017/18 and its meetings were around 2 hours long. The Committee Chair then reported to 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 Yes; the Board reacted immediately and appropriately in relation to significant concerns (namely, the DHH Emergency Department and breast cancer services, as mentioned elsewhere in this statement) as they arose and released staff and resources to address concerns.

[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 No, I have no knowledge of, or personal experience of, matters regarding clinical governance and patient safety not having been dealt with properly by the Trust and/or Trust Board.

35. [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 largest challenge is to identify key issues and understand their role in any incident. Staff cannot be appraised until the clarity of the learning has been obtained. In my view, issues are rarely the result of one single factor and a lot of time and effort needs to be directed at identifying interconnections. Sometimes it can be difficult to fully identify and explain how any one action fits into an overall issue. I believe that there were regular events which were organised by clinical governance coordinators, both within and between directorates, which all staff were encouraged to attend. These were aimed at securing learning from recent incidents, complaints, patient safety reports, new or amended standards, regional and national reports and other reviews. I do not have any recollection of examples of where improvements have been put in place beyond the examples on emergency and breast cancer services referenced above. I do not know of any presentations on reflective learning.

[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 Yes; a good example of this is the Trust Board following up on the learning from the 'Hyponatraemia Inquiry' while I held the post. I think everyone involved viewed this as essential. Lessons were shared between Trusts and within professions. This was a clear example on an issue impacting on multiple organisations and the Inquiry report provided a basis for all involved to fully understand what the shortcomings and failings were and what actions would be necessary to prevent similar problems in the future. The Inquiry resulted in the Regional Morbidity and Mortality review system which encourages staff to learn as a team. The Trust developed a process to implement the 96 recommendations. This was still in progress when I retired. It was clearly practicable that such lessons were learned and shared.

[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 Risk was reviewed on a regular basis with an emphasis on mitigation and management. The Trust faced a growing population and ever-increasing range of interventions across the full range of health and social care. It also operated in a severely constrained financial environment. There were severe shortages of clinical and all other staff. In terms of risk 'appetite', my opinion is that the Trust set out to maximise service but not beyond the point that service became unsafe. This required having systems of alert which operated in a timely manner to indicate that a point of risk was approaching. Risk was reviewed on a regular basis with the emphasis on mitigation, management and escalation to the most appropriate level of the organisation in the shortest period of time. Risk was also viewed in the total HSC family context and took account of the ability of the NI system to work as one when necessary. The corporate risk register was considered as part of the board

assurance programme . The register contained quality, safety, performance and finance. All risks were assessed for probability and impact and mitigations identified.

[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 The Trust Board received an assurance at mid-year and year end (copies attached) *relevant document can be located at S21 No 14 of 2022, 20171026 SHSCT Mid-year Assurance Statement* in relation to the effectiveness of the systems and procedures deployed to secure good governance. The Board Assurance Framework was informed by information gathered from internal and external sources and supported by policies and processes to track compulsory and voluntary education and training. This process covered all professions. The medical director provided a report on medical staffing, the executive director of nursing provided a report on these staff and the executive director for social work outlined issues for that profession. The medical director also reported on the arrangements for an annual national, regional and local work programme aimed at improving clinical services. I do not recall the process for managers, technicians and allied health professionals. I relied on the existing systems and procedures and the mid-year and year-end Board Assurance Framework to provide assurance on these and all other matters of governance. I did not seek to change any of these systems and was not aware of any report that the systems could not be relied upon to provide adequate assurance.

[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 At the Trust board meeting on 27 June 2017 the medical director reported on medical appraisal and revalidation. He advised that the Trust performed strongly and

99% of 2015 appraisals had been completed. He advised that the revalidation cycle was nearly complete and had gone well. He advised that 17 mentors had been trained and that all new permanent staff had to avail of mentor support. Internal Audit had completed a report (which I believe was their first one) on clinical audit in which their emphasis was more financial than clinical. They advised that the system of governance, risk and management was inadequate in respect of job planning, management of working hours and payments for additional work. The Medical Director created a task and finish group to implement the recommendations. I believe that this was complete at the date of my retirement. I did not have any concerns about clinical appraisal during my 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?

40.1 Budgets were based on historical allocations from commissioning bodies. It was excepted practice that the HSCB would hold funds centrally for any new risks. There was no discussion internally in relation to budget allocation and prioritisation of risk.

I was content that the HSCB mechanism had operated for many years and was the accepted process to bid for additional allocation to cover newly emerging risk.

[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 The minutes or notes of any meeting I attended which included a discussion on urology are set out in my response to question 1 above and are

in date order. None of these name Mr O'Brien in the context of a problem or an investigation. The report to confidential Trust Board on 27 January 2017 outlines the investigation in urology.

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

42.1 Yes; I believe that it did so operate.

[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 I have no memory of the Board discussions on the urology matters raised in September and November 2010.

43.2 The report to the Board on 27 January 2017 provided information that an investigation was underway. I suspect that members viewed this as being for information. I do not think, based on my experience, that the Board would shy away from any patient safety issue. Meetings were always open and transparent and members always asked probing questions.

43.3 The emergency service issue at Daisy Hill was exhaustively discussed at Trust Board over many months, the Chair opened the meeting to elected representatives and members asked challenging questions in relation to the suggested way forward. Their focus was to understand the issue and find an enduring solution. I believe staff felt supported. In my experience the Board had an 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?

44.1 It was anticipated that I would hold this role for around 16 weeks only so the normal process of annual appraisal was not utilised. I did meet the Chair regularly to discuss how I was getting on. I don't think she considered this an appraisal. I did not.

[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 Annual budgets were set on historical spending patterns and covered operational expenditure. The HSCB 'rules' were that Trusts could not hold funding in excess of that needed to run services on a day to day basis. The HSCB held contingency funds for the system as a whole. Funding for new risk had to be requested by way of a business case. The exception to this was that services would generate 'slippage' funding as a result of vacant posts. Directors were able to direct 'slippage' to areas of emerging risk pending a bid to the HSCB. The lack of resources to cover risk was recorded on the Directorate Risk Register and escalated to the Corporate Risk Register as necessary. The southern population was growing at a faster rate than others and this also created risk. The HSCB accommodated population shift by prioritising funding to those areas experiencing growth. The process was known as capitation. Capitation funding came with strict commissioner expectations as to its 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.

46.1 Directors would always seek additional funding. As outlined above, such funding was held by the HSCB and not the Trust. Every request for such funding was written up in the format required by the HSCB and submitted for consideration. Bids were made for waiting list initiatives in every speciality during the course of my tenure and additional funding was secured and allocated directly to the director. A bid for overall demand pressures in acute services was also submitted to the HSCB in 2017 and additional funding secured and allocated to the director.

[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 Directors always had the ability to request additional funding for a range of issues.

47.2 Most issues involved risk, for example, the lack of available staff to cover increased demand. As set out above, directors had the opportunity to bid to use 'slippage' funding to secure temporary solutions pending bids to the HSCB. Bids were made on a continual basis across the year and funding was provided for a range of issues including waiting list management and service provision challenges. I do not believe the system was different prior to my 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?

48.1 The bidding process for funding, held by the HSCB, applied to all Trusts. I am not aware that any other Trust operated a different system of securing additional funding to cover new risk.

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

49.1 I did not alter the budget allocation process. It was an historical process that had allocated scarce funding to new pressures and risks in an equitable way across the region. I do not believe that any other Trust had any other means of securing additional allocations over and above their historical position as uplifted for inflation. I believe that many would have preferred a three year allocation with the ability to create surplus funds which could then be carried forward and accumulated over time. Such funds might have allowed a greater prioritisation of risk in budget allocation.

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 I was an assistant director of finance in 2009 and became director in 2011. My role was the negotiation of funding with the HSCB in order to fund operational budgets . I had no role in the operation, staffing or management of the unit in the Southern Trust area.

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

51.1 The HSCB set contractual targets for numbers and waiting times for treatment in all services and these were regularly reviewed. I do not know what, if any, different indicators were used in urology 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?

52.1 The director of acute services was responsible for disseminating information to consultants and staff. I have no memory of ever receiving the Integrated Elective Access Protocol.

[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 I have no knowledge of how this protocol impacted on urology. I do not know how the director of acute services monitored time limits and I am not aware of the action taken if time limits were not met.

[54] The implementation plan, Regional Review of Urology Services, Team South Implementation Plan, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog.

I. What is your knowledge of and what was your involvement, if any, with this plan?
II. How was it implemented, reviewed and its effectiveness assessed?
III. What was your role, if any, in that process?
IV. Did the plan achieve its aims in your view? If so, please expand stating in what way you consider these aims were achieved. If not, why do you think that was?

54.1 I was director of finance in 2010. I did not have a role in the implementation, review or assessment of this plan. I do not know if it achieved its aims.

[55] As far as you are aware, were the issues raised by the Implementation Plan reflected in any Trust governance documents, minutes of meetings, and/or the Risk Register? Whose role was it to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.

55.1 I have set out, in my response to question 1, the minutes from board meetings on 30 September 2010 *relevant document can be located at Relevant to CX Chair's Office/Evidence after 4 Nov 21 CX Chair/ref no 35/20100930 Confidential TBoard Clinical Issues in Urology Service 09.2010* and 25 November 2010 *relevant document can be located at Relevant to CX Chair's Office/Evidence after 4 Nov 21 CX Chair/ref no 35/20101125 Confidential TBoard Update on Urology issues* which

highlight the papers (copies attached) presented to the board. This is the only information I received as director of finance. I did not have a role in this process. The matter would have been progressed by the then director of acute services, Dr Rankin.

[56] To your knowledge, were the issues noted in the Regional Review of Urology Services, Team South Implementation Plan resolved satisfactorily or did problems persist following the setting up of the urology unit?

56.1 I am not aware of the issues or whether they persisted following the setting up of the urology unit. I do not know if matters were resolved satisfactorily.

[57] Do you think the urology unit 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?

57.1 I do not recall anyone raising resource issues specific to urology services. However, I can say that every service provided by the Trust was challenged by limited resources, increasing demand and shortages of all types of staff, particularly medical and nursing staff, but there were issues with allied health professionals and social workers as well.

57.2 Directors were able to use 'slippage' funding (resulting from an inability to recruit) to address concerns pending funding bids to the HSCB. Slippage was used by most directors to fund temporary appointments.

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

I was not aware of any staffing issues specific to urology during my periods as Acting Chief Executive but was aware that most services were challenged by a national shortage in nursing, medical and most other health and social care professions. This was not a funding problem but one of staff availability.

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

59.1 I was not aware at the time that individual posts remained vacant within urology or in any other service. I did know that vacant posts had a very significant impact on all services. I was aware that staffing shortages persisted in every aspect of the service and all services, including urology faced significant challenges in treating patients within prescribed time limits. These difficulties were the non-availability of staff rather than the non-availability of funding. I would expect the director to manage these difficulties or escalate and maximise the potential to use non-recurring funding pending the outcome of a bid to the HSCB. In cases of severe shortage, the issues were usually escalated to a regional level in an effort to use any capacity that may exist elsewhere. I am not aware that this was utilised during my period of tenure.

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

60.1 I was aware of vacancies persisting across the Trust generally but I was not aware of what the situation in urology was. The many challenges of staff shortage were managed by each director. There were persistent recruitment problems in respect of doctors, nurses, allied health professionals and others. These vacant posts made the provision of service in line with commissioner intent on numbers and timescale very difficult and all directors had to balance risk and maximise the provision of treatment.

[61] Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?

61.1 I am not aware of any staffing changes in urology.

[62] 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?

62.1 No; my role did not change during my tenure as Acting Chief Executive.

[63] Explain your understanding as to how the urology unit and 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.

63.1 The Director of Acute Services and her management team were responsible for balancing the many competing demands between divisions and departments. I cannot provide any detail on the support provided by non-medical staff.

[64] Do you know if there was an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants? How was the administrative workload monitored

64.1 My understanding is that there was a mix of practice across the Trust generally. In some cases staff worked in teams and in other cases staff worked with a particular consultant. I do not know what practice was used in urology. The head of service

would be expected to review workload relative to staffing and adjust as funding allowed.

[65] 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.

65.1 I was not aware of concerns about administrative staff in urology. I am not aware that such concerns were raised with others. I was aware that staff vacancies persisted in all aspects of Trust service. A business case seeking funding for the impact of increased demand on acute services in general was submitted to the HSCB in 2017. *Relevant document can be located at S21 No 14 of 2022 Attachments, Acute Consultant Physician Posts IPT 2017_18 Demography.*

[66] 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.

No; I do not recall any administrative staff raising concerns directly with me.

[67] Who was in overall charge of the day to day running of the urology unit 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 the unit and to whom that person/those persons answered.

67.1 The Director of acute services, assistant directors and heads of service had operational charge of all acute services including the day to day running of the urology unit. The head of service reported to the assistant director. The assistant director reported to the director. The director reported to the chief executive.

[68] What, if any role did you have in staff performance reviews?

68.1 I had no role in respect of these reviews during my 2 short periods as Acting Chief Executive. As outlined above, my role as Acting Chief Executive was expected to last 16 weeks only.

[69] 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.

69.1 No; I was expected to hold this role for 16 weeks and I did not carry out a review of individual staff.

<u>Engagement with unit staff</u>

[70] Describe how you engaged with all staff within the unit. 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.

70.1 I had no involvement with staff in the unit

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

71.1 I did not have any daily, weekly or monthly scheduled meetings with urology staff.

[72] 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?

72.1 I did not have any informal meetings with urology staff or management.

[73] 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.

73.1 I do not know how well medical staff and operational managers in urology worked together.

Complaints

[74] 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.

74.1 I understood that complaints were managed in line with the regional 'Policy for the management of HSC complaints *relevant document can be located at Relevant to CSCG, reference no 2c, 20210212_Policy for the Management of HSC Complaints 2019*. The aim was to ensure that issues were addressed quickly and as close to the source as possible and then use learning for improvement. The process was managed by the assistant director of clinical and social care governance. A computerised data base (Datix) was used to manage the process.

My only direct involvement during my tenure was when a number of patients rang me to complain about the cancellation of their operations. I sought to reassure them that they would be rescheduled as quickly as possible. All advised that they did not wish to make a formal complaint.

In line with requirements, all complaints were acknowledged in 2 working days and reported on within 20 working days. The appropriate director investigated the matter and provided a response. Assistance was available from the RQIA and Patient Council to anyone wishing to make a complaint.

[75] 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.

75.1 The service director provided and maintained the policies and procedures for the operation of clinical governance. The medical director and the executive director for nursing and midwifery were responsible for the oversight of the clinical practice of staff and ensuring they were aware and responded to their individual responsibility to their patients by undertaking a programme of audit, training, awareness of standards

and guidelines and submitting for revalidation. I did not have a direct involvement in this process. My involvement in governance issues was as Chief Executive, as set out in answer to Question 12 above. I understood that clinical governance concerns were escalated through the organisation using the established processes and via the management structure.

[76] 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?

76.1 I thought that the relative responsibility for different aspects of governance was clearly allocated. I did not have cause to question this. In my understanding the medical director and the executive director for nursing oversaw the professional elements of governance. The service directors operated the control systems, policies and procedures. Individuals had their own professional responsibility. I was not aware of significant issues of demarcation within the senior management team and had no cause to seek improvement.

76.2 As outlined in my answer to Question 75, I think the different emphasis on individuals' roles was clear. My response to Question 12 outlines the substantial body of policies and procedures which set out such roles and responsibilities.

[77] 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?

77.1 I did not change any system or seek any improvement during my short periods of tenure. The complaints and whistle blowing processes were subject to periodic review. The HSC whistle-blowing framework, *relevant document can be located at Relevant to HR, reference no 2i, 20180401 Ref 2i - Regional Your Right to Raise a Concern Policy and Procedure,* was discussed by the senior management team in on 8 November 2017 and then incorporated into Trust policy.

77.2 I had no information to suggest that the complaints or whistle-blowing process could not be relied upon. I never experienced any staff, patient or others raise concerns about how effective the procedures were.

Governance – generally

[78] 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 the urology unit, 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.

78.1 I refer to my response to Question 12 setting out the governance processes and the roles of all involved in it.

78.2 It is my understanding that the service director was responsible to the chief executive for the provision of all and any systems of control necessary for the delivery of Trust services, including clinical governance. All staff had an individual, personal responsibility to operate within these systems and to follow policies and procedures. Clinical practice within a division was the responsibility of the clinical director supported by the medical director and covering the clinical competence of staff. All staff had a responsibility to escalate as appropriate. The aim would be to

resolve matters as quickly as possible and as close to the source as possible. The chief executive would take advice from the medical director, the HR director and the service director to secure an immediate response to a patient safety issue and return the service to a stable, safe and enduring basis of operation. The chief executive informed the chair and the chair would alert the board members. The chief executive would alert the HSCB and DOH if appropriate. I was not involved in the process in relation to urology.

[79] 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.

79.1 My understanding was that the service director provided the policies and procedures and the medical director and executive director for nursing were responsible for ensuring that each doctor and nurse carried out their professional obligations for clinical governance.

79.2 The Board Assurance Framework, as set out in my response to question 12, provided assurance that the policies and procedures existed, all staff were aware of them and aware of their obligations.

79.3 For example:-

- The executive director for nursing advised Trust Board on 30 March 2017 *relevant document can be located at S21 No 14 of 2022 Attachments, 20170330 Confidential Minutes* that the Trust continued to support pre-registration staff in order to ensure a workforce fit for purpose and with the appropriate level of knowledge and skills.

- The assistant medical director advised the board on 25 May 2017 *relevant document can be located at S21 No 14 of 2022 Attachments,20170525 Confidential Minutes* about a visit from the General Medical Council as part of its national review

of medical education and training. He assured members that areas for improvement were being implemented.

- The executive director for nursing advised on key risks in the NMC revalidation process and supervision rates at the board meeting on 08 June 2017 *relevant document can be located at S21 No 14 of 2022 Attachments, 20170608 Confidential Minutes*.

- The medical director provided an update on research and development to the board meeting on 31 August 2017 *relevant document can be located at S21 No 14 of 2022 Attachments,20170831 Confidential Minutes*. He also provided the annual report on medical appraisal and revalidation and gave assurance that consultants, SAS doctors and long term locums continue to meet the requirements of medical appraisal and revalidation as per General Medical Council requirements.

- The executive director of nursing, on 28 September 2017 *relevant document can be located at S21 No 14 of 2022 Attachments, 20170928 Confidential Minutes*, told members of the development of a Trust Nursing Quality Indicator Framework. She advised that a review is completed at the end of every audit and immediate learning is shared with clinical leads.

- The medical director presented the National Audit Assurance Report *relevant document can be located at Ongoing Discovery March 2022/MDO/Document No 2y/20171207_National Audit Assurance Report 2016-2017, 20171207 National Audit Assurance Report,* to the governance committee on 7 December 2017, and talked about the audits that the Trust was participating in. He drew attention to areas requiring improvement such as stroke services.

- A clinical governance report was provided to the governance committee on 2 February 2017 *relevant document can be located at Relevant to CX Chair's Office/ reference no 2k/ 20170202 Approved Governance Committee Minutes 2nd February 2017* which gave an overview of trends in adverse incidents and information on patient safety initiatives and linkages to the Regional safety forum and the use of an early indicator scoring system.

- The medical director provided assurance on safe and high quality care to the board on 25 January 2018 *relevant document can be located at S21 No 14 of 2022 Attachments, 20180125 Confidential Minutes with item 9 redacted.* He advised that 97% of medical appraisals had been completed. He advised of the roll out of the assistant medical director and clinical director programme to all consultant and SAS doctors. He also reported on medical leadership and development events with input from the General Medical Council.

[80] 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?

80.1 The Director of Acute Services was responsible for the provision of the service and its quality.

80.2 The Board Assurance Framework provided Trust Board with assurance that the systems in place to oversee quality in any Trust service were working as intended.

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

81.1 The Director of Planning, Performance and Reform reported on national benchmarking data. The Director of Acute Services was responsible for the delivery of service in accordance with contractual objectives set by commissioning colleagues in HSCB and local commissioning. The director of acute services was responsible for the delivery of services in accordance with contractual objectives set by the HSCB.

[82] 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?

82.1 The Board Assurance Framework, as described in my answer to question 12, provided assurances in relation to the management of risk and safety across all Trust services.

[83] 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 the unit, 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?

83.1 As outlined in my response to question 12, there were procedures for the escalation of any matter through the line of management. In addition, anyone from within or outside the organisation could ring the chief executive. I reminded colleagues on 17 May 2017 that all concerns should be set in context and brought to my attention. The management framework provided mechanisms for handling concerns from any source. I had no information that these systems were not working adequately. Each director had a duty to escalate as soon as it was apparent that the matter could not be dealt with within the directorate.

[84] Did those systems or processes change over time? If so, how, by whom and why?

84.1 There were no changes during my tenure.

[85] How did you ensure that you were appraised of any concerns generally within the unit?

85.1 The Trust is a very large and complex organisation. The system of control and feedback integral to the assurance framework tests that there is a robust and periodically tested process for bringing concerns to the appropriate level of the organisation. I was not aware of any report advising that systems could not be relied upon.

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

86.1 The control and assurance processes are designed to test that all systems of control are adequate. I was not aware of any system having been judged as unreliable or not fit for purpose.

[87] 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.

87.1 The most significant issues arising in my tenure were the overnight provision of emergency services at Daisy Hill Hospital, challenges in relation to waiting time breaches, and challenges in respect to breast cancer services. All were escalated to me and I advised Trust Board and HSCB/DOH. The progress in resolving these matters is recorded in Trust Board minutes and in the directorate/ corporate risk registers. I did not have any concerns that issues were not being identified or escalated. I was not aware that others had concerns.

[88] What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?

88.1 The Trust deployed standard patient information systems as used in the other Trusts.

I do not recall the details of this system

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

89.1 I am not aware of any significant problem with such systems and do not recall any change during my tenure.

[90] 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.

90.1 As mentioned at Question 39, I was aware that an internal audit report identified problems with job planning and that the medical director put a task and finish group in place to rectify the problem. I believe this was successful. Otherwise, the director was able to provide positive assurance on appraisal and revalidation. I was not aware that there was a problem with performance objectives in urology. I was not aware of the performance objectives relevant to urology and do not have any documentation. The Trust would hold all such information.

[91] How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?

The medical director achieved a high level of success in completing the appraisal and revalidation process during 2017/18.

[92] 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.

92.1 The Trust deployed standard Trust wide policy, procedures and systems for handling governance and other concerns. These policies, procedures and systems detail the mechanisms for recording, investigating, monitoring and reporting. These systems enable concerns of any nature to be escalated through the management structure to chief executive, chair and HSCB/DOH. The Trust's Guidelines for Handling Concerns about Doctors' and Dentists' Performance of 23 September 2010 detail the process specific to medical staff. I did not personally know the many personnel involved in this process during my tenure. The assistant director for clinical governance, Mrs Marshall, had responsibility for the maintenance of these systems. The medical director, Dr Wright, and the HR director, Mrs Toal, would be involved in matters of concern falling under the Maintaining High Professional Standards Framework. The Trust would hold information on the names of the governance coordinator in acute services at that time as well as the names of the associate director, the clinical director and the head of service.

92.2 I was aware that a consultant urologist had been excluded from the workplace in December 2016, and had then been allowed to return to work under supervision

and control. I was aware that an investigation, including a look-back exercise, was still ongoing over the course of my tenure.

92.3 I do not have any memory of any other significant issues arising in urology during my tenure which were additional to this matter.

[93] 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.

93.1 Yes; I felt all of my colleagues were supportive. For example, my colleagues knew that I had little experience of clinical issues and always took the time to make sure that I understood such matters as they arose.

<u>Concerns regarding the urology unit</u>

[94] 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 Roberta Brownlee

(iii) The Medical Director - the Inquiry understand this to have been Richard Wright;

(iv) The Director of Acute Services – the inquiry understands this to have been Esther Gishkori;

(v) The Director of Human Resources and relevant Human Resources personnel – the inquiry understands these to have been Vivienne Toal and Siobhan Hynds

(vi) The Assistant Directors - the inquiry understands these to have been Heather Trouton and Ronan Carroll;

(vii) The Associate Medical Director - the inquiry understands these to have been Mark Haynes (Surgery) and Damian Scullion (Anaesthetics)

(viii) The Clinical Director, the inquiry understands this to have been Colin Weir, however please name any other post holders during your tenure;

(ix) The Head of Service, namely Martina Corrigan,

(x) The consultant urologists in post.

(xi) The Nurse Managers –please name any post holders during your tenure.

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.

94.1 My liaison and meetings with these bodies or individuals can be summarised as follows:

(i) I attended every meeting of the Trust Board during 2017 and up to 31 March 2018 in my role as Director of Finance or my role as Acting Chief Executive.

(ii) I had an extensive involvement with Mrs Brownlee, Trust Chair, and attended many events to celebrate achievement with her. I never had a discussion, formal or otherwise on urology.

(iii) I had extensive contact with Dr Wright, mostly formal. As mentioned elsewhere in this statement, he and I worked together to resolve an issue with emergency services at Daisy Hill Hospital. This took up large amounts of time in 2017/18. I believe Dr Wright provided a briefing on the urology investigation (as set out in my response to question 1) in January 2010.

(iv) I had frequent contact with Mrs Gishkori. The look-back exercise and the waiting list problems referenced in my response to Question 1 were discussed during in-year monitoring meetings with the acute management team.

(v) I had frequent contact with Mrs Toal, HR director. I remember that she provided some training to me on the MHPS framework. I did not have much contact with Mrs Hynds and never discussed urology with her.

(vi) I had occasional contact with Mr Carroll, Assistant Director. This was mostly in the in-year monitoring meetings when the look-back and waiting lists were discussed. I do recall that he once challenged me about why a skilled doctor was sitting doing nothing when patients were having operations cancelled. I told him that I wasn't aware that I was stopping anyone from working and he should contact the appropriate Associated Medical Director. This was an informal exchange. I do not know the date. I don't recall that he named Mr O'Brien but I assume now that this is who he was talking about. I had occasional contact with Mrs Trouton, Assistant Director. Again, this was at in-year monitoring and the look-back and the waiting lists were discussed.

(vii) I met Mark Haynes a few times to discuss paediatric surgery. I met Damien Scullion once at an event.

(viii) I met Colin Weir once at an event.

(ix) to (xi) I never met the Head of Service, the Consultant Urologists (other than Mr Haynes as above) or the Nurse Manager.

94.2 My very limited engagement with some of the above bodies or persons in respect of any matters of concern regarding urology governance (where not addressed at all or in detail in the previous paragraph) is set out in my response to Question 1 and I would therefore refer the Inquiry to that answer as well.

[95] 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?

95.1 I understood that urology was supposed to operate in exactly the same way as other specialities. That is, in accordance with professional best practice and established Trust procedures. I was not aware of any divergence during my period of tenure other than the issue with one consultant mentioned at Question 1 and the issue of waiting lists (also mentioned above at Questions 11 and 23 and at Question 96 below).

[96] 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.

96.1 I, in common with all Trust Board members, was aware from performance reports that waiting list management was a challenge for urology due to a shortage of staff but the position had been stable for a number of months. My understanding did not change over time.

[97] 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:

97.1 As outlined in my response to question 94, the events leading to the investigation arose prior to my period of tenure.

(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.

97.2 The Aidan O'Brien Issue - As outlined in my response to questions 1 and 94, the events leading to the investigation arose prior to my period of tenure. As at 27 January 2017, I was aware that a consultant had been excluded, allowed to return and was working under control and supervision while an investigation took place. A risk assessment had been carried out and the controls were aimed at mitigating any further potential for patient harm. I subsequently became aware of a look-back

exercise which confirmed that some patients had suffered actual harm and preparations for serious adverse incident reviews were in progress. I did not take any steps to seek positive assurance but would have expected the director of acute services to report any breakdown. As mentioned earlier, ,my tenure was expected to be 16 weeks. I therefore had no expectation that I would undertake any review of the Trust's assurance system. I did not put any performance indicators in place to measure success. I understood that the consultant was working under supervision and applying professional practice and adhering to Trust established procedures in relation to record keeping.

97.3 The Waiting List Issue – The Director of Performance reports repeatedly noted waiting time breaches in a number of specialties. Urology was one of the most challenged services due to a shortage of consultants. My involvement and/or awareness of the Trust's responses to this issue during my tenure is addressed at various points above including at Questions 11, 23, 46, 47, 87, and 94 above.

[98] 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?

98.1 No one raised any fresh concerns with me about urology during my period of tenure. I was satisfied that the concerns raised prior to my period of tenure were properly risk assessed and the appropriate controls in place.

[99] 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. (Q114 will ask about any support provided to Mr. O'Brien).

99.1 I was not asked to provide any support to urology staff and I did not engage with other Trust staff.

[100] Was the urology department offered any support for quality improvement initiatives during your tenure?

100.1 I did not offer urology any support for quality improvement during my tenure and I am not aware that others did.

Mr. O'Brien

[101] 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)?

101. I never had any contact with Mr O'Brien during my tenure. My role would not have an expectation of any daily, weekly or monthly contact.

[102] 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.

102.1 I had no role in the formulation and agreement of Mr O'Brien's job plan

[103] 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?

103.1 My first exposure to this matter was in January 2017 (as set out at Question 1). I knew the matter involved the mismanagement of patient records and there was a possibility of resulting patient harm. As the look-back exercise progressed it was confirmed that there was actual harm to a number of patients. I did not know then but do know now that that the matter was known to managers in earlier years. At the point I became involved the consultant was, I understood, being monitored and working to the standard practice.

[104] 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.

104. I did not have any discussions about Mr O'Brien. I understood that the medical director and the HR director had such discussions. I also assume that Dr Weir and Dr Khan had been involved. My involvement is as set out at Question 1.

[105] 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.

105.1 I was not involved in agreeing the actions discussed with Mr O'Brien. I took it that these had been judged sufficient and robust enough to allow his return to work.

[106] 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

106.1 At the time this went to Trust Board in January 2017, I was aware that a consultant had been excluded, allowed to return and was working under control and supervision. I was aware that potential harm had been identified, a risk assessment had been carried out, and a range of controls put in place. I was not involved in the risk assessment. I believe this was done by the medical director and senior clinical colleagues.

[107] 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.

107.1 I did not come to an agreement with Mr O'Brien on the way forward. I understood that he agreed to strictly adhere to established practice on patient record management and was working under control and supervision. I believe the agreement was put in place prior to my period of tenure.

[108] 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.

108.1 To the best of my knowledge and recollection, I never spoke to Mr O'Brien formally or otherwise.

[109] 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?

109.1 I do not know what metrics were used. I understood the essence of the problem was his departure from established patient record management procedures. I understood that the risk was mitigated when he modified his practice and adopted the same practice as his consultant colleagues. I do not recall any concern being raised about his actual clinical skills and thought that he had returned to the workplace with an expectation that he would treat patients.

[110] 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?

110.1 I had no information that the controls were not robust or comprehensive or not working as intended. I understood the agreement was that he worked to professional standards and that he was doing so. I understood that he was working under control and supervision. I do not know what method of review was used or against what standards were methods assessed.

[111] 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?

111.1 I do not recall being told that the agreements and systems were not working. I understood that the problem was mitigated by a commitment to work to professional practice and standards and that this, under control and supervision, was being adhered to.

[112] 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?

112.1 Mr O'Brien did not raise any concerns with me.

[113] 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?

113.1 I did not raise any concerns about the conduct or performance of Mr O'Brien.

[114] 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.

114.1 I was not involved in supplying support to Mr O'Brien

[115] 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.

115.1 Based on my limited involvement in Aidan O'Brien matters, the only documents I am aware of reflecting these issues are those referred to in my response to Question 1.

[116] Did you communicate in any way, either formally or informally, with your predecessor Chief Executive, Francis Rice, or your successor, Shane Devlin, 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.

116.1 Save in one respect (mentioned in the following paragraph), I did not communicate in any way, formally or informally, with either Mr Rice or Mr Devlin in relation to any issues of concern regarding urology services, such as patient safety, clinical risk or governance issues. The matters resulting in the investigation were raised while Mr Rice was interim chief executive. I expected that he knew as much as I did about the matter. The investigation had not concluded at the date of Mr Devlin's arrival and I thought he would be given the investigation's results when they became available. I acknowledge that I nonetheless should have included this in my handover list to Mr Devlin but I did not. It was not something upon which I was working at the time of the handover and, as stated above, I thought it would in due course be drawn to his attention when the MHPS process was complete.

116.2 I have an incomplete recollection of Mr Rice mentioning something to me shortly before he went off and I started my first spell as Acting Chief Executive. However, I cannot recall the detail of it. As indicated at paragraph 1.5 above, it may be that this was in the context of Mr Rice advising me that I would likely become involved as Chief Executive in the MHPS investigation of which I had been aware in December 2016.

Learning

[117] 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?

117.1 At the close of my first period of cover I was aware that 4 patients had confirmed cancers and a further 6 patients required further review. I knew arrangements were in hand for serious adverse incident reviews. I had no experience of these investigations and thought that the look-back exercise took a lot of time because of the number of cases and the lack of skilled resource to carry out the review. I was not surprised that it took a long time. I was aware that the matter was first raised in the early months of 2016.

117.2 I had not been informed of any new instances of poor record keeping during my period of tenure.

117.3 I do not believe that I was concerned that the matter may still have been in progress when I commenced my second period of cover (and I do not recall seeking any information regarding it during that second period acting as Chief Executive). I recognise, therefore, that I did not actively manage the process during my second short spell covering the Chief Executive role.

[118] 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.

118.1 I have now been given a copy of the case investigator report and the case manager's report which detail the adverse outcomes to patients. The papers also give a much more detailed description of the patient record problems, most notably

the lack of triage, which were the cause of patient harm. I understand that, had these problems been addressed much earlier, patient harm may have been avoided.

118.1 The opportunity for earlier intervention arose prior to my tenure and would not have come to my attention.

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

119.1 I think Dr Khan is correct when he says that staff sought to work around rather than confront Mr O'Brien's clear departure from established procedure. I suspect staff felt this appropriate but did not take the opportunity to reflect and risk assess the back-up arrangement put in place. Decisions are taken in a very challenging and very fast moving work environment. No member of staff sets out to create a risk to patient safety.

[120] 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?

121.1 I think the lesson is that departure from established practice cannot be allowed or accommodated. Such departure creates its own set of risks. If Mr O'Brien was unwilling or unable to change his working practices, then he should have been subject to a conduct review and withdrawn from direct patient contact. Patient safety is the prime concern.

[121] 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.

121.1 I do not think staff knew there was a problem and made a deliberate decision not to engage. Rather, the issue was how they engaged. If the matter had been addressed head on and insisted that Mr O'Brien followed the correct practice then the adverse outcome may have been avoided.

[122] 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?

122.2 The matters arose prior to my period of tenure. Nonetheless, I accept that I did not proactively manage the investigation during my tenure.

[123] 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?

123.1 The paper description of the governance arrangements would indicate a robust system and, with knowledge of this, I was not concerned at the time and did not raise any concerns. I now believe that practice did not live up to the theory / system on paper? The system clearly depended on the people within it and it seems that concerns regarding Mr O'Brien ought to have been escalated and addressed more formally at an earlier stage. I can understand that there may have been some reticence in this regard, given that Mr O'Brien was a senior and highly respected colleague.

[124] 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?

124.1 I do not believe that I have any additional information which would be relevant to the Inquiry.

Signed: _____ Stephen McNally_____

Date: _____14th June 2022._____

S21 14 of 2022

Witness statement of: Mr Stephen McNally

Table of Attachments

Attachment	Document Name
1	*S.McNally – JD PS – AD Finance*
2	*Director of FP 2010.Stephen McNally*
3	*Chief Executive JD September 2017.*
4	20171026 SHSCT Mid-year Assurance Statement
5	Acute Consultant Physician Posts IPT 2017_18 Demography
6	20170330 Confidential Minutes
7	20170525 Confidential Minutes
8	20170608 Confidential Minutes
9	20170831 Confidential Minutes
10	20170928 Confidential Minutes
11	291890125 Confidential Minutes

Southern Health and Social Care Trust
Assistant Director of Finance – Resource Utilisation/Costing/Performance Management Band 8c

Job Description

JOB SUMMARY

The jobholder will be responsible to the Director of Finance for the development and delivery of costing strategies, the implementation of payment by results and submission of all reference cost and Strategic Resource Framework (SRF) information. He/She will lead on the development of trading accounts for programmes of care and for specialties / divisions. He/She will be responsible for developing a framework for business cases and their financial evaluation, for monitoring financial performance management, efficiency savings programmes (cash and non-cash), capital investment strategy, PPP / PFI partnerships, VfM and benchmarking. The jobholder will influence strategic decision making throughout the Trust through the provision of resource utilisation and performance management advice and support to Directors, Senior Managers and Budget Managers. The jobholder will deputise for the Director of Finance across a range of responsibilities as and when required.

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

KEY RESULT AREAS

Payment by Results, Costing and Capacity Planning

- lead on the implementation of payment by results (PbR) for the Trust, support the Director of Finance in agreeing the annual service and budget agreements (SABA) with commissioners.
- lead on the ongoing management of the tariff system for the Trust, and provide advice on managing the impact of the tariff and on the service changes required.
- lead on the development of costing methodologies and / or the robust implementation of regional methodologies to ensure that all relevant costs are accurately reflected in reference costs, e.g. HRGs and CSIs.
- lead on the production of TFRs, SRF and annual reference costs information ensuring ownership by senior operational managers and clinicians. Establish reasons and understanding in areas where the Trust

performance is considered adverse and work with clinical and other staff to improve performance where costs are above regional averages.

- lead on any financial modelling required for capacity planning exercises.

Capital Investment

- calculate capital charges for inclusion in the Trust's annual accounts.
- be responsible for all capital accounting entries and journals.
- lead on the development of the Trust's capital investment strategy including the acquisition and use of funds.
- lead on the development of public/private partnerships and other funding arrangements.
- lead on the production of business cases.
- lead on the production of capital and revenue costings and be responsible for the accuracy of the financial analysis. This includes the preparation of recognised investment appraisal techniques to improve decision making and ensure that developments can withstand robust financial scrutiny.
- monitor overall spend against CRL.
- ensure that the Trust complies with the requirements of the DHSSPSNI's Capital Accounting Manual.
- maintain the Trust's capital asset register on a timely basis and reconcile regularly.

Financial and Non Financial Performance Management

- lead on the development of financial and non-financial performance indicators (e.g. length of stay) to identify areas where the use of resources can be improved. Work with the programme of care accountants, operational managers and clinicians to improve productivity and demonstrate the impact of this on financial performance.

Efficiency and Value for Money

- lead on efficiency and VfM for the Trust. This principally will be concerned with matching the individual and non-clinical services with the income the Trust receives and advising on the optimal configuration of these services to ensure best value without compromising clinical performance.
- lead on the development of the Trust's overall cash and non-cash release efficiency savings programme in conjunction with directors, programme managers and the programme of care accountants.

Resource and Financial Management

- authorised signatory for expenditure up to a level determined by the Chief Executive's scheme of delegation.
- manage the costing/resource utilisation department within an agreed budget which will support the Director of Finance in delivering an overall balanced budgetary position for the finance function.
- act as signatory to the bank mandate schedule ensuring that appropriate financial controls are adhered to in the generation of cheques and automated bank payments out of the Trust's bank accounts.
- responsible for maintaining the physical assets of the costing/resource utilisation department.

Planning and Policy

- participate in and ensure compliance with the monthly reporting timetable for the finance department; liaising with other finance departments (and the shared services provider in due course) to incorporate timely feeder inputs, debtors, creditors and month-end closedown; incorporating agreed reserve closedown deadlines and divisional accountants reporting deadlines.
- implement and maintain adequate financial control systems to ensure that costing/resource utilisation/performance management staff adhere to the Trust's statutory standards, SFIs, policies and procedures. Ensure that appropriate departmental desk top procedures are in place and that they are harmonised and documented.
- interpret new guidance and ensure that systems are developed as required.
- assess and audit own work and that of the costing/resource utilisation/performance management department to further improve the quality and effectiveness of financial information.
- identify departmental or related system and procedure weaknesses and scope for improvements to enhance control and efficiency.
- be involved with the setting of policy and the strategic development of the finance department through membership of its senior management team.
- continually review working practices to ensure that the optimum use of resources is achieved. This may involve participation in multidisciplinary working groups taking a leading role when required.
- assist in the creation and maintenance of the appropriate financial culture in the Trust.

People Management

- provide clear leadership to staff within the costing/resource utilisation/performance management department and ensure it has a highly skilled, flexible and motivated workforce.

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

Information Management

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

Corporate Responsibilities

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

General Management Responsibilities

- participate in the Trust's Staff Development and Performance Review Scheme. Review individually on a regular basis the performance of immediately subordinate staff. Provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.
- ensure that the review of performance identified above is performed for all levels of staff within the Trust in accordance with the Trust Board's policy.
- maintain good staff relationships and morale amongst the staff reporting to him/her.
- where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.

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

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

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.

February 2007

Southern Health and Social Care Trust Assistant Director of Finance – Resource Utilisation, Costing and Performance Management

Personnel Specification:

Knowledge, skills and experience required:

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

- a CCAB recognised full accountancy qualification and a minimum of 3 years post qualifying experience in a senior finance role in a major complex organisation.
- delivered against challenging financial performance management programmes for a minimum of 2 years in the last 6 years meeting a range of key targets and making significant improvements.
- excellent communication and interpersonal skills with a proven track record of having worked with a diverse range of stakeholders, internal and external to the organisation, for a minimum of 2 years in the last 6 years.
- a proven track record of people management and organisational skills for a minimum of 2 years in the last 6 years.

SHORTLISTING

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

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

- Effective and strategic influencing

The following additional clarification is provided:

"senior finance role" is defined as experience gained at Director, Assistant Director or equivalent to mean reporting directly to a Director of Finance.

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

February 2007

Southern Health and Social Care Trust

APPLICANT INFORMATION PACK

DIRECTOR OF FINANCE & PROCUREMENT

CLOSING DATE FOR RECEIPT OF COMPLETED APPLICATIONS IS TUESDAY 14th DECEMBER 2010 AT 4.30PM

Southern Health and Social Care Trust

Contents

Southern Health and Social Care Trust

Dear Applicant

Thank you for your interest in the position of Director of Finance & Procurement, Southern Health & Social Care Trust. This pack is designed to provide you with information to support you in making your application for this highly challenging position.

I would encourage you to read all sections of this information pack in detail before completing your application form. In particular I would wish to highlight that the Trust will not accept CV's, letters, additional pages or any other supplementary material in place of, or in addition to completed application forms. Full details to support you in completing your application form may be seen at pages 21 – 26 of this pack. Please read this information carefully.

The Southern Health & Social Care Trust aims to deliver safe, high quality health & social care services, respecting the dignity and individuality of all those who use them. Despite the many challenges since merging the legacy Trusts we have achieved the performance targets set for us by Government due to the dedication and commitment of our staff in providing quality care and improving quality of life for people living within the Southern Trust area.

As a member of the Trust Board and the senior management team he/she will share corporate responsibility for the Governance of the Trust and compliance with legal requirements and contribute fully to the development, delivery and achievement of the Trust's corporate objectives.

For an informal discussion about this post please contact Mr Kieran Donaghy, Director of Human Resources & Organisational Development, on Personal Information redacted by the USI Personal Informatio or email to Personal Information redacted by the USI

Thank you again for your interest and we look forward to receiving your application.

Personal Information redacted by the USI

_____

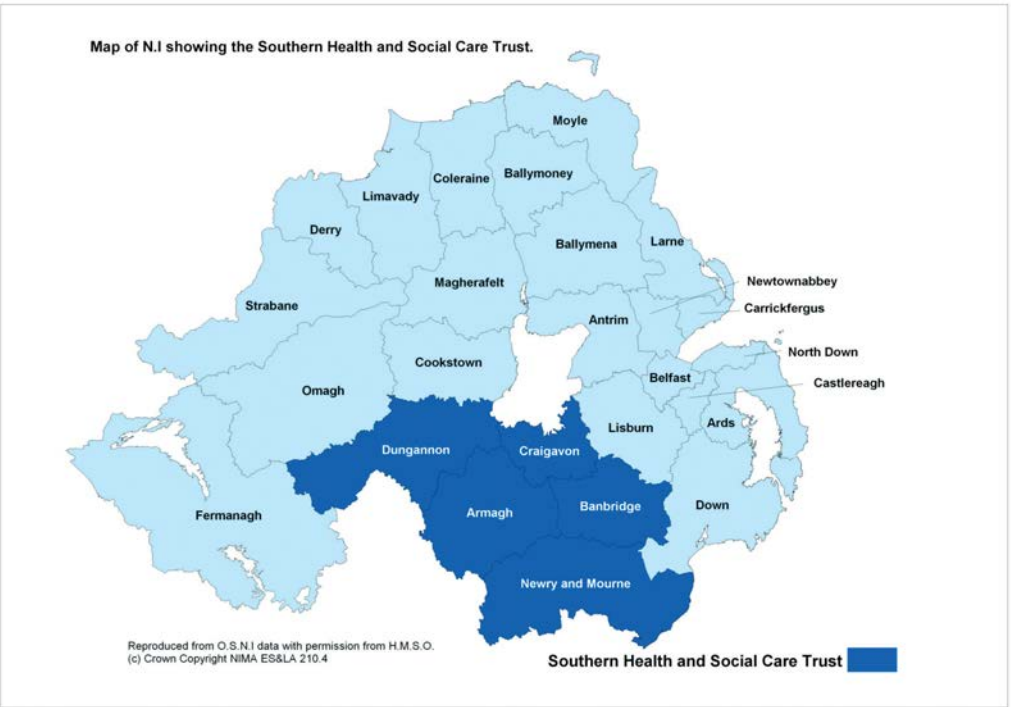
MRS MAIREAD MCALINDEN
Chief Executive

Southern Health and Social Care Trust

AN INTRODUCTION TO THE SOUTHERN HEALTH & SOCIAL CARE TRUST

The Southern Health & Social Care Trust (hereafter referred to as the Trust) was established on 1st April 2007, as part of the Review of Public Administration.

The Trust provides health and social care services to the council areas of Armagh, Banbridge, Craigavon, Dungannon, South Tyrone, Newry and Mourne. The Southern area has a population of 335,000 people.



The Trust provides a wide range of hospital, community and primary care services. Acute in-patient hospital services are located at Craigavon Area Hospital and Daisy Hill Hospital. Working in collaboration with GPs and other agencies, Trust staff provide locally based health and social care services in Trust premises, in people's own homes and in the community. The Trust purchases some services, such as domiciliary, residential and nursing care, from private and voluntary organisations.

The Trust has an income of £487 million and spends £1.3m per day delivering services to local people.

The Trust's vision is to deliver safe, high quality and responsive health and social care services, respecting the dignity and individuality of all who use them. This vision is underpinned by the Trust's values which shape what we do and how we do them. These values are:

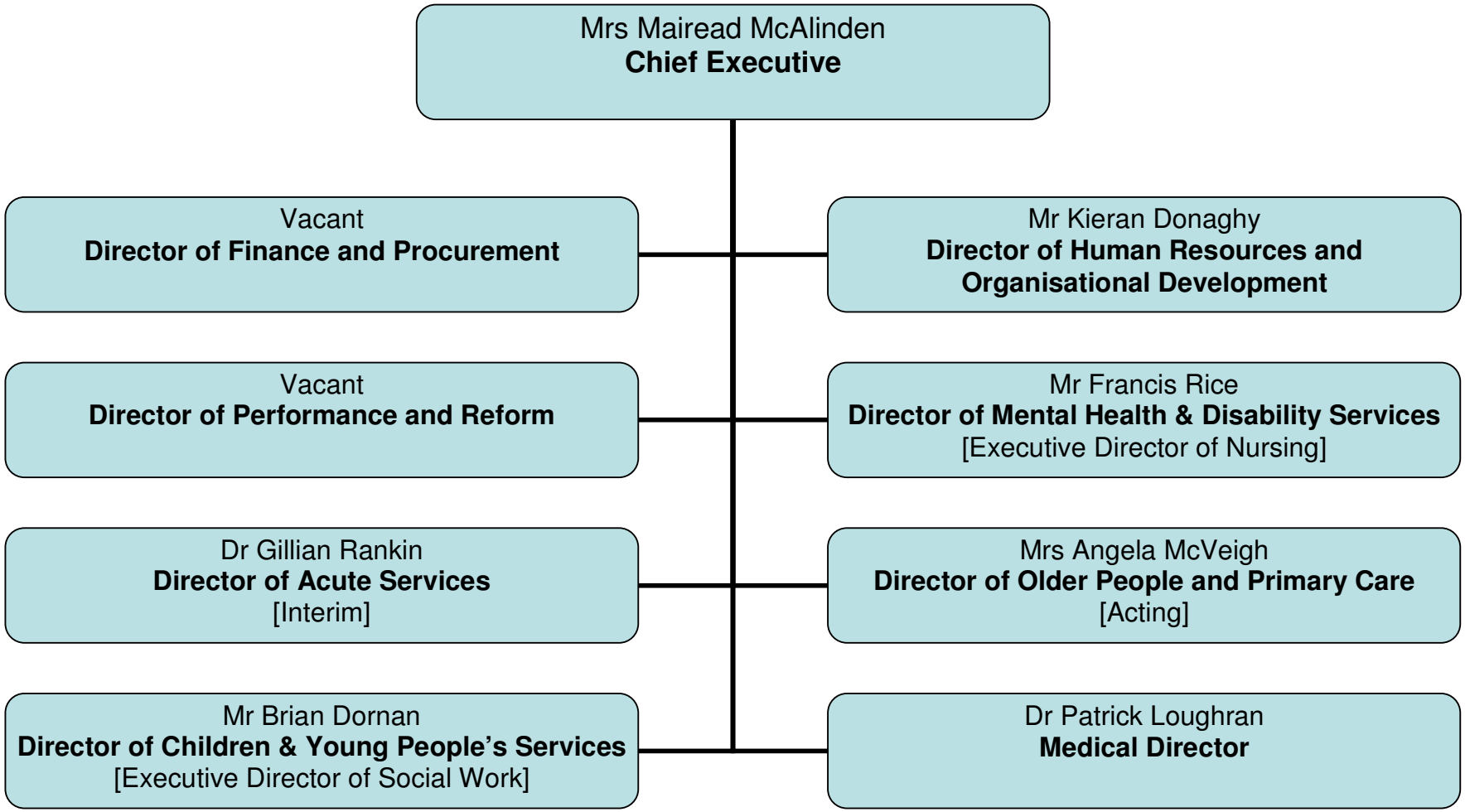
- *We will treat people fairly and with respect*
- *We will be open and honest, and act with integrity*
- *We will put our patients, clients, carers and community at the heart of all we do*
- *We will value and give recognition to staff, and support their development to improve our care*
- *We will embrace change for the better*
- *We will listen and learn.*

We want to be very clear about what is important to us as a Trust, and what we want to achieve. The Trust's priorities are:

- *Providing safe, high quality care*
- *Maximising independence and choice for our patients and clients*
- *Supporting people and communities to live healthy lives and to improve their health and wellbeing*
- *Being a great place to work, valuing our people*
- *Making best use of resources*
- *Being a good social partner within our local communities*

The SHSCT Structure is set out overleaf;

Southern Health and Social Care Trust



Southern Health and Social Care Trust

Southern Health and Social Care Trust

DIRECTOR OF FINANCE & PROCUREMENT

Salary Range £71,279 - £95,039 per annum

The Southern Health & Social Care Trust wishes to appoint a high calibre Director of Finance & Procurement to provide strong professional Financial leadership in delivering a range of hospital and community based services to a population of around 335,000 people in the Southern area.

The successful applicant will be an Executive Director and will be responsible for provision of specialist advice to the Trust Board on all financial matters, ensuring the financial plan for the provision of services fully reflects the priorities of the Trust and its expectations in terms of service delivery.

A full Job Description, Personnel Specification and associated information is available on line at www.HSCRecruit.com or by emailing recruitment.services@southerntrust.hscni.net

Application forms can be returned online through HSCRecruit or in hard copy format to Recruitment & Selection Services, Human Resources Department
The Hill Building, St Lukes Hospital site, Loughgall Road, ARMAGH, BT61 7NQ

The closing date for receipt of completed applications is Tuesday 14th December 2010 at 4.30pm

Applicants should note that it is currently anticipated interviews for shortlisted applicants will take place week commencing Monday 10th January 2011, however this may be subject to change.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Southern Health and Social Care Trust

JOB DESCRIPTION

JOB TITLE	Director of Finance & Procurement
INITIAL LOCATION	Trust Headquarters, Craigavon Area Hospital
REPORTS TO	Chief Executive
ACCOUNTABLE TO	Chief Executive

JOB SUMMARY

The Director of Finance is an Executive Director and a member of the Trust Board. The postholder will provide specialist advice to the Trust Board, Chief Executive and other Director colleagues on all financial matters. This will be in accordance with the Standing Orders and Standing Financial Instructions of the Trust and the requirements of the Health and Personal Social Services, the Health and Social Services Trust (Membership & Procedures & Regulation) (NI) 1991 Act.

He/She will be responsible for providing strong professional leadership and for ensuring the Trust's financial strategy and annual financial plan for the provision of services fully reflects the priorities of the Trust and its expectations in terms of delivery. As a member of the Trust Board and the senior management team he/she will share corporate responsibility for the Governance of the Trust and compliance with legal requirements and contribute fully to the development, delivery and achievement of the Trust's corporate objectives.

KEY RESULT AREAS

Service Delivery

1. Ensure that the statutory financial targets are met.

2. Lead the development of the Trust's financial strategy and annual financial plan for the provision of services in partnership with key stakeholders ensuring that the priorities and the expectations of the Trust's corporate plan and delivery plan are met.

3. Provide robust financial expertise to the development of the Trust's capital investment strategy including the acquisition and use of funds, the development of public / private partnerships and other funding arrangements.

4. Develop and maintain a financial performance management framework including the developing of costing systems in line with national, regional and local priorities, the production of benchmarking information and the development of targets and processes to improve performance and optimise value for money.

5. Lead the development, monitoring, measurement and reporting of key Trust financial performance management indicators. Deliver organisation financial targets with an emphasis on continuous improvement.

6. Lead the co-ordination of all procurement services across the Trust in the most cost-effective way and deliver targets through the management and leadership of the Heads of Department.

Quality

7. Ensure that the needs of patients, clients and their carers are at the core of the way that the Trust delivers services and that financial resources are effectively deployed to meet those needs.

8. Ensure that all statutory financial and integrated governance requirements are met, including the identification and management of financial risks.

9. Ensure compliance with standing financial instructions, professional standards, government accounting and treasury and departmental guidance in the use and deployment of public funds.

10. Ensure that robust financial and corporate performance management arrangements are developed and implemented.

Strategic Planning and Development

11. Lead the development of a strategic plan for the delivery of financial and procurement services in line with regional strategies, Ministerial and HSSA priorities.

12. Work closely with commissioners and relevant stakeholders to secure their commitment and involvement in the implementation of strategic planning initiatives and targets.

13. Lead the development of the Trust's procurement strategies.

Financial and Resource Management

14. Discharge all professional duties imposed on the Director of Finance by statute or the determination of the Department of Health, Social Services and Public Safety and to ensure adherence to professional accounting standards.

15. Accountable for the quality of financial services provided to the Trust both by internal departments and external services.

16. Establish collaborative relationships with external partners in the public, private and voluntary sectors to develop initiatives which will support and enable recurring investments and inter-agency working to improve performance and effectiveness of service delivery.

17. Develop and monitor financial plans and budgets to ensure that income matches expenditure and provide timely and accurate financial advice and support to allow Directors and budget holders to manage budgets successfully.

18. Provide resolved advice to Trust Board on the Trust's financial position and risk management expertise in relation to same.

19. Co-operate with and contribute to the establishment of an effective shared service framework for the delivery of appropriate financial and procurement services.

People Management

20. Provide clear and strategic leadership to staff within the directorate to ensure the Trust has a highly skilled, flexible and motivated workforce to provide high quality financial management.

21. Develop management information on staff utilisation, development and return on investment, which improve management decision making and support a rigorous continuous improvement culture.

22. Ensure that management structures and practices within the directorate support a culture of effective team working, continuous improvement and innovation.

Corporate Management

23. Contribute to the corporate decision making of the Trust Board and ensure compliance with the Trust's Standing Orders and Standing Financial Instructions.

24. Advise the Trust Board and Chief Executive on the development of the Trust's corporate investment strategy including the acquisition and use of funds and the development of public/private partnerships and other appropriate funding arrangements.

25. Contribute to the Trust's corporate planning, policy and decision making processes as a member of the senior management team and ensure the Trust's objectives and decisions are effectively communicated.

26. Develop and maintain working relationships with other director colleagues and non-executive directors to ensure achievement of Trust objectives and the effective functioning of the senior management team and Trust Board.

27. Ensure the Trust's Annual Accounts are compiled, audited and reported in accordance with the Trust's Standing Orders and Standing Financial Instructions.

28. Implement and maintain effective income and treasury management arrangements for financial assessment and charging which take account of developing case law and trust obligations to clients and carers.

29. Participate in and comply with Departmental requirements in the production of whole of government accounts.

30. Contribute to the Trust's overall corporate governance processes to ensure its compliance with public sector values and codes of conduct, operations and accountability.

31. Lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

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

HUMAN RESOURCE MANAGEMENT RESPONSIBILTIES

33. Review individually, at least annually, the performance of immediately subordinate staff, provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.

34. Maintain staff relationships and morale amongst staff.

35. Delegate appropriate responsibility and authority consistent with effective decision making, while retaining overall responsibility and accountability for results.

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

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

GENERAL REQUIREMENTS

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

39. Co-operate fully with the implementation of the Trust's Health and Safety arrangements.

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

41. All employees of the Trust are required to be conversant with the Trusts policy and procedures on records management. Trust Directors are 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.

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

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the postholder works.

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

Southern Health and Social Care Trust

PERSONNEL SPECIFICATION

JOB TITLE Director of Finance & Procurement

Ref No <>

Notes to applicants:

1. ***We will not accept CVs, letters, additional pages or any other supplementary material in place of, or in addition to completed application forms*;**

2. ***You must clearly demonstrate on your application form how you meet the required criteria. Failure to do so will result in you not being shortlisted****. Please note that whilst the Essential criteria sets out the minimum requirements it may become necessary to make this more stringent by the introduction of other job related criteria as set out in the Desirable Criteria.* ***Applicants are therefore strongly advised to clearly demonstrate how they meet each element of both the Essential AND the Desirable criteria on their application form.***

3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn*

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

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

QUALIFICATIONS / EXPERIENCE

1. Hold as a minimum a CCAB recognised full professional accountancy qualification AND have a minimum of 5 years experience in a senior financial management[1] role in a major complex organisation[2]

2. Have a minimum of 3 years' experience of delivering against challenging financial performance management programmes meeting a full range of key targets and making significant[3] improvements.

3. Have a minimum of 2 years experience working with a diverse range of both internal and external stakeholders to achieve successful outcomes.

4. Demonstrate a minimum of 2 years experience in successful Financial Control at a senior[1] level within a major complex organisation[2]

5. Hold a full current driving license valid for use in the UK and have access to a car on appointment[4]. In respect of this point the successful applicant may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere.

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

KNOWLEDGE, TRAINING & SKILLS

6. Have an ability to provide effective leadership to enable transformation of services.

7. Demonstrate evidence of high level skills in;
   (a) Effective planning and organisation
   (b) Governance and Risk Management
   (c) People Management

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

9. Demonstrate effective communication skills to meet the needs of the post in full.

DESIRABLE CRITERIA – *these will only be used where it is necessary to introduce additional job related criteria to ensure files are manageable. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted*

1) 3 years experience in a senior financial management[1] role within a health and / or social care setting.

The following further Clarification on the terms used in the Specification are provided below;

[1]'senior financial management' is defined as financial experience gained at Director, Assistant Director or equivalent in a major complex organization

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

[3]'significant' is defined as contributing directly to Key Corporate Objectives of the organisation concerned.

[4]This criterion will be waived in the case of a suitable applicant who has a disability which prohibits from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.

PLEASE NOTE:

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. It is therefore intended that shortlisted applicants will be assessed against the criteria stated in this specification, linked to the qualities set out in the NHS Leadership Qualities Framework. Whilst candidates should be prepared to provide examples of their competence against any of the leadership qualities, particular attention will be given to the following elements;

- Drive for results
- Seizing the future
- Effective and strategic influencing
- Leading Change through people
- Holding to Account
- Drive for Improvement
- Self Management

As part of the Recruitment & Selection process it will be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

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

PERFORMANCE MANAGEMENT ARRANGEMENTS

Performance in the HSCNI is managed under four main areas:

- Promoting and improving health and social well-being status which is a form of demand management for the HSC.
- The delivery of accessible, flexible and responsive services.
- Safe and effective care.
- Value for money, efficiency and productivity.

Performance management and improvement in the HSCNI includes:

- measurable objectives, standards and targets which define what the HSC has to achieve with clear lines of accountability;

- clear links between resources allocated and outcomes required, with strong commissioning arrangements;

- incentives to ensure targets are achieved;

- robust and appropriate monitoring and information systems;

- assessment, audit and reinforcement measures;

- strong financial control systems with flexibility to innovate and reform at local level

The successful postholder will be required to operate within arrangements to support the Trusts overall agenda through ongoing delivery of services against the challenging agenda set by Government and Regional Health & Social Care Bodies with whom the Trust works.

Southern Health and Social Care Trust

TERMS & CONDITIONS OF SERVICE

Hours

Full Time

Remuneration

Salary Range : £71,279 - £95,039 per annum

HSC Pension Scheme / HPSS Superannuation Scheme

Trust staff may choose to join the Health & Social Care Superannuation Scheme. Further information may be obtained from the HSC Pension Service Website at **www.hscpensions.hscni.net**

Applicants who are already members of the HPSS Superannuation Scheme may continue with their current arrangements.

Annual Leave and General Public holidays

The Trust offers excellent provision for annual leave and General Public Holidays as follows;

On appointment	27 days plus 10 public holidays
After 5 years service	29 days plus 10 public holidays
After 10 years service	33 days plus 10 public holidays

Human Resources Policies

The Trust offers a wide range of Human Resource Policies to underpin the value that is place on its staff. Further details are available on request.

Committed to Equality of Opportunity

The Trust recognises and values the diversity of its workforce and the population it serves. The Trust is committed to a working environment free from intimidation of any kind. Through a systematic and objective recruitment & selection process the Trust is committed to ensuring that appointment decisions are taken solely on the basis of merit.

Southern Health and Social Care Trust

CLOSING DATE FOR RECEIPT OF COMPLETED APPLICATIONS

The closing date for receipt of completed applications is Tuesday 14th December 2010 at 4.30pm

Applications can be submitted on line at www.HSCRecuit.com or in hard copy format to;

Recruitment & Selection Services
Human Resources Department
The Hill Building,
St Lukes Hospital site
Loughgall Road,
ARMAGH, BT61 7NQ

Please note the Trust will not accept any late, incomplete or reformatted application forms received after the closing date and time.

Applicants using Royal Mail should note that 1st class mail does not guarantee next day delivery. It is the responsibility of the applicant to ensure that sufficient postage has been paid to return the form to the address above by the stated closing date and time. Existing Health & Social Care staff should not rely on the internal postal system.

SELECTION PROCESS

In accordance with best practice all appointments within the Trust are made under the 'merit principle' where the best person for any given post is selected in fair and open competition.

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. Only those applicants who clearly demonstrate on their application form how they meet the essential criteria, and if applied, the desirable criteria, will be shortlisted for 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 Trust is under no obligation to take account of your planned holiday arrangements.

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

- Drive for results
- Seizing the future
- Effective and strategic influencing
- Leading Change through people
- Holding to Account
- Drive for Improvement
- Self Management

At this stage it is anticipated that interviews for shortlisted applicants will be scheduled during week commencing Monday 10th January 2011, however this may be subject to change.

Candidates will be contacted by telephone immediately following completion of the shortlisting to ensure those being invited to interview have as much time available for preparation as possible. Candidates are therefore asked to ensure that mobile telephone numbers are provided where possible and that in any event the contact telephone numbers stated provide for ease of contact. All such communication will be followed up in writing.

Southern Health and Social Care Trust

PRACTICAL TIPS ON COMPLETING YOUR APPLICATION

The application form is designed to ensure that applicants provide the necessary information to determine how they meet the essential criteria. Some useful tips on completing an on line application on HSCRecruit.com are given overleaf.

To Ensure Equality of Opportunity for all Applicants

- The space available on the application form is the same for all applicants and must not be altered;
- We will not accept CVs, letters, additional pages or any other supplementary material in place of, or in addition to completed application forms;
- Applicants must complete the application form on line or in either typescript font size 12, or legible block capitals using black ink;
- Applicants must not reformat electronic application forms;
- Information in support of your application will not be accepted after the closing date and time for receipt of application;
- Applications will not be examined until after the closing deadline;
- Do not use acronyms, complex technical detail etc. Write for the reader who may not know what it means. Include concise examples and be sure you can expand on these at interview;
- Complete the application form in full.
- Write down clearly your personal involvement in any experience you quote; Write "I" statements e.g. I planned meetings, I managed a budget, I prepared a presentation. It is how you actually carried out a piece of work that the panel will be interested in;
- Identify relevant examples. This is very important as the examples which you provide may be checked out at interview and you may need to be prepared to talk about these in detail if you are invited to interview. It is your unique role the panel are interested in, not that of your team or division.

- Completing the Criminal Convictions / Offences Section - Legislation requires you to tell us about any criminal convictions or offences that you may have. Within the Health and Social Care Service, criminal convictions are never regarded as spent and therefore you must tell us about all previous or pending convictions or offences, even if they happened a long time ago, this even includes motoring offences.

  The Trust is committed to the equality of opportunity for all applicants, including those with criminal convictions. Whilst the disclosure of information does not automatically debar an individual from employment, it is essential that all convictions are disclosed to allow the Trust to adequately consider their relevance to the post in question. The Trust considers that failure by an applicant to declare complete and accurate information about convictions to be a serious breach of trust.

- AccessNI Disclosure – In accordance with the requirements of the Safeguarding Vulnerable Groups (NI) Order 2007 and the successful applicant will be required to undergo an Enhanced Disclosure check before any appointment can be confirmed. Further details will be provided to the successful applicant. The Trust operates in line with the ANI Code of Practice. Further details can be obtained on request.

- Completing your current / previous Employment details please;
  - Ensure that full details are provided.
  - Be specific about all the dates that you provide, these should be stated in the following format DD/MM/YYYY.
  - Explain any gaps between periods of employment.
  - Provide a list of key duties that you have been responsible for in current post / previous posts.

Southern Health and Social Care Trust

Some Useful Tips when Completing an Online Application Available on www.HSCrecruit.com

Getting Started

- The online application can be found at: http://www.HSCRecruit.com
- Read the information provided online carefully
- If this is your first visit to HSCRecruit.com you will need to create an Account. Full details are available on the website.

Application Form

- There is no master form however when you select the post you wish to apply for you will be able to apply on line or download the application form.
- If you select the online application it will take you through a series of tabs which must be completed in full. Each of the tabs is a different section of the same form. Each tab/page MUST be completed.
- You should save your work regularly
- You do not need to complete your form at one sitting. You can save it and come back to it later.
- No one has access to your form until you submit it and apply for a job except for you.
- **Please, do not leave it until the last minute as something could happen to the internet at either end.**
- When you submit/apply for a post, sometimes the computer will 'time out' if the internet is running slow. You will need to click on the back button and try submitting again to ensure the application is received.
- Once your form has been submitted you will receive an email confirmation.
- You can print your form before you submit it. It can also be printed after you have applied for a job.

Criteria

- There is a word limit for each criteria – approximately one A4 page of typed text
- You cannot change the font style or size.
- Main formatting tools at your disposal are:
  - New lines and line spaces
  - Capital letters for headings
  - Bullet points - use a hyphen (-) or an asterisk (*).
- When putting in acronyms eg HSC it will automatically change it to Hsc. To avoid this put in spaces between each letter H S C.

- If you have not used your word limit and want to space the text out on the page use returns.

Equal Opportunity Monitoring Form

You are strongly encouraged to complete this section of the form which is used purely for monitoring purposes. This information is treated in the strictest of confidence. The selection panel have no access to this information.

Disability requirements

We ask on the application form if you require any reasonable adjustments, due to disability, to enable you to attend the interview. Details of any disability are only used for this purpose and do not form any part of the selection process.

If you wish to discuss your disability requirements further, please contact Karyn Patterson, Head of Recruitment & Selection Services on Personal Information redacted by the USI or Personal Information redacted by the USI or by email to Personal Information redacted by the USI

Southern Health and Social Care Trust

Useful Links

Further details on the HSCNI may be obtained from;

Southern Health and Social Care Trust
www.southerntrust.hscni.net

Department of Health, Social Services and Public Safety www.dhsspsni.gov.uk

Further details on the NHS Leadership Qualities Framework may be obtained from;

www.nhsleadershipqualities.nhs.uk

Further Enquiries / Information

Applicants requiring any further information on the Trust or this post should contact Mr Kieran Donaghy, Director of Human Resources & Organisational Development, telephone Personal Information redacted by the USI or email to Personal Information redacted by the USI

Applicants requiring any further information on the application process, shortlisting or interview arrangements should contact Karyn Patterson, Head of Recruitment & Selection Services on Personal Information redacted by the USI or Personal Information redacted by the USI or by email to Personal Information redacted by the USI

Southern Health and Social Care Trust

Quality Care - for you, with you

Applicant Information Pack for position of

CHIEF EXECUTIVE

Ref 73217002

Closing Date for Receipt of Completed Applications is Monday 2nd October 2017 at 12.00 noon

Craigavon Area Hospital

Daisy Hill Hospital

South Tyrone Hospital

Lurgan Hospital

St Luke's site

Armagh Community Hospital

Southern Health and Social Care Trust
Quality Care - for you, with you

CONTENTS

Southern Health and Social Care Trust

Quality Care - for you, with you

Invitation from the Chair

We are seeking a Chief Executive to lead our integrated, high performing, ambitious organisation which has a values-based reputation for excellent care, innovation and a focus on improving the experience and outcomes of all who use our services.

At this time of significant change in health and social care infrastructure within Northern Ireland, this also represents an exciting opportunity to influence and lead changes in health and social care through innovation and collaboration and strong partnership working.

The role requires a talented leader who can build on what we have already achieved and continue the delivery of our future vision. With a relentless focus on the needs of the communities we serve, the successful applicant must be able to champion clinical leadership and engage a range of partners through their strong commitment to co-production and co-design to deliver truly integrated care and improved outcomes for our population.

With a wide range of stakeholders, the Chief Executive must be a relationship builder with a focus on achievement of strategic change. Powers of persuasion and influence are essential as is the ability to act in a politically astute manner. A focus on delivery of internal and external quality, measures of good care, and the ability to effectively hold others to account to ensure delivery is a key requirement. This is a role that requires self-confidence, enthusiasm and resilience.

Above all the role requires an individual who can lead a large, complex health and social care provider organisation with a multidisciplinary workforce delivering integrated services across a dispersed geography at a time of systemic change and challenge for health and social care within Northern Ireland.

Southern Health and Social Care Trust
Quality Care - for you, with you

The successful applicant will need strategic vision, the ability to inspire and motivate staff and a track record of leading successful change to ensure the continued development of the Trust, the strong partnerships within our workforce and with our many partners in our community and beyond.

If you have:

- the **enthusiasm and commitment** to keep the Southern Health & Social Care Trust at the **forefront of development in health and social care**;
- the **passion** and **expertise** to make a real contribution to our journey of **continual improvement;** and,
- a strong value base of **service to our patients, clients and community,**

then I look forward to receiving your completed application form.

For an **informal discussion about this post**, please contact:

Mr Wesley Emmett, Strategic Investment Board NI
on Personal Information redacted by the USI
or by e-mail to Personal Information redacted by the USI

S R BROWNLEE
Chair

Southern Health and Social Care Trust

Quality Care - for you, with you

Profile of the Trust

The Southern Health & Social Care Trust provides integrated patient / client centred services to a population of c.370,000 people in the local areas of Armagh, Banbridge, Craigavon, Dungannon, South Tyrone, Newry and Mourne (see map outline below):

The Trust provides a wide range of hospital, community and primary care services. General acute in-patient hospital services are located at Craigavon Area Hospital and Daisy Hill Hospital and acute mental health and learning disability in-patient hospital services are located in the Bluestone Unit also on the Craigavon Area Hospital site. Working in collaboration with GPs and other agencies, Trust staff provide locally based health and social care services in Trust premises, in people's own homes and in the community. The Trust purchases some services, such as domiciliary, residential and nursing care and day care from private and voluntary organisations.

The Trust has an annual income of c.£575m and approximately 14,000 staff. Our geographical area covers in whole or in part, three of the new super-councils – Armagh, Banbridge and Craigavon; Newry, Mourne and Down; Mid-Ulster.

Southern Health and Social Care Trust
Quality Care - for you, with you

Key Facts

- Second largest resident population compared to other Trusts in Northern Ireland at 370,000 (20% of population).

- Over the 10 year period from 2014 to 2024 - Armagh City, Banbridge and Craigavon Council Area population is projected to grow by 10.4 per cent (i.e. 21,400 people). Newry and Mourne Council Area population is projected to grow by 7.4% (i.e. 13,100 people). Both growth rates are projected above the Northern Ireland average (5.3%).

- Over the past 10 years, there has been a 15% increase in the number of births in the Southern Area compared to a regional increase of 8% for the same period..

- 14% of the Southern Trust population is over 65 years. By 2039 this is projected to grow to 60% which is higher than the NI expected growth rate of 54%.

- 16% of the Southern Trust population falls within the NI's most deprived quintile.

- The Trust has the highest level of children with statements of educational need in NI.

- Central & Eastern European migration accounts for 4.2% of the Trust population, compared to the NI average of 2.2%.

Southern Health and Social Care Trust

Quality Care - for you, with you

We spend almost £1.8m per day delivering care to local people

Each year across our 2 acute hospitals the Southern Trust treats:

120,000 Emergency Department Attendances

50,000 Inpatients

190,000 Outpatient Appointments

Each year across the Southern Trust area we support people to remain independent in their own homes within our community through:

6,000 people supported by Domiciliary Care Services in their own Home

2,223 Residential and Nursing Home placements

£1.5m annual expenditure on community equipment

Southern Health and Social Care Trust
Quality Care - for you, with you

Northern Ireland Health Policy and Commissioning Context

In January 2015, the Minister commissioned an expert examination of the application of quality of care provision in Northern Ireland. The review led by Professor Sir Liam Donaldson recommended changes to the commissioning structure in Northern Ireland.

The then Health Minister, Simon Hamilton announced reform of the current commissioning structure and proposed standing down the Health and Social Care Board in favour of the Department of Health (DOH) taking strategic control of the Health and Social Care system with Trusts having more direct responsibility for the planning of care in their areas and the operational independence to deliver it.

Service Transformation

In Northern Ireland, as in all health and social care systems, there are significant pressures which can only be addressed by radical change: a growing and ageing population; a growth in chronic conditions; a growth in demand and an over-reliance on hospital beds. There are also advances in medicine and technology which require innovation and the need to address growing public expectations about the need for high quality and compassionate health and social care services.

The Bengoa review, *Systems not Structures*, report of the expert panel and subsequent Minister's vision Health and Wellbeing 2026: Delivering Together (Oct 16) presents the case for the reform of health and social care services with strategic proposals that have the potential to make a huge difference to how we plan and deliver care in the medium and longer term based on a model of integrated health and social care services focused on prevention initiatives and early intervention, and on promoting health and wellbeing with particular emphasis on ensuring service transformation is co-produced and co-designed with service users and endorses the need to provide more

care in the community, closer to people's homes where possible and more personalised care.

The transformation agenda is progressing well in the Southern Trust, locally we are moving forward with new service developments that are making a real difference to individuals and are supporting our health and social care system in ways that are maintaining individuals' independence and involvement in their local community as well as reducing the need for hospital admissions. Some examples of where these changes are making a difference to the lives of local people include:

- resettlement of people with a learning disability and / or mental ill health from long stay hospitals into supported living models in the community
- reablement services that support people living in the community and those who have experienced acute illness to regain their independence
- Acute Care at Home service that avoids the need for hospital admissions
- Family Support Hubs offering early intervention and prevention services for local families.

Making Life Better 2013-2023

'Making Life Better' is the 10-year strategic framework which provides direction for policies and actions to improve the health and well-being for people in Northern Ireland. It has 6 key aims:

1. Giving Every Child the Best Start
2. Equipped Throughout Life
3. Empowering Healthy Living
4. Creating the Conditions
5. Empowering Communities
6. Developing Collaboration

Southern Health and Social Care Trust

Quality Care - for you, with you

In the Southern Trust we have well established collaborative inter-agency networks in place to help us implement and drive this strategic vision and seek to influence the future patterns of demand for health and social care. We have a dedicated Health and Well-Being Team and are regionally recognised as leading the way in PPI (patient, public involvement) with this approach embedded in how all our team deliver care.

Southern Health and Social Care Trust

Quality Care - for you, with you

Vision, Values & Priorities of the Trust

Trust Vision: 'Quality Care – for you, with you'

Our vision encompasses our core commitment to deliver safe, high quality care that is co-produced and co-designed in partnership with service users and staff who deliver our services. This vision is underpinned by the **Trust's Values** which shape what we do and how we do it.

Southern Health and Social Care Trust

Quality Care - for you, with you

Our **Corporate Objectives** reflect our priorities for the delivery of health and social care services to our local population. Achieving our objectives and delivering safe, quality care and services which are accessible and responsive to our patients and carers will remain our central focus:

Southern Health and Social Care Trust

Quality Care - for you, with you

Strategic Direction of the Trust

Our Corporate Plan "Improving Together" 2017/18 - 2020/21

"Improving Together" 2017/18 - 2020/21 is the prevailing strategic plan that sets out how we intend to deliver against regional and corporate priorities in our local area. This response is informed by the changing needs of local people, by new technologies and ways of delivering care and by the resources made available to the Trust by our local assembly. The strategic plan explains what we want to achieve, how we plan to achieve and how we will know if we have made a difference. It sets a roadmap of how we would like Trust services to look and what outcomes we expect four years from now. Read more here

For further information on the documents below visit:
http://www.southerntrust.hscni.net/about/Publications.htm

- Trust Delivery Plan
- Annual Report
- Annual Quality Report
- Board Assurance Framework

Southern Trust on Social Media

Click here to view the Southern Trust's Facebook page.
Click here to view the Southern Trust's Twitter account.
Click here to view the Southern Trust's YouTube Channel.

Southern Health and Social Care Trust

Quality Care - for you, with you

Key Achievements & Recognition of the Trust

High Performing Trust

Demand for NHS services continues to present significant challenges for NI Health & Social Care. In particular from 2016/17, all Trusts in the region have experienced significant challenge in meeting performance targets. The Southern Trust performs relatively well against current Commissioning Plan standards and targets within the region. The Trust is taking a lead role in developing new service models to continue to respond to year on year growth in referrals. The Trust has in place strong and effective teams to monitor and manage referrals and to ensure effective governance, safety and high quality services remain priority. Within Northern Ireland, the Southern Trust has:

- the highest throughput with 61.9 admissions per bed
- the shortest average length of stay
- the lowest hospital cancellation rates over the last 5 years
- the lowest Do Not Attend (DNA) rates

Performing well against Ministerial targets will always be important for the Trust. However, the Trust believes we can move beyond the target culture, to reform and improve services because it is the right thing to do for the people we serve. The Trust has signalled in its most recent Corporate Plan a specific corporate objective aimed at 'Improving our Services'.

In community based services, the Southern Trust was the first to complete the resettlement of long stay patients from both learning disability and mental health long stay hospital wards to innovative community based living options and has received national recognition in our approach to avoiding hospital admissions through our innovative crisis response service.

Southern Health and Social Care Trust
Quality Care - for you, with you

CHKS Top 40 Hospitals

In 2016, for the fifth consecutive year, the Southern Trust's acute hospital network – Craigavon Area and Daisy Hill - was reaffirmed as one of the UK's Top Hospitals. The national CHKS Top 40 Hospitals programme recognises acute sector organisations for their achievements in healthcare quality, improvement and performance. The Southern Trust was also one of the top five in the UK for Patient Safety at the CHKS Awards as well as being the first in Northern Ireland to receive the National Data Quality Award (for Northern Ireland, Scotland and Wales). The Data Quality Award recognises a commitment to driving improvement in clinical coding and data quality to the highest standard.

Both Daisy Hill and Craigavon Area are 'Queen's Teaching Hospitals' offering high quality clinical placements to medical students as part of the student doctor undergraduate programme.

Innovation & Service Modernisation

The Trust has received a number of local and national awards for innovative ways of improving the quality, efficiency and effectiveness of care delivery and adopts a Quality Improvement approach to all our services. This is underpinned by the Quality Improvement Framework adopted within the Trust, which supports the development of Quality Improvement knowledge and expertise of all staff.

The Southern Trust has been nationally recognised for innovation in improving patient care. Examples include:

Telepresence Robot

In 2012, the Southern Trust was the first in the UK to use a Telepresence robot to allow intensive care specialists from Craigavon Area Hospital to remotely assess patients in the High Dependency Unit in Daisy Hill.

Southern Health and Social Care Trust
Quality Care - for you, with you

First Dedicated Health Visitor for Multiples in UK

In 2014, the first ever dedicated health visitor for twins and multiple birth families in the UK took up post in the Southern Trust.

Leading the Way in Paediatric Training

Also in 2014, Daisy Hill Hospital was the first in NI to introduce the most state of the art paediatric simulators in paediatric training.

The mannequins which simulate an infant and an older child, are helping to ensure that nurses and doctors are equipped in the very latest training and are delivering the best possible standards of care.

Cancer Services – Macmillan Quality Environment Mark (MQEM)

The Macmillan Cancer Information and Support Centre in Craigavon Area Hospital, has been publicly recognised for the high standards of care it provides to people living with cancer. The Trust has been awarded a Macmillan Quality Environment Mark (MQEM). The centre opened in 2014, and since then we have supported more than 2,000 people affected by cancer in the local area to access the help they need. The MQEM award recognises that our centre is welcoming and accessible, respectful of people's dignity, supportive of their well-being and has the voice of people living with cancer at its heart.

New Emergency Physiotherapy Service

The First Contact Physiotherapy Practitioners are the first of their kind in Northern Ireland to be based in an Emergency Department, seven days a week. This new physiotherapy service is helping to speed up care for patients who come to Craigavon Area Hospital's Emergency Department with musculoskeletal problems. The team of Advanced Clinical Specialist Physiotherapists are seeing around 70 patients a week, managing their full care plan from assessment, investigations, diagnosis, right through to treatment and onward referral if needed. The First Contact Physiotherapy Practitioners have been funded by the Health and Social Care Board to embed the role of Physiotherapy in

Emergency Departments and help improve care for those patients with minor injuries.

Award winning Partnership with Marie Curie

In September 2015 Marie Curie launched an 18-month charity partnership with the Southern Trust. Through a range of fundraising activities a total of £205,000 has been raised. This allows Marie Curie to deliver 10,200 hours of nursing care to terminally ill people and their families. This Partnership has been recognised at the annual Institute of Fundraising Awards by winning Partnership of the Year in Northern Ireland.

Platinum Status at NI Environmental Benchmarking Survey

The Trust has achieved Platinum status at the recent 2016 Northern Ireland Environmental Benchmarking Survey, the highest scoring level. The Survey, which is run by Business in the Community, recognises and rewards those organisations that are going above and beyond their legal requirements to minimise their environmental impacts and better manage their resources.

Through its Sustainability Strategy 2020, the Trust promotes a proactive approach to management of its environment and aims to maximise benefits and minimise risks to clients, staff, visitors, contractors and others.

Hospital at Home for Older People

In September 2014, the Southern Trust launched the first consultant led Acute Care at Home Service in Northern Ireland which is now offering hospital care to older people either in their own house or nursing/residential home to avoid admission to hospital.

To date the Trust can evidence that this innovative service has prevented 1,561 hospital admissions and has facilitated the early discharge of 425 older people It is now being extended to a wider area.

Southern Health and Social Care Trust
Quality Care - for you, with you

National Recognition for Learning Disability Crisis Response

The Southern Trust's Learning Disability Crisis Response Team has received national recognition as an example of Positive Practice in the 'Strengthening the Commitment: Living the Commitment' National Report.

This Crisis Response Service is the first of its kind in Northern Ireland and helps adults with learning disabilities avoid a hospital admission in a time of difficulty. It has also been identified by the Health and Social Care Board as a model upon which similar services are to be established regionally.

National Recognition for Lung Cancer Project

In 2015 an innovative service to raise awareness of the signs and symptoms of lung cancer and encourage over 50s to seek an urgent diagnosis received national recognition.

The Southern Trust was the first in Northern Ireland and just the second in the UK to offer open access chest x-ray clinics for those over 50 with a cough or other chest symptom lasting more than three weeks.

In a three month pilot scheme launched last year - 270 people attended clinics for a drop in x-ray, abnormalities were detected in 12 of these patients and three were diagnosed with lung cancer.

The 'Look After Your Lungs' was finalist at the UK wide Chartered Institute of Public Relations awards and locally received Best Healthcare Campaign at the NI Chartered Institute of Public Relations Awards.

Craigavon Radiographers Recognised as Top in UK

In November 2015 a Radiography Team from Craigavon Area Hospital not only received the Northern Ireland Team of the Year but were also recognised as top across the UK.

The Team were recognised for their innovation, dedication and intuition in delivering a life changing service to women with fertility problems.

Their service redesign which is the first of its kind in the UK has completely streamlined the way fertility problems are diagnosed and treated, increasing the number of procedures carried out each day, reducing waiting lists and greatly improving the patient experience.

Daisy Hill Pioneers Baby Heart Screening Test

Daisy Hill is the first hospital in Northern Ireland to trial a new baby heart screening test. The paediatric team have worked closely with their maternity colleagues to introduce a routine oxygen saturation test for all new babies before they are discharged home.

Technology to Make Life Easier for Stroke Patients

A new video conferencing speech and language service is making life easier for people who have had a stroke and live in the Newry and Mourne area.

The Southern Trust was the first to pilot the programme which offers video link sessions between the specialist stroke speech and language therapists at Daisy Hill Hospital and Kilkeel Health Centre and the patient in their own home.

First mental health service for children with intellectual disability

In 2016 the Trust is the first in Northern Ireland to offer a fully comprehensive Child and Adolescent Mental Health Service (CAMHS) that is fully inclusive of Children and Adolescents who have an Intellectual Disability. One in forty children and young people have an intellectual disability, which means they have difficulty understanding information and learning the skills needed for everyday life. The team is playing a leading role regionally in establishing support networks for practitioners interested in delivering the best possible services for children and young people and for the first time have brought a highly regarded Intellectual Disabilities Conference to Ireland.

Southern Health and Social Care Trust
Quality Care - for you, with you

Improving Patient Safety through E-Discharge

The Southern Trust was the first in Northern Ireland to use an electronic system to discharge patients from its two acute hospitals, Daisy Hill and Craigavon Area.

Activated on admission, the system details all information to be captured to help facilitate timely discharge, including reasons for admission, tests, diagnosis and any follow up required by the hospital or GP.

By increasing the accuracy and quality of information, the system is greatly improving patient safety and gives GPs discharge information much more promptly.

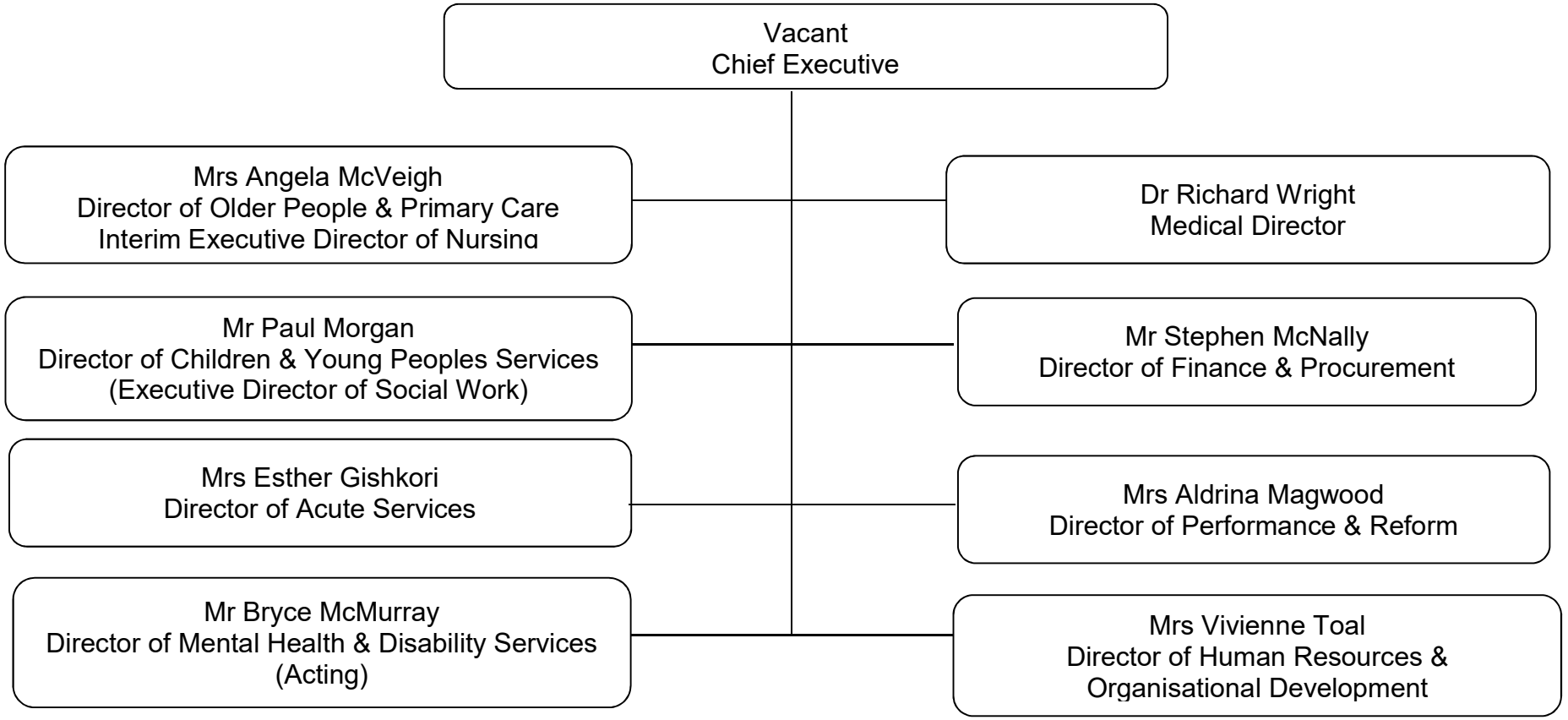
Patients go with the FLOW

The Southern Trust was the first in Northern Ireland to introduce a bespoke electronic system which is providing real time information on patient care and bed availability.

FLOW is a tailor-made system developed to match how our staff care for patients and how they move through our hospital system, from admission, throughout their treatment, including any ward transfers, right through to discharge. Each ward has an electronic screen which displays the needs of every patient and includes alerts and tasks to ensure effective communication between all staff.

The SHSCT Senior Management Team Structure is set out overleaf.

Southern Health and Social Care Trust
Quality Care - for you, with you



Southern Health and Social Care Trust

Quality Care - for you, with you

CHIEF EXECUTIVE

Salary Range: £96,949 - £129,264 per annum

Ref No: 73217002

Southern Health and Social Care Trust

Quality Care - for you, with you

The Southern Health & Social Care Trust wishes to appoint a high calibre Chief Executive to lead our high performing, ambitious organisation which has a values-based reputation for excellent care, innovation and a focus on improving the experience and outcomes of all who use our services. This is a highly challenging position which requires exceptional strategic vision and outstanding leadership qualities.

The successful applicant will act as a champion for the organisation and must be able to quickly establish credibility and effective relationships with a wide range of key stakeholders.

At a time of systemic change and challenge for health and social care, the successful applicant will need strategic vision, the ability to inspire and motivate staff and a track record of leading successful change to ensure the continued development of the Trust, the strong partnerships within our workforce and with our many partners in our community and beyond.

A full Applicant Pack is available online at **www.southerntrust.hscni.net**

For an informal discussion about this post, please contact Mr Wesley Emmett, Strategic Investment Board NI on 078 7506 6099 or e-mail: wesley.emmett@sibni.org

The closing date for receipt of completed applications is **Monday 2nd October at 12.00 Noon.**

For shortlisted applicants it is anticipated that an assessment centre will take place week commencing 23rd October 2017 and if necessary, preliminary interviews will also be held this week. Final interviews are planned for week commencing 30th October 2017. These are provisional dates which may be subject to change.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Southern Health and Social Care Trust
Quality Care - for you, with you

JOB DESCRIPTION

JOB TITLE Chief Executive

BASE Trust Headquarters,
Craigavon Area Hospital

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 Department of Health (DoH) and the Health and Social Care Board (HSCB).

As the Accountable Officer for the Trust, the Chief Executive is accountable to the Trust Board, DoH and HSCB 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 prevailing performance standards and targets.

The Chief Executive has overall responsibility for the management and performance of the Trust, including meeting Ministerial priorities as defined by the DoH and HSCB, fulfilling statutory requirements, delivering against clinical and non-clinical performance targets, securing continuous improvement and for providing safe, high quality and effective services within a clear financial framework.

The Chief Executive will lead on-going modernisation and reform within the Trust including the achievement of all organisational objectives, ensuring that appropriate, robust systems are in place and necessary changes are achieved within a transparent and effective governance framework.

The Chief Executive is responsible for ensuring the Trust delivers on its vision, values and priorities, continually aligning these to the Trust's Strategic Plan.

KEY RESULT AREAS

DELIVERY

1. Lead the development of the annual business plan for the provision of services in partnership with key stakeholders internally and externally.

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

3. 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 targets, and achieve the best outcomes possible.

4. 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.

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

6. 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.

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

8. 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.

PATIENT/CLIENT CARE

10. Ensure that the needs of patients, clients and their carers are at the core of the way that the Trust delivers services. In so doing, ensure that a culture, which is fully consistent with the Trust vision and values, is embraced by every member of staff.

11. Ensure consistent application of the highest standards of clinical, social care and corporate governance.

STRATEGIC LEADERSHIP

12. Provide clear leadership for the Trust in the development of strategic plans, ensuring these are aligned with regional requirements and are effectively implemented through annual business plans.

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

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

15. Work with the Trust Board, staff and partners in the local health economy to ensure aligned delivery against strategic plans.

16. Work with other key strategic partners, both within and outside of the health and social care economy, to ensure key issues associated with health inequalities are addressed.

CORPORATE MANAGEMENT

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

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

19. 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.

20. 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 and innovation.

21. Ensure that systems and processes are in place to enable the Trust Board and relevant external bodies 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 address under-performance quickly and effectively.

GOVERNANCE

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

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

24. Work with the senior management team to ensure that assessment of fulfilment of statutory functions and associated reports to Trust Board and externally, are completed as necessary ensuring that any action to manage risks internally in the Trust is taken promptly.

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

26. Ensure that arrangements are in place to assure all quality standards.

27. Monitor and report on performance against delivery targets, risk assessment and mitigation and ensure corrective action is taken when there is unacceptable deviation from the Trust's agreed business plan.

EXTERNAL RELATIONSHIPS

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

29. Develop linkages with other Trusts, the HSCB, Public Health Agency (PHA) and the DoH to promote best practice and innovation in the provision of services.

30. Work with the DoH, the HSCB, the PHA and other Trusts in developing a strategy for dealing with the media which reflects Ministerial views and which secures the confidence of public representatives.

31. Develop a strategy to maximise effective engagement of the local population with the Trust and ensure that Public, Patient Involvement (PPI) and co-production is embedded in Trust processes.

32. Ensure effective on-going political engagement with public representatives including members of the UK Parliament, members of the Northern Ireland Assembly and elected representatives of the District Councils within the Trust's geography.

FINANCES

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

34. 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.

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

STAFF RESOURCES

36. 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.

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

38. Develop and maintain systems to support performance appraisal for all staff to ensure that staff are encouraged and developed to their fullest potential and that under performance is dealt with quickly and remedial action taken.

39. Develop, through the Director of Human Resources & Organisational Development, management information on staff utilisation, development and return on investment, which improve management and a rigorous continuous improvement culture.

40. 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

41. 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.

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

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

HUMAN RESOURCE MANAGEMENT RESPONSIBILTIES

44. Review individually, at least annually, the performance of immediately subordinate staff, provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.

45. Maintain staff relationships and morale amongst staff.

46. Delegate appropriate responsibility and authority consistent with effective decision making, while retaining overall responsibility and accountability for results.

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

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

GENERAL REQUIREMENTS

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

50. Co-operate fully with the implementation of the Trust's Health and Safety arrangements.

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

52. All employees of the Trust are required to be conversant with the Trusts policy and procedures on 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.

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

54. Available / able to work any 5 days out of 7 over the 24 hour period, which may include on-call / stand-by / sleep-in duties, shifts, night duty, weekends and Public Holidays if required immediately on appointment or at a later stage following commencement in response to changing demands of the service.

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

56. As Accountable Officer comply with the Code of Business Conduct.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the postholder works.

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

PERSONNEL SPECIFICATION

JOB TITLE Chief Executive

ESSENTIAL CRITERIA – *these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview. Applicants MUST demonstrate how they meet these criteria with their application form.*

QUALIFICATIONS / EXPERIENCE

1) Successful senior leadership and management[1] for a period of at least 3 years in a major complex organisation[2] with a strong service user / customer focus.

2) Effective delivery of improving corporate performance in a service user/customer focused context.

3) Effective contribution to the development of strategic thinking as part of a corporate team.

4) Effective leadership and management of people from multi-disciplinary backgrounds.

5) Effective financial management in a major complex organisation[2], securing value for money.

6) Effective external stakeholder management demonstrating careful analysis and authoritative judgment and building organisational reputation.

7) A Degree OR equivalent Professional Qualification OR evidence of continuing management development[3].

8) Hold a full current driving licence valid for use in the UK and have access to a car on appointment[4]. In respect of this point the successful applicant may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere.

[1]'senior leadership and management' is defined as experience gained at Chief Executive, Director, Assistant Director or equivalent in a major complex organisation

[2]'major complex organisation" is defined as one with at least 200 staff or an annual budget of at least £25 million and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders'

[3]management development is the structured process by which managers enhance their skills, competencies and/or knowledge, via formal or informal learning methods, to the benefit of both individual and the organisation.

[4]This criterion will be waived in the case of a suitable applicant who has a disability which prohibits them from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.

PLEASE NOTE:

Shortlisted candidates invited for interview will be assessed against the criteria stated in this specification, linked to the Dimensions set out in the NHS Healthcare Leadership Model.

Further information can be found at
http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

PERFORMANCE MANAGEMENT ARRANGEMENTS

Performance in the HSCNI is managed under four main areas:

- Promoting and improving health and social well-being status which is a form of demand management for the HSC.
- The delivery of accessible, flexible and responsive services.
- Safe and effective care.
- Value for money, efficiency and productivity.

Performance management and improvement in the HSCNI includes:

- measurable objectives, standards and targets which define what the HSC has to achieve with clear lines of accountability;
- clear links between resources allocated and outcomes required, with strong commissioning arrangements;
- incentives to ensure targets are achieved;
- robust and appropriate monitoring and information systems;
- assessment, audit and reinforcement measures;
- strong financial control systems with flexibility to innovate and reform at local level

The successful postholder will be required to operate within arrangements to support the Trusts overall agenda through ongoing delivery of services against the challenging agenda set by Government and Regional Health & Social Care Bodies with whom the Trust works.

TERMS & CONDITIONS OF SERVICE

Hours - Full time. The set hours of work are 37.5 hours per week however the number and pattern of hours will reflect the demands of the post.

Remuneration - Salary Range : £96,949- £129,264 per annum

Annual Leave and Statutory / Public holidays

The Trust offers excellent provision for annual leave and Public / Statutory Holidays. In addition to 10 statutory/public holidays, the annual leave allowance will be between 27 and 33 days.

HSC Pension Scheme / HPSS Superannuation Scheme

One of the leading pension schemes available, Trust staff are automatically enrolled in the Health & Social Care Pension Scheme upon taking up employment within the HSCNI. Further information may be obtained from the HSC Pension Service Website at **www.hscpensions.hscni.net.** Applicants who are already members of the HPSS Superannuation Scheme may continue with their current arrangements

Current contributions are as follows:

Employer contribution rate:	16.3%
Employee contribution rate:	13.5%

Human Resources Policies

The Trust offers a wide range of Human Resource Policies to underpin the value that is placed on its staff such as:

- A range of Work Life Balance/Flexible Working Policies;
- Special Leave;
- Child Care Voucher Scheme;
- Cycle to Work Scheme;
- Access to savings on Social and Leisure Activities;

The HSC Code of Conduct is available on request.

Committed to Equality of Opportunity

The Trust recognises and values the diversity of its workforce and the population it serves. The Trust is committed to a working environment free from intimidation of any kind. Through a systematic and objective recruitment & selection process the Trust is committed to ensuring that appointment decisions are taken solely on the basis of merit.

COMPLETING YOUR APPLICATION FORM

The application form is designed to ensure that applicants provide the necessary information to determine how they meet the essential criteria. To ensure Equality of Opportunity for all applicants:

- The space available on the application form is the same for all applicants and must not be altered;
- We will not accept CVs, letters, additional pages or any other supplementary material in place of, or in addition to completed application forms;
- Applicants must complete the application form in either typescript font size 12, or legible block capitals using black ink;
- Applicants must not reformat electronic application forms;
- Information in support of your application will not be accepted after the closing date and time for receipt of applications;
- Applications will not be examined until after the closing deadline;

Completing the Criminal Convictions / Offences Section

The application form requires you to confirm your understanding that the Trust's positions fall under the Rehabilitation of Offenders Exceptions (NI) Order 1979 as amended. Within the Health Service, criminal convictions are never regarded as spent and therefore if you are offered a post with the Trust you must tell us about all previous or pending convictions or offences (including motoring convictions), even if they happened a long time ago (other than protected convictions).

The Trust is committed to the equality of opportunity for all applicants, including those with criminal convictions. We will undertake to ensure an open, measured and recorded discussion on the subject of any offences or other matters that might be considered relevant for the position concerned e.g. the individual is applying for a driving job but has a conviction history of driving offences. This will be conducted following the selection process if this applies to the successful candidate. Whilst the disclosure of information will not automatically prevent an individual from obtaining employment, it is essential that all convictions (other than protected convictions) are disclosed to allow the Trust to adequately consider their relevance to the post in question. The Trust considers failure by applicants to declare complete and accurate information about convictions to be a serious breach of trust.

Access NI Disclosure – the Trust operates in line with the Access NI Code of Practice. Further details can be obtained from www.accessni.gov.uk

It should be noted that some posts will fall within the definition of 'Regulated Activity'. Further information on Regulated Activity can be obtained on request. Any post falling within the definition of Regulated Activity will be subject to an Access NI Enhanced Disclosure check with Barred list check.

Completing the Medical History Section

The application form requires you to confirm your understanding that you must be in a fit state of health to render regular and reliable service in the post you are applying for. If successful, you will be asked to tell us about any periods of sickness you have had in the last 3 years, whether you have been in employment or not. Your sickness absence record will be verified through the reference checking process; therefore it is important that you give full and accurate information when requested.

Meeting the Criteria set out in the Personnel Specification

- Always refer to the Job Description and Personnel Specification when completing your application form.
- Clearly demonstrate on your application form how you meet the essential shortlisting criteria as detailed in the Personnel Specification. Failure to do so will result in you not being shortlisted for interview. Please remember that selection panels cannot make assumptions on whether or not you meet the essential shortlisting criteria.

Completing the Reference Section

We will want to seek references which cover the previous 3 years to the date of application in relation to your employment / training / education.

Completing Your Current / Previous Employment Details

- Ensure that full details are provided.
- Be specific about all the dates that you provide, in the format DD.MM.YYYY.
- Explain any gaps between periods of employment and include reasons for leaving each post.
- Provide a list of key duties that you have been responsible for in current post / previous posts.

Disability requirements

We ask on the application form if you require any reasonable adjustments, due to disability, to enable you to attend the interview or undertake the duties of the post. Details of any disability are only used for this purpose and do not form any part of the selection process. If you require any reasonable adjustments to be made during the Recruitment Process please contact Mr Iain Gough, Acting Head of Resourcing by email to Personal Information redacted by the USI or by phone to Personal Information redacted by the USI who will be happy to discuss your requirements

Completing the Personal Declaration

It is important to remember that when signing the personal declaration section or submitting your form via email you are stating that the information is true, complete and accurate, and confirming your understanding that giving wrong information or leaving information out could lead to the withdrawal of an offer of employment, or dismissal if you take up a post.

Data Protection

The information you provide the Trust will be processed in accordance with the Data Protection Act 1998.

Completing the Equal Opportunity Monitoring Form

Please note that this information is regarded as part of your application and you are strongly encouraged to complete this section. This information is treated in the strictest confidence and is for monitoring /statistical purposes only. Selection panels do not have any access to this information at any stage of the recruitment process.

Advising us if you are not available to attend for interview

If you have any planned holidays, it is useful to tell us about this by detailing it on your application form. However please note that the selection panel are under no obligation to take these into account when arranging interview dates.

Submitting your completed form

Forms must be received by the stated closing date and time, as **late applications will not be accepted.**

Please remember that the Trust's standard Application Form is the only acceptable method of application to the Trust.

Closing Date for Receipt of Completed Applications

The closing date for receipt of completed applications is **Monday 2nd October 2017 at 12.00 noon**.

Applications can be submitted by email to [redacted] or in hard copy format to:

Mrs Vivienne Toal
Director of Human Resources & Organisational Development
Trust Headquarters
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

Please note the Trust will not accept any late, incomplete or reformatted application forms received after the closing date and time.

Applicants using Royal Mail should note that 1st class mail does not guarantee next day delivery. It is the responsibility of the applicant to ensure that sufficient postage has been paid to return the form to the address above by the stated closing date and time. Existing Health & Social Care staff should not rely on the internal postal system.

Selection Process

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 skills are relevant to this post and the extent to which they satisfy each criterion specified. This includes demonstrating how they meet the definitions of 'major complex organisation', and 'senior management' as defined within the Personnel Specification. **Please note this should be detailed under each appropriate criterion heading on your application form.** Only those applicants who clearly demonstrate on their application form how they meet the essential criteria, and if applied, the desirable criteria, will be shortlisted. Failure to demonstrate clearly how you meet each element of the essential / desirable criteria will result in you not being shortlisted for the further stages in the assessment process.

Candidates who are shortlisted following a review of their application form will then be invited to the further stages in the assessment process. The Trust reserves the right to incorporate additional shortlisting stages dependent on the number of applications received.

At this stage it is anticipated that an assessment centre will take place week commencing 23rd October 2017 and if necessary preliminary interviews will also be held this week. Final interviews are planned for week commencing 30th October 2017. These are provisional dates which may be subject to change.

Throughout the assessment process applicants will need to demonstrate that they have the required competencies to be effective in this demanding leadership role. It is therefore intended that applicants who meet the essential criteria will be assessed against the criteria stated in this specification, linked to the Dimensions set out in the NHS Healthcare Leadership Model.

In accordance with best practice all appointments within the Trust are made under the 'merit principle' where the best person for any given post is selected in fair and open competition.

Candidates may be contacted by telephone following each stage of the assessment process to confirm onward arrangements. This method, if used, is to ensure those being invited to the next stage have as much time available for preparation as possible. Candidates are therefore asked to ensure that mobile telephone numbers are provided where possible and that in any event the contact telephone numbers stated provide for ease of contact. All such communication will be followed up in writing.

Please note that the Trust is under no obligation to take account of your planned holiday arrangements.

Useful Links / Further Information

Further details on the HSCNI may be obtained from;

Southern Trust Website - http://www.southerntrust.hscni.net/ or you can follow us on facebook or Twitter

Click here to view the Southern Trust's Facebook page.
Click here to view the Southern Trust's Twitter account.
Click here to view the Southern Trust's YouTube Channel.

Department of Health www.doh.gov.uk

Further Enquiries / Information

Applicants requiring any further information on the application process, shortlisting or interview arrangements should contact Mr Iain Gough, Acting Head of Resourcing on Personal Information redacted by the USI or by email to Personal Information redacted by the USI

DoH ARM'S LENGTH BODY: MID-YEAR ASSURANCE STATEMENT

This statement concerns the condition of the system of internal governance in the **Southern HSC Trust** as at 30 September 2017.

The scope of my responsibilities as Accounting Officer for the Southern HSC Trust, the overall assurance and accountability arrangements surrounding my Accounting Officer role, the organisation's business planning and risk management, and governance framework, remain as set out in the Governance Statement, as part of the Accountability Report, which I signed on 8 June 2017. The purpose of this mid-year assurance statement is to attest to the continuing effectiveness of the system of internal governance. In accordance with Departmental guidance, I do this under the following headings.

1. Governance Framework

The Governance framework as described in the most recent Governance Statement continues in operation. The Trust adopts an integrated approach to governance and risk management and the current Governance Framework was revised and endorsed by the Governance Committee at its meeting on 7th September 2017. Through this framework, the Board exercises strategic control over the organisation which includes a firmly established Committee structure comprising an Audit Committee; Governance Committee; Remuneration Committee; Endowments and Gifts Committee and Patient and Client Experience Committee. These Committees have continued to meet and to discharge their assigned business. Minutes of their meetings, together with Board meeting minutes containing the Committees' reports, are available for Departmental inspection to further attest to this.

2. Assurance Framework

A Board Assurance Framework, which operates to maintain, and help provide reasonable assurance of the effectiveness of controls, has been approved and is reviewed by the Trust Board. Minutes of Board meetings are available to further attest to this. The framework has continued to be enhanced during 2017/18 and an update was recently presented at the Trust Board meeting on 28th September 2017.

3. Risk Register

As part of the Board-led system of risk management, I confirm that the Corporate Risk Register has been regularly reviewed by the Governance Committee, most recently on 7th September 2017 and by the Trust Board, along with the Board Assurance Framework on 28th September 2017. A review of the format of the Corporate Risk Register was undertaken in April 2017 to make control measures, action planning and the articulation of residual risk more explicit.

In addition I confirm that Information Risk continues to be managed and controlled as part of this process.

4. Performance against Business Plan Objectives/Targets

In May 2017 HSCB advised the Trust that in the absence of a Commissioning Plan Direction, the Trust should continue to monitor performance against the extant 2016/17 objectives and goals for improvement (OGIs). The Trust is now in receipt of a draft Commissioning Plan Direction for 2017/18 and the Draft Commissioning Plan and will respond to this via the Trust Delivery Plan. In the interim, the Trust will continue to assess performance against the 2016/17 OGIs. On this basis I can confirm satisfactory progress towards the achievement of these objectives and targets The following exceptions are noted below.

.

- **Healthcare Acquired Infections – OGI 2.1(.1): MRSA**

Whilst the Trust's performance against this target has been regionally strong, and remains so, the Trust is not on track to achieve the target sought, with 2 reported cases against a low target of 4. The Trust continues to promote robust infection prevent and control strategies to prevent avoidable cases.

- **GP Out of Hours – OGI 4.2: Triage of Urgent Calls**

. Cumulative performance for April to August 2017 demonstrates 88% performance against this objective, which whilst reflecting an improvement from 2016/17 is unlikely to increase further. This is primarily associated with the inability to secure a sufficient level of General Practitioners to cover the out of hours rotas despite enhanced payment rates.

There are on-going regional and Trust initiatives to encourage an increase in medical capacity and to improve the service, including enhanced skill mix with greater utilisation of nurse and pharmacy triage.

- **Emergency Department (4-hour and 12-hour) – OGI 4.4(.1) & (.2)**

Cumulative performance for April to August demonstrates 80% of attendances were treated, discharged or admitted within 4-hours and 578 patients waited in excess of 12-hours.

4-hour performance has been challenging to deliver both locally and regionally and is set locally in the context of increasing ED demand, particularly on the DHH site. Ongoing challenges associated with the ability to attract and retain a substantive medical workforce, with greater reliance on locums, effecting emergency medicine and general medicine, continue to challenge the whole system flow therefore affecting performance and patient experience.

A range of actions and resources to improve unscheduled care have been identified via the Trusts 100% challenge event and a review of the 2016/17 unscheduled care resilience plan. The 2017/18 resilience plan is based on learning from 2016/17 and includes a focus on alternatives to hospital admission (particularly for older people), options to promote effective control and optimising available bed capacity to effect timely discharge. Delivery of the resilience plan is set the in the context of the Trusts requirement to implement in year savings plans and challenges associated with securing appropriate workforce.

The Trust continues to utilise the external support of the North West Utilisation Management Group and its locality and regional networks for sharing of best practice and learning.

- **Fracture Neck of Femur – OGI 4.6**

The Trust is challenged to secure a substantive improvement on this OGI to ensure 95% of patients treated within 48 hours and cumulative performance from April to August 2017 was 86%. To date in 2017/18 there have been 26 breaches of the 48-hour OGI, compared to 14 in the same period last year; however this is set in the context of 40 more patients with fractures presenting in the same time period.

Challenges are associated with general demand in trauma above capacity, the need to clinically prioritise all trauma cases, not just those within the scope of this OGI and the balance of matching case mix to specialist trauma surgeons to ensure best clinical outcomes.

The impact of this is reflected in the current performance against the OGI and the requirements to cancel elective orthopaedic cases to accommodate trauma demands. From April – July 2017, 76 elective orthopaedic procedures have been cancelled to accommodate trauma.

The Trust has secured additional consultant staff to commence in 2017/18 which will contribute to future trauma capacity; however resource will be required to provide infrastructure including additional theatre and bed capacity.

- **Elective Access OGIs – OGI 4.8; 4.9; and 4.10**

The Trust continues to work towards the elective access OGI of 9-weeks for an out-patient appointment; 13-weeks for in-patient/day case treatment; and 9-weeks for diagnostics. However, due to increasing access times the Trust is now focusing on measuring performance against the maximum backstop of 52-weeks for outpatients, in-patients/day cases and 26-weeks for diagnostics.

Performance has become increasingly challenging related to demand exceeding commissioned capacity, increase in urgent demand, insufficient recurrent investment resulting in ongoing capacity gaps and accruing backlogs. Further, the short term nature of non-recurrent funding does not permit forward planning, resulting in increasing challenges to the ability to increase capacity in-house and in the independent sector.

The Trust is also required to ensure capacity to manage the ongoing need for review and intervention as part of its governance arrangements and must balance elective demand for new assessment and treatment against ongoing requirements for review.

Unscheduled care pressures also impact the management of elective services. T The application of prudent scheduling of inpatients and cessation of routine elective surgical services at peak times (post New year) and over periods of heightened unscheduled care pressures, to protect bed capacity for unscheduled care admissions, impacts on the level of core commissioned elective activity delivered.

The following actions are being taken to manage and improve where possible, the current position: monitoring access times for red flag and urgent cases and prioritising capacity to this demand; chronological management to ensure routine patients are

treated in turn; measures to minimise lost capacity from those who do not attend or cancel their appointment/procedures in the day; and provision of monthly information to General Practitioners to ensure referrers and patients are aware of current and projected waiting times by speciality.

The Trust continues to re-direct internal funding as available, to improve the management of new and review elective patients.

- **Out-Patients – OGI 4.8 –** The Trust does not anticipate that either part of this OGI will be achieved in-year. At August 2017 32% off patients are waiting less than 9-weeks, with 3,793 patients waiting in excess of 52-weeks which reflects an increase of 2,206 from the same time last year.

  Specialties, at the end of August that are in excess of the 52-week backstop are: Breast Surgery; Cardiology; Diabetology; Endocrinology; Ear, Nose & Throat; Gastro-enterology; General Surgery; Neurology; Ortho-Geriatrics; Orthopaedics; Pain Management; Rheumatology; Thoracic Medicine and Urology.

  At 31 July 2017 there were 20,649 patients (excluding visiting specialties) waiting beyond their clinically indicated timescale for review which is an increase of approximately 4,000 from the same period last year.

  The Trust continues to direct any internal resources to areas with long waits, patient safety issues and processes are in place to ensure reviews which are urgent or present high clinical risk, are given priority.

- **Diagnostics – OGI 4.9 (Imaging; Non-Imaging; Endoscopy) – Whilst** the Trust anticipated this OGI would be partially achievable, this was very dependent on the availability of additional resources and the ability to secure the required levels of additional capacity. The volumes waiting over 26 weeks however continue to increase and at August 2017 2,021 patients were waiting for

diagnostics over 26 weeks with long waits in some specific sub-specialist areas, e.g. CT angiography.

The Trust has received both recurrent and non-recurrent funding allocations in year from HSCB for additional capacity and has secured additional capacity, for example CT via a lease mobile unit on the CAH site, and sourced additional reporting capacity both in-house and in the independent sector. The ability to further increase capacity is subject to resources and also challenged by *the* availability of the medical workforce, placing a greater reliance now on independent sector activity.

- **Imaging –** Imaging forms part of the diagnostic OGI and at end of August 2017 69% of patients waited less than 9-weeks; at end of July 1,717 patients waited in excess of 26-weeks.

- **Non-Imaging –** Non-Imaging forms part of the diagnostic OGI and at end of August 2017 48% of patients waited less than 9-weeks, with 284 patients in excess of 26-weeks.

- **Endoscopy** – Endoscopy forms part of the diagnostic OGI and at end of August 2017 48% of patients waited less than 9-weeks, with 121 patients waiting in excess of 26-weeks.

  Endoscopy is particularly affected by demand for red flag, urgent and planned (repeat cases) and over the last two years has been affected by workforce issues with vacancies and more recently maternity leaves in the cohort of staff that undertake the highest volumes of activity. The Trust is unable to replace these operators in the short term impacting on the ability to deliver the commissioned volumes of activity and had made a proleptic appointment for succession planning.

- **<u>In-patients and Day Cases</u> – OGI 4.10** –Whilst the Trust anticipated that this OGI would be partially achievable this was dependent on the availability of additional resources and ability to secure additional capacity. At the end August 2017, there were 35% of patients waiting less than 13-weeks with 1,593 patients waiting in excess of 52-weeks.

  Specialties that are in excess of the 52-weeks include Cardiology, General Surgery, Orthopaedics, Pain Management and Urology which all have substantive capacity gaps.

- **<u>Diagnostic Reporting Turnaround Time (DRTT) (Urgents) – OGI 4.11</u>**

The Trust is not on track to achieve the OGI that all urgent diagnostic tests should be reported on within 2-days. As at end August 2017, performance (for combined Imaging and Non-Imaging) was 78.9% of urgent diagnostic tests were reported within 48-hours. Imaging reporting is more challenged than non-imaging report with cumulative performance at end August 77.9% reported within 48-hours and 92.8% of non-imaging reported within 48-hours.

Workforce issues, associated with vacancies within the medical workforce in the diagnostic imaging service, continue to be the dominant factor impacting on performance.
Actions being taken to seek to manage and improve performance include increasing capacity in-house and in the independent sector; implementing skill mix via Reporting Radiographers and active recruitment strategies with radiology identified as one of the workforce areas for recruitment as part of the Regional International recruitment exercise. It is not anticipated performance will improve until workforce issues are resolved.

- **14-Day Breast Cancer – OGI 4.12(.1)**

Pressures felt in 2016/17 associated with workforce have continued into 2017/18. The inability to attract breast radiologists limits the level of capacity that can be provided for assessment and is well below the level of demand with an estimated gap of 80 assessments per month. In the period April – August 2017, 622 patients seen were not assessed within the 14-days and cumulatively only 21% of patients have been seen within 14-days.In addition to the red flag referrals, approximately 1,000 patients are waiting for routine assessment.

This risk has been escalated and regional agreement now reached for other Trusts to provide a level of capacity to SHSCT to enable the demand for red flag referrals to be met. The SHSCT has increased its own in-house capacity for assessment, has implemented strategies for the management of low risk referrals and continues to explore options to establish additional capacity via engagement of a range of locum staff.

The Trust continues to participate in the regional review of breast assessment services to seek a sustainable regional solution.

- **Cancer 62 –Day Pathway – OGI 4.12(.3)**

The Trust is not achieving the OGI that at least 95% of patients, urgently referred with a suspected cancer, should begin their first definitive treatment within 62-days. In July 2017 (latest available position) 66.9% of patients began their treatment within 62-days. Focus remains on the Day 85 backstop and in July there were 24 breaches of the Day 85 cancer pathway associated with complex patient pathways.

Increase red flag demand has resulted in a higher level of patients on the cancer pathways which makes the objective more challenging to achieve with particular pressures on assessment and diagnostics aspects of the pathway. Key challenges

remain in urology and upper and lower GI. It is important to note that the number of confirmed cancers has not increased disproportionately despite the increased pathway demand.

- **Mental Health Elective Services – OGI (14.3)**

The Trust continues to work towards the elective access OGI of 9-weeks for mental health out-patient appointments including adult, dementia and child and adolescent mental health services (CAMHs) and 13-weeks for psychological therapies. However, performance has become increasingly challenging related to demand exceeding commissioned capacity, increase in urgent demand and insufficient recurrent investment resulting in ongoing capacity gaps and accruing backlogs.

Further, the short term nature of non-recurrent funding, which while welcomed, does not permit forward planning resulting in increasing challenges to the ability to increase capacity.

The Trust is also required to ensure capacity to manage the ongoing need for review and intervention as part of its governance arrangements and must balance elective demand for new assessment and treatment against ongoing requirements for review on the active caseload.

- **Child and Adolescent Mental Health – OGI 14.3 (1)**

At the end August 2017, 33 patients waited greater than 9-weeks and the performance trajectory for this service anticipates further growth in excess waits towards the end of the year.

Key challenges relate to demand which is in excess of capacity and in sustaining the substantive level of capacity which is significantly affected by sickness absence currently. Recurrent investment will be required to improve this service outlook. The

Trust will seek to improve this position with the application of non-recurrent resources where it is possible to temporarily increase capacity.

- **Adult Mental Health (Primary MHC) – OGI 4.13(.2)**

At the end August 2017, 87 patients were waiting greater than 9-weeks.

Performance is affected by an increase in demand over the last 3 years and has also been impacted by workforce vacancies. A number of actions have been taken to manage and improve performance and include recurrent investment in additional staffing in 2016/17 and increased capacity in the independent sector (IS). The Trust will seek to continue to utilise the IS for the management of lower level referrals and develop services in-house to deal with more complex referrals.

- **Mental Health Services (Dementia) – OGI 4.13(.3)**

The Trust continues to be challenged by this target due to demand which is in excess of capacity and at the end of August 2017, 23 patients were waiting greater than 9-weeks.

The Trust continues to work with the regional group in development of models and pathways in keeping with the regional review of dementia services however has an established capacity gap which will prevent full implementation of the agreed pathways when finalised. In addition, workforce issues related to the ability to attract psychiatrists of old age are starting to impact service delivery. Performance trajectories project an increase in waits over 9 weeks towards year end.

- **Mental Health Services (Psychological Therapies) – OGI 4.13(.4)**

The Trust identified that this OGI was not achievable and at the end of August 2017 performance demonstrates 62 patients waited greater than 13-weeks.

Key challenges, which have been experienced regionally, relate to workforce and the inability to recruit specialist posts. The Trust has reviewed and restructured its service delivery model and is currently recruiting to this. A range of pathways have been explored to facilitate streaming of appropriate referrals to alternative services to reduce the demand on specialist psychological services.

- **Unplanned Admissions (Specified Long-Term Conditions) – OGI 5.2**

This OGI was not achieved in 2016/17 and this continues to be the case for this year.

Increases in demography and increases in the prevalence of specific long term condition present challenge to the achievement of this objective which is outcomes based and requires the input of multiple stakeholders.

A number of actions are being undertaken to improve management and support to long term conditions where the patients are known to the service via self-management and specialist management in the community.

- **Allied Health Professionals – OGI 5.3**

At the end of August 2017, 6 of a total of 6,668 patients were waiting greater than 13-weeks with the greatest volumes, approximately 67% in Physiotherapy All professions have waits greater than 13-weeks.

Recurrent investment by the Trust in 2016/17 increased capacity by 14.5wte however demand continues to exceed capacity and accrued backlogs see continued long waits.

The Trust has in addition, continued to direct non recurrent resource to increase capacity within AHP but this has been challenged by the inability to increase capacity on a short term/temporary basis. A peripatetic pool of staff has now been developed to

enable the service to be able to more responsively increase capacity, subject to funding, and provides for succession planning.

- **Hospital Cancelled Out-Patient Appointments – OGI 7.1**

Whilst the Trust has the lowest level of hospital initiated cancellations regionally it is not on track to achieve the further improvement sought this year. At the end of August, the Trust had exceeded the volume of cancellations sought by 18% with 7,109 cancellations.

The Trust has the lowest target, approximately 6,000 lower than any other Trust due to early good performance and thethe abilitye to continue to improve is challenged.

The Trust is continuing to promote activities to further reduce cancellations which in the main relate to late notification of availability for sessions, related to annual leave, changes in schedules associated with workforce issues/unscheduled care demands.

- **Service & Budget Agreements – OGI 7.4**

This OGI, seeks improvement across levels of commissioned elective activity delivered however performance trajectories for this year indicate a position less favourable than 2016/17.

This is predominantly associated with workforce challenges, particularly related to middle grade doctor availability, the competing pressures of unscheduled care demands and to a lesser extent changes in practice.

The Trust continues to work with the local commissioner to ensure SBA volumes are as reflective as possible however protecting elective capacity continues to be challenging. Regional work is ongoing to explore ability to increase elective capacity and the Trust is participating in this.

Whilst the Trust will continue to seek opportunities to improve performance over the remainder of this year, it is anticipated this position will not change substantially in this period.

5. Finance

I confirm that proper financial controls are in place, with the exception of those areas subsequently identified in sections 6 to 13 of this report, to enable me to ensure value for money, propriety and regularity of expenditure under my control, manage my organisation's budget, protect any financial assets under my care and achieve maximum utilisation of my budget to support the achievement of financial targets.

I confirm compliance with the principles set out in MPMNI and the Financial Memoranda which includes:

- safeguarding funds and ensuring that they are applied only to the purposes for which they were voted;
- seeking Departmental approval for any expenditure outside the delegated limits in accordance with Departmental guidance;
- preparation of business cases for all expenditure proposals in line with Northern Ireland Guide Expenditure Appraisal and Evaluation (NIGEAE) and Departmental guidance and ensuring that the organisation's procurement, projects and processes are systematically evaluated and assessed;
- accounting accurately for the organisation's financial position and transactions;
- securing goods and services through competitive means unless there are convincing reasons to the contrary; and
- procurement activity should be carried out by means of a Service Level Agreement with a recognised and approved Centre of Procurement Expertise (CoPE)

The adequacy and effectiveness of these controls are regularly reviewed by Internal and External Audit, as well as the completion of controls assurance standard self-assessments.

6. Information Governance - General Data Protection Regulation (GDPR)

I can confirm that my organisation is taking appropriate steps and carrying out the necessary actions to ensure we are appropriately prepared for GDPR by May 2018. The Information Governance Department participates in the work of the regional GDPR Sub Group which was commissioned by the Department of Health in 2016. An Action Plan has been developed by this group and is being progressed by Information Governance leads in all Trusts. A Fair Processing (Privacy Notice) which provides details of the processing of personal data has been developed and will be rolled out to all Trusts. Liaison with the ICO is ongoing as guidance and advice on GDPR is disseminated and clarified. Internally, the Information Governance Department has drafted a Communications Plan to ensure all staff groups are informed of changes in legislation appropriate to their service area. Privacy Impact Assessments have been implemented in the Trust, which are now a mandatory requirement in line with the DoH instruction issued July 2017. To meet the strengthened emphasis on accountability and transparency, the Trust has a robust information governance framework in place to identify major data processing flows. These are captured in an Information Asset Register which is reviewed and updated to ensure the appropriate protection measures are in place.

7. Controls Assurance

I confirm implementation of action plans arising from the year-end self-assessments of compliance with Controls Assurance Standards. In addition, a composite action plan is in place to address areas where individual criterion performance was <75%. The Trust has commenced the CAS process for 2017/18.

8. External Audit Reports

I confirm that action is being taken on all of the External Auditor's accepted recommendations. Not all of these recommendations are wholly within the control of the Trust but dependent on regional action/other HSC bodies in some cases as below:

- The Trust should continue to develop its processes and controls to ensure that notifications are being made to PSS on a timely basis and work with PSS and other health bodies to address the points raised by Internal Audit to clearly define roles and responsibilities in the payroll process.

- The Trust should co-ordinate with the BSO Payment SS department to ensure that the Trust complies as far as possible with all Departmental targets.

Progress on the implementation of all external audit recommendations as detailed in the Report to those charged with Governance is reviewed regularly at Audit Committee meetings with the next review scheduled for 12th October 2017.

9. Internal Audit

To date, Internal Audit has issued the following reports in 2017/18:

AUDIT ASSIGNMENT	LEVEL OF ASSURANCE PROVIDED BY INTERNAL AUDIT
Financial Assessments	Satisfactory
Adult Supported Living	Satisfactory
Self-Directed Support Payments	Satisfactory
Claims Management	Satisfactory
Non pay expenditure	Satisfactory Limited for agency payments

AUDIT ASSIGNMENT	LEVEL OF ASSURANCE PROVIDED BY INTERNAL AUDIT
Client Monies in Independent Sector (Residential Homes and Adult Supported Living Facilities in Independent Sector)	Satisfactory – 10 out of 12 facilities visited Limited – 2 out of 12 facilities visited
Acute Directorate Finance Audit - Catering	Satisfactory – procurement/contract management/cash management Limited – stock management at Daisy Hill Hospital
Management of medical locums	Limited
Non pay – invoice testing	N/A

4 priority one findings were identified in the above audit assignments. These will be addressed by Trust management. They related to:

- All agency invoices should be properly checked and verified back to contract rates prior to approval.

- Direct Award Contract documentation should be put in place for off-contract Locum spend, where such spend cannot be avoided.

- The Trust should carry out a review of non-contract locum use. Where the use of non-contract agencies cannot be avoided, the Trust should have policies in place to maximise value for money. The Trust should seek policy direction from DoH over the continued use of non-contract agencies.

- The Trust should develop policy to maximise value for money and the ability to control expenditure, when using locums. Internal Audit appreciates that co-ordination with other Trusts and DoH will be required to address this issue effectively.

The Trust has a system in place to track progress on the implementation of all outstanding internal audit recommendations in conjunction with Internal Audit. Progress is reviewed and robustly challenged at each meeting of the Audit Committee and most recently on 12th October 2017.

Shared Services Audits

The Trust has been made aware of the results of 3 internal audits carried out in BSO Shared Services, of which the Trust is a client. A satisfactory level of assurance was provided in respect of Accounts Receivable Shares Services and the FPL upgrade.

A follow up of previous audit recommendations for BSO Payroll Shared Services was conducted in September however, the assurance level remains at Limited/unacceptable as was reported in March 2017.

Trust management will continue to monitor the implementation of associated action plans with BSO Shared Services and progress is also reported to Audit Committee.

This has been further referenced below in internal control divergences.

During their mid-year follow up, Internal Audit found that 72% of the Trust's recommendations examined were fully implemented, a further 21% were partially implemented and 7% were not implemented at the time of review. Monitoring of the progress of all outstanding recommendations will continue on a regular basis through Audit Committee.

10. RQIA and Other Reports

I confirm implementation of the accepted recommendations made by RQIA. The Trust has established a corporate system to provide timely updates on the progress made against recommendations of RQIA reviews to the Department of Health.

In relation to licensing bodies, the Trust has a central log in place. The RQIA Child Protection Review was completed during November 16 to January 17 and the Trust is awaiting feedback and the Review report from RQIA.

11. NAO Audit Committee Checklist

I confirm completion of the NAO Audit Committee Checklist and there were no issues that required to be addressed.

12. Board Governance Self-Assessment Tool

I confirm completion of the Board Governance Self-Assessment Tool and this did not indicate any significant governance issues.

13. Internal Control Divergences

New Control Issues for 2017/18

Fraud cases

There have been 8 cases of fraud reported to the Counter Fraud and Probity Services to date this year. There are also 10 cases from prior years under investigation by them.

Progress on each of the on-going internal control divergences as reported in the Governance statement for the year ended 31 March 2017 is given below:

Contract & Procurement Management

Estates

The new HSC regional model, a collaboration between BSO Procurement and Logistics Service (PaLS) and Trust Estates teams is now established and the regional programme is being overseen by the Regional Estates Procurement Group.

A Contract Managers Group (sub group of the REPG) with practitioners from all Trusts was established in 2017 to help drive the Regional Programme forward. Several regional contracts have now been awarded and a number are at various stages of procurement.

Estates maintain a database of all contracts including key dates and monitor the performance of all contracts taking such action as necessary to ensure continued compliance and effectiveness.

All procurement is undertaken in accordance with COPE guidance and using the ETendersNI system.

The DAC process is followed as appropriate to specific procurements (e.g. where there is only one provider or in order to achieve alignment with the Regional Plan).

Social Care Procurement

The Regional Procurement Board agreed an approach/strategy for over threshold (EU level) social care procurement.

The Social Care Procurement Implementation Board is now charged with implementing that approach and the SHSCT has representation on that Board.

No common regional approach has been agreed for contracts under threshold.

General Contract Management

The position remains that no progress has been possible on the implementation of a central contract database or improvement general contract management arrangements. The Trust continues to use Direct Award Contracts and these are monitored and reported.
Procurement awareness training has been delivered by PALS in 2017/18, including some DAC training.

The establishment of a central contract management team with supporting systems will be reviewed on a regular basis as opportunities for managerial/administrative changes arise and provide the potential for re-investment.

Estate Risks

Water Borne Risks (Legionella, Pseudomonas etc.)

The Trust continues to manage Water Borne Risks through implementation of the arrangements set out in its Water Safety Plan. Performance against this plan was validated in early 2016/17 and again in January 2017 by independent specialists. The plan is presently being reviewed in light of this specialist input and works to refurbish the CAH Hydrotherapy Pool, a recommendation from the reviews, will be completed in 2017/18.

Installation of a Copper Silver ionisation system for the treatment of water and control of pathogens such as Legionella and Pseudomonas in Craigavon Area Hospital has exhibited success in reducing the instances of positive legionella detections. The roll out of similar systems across other hospital sites and facilities was made operational at the end of 2016/17.

A Water Safety sampling contract was re-procured in 2016/17 and a revised sampling regime is now in place.

Trust Estate Risks

The age, condition and nature of the estate continue to pose potential risks and are exacerbated by limited investment in major renewal and replacement projects. With respect to the previously identified risk regarding business continuity, progress has been made. The new HV electricity supply arrangements for Craigavon Area Hospital are now complete and a review of LV infrastructure is under way. A Trust wide telecoms infrastructure upgrade which progressed well during 2016/17 has been slowed due to the present funding constraints. These initiatives include increased resilience in support of patient services.

Clinical and Social Care Risks

Elective Care/Unscheduled Care/Breast Service

As noted in section 4, performance targets in 2017/18 are not being met with significant challenges in each of these areas. The Trust continues to work to try to find resolutions going forward.

The Donaldson Report

The new electronic Morbidity & Mortality system has now been fully implemented across the Southern Trust, and usage has increased significantly in the last quarter.

Food safety testing

The Trust is still pursing the external laboratory for compensation via the Directorate of Legal Services.

Recruitment

The Trust continues to experience significant recruitment challenges across many professions, including medical, nursing and midwifery and GP staff as well as a number of other workforce areas, including AHP, Psychology and Social Care. This requires a wide range of actions, both locally and regionally, to address the gaps in the workforce on an ongoing basis to ensure service continuity, quality and patient / client safety.

The Trust continues to work collaboratively with other Trusts where possible, as well as with the HSCB and the DOH to address this, including measures to minimise competitive tensions within the HSC caused by a limited pool of staff resources. In particular, a process is in place to ensure our vulnerable medical specialities are flagged, in an effort to ensure greater collaboration around recruitment plans to avoid destabilisation of existing 'at risk' services. In addition, International Recruitment campaigns for medical and nursing staff have continued in 2017/18 as a means to ease workforce pressures in these areas.

For other areas of the workforce, significant local and regional work is being undertaken in conjunction with the BSO Recruitment & Selection Shared Service Centre (RSSC). A new regional group has been established – the Strategic Resourcing Innovation Forum (SRIF) – which is accountable to HR Directors and on which the Trust is represented at Assistant Director and Head of Service level. There is also DOH representation on this group. A Programme of Work has been developed across four work streams, each led by an Assistant Director from across the HSC to collaboratively progress a range of actions aimed at improving the number and quality of applicants to the Trust and the speed with which appointments are made.

A local Trust Resourcing action plan has also been developed, which seeks to ensure that all unnecessary delays in the recruitment and selection process which are caused by factors within the control of Trust managers and/or HR teams, are minimised or eliminated as well as ensuring that all necessary action is taken to widen the pool of talent applying for our posts, particularly in 'hard-to-fill' areas.

Emergency Department at Daisy Hill Hospital

The Southern Trust has commenced a Pathfinder Project, involving a wide range of stakeholders including community representatives. It has recently published its first interim report, which supports the Trust's position that a 24/7 Emergency Department should be maintained at Daisy Hill Hospital. Whilst it is recognised that challenges remain, through the Pathfinder Project the Southern Trust will continue to work together to develop a sustainable model for the service that will support our workforce and ensure that we can achieve the very best outcomes for our patients.

Serious Adverse Incident

The Trust received a safeguarding alert on 14 April 2017 with regard to an elderly man who was resident in Irrelevant information redacted by the USI. A thorough PSNI investigation was completed and no prosecutions have been made. The care of all other residents in the Home has been reviewed and ongoing communication with families was established at the start of the investigation. No other concerns have been raised.

Financial Risks

Performance of Finance Functions within BSO Shared Services Centres

The Head of Internal Audit has followed up the audit recommendations made for the BSO Payroll Shared Services Centre in March 2017 when a limited assurance was

provided with unacceptable assurance in respect of the payroll system and function stability. Whilst the assurance levels have not improved in September 2017, good progress in a number of areas has been recognised.

There is also now an established BSO Payroll Improvement Project consisting of 3 workstreams: system performance; independent review of structures; and payroll quality. Trusts have contributed resources to this project. A customer assurance board, chaired by the BSO DOF and a Trust DOF oversee this project. The project reports on progress monthly to the regional Business Systems Improvement group and the Business Systems Forum.

BSO Recruitment Shared Services Centre (RSSC)

During 2016/17, concerns were expressed by Trust managers about the performance of RSSC and resulted in a formal recovery plan, overseen by a regional 'Task & Finish' group. This group was stood down in May 2017, having implemented a range of initiatives to standardise and streamline processes regionally, along with other elements of improvement work.

The recently established Strategic Resourcing Innovation Forum (SRIF) has an overall programme of work which incorporates four workstreams, tasked with identifying and delivering on actions impacting on the performance of the Recruitment & Selection Shared Service Centre as well as the wider Resourcing function across the HSC.

A key piece of work which the Trust has commenced in conjunction with RSSC is to review and consolidate the Trust's approach to waiting list management. In response to the Trust's concerns about failure to meet agreed KPIs for appointments from waiting lists, RSSC has implemented changes to its team structures and processes, which has been welcomed although remains 'work in progress' to achieve tangible improvements in KPIs for the remainder of 2017/18.

The current quality and depth of management information being provided by the RSSC, facilitated by continuing enhancements to reporting functionality in the E-Recruitment system as well as significant improvements in data quality, enables the Trust to gain greater understanding of the particular barriers and delays which need to be addressed. This is progressed through a structured schedule of Customer Forum, operational review meetings and day-to-day management of issues, assisted by identified 'Directorate liaison' staff within the Trust's Resourcing Team.

Failures in supervisory and managerial controls

Initiatives continue in 2017/18 in raising awareness of the importance of robust managerial controls via learning from disciplinary and fraud cases, Trust communications, internal audit findings, dissemination of greater management information on overpayments and their causes etc. This is a continuous process, constantly evolving and developing and will continue throughout 2017/18.

Domiciliary Care Services

The Trust has carried out further validation work on 6 independent sector providers (ISPs) during 2017/18 following the Counter Fraud and Probity Services report issued in March 2017. A draft report of these findings and an associated action plan has been prepared and presented to the Trust's senior management team. The Trust will continue to work through the action plan over the remainder of 2017/18.

Internal Audit has also conducted two ISP audits as part of the Internal Audit Programme for 2017/18 and these will be reported to the Audit Committee in due course.

Waiting List Initiative Payments

The Trust is progressing the audit recommendations made and awaits a formal written response from the Department of Health.

Financial Outlook 2017/18

The Trust began 2017/18 with a total recurrent opening gap of £20.6m, however, over recent months with a combination of recurrent and non-recurrent funding support this opening gap has been reduced to nil for the current year. In addition, however, the Trust was tasked with achieving a new savings target of £6.4m together with £1.5m pharmacy efficiencies. In accordance with Departmental guidance, the Trust is currently out to public consultation on a range of savings measures to achieve the £6.4m.

There is no doubt that 2017/18 is proving to be another exceptionally difficult year for the entire Health and Social Care System but as with other financial years the Trust remains committed to achieving financial break-even.

Irregular Expenditure on Trust Lease

A business case concerning the lease for premises used to store and dispense incontinence products for which the Trust incurred irregular expenditure has been submitted to the DoH by the Trust in 2017/18.

The Trust has also reinforced procedures in order to prevent a further reoccurrence of this situation arising. The process for review and renewal of other leases has been delayed in 2017/18 due to staff shortages, however, a recruitment process is underway and it is anticipated that a replacement Property Manager will be in post by December and the Action Plan to take this forward, finalised by the end of October.

14. Mid-year assurance report from Chief Internal Auditor

I confirm that I have referred to the Mid-Year Assurance report from the Chief Internal Auditor, which details the organisation's implementation of accepted audit recommendations e.g. Controls Assurance Action Plans and Risk Register Action Plans.

Signed Personal Information redacted by the USI

INTERIM CHIEF EXECUTIVE & ACCOUNTING OFFICER

13 October 2017

REVENUE BUSINESS CASE PROFORMA COVER

(To be submitted with every business case)

Name of organisation	Southern Health and Social care Trust
Project Title	Acute Consultant Physician & Specialty Doctor Posts IPT (Demography Funding)
Total Cost	£1,005k FYE
Start date	01 January 2018
Completion date	Recurrent funding

Complete this section if bid is for new funding

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	N - Demography Funding 2017/18
How much total funding required?	
How much funding required per year?	
Is this funding to be made recurrent?	

Complete this section if funding available within existing allocation

Funding available within existing allocation (Y/N)	Y (Demography Funding 2017/18)
Total cost of proposal	£1,005k FYE
Cost of proposal per year	£1,005k FYE, 2017/18 £252k CYE
Is this cost within recurrent allocation?	Y (2017/18 Demography Funding)

Is this business case	***Y/N***
(a) Standard	Y
(b) Novel	N
© Contentious	N
(d) Setting a precedent	N
If yes to (b) or (c) or (d) , requires Departmental & DoF approval Is Departmental / DOF approval required	

Approval & submission by Trust

This section to be completed by Trusts for all submissions

Responsible Director Signature (required for all submissions)

Name Printed: Esther Gishkori (signed) Personal Information redacted by the USI

Grade/ Title Director of Acute Services

Date 18-Oct-17

Trust Director of Finance Signature (required if bid is over £100k)

Name printed pp. Helen O'Neill **(signed)** Personal Information redacted by the USI

Date 18-Oct-17

pp

Trust Chief Executive Signature (required if bid is over £100k)

Name printed STEPHEN MCNALLY **(signed)** Personal Information redacted by the USI

Date 18-Oct-17

Complete this section if Department / DOF approval required

Date submitted to Department

Department/ DOF approval (y/n)

Date approved

BUSINESS CASE TEMPLATE - £1m **REVENUE FUNDING £250k**

SECTION 1(a): PROJECT BACKGROUND AND STRATEGIC CONTEXT

The Southern Health and Social Care Trust (Southern Trust) provides acute and community health and social care services to a population of some 380,000 adults and children living in the legacy council areas of Armagh, Banbridge, Craigavon, Dungannon, and Newry and Mourne. The Trust has an income of approximately £576m and employs some 14,000 people to provide health and social care to the local population. The acute hospital services are used by people outside the Southern area including Fermanagh, Down and Lisburn, Antrim, Cookstown, Magherafelt and the Republic of Ireland.

Non elective hospital services, including Emergency Department (ED) and inpatient admissions, are delivered from Craigavon Area and Daisy Hill Hospitals.

The Trust has been facing increasing challenges with regard to ED attendances and consequently the number of non-elective admissions which have been increasing year on year. There had been limited expansion in consultant physician numbers and the funded establishment had fallen short of the numbers recommended by the Royal College of Physicians for the catchment population size. It was also lower than other Trusts within Northern Ireland. Repeated recruitment drives had failed to fill vacant, funded posts, leading to an over-reliance on locums. Early in 2017 the Acute Directorate presented a paper to the Senior Management Team highlighting concerns regarding the delivery of acute medical care in Craigavon Area Hospital (CAH). These were:

- Increasing non elective activity – ED attendances and medical inpatient admissions;
- Elective waiting lists growing due to a shift in focus to managing unscheduled care pressures;
- Growing demographic pressure – increasing numbers of older people requiring hospital services;
- Under resourced medical workforce compared to other NI sites;
- Availability of medical and clinical posts regionally;
- Safety and governance concerns.

A further paper was presented to SMT in October 2017, recommending that the Trust increase the numbers of consultant physician and specialty doctor posts at CAH to reduce the risks associated with the stated concerns.

SECTION 1(b): DEMONSTRATE THE NEED FOR THE PROJECT

Medical Staffing Levels at CAH

The acute medical model in Craigavon Area Hospital (CAH) is provided by the following specialties:

- Acute Internal Medicine
- Respiratory
- Endocrinology
- Gastroenterology

Table 1 shows the number of funded consultant posts at September 2017, along with the numbers of permanent and locum staff in post. Table 2 provides the same information for specialty doctor/associate specialist posts.

Table 1: Consultant Physicians for Acute Take at CAH, September 2017

Specialty	Funded Posts	Permanent Consultants	Locums	Vacant
Acute Medicine	4	2	2[1]	0
Gastroenterology	4	3	0	1
Respiratory	3	3	0	0
Endocrinology	2	2	0	0
Rheumatology[2]	1	1	0	0

Notes to Table 1:

1) There are a further 2 locums covering temporary posts to manage outlying patients. These are not funded vacancies.
2) The specialty of rheumatology does not generally participate in the acute take. However, there is one post which is 50% acute medicine and 50% rheumatology.

Table 2: Specialty Doctors/Associate Specialists for Acute Take at CAH, September 2017

Specialty	Funded Posts	Permanent SASs	Temporary/ Locums	Vacant
Acute Medicine	5[1]	4	1	0
Gastroenterology	1	1	0	0
Respiratory	1	1	0	0
Endocrinology	0	0	0	0

Non-Elective Activity CAH

Table 3 provides non elective activity for the period 2013/14 to 2016/17. The following specialties on admission have been included:

- Accident & Emergency
- General Medicine
- Gastroenterology
- Respiratory Medicine

The figures show a significant rise of 15.2% in the 4 year period.

Table 3: Non Elective Admissions to Craigavon Area Hospital

	2013/14	2014/15	2015/16	2016/17	% Increase
Non Elective Admissions	9,853	10,906	10,831	11,347	15.2%

A high level comparison of Southern Trust performance with that of other Trusts demonstrates consistently high performance across a range of indicators. Tables 4 and 5 provide data from the Department of Health *Hospital Statistics: inpatient and day case activity statistics 2016/17* for the Acute Programme of Care and for the specialty of general medicine.

Table 4: Hospital Statistics – Hospital Statistics for Acute Programme of Care 2016/17

	% Occupancy	Throughput	Average Length of Stay	Turnover Interval
Belfast HSCT	79.8	47.2	6.2	1.6
Northern HSCT	85.3	55.6	5.6	1.0
South Eastern HSCT	86.0	62.5	5.0	0.8
Southern HSCT	88.6	75.3	4.3	0.6
Western HSCT	83.6	72.9	4.2	0.8
NI Average	83.5	58.5	5.2	1.0

Table 5: Hospital Statistics for General Medicine - 2016/17

	% Occupancy	Throughput	Average Length of Stay	Turnover Interval
Belfast HSCT	70.4	39.7	6.5	2.7
Northern HSCT	92.2	52.4	6.4	0.5
South Eastern HSCT	94.1	55.6	6.2	0.4
Southern HSCT	95.2	63.2	5.5	0.3
Western HSCT	91.8	55.6	6.0	0.5
NI Average	90.5	54.5	6.1	0.6

Regional medical Workforce

Table 6 shows the number of funded consultant physician posts by Trust and hospital for acute medicine, gastroenterology, respiratory and endocrinology. As the data demonstrate, the SHSCT/CAH has a significantly lower level of funded staff in relation to other Trusts and comparable hospitals.

Table 6: Funded Consultant Posts by Trust and Hospital[1]

	Funded Posts	Permanent Consultants	Locums	Vacant	Population	Funded Posts per 250,000 Pop
Acute Medicine						
Royal	6	5	0	1		
Royal/City	4	4	0	0		
Mater	1	1	0	0		
Total BHSCT	11	10	0	1	354,706	**7.75**
Antrim	7	5	0	2		

[1] *Source: Medical Workforce Planning in Northern Ireland for acute medical specialties Draft PHA June 2017*

Causeway	1	1	0	0		
Total NHSCT	8	6	0	2	473,076	**4.23**
Ulster	6	6	0	0		
Total SEHSCT	6	6	0	0	356,693	**4.21**
Craigavon	4	2	2	0		
Total SHSCT	4	2	2	0	377,231	**2.65**
Altnagelvin	7	3	2	2		
South West	1.5	1	0	0.5		
Total WHSCT	8.5	4	2	2.5	300,431	**7.07**
Gastroenterology						
Royal/City/Mater	10	10	0	0		
City	1	1	0	0		
Mater	2	2	0	0		
Total BHSCT	13	13	0	0	354,706	**9.16**
Antrim	7	7	0	0		
Causeway	2	2	0	0		
Total NHSCT	9	9	0	0	473,076	**4.76**
Ulster	3	3	0	0		
Ulster/Lagan Val	1	1	0	0		
Ulster/Downe	1	1	0	0		
Lagan Valley	1	1	0	0		
Total SEHSCT	6	6	0	0	356,693	**4.21**
Craigavon	4	4	0	0		
Daisy Hill	2	2	0	0		
Total SHSCT	6	6	0	0	377,231	**3.98**
Altnagelvin	4	3	0	1		
South West	2	2	0	0		
Total WHSCT	6	5	0	1	300,431	**4.99**
Respiratory						
Royal	8	8	0	0		
City	9	8	0	1		
Mater	4	4	0	0		
Total BHSCT	21	20	0	1	354,706	**14.80**
Antrim	7	6	0	1		
Causeway	2	1	0	1		

Total NHSCT	9	7	0	2	473,076	**4.76**
Ulster	5	5	0	0		
Ulster/Downe	1	1	0	0		
Lagan Valley	1	1	0	0		
Total SEHSCT	7	7	0	0	356,693	**4.91**
Craigavon	3	3	0	0		
Daisy Hill	2	2	0	0		
Total SHSCT	5	5	0	0	377,231	**3.31**
Altnagelvin	5	4	1	0		
South West	1	1	0	0		
Total WHSCT	6	5	1	0	300,431	**4.99**
Endocrinology[3]						
Royal	6	5	0	1		
City	1	1	0	0		
Mater	2	2	0	0		
Total BHSCT	9	8	0	1	354,706	**6.34**
Antrim	3	3	0	0		
Causeway	1	0	0	1		
Total NHSCT	4	3	0	1	473,076	**2.11**
Ulster	4	4	0	0		
Lagan Valley	1	1	0	0		
Downe	1	1	0	0		
Total SEHSCT	6	6	0	0	356,693	**4.21**
Craigavon	2	2	0	0		
Daisy Hill	2	2	0	0		
Total SHSCT	4	4	0	0	377,231	**2.65**
Altnagelvin	2	2	0	0		
South West	2	0	1	1		
Total WHSCT	4	2	1	1	300,431	**3.33**
Summary of Specialties						
BHSCT	54	51	0	3	354,706	**38.06**
NHSCT	30	25	0	5	473,076	**15.85**
SEHSCT	25	25	0	0	356,693	**17.52**
SHSCT	19	17	2	0	377,231	**12.59**
WHSCT	24.5	16	4	4.5	300,431	**20.39**

Notes to Table 6:

1) Only funded posts are included in the analysis.
2) Data relate to the position at March 2017 for all Trusts except the Western Trust. The Western Trust data relate to the September 2016 position.
3) **Two additional** consultant gastroenterologists have been appointed by SEHSCT to the Ulster Hospital since March 2017, bringing the total complement at **SEHSCT to 8** which equates to **5.61 funded posts per 250,000 population.**
4) Northern Ireland Statistics and Research (NISRA) 2016 mid-year population estimates (published 22 June 2017) for Health & Social Care Trusts have been used.

RCP Guidelines for Consultant Physicians

The Royal College of Physicians *''Consultants working with Patients 2013''*, provides guidance on the consultant requirements by specialty for the population. The whole time equivalent (WTE) numbers for acute medicine, gastroenterology, respiratory and endocrinology are set out in Table 7. The figures demonstrate significant deficits across all sub specialty areas.

Table 7: Royal College of Physicians Guidance on Consultant Requirements

Specialty	RCP WTEs	SHSCT Requirement[1]	SHSCT Funded Posts	Deficit
Acute Medicine[2]	4 per site	4.00	4.00	0.00
Gastroenterology	6.9 per 250,000 population	10.41	6.00	4.41
Respiratory	7 per 250,000 population	10.56	5.00	5.56
Endocrinology	4 per 250,000 population	6.04	4.00	2.04

Notes to Table 7:

1) Northern Ireland Statistics and Research (NISRA) 2016 mid-year population estimate (published 22 June 2017) for Southern Health & Social Care Trust (377,231) has been used to calculate the SHSCT WTE requirement.
2) Acute medicine figures relate to the CAH site only.

Population Projections

Table 8 gives the population projections for Northern Ireland and the Southern Trust area for all ages and also for the 65 and over age group. The figures demonstrate a significant projected increase with a higher increase for the Southern Trust area than Northern Ireland as a whole, in total population numbers and also in the 65 years and older population. The older population tends to be the most reliant age group on acute hospital care.

Table 8: Northern Ireland Population Projections[2]

	2017	2020	2023	2026	2029	2032	2035	2039	% Increa 2017-
All Ages									
NI	1,873,502	1,903,663	1,930,407	1,954,144	1,974,120	1,990,810	2,005,005	2,021,322	**7.**
SHSCT	381,731	393,503	404,753	415,559	425,826	435,623	445,149	457,686	19.
Age 65 and Over									
NI	304,302	325,025	350,448	379,629	411,899	443,646	471,014	498,528	**63.**
SHSCT	55,427	59,798	65,003	70,998	77,832	84,632	90,973	98,104	**77.**

[2] Northern Ireland Statistics and Research Agency (NISRA) 2014 Based Population Projections, Published 2016

SECTION 2(a): OBJECTIVES

<table>
<tr><th>Project Objectives</th><th>Measurable Targets</th></tr>
<tr><td>1. Provision of a robust acute medical model at CAH.</td><td>1.1 Improve compliance with the RCP guidelines for acute medicine, gastroenterology by March 2018. RCP guidelines for SHSCT are as follows:
<table>
<tr><td></td><td></td></tr>
<tr><td>Acute Medicine</td><td>4.00</td></tr>
<tr><td>Gastroenterology</td><td>10.41</td></tr>
<tr><td>Respiratory</td><td>10.56</td></tr>
<tr><td>Endocrinology</td><td>6.04</td></tr>
</table>
Baseline:
<table>
<tr><td></td><td></td></tr>
<tr><td>Acute Medicine</td><td>4.00</td></tr>
<tr><td>Gastroenterology</td><td>6.00</td></tr>
<tr><td>Respiratory</td><td>5.00</td></tr>
<tr><td>Endocrinology</td><td>4.00</td></tr>
</table>
1.2 Comparable consultant staffing levels with other similar hospitals in NI by March 2018. (for baseline please refer to Table 6).</td></tr>
<tr><td>2. To improve senior medical cover on acute medical wards by March 2018</td><td>2.1 Increase capacity for specialist ward consultations by March 2018.
Baseline:
Two specialty doctors (1 in gastroenterology and 1 in respiratory medicine) are available to undertake specialist ward consultations.
2.2 Increase support to twice daily consultant ward rounds by March 2018.
Baseline:
There are currently 7 specialty doctor/associate specialist funded posts to support the consultant ward rounds.</td></tr>
<tr><td>3. To maintain high performance with regard to key performance indicators for acute medicine.</td><td>3.1 Maintain current performance with regard to KPIs for general medicine during 2018/19 and 2019/20:
Baseline:
2016/17 performance for general medicine:
<table>
<tr><th>KPI</th><th></th></tr>
<tr><td>% Occupancy</td><td>95.2%</td></tr>
<tr><td>Throughput</td><td>63.2</td></tr>
<tr><td>Average LOS</td><td>5.5</td></tr>
<tr><td>Turnover Interval</td><td>0.3</td></tr>
</table></td></tr>
</table>

SECTION 2(b): CONSTRAINTS

Constraints	Measures to address constraints
1. Availability of Funding	Additional funding has been identified within the Acute Directorate demography allocation.
2. Availability of Staff	Please refer to 'Risks' section 6

SECTION 3: IDENTIFY AND SHORTLIST OPTIONS

Option Number/ Description	Shortlisted (S) or Rejected (R)	Reason for Rejection
1. **Status Quo - continue with existing arrangements**	**S**	
2. **Increase Number of Consultant Physician Posts by 5** See below for detail.	**S**	
3. **Increase Number of Consultant Physician Posts by 5 and Specialty Doctor Posts by 3** See below for detail.	**S**	
4. Transfer Patients to Alternative NHS Provider	**R**	This option was considered but was not deemed to be feasible. Medical beds and consultants across the region are limited and the Trust does not believe that any other Trust has sufficient spare capacity to accommodate additional patients.

Option 2 - Increase Number of Consultant Physician Posts by 5

Option 2 involves providing funding for 5 new consultant physician posts, based at CAH:

Consultant	Respiratory	2
	Gastroenterology	2
	Endocrinology/Diabetology	1

In addition 0.50 WTE of a band 4 Personal Secretary will be funded for each new consultant (2.50 WTE in total).

Option 3 Increase Number of Consultant Physician Posts by 5 and Specialty Doctor Posts by 3

Option 3 also involves providing funding for 5 new consultant physician posts based at CAH. The acute medical model would be further enhanced by funding 3 new specialty doctor posts:

Consultant	Respiratory	2
	Gastroenterology	2
	Endocrinology/Diabetology	1
Specialty Doctor	Respiratory	1
	Gastroenterology	1
	Endocrinology/Diabetology	1

In addition 0.50 WTE band 4 Personal Secretary would be funded for each new consultant team - (2.50 WTE in total).

SECTION 4: MONETARY COSTS AND BENEFITS OF OPTIONS

Option 1: Status Quo	17/18 Year 0 £000's	18/19 Year 1 £000's	19/20 Year 2 £000's	20/21 Year 3 £000's	21/22 Year 4 £000's	22/23 Year 5 £000's	Totals £000's
Capital Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(a) Total Capital Cost	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Revenue Costs							
Revenue Baseline	53,594.2	53,594.2	53,594.2	53,594.2	53,594.2	53,594.2	321,565.2
(b) Total Revenue Cost	**53,594.2**	**53,594.2**	**53,594.2**	**53,594.2**	**53,594.2**	**53,594.2**	**321,565.2**
(c) Total Cost = (a) + (b)	**53,594.2**	**53,594.2**	**53,594.2**	**53,594.2**	**53,594.2**	**53,594.2**	**321,565.2**
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	**53,594.2**	**51,782.7**	**50,030.2**	**48,336.6**	**46,702.0**	**45,126.3**	**295,572.0**

COST ASSUMPTIONS:

Finance Assumptions:

1. Year 0 is 2017/18 Financial Year.
2. Baseline costs refer to the 2017/18 recurring revenue budget under AD for MUSC within the Acute directorate of SHSCT.
3. No other revenue or capital costs are associated with this option
4. A discount factor @3.5% pa has been applied to calculate the NPC.
5. Please note all figures above have been rounded to thousands and shown to one decimal point.
6. Total Net Present Cost (NPC) equates to £295,572.0k for this option

Option 2: Appoint 2 Consultants for Respiratory, 2 Consultants for Gastroenterology and 1 Consultant for Endocrinology/Diabetology with 0.50 Band 4 Personal Secretaries for each.	**17/18 Year 0 £000's**	**18/19 Year 1 £000's**	**19/20 Year 2 £000's**	**20/21 Year 3 £000's**	**21/22 Year 4 £000's**	**22/23 Year 5 £000's**	**Totals £000's**
Capital Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(a) Total Capital Cost	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Revenue Costs							
Revenue Baseline	53,594.2	53,594.2	53,594.2	53,594.2	53,594.2	53,594.2	321,565.2
Payroll	177.8	708.3	708.3	708.3	708.3	708.3	3,719.3
Payroll G&S	12.9	51.8	51.8	51.8	51.8	51.8	271.9
(b) Total Revenue Cost	**53,784.9**	**54,354.3**	**54,354.3**	**54,354.3**	**54,354.3**	**54,354.3**	**325,556.4**
(c) Total Cost = (a) + (b)	**53,784.9**	**54,354.3**	**54,354.3**	**54,354.3**	**54,354.3**	**54,354.3**	**325,556.4**
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	**53,784.9**	**52,517.1**	**50,739.7**	**49,022.1**	**47,364.3**	**45,766.3**	**299,194.4**

COST ASSUMPTIONS:

Finance Assumptions:

1. Year 0 is 2017/18 Financial Year.
2. Baseline costs refer to the 2017/18 recurring revenue budget under AD for MUSC within the Acute directorate of SHSCT.
3. The 5.00 WTE Consultants and 2.50 WTE Band 4 staff identified in Section 3 are costed according to the HSCB - General Costings - 2017/18.
4. All the Consultants have been costed at on-call Cat A with a 5% supplement and an excess travel allowance. Respiratory at 10.41 PA's, Gastroenterology at 11 PA's and Endocrinology/Diabetology at 10.91 PA's.
5. An allowance has been included for 10% Employee related G&S but not unsocial hours payments or annual leave and sickness cover.
6. We assume a three month impact in Year 0 (2017/18).
7. No capital costs are identified in this case.
8. A discount factor @3.5% pa has been applied to calculate the NPC.
9. Please note all figures above have been rounded to thousands and shown to one decimal point.
10. Total Net Present Cost (NPC) equates to £299,194.4k for this option.

Option 3: Appoint 2 Consultants for Respiratory, 2 Consultants for Gastroenterology and 1 Consultant for Endocrinology/Diabetology with 0.50 Band 4 Personal Secretaries for each and 3 Specialty Doctors	**17/18 Year 0 £000's**	**18/19 Year 1 £000's**	**19/20 Year 2 £000's**	**20/21 Year 3 £000's**	**21/22 Year 4 £000's**	**22/23 Year 5 £000's**	**Totals £000's**
Capital Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(a) Total Capital Cost	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Revenue Costs							
Revenue Baseline	53,594.2	53,594.2	53,594.2	53,594.2	53,594.2	53,594.2	321,565.2
Payroll	234.7	936.1	936.1	936.1	936.1	936.1	4,915.2
Payroll G&S	17.3	69.0	69.0	69.0	69.0	69.0	362.3
(b) Total Revenue Cost	**53,846.2**	**54,599.3**	**54,599.3**	**54,599.3**	**54,599.3**	**54,599.3**	**326,842.7**
(c) Total Cost = (a) + (b)	**53,846.2**	**54,599.3**	**54,599.3**	**54,599.3**	**54,599.3**	**54,599.3**	**326,842.7**
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	**53,846.2**	**52,753.8**	**50,968.4**	**49,243.1**	**47,577.8**	**45,972.6**	**300,361.9**

COST ASSUMPTIONS:

Finance Assumptions:

1. Year 0 is 2017/18 Financial Year.
2. Baseline costs refer to the 2017/18 recurring revenue budget under AD for MUSC within the Acute directorate of SHSCT.
3. The 5.00 WTE Consultants, 3.00 WTE Speciality Doctors and 2.50 Band 4 staff identified in Section 3 are costed according to the HSCB - General Costings - 2017/18.
4. All the Consultants have been costed at on-call Cat A with a 5% supplement and an excess travel allowance. Respiratory at 10.41 PA's, Gastroenterology at 11 PA's and Endocrinology/Diabetology at 10.91 PA's.
5. The Speciality Doctors Consultants have been costed at 10 PA's with an excess travel allowance but no allowance for on-call.
6. As per Option 2 we assumed a three month impact in Year 0 (2017/18).
7. No capital costs are identified in this case.
8. A discount factor @3.5% pa has been applied to calculate the NPC.
9. Please note all figures above have been rounded to thousands and shown to one decimal point.
10. Total Net Present Cost (NPC) equates to £300,361.9k for this option.

SECTION 5: NON MONETARY COSTS AND BENEFITS Weighting method

Benefit criteria are used as a basis against which each of the shortlisted options can be evaluated in terms of their potential to meet the specific project objectives. Taking into account the objectives of the proposed project, a list of benefits has been determined which could accrue from the project if implemented successfully. The criteria employed to select and evaluate the options, along with their weighting, are described below.

	Benefit Criterion	Weighting	Explanation
1	Compliance with RCP Guidelines	30	The Royal College of Physicians are best placed to advise on the optimum level of consultant support required by the service. Compliance with this criterion will have a very positive impact on local people requiring urgent medical care and it is therefore considered to be the most important criterion.
2	Comparable Consultant Levels with the region	25	It is important that local people have access to an equitable service compared to the rest of NI. The Regional Medical Workforce Review in 2017 highlighted the fact that the SHSCT had the lowest number of funded consultant posts per 250,000 population.
3	Capacity for Specialist Consultations	20	Hospital inpatients can often require a specialist consultation from a physician with expertise in respiratory medicine, gastroenterology or endocrinology. Access to such expertise can support early diagnosis and treatment.
4	Support to Ward Rounds	15	Twice daily consultant ward rounds are undertaken within acute medicine at CAH. Senior medical presence on the wards is also required to support the ward rounds and follow up on agreed care plans.
5	KPI Performance	10	The Trust currently performs well when compared to other Trusts in terms of bed occupancy, throughput, average length of spell and turnover interval. It is essential that the preferred option supports the continuation of this good performance.

For each criterion, the options were rated on a score between 0 and 10, with 0 meaning that the option did not meet the criterion at all and 10 indicating that the option fully met the criterion. The weighted scores were calculated by multiplying the weight by the score. The weighted scores were then totaled for each of the options. The results of the exercise are given in the table overleaf.

			1 Base case		**2** 5 Consultant Posts		**3** 5 Consultants + 3 Specialty Doctors	
	Criterion	**Weight**	Score	Score x Weight	Score	Score x Weight	Score	Score x Weight
1	Compliance with RCP Guidelines	30	5	150	6	180	6	180
2	Comparable Consultant Levels with Region	25	5	125	8	200	8	200
3	Capacity for Specialist Consults	20	2	40	2	40	5	100
4	Support to Ward Rounds	15	7	105	7	105	10	150
5	KPI Performance	10	5	50	7	70	9	90
	Totals	**100**		**470**		**595**		**720**
RANKING				**3**		**2**		**1**

Benefit	**Option 1** Status Quo	**Option 2** 5 Consultant Posts	**Option 3** 5 Consultants + 3 Specialty Doctors
Compliance with RCP Guidelines	RCP guidelines indicate that the SHSCT should have 31.01 consultants across acute medicine, gastroenterology, respiratory medicine and endocrinology for the resident population, indicating a deficit of some 12 consultants.	Options 2 and 3 will both facilitate an increase in funded consultant posts of 5 to 24, reducing the deficit to 7 consultant posts. Options 2 and 3 have therefore been awarded a higher score of 6.	Options 2 and 3 will both facilitate an increase in funded consultant posts of 5 to 24, reducing the deficit to 7 consultant posts. Options 2 and 3 have therefore been awarded a higher score of 6.
Comparable Consultant Levels with Region	The Trust is currently funded for 12.59 posts per 250,000 population across acute medicine, gastroenterology, respiratory medicine and endocrinology. This is the lowest funded level in NI, the range being 12.59 – 38.06	Options 2 and 3 both involve appointing an additional 5 consultants increasing the funded posts per 250,000 population from 12.59 to 15.90 across the 4 specialties. Excluding Belfast Trust from the analysis this increases the score for options 2 and 3 from a baseline of 5 to 8.	Options 2 and 3 both involve appointing an additional 5 consultants increasing the funded posts per 250,000 population from 12.59 to 15.90 across the 4 specialties. Excluding Belfast Trust from the analysis this increases the score for options 2 and 3 from a baseline of 5 to 8.
Capacity for Specialist Consults	There are currently 2 specialty doctors working in the acute medical model, 1 in gastroenterology and a second in respiratory medicine, who are available to undertake specialist ward consultations.	There would be no change to the current specialty doctor capacity for specialist ward consultations with option 2.	As option 3 includes 3 new specialty doctor posts (one each in respiratory medicine, gastroenterology and endocrinology) there would be significantly more capacity for ward consultations. This option has therefore been given a higher score of 5, compared to 2 for the other 2 options.
Support to Ward Rounds	There are currently 7 funded specialty doctor/associate specialist posts, including 5 in acute medicine. These doctors are on the wards, supporting the twice daily consultant ward rounds, following up on care plans and dealing with medical	There would be no change to the current specialty doctor/associate specialist capacity. Option 2 has therefore been awarded the same score as option 1 (7 points).	Option 3 would increase the specialty doctor/associate specialist funded posts from 7 to 10, significantly increasing the capacity to support the consultant ward rounds, follow up on care plans and deal with medical issues on the

Benefit	Option 1 Status Quo	Option 2 5 Consultant Posts	Option 3 5 Consultants + 3 Specialty Doctors
	issues as they arise.		wards as they arise. It has therefore been given a higher score of 10.
KPI Performance	The Trust currently performs well when compared to other Trusts in terms of bed occupancy, throughput, average length of spell and turnover interval across the acute programme of care and also for general medicine. However, with the increasing volume of activity this will become more difficult to sustain.	Option 2 will support the Trust to sustain its current good performance in terms of inpatient KPIs. It scores more than the status quo but less than option 3 as option 3 provides a more robust model with additional cover and specialist medical support.	Option 3 achieves the highest score of the 3 options as it provides the most robust model with additional cover and specialist medical support and is the most likely of the 3 to deliver the current good performance.

SECTION 6: ASSESS RISKS AND UNCERTAINTIES

Risk Description	Likely impact of Risk H/M/L			State how the options compare and identify relevant risk management / mitigation measures
	Opt 1	Opt 2	Opt 3	
1. **Inability to appoint consultants**	N/A	M	M	This risk applies to options 2 and 3. The Trust proposes a high profile recruitment drive which will include recruitment for existing vacancies. We believe that this will demonstrate to potential applicants that there will be a robust and well supported acute medical model in place. If it were not possible to appoint permanently to all posts in the first instance, then the Trust would seek to recruit locums as an interim measure.
2. **Inability to appoint specialty doctors**	N/A	N/A	M	This risk applies to option 3. The Trust would make every effort to appoint permanent doctors. If it were not possible to appoint permanently to all posts in the first instance, then the Trust would seek to recruit locums as an interim measure.
Overall Risk (H/M/L):	N/A	M	M	

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

The Status Quo would not deliver any of the identified benefits and does not align with the project objectives. It has therefore been discounted.

Option 2 will partially achieve the objectives and deliver some of the identified benefits.

- It will achieve improved compliance with the RCP guidelines increasing the funded consultant posts by 5 to 24, and reducing the deficit to 7 consultant posts;
- It will increase the funded consultant posts per 250,000 population from 12.59 to 15.90 across the 4 specialties of acute medicine, gastroenterology, respiratory medicine and endocrinology. This will improve the Trust's position within the region, albeit there will still be a deficit compared to the South Eastern, Western and Belfast Trusts;
- The current good performance in terms of inpatient KPIs is likely to be sustained.

Option 2 will not improve on the current specialty doctor support for ward rounds and day to day senior cover on the wards. In addition there will be no further capacity provided for specialist ward consultations.

Option 3 achieved the highest score in the non-financial appraisal, scoring 720 compared to a score of 595 for option 2. In addition to the benefits that will be produced by option 2, option 3 will also provide an additional 3 specialty doctors, increasing the support for ward rounds and enhancing the day to day senior cover on the wards. There will also be further capacity for specialist ward consultations.

Both options 2 and 3 have an overall risk rating of 3 which relates to the ability to appoint staff. However, as noted, locum staff may be appointed as an interim measure.

Option 3 Increase Number of Consultant Physician Posts by 5 and Specialty Doctor Posts by 3 has therefore been identified as the preferred option.

SECTION 8: ASSESS AFFORDABILITY AND FUNDING ARRANGEMENTS

AFFORDABILITY STATEMENT	2018/19 Year 0 £000's	2019/20 Year 1 £000's	2020/21 Year 2 £000's	2021/22 Year 3 £000's	Totals £000's
Required					
Capital required	0.0	0.0	0.0	0.0	0.0
Revenue required	53,846.2	55,418.2	56,249.5	57,093.2	222,607.1
Existing budget :					
Capital	0.0	0.0	0.0	0.0	0.0
Revenue	53,594.2	54,398.1	55,214.1	56,042.3	219,248.7
Additional Allocation Required:					
Capital	0.0	0.0	0.0	0.0	0.0
Revenue	252.0	1,020.1	1,035.4	1,050.9	3,358.4

Affordability Narrative

Finance Assumptions:

1. Year 0 is 2017/18 Financial Year.
2. Baseline costs refer to the 2017/18 recurring revenue budget under the AD for MUSC within the Acute directorate of SHSCT.
3. The posts identified for Option 3 were costed as per HSCB - General Costings - 2017/18.
4. A three month impact is assumed in Year 0 (2017/18).
5. Revenue costs uplifted by 1.5% from 2018/19 annually within section 8 only for inflation
6. No capital costs are identified in this case.
7. Please note all figures above have been rounded to thousands and shown to one decimal point.

SECTION 9: PROJECT MANAGEMENT (Please see Benefits Realisation Plan in Annex B)

It is proposed to implement the organisation and management of this scheme in accordance with the requirements of the Department of Finance and Personnel guidance relating to successful project management.

The following key roles have been identified:

- Project Owner – Anne McVey, Assistant Director of Medicine and Unscheduled Care
- Project Managers – Kay Carroll/Louise Devlin, Heads of Service, Medicine and Unscheduled Care

A review of the project in relation to the stated objectives will be undertaken 12 months after full implementation.

SECTION 10: MONITORING AND EVALUATION

Who will manage the implementation? (please provide the name of the responsible individual where possible)	• Kay Carroll/Louise Devlin, Heads of Service, Medicine and Unscheduled Care
Who will monitor and evaluate the outcomes? (please provide the name of the responsible individual where possible)	• Acute Head of Service (independent to the project) will undertake post project evaluation
What other factors will be monitored and evaluated?	• Appointment and commencement of staff • Measurable targets as specified in the Benefits Realisation Plan (Appendix 1)
When will this take place? (preferably 4 to 12 months after project closure)	• During the implementation phase for recruitment and enhancement of the service model. • A Post Project Evaluation will be undertaken 12 months after implementation.

SECTION 11: ACTIVITY OUTCOMES (TRUSTS ONLY)

Not applicable – this IPT focuses on the safe and effective treatment of non-elective patients.

Appendix 1 - Benefit Profile

Signed off by:	Date:

Benefit Owner	Benefit	Baseline value	Target Value	Measurement	Timing	Responsibility
AD Medicine & Unscheduled Care	Compliance with RCP Guidelines	**Specialty** / **SHSCT Funded Posts**: Acute Medicine 4.00; Gastro. 6.00; Respiratory 5.00; Endocrinology 4.00	**Specialty** / **Target**: Acute Med. 4.00; Gastro 8.00; Respiratory 7.00; Endocrinology 5.00	Number of consultants funded & number in post	2018/19	Project Manager
AD Medicine & Unscheduled Care	Comparable Consultant Levels with Region	12.59 per 250,000 population across acute medicine, gastroenterology, respiratory medicine and endocrinology.	15.90 per 250,000 population	Number of consultants per 250,000 population	2018/19	Project Manager
AD Medicine & Unscheduled Care	Capacity for Specialist Consults	Two specialty doctors (1 in gastroenterology and 1 in respiratory) are available to undertake specialist ward consultations in CAH.	Five specialty doctors on CAH wards (gastroenterology, respiratory medicine and endocrinology)	Number of specialty doctors	2018/19	Project Manager
AD Medicine & Unscheduled Care	Support to Ward Rounds	**Specialty** / **SHSCT Funded Posts**: Acute Medicine 4.00; Gastro. 6.00; Respiratory 5.00; Endocrinology 4.00	**Specialty** / **Target**: Acute Med. 4.00; Gastro 8.00; Respiratory 7.00; Endocrinology 5.00	Number of specialty doctors (including acute medicine)	2018/19	Project Manager

AD Medicine & Unscheduled Care	KPI Performance	**KPI** |	**KPI** |	KPI performance	2018/19 & 2019/20	Project Manager
		% Occupancy | 95.2%	% Occupancy | 95.2%			
		Throughput | 63.2	Throughput | 63.2			
		Average LOS | 5.5	Average LOS | 5.5			
		Turnover Interval | 0.3	Turnover Interval | 0.3			

Summary Costing schedule for Investment Decision Making Templates	Ref Number
Provider	SOUTHERN
Hospital Site or Community development	CRAIGAVON
Scheme Title	Demography 2017/18 - Acute Consultant Physician & Specialty Doctor Posts IPT (Demography Funding) v0.1
Pay and Price Levels	2017/18

Commissioner Use only

Sign and Date for TRAFFACS update

		Base Case - option 1				Option 2				Option 3				Option 4			
Pay Costs	Description	months claimed	wte	fye	cye	months claimed	wte	fye	cye	months claimed	wte	fye	cye	months claimed	wte	fye	cye
	BASELINE -			53,594,178	53,594,178			53,594,178	53,594,178			53,594,178	53,594,178				0
BAND 1					0				0				0				0
BAND 2					0				0				0				0
BAND 2					0				0				0				0
BAND 3					0				0				0				0
BAND 4	Personal Secretary				0	3.00	2.50	68,013	17,003	3.00	2.50	68,013	17,003				0
BAND 5					0				0				0				0
Non-AFC posts please detail below																	
Consultant	Respiratory				0	3.00	2.00	244,244	61,351	3.00	2.00	244,244	61,351				0
Consultant	Gastroenterology				0	3.00	2.00	258,086	64,812	3.00	2.00	258,086	64,812				0
Consultant	Endocrinology/Diabetology				0	3.00	1.00	127,987	32,147	3.00	1.00	127,987	32,147				0
Specialty Doctor	Respiratory				0			0	0	3.00	1.00	73,907	18,477				0
Specialty Doctor	Gastroenterology				0			0	0	3.00	1.00	73,907	18,477				0
Specialty Doctor	Endocrinology/Diabetology				0			0	0	3.00	1.00	73,907	18,477				0
Consultant Dermatologist (No On-Call) 10.21 APA					0			0	0			0	0				0
Allowances for posts noted above - please detail below																	
Unsocial Hours/Travel Allowance																	0
Excess Travel	Consultant					3.00		10,000	2,500	3.00		10,000	2,500				
Excess Travel	Specialty Doctor					0.00		0	0	3.00		6,000	1,500				
									0				0				
						12.00			0	12.00			0				
G&S Costs associated with the above posts																	
Employee Related G&S @ 10% as per HSCB Costing Schedule																	
Consultant	Respiratory					3.00		18,538	4,635	3.00		18,538	4,635				
Consultant	Gastroenterology					3.00		18,538	4,635	3.00		18,538	4,635				
Consultant	Endocrinology/Diabetology					3.00		9,269	2,317	3.00		9,269	2,317				
Specialty Doctor	Respiratory							0	0	3.00		5,745	1,436				
Specialty Doctor	Gastroenterology							0	0	3.00		5,745	1,436				
Specialty Doctor	Endocrinology/Diabetology							0	0	3.00		5,745	1,436				
BAND 4	Personal Secretary					3.00		5,423	1,356	3.00		5,423	1,356				
									0				0				
Exceptional Recruitment and Retention costs for posts above the mean plus x% (please provide detail)																	
					0				0				0				0
					0				0				0				0
TOTAL PAY COSTS			**0.00**	***53,594,178***	***53,594,178***		**7.50**	***54,354,275***	***53,784,932***		**10.50**	***54,599,231***	***53,846,171***		**0.00**	**0**	**0**
Non-Pay Costs - please detail below																	
					0				0				0				0
									0				0				
OTHER GOODS & SERVICES																	
					0				0				0				0
									0				0				
					0				0				0				0
					0				0				0				0
TOTAL NON-PAY COSTS				**0**	**0**			**0**	**0**			**0**	**0**			**0**	**0**
GRAND TOTAL				***53,594,178***	***53,594,178***		7.5	***54,354,275***	***53,784,932***		10.50	***54,599,231***	***53,846,171***			**0**	**0**
								760,097	190,754	1,005,000	53	1,005,053	251,993				

Phasing/Timescale	(Can development be phased, if so provide details in this box)	(Can development be phased, if so provide details in this box)	(Can development be phased, if so provide details in this box)	(Can development be phased, if so provide details in this box)
PROGRAMME OF CARE	acute	acute	acute	
SUB-SPECIALTY INFORMATION eg inpatients, outpatients, daycases if				
LCG	Southern	Southern	Southern	
If more than one LCG in option above please give details				
LGD				
If more than one LGD in option above please give details				

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a confidential meeting of Trust Board held on Thursday, 30th March 2017 at 9.15 a.m. in the Boardroom, Trust Headquarters

PRESENT

Mrs R Brownlee, Chair
Mr S McNally, Acting Chief Executive
Ms G Donaghy Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Ms E Mullan, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mrs A McVeigh, Director of Older People and Primary Care Services/Interim Executive Director of Nursing
Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work
Ms H O'Neill, Acting Director of Finance and Procurement
Dr R Wright, Medical Director

IN ATTENDANCE

Mrs A Magwood, Director of Performance and Reform
Mr B McMurray, Acting Director of Mental Health and Disability Services
Mrs A McVey, Assistant Director of Medicine and Unscheduled Care *(for Mrs E Gishkori)*
Mrs V Toal, Director of Human Resources and Organisational Development
Dr G Hampton, Clinical Director, ED (item 4i)
Ms C Stoops, Assistant Director of Corporate Planning (item 4i)
Mrs L Gordon, Head of Equality Assurance Unit (item 4i)
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

Apologies were recorded from Mr F Rice, Interim Chief Executive and Mrs E Gishkori, Director of Acute Services.

1. **CHAIR'S WELCOME**

Mrs Brownlee welcomed everyone to the meeting.

The Chair reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/IPads are to be used for accessing Trust Board papers only during the meeting.

2. **DECLARATION OF INTERESTS**

Mrs Brownlee requested members to declare any potential conflicts of interest in relation to any matters on the agenda. None were declared.

3. **MINUTES OF PREVIOUS MEETING**

The Minutes of the meetings held on 27th January 2017 and 14th March 2017 were agreed as accurate records.

4. **MATTERS ARISING FROM PREVIOUS MEETINGS**

i) **ED DHH**

Mr McNally advised of his letter to Mrs V Watts, HSCB, in relation to ED DHH and the response from Mr J Johnston, HSCB, accepting the position set out in Mr McNally's letter. Mr McNally outlined subsequent telephone conversations with Mr D Sullivan, HSCB, on the availability of region wide support to sustain the service. Whilst accepting Mr D Sullivan has made some progress, Mr McNally stated that this is still short of what would be required to have absolute confidence in securing senior medical cover overnight on a sustained basis. Mr McNally stated that the current position is that that the Trust will allow a further two week period for the HSCB process to progress. Therefore the approval to proceed to develop a public consultation plan will not be sought from Trust Board at this time.

Members noted the content of a presention on ED DHH. Dr Wright began by outlining the 3 main reasons for concern:- i) Recruitment and Retention of Medical Staff; ii) Training and Supervision; and iii) increased demand and Intensity of Workload.

The Chair invited Ms Charlene Stoops, Assistant Director of Corporate Planning to speak on the appraisal of options. Ms Stoops explained that the Trust has established a project team and agreed 4 benefit criteria. Of 3 short-listed options, the preferred option is to close DHH ED 8pm – 8am.

Members discussed the analysis of attendances and analysis of patient need to DHH ED. The Chair referred to the preferred option and in terms of actions required, asked how the Trust would deal with capacity to meet demand in CAH. Mrs Toal advised that an exercise has been undertaken to inform and develop potential Estates solutions to increase capacity at CAH and she outlined potential solutions.

Members noted the process for public consultation outlined in the Presentation and Mrs Gordon outlined the Equality and Human Rights considerations. Mr McNally clarified that with the agreement to allow the HSCB a further two weeks to complete their process, the process for public consultation will not now commence.

Members commented on the draft press statement. Mrs Rogers agreed to amend in light of members' comments.

Members welcomed the detailed presentation and the work by Trust staff on this matter to date.

ii) **Waiting List Initiatives**

Mr McNally and Dr Wright spoke of structured meetings with Radiologists to ensure there is a robust system going forward for WLIs. Mrs McCartan noted that the Internal Audit report of WLI payments made 11 recommendations and stated the seriousness of the situation that from a Trust perspective if the accounts are qualified on the grounds of irregularity. Mr McDonald concurred with Mrs McCartan's comments and emphasized the importance of a

detailed action plan to ensure a strengthening of controls in the current system . Mr McNally stated that work on the Trust action plan was almost complete. Mr McNally concluded the discussion by advising that the Trust has not yet had a response to its application to the Department of Health for approval of write off.

iii) **Endoscopy Decontamination Incident**

Members discussed the action plan and were assured by Dr Wright that there was no harm to patients as a result of this incident.

5. PROGRESS UPDATES

i) Personal Information redacted by the USI

Mr McMurray advised that the application for leave for Judicial Review is scheduled for Court on 5th April 2017. He also advised that the Trust has received a detailed letter from the Nursing and Midwifery Council in relation to the case review of Personal Information redacted by the USI

ii) Personal Informati on redacted

Mr McMurray verbally updated members on the current position. He advised that the gentleman remains in Personal Information redacted by the USI and the Trust is attempting to procure a bespoke care package which is likely to be at a significant cost.

6. COMPLAINTS HANDLING – A GUIDE TO PRINCIPLES AND PROCESS

Mr McNally spoke to the above-named paper which sets out the process for complaints handling within the Trust. He stated that this is to be read in conjunction with the Trust Policy for the Management of Complaints and has been agreed by SMT to ensure that complaints are dealt with fairly, equitably and in a transparent manner.

The Chair acknowledged and accepted the complaints process, however, she stated that when she receives a complaint or informal enquiry into her office, she feels strongly that as a point of good practice, she should at least acknowledge receipt of these. She also stated that she forwards such correspondence to the Chief Executive and relevant Director for follow up and response . Members acknowledged the need for a centralised, co-ordinated approach to complaints handling and agreed further work was required to address the view expressed by the Chair.

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a confidential meeting of Trust Board held on Thursday, 25th May 2017 at 9.30 a.m. in the Boardroom, Trust Headquarters

PRESENT

Mrs R Brownlee, Chair
Mr S McNally, Acting Chief Executive
Ms G Donaghy Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Ms E Mullan, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mrs A McVeigh, Director of Older People and Primary Care Services/Interim Executive Director of Nursing
Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work
Ms H O'Neill, Acting Director of Finance and Procurement

IN ATTENDANCE

Mrs A Magwood, Director of Performance and Reform
Mr B McMurray, Acting Director of Mental Health and Disability Services
Mrs E Gishkori, Director of Acute Services
Mrs V Toal, Director of Human Resources and Organisational Development
Mr S Gibson, Assistant Director, Medical Directorate *(for Dr Wright)*
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

Apologies were recorded from Mr M McDonald, Non Executive Director, Mr F Rice, Interim Chief Executive and Dr R Wright, Medical Director.

1. **CHAIR'S WELCOME**

The Chair welcomed everyone to the meeting.

The Chair reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/IPads are to be used for accessing Trust Board papers only during the meeting.

2. **DECLARATION OF INTERESTS**

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. None were declared.

3. **MINUTES OF PREVIOUS MEETING**

The Minutes of the meeting held on 30th March 2017 were agreed as an accurate record.

4. **MATTERS ARISING FROM PREVIOUS MEETINGS**

There were no matters arising.

5. **PROGRESS UPDATES**

i) Personal Information redacted by the USI

Mr McMurray advised that the application for leave to apply for Judicial Review was withdrawn by the Home Owners and dismissed by consent in Court on 5th April 2017. The Judge directed that the dispute over the matter of the Trust's costs would be heard on 15th May 2017 and on 15th May, the Judge decided against making an order for costs. Mr McMurray referred to the recent extensive Personal Information redacted by the USI coverage of the Home Owners based on legal documents that were recently made public.

In relation to the NMC referral relating to Personal Information redacted by the USI Mr McMurray stated that the Trust was advised on 7th April 2017 that the Panel of the Investigating Committee has referred the matter to the Conduct and Competence Committee who will meet to decide whether the

allegation will be considered at a private or public hearing. The NMC will write to the Trust to advise of their decision.

The issue of engagement with the Home Owners was discussed, in which it was agreed that an offer to meet, would be made by the Trust in the spirit of trying to move forward.

RQIA inspections to these two homes was raised and Mr McMurray agreed to clarify what inspections RQIA have undertaken for the next meeting.

Action: Mr McMurray

ii) Personal Information redacted

Mr McMurray advised that there was no further update as the gentleman remains in Personal Information redacted by the USI. The Trust is attempting to procure a bespoke care package, which is likely to be at a significant cost.

6. **ED DHH**

Mr McNally spoke of the concerted support from across the Health and Social Care system to develop a viable plan that will address the immediate pressures and look to stabilise the provision of emergency services at Daisy Hill. Detailed discussions are continuing with colleagues in other Trusts and these are progressing positively. Following the recent summit convened by the Department of Health, the Trust is fully engaged with HSC stakeholder organisations to pursue actions to stabilise and sustain the ED service – in particular a Daisy Hill Hospital Pathfinder Group has been tasked to produce an acute and emergency care implementation plan by September 2017.

Members noted that ED services at DHH are secured for next 15 - 18 months and queried the ability to deliver the programme of work within this timeframe. Mr McNally acknowledged this constraint as well as the ability to ensure meaningful engagement within the time available. External expertise for this project is required which Dr McBride is pursuing. Mr McNally advised that he had been informed that in the next 18 months, it is expected that 15 new ED

Consultants will qualify and it is hoped this Trust will be able to attract a proportion of these.

7. **UPDATE ON DRAFT YEAR-END POSITION**

Ms O'Neill reported on the draft year end position. She advised that the Trust is reporting a break even position with a year end surplus of £91k (total Revenue Resource Limit of £600m). External Audit continue to work through the accounts.

Ms O'Neill highlighted that in terms of the prompt payment performance indicator, the Trust's performance has marginally reduced against the 30 day target. She assured members that the Trust continues to work with BSO payment Shared Services and internally within the Trust to improve compliance with reports to Directors, highlighting overdue invoices by approver. Ms O'Neill also highlighted the positive growth in WTEs (Whole Time Equivalents), an increase of approximately 250 WTEs.

Following discussion, it was agreed that the Chair of the E&G Committee would be invited to attend the Audit Committee meeting when the draft Trust Funds accounts were being presented.

8. **UPDATE ON** Irrelevant information redacted by the USI

Mrs McVeigh advised of a safeguarding referral made on 14th April 2017 in respect of an Irrelevant information redacted by the USI who was admitted to Craigavon Area Hospital following an alleged incident in which he sustained a number of injuries. Irrelevant information redacted by the USI The PSNI investigation continues. Mrs McVeigh stated that the resident has now made a good recovery and is now resident in a different care home where he has settled well. The Trust's Care Home Support Team is very involved and there is a high level of satisfaction with the care provided at this home. The SAI review is being progressed.

9. Personal Information redacted by the USI

Mr Morgan referred to the recent media coverage regarding the conviction of two individuals and their involvement Personal Information redacted by the USI

[redacted]. Mr Morgan stated that on the back of this case, a critical look back exercise was underway within his Directorate in terms of the Trust's involvement and to identify any learning. Mr McMurray stated that a similar exercise was underway in Learning Disability. Mr Morgan is preparing a report which he agreed to share with the Chair and Chief Executive in the first instance and the HSCB.

10. BCBV CORPORATE DASHBOARD

Members discussed the dashboard at year-end for 2016/17.

Mrs Magwood explained that this highlights the scale of achievement mainly resulting from non-recurrent savings in year. In response to a question from Mr Wilkinson on service user impact, he was advised that the projects have minimal, if any, impact on service users. The Chair asked about Dementia Services to which Mr McMurray explained that a number of work streams have been identified to look at how services should be shaped to meet the regional Dementia pathway. He spoke of the challenge in meeting the needs of those under 65 who are diagnosed with Dementia given there is no commissioned service. The Chair asked that the patient's experience aspect of early onset Dementia be brought to a future Trust Board meeting.

Action – Mr McMurray / Mrs McVeigh

Members requested that more detail be provided in the next report to Trust Board.

11. HEAD OF INTERNAL AUDIT ANNUAL REPORT

Ms O'Neill stated that this report is presented annually to the Audit Committee and was presented at the recent meeting on 4th May 2017. There were 12 limited assurance reports and Ms O'Neill explained that Directors attend the Audit Committee to update on actions to take forward recommendations. 74% of Priority 1 and 2 recommendations were fully implemented at year end, a further 20% were partially implemented and 6% have not yet been implemented.

12. **CYBER SECURITY ISSUE**

Mrs Magwood spoke of the well-publicised significant Cyber-attack launched on the 12th May that affected over 50 NHS organisations and including parts of the HSE in Ireland. She stated that to date, the HSCNI has not been affected by this particular attack and it would appear on analysis that the Cyber-attack was stopped by the HSCNI firewalls. However, every organisation is vulnerable to Cyber-attacks and the Trust continues to work with the region in taking forward additional actions to improve IT security.

Mrs Magwood outlined a number of immediate actions that have been taken in the Southern Trust to attempt to mitigate the risk of this Cyber-attack. Mrs Magwood agree to circulate a short briefing paper on this issue. Members noted that Cyber security will be an item on the Governance Committee agenda going forward.

13. **ANY OTHER BUSINESS**

i) **SAI**

Mr Morgan reported on the recent tragic death of a young female in [redacted]. He advised that support has been provided to the family and a SAI investigation is underway.

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a confidential meeting of Trust Board held on Thursday, 8th June 2017 at 9.30 a.m. in the Boardroom, Trust Headquarters

PRESENT

Mrs R Brownlee, Chair
Mr S McNally, Acting Chief Executive
Ms G Donaghy Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non Executive Director
Ms E Mullan, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mrs A McVeigh, Director of Older People and Primary Care Services/Interim Executive Director of Nursing
Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work
Ms H O'Neill, Acting Director of Finance and Procurement
Dr R Wright, Medical Director.

IN ATTENDANCE

Mrs A Magwood, Director of Performance and Reform
Mr B McMurray, Acting Director of Mental Health and Disability Services
Mrs E Gishkori, Director of Acute Services
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

Apologies were recorded from Mr F Rice, Interim Chief Executive and Mrs P Leeson, Non-Executive Director

1. CHAIR'S WELCOME

The Chair welcomed everyone to the meeting. At the outset, the Chair advised that Dr Wright would be leaving the meeting mid-morning to attend the funeral of Professor Johnston, an outstanding academic and leader in the Province. On behalf of the Trust Board, the Chair expressed deepest sympathy to Professor Johnston's family at this sad time.

The Chair reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/IPads are to be used for accessing Trust Board papers only during the meeting.

2. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. None were declared.

3. PROGRESS UPDATES

i) Personal Information redacted by the USI

Further to a query at the previous meeting, Mr McMurray clarified that RQIA have completed regular reviews of care and estates in both Personal Information redacted by the USI. However, these inspections did not scrutinise any of the financial procedures or practice in both homes. He advised that RQIA have never repeated a financial audit of the homes procedures since 2011 and have deferred this responsibility as a contractual management issue for the Trust to manage and take forward. Mr McMurray confirmed that following the discussion at the previous Trust Board meeting, he has written to RQIA asking if they would consider undertaking a financial inspection of the homes and their response is awaited. Mr McMurray also confirmed that as agreed at the previous Trust Board meeting, he wrote again to Personal Information redacted by the USI requesting a meeting between the Trust and the Home Owners to resolve outstanding issues.

Mr McNally advised that the Chair and himself had discussed this matter with the Permanent Secretary at the Trust's recent End Year Accountability meeting. The Permanent Secretary agreed with the Trust's view that this matter needs to be brought to a conclusion. To that end, he agreed with the proposed approach that the Home Owners should be afforded one final opportunity to meet with the Trust. Mr McNally agreed that a letter would be sent to the Home Owners.

4. **EMERGENCY DEPARTMENT, DAISY HILL HOSPITAL**

Mr McNally advised that whilst there is commitment from across the Health and Social Care system to stabilize and sustain the ED service in DHH, the process for this has yet to be fully described. He spoke of the Pathfinder Project tasked with developing proposals to meet the acute unscheduled care needs of the Newry and Mourne population. Dr Wright stated that the current workforce position is stable with longer term locum staff secured and he welcomed the input from the region.

In discussion, members highlighted the importance of meaningful community engagement from the outset. Mr McNally spoke of the Project Initiation Document, which will set out the approach for the involvement of the local community. During discussion, members asked a number of questions about the proposed project structure, particularly the role of the Interim Chief Executive, the SMT and Trust Board. Mr McNally agreed to discuss these matters with Dr McBride.

Action – Mr McNally

5. **INQUESTS**

Dr Wright provided a verbal update on three recent Coroner's cases, as well as an upcoming case scheduled for Court on 12th June 2017.

Dr Wright spoke of the demands on staff attending Court. Members emphasised the need to ensure that staff attending Judicial Reviews and Coroner's Inquests are provided with the necessary support. Dr Wright spoke of the intention to set up an informal support network for enhanced support for Trust staff.

Dr Wright left the meeting at this point (10.35 a.m.)

6. FEEDBACK FROM END YEAR ACCOUNTABILITY MEETING

The Chair and Acting Chief Executive reported on a very positive meeting held on 30th May 2017 at which finance and performance were discussed. Also discussed was the role of Directors and Non-Executive Directors in terms of decision-making and the view was that Non-Executive Director input should be focused on corporate and strategic issues.

7. SAI LEVEL 3

Mr McMurray advised of a level 3 SAI investigation in relation to the murders in Personal Information redacted by the USI on Personal Information redacted by the USI Personal Information redacted by the USI.

8. ANY OTHER BUSINESS

i) **Retirements**

The Chair advised of the retirements of Mrs A McVeigh, Director of Older People and Primary Care Services/Interim Executive Director of Nursing and Mr B McMurray, Acting Director of Mental Health and Disability Services, both highly experienced professionals who will be a big loss to the Trust.

ii) Mrs Giskhori, on behalf of her mother, sister and herself thanked members for their support and generous donations following the death of her father.

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a confidential meeting of Trust Board held on Thursday, 31st August 2017 at 9.30 a.m. in the Boardroom, Trust Headquarters

PRESENT

Mrs R Brownlee, Chair
Mr F Rice, Interim Chief Executive
Mr S McNally, Acting Chief Executive
Ms G Donaghy, Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Ms E Mullan, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr J Wilkinson, Non-Executive Director.
Mrs A McVeigh, Director of Older People and Primary Care Services/Interim Executive Director of Nursing
Ms H O'Neill, Acting Director of Finance and Procurement
Dr R Wright, Medical Director

IN ATTENDANCE

Mrs E Gishkori, Director of Acute Services
Mrs A Magwood, Director of Performance and Reform
Mr B McMurray, Acting Director of Mental Health and Disability Services
Mrs V Toal, Director of Human Resources and Organisational Development
Ms F Leyden, Assistant Director for Social Work Governance, Workforce Development and Training (*for Mr P Morgan*)
Mrs J McKimm, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

Apologies were recorded from Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work.

1. **CHAIR'S WELCOME**

The Chair welcomed everyone to the meeting.

The Chair reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/IPads are to be used for accessing Trust Board papers only during the meeting.

2. **DECLARATION OF INTERESTS**

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. None were declared.

3. **MINUTES OF MEETINGS HELD ON 25TH MAY, 8TH JUNE AND 27TH JUNE 2017**

The minutes of the above meetings were agreed as accurate records.

4. **MATTERS ARISING**

Members reflected on the extraordinary Trust Board meeting held in public the previous week and provided some suggestions for improvement. It was agreed that useful information for those attending the meetings would be produced to include information on speaking rights. Rotation of meetings across venues in the Trust area to be kept under review.

In response to a question from Ms Donaghy on the consultation process for the Trust's draft savings plan 2017/18, Mr Rice advised that this was driven by the Department with responses to be provided in writing. He further advised that the Trust will be holding 3 public meetings as part of the consultation on its draft savings plan.

5. PROGRESS UPDATES

i) Personal Information redacted by the USI

Mr McMurray stated that there was little progress to report. The Home Owners have been afforded another opportunity to meet with the Trust and collectively seek a way forward, but no response has been received to date. The hearing of the NMC case relating to Personal Information redacted by the USI has been postponed to January 2018 and three members of staff have been asked to attend to provide evidence on behalf of the Trust.

Mr McMurray informed members that Case Managers have highlighted an ongoing situation whereby clients' monthly invoices for travel and staff supervision far exceeds their mobility award despite Personal Information redacted by the USI being requested to limit the journeys undertaken to the clients mobility amount. They are therefore allowing some clients to accrue debt in that regard. He stated that invoices submitted are reviewed and approved for payment minus any disputed amounts until such time as those disputed amounts are resolved.

Mr McMurray stated that the Trust has asked RQIA to advise when they will be completing a financial inspection in Personal Information redacted by the USI.

The Chair expressed concern at the length of time taken on this matter and she made reference to the Trust's repeated willingness to meet with the Home Owners to resolve outstanding issues of concern. The Chair also reminded members about the potential impact of the suspension of admissions on the Home Owners' business. It was agreed to invite Mrs Wendy Beggs, DLS, to a Trust Board meeting in the near future to discuss a way forward.

ii) **SAI Level 3**

Mr McMurray provided a verbal update on the level 3 SAI investigation involving a Personal Information redacted by the USI Personal Information redacted by the USI. He stated that this case is subject to a

Level 3 SAI review. The independent Chair of the Review team is not employed with the Trust and the Review team will include a senior independent ED practitioner/manager. Meetings of the review team have commenced and Mr McMurray referenced that this review is likely to take some time. The SAI review will run in parallel with the PSNI criminal investigation and the PSNI Ombudsman review of police involvement in this case [Personal Information redacted by the USI] [redacted].

iii) **Third Party payments for clients placed in Independent Sector Provider Homes**

Members noted the update on third party contributions and the potential impacts.

iv) **Bannview Medical Practice**

Mrs McVeigh reminded members that the Trust took over operational responsibility for this Medical Practice on 16th January 2017 and advised that feedback from the Practice population has been positive. The HSCB has confirmed that it would wish the Trust to continue to manage the Practice beyond September 2017. Mrs McVeigh spoke of the challenge to recruit salaried GPs with no applicants to a recent advertisement. The Trust is in discussions with the HSCB on GP's salary and recruitment with a view to re-advertising. Dr Wright advised that GPs are looking for a portfolio job with opportunities to work within other areas such as Acute Care at Home etc.

6. **STRUCTURES REVIEW**

Mr Rice advised that a review of the Trust's management structures was underway and the Senior Management Team would be taking time on 5th September 2017 for this purpose. The Chair highlighted the importance of Trust Board input and sharing of views in this review. Mr McDonald concurred with the Chair's comment and stated that from a Non Executive Director perspective it would be useful to have sight of all of the proposed options and the reasons for discounting them as opposed to being presented with a final model.

7. DRAFT HSC PERFORMANCE MANAGEMENT FRAMEWORK

Mrs Magwood advised that the Transformation Implementation Group had approved the draft HSC Performance Management Framework in June 2017 (subject to Ministerial approval). Mrs Magwood referred to the Departmental Policy Guidance Circular in members' papers which was subsequently issued to Trusts. This guidance identifies no need for a regional performance management role and instead a more direct/'sharper' accountability role for Trust Boards. The Chair stated that any specific training/development that Trust Board members require would be facilitated.

8. UPDATE ON DHH PATHFINDER PROJECT

The Chair welcomed Dr Telford, Project Director and Ms C Stoops, Project Manager to the meeting to update members on progress. At the outset, Dr Telford thanked all those who had assisted in the project to date. Dr Telford advised that a communications and engagement strategy has been produced as has a draft needs assessment which is currently interim. This has been approved by the SMT and submitted to the Department. Once finalised, this report will be shared with Trust Board members.

Dr Telford shared the key messages. Overall, the conclusion is that the needs assessment data supports the need to sustain a 24/7 ED in DHH. Dr Telford advised that the next phase of the project will be to develop proposals on how to do that as well as a focus on the clinical staffing issues and exploring opportunities of other and new ways of working.

Journey times and accessibility were raised to which Dr Telford stated that it should be noted that there is no definitive standard which indicates an appropriate drivetime to an ED. Mr McDonald asked that the travel time data is looked at in a relative sense and he suggested using the rural proofing concept in this work. Dr Telford suggested that it would be useful to have a presentation from Dr B Farrell, Chair, Needs Assessment Group, at the next Trust Board meeting. The Chair asked that Trust Board members have sight of the reports once the Department has responded.

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a confidential meeting of Trust Board held on Thursday, 28th September 2017 at 9.30 a.m. in Newry, Mourne and Down Council Chamber, Newry

PRESENT

Mrs R Brownlee, Chair
Mr F Rice, Interim Chief Executive
Ms G Donaghy, Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Ms E Mullan, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mr S McNally, Director of Finance and Procurement
Mrs A McVeigh, Director of Older People and Primary Care Services/Interim Executive Director of Nursing
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Dr R Wright, Medical Director

IN ATTENDANCE

Mrs A Magwood, Director of Performance and Reform
Mr B McMurray, Acting Director of Mental Health and Disability Services
Mrs V Toal, Director of Human Resources and Organisational Development
Dr T Boyce, Director of Pharmacy (*for Mrs Gishkori*)
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

Apologies were recorded from Mrs E Gishkori, Director of Acute Services.

1. **CHAIR'S WELCOME**

The Chair welcomed everyone to the meeting, particularly Mrs M McClements, recently appointed Interim Director of Older People and Primary Care and Dr T Boyce, Director of Pharmacy. The Chair stated that this was Mrs A McVeigh's last Trust Board meeting as she was retiring from the Trust at the end of September 2017 after almost 40 year's dedicated service. The Chair spoke of Mrs McVeigh's high personal and professional values and thanked her for the outstanding contribution she has made to health and social care over the years. On behalf of Board members, the Chair wished Mrs McVeigh a long and happy retirement.

The Chair reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/IPads are to be used for accessing Trust Board papers only during the meeting.

2. **DECLARATION OF INTERESTS**

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. None were declared.

3. **MINUTES OF MEETINGS HELD ON 17th AUGUST 2017 AND 31ST AUGUST 2017**

The minutes of the above meetings were agreed as accurate records.

4. **MATTERS ARISING**

There were no matters arising.

5. **PROGRESS UPDATES**

i) Personal Information redacted by the USI

Mr McMurray provided a verbal update. He reminded members that the Trust had written again to the Home Owners Solicitor affording them another opportunity to meet with the Trust and

collectively seek a way forward, but no response has been received to that invitation.

Mr McMurray informed members that the Trust had received a letter from the Home Owners' Solicitor the previous day requesting a significant amount of information to assist in their clients defence with NMC. The Trust will seek legal advice as regards a response.

Mr McMurray reported on a useful meeting between the Trust and the RQIA on 11th September 2017 in which RQIA's position regarding a financial inspection of Personal Information redacted by the was discussed. RQIA has asked the Trust to consider including Personal Information redacted by the in the rolling programme of financial audits undertaken by BSO Internal Audit. Members discussed this suggestion and it was agreed not to make a decision to engage Internal Audit until members had a full discussion with Mrs Wendy Beggs, DLS, on 26th October 2017.

6. DRAFT SAVINGS PLAN 2017/18

Mr Rice summarized the two public meetings held to date on the Trust's 2017/18 draft Savings Plan. A third public meeting is being held that afternoon in Armagh. In the main, comments received were related to Belfast Trust cost savings proposals on MS drugs, fertility treatments etc. and impact on patients across Trust boundaries. Mr Rice advised of the HSCB's intention to scope the impact of these cost savings proposals across Trusts. Mrs McVeigh advised of the high level of engagement from the Community Pharmacists in relation to the proposed non-operation of the community voucher scheme. Ms Mullan suggested that it would be useful to include a timeline to set out clearly the next steps following the Trust Board decision on 13th October 2017.

The Chair reiterated the Trust's requirement to breakeven and commended the strong leadership in the Trust to achieve a saving of £6.4m.

7. UPDATE ON DHH PATHFINDER PROJECT

The Chair welcomed Dr Telford, Project Director and Dr Farrell, Public Health Agency – Chair of Needs Assessment Group to the meeting. Members had received the draft Phase 1 report and the interim report of the Needs Assessment Group.

Dr Telford stated that the message from the needs assessment data underpins the value of having an ED in DHH 24/7. She explained that the interim report will be finalised when two further clinical audits are completed. These will provide more detailed clinical information which will assist the Pathfinder Group in planning the future model of unscheduled for the Newry and Mourne population. A working group looking at workforce issues which is chaired by Dr Wright, is expected to complete its work in October 2017.

Dr Farrell outlined the structure of the report – the place and the people; service utilisation; right care right place/clinical interfaces; accessibility and rapid review of evidence base re ED. Members discussed the key findings and asked a number of questions to which Dr Farrell responded. In relation to accessibility of services, Dr Farrell made the point that the timing of the start of appropriate treatment rather than arrival at hospital affects outcomes. To this end, there has to be a balance between access to ED services and overall quality of care. Dr Farrell went on to advise that the report identifies the challenge which would be presented in regards to travel times for the population should a 24/7 type 1 ED service not be available at DHH. Mrs McCartan noted that the % of people within a 60 minute drive would fall from 99.6% to 97.5% and asked how many people this would equate to. Dr Farrell advised approximately 40,000. Members also discussed the fact that from the age of 74 years onwards, more than half of attendances to ED result in admission.

In terms of the next steps, Mr McDonald asked if further analysis would look at the cost of staffing an ED against enhancing models of care in the community. Dr Wright made the point that both are required and will be at a cost.

SIGNED: _____

DATED: _____

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a confidential meeting of Trust Board held on Thursday, 25th January 2018 at 10.15 a.m. in the Boardroom, Trust HQ, Craigavon

PRESENT

Mrs R Brownlee, Chair
Mr S McNally, Acting Chief Executive
Ms G Donaghy, Non-Executive Director,
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Ms E Mullan, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Ms H O'Neill, Acting Director of Finance and Procurement
Dr R Wright, Medical Director
Mrs H Trouton, Interim Executive Director of Nursing and AHPs

IN ATTENDANCE

Mrs E Gishkori, Director of Acute Services
Mrs C Harney, Interim Director of Mental Health and Disability Services
Mrs A Magwood, Director of Performance and Reform
Mrs M McClements, Interim Director of Older People and Primary Care
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

Mr F Rice, Interim Chief Executive

1. **CHAIR'S WELCOME**

The Chair welcomed everyone to the meeting, particularly Mrs C Harney, Interim Director of Mental Health and Disability Services and Mrs H Trouton, Interim Executive Director of Nursing and AHPs.

The Chair reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/IPads are to be used for accessing Trust Board papers only during the meeting.

2. **DECLARATION OF INTERESTS**

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. None were declared.

3. **MINUTES OF PREVIOUS MEETING**

The Minutes of the meeting held on 30th November 2017 were agreed as an accurate record and duly signed by the Chair.

4. **UPDATE ON DHH PATHFINDER PROJECT**

Mr McNally gave a verbal update on the current position. He advised that the final report of the Daisy Hill Hospital Pathfinder Project was submitted to the Department of Health on 20th December 2017 and endorsed by the Emergency Care Regional Collaborative at its meeting on 5th January 2018 and by the Transformation Implementation Group (TIG) on 24th January 2018. Mr McNally further updated on the discussion at the TIG meeting and advised that the endorsement of the report by TIG would be brought to the Minister and/or the Department for approval.

Mr McNally stated that the Chief Medical Officer and Deputy Permanent Secretary visited Daisy Hill Hospital on 23rd January 2018 to meet the team and gain further insight and understanding of the Pathfinder implementation and investment plan and gave their recommendation to the TIG meeting on 24th January that they endorse the report. Both the Chair and Dr Wright spoke of the success of the

visit to Daisy Hill Hospital on 23rd January 2018 with very positive feedback received.

In response to a question from Mr McDonald on costs, McNally advised that the total additional cost of the service model is approximately £6m and he reminded members that the Trust has invested £1.9m of demography funding to support locum costs and the Trust will work to ensure that this is made available to DHH ED. Therefore, approval will be sought for remaining funding requirement of £4.1m to fund the overall service model.

Ms Mullan commended the progress achieved to date and commented that it was important not to lose the sense of momentum.

5. MATTERS ARISING

There were no matters arising.

Ms Mullan left the meeting at this point (10.45 a.m.)

6. PROGRESS UPDATES

i) Personal Information redacted by the USI

Mrs Harney spoke to the written update. She stated that of particular note was the fact that four residents were currently being assessed with respect to their need for Nursing Home placements rather than residential accommodation. Members discussed the fact that if the residents needs were assessed as being best suited to the Nursing Home environment, this would further pressurise the sustainability of both these homes. The Chair asked that the occupancy levels in both homes are included in future update reports to Trust Board. Mr McNally raised a query about new clients being placed in Personal Information redacted by the USI from another Trust. Mrs Harney undertook to clarify the position and also confirm with the Directorate of Legal Services if the Executive Director of Social Work should formally share with his regional counterparts the Trust's experience of Personal Information redacted by the USI.

7. **SAI UPDATE**

i) Personal Information redacted by the USI

Mrs Harney verbally updated on the incident involving the alleged assault of a patient by nursing staff in Personal Information redacted by the USI. She advised that the Court Hearing for Personal Information has been deferred to Personal Information redacted by the USI. Agreement has been secured for the Trust to proceed with its internal investigation and a Panel has been established. Mrs Harney further advised that Personal Information redacted's case is still with the PPS. The NMC process has been put in place for both staff members.

8. **UNSCHEDULED CARE PRESSURES – CHRISTMAS AND THE NEW YEAR PERIOD**

Mr McNally stated that this matter was set in the wider context of the Department's decision in mid October/early November 2017 that there were to be no cancellations of urgent and red flag referrals. Mr McNally reported that unfortunately the Trust had to postpone 222 elective cancellations, including 30 red flags over the Christmas and the New Year period and he provided detail of the 2 pressure points that led to the postponement of planned elective admissions over this period. Mrs Gishkori provided assurance that those patients categorized as red flag who did not have their surgery carried out as planned were rescheduled in and all have been seen by 24.1.2018. Mr McNally further advised that whilst SMT had reaffirmed its decision to protect capacity for red flag and urgent patients, the Trust was now aware that the onward communication of this decision was unclear, which has resulted in the unintended postponement of additional patients. Mr McNally accepted that a process for escalation is required and this requires further discussions internally.

The Chair expressed her disappointment that she was not aware of the cancellation of red flag referrals until immediately prior to the Trust's Accountability meeting on 10th January 2018 when the Permanent Secretary raised the issue and she apologised to Trust Board that they had also not been informed. She asked that an update be provided for the next meeting.

At the request of the Chair, Mr McNally, Ms O'Neill, Mrs Harney and Mrs Trouton left the meeting for item 9.

10. **ANY OTHER BUSINESS**

i) Trust's Mid Year Accountability meeting

The Chair reported on the above meeting held on 10th January 2018 when the Permanent Secretary had asked for an explanation on the cancellation of red flag referrals.

ii) Young People's Pledge

The Chair reminded members of the Board's commitment to the Pledge and advised that the next meeting with the young people will take place on 22nd February 2018 in The Acorns, Armagh. Timing to be confirmed.

SIGNED: _____

DATED: _____